NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

Wednesday, 16th October, 2019, 2.00 pm - Civic Centre, High Road, Wood Green, N22 8LE

Members: Please see attached list.

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. Although we ask members of the public recording, filming or reporting on the meeting not to include the public seating areas, members of the public attending the meeting should be aware that we cannot guarantee that they will not be filmed or recorded by others attending the meeting. 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 and using the public seating area, 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 14).

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, PETITIONS

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

7. MINUTES (PAGES 3 - 10)

To consider and agree the minutes of the meeting of the Board held on 12th June 2019.

8. GP PRACTICES IN HARINGEY

Verbal Update from Tony Hoolaghan (Managing Director – Haringey and Islington CCGs).

9. NORTH CENTRAL LONDON (NCL) LONG TERM PLAN (PAGES 11 - 44)

To note the NCL Long Term Plan update.

10. PROPOSED MERGER OF CCGS WITHIN NORTH CENTRAL LONDON (PAGES 45 - 118)

To note and discuss the proposed merger of CCGs within North Central London update.

11. AGEING WELL STRATEGY (PAGES 119 - 188)

This report asks the Board to endorse the Haringey Ageing Well Strategy 2019-2022.

12. CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) TRANSFORMATION UPDATE (PAGES 189 - 200)

To note Haringey's CAMHS Transformation Programme update, including the Trailblazer and School Links Programmes.

13. URGENT DECISION TAKEN BETWEEN MEETINGS : HARINGEY BETTER CARE FUND (BCF) PLAN (PAGES 201 - 264)

To approve the decision taken by the Chair on the Haringey Better Care Fund (BCF) Plan.

14. NEW ITEMS OF URGENT BUSINESS

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

15. FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS

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

The dates of future meetings are as follows:

12th February 2020

Ajda Ovat, Principal Committee Co-ordinator
Tel – 020 8489 1859
Fax – 020 8881 5218
Email: ajda2.ovat@haringey.gov.uk

Bernie Ryan
Assistant Director – Corporate Governance and Monitoring Officer
River Park House, 225 High Road, Wood Green, N22 8HQ

Tuesday, 08 October 2019

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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	*Leader of the Council	Cllr Joseph Ejiofor
			*Cabinet Member for Children and Families	Cllr Zena Brabazon
			*Cabinet Member for Adults and Health – Chair	Cllr Sarah James
	Officers' Representatives	4	Director of Adults and Health	Beverly Tarka
			Director of Children's Services	Ann Graham
			Interim Director for Public Health	Dr Will Maimaris
			Chief Executive	Zina Etheridge
NHS	Haringey Clinical Commissioning Group (CCG)	4	*Chair	Dr Peter Christian
			*Vice Chair	John Rohan
			Chief Officer	Tony Hoolaghan
			*Lay Member (confirmed as voting member by Full Council 23/02/15)	Cathy Herman
Patient and Service User Representative	Healthwatch Haringey	1	* Chair	Sharon Grant
Voluntary Sector Representative	Bridge Renewal Trust	1	Chief Executive	Geoffrey Ocen
Haringey Local Safeguarding Board		1	Interim Independent Chair	David Archibald

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MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON WEDNESDAY, 12TH JUNE, 2019, 2.00 - 4.00 pm

Present: Cllr Sarah James (Cabinet Member for Adults and Health – **Chair** – Voting Member), Cllr Zena Brabazon (Cabinet Member for Children, Education and Families – Voting Member), Tony Hoolaghan (Chief Officer CCG), Cathy Herman (Lay Member CCG – Voting Member), Peter Christian (Chair Haringey CCG) Sharon Grant (Chair Healthwatch Haringey – Voting Member), Will Maimaris (Interim Director for Public Health), Geoffrey Ocen (Chief Executive Bridge Renewal Trust), and David Archibald (Interim Independent Chair Haringey Local Safeguarding Board).

Officers: Zina Etheridge (Chief Executive of London Borough of Haringey), Beverly Tarka (Director of Adults and Health), Ann Graham (Director of Children's Services), Charlotte Pomery (Assistant Director of Commissioning), Rachel Lissauer (Director of Commissioning AND Integration– Haringey CCG), Steven Lawrence (Legal Advisor to the Board), Vikki Monk Meyer (Head of Integrated SEND),

Also present: Siobhan Harrington (Chief Executive of Whittington Health), Richard Gourlay- (Director of Strategic Development – NMUH), Samantha Rostom (Programme Director CYP, North Central London STP) and Richard Miller (BEH MHT).

50. FILMING AT MEETINGS

The Chair referred Members present to agenda item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'.

51. WELCOME AND INTRODUCTIONS

The Chair welcomed members of the Board and attendees to the meeting.

52. APOLOGIES

Apologies for absence were received from Cllr Ejiofor.

53. URGENT BUSINESS

There were no items of urgent business.

54. DECLARATIONS OF INTEREST

No declarations of interest were received.

55. QUESTIONS, DEPUTATIONS, PETITIONS

None.

56. MINUTES

The minutes of the meeting of the 19th February 2019 were agreed as a correct record.

57. NORTH CENTRAL LONDON SYSTEM-WIDE PAEDIATRIC ASTHMA PLAN

The Board received a report which outlined the approach being taken across Haringey to improving outcomes for children with asthma and how Haringey's plan contributed to, and was in line with, the NCL approach. The report was introduced by Samantha Rostrum, Programme Director CYP – NCL STP, as set out in the agenda pack at pages 11 – 15. The following was noted in discussion of the report:

a. The Board set out that more should be made of asthma as an equality issue, as it disproportionally affected children from poorer backgrounds and that the inequality aspect should be at the forefront of everyone's mind when tackling the issue. In response, it was acknowledged that people from deprived areas were 2.5 times more likely to attend hospital and be admitted and 3 times more likely to have poor quality housing..
b. The Board sought clarification around who was ultimately responsible for driving progress against the different strands that fed into asthma, such as housing. In response, the Board was advised that the there was a NCL Asthma Network Group which was responsible for coordinating this. The group had met the same day including individual leads from the 5 boroughs, to develop asthma plans at the local level. The Programme Director acknowledged the need for these plans to go beyond health and into a range of issues such as housing.
c. The Board expressed that the Haringey specific element of all of this needed to be developed a bit further, particularly in terms of how to get the clinical networks going locally. The Board also set out that the role of air quality and pollution needed to be better communicated to residents through the use of apps such as Air Visual.
d. The Board sought assurances about whether specific schools, who had high levels of asthma, had been engaged with and that this data was being cross referenced with other data sources for housing and air quality for example, to develop a robust analysis. In response, the Board was advised that a baseline analysis of schools has been undertaken and would form part of the asthma plan and that a robust evidence base was being developed which would include all of the different areas raised as part of this discussion.
e. The Board sought assurances about whether workshops had been set up with Environmental Health Officers, who would be licencing private sector accommodation, particularly in light of the whole-systems approach being adopted. In response, officers advised that these conversations had taken place at a strategic level but further work was needed to engage with officers on the frontline.
f. The Board endorsed the adoption of a whole-systems approach and commented that there needed to be a strategic forum within the Council, where corporate leads could be brought in to discuss issues such as air quality and asthma.

g. The Board requested some work be done to pull out some of the data and evidence from the North Tottenham Area project and that this could be used to shore up some of the responses raised here around the impact of health and housing inequalities. **(Action: Samantha Rostom).**
h. The Board also advocated that the benefits of being physically active should be put forward as part of this agenda and suggested promoting examples of sporting greats who had asthma to encourage people to be physically active. Officers acknowledged this and set out that the membership of the Board was reflected at the Network Board and that there was good engagement at a partnership level. Officers also set out that smoking cessation also played a key role into this agenda. **(Action: Samantha Rostom).**
i. In response to a question, the Board was advised that the outcomes from the asthma plan would be monitored through the Network Board. Officers agreed to share the development of the performance dashboard with the Board. **(Action: Charlotte Pomery).**

RESOLVED

That Haringey Health and Wellbeing Board:

I. Endorsed the approach being taken across Haringey to improving outcomes for children with asthma and their families and the strategic outcomes this work is seeking to deliver; and
II. Supported the development and delivery of complementary North Central London and local system-wide asthma plans, focused on those common strategic outcomes.

58. IDENTIFYING, MEETING NEEDS AND IMPROVING OUTCOMES IN A LOCAL AREA FOR CHILDREN WITH SPECIAL EDUCATIONAL NEEDS AND OR A DISABILITY

The Committee received a report, presentation and an appendix with a copy of the self-evaluation, on improving outcomes for children with Special Educational Needs (SEND) or a disability from Vikki Monk-Meyer, Head of Service Delivery SEND, as set out in the report pack at pages 33-74. The paper set out the scope of recent reforms, the response by partners in Haringey and the key next steps to continuing to improve outcomes for children and young people with special educational needs and or a disability. The following was noted in discussion of this item:

a. The Board raised concerns with weakness in the JSNA impacting on joint-commissioning. In response, officers acknowledged that the JSNA did not sufficiently reflect SEND needs. Officers added that there was a detailed piece of work underway to drill down on SEND issues within the JSNA. The Board suggested that this highlighted a further example of where there needed to be tighter strategic leadership. In reference to joint commissioning, officers advised that there was joint commissioning of speech and language therapy and on equipment but acknowledged that the strategic oversight could be improved.
b. In response to a question around what could be done to improve dissatisfaction from parents on education, health and care plans, officers advised that this was

primarily an issue about how the SEND team wrote plans and the need to ensure that training, advice and support was offered to staff in writing those plans.

c. In response to a question about the workings of the Joint Executive Committee and whether commissioners and providers were being brought closer together, officers advised that the Joint Exec had been set up in recognition of the need for strategic oversight of key issues across the partnership. There had been two meetings so far and these included representation of commissioners. It was anticipated that the group would grow and develop further in due course.
d. The Committee raised concerns with a lack of equalities comments in the report. In response, officers acknowledged that this was an oversight and commented that there was significant equalities data at a local level but this data needed to be drawn out from the JSNA at a borough-wide level. The Chair requested that the equalities section be added in to the report. **(Action: Will Maimaris).**
e. The Board asked officers to say a bit more around the support offered for the transition from childhood to adulthood. In response, officers set out that there were a number of areas of employment support being introduced such as offering supported internships in Haringey and work experience placements at the DWP. At a more local level, support was being offered around basic advice in terms of paying rent and accessing support services. Officers gave details about the Community First programme, which was a low level early intervention model and offered a one stop shop advice service.
f. The Board raised the link between youth violence and SEND and queried whether there was sufficient consideration given to the wider links involved when identifying people and undertaking early-years assessments.
g. The Chair raised concerns about the level of support for school exclusions and questioned whether there was an action plan in place. In response, the Chief Executive acknowledged these concerns and set out her concerns in relation to the length of time taken to diagnose conditions such as autism and ADHD, leading to long delays in those children getting the support they required.
h. The Chief Executive also set out the need for good tapered services to prevent people from falling through the gaps and the need for capacity building work to improve the drop off from childhood to adulthood. The Board also heard that following a high profile child protection case, the Council had brought in focused health visits for families with significant child protection risks, and that there was then a significant exercise to expand this. The Board considered that there was some lessons to be learned from this as a system. The Chief Executive set out the Government's decision to expand the age range of SEND services had introduced significant additional cost pressures to the Council and advocated the importance of having a place for the Council and partners to adequately track how much the additional costs were.
i. In response to the above points, officers acknowledged some of the concerns raised and highlighted the challenges faced in expanding age ranges for SEND whilst many other services still had a cut-off point of 18. Officers also highlighted the association between children that had poor speech and language skills at a young age and who were subsequently over-represented in the high needs block and later school exclusions.
j. The Cabinet Member for Children and Families highlighted the issue of 2 year old children not taking up free nursery care places and the need for the Board to get a better understanding of why some parents did not make use of this, given the significant improvements to speech and language skills involved. It was suggested

that of the 1200 eligible children in the borough only around 700-800 took up this offer, which was paid for by central government. The Cabinet Member advocated that, as part of a whole systems approach, the Board should be focusing on and improving provision for 2-3 year olds and chasing families to take up the offer of free nursery placements. In response, officers advised that a Huddle group had been established at children's centres to help families with SEND, who wouldn't ordinarily go to a children's centre, and give them access to a health visitor amongst other services. The programme also matched the family to a nursery placement and gave support to transition them in to that placement. There had been three sessions so far, each with 13 families attending and take up had been positive.

k. In response to concerns raised about the tension between inclusion and exclusion for older children and what additional support was being offered, officers advised that they were working with the college to encourage more entry level placements, such as a Level 1 Catering course that was now on offer. There were also 70 specially funded entry and foundation level places on offer, with another further 50 places which offered additional support needs. The Board were also advised that a new high needs provision at The Grove was being opened in September to provide additional support around exclusions.
l. The Chair requested that officers come back to the Board at a future date to provide a further update. **(Action: Vikki Monk Meyer).**

RESOLVED

That the Health and Wellbeing Board:

I. Endorsed the emphasis on partnership working needed to underpin the effective implementation of the SEND reforms;

II. Supported the new governance arrangements recently put in place through the SEND Board to ensure improved outcomes for children and young people; and

III. Agreed to receive an updated Self Evaluation Framework on an annual basis.

59. DEVELOPING LOCALITY-BASED CARE IN HARINGEY

The Board received a report for information and an accompanying presentation, which described the progress made with developing locality-based care in North Tottenham. The report was introduced by Beverley Tarka, Director of Adults and Health and the presentation was introduced by Charlotte Pomery AD Commissioning, as set out in the agenda pack at pages 75-88. The following was noted in response to the discussion:

a. The Board commented on the important role played by local area coordinators in successfully delivering these proposals.
b. The Board commented that the presentation gave the impression that specialist and emergency services, such as the district nurse community matron were outside of placed based care. The Board suggested that those resources needed to be seen as part of the place based model. Comments were also made around the need for the risk and issues log to reflect culture change across both providers as well as commissioners. Officers responded that the

logs were supposed to reflect both groups as well as accurately reflecting the situation on the ground and elsewhere.

c. In response to a question around whether there was a requirement to consult with end users on these proposals, the Board was advised that any changes to the location or the nature of provision would require consultation, but that proposals were not at that stage as yet. The Board was advised that the information contained in the presentation would provide useful evidence to the NHS if engagement work was required
d. The Board commented that some of the engagement work set out in the presentation was over reliant on technical or managerial terminology and some examples of how this would affect residents on the ground would be useful in terms of wider community engagement. In response, officers acknowledged thee concerns and highlighted the video produced around Community First as an example of how partners were looking to capture real life stories as part of consultation and engagement exercises.
e. The Chair requested that a further update on locality-based care be brought to the Board around the time of the workshop taking place. The update to also include some case studies around how the proposed changes would work. **(Action: Charlotte Pomery/Clerk).**

RESOLVED

I. That that Health and Wellbeing Board noted and supported the development of Haringey's approach to locality based care in North Tottenham.

60. INTER-GREAT - VERBAL UPDATE

The Board received a verbal update for noting around Inter-great from Tony Hoolaghan, Chief Operating Officer for Haringey and Islington CCGs. The COO recapped that the Inter-great events involved simulated exercises to imagine what it would be like to operate within an integrated care system. At these events were a small team with a NCL strategic commissioning function working together with partners responsible for the operational delivery, to test current arrangements and how these organisations would work together in an integrated care system.

The Board was advised that so far there had been one Haringey Borough Partnership development meeting that was focused upon governance, vision and outcomes. The Board was advised that work was ongoing to continue to set up the Borough Partnership and it was anticipated that these structures would be in place by autumn. A meeting was scheduled for the 28th June to look at the Inter-great outputs and try to finalise what would be done at an NCL level and what would be done at a local level. The next formal meeting would include discussion around PMO and mobilising staff to take the project forward. Overall, it was noted that, good progress was being made to build on the work of the Haringey and Islington Wellbeing Partnership.

RESOLVED

The update was noted.

61. NEW ITEMS OF URGENT BUSINESS

N/A

62. FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS

The dates of future meetings were noted as:

- 16 October 2019
- 12 February 2020

CHAIR: Councillor Sarah James

Signed by Chair ……..

Date ……

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Report for: **Health and Wellbeing Board – 16 October 2019**

Title: Response to the Long Term Plan

Report Authorised by: Tony Hoolaghan, Managing Director, Haringey and Islington CCGs

Lead Officer: Rachel Lissauer, Director of Commissioning and Integration, Haringey CCG

1. Describe the issue under consideration

This paper summarises the requirements of the NHS Long Term Plan, the high level approach being taken to developing this collective response and outlines the engagement work that has been carried out so far and is planned over coming months.

2. Recommendations

The Health and Wellbeing Board is asked to **note** this update and that working drafts of chapters from the Long Term Plan are available for comment: http://www.northlondonpartners.org.uk/ourplan/the-nhs-long-term-plan.htm

3. Background Information

3.1 Earlier this year, across North Central London (NCL), health and care system partners took part in a series of “Inter-great” events. These resulted in a consensus on the need to work together in new ways, building on the close working of our local NHS, councils and residents, to focus on delivering patient-centred care closer to home, based on individuals’ whole needs.

3.2 The NHS Long Term Plan, published in January 2019, aligns closely with this direction of travel and current system transformation programmes. Developing a collective response to this provides an opportunity for us to work with partners to begin to design health services around residents’ needs, rather than organisations.

3.3 These plans are currently a work in progress, and we now require the engagement and involvement of all local partners, stakeholders and residents over the next few

months. In this time, they will also be cross-referenced, financially costed and refined for final agreement in November.

4. Contribution to strategic outcomes

The NHS Long Term Plan is a key NHS strategy. There will be strong links to delivery of the People Theme of Haringey's Borough Plan.

5. Statutory Officer Comments

5.1 Legal and Finance

N/a. There are no direct resource implications for this paper, as it is not a project proposal for additional internal resourcing, nor is it assuming additional external resourcing.

5.2. Environmental Implications

There are none.

5.3 Resident and Equalities Implications

Engaging residents in the development of these plans will lead to better plans, more tailored to our local communities' needs. We are working with Healthwatch as partners in engaging and involving local people in different ways as the plans develop.

For the first phase (April to June): The five Healthwatch organisations across NCL were commissioned to undertake a range of engagement activities with residents, including a survey and series of focus groups. Headline areas coming out of this engagement include: access to services, patients being involved in decision-making, use of technology and access to information for residents.

Phase two (July to September): includes further engagement across NCL and at a local level to engage with residents on these specific issues in more detail, as well as a detailed review of existing engagement work for gaps to understand where further conversations are needed. This will also include targeted engagement with specific seldom heard groups in each borough.

Phase three (September to November): will be further engagement on our overall Long Term Plan and the London vision ahead of the full submission of our plan in November 2019.

5. Use of Appendices

Not applicable.

6. Background Papers

Delivery of the Long Term Plan in North Central London

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NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

NHS

Delivering the NHS Long Term Plan in North Central London:

Developing our collective plans

September 2019

Will Huxter, Director of Strategy NCL CCGs

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Contents:

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Context and purpose of paper:

Building on local work with partners through the STP programmes, it is clear there is a collective commitment to deliver changes that will improve the health and wellbeing of residents living in Barnet, Camden, Enfield, Haringey and Islington ('North Central London').

Earlier this year, across NCL, health and care system partners took part in a series of "Inter-great" events. These resulted in a consensus on the need to work together in news ways, build on the close working of our local NHS and councils, with residents, to focus on delivering patient-centred care closer to home, based on individuals' whole needs.

The NHS Long Term Plan, published in January 2019, aligns closely with this direction of travel and current system transformation programmes. Developing a collective response to this provides an opportunity for us to work with partners to begin to design health services around residents needs, rather than organisations.

These plans are currently a work in progress, and we now require the engagement and involvement of all local partners, stakeholder and residents over the next few months. In this time, they will also be cross referenced, finically costed and refined for final agreement in November.

This paper summarises the requirements of the NHS Long Term plan, the high level approach being taken to developing collective plans and shares summaries of key areas for discussion.

The board is asked to:

- **Note** the alignment to current plans and direction of travel
- **Note** that working drafts of chapters are available for comment and input: http://www.northlondonpartners.org.uk/ourplan/the-nhs-long-term-plan.htm

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There a chance to build on existing, ongoing work

Following the Inter-great events held across North Central London, work has been progressing with partners to develop new ways of working with the aim of having the greatest positive impact for the health and lives of North Central London residents.

This work is developing collective plans for and integrated care system, which would a move to planning services based on populations and individuals rather than institutions to maximise the impact we can have. It will support the reduction of health inequalities across North Central London through working to support borough based integration of services to increase the focus on residents, communities and prevention.

This direction of travel is closely aligned to that set out in the NHS Long Term Plan and means as a system, we are well placed to use this opportunity to refresh plans in areas that may need strengthening or additional focus.

Following a review of the Long Term Plan requirements, it is clear that many of the ambitions and clinical priorities set out are already being progressed or are a logical next step for our current partnership programmes of work. For example:

- Developing integrated networks based around 30-50k population through our Health and Care Close to Home programme
- Simplification of the emergency care system across NCL
- Radical transformation of planned care and outpatients

In addition, to this, the LTP's strong focus on workforce and digital as drivers for change is reflected by the dedicated North Central programmes established locally to deliver change in these areas.

We want to work with partners to refresh plans to take account of the latest context and support the tangible changes required across the health system as we move to integrated care.

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Process for developing our collective plans

July and August

Critical system inputs:

- Local population health profile
- Existing STP and Org plans
- Requirements from LTP Plan
- Key themes from resident engagement
- London Vision
- Priority areas from benchmarking
- Outputs of "Inter-great" events

Plan sections drafted based on LTP implementation framework in line with principles:

- ✓ Clinically-led
- ✓ Locally owned
- ✓ Realistic workforce planning
- ✓ Financially balanced and supports delivery of MTFS
- ✓ Delivers all LTP commitments and national access standards
- ✓ Phased - based on local need
- ✓ Reducing health inequalities
- ✓ Focussed on prevention
- ✓ Builds on existing work and programmes and engages with Local Authorities
- ✓ Drives innovation

Drafted by authors, reviewed by clinical leads SROs and review groups (see slide 13)

Sept and October

Coordinated engagement with partners boards and resident on:

- Priority areas
- Risks
- Alignment with organisational plans

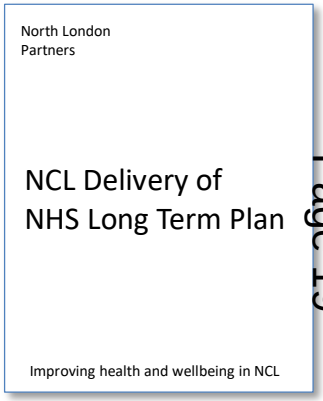
Work to cross referencing sections for:

- Interdependencies
- Alignment with activity and finance

Drafts sections shared on websites for review by staff, partners and residents

November

Final plan for submission



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Long Term Plan Implementation Framework: summary

The LTP Implementation Framework (LTPIF) sets out the approach health systems are asked to take to create their plans. It included further details and information to help local system leaders refine their planning and prioritisation and detail about whereadditional funding will be made available to support specific commitments. It sets out the requirements in the sections listed below:

Seven sections on service changes. Two are national 'fundamental service changes' delivered in line with national timetablesand trajectories:

- Transformed 'out-of-hospital care' and fully integrated community-based care
- Reducing pressure on emergency hospital services
- Giving people more control over their own health and more personalised care
- Digitally-enabling primary care and outpatient care
- Better care for major health conditions: Improving cancer outcomes
- Better care for major health conditions: Improving mental health services
- Better care for major health conditions: Shorter waits for planned care
- Increasing the focus on population health

Five section on the themes below. With Local freedom to set priorities / agree pace of delivery based on need; all LTP commitments must be delivered by the end of the five-years:

- More NHS action on prevention
- Delivering Further progress on care quality and outcomes
- Giving NHS staff the backing they need
- Delivering digitally-enabled care across the NHS
- Using taxpayers' investment to maximum effect

https://www.england.nhs.uk/wp-content/uploads/2019/06/NHS-LTP-Implementation-Framework.pdf

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Our plans must support the delivery of the Medium Term Financial Strategy currently being developed

The NCL Health system has an underlying deficit of £200m per year. Work is underway to develop a medium term financial plan which will outline the work needed to support the financial sustainability of the health service, with a plan across multiple years to reduce and remove costs out of the system through a set of collective actions across NHS partners.

The financial principles will need to underpin the deliver of the MTFS, which is plan is still in development but has the following emerging themes:

- Focus on organisational recovery plans in light of the constrained income environment
- Reduce demand and activity growth particularly non elective
- Limit acute trust income growth to less than 2% from 2020/21 - 2023/24
- Implementation of new models of care that support the three core themes above

These themes will need to be reflected in the NCL Long Term plan response.

NORTH LONDON PARTNERS in health and care
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Working with Local Authorities to develop plans

Working collectively with local authorities is critical to the delivery of changes that will improve the health and wellbeing of residents across North Central London.

To support us in developing these plans, we have worked with local authorities in the early stages of developing draft sections. We have done this through:

- Local authorities representatives have been involved in early system review groups to comment on and improve the draft sections
- We have had a dedicated Public health leads for all sections
- Some of the section SROs are Local Authority senior leaders

In addition to this, over the next months, we will be working with local authority colleagues to review the drafts and develop the next iteration of these plans. We will do this through:

- Cross referencing the drafts against key themes of local authority plans strategic plans.
- Review of the working drafts by senior Local Authority colleagues.
- Review of sections by new borough partnerships, of which local authorities are a key member.

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

We are already engaging with our residents on plans

Engaging residents in the development of these plans will lead to better plans, more tailored to our local communities needs. We are working with HealthWatch as partners in engaging and involving local people in different ways as the plans develop.

For the first phase (April to June): The five Healthwatch organisations across NCL were commissioned to undertake a range of engagement activities with residents, including a survey and series of focus groups. Headline areas coming out of this engagement include: access to services, patients being involved in decision-making, use of technology and access to information for residents (please see next slide for these).

Phase two (July to September): includes further engagement across NCL and at a local level to engage with residents on these specific issues in more detail as well as a detailed review of existing engagement work for gaps to understand where further conversations are needed. This will also include targeted engagement with specific seldom heard in each borough.

Phase three (September to November): will be further engagement on our overall Long Term Plan and the London vision ahead of the full submission of our plan in November 2019.

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The following themes from resident engagement will be used to guide the development of our plans:

From the HealthWatch surveys and focus group north central London residents told us about their priorities which we will include as themes throughout the sections of our plans:

- Increased access to services
- Importance of involving patients in discussions and decisions about their care
- Availability of clear and accessible information for patients, including easy read versions and access to interpreters
- Patients provided with the knowledge to keep themselves well and promote wellbeing
- Integrated personalised care
- Use of technology both to increase access to services and to health information
- Better joint working between health and social care
- Focus on prevention and early interventions
- Everyone gets the same care, regardless of where they live

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Approach to drafting sections: chapter authors, SROs and system review groups

To ensure local plans respond to the requirements of the LTP implementation framework, we are drafting sections to cover each of the sections of the framework. To support a system approach to these, we have identified an senior responsible officer, clinical care lead, author and a system review group for each one. In addition, we have also nominated a public health lead to support the drafting of these.

The outline of these roles is listed below and the individuals responsible for each section are detailed on the following slide.

Section SRO: A nominated senior lead responsible for ensuring the completion of the content for the section and the appropriate level of engagement as required across organisations. They are responsible for ensuring a system response, rather than an organisational one.

Clinical/Care Lead(s): A nominated clinical or care lead who can provide professional input into the clinical and care professional elements of the plan. They are responsible for ensuring the clinical and care models align with the direction of travel and the needs of local populations.

System Review group: This is the current system group – or specifically nominated group that contributes, develops and reviews the section. It does not have final sign off, so does not need to be representative of all organisations but its member should be confident that engagement has happened with the key organisations as required and the section aligns with the systems direction of travel.

Section author: This is the management lead nominated to draft the section based on the guidance from the change team. They will liaise with SROs, clinical leads and the review groups to draft the proposed content for the section. They will work with those identified by the review group to engage and test the sections ahead of submitting the section to the change programme team.

Theme	SRO	Clinical Lead(s)	System review group	Author	Public Health Lead
Section 2 Delivering A New Service Model For The 21st Century: Themes And Leadership					
Fully integrated community-based health care	Tony Hoolaghan	Dr Katie Coleman	Nominees from Health and Care Close to Home Board	Sarah McIlwaine	Will Maimaris
Reducing pressure on emergency hospital services	Sarah Mansuralli	Dr Chris Streather, Dr Shakil Alam	Nominees from STP UEC board	Alex Faulkes	Will Maimaris
Giving people more control over their own health and more personalised care	Kay Mathews	TBC	NCL CCG SMT	Shelia O'shea and Sarah D'Souza	Lilly Barnett Seher Kayikci Sue Hogarth
Digitally-enabling primary care and outpatient care	John-Jo Campbell	DrZuhaib Keekeebhai, Dr Cathy Kelly	STP Digital Board, STP planned care steering group	Martyn Smith	Sarah Dougan
Improving cancer outcomes	Paul Sinden	Dr Clare Stephens	Cancer Alliance Board	Naser Tarubi	Mary Orhewere, Aparna Keegan
Improving mental health outcomes	Sarah Mansuralli and Paul Jenkins	Dr Alex Warner, Dr Jonathan Bindman, Dr Vincent Kirchner	STP Mental Health Board	Chris Dzikiti	Tamara Djuretic
Shorter waits for planned care	Paul Sinden	Dr Dee Hora, Dr John Connolley	STP Planned Care Steering Group and NCL Performance meeting	Edmund Nkrumah and Donal Markey	Glenn Stewart
Section 3 Increasing The Focus On Population Health					
Moving to integrated care systems everywhere	Will Huxter	Dr Jo Sauvage, Dr Chris Streather	NCL ICS design group	Richard Dale	Tamara Djuretic
Section 4 More NHS Action On Prevention					
Focus on prevention	Julie Billet	Directors Of Public Health/Public Health Consultants	Directors of public health	Dr Hannah Logan	-
Section 5 Delivering Further Progress On Care Quality And Outcomes					
A strong start in life for children and young people	Charlotte Pomery	Dr Oliver Anglin	STP Children's Board	Sam Rostom	Susan Otiti, Duduzile Sher-arami
Learning difficulties and autism	Paul Sinden	TBC	NCL CCG SMT	Kath McClinton	
Better for major health conditions – Cardiovascular, Stroke, Diabetes, Respiratory	Will Huxter	Dr Will Maimaris, Dr Julie Billet	NCL CVD steering group, NCL Diabetes Group, NCL Respiritory group	Richard Dale	Will Maimaris, Stuart Lines,Julie Billett
Research and innovation to drive future outcomes improvement	London wide section				
Genomics	London wide section				
Volunteering	Will Huxter	Directors of nursing	TBC	Richard Dale	-
Wider Social Impact and move to Population Health	Will Huxter	TBC	TBC	TBC	Sarah Dougan
Section 6 Giving NHS Staff The Backing They Need					
Feeding Back In Line With The Themes from the interim NHS People Plan	Siobhan Harrington	Dr Jo Sauvage	STP Workforce Steering Group and NCL Local Workforce Action Board	Sarah Young	Tamara Djuretic
Section 7 Delivering Digitally-Enabled Care Across The NHS					
Increase the use of digital tools to transform how outpatient services are offered and provide more options for virtual outpatient appointments	John-Jo Campbell	Dr Zuhaib Keekeebhai, Dr Cathy Kelly	STP Digital board	Martyn Smith and Hasib Aftab	Sarah Dougan
Section 8 Using Taxpayers' Investment To Maximum Effect					
Financial & Planning Assumptions, Improving Productivity and Reducing Variation	Simon Goodwin	TBC	STP Directors of Finance	Gary Sired	-

Appendix 1:
Summary of plans and links to working drafts

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Notes on drafts

The next slides summarise some of the sections in development – to support discussion at CCG Governing Bodies in September. In addition, we are making all of the full working drafts available on our website for review and comment. These can be found here: http://www.northlondonpartners.org.uk/ourplan/the-nhs-long-term-plan.htm

Please note:

- The documents are intended as a 'system' documents (i.e. a working draft to be shared between partners) which are in the public domain, rather than a document designed for the public. A public version will be developed as part of the next stage of the process.
- These sections build on local plans and are being shared early on with partners and in public in the spirit of transparency and for constructive comment and iterative development.
- These are the first working draft of the sections and are the output of discussion and debate through a series of system review groups.
- These sections have not yet been fully cross referenced with each other for interdependencies.
- These are yet to be fully costed and financially modelled although have been developed in line with current funding assumptions.
- This draft does not yet represent finalised policy positions. The document will undergo significant change through a series of drafting iterations.

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Delivering a service model for the 21st century:

PCN development and building community capacity

Health and Care Closer to Home brings together system partners from primary, community, and acute services, local authority, commissioning and the voluntary sector via its Programme Board.

Development of PCNs

All mainstream primary care services are included in PCNs. There is now full coverage across NCL, with 30 PCNs (Barnet 7; Camden 7; Enfield 4; Haringey 8; Islington 4), based on geographical contiguity between practices; many are on the same footprint as the earlier CHINs/ neighbourhoods. As integrated care partnerships develop at borough level, community providers will configure teams on the same footprints and develop a roadmap to ensure readiness to deliver the anticipatory care PCN DES specification from April 2020.

PCNs are at varying stages of maturity. Clinical Directors are currently diagnosing the support they will need to develop the PCN, which will inform how development funding is allocated. The emerging themes are:

- Organisation development and change
- Leadership development support (inc Clinical Directors)
- Supportive collaborative working (MDTs)
- Population health management
- Social prescribing and asset-based community development
- Identifying, evaluating and sharing learning

Developing workforce and capacity in the community

Our NCL workforce programme, and specific Health and Care Closer to Home workforce action plan, describe our plans to develop, retain and recruit our workforce. We are using tools such as e-rostering, standardisation of shift patterns and the adoption of Care Hours per Patient Day to better understand our staffing requirements.

Our digital programme includes the introduction of a population health management approach, a health information exchange across NCL, and the development of a patient-facing digital record, and the development of digital and telephony-based services, which will increase capacity and support delivery of more efficient care In one borough, work is underway to align the community health care service system with that of GPs to include e-referrals, e-care plans and shared care planning. HealtheIntent is a local digital solution to support effective anticipatory care at a population level, which will integrate near real time data to deliver actionable analysis for anticipatory or proactive care.

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Delivering a service model for the 21st century: community crisis response and anticipatory care

Community health crisis response within 2 hours and reablement care within 2 days

We have established a crisis response model from 8am-8pm, 7/7, and are working with our three community providers to ensure a high degree of consistency including standard approaches to referral, eligibility criteria and operating hours. This is already being achieved in some boroughs, but not all. **We will seek to include a standard contract KPI across the 5 boroughs from 20/21.**

We are working with local authorities to ensure reablement care is delivered consistently within 2 days. Health-based community reablement is delivered same day in some but not all of our boroughs currently. We are seeking to increase the speed that patients access community-based rehabilitation**. A transition plan for contractual KPIs will see a shift from an expectation of a 2 week wait to a 2 day wait by 2023.**

Bed-based rehabilitation has varied, and significant work has taken place to embed an effective Discharge to Assess model with an emphasis on 'home first'. Further work is being undertaken in each borough with local authorities. Bed-based rehabilitation is often dependent on local authorities locating appropriate accommodation for patients deemed to require a supported care arrangement.

Anticipatory care by integrated primary and community services, together with local authority and voluntary sector providers

We have developed effective models of practice around a number of different patient cohorts (e.g. frailty, long term conditions, SMI), and each borough has developed MDT working with key elements of the health and care closer to home approach embedded (population segmentation / development of register, proactive case finding based on risk, outreach, care planning, MDT review and proactive case management, support to self care and self manage. Further work in 19/20 will develop the contribution of community providers, including caseloads, and operating policies. Some community health services are exploring operating from GP premises, including services for MSK, diabetes and asthma Self care is central to the plans. We have introduced the Patient Activation Measure (PAM) in one borough, focussing first on all care planned patients. This links to wider work on embedding the personalised care to spread best practice on the different elements of the universal personalised care model across NCL. **We will further review the models of care as further detail of national specifications are published.**

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Delivering a service model for the 21st century:
Enhanced health in care homes

Enhanced health in care homes

The 230 care homes in NCL are an important part of our health and care infrastructure, with care homes providing homes to 6,000 of our frailest residents outside of hospital (there are more care home beds than NHS beds in NCL). There is uneven distribution of care homes across NCL; around 90 care homes in Barnet (>70% of care home beds in NCL are in Barnet and Enfield), only 8 within Islington. There is a range of locally commissioned services for care homes across NCL, including GP in-reach, MDT support and a range of quality and workforce initiatives to support care homes. There are different models of care in each borough and some gaps, for example, benchmarking identified considerable variation in primary care input to care homes between boroughs, such as access to a named GP. NCL's care home residents experience high acute admissions and LAS call outs, costing our CCGs £42m in 2017/18. This is above peer benchmarks and the London and national averages.

Working in partnership with the Local Authorities, NCL CCGs are working to join up health and social care and dedicated services in this area. The intention is to shift the reactive, expensive reliance on acute care, to a pro-active community based model that delivers better outcomes and meets the LTP ambition for consistent service delivery against the EHCH Framework by 23/24. This includes:

- an innovative workforce programme that is supporting social care providers to recruit and retain staff, develop progression pathways that increase staff skills and leadership capacity, which will support the NHS to meet the health care needs of care home residents.
- actions that will support PCNs, including commissioning a care home dashboard to give us up to date information on activity levels and quality; contributing to the development of the national PCN DES specification for EHCH, (some parts of NCL are likely to commission above this already).
- a Darzi fellow starting in September 2019 focusing on care homes to bring the system together to co-design and implement a new model for primary care input in line with the EHCH framework. This will strike a balance between standardisation of systems and processes, and necessary adaptation to local context, to address unwarranted variation.

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A focus on prevention:

Smoking and Alcohol

Smoking

Around 14% of people across NCL smoke, varying from 10% in Barnet to 17% in Haringey. It is the single largest cause of health inequalities and premature death. There is significant variation in the availability and capacity of smoking cessation services; each borough commissions smoking services differently, both in the community and secondary care. Services are accessed through a range of providers, and residents can access the London-wide Stop Smoking portal.

We are developing a system-wide map of current investment, service delivery, and stop smoking activity and outcomes across secondary care providers in NCL, alongside LA-commissioned community cessation services to identify gaps and investment requirements, ranging from the identification of smokers, provision of brief advice, provision of pharmacotherapy, and onward referral into community stop smoking support. We are exploring opportunities to reduce variation through initiatives such as developing a NCL smoke free policy and options to standardise very brief advice training. Smoking in pregnancy has already been identified as a priority and a joint programme of work is being delivered by a partnership of maternity services, public health, service users, and stop smoking services across NCL.

Alcohol

NCL has some of the highest rates of alcohol specific admissions in London with Camden and Islington significantly worse than London and England. Haringey, Camden and Islington also have some of the highest death rates for alcohol related mortality across NCL.

There are some excellent alcohol support services (including preventative and treatment services) across community, primary and secondary care, like commissioned online support (Barnet, Camden, Haringey and Islington), community outreach teams (Camden, Haringey and Islington), formalised detox and recovery services (Barnet, Camden, Haringey and Islington). The LTP highlights ACTs as being an effective approach to preventing alcohol related harm. Within NCL, services for alcohol liaison play a similar rde to ACTs (in Camden, Haringey and Islington), funded by boroughs and situated in the local acute trusts, which are improving outcomes and a good return on investment. However, there is variation across NCL and where there are good services being provided, there are opportunities to upscale and reach a larger proportion of those in need.

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A focus on prevention:

Obesity, Air pollution and Antimicrobial resistance

Obesity

Being overweight is partly responsible for more than a third of all long term health conditions in NCL, with two of the five NCL boroughs (Enfield and Haringey) having a higher obesity prevalence (those with BMI of 30+) amongst 16+ than the London average. NCL's National Diabetes Prevention Programme is now provided by a single provider, which includes a more comprehensive face-to-face behaviour change programme and a digital platform. Local public health teams will support general practice to maintain referrals into the programme and improve equity of access, particularly to reduce variation and inequalities with 'at risk' groups. Adults and children have access to NICE recommended Tier 1 and Tier 2 weight management support in four out of five NCL boroughs through community and primary care initiatives, funded by local public health teams. There are no Tier 3 specialist support in NCL. We will look to develop a system business case for tackling this. There are system approaches targeting the obesogenic environment through sugar reduction, nutrition advice, physical activity schemes and promoting a healthy urban environment.

Air pollution

The fraction of mortality attributable to air pollution particulate matters in NCL vary from 6.3% in Barnet to 6.9% in Islington, compared to 5.1% in England. Specific projects across NCL include work with schools, focus on Active Travel plans linked with local Transport Strategies and Local Implementation Plans, Healthy Streets approach, AirText messaging to residents that link with primary care, installing new electric charging points, and a health and care wide partnership on paediatric asthma pathways. Additional work will look at supporting NHS Trusts to sign up to the Clean Air Hospital Framework, and reduce business mileage and fleet air pollutant emissions.

Antimicrobial resistance

NCL CCGs are prescribing significantly below the national target of reducing antimicrobial use by 15% from the current national rate. Camden is the only borough achieving the target of broad spectrum antibiotics of less than 10% of the total antibiotics prescribed. 2018/19 AMR CQUIN data for NCL Trusts demonstrated improvements in total antibiotic usage - many found it difficult to reduce total carbapenem usage. The future focus will build on this and include: GP prescribing of broad spectrum antibiotics; healthcare associated Gram-negative blood stream infections and reducing UTI infections; evolving the Antimicrobial Pharmacists Group to become a multidisciplinary strategy group providing system wide leadership; establishing and improving antifungal stewardship; education & training; scoping work with all providers to support delivery.

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Improving mental health outcomes (i)

Ambitions

NCL's vision for mental health support is based on the principles established by our Expert by Experience Board. The ambitions are:

- **Improved access to care and support** (embedding "no door is the wrong door"; addressing significant areas of unmet need; provide support in the interim where people are on waiting lists for complex care treatment,; better coordination of access to specialist support once patients are discharged from secondary care, and develop fast track access to specialist mental health teams in a crisis)
- **Service provision and development** (reducing variation in support services; a greater community support offer and Crisis Cafes; stronger support and funding for the Voluntary and Community Sector, while subject to the same outcome measures as statutory services; transparency in addressing gaps in service provision and supporting people who require "complex care/the level above IAPT but below crisis intervention", expanding the workforce particularly peer support roles)
- **Outcomes and monitoring** (increased focus on patient-centred goals like patient recovery outcomes, housing and employment, patient and public participation in evaluation and monitoring of services)

Strategic approach

- **Provider collaboratives**: there are three NHS Provider Collaboratives in development that are aiming to take over NHSE Specialised Commissioning budgets. The main objectives are to ensure: care closer to home through the elimination of external placements; incentives for community care; joined up pathways with secondary / primary care; providers in North London working as a system not in competition. All three have had their interview with NHSE following the first stage of the approval process and are awaiting feedback. If they progress into the fast track, they will need to submit a final business case by November with a start date of April 2020. They will be engaging with local authorities, CCGs and the NCL Transforming Care Partnership.

- **Stabilising and expanding community teams**: (i) implementing a new digital system across NCL, including a registry for physical health checks for adults with Serious Mental Illness, and automating identification of GP practices with low completion rates of health checks for this cohort, improving the support available for these practices and their patients through existing QUIST initiatives; (ii) expanding primary care workforce and further upskilling, including links to specialist support from mental health trusts, enabling the expansion of health checks and looking at further evidence of effective interventions that can be facilitated in part with Personal Health Budgets for this group; (iii) Individual Placement and Support services are available across NCL. The access standard for Early Intervention in Psychosis is already met across NCL and Service Development and Improvement Plans are now in place to ensure all services achieve Level 3.

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Improving mental health outcomes (ii)

- **Initiatives via additional fair share funding to expand access:**
  - **CYP aged 0-15 services:** NCL has good examples to learn from, including an open access / voluntary service models called 'HIVE' in Camden and 'Choice' in Haringey, with principles, which could be replicated across the STP.
  - **access to specialist community perinatal mental health services:** NCL is collaborating to deliver a specialist community perinatal mental health service for women with severe or complex mental health needs. Evidence-based care pathways operate locally and there are examples of initiatives that continue to inform the development of the new service, which will continue to focus resources and engage people who find help harder to access including teenagers and mothers from some BME groups including those for whom English is not their first language.
  - **24/7 adult crisis resolution and home treatment teams (CRHT):** there is 100% coverage of CRHT services which operate on a 24/7 basis and include Crisis Single Point of Access functions in addition to Home Treatment and Assessment teams. Camden and Islington also have a specialised Older Adults Home Treatment Team. CRHT provision will be able to deliver a high-fidelity service by 2021, maintain high-fidelity coverage of UCL Core Fidelity scales to 2023/24. There is a commitment to review Crisis Pathways in BEH; strengthening CRHT Teams and providing care closer to home will be critical to managing the increasing pressures on inpatient beds and to reducing out of area placements.
  - **CYP mental crisis services:** NCL will develop a local integrated pathway for children and young people with higher tier mental health needs, including rapid community-based and out-of-hours responses to crisis. Investment will focus on expanding the crisis workforce and training for the crisis response team, with a focus on Dialectical Behaviour Therapy (DBT).
  - **Alternative crisis provision:** current provision across NCL is varied. The planned transformation funding will evolve alternative crisis services to become increasingly uniform and equitable across the STP to all age groups for people, and their carers.
- **Initiatives via additional targeted funding allocations (to be agreed with NHS England and NHS Improvement):**
  - **Salary support for IAPT trainees:** IAPT trainee numbers have been agreed across NCL, with contract variations in place to provide salary support in line with regional funding requirements.
  - **CYP mental health support teams:** all five boroughs in NCL had successful bids for Mental Health Support Teams in schools trailblazer sites. Camden and Haringey went live in late 2018, Enfield go live in September 2019, and Islington and Barnet will go live in January 2020.
  - **Maternity outreach clinics in 2020/21 and 2021/22**

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Improving mental health outcomes (iii)

- **Initiatives that could be funded via additional targeted funding allocations (to be agreed with NHS England and NHS Improvement):**
  - **New models of integrated primary and community care for adults and older adults with SMI:** this is central to the joint clinical strategy by our mental health trusts over the next six months. Developments in community provision will continue over the next two years through transformation funding, using devolved specialised commissioning budgets, and expanding Primary Care Mental Health services across NCL.
  - **Mental Health Liaison Services:** these are delivered 24/7 in all 5 Acute sites in NCL, with a commitment to consolidate and expand MHLS. Partners have adopted a MHLS Collaborative Agreement, Core 24 service specification and associated KPIs. This system wide approach has attracted Wave 2 MHLS transformation funding to enhance provision and ensure all hospitals in NCL meet Core 24 Standards for adults and older adults by 2021.
  - **Individual Placement Support (IPS):** services are available across NCL following close working between health and social care, and a further two-year expansion will be supported through Wave 2 funding to extend access in primary and secondary care.
  - **Testing of clinical review of standards in 2019/20** (TBC)
  - **Model for problem gambling:** NCL was not successful in securing problem gambling funding in 19/20. It is considered a future ambition due to established existing services and ability to expand the model.
  - **Specialist Community Forensic Care and women's secure:** North London Forensic Consortium will be a wave 2 pilot site for the new specialist community forensic team model, which will be rolled out over a 2-3 year period, initially covering Barnet, Enfield and Haringey, expanding to Camden and Islington from 2022/23. It will support development of accommodation pathways by co-commissioning housing providers, which will reduce length of stay for forensic inpatients, improve housing pathways and increase community resource.
  - **Enhanced suicide prevention initiatives and bereavement support services:** NCL successfully bid for PHE funding to develop a post-intervention suicide bereavement support service. Procurement will take place by March 2020.
  - **Mental health services to support rough sleepers:** Haringey is a national pilot site and has taken an integrated multi-disciplinary approach to co-produce services for rough sleepers. It will integrate existing homelessness services in a co-located outreach teams. It will further integrate with health services (including GPs, Psychiatrists and Psychologists, occupational therapists, peer support workers) and integrated substance use treatment pathways to ensure effective holistic support. An MDT led by public health developed a funding proposal for Camden and Islington but was unsuccessful. It is a priority for future funding.

Appendix 2:

- Summary of the Long Term Plan
- Fair Shares allowances
- London Vision

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Headlines from the NHS Long Term Plan (Jan 2019)

The NHS will increasingly be:

- more joined-up and coordinated in its care
- more proactive in the services it provides
- more differentiated in its support offer to individuals.

Five major, practical changes to the NHS service model over the next five years:

- Boost 'out-of-hospital' care and reduce primary and community health services divide
- Redesign and reduce pressure on emergency hospital services
- People will get more control over their own health, and more personalised care
- Digitally-enabled primary and outpatient care will go mainstream across the NHS
- Local NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere.

The NHS Long Term Plan describes transition to Integrated Care Systems.
This would be supported by a single CCG in the North Central London area.

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Fair shares allocations and Targeted funding

The framework sets out the national funding which will be allocated to systems on a fair shares basis and provides an indication of the national total for targeted funding, to support specific projects.

The details of the requirement linked to the fair shares distribution and targeted funding are on the following slides.

System plans must set out how they will use their resources to deliver the commitments within the NHS long-term plan and meet the financial tests set out within it. This will include detail on the NCL Medium Term Financial plan required as the NCL system is in deficit.

Plans must also incorporate system actions to maximise efficiencies and support appropriate reductions in growth of demand.

In addition, spending plans must be consistent with the commitments to increase investment in certain areas such as mental health, primary medical and community health services.

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LTP allocations: Fair Share detail on requirements

The commitments to be delivered through the fair shares funding are as follows:

Mental Health	The expansion of community mental health services for Children and Young People aged 0-25; funding for new models of integrated primary and community care for people with SMI from 2021/22 onwards; and specific elements of developments of the mental health crisis pathways. See 2.27.
Primary Care	This funding includes the continuation of funding already available non-recurrently to support Extended Access and GP Forward View funding streams, (e.g. practice resilience programme), and associated commitments must be met. Additional funding is also included to support the development of Primary Care Networks.
Ageing Well	Deployment of home-based and bed-based elements of the Urgent Community Response model, Community Teams, and Enhanced Health in Care Homes.
Cancer	Rapid Diagnostic Centres funding in 2019/20 only; Cancer Alliance funding to support screening uptake delivery of the Faster Diagnosis Standard and timed pathways, implementation of personalised care interventions, including personalised follow up pathways and Cancer Alliance core teams.
CVD, Stroke and Respiratory	Increased prescribing of statins, warfarin and antihypertensive drugs; Increased rates of cardiac, stroke and pulmonary rehabilitation services; increased thrombolysis rates; and early detection of heart failure and valve disease.
CYP & Maternity	Local Maternity Systems funding; Saving Babies Lives Care Bundle funding from 2021/22; postnatal physio funding from 2023/24; funding for integrated CYP services from 2023/24.
LD Autism	Funding for rollout of community services for adults and children and keyworkers from 2023/24.
Prevention	Tobacco addiction - inpatient, outpatient/day case and Smoke Free pregnancy smoking cessation interventions.

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LTP allocations: Targeted funding detail on requirements

The commitments to be delivered through targeted funding are as follows:

Mental Health	Includes: - funding for continuation of previous waves such as mental health liaison or Individual placement support funding; pilots as part of the clinical review of standards, and other pilots such as rough sleeping. - funding to be distributed in phases in consultation with regional teams including: funding for testing new models of integrated primary and community care for adults and older adults with severe mental illness, community based integrated care, rolling out mental health teams in schools and salary support for IAPT trainees.
Primary Care	Digital First Primary Care support funding; the Investment and Impact Fund; and Estates and Technology Transformation Programme.
Ageing Well	Targeted funding to accelerator STPs to rollout the Ageing Well models.
Cancer	Development and roll out of innovative models of early identification of cancer (starting with lung health checks); funding for the development of Rapid Diagnostic Centres from 2020/21 onwards; support for further innovations to support early diagnosis.
Technology	Revenue funding for Provider Digitisation and Local Health and Care Records.
Cardiovascular Disease, Stroke and Respiratory	Pilots for improving access to cardiac, stroke and pulmonary rehabilitation services and early detection of heart failure and valve disease.
Maternity and Neonates	Continuity of carer for BME and disadvantaged women from 2021/22; funding to support the UNICEF Baby Friendly Initiative; funding to support the expansion and improvement of neonatal critical care services from 2021/22; funding from 2020/21 for Family Integrated Care; funding to support the rollout of postnatal physiotherapy and multidisciplinary pelvic health clinics from 2021/22 to 2022/23.
Diabetes	Funding to pilot the use of low calorie diets from 2019/20 until 2022/23; funding to support delivery of recommended treatment targets; funding for multi-disciplinary foot care teams and diabetes inpatient specialist nurses (see 4.31).
Learning Disabilities and Autism	Funding to pilot and develop community services for adults and children and keyworkers from 2020/21 to 2022/23; piloting of models to expand Stopping Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes from 2020/21 to 2023/24; testing the model for ophthalmology, hearing and dental services to children and young people in residential schools from 2021/22; funding to reduce the backlog of the Learning Disabilities Mortality Review Programme (LeDeR).
Personalised Care	Targeted transformation funding to deliver the NHS Comprehensive Model for Personalised Care from 2019/20–2021/22.
Prevention	Alcohol Care Teams from 2020/21 to 2023/24; Tobacco addiction services early implementer sites from 2020/21; targeted support for weight management service improvements from 2020/21.

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The London Vision (2019)

The London Vision will focus on areas that only a partnership at London level can address, to make sure:

- Londoners get better outcomes regardless of who they are or where they live
- Mental health is treated with the same importance as physical health
- Londoners have greater control and choice of their health and care
- People receive good joined up care throughout their life regardless of which organisation provides the service

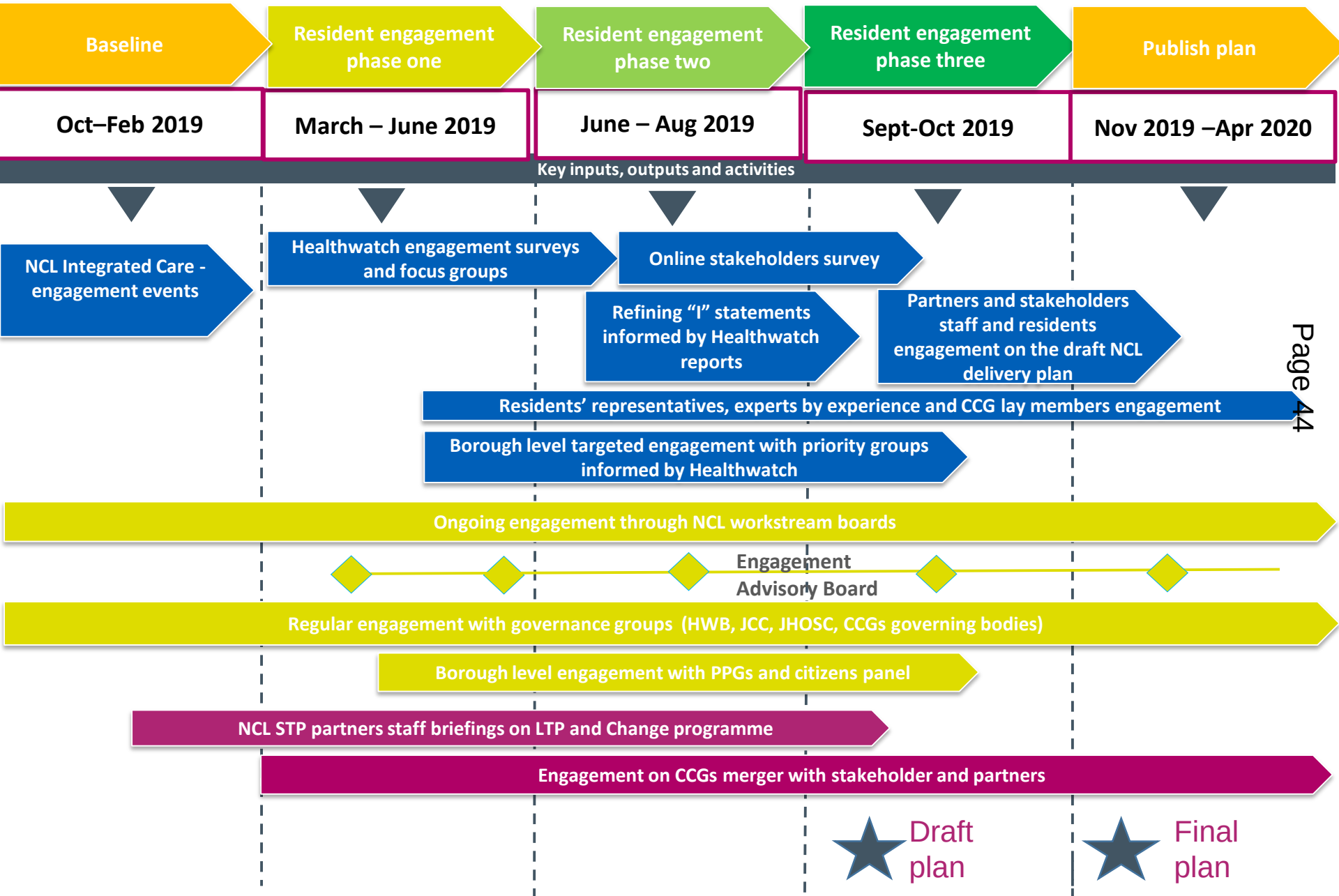
Over the coming months priorities and goals will be set. The work being undertaken across London and will feed into the plans in North Central London.

Emerging Priorities

1. Reducing childhood obesity
2. Improving mental health of children & young adults
3. Reducing inequalities and preventing illness
4. Improving air quality
5. Improving sexual health
6. Reducing the impact of violent crime
7. Improving mental health
8. Improving the quality of specialised care
9. Making health and care more personalised and joined up at every stage of a Londoner's life from birth to end of life
10. Improving the health of homeless people

Appendices 3:
Detail on resident engagement

NCL Long Term Plan: Engagement Plan



Report for: **Health and Wellbeing Board – 16 October 2019**

Title: **Proposed merger of CCGs within North Central London**

Report Authorised by: Tony Hoolaghan, Managing Director, Haringey and Islington CCGs

Lead Officer: Rachel Lissauer, Director of Commissioning and Integration, Haringey CCG

1. Describe the issue under consideration

CCG Governing Bodies within North Central London are considering the proposal to form a single statutory organisation from April 2020. If approved, the formal application to merge will be submitted at the end of September to NHS England.

This paper attached for the Haringey Health and Wellbeing Board is the proposal that was taken to Governing Bodies for discussion and decision. It summaries the case for change; provides details on the plan for delivering the merger and for the supporting communications and engagement work. Appended to the paper are a series of appendices which provide an overview of how the new organisation would function.

Recommendations

The Health and Wellbeing Board is asked to **note and discuss** this update.

2. Background Information

2.1 NCL CCGs have been working together under a joint Accountable Officer and Chief Finance Officer for the last two and a half years. As part of this, some functions have been delegated to NCL wide Committees to support more effective working. Alongside this, the NCL CCGs have been working together with partners on a range of transformational programmes through the STP to build on organisational ambitions which include:

- Improving the health and wellbeing of the local population
- Reducing health inequalities
- Maximising out of hospital care and build resilient, well supported communities

2.2 In NCL, significant progress on transforming services, to address the three gaps set out in the NHS Five Year Forward View, has already been undertaken including mental health crisis provision, to consistent and quicker discharge home from hospital, and the development of primary care networks.

2.3 Whilst progress has also been made against the three gaps set out in the NHS Five Year Forward View, the CCGs are now faced with considerable financial challenges and a need to reduce system costs alongside preparing our organisations to work in more integrated and collaborative ways that ensure there is a sustainable health and care system to improve outcomes of our diverse and growing population.

2.4 The NHS Long Term Plan published in January 2019 sets out a refreshed vision for the future of NHS services, building on the Five Year Forward View. The plan confirms the need to streamline commissioning arrangements via a single CCG for each Integrated Care System (ICS) rather than the existing CCGs that we currently have across North Central London. This will enable a single set of commissioning decisions at system level that includes the development of local Integrated Care Partnerships (ICPs) which would be underpinned by Primary Care Networks (PCN).

2.5 In view of the above, every system will need streamlined commissioning arrangements to enable a single aligned strategic commissioning direction that will support a new system accountability framework and provide a consistent and comparable set of performance measures.

2.6 The paper attached sets out the benefits and opportunities of merging in enabling CCGs to work more consistently and efficiently as well as to drive a focus on prevention and reducing health inequalities.

2.7 Appended to the paper are a series of documents which provide an overview of how the new organisation would function – focussing on:

- Proposed approach to Patient and Public Engagement;
  Proposed Financial Strategy and arrangements for delegated decision-making;
- Further governance arrangements.

2.8 The appendices also include:

3. A transition schedule setting out the key next steps in establishing the governance required for the new organisation;
4. Letters of support for the proposed merger from partners.

4. Contribution to strategic outcomes

Statutory Officer Comments (Legal and Finance)

a. Legal

Resources are already in place to deliver the merger as part of the NCL Change Programmes, including leadership from the NCL CCGs' Senior Management Team and the establishment of a single programme team.

b. Finance

The report presents no immediate financial implications to the council.

c. Resident and Equalities Implications

We recognise that any change to the way that CCGs operate has the potential to impact on equalities. For this reason, an independent equalities impact assessment has been commissioned to review the impact of the proposed merger – with key focus on:

- Governance and decision making for the proposed CCG;
- Maintaining the resident voice.

Section 1 of the report includes the outputs from this work and recommendations for associated next steps.

The report also highlights the importance, from an internal perspective, of the proposed new CCG fully embracing all aspects of equality, diversity and inclusiveness – including to support staff and office holders in their roles.

An extensive engagement process has been conducted at CCG and NCL level to ensure that all partners are aware of, and have had the opportunity to feedback on, our plans for merger. A summary of the communications and engagement plan to support the merger, engagement activity that has been undertaken, and feedback received, is set-out in Section 3 of the report.

Appendix E includes letters of support for the proposed merger received to-date from the CCGs' key partners.

5. Use of Appendices

6. Background Papers

North Central London CCGs Paper – Proposed Merger of CCGs

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North Central London CCGs

Governing Body Paper:

Proposal for Merger of NCL CCGs

Contents

1. Our Case for Change

We believe there is a strong case for merging the CCGs in North Central London into a single statutory body from April 2020. This will enable us to:

1. Accelerate our work to build new ways of working across the system
2. Build a more efficient and effective operating model
3. Make better use of our resources for local residents and achieve economies of scale
4. Support the development of local, borough-based Integrated Care Partnerships and primary care networks
5. Become a larger organisation with much greater resilience
6. Provide a single, strong and consistent vision / voice for our partners
7. Enable greater opportunities for working together as 'one NHS' – ultimately delivering improved patient outcomes for our population and reduce health inequalities.

A key driver for the merged CCG will be to deliver commissioning functions at the most effective level for the benefit of improving patient outcomes and reducing health inequalities.

The proposed CCG will take a multi-layered approach with planning and commissioning being co-ordinated at an NCL level, led by the Governing Body, its committees and borough-based boards or sub-committees. Organisational design will support both NCL-level and borough-based working.

This document sets out the reasons for merging, an overview of the proposed new CCG and how it will operate, and the benefits and impacts of merger.

Executive Summary of Benefits

1 - Accelerate our work to build new ways of working across the system

Building on our work with partners on the future of health and care across North Central London, and in line with the NHS Long Term Plan, **the CCGs will need to move to a new, more strategic commissioning model and support the development of integrated partnerships at a borough level.** The boroughs will in turn have an important role in supporting sub-borough frontline integration and development of services.

As part of this new way of working, we will need to **move to new ways of planning and paying for services and take a population based approach to healthcare.** This will mean the development of longer term outcomes frameworks set for populations, based on health inequalities and priorities that take into account the wider determinants of health, not just service or contract based key performance indicators. This would also mean that **some of the functions traditionally undertaken by both commissioners and providers, would be undertaken once for the system.**

2 - Build a more efficient and effective operating model

The current NCL operating model, with a shared Accountable Officer and CFO with joint CCG committee structures in place for acute commissioning, primary care commissioning and audit, provides a strong existing base to support the merger of the CCGs. However **there are elements of duplication across organisations and decision making can be slow. This also means that transformation is not taken forward consistently, or at pace across all of NCL – all of which would be addressed under a merged CCG.**

The new operating model, will need to take into account the above points – with a key principle being to **deliver functions at the most effective level** including those areas most suited for borough-level

delivery (e.g. primary care commissioning) and NCL-level delivery (e.g. acute commissioning). The model will deliver **a flexible, more efficient commissioning function and support borough integration.** This is reflected in the proposed, new single executive team. The application to merge the CCGs will formalise the new ways of working and governance associated with this and support the effective delivery of this new way of working.

3 - Make better use of our resources for local residents and achieve economies of scale

The future model looks to centralise certain functions under members of the executive team where there is benefit in **a larger planning footprint to maximise the impact for local residents** i.e. where doing so will allow best use of resources, deliver efficiencies for the population who will benefit from a coordinated at scale approach. These centralised commissioning functions will need to evolve over time into strategic functions making use of new mechanisms to enable the system and partnerships to deliver on outcomes over longer periods of time. Those functions that are best delivered at a borough level will continue to be overseen at a local level e.g. primary care commissioning.

4 - Support the development of local, borough-based Integrated Care Partnerships and primary care networks

Under the new executive team, the CCG will also have **clear borough facing functions with senior leaders based at borough level. The primary role of these will be to work with partners to facilitate the development of borough based partnerships (ICPs).** This will mean working together with primary care, community, mental health and social care partners to configure their services around individuals rather than organisations.

Over time, there will be delegation of responsibilities to the local integrated care partnerships. The development of the partnerships, will be an important building blocks around which the NCL integrated care system will be built.

There will **continue to be an important interface with borough democratic structures:** Health & Wellbeing Boards and overview and scrutiny committees, via senior local NHS staff. At North Central London level we will continue to work closely with the Joint Health Overview and Scrutiny Committee.

5 - Become a larger single organisation with much greater resilience

The development of a single CCG for North Central London will create an organisation with a single staffing base and as a result **much greater flexibility to move resources to where they are needed most in the system, to help tackle emerging priorities and challenges**. This enhanced resilience will enable the CCG to better support the wider system to manage issues as they arise.

The greater scale of the organisation will also increase the opportunities for staff to grow and develop within the CCG. A single management structure will create the opportunity for a more concerted, strategic and consistent approach to organisational development, staff and office-holder development and staff retention – and enable all colleagues to work to a single set of organisational objectives and values.

6 - Provide a single, strong and consistent vision / voice for our partners

The move to a single CCG will ensure **consistency of messages and alignment in our approach to joint working with partners and service providers across the system**. The new model will provide a greater degree of influence over the system for the benefits of patients and residents – and this will become increasingly important as we work towards the development of an Integrated Care System for North Central London. There will be a single NHS commissioning voice and vision that will feed into that process, something we know from feedback will be welcomed by our partners.

7 - Enable greater opportunities for working together as 'one NHS' – ultimately delivering improved patient outcomes for our population and reduce health inequalities

The development of a more consistent, aligned, efficient, and effective NHS commissioning function for North Central London will ensure that we maximise investment in frontline services and are able to work in a more collaborative way with our partners to facilitate and support improvements in the way healthcare services are commissioned. This, alongside a more strategic and efficient system-focused approach to decision making, will ultimately lead to the **improvement in outcomes for our patients and residents and the reduction in health inequalities across the system.**

Our Strategic Commissioning Approach

Regardless of the future arrangements for commissioning, there are a number of 'must- haves' and principles, that we are committed to delivering. Mostly these are examples of good practice we are already doing and form the basis of our draft proposals.

Our 'Must-Haves'

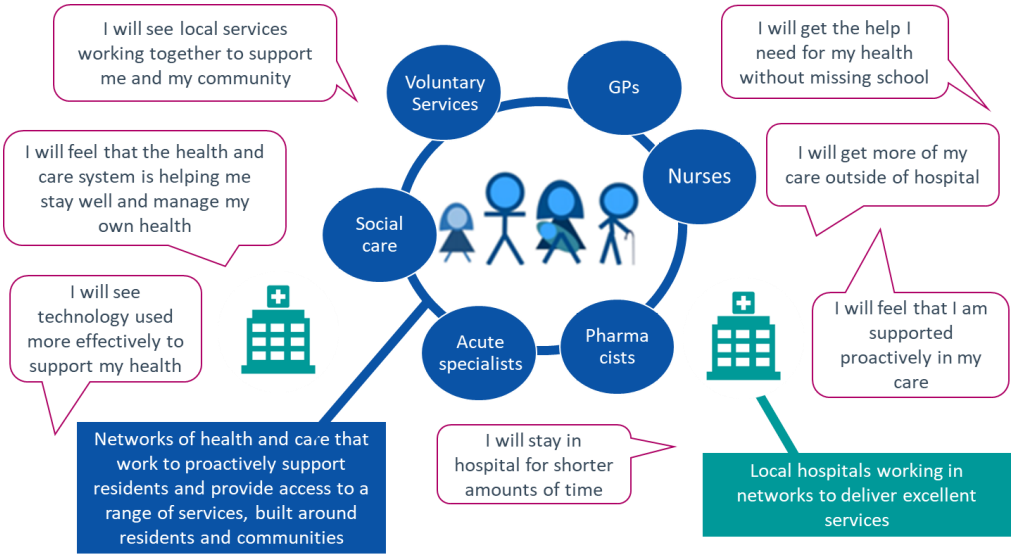
- ✓ The ability to deliver our commissioning ambitions and responsibilities effectively and as quickly as possible, both at neighbourhood level and across the entire geography we serve
- ✓ Strong clinical leadership and involvement in the new arrangements
- ✓ Effective engagement with local people, clinicians, health and care partners and others to inform commissioning decision making and activities from neighbourhood to system-wide
- ✓ An ongoing focus on the health and care needs of neighbourhoods or specific populations, as well as a strategic focus across north central London
- ✓ A single commissioning vision with strategic priorities and health outcome goals at system, place and neighbourhood levels
- ✓ The opportunity to work effectively with our partners and pave the way for better integration of health and care services, at borough level through integrated care partnerships and at system level through our emergent integrated care system
- ✓ An efficient, Value for Money commissioning structure that can deliver both the 20% savings in CCG running costs by 2020/21, and support financial recovery and sustainability across the system, including protecting our primary and community care expenditure
- ✓ The required level of capability and capacity in our clinical, management, and staffing resources to drive forward the changes required and achieve the benefits of merging

Our Principles for the New System

- ✓ We will work as one system to benefit the whole population of North Central London and work together to drive health equalities. We will agree key areas to systematically focus upon as a single CCG
- ✓ We intend to move away from the payment by results system, to place-based budgets, based on population need
- ✓ Where it makes sense and there is a clear benefit to patients of doing so – we will drive efficiency by commissioning a standardised offer to a uniform value with consistent outcomes. We will continue to support local variation where it will help to reduce health inequalities
- ✓ We will work on a population health management basis, as a system, as local partnerships and as neighbourhoods/ networks

- ✓ We will retain the local patient, resident and clinical voice in the commissioning and delivery of health and care, by working effectively together at the three levels of our system
- ✓ We will value our staff, our partners and their expertise to deliver the best health and care possible for North Central London
- ✓ We will drive forward our integration agenda, to deliver joined-up care for population
- ✓ We will emphasise the value of subsidiarity, working as locally as is feasible whilst retaining strategic, effective commissioning for North Central London

The development of the NCL CCG will support the delivery of these system-wide principles, culminating in improved outcomes for patients, as set out in the diagram below:

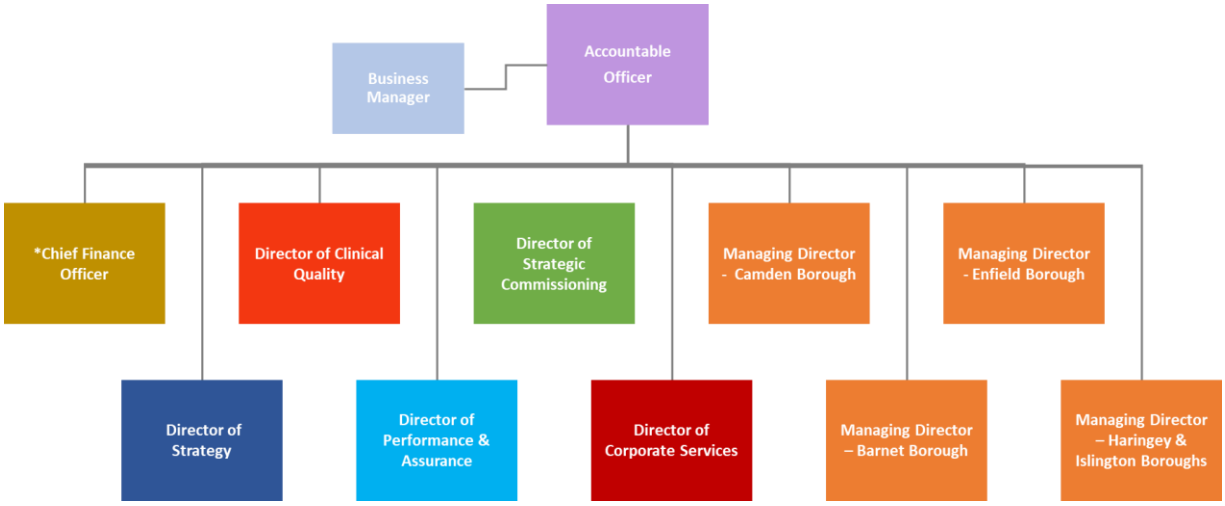


Our Operating Model

We are in the process of developing a new operating model for the single CCG that ensures we deliver on the principles and 'must-haves' for both the CCG and the wider system. This has begun with the development of a new Executive Management Team structure for NCL CCG. This builds on the existing joint management structure for the NCL CCGs, but in addition moving to the new Executive Management Structure will enable:

- A realistic balance between BAU and the work required to transform and move to new commissioning arrangements.
- Increased local capacity for the development of our Borough based Integrated Care Partnerships.
- Retention of scarce talent and allowing all boroughs to benefit from this talent. It will also enable continuity during complex change.
- Shared senior commissioning leadership capacity and capability to support greater outcomes focus and alignment of contracting.
- Improved clinical input at the most senior level with a full time lead for Quality at SMT level.
- Retention of corporate knowledge essential for delivering priorities outline within NHS Plan.

The new NCL CCG Executive Management Team structure:



The new arrangements have been confirmed following consultation and the transition process for the portfolios of the Executive Management Team will be confirmed shortly. Work has now commenced on the next stage of design of the CCG operating model and staffing structures, focused on ensuring that the right capacity is in place to deliver the required functions at each level of the model.

How functions might work in the new model

Below we have set out at a high level how the functions in the new operating model could work. This will be reviewed by the new executive team once in place and will be further updated at this point. It will need to align with the development of integrated care partnerships and the work on the integrated care system across NCL.

Borough based teams would focus on:

- Development of local Integrated Care Partnerships
- Supporting improvement in primary care and primary care network development, and working with practices to optimise medicines and prescribing
- Coordination of local services such as mental health, learning disability, children's services and older people
- Supporting operational performance of local services
- Delivery of system improvements and efficiencies through local implementation of new ways of working
- Local services linked to the council such as adult and children's safeguarding

At an NCL level this would mean focussing on:

- Commissioning of services where there is benefit in a larger planning footprint to maximise the impact for local residents. i.e. where doing so will allow best use of resources, deliver efficiencies, and/or the population will benefit from a coordinated at scale approach.
- Providing a single source of truth in terms of monitoring and scrutinising important elements of services like quality and performance, and outcomes.
- The development of new cross-NCL pathways, transformational change programmes and reconfiguration of services.

All these teams will need to work closely together - we will need to work through with teams how this can work best.

Some already work on an NCL basis with and we will need to review how they work closely with boroughs:

- Primary care contracting functions
- Corporate services and those such as finance, estates
- Work to develop long term system plans and overall strategy
- System performance management and oversight
- System demand and capacity planning

Features of our multi-layered commissioning approach will include:

- The specialised / acute planning and commissioning function being undertaken once across NCL – with associated responsibility, authority, budget and capacity;

- The ability and structure that enables commissioning activity and decision-making at a borough-level, where this is most effective to do so. This will include the responsibility, authority, budget and capacity for primary care commissioning (strategy development, planning and commissioning intention) and community care and out-of-hospital commissioning – which will be delegated to borough-level arrangements;

- From a decision-making perspective, borough-level groups or sub-committee may be established. These arrangements will help ensure the ongoing strength in local partnership working – helping to maximise commissioning outcomes for patients;

- Borough-based teams having an interest in and influence upon NCL commissioning activity - including the generation of borough-level priorities with borough member practices (including through local primary care networks) and clinicians to feed into the development and delivery of NCL wide plans.

Clinical Leadership in the new CCG

The new single CCG for North Central London, and our Integrated Care System, will be underpinned by a strong clinical leadership and engagement model.

The principles that will inform the development of the model are:

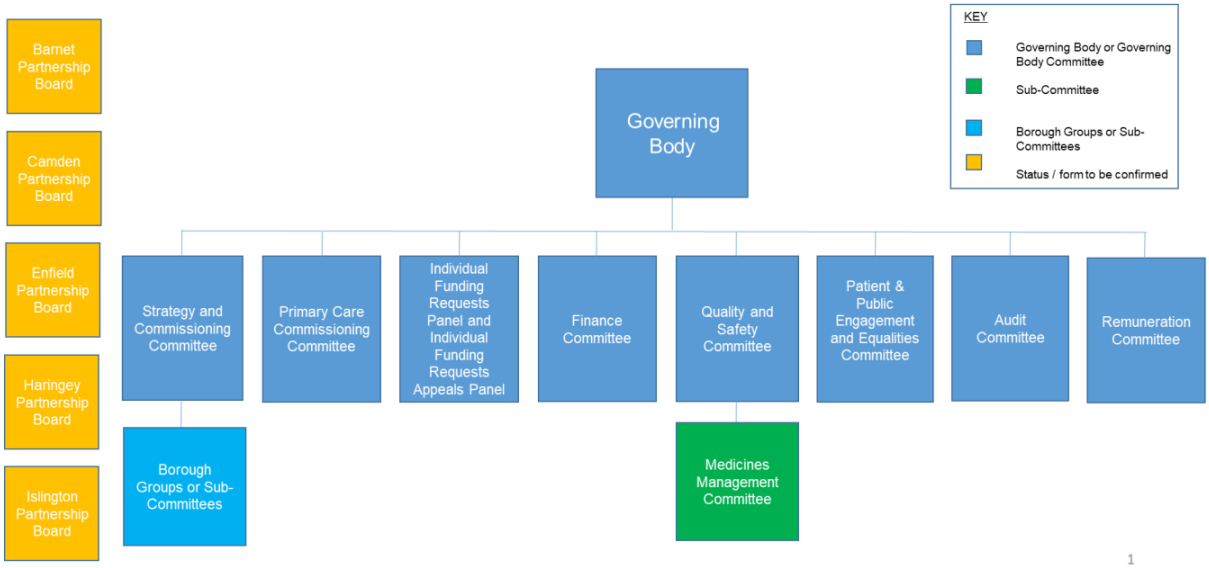
- ✓ A single CCG will allow us to set, implement and monitor a uniform set of clinical standards across NCL, enabling us to drive down the unwarranted variations in care delivery that currently exist and ensure a higher standard of care our residents.
- ✓ The CCG retains a clinical majority at the Governing Body.
- ✓ Strong clinical leadership and involving clinicians in making healthcare decisions are essential aspects of commissioning.
- ✓ All GP practices are members of a CCG and have a say in what, and how, local NHS services are provided.
- ✓ There are outstanding examples of clinical leadership across NCL already and we will seek to learn from and build upon the best approaches already in place in the existing CCGs.
- ✓ We will seek to ensure we have the right level of clinical resource and input at each level in the new system including the borough based ICPs and Primary Care Networks.

Governance arrangements

Robust, transparent and efficient governance arrangements will be at the heart of the North Central London CCG.

The Governing Body will be the primary decision-making vehicle for the NCL CCG – supported by eight Governing Body Committees reporting into it. These are set out in the below diagram. This governance model also highlights the importance of making links to the emerging borough-based partnerships.

Proposed Committee Structure



The Governing Body (GB) of the NCL CCG will meet on a minimum of 4 times per year, with the discretion to meet at more frequent intervals, as required. The Governing Body will have a clinical majority and comprise **17 Voting Members:**

- Elected roles
    - 10 Elected Clinical Representatives (2 from each Borough area)
- Appointed roles
    - 1 Secondary Care Consultant
    - 1 Registered Nurse
    - 1 Lay Member with a lead NCL portfolio overseeing key elements of **financial management, audit and governance**
    - 1 Lay Member with a lead NCL portfolio championing **patient and public involvement**
    - 1 Lay Member with a **general NCL portfolio** including, for example, to champion the CCG's work on **equalities, diversity & inclusion** and the CCG's delivery of its annual **QIPP** programme.
- Executive Director roles
    - 1 Accountable Officer
    - 1 Chief Finance Officer
- **Attendees (non-voting)**
    - Other Executive Directors on the NCL Executive Management Team
    - 1 Healthwatch representative from across NCL
    - 1 Director of Public Health from across NCL
    - 1 local authority Councillor from across NCL

Whilst not mandatory, we will look to encourage each of the Healthwatch, Director of Public Health and local authority Councillor representation being from different boroughs across the North Central London footprint.

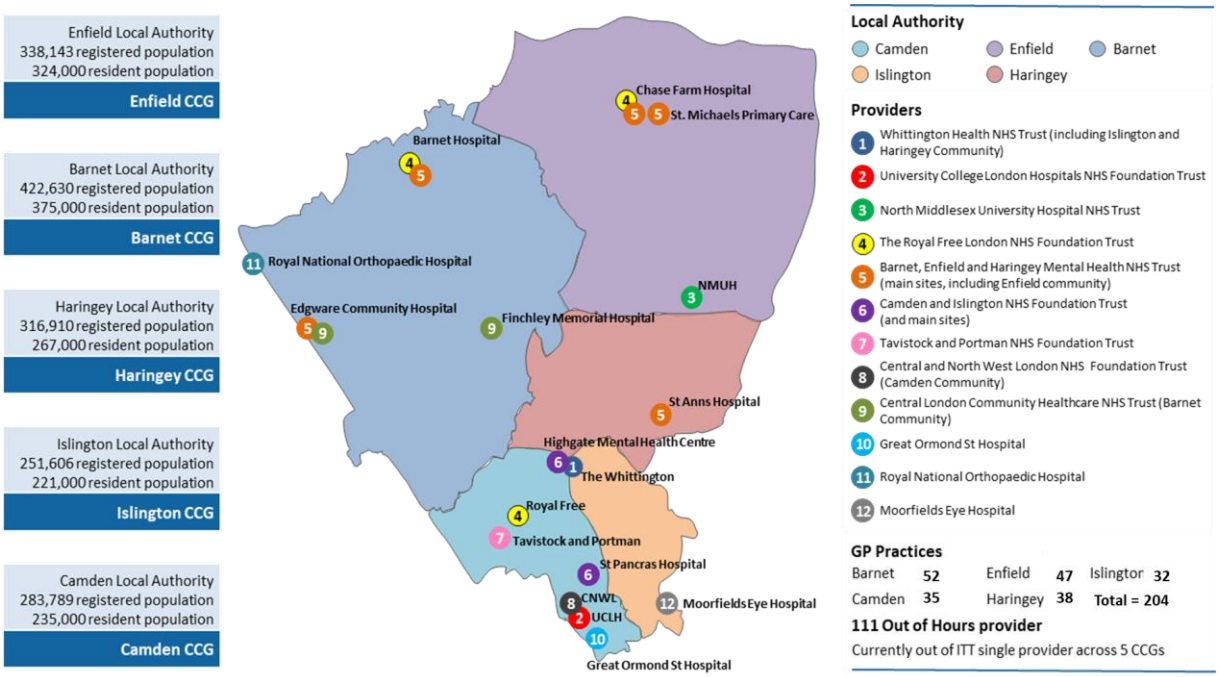
It should be noted that:

- The Chair of the GB will be from one of the 10 Elected Clinical Representatives. The Chair will be elected following a vote of all voting members of the GB;
- The Deputy Chair will be appointed by the GB Chair from one of the Governing Body Lay Members;
- The GB will appoint a Clinical Vice-Chair (from the remaining elected clinical representatives);
- The Chair and Clinical Vice-Chair should not be from the same borough area;
- The move to a single CCG will provide opportunity for consistent arrangements across North Central London for GB members' terms and conditions.

Further details on proposed governance arrangements for the new CCG (including on local decision-making) are set-out in Appendix B and C.

The NCL CCGs

North Central London is a diverse area covering five local authorities and five co-terminus Clinical Commissioning Groups, 12 Trusts and 204 GP practices.



The Profile of the New Proposed CCG

It is proposed that the merger of the CCGs will lead to the creation of a new single statutory organisation:

- NHS North Central London Clinical Commissioning Group.

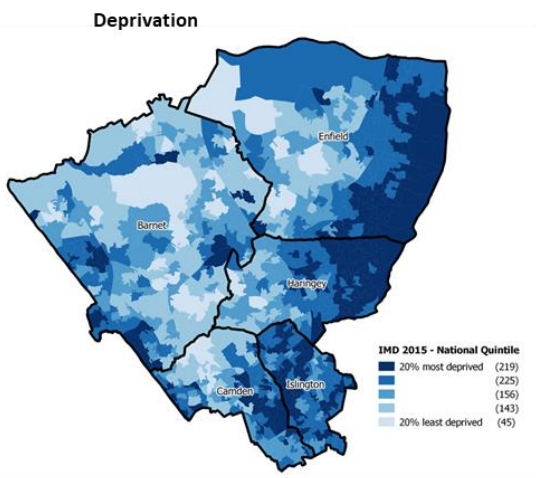
The new CCG will:

✓ Have 204 GP Practices as members

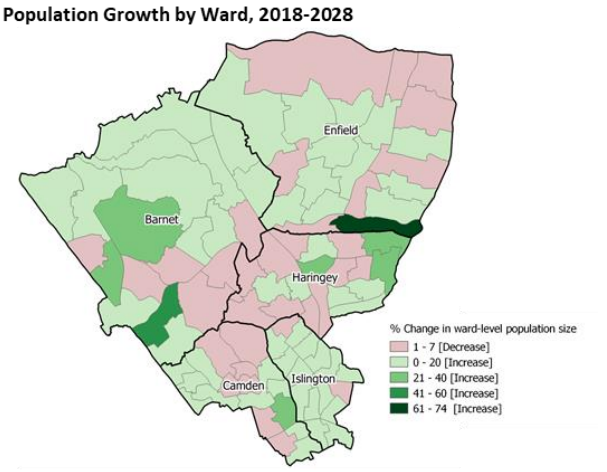
- ✓ Be coterminous with five local authorities
- ✓ Be lead commissioner for 4 major acute trusts and 2 mental health trusts
- ✓ Include within its geography 4 major specialist tertiary centres
- ✓ Serve a resident population of 1,422,000 people
- ✓ Serve a GP-registered population of 1,613,078 people
- ✓ Be allocated £2.1bn to spend on core health and care services for our populations in 2020-21
- ✓ Be allocated £227m per year to spend on primary medical services in 2020-21

Our Local Population

NCL is a diverse area containing both some of the most deprived and more affluent populations in the country. Across North Central London we face differing issues on health inequalities within each borough.



Source: IMD, 2015



Source: GLA ward population projections, 2016

High level population statistics

- 30% of NCL children are growing up in poverty[1]
- Islington, Enfield and Haringey have the highest rates of deprivation relative to the national picture, although pockets of deprivation are dispersed across all boroughs in NCL[2]
- At ward level, the highest forecast population growth is **Upper Edmonton in Enfield** and **Golders Green in Barnet**[3] due to development at Meridian Water in the Lee Valley in Enfield and around Brent Cross in Barnet
- Housing and population growth is concentrated in specific locations. There are currently seven housing Opportunity Areas in the NCL geography (numbers show new homes in 2018 draft London plan):
    - Colindale / Burnt Oak (7,000)

[1] NCL Sustainability and Transformation Plan – Case for Change – September 2016
[2] Primary Care Strategy Data Pack – GLA, 2016; North Central London Devolution Pilot Outline Business Case November 2017

- Cricklewood / Brent Cross (9,500)
- Upper Lee Valley (cross border) (21,000)
- City Fringe (cross border) (15,500)
- Euston (2,800 – 3,800)
- Kings Cross (1,000)
- Tottenham Court Road (300)

- With two additional areas identified in the draft London Plan (2018) at Wood Green and New Southgate, reflecting the potential for Crossrail 2 to unlock additional housing in those areas[3].

Life expectancy and inequality

All NCL residents have seen an increase in life expectancy over the past decade with current life expectancy for men and women across NCL higher than the England average, with the exception of Haringey and Islington. Despite the higher life expectancy, overall, residents spend approximately 20 years of their life living in poor health. Trends in healthy life expectancy show there has not been a significant change in the number of years people are living healthy lives.

There are stark differences in life expectancy between those living in the most affluent areas compared to the most deprived. Across the NCL boroughs, Camden has the highest life expectancy gap for men, with those living in the most deprived areas living on average 10 years less than the least deprived as the image below demonstrates.

Prevalence of long term conditions

Across NCL, the three most common long term conditions are Hypertension (11%), Depression (7%) and Diabetes (6%). Barnet and Enfield have significantly higher prevalence of Hypertension, Diabetes, Coronary Heart Disease (CHD), Chronic Kidney Disease (CKD) and cancer than the NCL averages. In comparison Camden, Islington and Haringey are broadly in line with the NCL averages, although in some cases having higher prevalence of depression and severe mental illness (SMI)[4].

Our Public Sector Equality Duty (PSED)

We recognise that any change to the way that CCGs operate has the potential to impact on equalities. For this reason, an independent Equalities Impact Assessment (EIA) on the impact of merger on our Public Sector Equality Duty was commissioned – with the conclusions from this assessment being set out below.

Equalities analysis

To support the proposal for the merger of the NCL CCGs, and to consider the potential impacts on people with characteristics protected under the Equality Act 2010 , plus those who identify as carers and those affected by deprivation, Verve Communications was commissioned to undertake an independent initial equalities analysis. As the process continues further equalities impact assessments should be undertaken to assess the impact of changes as the plans become clearer and further information is available.

Desk research was undertaken for this exercise using documents produced to support the proposed merger and existing data on the populations of the current CCGs.

[3] NCL: Growth and S106, HUDU 2018

[4] Source: Office for National Statistics 2014/2016 Pubic Health England HSCIC 2015

Scope and objectives

The objective of this work was to carry out an initial impact assessment in relation to two core functions of the CCGs:

- Governance and Decision Making
- Engaging with the public and hearing the resident voice

The work looks at the current approach and considers some potential benefits and risks to the merger proposals – including in context of the eleven protected characteristic groups.

The output of the impact assessment work provides recommendations on potential mitigations for risks and a timetable for further EIAs.

This equalities analysis is designed to be an iterative process which will be revisited during the process of the merger of the CCGs.

Conclusions from independent EIA

We believe that merging the North Central London CCGs provides an excellent opportunity to tackle health inequalities by working at scale across the NCL population.

Changing governance structures and processes have only an indirect impact on inequalities. However, planning and decision-making on a larger scale across a greater population could enable a step-change: sharpening the focus on equalities impacts and commissioning services which have equalities 'designed-in' from the outset.

This would bring direct benefits for residents sharing the nine 'protected characteristics' identified in the Equality Act; other groups at risk of health inequalities; and enable a reduction in inequality of provision and outcomes (the 'public sector equality duty').

To achieve this, structures and processes must be designed which incorporate: robust and rigorous analyses of the equalities implications of commissioning decisions through equality assessments; a structured approach to the measurement, evaluation and reporting of impacts on different groups and communities; and decision-making appropriately informed by these processes and set in a framework where tackling inequalities is an explicit objective.

The merger will also have an impact through its effect on the CCGs' engagement with communities and partners, and commissioners' ability to hear the resident voice.

We would stress the importance of close local liaison and recognise existing strengths and relationships in CCGs in NCL, on which strengthened engagement can be systematically built.

The merged CCG must ensure that local engagement sits within a structured framework. This will enable a richer mix of channels through which to involve residents in planning; develop a deeper understanding of health needs, patient experience, and "what works"; and hear the resident voice at the right time and place to shape decisions.

Beyond this, the merged CCG, coupled with the advent of increasing integration within and across traditional fault-lines in health and care, will enable the wider determinants of health and wellbeing to be supported. Achieving these promises to bring benefits for residents experiencing inequalities or exclusion and support the development of healthy and resilient communities.

We make recommendations in the section below which we believe would support these goals. In developing recommendations, we have considered both the opportunities and potential risks in relation to governance, decision-making and resident voice.

Recommendations from independent EIA:

1. Making shared commitments

Differential priorities across the NCL population – defining equalities clearly

Commissioning decisions must recognise and reflect the differential needs and priorities across the population of NCL. There are statutory responsibilities to consider the needs and preferences of residents sharing protected characteristics and to tackle inequality. Beyond this, the merged CCG should adopt clear policies on meeting the needs of other groups at risk of health inequalities, for example communities with high levels of deprivation, carers or refugees.

Complexity and diversity – developing equalities policies which look outward

The merged CCG should take account of data and insight developed locally and nationally and set equalities policies based on a nuanced understanding of the complexity and diversity of the NCL population, where groups may suffer multiple causes of deprivation or individuals share several protected characteristics. This means equalities policies should be developed from the outset through collaboration with residents and partners and based on an understanding that services commissioned by CCGs sit within a broader system of health and care.

Shared understanding - identifying health inequalities baselines

We recommend an audit of differential health needs and local health inequalities across the five boroughs to provide baselines to enable future commissioning decisions to systematically promote better health equality.

2. Developing processes which will make a difference

Processes - equalities at the heart of decision-making

Commissioning processes should incorporate a clear, structured methodology to ensure that the potential impacts are considered in an effective, proportionate and timely manner to shape decisions. All options considered should be evaluated through rigorous and robust Equality Impact Assessments (EIAs), and decision-making processes should be transparent, accountable and consider equalities explicitly, fully and appropriately.

Subsidiarity – making decisions at the right level

Decisions should be taken at the right level to make the most positive impact possible on equalities. Structures and processes should be based on the principle of 'subsidiarity' and designed to recognise the complexity of commissioning decisions and the broad range of voices to be heard. In principle, processes should ensure that decisions are informed through the most local relevant structures possible.

Leadership - clear structures and lines of responsibility

After the merger, lines of responsibility and the mechanisms for ensuring equality issues are considered during decision making should be as clear and straightforward as possible to ensure equality impacts are understood and people can take part in decision making. As well as individual commissioning decisions, individual responsibilities, authority and accountabilities should also be allocated for overall leadership and development of equalities policy, practice and performance across the merged CCG.

Levelling up - building on best practices

An audit across NCL of existing governance and decision-making processes and channels for hearing resident voice should be undertaken. This should focus on identifying examples of current best practices across the five CCGs and developing clear benchmark standards for the merged CCG in agreed key areas. There is much good practice to build on, and within the merged CCG the aim should be to 'level up' to meet this. Specifically, no processes in these key areas should be adopted across NCL which would result in a reduction of quality in any existing CCG practice or amount to 'levelling down'.

3. Working with residents

Representation – building structures to ensure inclusion of protected characteristic groups

Resident voice panels and committees should have formally agreed structures and processes for ensuring that residents sharing protected characteristics are adequately represented.

Supporting people to represent themselves - transparency about resident voice

It should be clear to residents how they are represented on panels and committees and how the panels and committees work. It is important that there is clarity about how resident voice was considered in any decision made.

Focus on resident voice – reviewing local engagement

We recommend that a specific EIA is undertaken on the arrangements to hear resident voice and this should have the active involvement of the NCL PPE committee.

Transparency - about the merger and local involvement

In order to facilitate resident voice, the rationale, process, timetable and expected outcomes for the merger must be explained clearly. In setting the tone for strengthened engagement, it is essential that local people and groups – particularly those sharing protected characteristics or at risk of health inequalities – can participate in the design of engagement and equalities policies and help to shape the development of the merged CCG.

We have made recommendations, above, about future work to be undertaken as the merger progresses and afterwards, including audits of current best practices in the five CCGs in terms of governance, decision making and resident voice - and an audit of current health inequalities across North Central London.

Recommendations for future work

We would also recommend an audit of health outcomes across the NCL CCGs to enable future EIAs to identify key inequalities across the merged CCG.

Over time, and as local integrated care systems mature, it may also be appropriate to evaluate the effects of the merger on the wider determinants of health, for example:

- Ways in which the merged CCG could support asset-based community development approaches to tackle existing inequalities
- Ways of supporting individuals and developing the social and cultural capital which could enable residents to access services, take a more active part in improving their own health, manage their own care, and build more resilient communities
- The effect of the digital workstream on people's confidence in accessing care

- Whether the merged CCG's priorities and decision-making processes encompass the wider determinants of health and support integration effectively
- Identifying specific deprived groups where there are opportunities to deliver broader benefits in health, wellbeing and resilience.

Internal Impact

In addition to the work undertaken by Verve Communications, it is also important to ensure internal 'equalities' focus on the merger proposal.

From an internal perspective, whilst there are no direct equality impacts of the decision to support the submission of the merger application – it will be important going forward to ensure that:

- The work to implement the new operating structure and establish the proposed new CCG fully embraces high standards with regards to assessing any impacts from an equalities perspective;
- On an ongoing basis, the new CCG proactively and robustly embraces all aspects of equality, diversity and inclusion in its operating practices and in supporting staff members and officer holders in their roles.

The Drivers and Benefits of Merging

NCL CCGs have been working together under a joint Accountable Officer and Chief Finance Officer for the last two and a half years. As part of this, some functions have been delegated to NCL wide Committees to support more effective working. Alongside this, the NCL CCGs have been working together with partners on a range of transformational programmes through the STP to build on organisational ambitions which include:

- Improving the health and wellbeing of the local population
- Reducing health inequalities
- Maximising out of hospital care and build resilient, well supported communities

In NCL, significant progress on transforming services, to address the three gaps set out in the NHS Five Year Forward View, has already been undertaken including mental health crisis provision, to consistent and quicker discharge home from hospital, and the development of primary care networks.

Whilst progress has also been made against the three gaps set out in the NHS Five Year Forward View, the CCGs are now faced with considerable financial challenges and a need to reduce system costs alongside preparing our organisations to work in more integrated and collaborative ways that ensure there is a sustainable health and care system to improve outcomes of our diverse and growing population.

Strategic Drivers

The NHS Long Term Plan published in January 2019 sets out a refreshed vision for the future of NHS services, building on the Five Year Forward View. The plan confirms the need to streamline commissioning arrangements via a single CCG for each Integrated Care System (ICS) rather than the existing CCGs that we currently have across North Central London. This will enable a single set of commissioning decisions at system level that includes the development of local Integrated Care Partnerships (ICPs) which would be underpinned by Primary Care Networks (PCN).

In view of the above, every system will need streamlined commissioning arrangements to enable a single aligned strategic commissioning direction that will support a new system accountability framework and provide a consistent and comparable set of performance measures.

The Plan confirms existing clinical priorities and makes a number of commitments in that the NHS will:

- Do things differently through a new service model
- Take more action of prevention and health inequalities
- Improve care quality and outcomes for major conditions
- Ensure the NHS staff get the backing they need
- Make better use of data and digital technology
- Ensure we get the most out of tax payers' investment in the NHS – including that CCGs will deliver a 20% management cost reduction

In line with the NHS Long Term Plan, over the past 6 months, across NCL, there has been a co-ordinated programme of events (The Inter-great events) exploring potential future arrangements for integrated health and care, at borough level and across the five boroughs. This has identified a number of opportunities to increase the level of collaborative working, to work differently, to strengthen front-line support to residents and a population-wide approach to health and wellbeing.

Alignment of Commissioning and Operational Delivery

The key drivers for change that have been identified to support the alignment of our Commissioning arrangements and operational delivery have been identified as:

- The NHS Long Term Plan sets out that there will be one CCG per Integrated Care System (and therefore one for North Central London)
- Current governance and decision points are duplicative and can slow down the impact we can have for residents
- We need to move away from transactional processes to delivering transformational change
- We need to dedicate more time and focus to borough-based integration to increase our focus on communities and prevention
- We need to improve how we plan services based on population health in order to maximise the impact we can have

Benefits of Merging

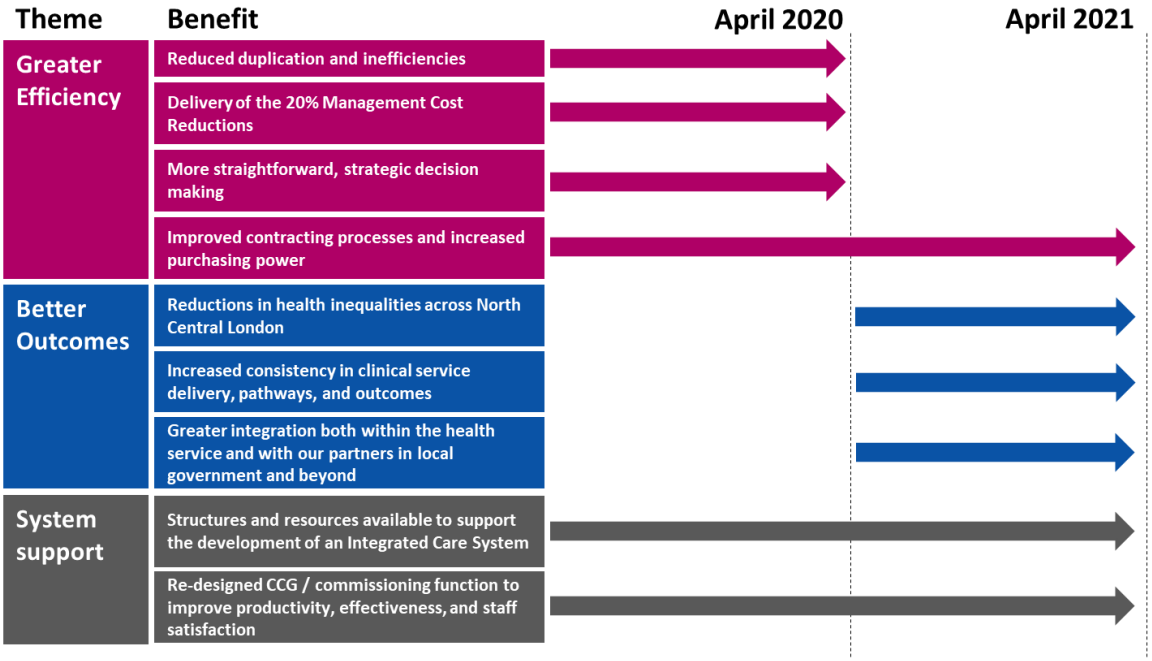
There are different types of benefit that will occur from merging our CCGs. These include:

- Economic Benefit - Financial Improvement, releasing cash, increased income, better use of funds;
- Effectiveness Benefits - Doing things better or to a higher standard;
- Efficiency Benefits - Doing more for the same or the same for less;
- People Benefits – A benefit that although it has an economic, efficiency or effectiveness reason has a direct benefit to our people;
- System Benefit - A benefit that although it has an economic, efficiency or effectiveness reason has a direct benefit on our systems.

These will benefit - either directly or indirectly - patients and local people, GPs and other clinicians, health and care partners and many others. Some benefits will be achieved through the bringing together of the existing organisations in the short term, whilst other benefits will result from the support that a single CCG can provide to the development of an Integrated Care System for North Central London over time.

Moving to the new operating model and the merger of the CCGs to a single CCG will support the achievement of the 20% management cost reduction set out for CCGs in the Long Term Plan.

To realise the full scale of the benefits of merger, we have begun to map out some of these benefits as part of our Benefits Realisation Plan for Merger. Below is a summary of some of the benefits that will come from merging, and how they will be delivered over time:

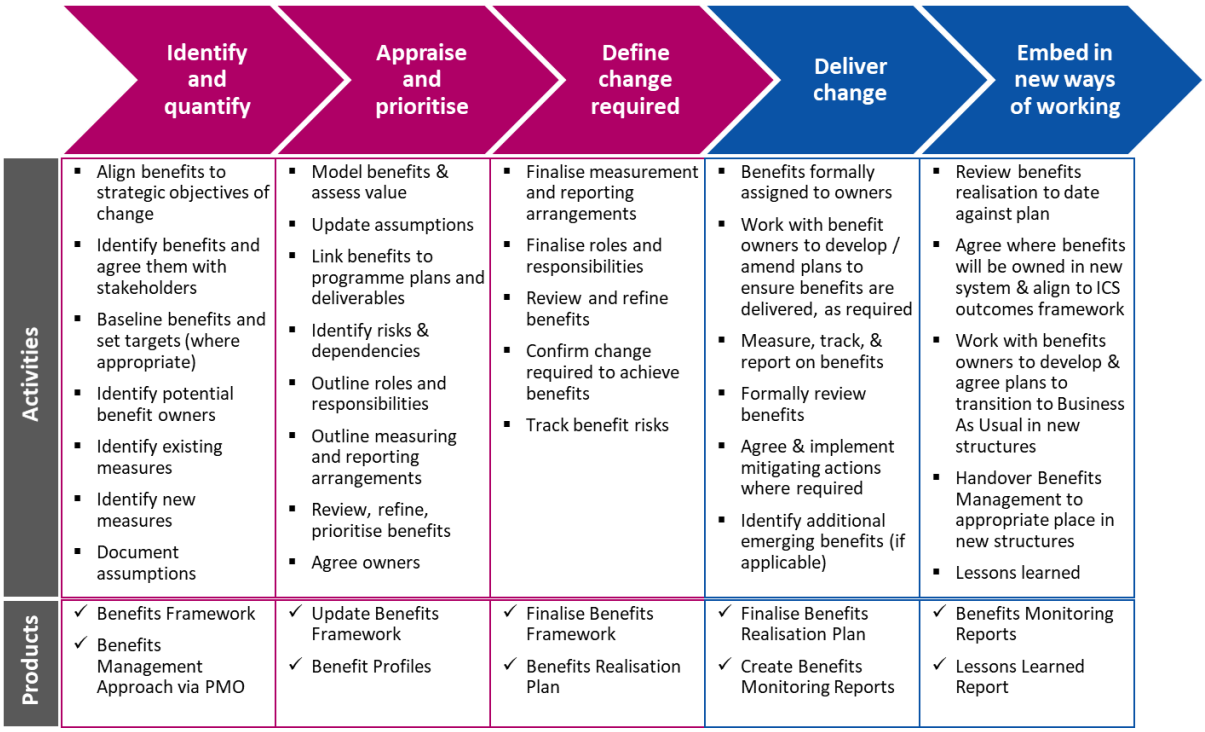


Benefits Management Approach

To deliver these we will be following a benefits management approach within the change programmes.

We are currently in the identification and quantification stage – which is being considered by the finance working group with representatives from the CCGs' finance teams.

Initial focus for quantification is on those benefits relating to greater efficiency where changes need to be in place for 2020. Work on longer term improvements to outcomes will follow this work.



Our History of Joint Working

Collaboration across the North Central London, both externally with partners and internally across the CCGs, has increased at significant pace over the past two and half years – following on from the appointment in 2017 of a single Accountable Officer and Chief Finance Officer for the NCL CCGs.

Collaboration with Partners

The geographic boundary for a single North Central London CCG will have strong alignment with key partners and partner organisations within the current STP footprint:

- General Practices and GP Federations
- Patients and the Public
- Healthwatch
- NHS Provider Trusts
- Local Authorities and Public Health

This in-turn will provide a natural path to all key partners working together with an Integrated Care System for NCL and therefore fulfill the requirement of the NHS Long Term Plan of a single strategic commissioner within the footprint.

Whilst, on occasion, the existing NCL CCGs also work with other CCGs – this will not be impeded by moving to a single CCG:

- The proposed operating model will enable local teams to work with other 'cross-border' CCGs. Similarly, the model will also support local working with other local partners.
- The current CCG-led consultation on the proposed redevelopment of Moorfields Eye Hospital has required working a number of other CCGs outside of North Central London. The links to NCL CCGs has been coordinated through the NCL Joint Commissioning Committee (see below) and therefore is already being managed in a collaborative manner.

Collaboration across CCGs - Governance

Since 2017 the NCL CCGs have operated an increasing number of collaborative governance arrangements – ensuring both consistency and efficiency across a number of key committees:

- Joint Commissioning Committee – including, for example, acute commissioning, learning disability contracting associated with the Transforming Care programme, integrated urgent care (including 111/ GP Out-of-Hours services) and any specialised services not commissioned by NHS England
- Primary Care Commissioning Committee in Common
- Audit Committee in Common
- Independent Funding Requests Panel

Specific examples of commissioning that has benefitted from the single NCL committee approach are:

- The clinical delivery model for the Adult Elective Orthopaedic Services which will deliver improved quality of care and outcomes through increased provider collaboration across base hospitals and elective centres;
- NCL integrated Out-of-Hours service which brings together NHS111 and GP Out-of-Hours to deliver a consistent and equitable quality of service across the STP footprint while also delivering economies of scale, such as enabling CCGs to monitor a single contract.

The appetite for, and benefits of, collaboration across NCL can be further illustrated through the joint commissioning of the Health Information Exchange project – which will create a single, comprehensive view of an individual's health record, available to health professionals at the point of care.

A single CCG will provide a strong platform to enable further efficient and effective commissioning of consistent healthcare service to all patients across North Central London.

Collaboration across CCGs – single management structure

Also since 2017, the CCGs have benefitted from a single Senior Management Team including the single Accountable Officer, Chief Finance Officer and a number of Director-levels posts undertaking roles on behalf of all NCL CCGs:

- Director of Strategy
- Director of Performance, Planning and Primary Care
- Director of Acute Commissioning
- Director of Corporate Services

Taking Corporate Services as an example, a single NCL directorate has now been in place for over a year - delivering a range of joined-up corporate functions to each CCG (Governance, Risk, Secretariat, IG, HR & OD and Communications & Engagement). This approach has delivered strong consistency in service delivery and realised both financial and process efficiencies. Under a merged CCG for North Central London – we will be in a strong position to implement a similar model and realise similar benefits for other areas of the operating structure.

Recently, a Director of Quality position has been added to the NCL Senior Management Team – again to provide cross-CCG consistency in Quality and Safety work, also complementing the existing network of Directors of Quality working together across NCL.

Communicating and Engaging on Our Merger Plans

Effective communications and engagement have been central to the development of our plans for merging the existing CCGs across North Central London. This has taken place in conjunction and

alignment with communications and engagement on the Long Term Plan and our local plans for developing an Integrated Care System and borough based Integrated Care Partnerships. This has allowed us to demonstrate the relationship between the different developments whilst also ensuring that core stakeholders and messages specific to the CCG merger are clearly communicated.

Communications and engagement principles

Through our Engagement Advisory Board we have developed the following principles for how we will engage around the Long Term Plan, London Vision, and the NCL Change Programmes:

- The NCL CCG communications and engagement plan will be updated on an iterative basis, aligned with the key phases of the change programme plans. Under this, local CCG communications and engagement teams will work with their leadership to develop CCG-specific communications and engagement plans
- Regular updates will be provided to all key audiences and the main stakeholders for the change programme will be fully engaged and, where appropriate, formally consulted
- To ensure clarity, NCL change programme messaging and core communications materials will be produced centrally and updated on a rolling basis – circulated to local CCG teams to be appropriately tailored and used locally
- Insights from communications and engagement activity undertaken by all partner organisations will be collated to inform the change programme on an ongoing basis
- An appropriate HR process will be set out in an HR Transition Plan – which will be closely aligned with the communications and engagement plan to avoid duplication or confusion

Communications and engagement on the merger

Robust engagement has been undertaken at both borough and North Central Level to support our application to merge. Key stakeholders have confirmed their support for the CCGs moving to a streamlined NCL health commissioning function and for our ambitions to assist the development of an NCL Integrated Care System.

A summary of our full communications and engagement activity, and the feedback received to date, is included in section 3 of this document.

Support for Merger

The existing CCG Governing Bodies in North Central London agreed to pursue a merger to a single CCG following seminars in May 2019. Since that decision extensive work has been undertaken, both within the organisations and with our partners, to ensure full support for the merger and consensus on the case for change.

Support from CCG Governing Bodies

The CCGs in North Central London already operate under a single Senior Management Team (SMT) structure, including a single Accountable Officer and Chief Finance Officer. The programme to develop the merger has been led by the SMT.

The NCL CCGs' Assurance and Oversight Group (AOG) was established in July 2019 to oversee progress towards merger and to ensure that key issues that may impact on support for the merger from Governing Body members are addressed in a satisfactory way. This group consists of the chairs from each CCG and a nominated lay member, plus members of SMT and the programme team.

So far a number of priority areas for assurance have arisen from these discussions and we have sought to resolve these through the development of documentation to support the merger that provides the required assurances and safeguards to address the core concerns. The key points have been captured in appendices to this paper, including:

- The financial principles of merger, including the treatment of historical deficits and surpluses, and the approach to budget setting at a borough level (see Appendix B – Our Financial Strategy & Arrangements for Delegated Decision-Making);
- The future approach to Patient and Public Engagement (PPE) in the new single CCG, including how we will ensure no dilution of the resident voice in decision making (see Appendix A – Our Approach to Patient and Public Engagement);
- The governance structures and Governing Body make-up in the new single CCG (see Appendix B, C and related content above).

Prior to submission of our formal application to merge to NHSE England full confirmation of Governing Body support will need to be confirmed and documented.

Support from our partners

As set out in our communications and engagement plan we have conducted extensive engagement both at borough and NCL level throughout the last few months to ensure that key partners are briefed on and supportive of our proposal to merge. This includes listening to and responding to any concerns raised.

The programme to develop and implement the merger of the CCGs has been run as part of the broader NCL Change Programme approach, which includes the programme to support the development of an Integrated Care System and borough-based Integrated Care Partnerships. This has ensured that there is consistency between the development of the future operating model for a single NCL CCG and the emerging principles for a working as a single Integrated Care System. For example, the cross-partner ICS Design Group has agreed the levels at which each function will operate and be owned within an Integrated Care System. This has in turn been used to inform and guide the development of the operating model for the single CCG, and which commissioning functions would need to sit at which level.

This alignment has helped ensured that partners are bought into and supportive of the merger process. As evidence of this, letters of support received to-date from partners are included at Appendix E.

Intervention and Delegated Authority

Intervention

Currently none of the existing NCL CCGs are under directions from NHS England.

Delegated Authority

The North Central London CCGs (NCL CCGs) became responsible for fully delegated primary care commissioning in 2017. This built on the experience, skills and knowledge gained from being joint commissioners with NHS England from October 2015.

The NCL CCGs have robust and effective arrangements in place for delegated primary care commissioning. This includes the NCL Primary Care Commissioning Committee in Common between the CCGs to exercise oversight and decision making, a central NCL wide team for GP core contracting from NHS England who are now CCG employees, a central director with responsibility for delegated primary care commissioning who is a member of the NCL CCGs' central Senior Management Team,

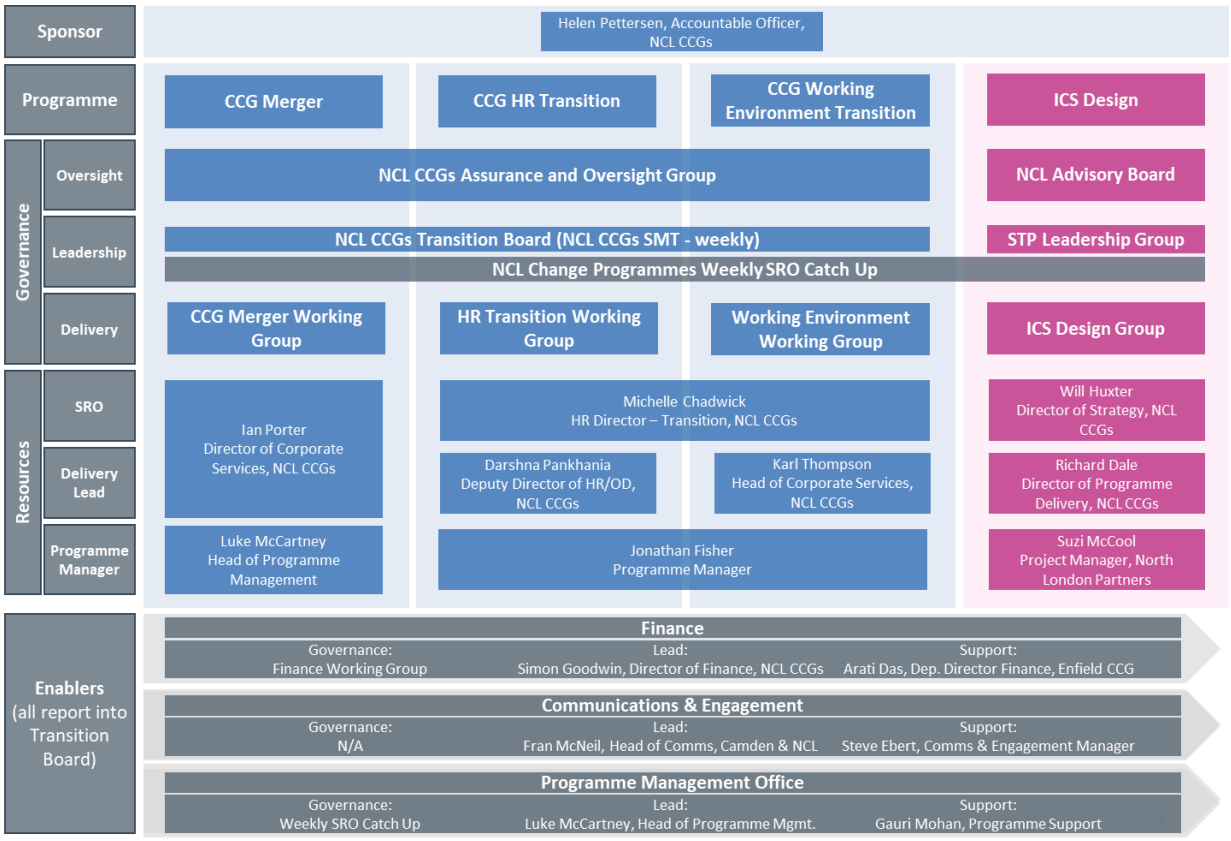
reports directly to the Accountable Officer and works with the primary care teams in each of the CCGs. The CCGs' internal auditors recently conducted an audit on commissioning and procurement of services and found that there was 'reasonable assurance.

The above arrangements would smoothly transition to a new single CCG with a single Primary Care Commissioning Committee providing oversight of the arrangements and exercising decision making in accordance with NHS England statutory guidance.

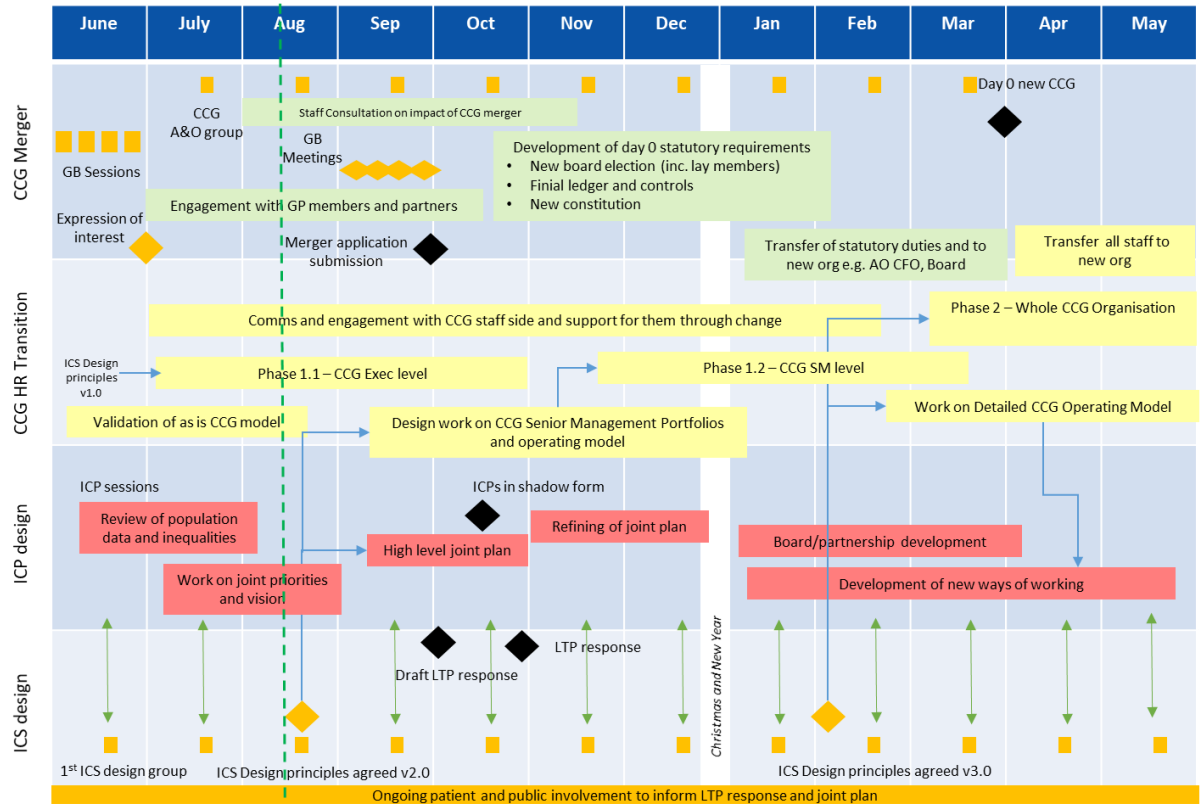
2. Our Approach to Delivering the Merger

The North Central London Change Programmes, including the CCG merger programme, are led by the NCL CCGs Senior Management Team. SROs for each programme have been appointed from within the SMT and support for each programme and workstream has been identified from within CCG resources.

The below diagram provides an overview of the structure of the programmes and the staffing resources allocated to the management and delivery of each programme. In addition, support is being drawn from the relevant CCG and STP leads within the system to develop and deliver the specialist content of each programme.



The below timeline outlines the key milestones across the North Central London Change Programmes, and how they align. This includes the key merger timetable but aims to set this is in the context of wider development across the system to implement the Long Term Plan and develop Integrated Care.



PMO

The CCG Merger process is supported by a centralised Programme Management Office, working across three broad change programmes given their interdependencies:

These are:

- Management Cost Reduction/Service redesign;
- The CCG merger;
- Establishing an Integrated Care System and borough-based Integrated Care Partnerships.

Managing the programmes together allows to ensure that we effectively manage the interdependencies between them. For example, ensuring that the design of the single CCG operating model takes account of how the whole system needs to work differently in the future, and explicitly supports and enables the development of integrated care partnerships at a borough level. Aligning the timelines for the programmes is also expected to support staff to work in new ways and be part of creating the new integrated system, solving some of the issues of fragmentation across organisations that mean our residents do not always get the very best care possible.

A shared programme office supports both the day-to-day activities leading to the merger as well as the assurance and senior oversight functions into the process. The PMO is responsible for tracking deliverables, ensuring all assurance criteria are met, monitoring risks, issues and dependencies between the workstreams, and ensuring reporting and information flows.

SRO and Change Management Team

The key personnel responsible for the day-to-day deliverables and overall assurance are:

Role	Key Tasks	Who
NCL Change Programmes Sponsor	• Oversight of overall programme	Helen Pettersen
CCG COOs	• Leading the development of borough based Integrated Care Partnerships • Provide input as require via the Transition Board to manage risks • Ensuring timely briefing of staff	CCG COOs
Programme SRO	• Ensuring that the workstreams plan is realistic and includes the correct list of products/deliverables with the right programme management in place. • Ensuring that the deliverable owner has the necessary skills, resources and experience required to deliver the change. • Assuring the programme's engagement approach, including leading high-level engagement activities as required (for example with Governing Body members, staff, LA Partners and NHSE.)	Ian Porter, Michelle Chadwick, Will Huxter
Organisational Development lead	• Provide specialist input, advice and lead the organisational development elements across the workstreams.	Michelle Chadwick
NCL Change Programmes Director	• Ensuring progress to plan – and any governance deadlines – across the programme as a whole. • Ownership of list of deliverables as defined by SROs. • Oversight and management of programme office and programme managers. • Ensuring that all members of the project team have clear responsibilities. • Overall responsibility for managing risks and issues associated with the programme.	Richard Dale
Head of Communications and Engagement	• Responsible for the development and implementation of a robust communications and engagement strategy is in place • Manages key programme communications and engagement with staff, local stakeholders and the public working with CCG communisations teams • Provides specialist input and advice to SROs and deliverable owners	Fran McNeil
Delivery lead	• Develop detailed solutions and leading analysis and design to complete deliverables as defined by SRO. • Supported by programme management office and programme leads and sub groups as required	As required based on skills required

Programme Governance

The following distinct groups oversee change management governance:

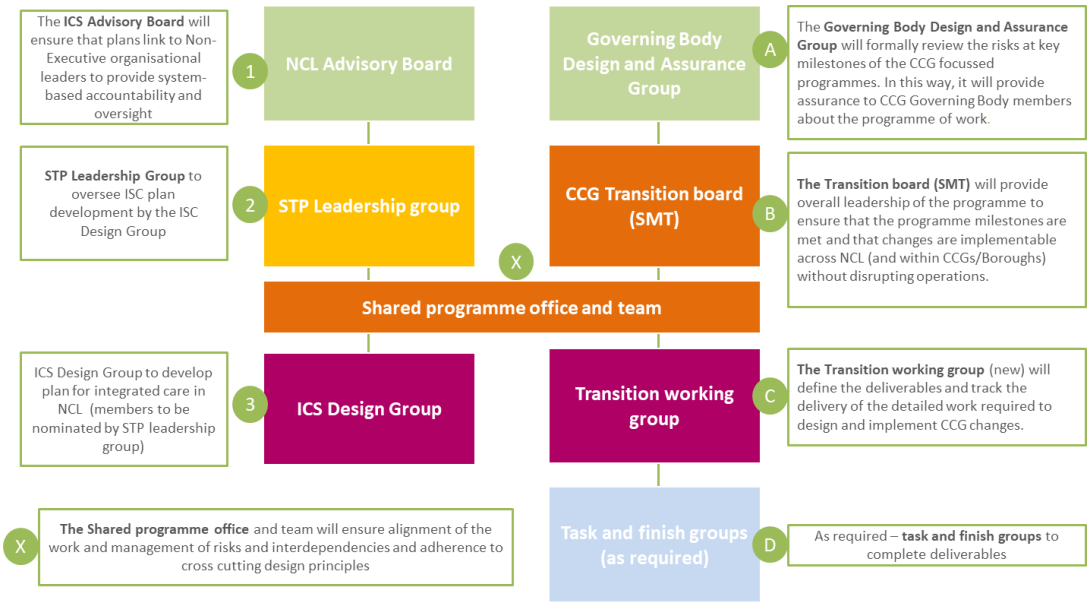
The Transition Working Group is chaired by the Programme Director and includes the Head of the Programme Management Office and SROs from all the work streams. The group meets weekly to review

progress against plans, track delivery and detailed work, identify and mitigate key risks and determine next steps. The group is supported by task and finish groups to enable specific deliverables as and when required.

The CCG Transition Board consists of Helen Pettersen, NCL CCGs' AO; COOs of all CCGs; the Chief Finance Officer, the other members of the NCL CCGs' Senior Management Team, the Programme Director and the SROs of all workstreams - and reviews the programme highlights and key risks. The group provides overall leadership to the programme and helps ensure that the programme milestones are met and that changes are implementable across NCL (and within CCGs/Boroughs) without disrupting operations. The group meets once a week.

The Assurance and Oversight Group consists of the Chairs of each NCL CCG, a lay member from each NCL CCG, the Accountable Officer (& sponsor of Change Programme), the Chief Finance Officer, Director of Corporate Services for NCL CCGs (& SRO for CCG Merger), HR Transition Director (Interim) (& SRO for Management Cost reductions), Programme Director for NCL Change Programme and Head of Communications & Engagement (for NCL corporate activity). The group meets monthly and its role is to:

- Take a strategic overview of the development and delivery of the change programme;
- Review key proposals and plans and progress in delivering the related key milestones – providing steer and feedback to the implementation groups / teams;
- Provide a Clinical Member and Lay Member view on the emerging proposals, and so provide assurance to other Governing Body members that these perspectives have been taken into account in the planning and delivery work;
- Take an overview of the key risks and issues associated with the delivery of the programme – also helping to identify any new risks or issues arising (including through group members' discussions with other Governing Body members or key stakeholders);
- Be assured that robust stakeholder engagement is being undertaken and that key feedback is being reflected in ongoing planning and implementation work;
- Help provide a strategic view on external and internal communications, and organisational development priorities in relation to the programme;
- Be assured that all mandatory requirements associated with the programme (e.g. CCG merger application process) are being met.



Summary of current risk register

Below is a summary of the key risks from the programme risk register.

Key: L = Likelihood; C = Consequence

ID	Summary Risk description	L	C	Score	Mitigation(s)	Named owner
R01	Approach to treatment of historic CCG surplus/deficits not confirmed in time to inform case for merger	2	4	8	• Escalated to NHS England/Improvement for view on their expectations regarding treatment of CCG historic surpluses and deficits • Proposed approach now included in Appendix B	Simon Goodwin
R02	Staff leave as they do not feel informed and involved in changes	3	4	12	• 2020 date for merger to minimise disruption for staff • Communications plan in place • HR framework developed and staff support plan in place	Helen Pettersen / Michelle Chadwick
R03	Decision to merge is delayed due to inability of CCGs agree shared financial principles of merger	3	4	12	• Meeting with CCG Chairs to discuss proposed principles	Helen Pettersen / Simon Goodwin
R04	Wider care systems stakeholders do not support merger	2	5	10	• Communications plan in place • Senior briefings with Local Authorities • Briefings with NHS Trust Chairs	Helen Pettersen
R05	CCG Merger process impacts on business as usual for existing CCG functions	2	4	8	• 2020 date for merger to minimise impact on BAU • Wider Leadership Team meeting and director briefings to focus on resilience and supporting staff through change • New operating model and governance structure rapidly developed	Helen Pettersen / COOs
R06	Merger does not realise potential benefits: • Reduction in transaction costs • Support development of ICPs • Tackling inequalities across our communities	2	4	8	• New operating model and governance structure rapidly developed • Financial and strategic principles and checkpoints to be used throughout process • ICS principles to be developed by ICS design group • Joint programme management office to link to ICS work • Benefits framework developed	Simon Goodwin / Will Huxter
R07	Merger application developed for submission does not meet local & national requirements	2	4	8	• Programme plan and PMO process in place to manage application • Application Development Framework in place • Assurance and Oversight Board in place • Guidance sort from NHSE/I on 'must-do' requirements for submission	Ian Porter
R08	New CCG model does not support move to new ways of working for ICS	2	4	8	• Design principles developed via ICS group • New governance model is future-proofed and focusses on core functions • Work on borough level Integrated Care Partnerships prioritised by COOs	Ian Porter /COOs
R09	GP Practices do not support the new Constitution for single NCL CCG	2	4	8	• Constitution drafted based on model constitution and best practice • Ongoing engagement with practices	Ian Porter
R10	Delay in in-Housing of CSU Contracting / POD teams prevents some benefits realised	2	3	6	• Written to CSU MD outlining intensions • Working closely with CSU POD team to keep staff informed	Helen Pettersen

3. Our Merger Communications and Engagement Plan

A robust programme of engagement and communications on the North Central London Clinical Commissioning Groups (NCL CCGs) proposal to merge was undertaken between May – September 2019, meeting the requirements set out in the published NHS England guidance. The following paper provides a summary of the strategic approach, activity undertaken and a thematic summary of the feedback received. Engagement will continue through 2019-20.

The following principles for merger engagement were agreed:

- The NCL CCG communications and engagement plan will be updated on an iterative basis, aligned with the key phases of the change programme plans. Under this, local CCG C&E teams will work with their leadership to develop CCG-specific engagement plans
- Regular updates will be provided to all agreed key audiences and the main stakeholders for the change programme will be fully engaged
- To ensure clarity, NCL change programme messaging and core communications materials will be produced centrally and updated on a rolling basis
- Insights from communications and engagement activity undertaken by all partner organisations will be collated to inform the change programme on an ongoing basis
- An appropriate HR process will be set out in an HR Transition Plan – which will be closely aligned with the communications and engagement plan to avoid duplication or confusion

Borough- and NCL-level engagement

The overarching NCL CCG communications and engagement plan outlined the required activity to be delivered by each CCG for their boroughs across June to September. Local CCG leaders were supported by their Head of Communications and Engagement to produce detailed local engagement plans, aligned to the NCL plan. It was agreed that wherever possible existing CCG channels and meetings should be utilised.

In addition to CCG borough-level engagement, members of the NCL CCG SMT also undertook engagement activity with some key audiences at an NCL level. Specifically, it was agreed that

NCL Joint Health Overview and Scrutiny Committee (JHOSC) would be engaged, rather than the five local OSCs. Engagement has also been undertaken with the borough LMCs at an NCL level.

Across May – September, robust engagement with the agreed key audiences was undertaken to inform, and evidence support, for the CCG's application to merge. Multiple opportunities were identified for discussions, per audience, through a variety of methods. These included meetings, briefing events, calls, letters, newsletters, webinars, website and intranet information and published Frequently Asked Questions. Further detail in set out in Table 2, below.

Summary of engagement activity undertaken

The NCL CCG SMT Transition Board, and the CCG Assurance and Oversight Group, are confident that robust engagement has been undertaken to inform our merger planning and that no issues arose regarding the engagement approach we have taken that would impact our application to merge. As well as engagement activity specifically focused on the CCG merger, NCL and borough meetings focused on developing integrated care systems – including information around the future direction of travel for commissioning (in NCL, with one merged CCG).

Key themes from stakeholders is set out below – which is supported by the following tables:

- Table 1 - illustrates, per audience, whether engagement activity was undertaken by individual CCGs, or at an NCL-level, or both;
- Table 2 – summarises the engagement activity undertaken with stakeholders;
- Table 3 - provides a summary of feedback from each stakeholder category.

Table 1 – Engagement Activity

	NCL	Barnet	Camden	Enfield	Haringey	Islington
Governing Bodies		✓	✓	✓	✓	✓
Member practices		✓	✓	✓	✓	✓
CCG staff	✓	✓	✓	✓	✓	✓
Unions / staff side	✓					
PPE Committees		✓	✓	✓	✓	✓
Council Chief Executives*	✓	✓	✓	✓	✓	✓
Council Leaders*		✓	✓	✓	✓	✓
Council Leads for Health*		✓	✓	✓	✓	✓
Directors of Adult Social Care		✓	✓	✓	✓	✓
Trust Chief Executives	✓	✓	✓	✓	✓	✓
HWBB Chairs*		✓	✓	✓	✓	✓
LMCs	✓	✓	✓	✓	✓	✓
Healthwatch	✓	✓	✓	✓	✓	✓
J/HOSC Chairs*	✓	✓	✓	✓	✓	✓

*In some boroughs these stakeholders were engaged via the Health and Wellbeing Board.

Table 2 - Summary of NCL CCGs' engagement approach

Audience	Engagement activity summary
Governing Bodies	▪ CCG Governing Body members were engaged in the merger planning programme through a number of seminars specifically focused on the merger, as well as other existing Governing Body fora. ▪ Governing Body members also received email briefings in addition to the updates of merger planning included in fortnightly staff newsletter. ▪ Chairs and Lay Members with responsibility for PPE participated in the NCL CCG Assurance and Oversight Group, assuring the merger plan and process. ▪ Lay Members with responsibility for PPE also participated in the NCL Engagement Oversight Group, where the NCL change programme (including merger) was discussed.
Member practices	▪ Merger plans were presented and discussed at existing member practice meetings. Practices received the commissioning meeting papers via email/websites. ▪ Practices that were not engaged at commissioning meetings where merger planning was discussed were contacted, offering the opportunity to discuss this directly with the CCG. ▪ Information on integrated care / the NCL change programme was shared on CCG GP websites, and included in GP bulletins. In one borough, a webcast was held with Primary Care Network leads. ▪ Federations were engaged via borough Integrated Care Partnership meetings and in some boroughs, direct discussions with the CCGs
Unions / staff side reps	▪ Joint Partnership Group meeting held with management and local/regional representatives in August 2019 to share the approach of managing the HR transition programme in line with the HR Transition Framework. ▪ Monthly Joint Partnership Group meetings scheduled with management and local/regional trade union representatives to ensure staff side are kept up to date on progress. ▪ Summary of communications to staff and support to be available for staff on the transition programme shared with Regional Representatives from recognised trade unions ▪ Pre-engagement and engagement with staff side as part of formal consultation processes during each wave.
PPE Committees	▪ Patient and public engagement committees/groups was engaged through existing meetings, where updates on the NCL change programme were brought for discussion
Council officers and political leaders	▪ The NCL CCGs' senior leadership, through existing meetings, ensured that the CCG merger plans were shared and discussed with Council Chief Executives, Council Leaders, Directors of Adult Social Care and Councillors with a health portfolio, and in some boroughs, Public Health colleagues ▪ Senior council representatives have participated in regular borough level meetings to discuss development of borough Integrated Care Partnerships, within which CCG merger has been discussed.
Providers	▪ The NCL CCGs' senior leadership, through existing meetings, ensured that the CCG merger plans were shared and discussed with Trust Chief Executives ▪ Trust leaders were represented at the NCL Integrated Care System Design Group, meeting monthly from July – September, to shape plans for integrated care. The requirements of a strategic NCL commissioning function to support the development of ICS and borough ICPs was considered within design planning.

	▪ Acute Trust representatives and other Provider leaders have participated in regular borough level meetings to discuss development of borough Integrated Care Partnerships, within which CCG merger information has been shared.
LMCs	▪ NCL SMT members have met with LMC representatives at an NCL level. In some boroughs, LMC senior representatives have also been engaged via meetings.
Health and Wellbeing Board Chairs	▪ Per borough, Health and Wellbeing Board Chairs have been engaged via meetings, conversations and/or sharing of merger planning information via email, through the engagement period. ▪ Health and Wellbeing Board representatives have also participated in borough level meetings on the development of borough Integrated Care Partnerships, including discussion on commissioning at an NCL, borough and neighbourhood level.
Health Overview and Scrutiny Committees	▪ It was agreed that formal engagement with HOSCs would be undertaken at an NCL level with JHOSC. Information on merger plans was brought to JHOSC in March, and an update is scheduled for the September JHOSC. Per borough, information has been shared with HOSC Chairs, as part of discussions on local and NCL plans for the development of integrated care.
Healthwatch	▪ Per borough, a variety of different methods have been used to engage Healthwatch organisations, including briefing meetings with COOs/Chairs and participation as members of PPE Committees (where merger planning was discussed. ▪ The five Healthwatch organisations also participate in the NCL Engagement & Advisory Board, where the NCL change programme (including merger) has been discussed.
Staff	▪ NCL CCG staff were regularly engaged through the merger planning process through updates at fortnightly staff briefings, fortnightly staff newsletters, and in some boroughs, away days. ▪ Staff were able to submit questions via the five intranets, their line manager, to HR or directly to the merger programme team inbox. ▪ Senior staff participated in two Wider Leadership Meetings focused on the change programme, including the merger. ▪ In some CCGs, staff briefing sessions (lunch and learns) were run to provide staff on key topics related to the NCL change programme (e.g. integrated care partnerships, primary care networks).

Themes of Stakeholder Engagement Feedback

The main themes of the feedback received to date through the CCG's collective stakeholder engagement regarding the proposals to merge have been summarised in this section.

Overall, across the five boroughs, our engagement identified that there is support for the direction of travel, set out in national policy, to streamline commissioning arrangements to enable a single set of commissioning decisions at system level – in NCL, by proposing to form a single CCG.

Stakeholders recognised the benefits that merging could deliver around reducing health inequalities, making greater collective progress on improving health outcomes, streamlining commissioning decision making, reducing duplication and reducing transactional costs, and enabling us to deliver the required 20% reduction in manage costs from April 2020. The proposal to merge was often discussed in the context of creating commissioning functions that align with, and support, the establishment of Integrated Care System and borough ICPs – on which positive progress is being made in NCL.

Our engagement was undertaken in parallel with the CCG's merger planning. As such, there was recognition that detailed information on some key areas is currently in development. There was interest among stakeholder groups to continue to receive updates, including detail on the following when available: what will 'happen' at what levels, the future clinical leadership model for the CCG (and integrated care system), how strong borough commissioning relationships at a borough level will be maintained (e.g. with member practices), and how the support currently offered by CCGs locally would be maintained. Feedback captured from engagement has, and will continue to inform our planning.

Some themes around potential concerns have been identified through our engagement activity. These included around successfully delivering the merger a short timeframe (if working towards April 2020), some financial issues related to merger of CCG budgets and protecting levels of local investment, and maintaining local commissioning accountability. There was recognition that any significant transition period is unsettling and may impact CCG staff retention and morale, and that merging sooner would avoid an extended period of uncertainty.

Table 3 - Audience-specific feedback summary

Members	▪ Interest in future GP clinical leadership model ▪ Keen to understand role of GP federation and neighbourhoods in new system ▪ Queries / interest in how budget allocations will work under a single CCG, and GP funding ▪ Interest in protecting quality and maintaining safety ▪ Queries how different population health profiles per borough would be managed under a single CCG ▪ Concerned with maintaining local commissioning relationship and support (e.g. GP IT, GP websites, links with CCG primary care teams) ▪ An opportunity for standardised training across the NCL ▪ Keen local CCG knowledge and relationships are retained ▪ Interest in future governance arrangements, including clinical representation on Governing Body by borough
Council / Public Health / LMC	▪ Councillors keen to understand role of Health and Wellbeing Boards (HWBBs) in new structures ▪ HWBBs, Councillors, and LA colleagues want to understand how local funding and current services will be preserved ▪ Public Health colleagues keen to understand future levels of services centrally and with boroughs ▪ Keen to be kept informed of changes as they develop ▪ LMC welcomed opportunity to discuss the change programme in depth and want to be kept informed ▪ Interest in what will remain commissioned locally and retaining local commissioning expertise
Healthwatch	▪ Healthwatch want to see a transparent process continuing, receive regular updates and to understand how they can be involved (in the wider NCL change programme) ▪ Keen to receive further information, when available, on:

	▪ New governance structures ▪ How changes will impact residents and the local population ▪ Impact of CCG management cost reduction on patients and residents ▪ How the local voice will continue to be heard in the single CCG structure / future PPE model
Staff	▪ High levels of interest in the HR transition process and merger process ▪ Key themes from staff questions include: the future operating model, changing roles and functions, redundancies, future office locations

Engagement Next Steps

- The NCL CCGs will continue to maintain an open dialogue with all our key stakeholders on the merger proposals, and are committed to sharing further detail on all the key elements of our merger plans as these become available. Key decisions will be communicated promptly.
- Communications materials and messages will be regularly updated and published/disseminated through all our available channels, to ensure the latest information is easily accessible.
- The feedback generated through our ongoing engagement will continue to be captured and analysed on a rolling basis, and brought to CCG Governing Bodies, NCL CCG Senior Management Team and other key leadership fora, to inform the CCGs' merger plans.
- If a decision is made to proceed with a merger from April 2020, detailed planning will be undertaken to ensure that we have robust communications and engagement processes in place for the newly merged CCG for 2020-2021, including on our NCL CCG patient and public engagement strategy.

Appendix A: Our Approach to Patient and Public Engagement

Patient and public involvement is a key role for the CCG.

The Health & Social Care Act 2012 sets out that CCGs ***must make arrangements*** to secure that individuals to whom the services are being or may be provided are *involved in*:

a) the ***planning*** of the commissioning arrangements;

b) the ***development and consideration of proposals*** for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the ***manner*** in which the services are delivered to the individuals or the ***range*** of health services available to them

c) ***decisions*** affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

Through the NHS England Improvement and Assessment Framework (IAF), CCGs are assessed on how statutory duties are met in relation to patient and community engagement. Our aspiration for an NCL CCG should be to achieve an 'Outstanding' rating for the patient and community engagement indicator by 2020/21.

Across NCL, we face a wide range of health inequalities - and reducing these inequalities will continue to be a key priority for a single NCL CCG and local borough partnerships. Our approach to patient and community engagement should also therefore encompass and consider the CCG's responsibilities around equality, diversity and inclusion.

This paper sets out how these principles will be delivered through the new single CCG for North Central London. This will form the content for our application for merger.

Partnership Working - NCL Engagement & Advisory Board

In the context of a changing landscape for the commissioning and delivery of healthcare services – it will be important for engagement activity to be planned with key partners.

The NCL Engagement & Advisory Board (membership includes CCG lay members, Healthwatch, Voluntary sector, Councillors and CCG communications and engagement colleagues) that has recently been established has developed a set of principles that will guide partnership-based engagement approaches on the NCL Change Programmes across North Central London. These principles are to:

- identify, understand, listen to and respond to our stakeholders;
- put residents and patients at the heart of our work – by making sure they are involved early and represented in discussions;
- ensure residents and communities have opportunities to influence our work;
- engage with residents experiencing the greatest health inequalities;
- build and protect local relationships with residents, communities and community groups;
- be clear about why we are engaging with patients and the public;
- listen and respond to feedback, being honest about what we can and can't do;
- be clear about the impact that resident engagement has made;

- involve voluntary, community and representative groups as partners and enablers;
- work with our health and care partners rather than creating additional systems, processes and channels;
- be open and transparent by providing accessible, clear, meaningful and timely communications; and
- ensure equality impact assessments are robust and are carried out to inform our work.

Foundations for Patient, Public Engagement & Involvement in a single NCL CCG

Specifically focusing on a potential move to a single NCL CCG, work has been undertaken with the CCG lay members, clinical leads for engagement, and CCG communications and engagement colleagues to consider a proposed approach for the new CCG. The following statements outline how the proposed new PPE function of the CCG will work:

- A commitment to patient and community engagement, reducing health inequalities and supporting people to manage and improve their health and wellbeing should be very clear throughout the NCL CCG's vision and values. The CCG's governance arrangements should also be very clear and transparent for the public.
- The CCG move to a larger geographical footprint will not restrict the ability to engage with and be influenced by the needs of local communities within boroughs.
- The CCG will fulfil its statutory duties.
- The CCG will use the IAF domains to guide patient and community engagement – maximising best practice currently in place across the existing CCGs.
- Engagement activity will be needed at NCL and borough levels to support the CCG and borough partnerships with this work. Accountability and opportunities to influence should be 2-way between the NCL CCG and the boroughs.
- The proposed approach will need to be flexible as borough partnerships and the NCL integrated care system develop.
- Working in partnership, we should strive to widen the reach of our engagement activity – ensuring the focus remains on improving health outcomes and reducing health inequalities through the CCG's commissioning activity.

Proposed approach

Under a single CCG – there will need to be a balance between the work undertaken across NCL and the work undertaken at a local, community-based level. Examples include:

NCL wide activity:

- To develop and oversee delivery of NCL engagement/involvement strategy
- To lead and manage engagement work on pan-NCL programmes, commissioning intentions and strategic plans
- To work with local borough teams - utilising local approaches, relationships, knowledge
- To support stakeholder engagement at an NCL-wide, strategic level e.g. working with JHOSC

Borough activity:

- To support specific borough-level engagement work

- To support borough partnerships – which will provide excellent opportunities to work closely with local authority colleagues, Health and Wellbeing Boards and providers
- To support primary care networks to meet their engagement requirements (delivered locally, but with as much consistency as possible across NCL).

Within the CCG, planning and delivery of communications and engagement activity will be well-coordinated between the NCL- and borough-level, and NCL PPE will be reflected within local PPE activity. This will ensure there is no duplication of CCG effort and that the CCG does not overburden partners will poorly coordinated requests to work together. Intelligence gathered through CCG engagement work across NCL will be triangulated to form an in-depth picture of our residents' views and experiences. We will also ensure that we can show 'You Said - We Did - It Made a Difference".

CCG PPE activity will also be well coordinated, and will support, PPE work planned at an NCL level by the Integrated Care System and at a borough level by the Integrated Care Partnerships. We will support ensuring there is clarity for voluntary and community sector organisations on where there involvement would be most effective, and where there are opportunities for organisations (e.g. the five Healthwatches) to link up and be involved.

Proposed Governance arrangements

Recognising the importance of the CCG's patient and public responsibilities and activity, it is proposed to establish a single NCL Committee for Engagement & Equalities – that reports directly into the NCL CCG governing body (ensuring that patient and community engagement is on equal footing with the other main CCG committees).

Committee membership should include NCL CCG lay members with portfolios for equalities and engagement, relevant clinical leads, representation from Healthwatch and the voluntary and community sector, patient representatives, local authorities, representatives from borough partnership teams, and other officers/directors. [To note, the current NCL Engagement Advisory Board would be stood down post-CCG merger].

The role of the CCG's Committee would include:

- Assuring the CCG that effective engagement and involvement is taking place across NCL and throughout the CCG and that the CCG is meeting its statutory duties and the IAF criteria
- Having oversight of the CCG's engagement/involvement strategy, action plan and activity
- Ensuring that meaningful engagement is undertaken to help inform commissioning and commissioning decisions, and that the CCG is really acting on the feedback heard from local communities
- Supporting and helping to ensure co-ordination and consistency of local engagement activity undertaken through borough-based partnership working
- Sharing good practice and successes in local engagement work with other parts of NCL;
- Being an advocate for ensuring the NCL CCG engagement and involvement approach is best practice, not overly bureaucratic and enables us to demonstrate the value and benefits to residents
- Having oversight of the CCG's equality, diversity and inclusion strategy, action plan and activity
- Ensuring the CCG is successfully holding providers to account for their engagement and equalities duties

Additionally, we will seek opportunities for patient representatives sitting on the PPE Committee to also sit on relevant other NCL CCG committees.

Working at a local, community level

Engagement structures and approaches will need to be discussed and developed locally by the borough partnerships, building on the existing structures, approaches and local knowledge that exist across partners.

However, it is recognised that it will be helpful to have a borough-level partnership engagement group/committee which will have a dual reporting role into the NCL CCG committee and to the borough partnership boards.

The approach will need to be flexible as the borough partnerships develop over time.

Appendix B: Our Financial Strategy & Arrangements for Delegated Decision-Making

Approach to in year budget setting and transition to new ways of working

Introduction and context

North Central London CCGs are proposing to merge to a single commissioning body in April 2020. This will mean adopting new governance structures across NCL with an aim of reducing unnecessary and duplicative decision-making.

As part of the process of moving to a single statutory organisation, the Governing Bodies for the existing CCGs in North Central London have asked for the development of financial principles to provide assurance on how the new single CCG will take financial decisions. In particular assurance is sought in relation to decisions on in year budget setting and the mechanisms for ensuring subsidiary and effective decision making in the new organisation.

The financial principles will need to:

a) Comply with national guidance and CCGs' statutory duties,
b) Support delivery of the NHS Long Term plan
c) Support delivery of the NCL Medium Term Financial Strategy, which is currently in development.

This paper sets out a proposed approach to this, including how the principles may translate into changes in decision making and budget setting in the future, based on current known information.

Context: New operating model

The future model looks to centralise certain functions under members of the executive team where there is clear benefit to working across the larger footprint to maximise the impact for local residents. This will include, for example, where working at scale will allow best use of resources, will deliver greater efficiencies for the population, or will ensure a more coordinated approach across the system. These centralised commissioning functions will need to evolve over time into strategic functions, making use of new mechanisms to enable the system and Integrated Care Partnerships to deliver against outcomes which are set over longer periods of time.

Under the new executive team, the CCG will also have clear borough facing functions with senior leaders based at borough level. The primary role of these roles will be to work with partners to facilitate the development of borough based partnerships (ICPs). This will mean working together with primary care, community, mental health, social care and voluntary sector partners to configure their services around individuals rather than organisations.

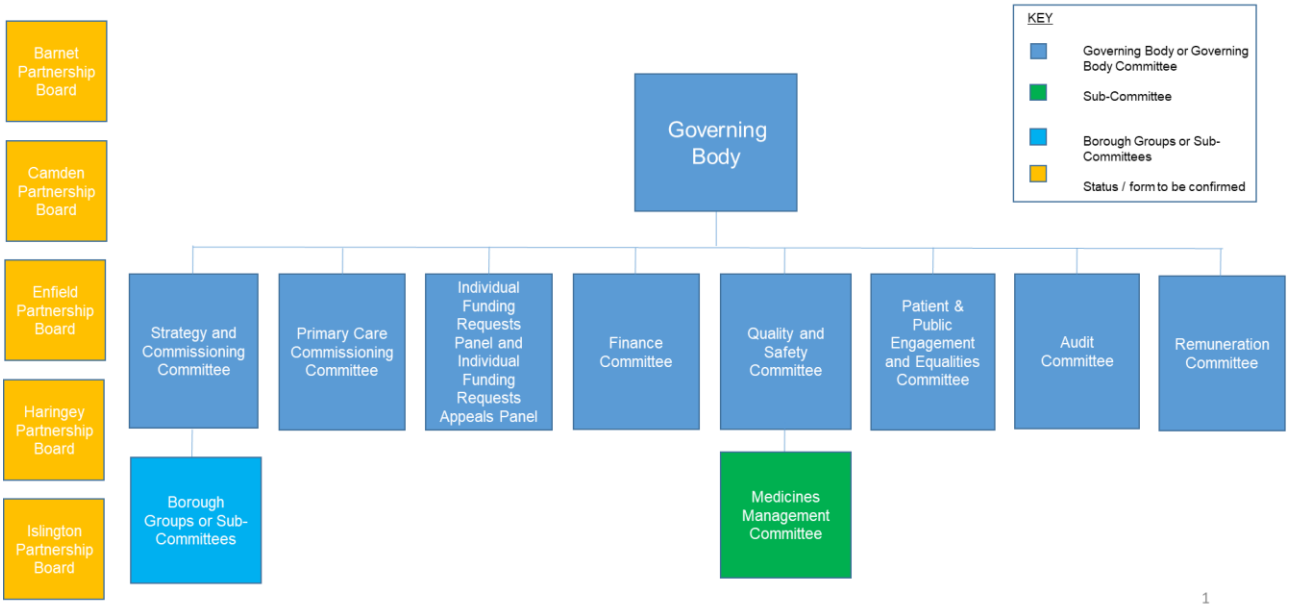
Over time, there will be delegation of responsibilities to the local Integrated Care Partnerships. The development of the partnerships will be important building blocks around which the NCL Integrated Care System will be built.

Benefits of the merger: reducing duplication and increasing effectiveness of decision-making

One of the benefits of merging is to move to a more effective decision making process that reduces duplication.

The proposed new committee structure is set out in the following diagram:

Proposed Committee Structure



In this model, single NCL committees will support the longer term planning and streamlined decision making across NCL. For example, the Finance Committee will set out the coming year's budget and financial strategy which will be guided by the financial principles proposed further below in this document.

Borough based decision-making

In the proposed governance structure for the NCL CCG, it is not feasible, nor desirable, for all financial decisions to be taken at an NCL level and a key feature of the model includes the ability to commission local and, in-particular, community-based health care services at borough level. A key principle for the CCG will be to deliver functions at the most appropriate level to maximise commissioning outcomes and the associated benefits for our patients.

Therefore, to support the principle of subsidiarity, deliver the benefits of effective delegated decision making and ensure alignment with integrated care developments at borough level, it is proposed that relevant decision-making arrangements and thresholds are set at a borough-level. This will delegate responsibility, authority and budget related to Primary / community / out of hospital services to borough based groups. To ensure the ongoing provision of strong clinical leadership, it will be important these arrangements involve the elected clinical representatives from the relevant borough area.

These local arrangements could take the form of a borough-based group or formal sub-committee of the NCL Strategic & Commissioning Committee – helping to ensure a consistent and coherent approach across the sector. Alternatively, borough areas will have the option (through the Scheme of Delegation) to delegate specific decisions to, for example, the respective elected GPs and Managing Director.

Where a borough-based group or sub-committee is established – it is proposed that the membership, as a minimum includes:

- The two elected clinical representatives from the borough area;
- An NCL lay member;
- The borough-based Managing Director.

It is also proposed that the Chair is one of the two elected clinical representatives and, where required, the Chair will have the casting vote.

It will be important for the groups or sub-committees to be supported by the Executive Director of Strategy and Executive Director of Strategic Commissioning - to ensure congruence of borough and NCL wide integrated care system developments. The groups will also need to draw on senior support from the NCL Finance Directorate.

The members of the group or sub-committee will work as appropriate with their local teams, relevant clinical leads (non-GB) and take account of the work to develop borough Integrated Care Partnerships (ICPs) - to make decisions in line with local needs. Typically this may include, but not limited to, the group or sub-committee working with colleagues from respective local authorities and patient representatives.

The level of delegation, remit and membership of the borough-based groups or sub-committees will need further development over the coming weeks to ensure robust levels of accountability and transparency. However, initially it is envisaged that the primary function of these groups would be to oversee and manage borough based joint, primary and community service development, coordination and in year investment and business case approval in line with the scheme of delegation through membership of the group.

It is envisaged that in time delegated borough-based decision-making will be through Integrated Care Partnerships as these become formal entities, supported by the CCG borough based leadership teams. This formal delegation process through ICPs is yet to be fully developed and may in-time supersede the need for specific borough based groups or sub-committees as proposed above.

Development of the financial principles

In planning future spending, CCGs principles will still need to support and be in line with the following national and legal financial restrictions and guidance:

a) Implementation of the NHS Long Term Plan

As part of the national planning approach the NCL CCGs need to submit a five year finance and activity plan setting out finance and activity assumptions based on the delivery of the NHS Long Term Plan.

This includes the indicative allocations across providers. Detailed work on this is taking place through local director leads and Governing Bodies, and system plans should be agreed with regional teams, in consultation with National Programme Directors, by 15 November 2019.

This strategic planning will support and inform operational planning in 2020/21, and strategic plans will provide the basis for agreeing indicative contract values and activity levels for 2020/21 as well as setting out clear direction of travel for the next four years.

b) The Mental Health Investment Standard

The Mental Health Investment Standard (MHIS) was previously known as Parity of Esteem (PoE) and is the requirement for CCGs to increase investment in Mental Health (MH) services in line with their overall increase in allocation each year.

c) Primary Care contracts

The North Central London CCGs ('NCL CCGs') became responsible for fully delegated primary care commissioning in 2017.

The NCL CCGs have robust and effective arrangements in place for delegated primary care commissioning. This includes the NCL Primary Care Commissioning Committee in Common between the CCGs to exercise oversight and decision making, a central NCL wide team for GP core contracting from NHS England who are now CCG employees, a central director with responsibility for delegated primary care commissioning who is a member of the CCGs' central Senior Management Team, reports directly to the Accountable Officer and works with the

primary care teams in each of the CCGs. The CCGs' internal auditors (RSM) recently conducted an audit on commissioning and procurement of services and found that there was 'reasonable assurance'.

The above arrangements would smoothly transition to a new single CCG with a single Primary Care Commissioning Committee providing oversight of the arrangements and exercising decision making in accordance with NHS England statutory guidance.

d) Medium Term Financial Strategy

The NCL Health economy has an underlying deficit of £200m per year. Work is underway to develop a medium term financial plan, which will outline the work needed to support the financial sustainability of the health service, with a plan across multiple years to reduce and remove costs out of the system through a set of collective actions across NHS partners.

The financial principles will need to underpin the delivery of the MTFS, which is plan is still in development but has the following emerging themes:

- Look at limiting acute trust income growth to less than 2% from 2020/21 - 2023/24
- Focus on organisational recovery plans in light of the constrained income environment
- Reduce demand and activity growth particularly non elective through out of hospital services and primary care

The Medium Term Financial Strategy will be developed collaboratively across all NCL NHS organisations and will be signed up to by all NHS organisations in North Central London to support future planning and delivery of services.

Growth in allocation:

The published allocations for the CCGs are as follows. The growth per year figure varies based on how far from target allocation each borough is (historic underfunding/overfunding).

These allocations are part of the deployment of NHS England's five-year revenue funding settlement, averaging 3.4% a year in real terms and reaching £20.5bn extra a year by 2023/24. CCG allocations are being set on the basis of NHS England's five-year real terms revenue funding profile, which has now been set by Government as 3.6%, 3.1%, 3.0%, 3.0% and 4.1%.

NCL CCGs Core services allocation

CCG	Core Services	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Barnet	Allocation £'000	495,248	525,288	549,103	572,344	594,819	616,339
	Headline growth £'000		30,040	23,815	23,241	22,475	21,520
	Headline growth %		**6.07%**	**4.53%**	**4.23%**	**3.93%**	**3.62%**
Camden	Allocation £'000	364,048	381,741	394,402	405,504	415,801	425,897
	Headline growth £'000		17,693	12,661	11,102	10,297	10,096
	Headline growth %		**4.86%**	**3.32%**	**2.81%**	**2.54%**	**2.43%**
Enfield	Allocation £'000	412,335	436,688	455,965	474,835	493,181	510,795
	Headline growth £'000		24,353	19,277	18,870	18,346	17,614
	Headline growth %		**5.91%**	**4.41%**	**4.14%**	**3.86%**	**3.57%**
Haringey	Allocation £'000	364,654	387,514	406,674	424,952	442,408	458,759

	Headline growth £'000		22,860	19,160	18,278	17,456	16,351
	Headline growth %		**6.27%**	**4.94%**	**4.49%**	**4.11%**	**3.70%**
Islington	Allocation £'000	352,245	371,367	385,578	398,834	411,092	422,565
	Headline growth £'000		19,122	14,211	13,256	12,258	11,473
	Headline growth %		**5.43%**	**3.83%**	**3.44%**	**3.07%**	**2.79%**
NCL	Allocation £'000	1,988,530	2,102,598	2,191,722	2,276,469	2,357,301	2,434,355
	Headline growth £'000		114,068	89,124	84,747	80,832	77,054
	Headline growth %		**5.74%**	**4.24%**	**3.87%**	**3.55%**	**3.27%**

NCL CCGs Primary Medical allocation

CCG	Primary Medical	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Barnet	Allocation	51,330	54,797	57,463	60,807	63,533	66,363
	Headline growth		3,467	2,666	3,344	2,726	2,830
	Headline growth %		**6.75%**	**4.87%**	**5.82%**	**4.48%**	**4.45%**
Camden	Allocation	37,814	40,397	42,293	44,846	47,252	49,280
	Headline growth		2,583	1,896	2,553	2,406	2,028
	Headline growth %		**6.83%**	**4.69%**	**6.04%**	**5.37%**	**4.29%**
Enfield	Allocation	43,225	46,040	48,083	50,684	52,775	54,931
	Headline growth		2,815	2,043	2,601	2,091	2,156
	Headline growth %		**6.51%**	**4.44%**	**5.41%**	**4.13%**	**4.09%**
Haringey	Allocation	43,054	45,855	47,862	50,412	52,444	54,523
	Headline growth		2,801	2,007	2,550	2,032	2,079
	Headline growth %		**6.51%**	**4.38%**	**5.33%**	**4.03%**	**3.96%**
Islington	Allocation	37,321	39,988	41,920	44,292	46,160	48,055
	Headline growth		2,667	1,932	2,372	1,868	1,895
	Headline growth %		**7.15%**	**4.83%**	**5.66%**	**4.22%**	**4.11%**
NCL	Allocation	212,744	227,077	237,621	251,041	262,164	273,152
	Headline growth		14,333	10,544	13,420	11,123	10,988
	Headline growth %		**6.74%**	**4.64%**	**5.65%**	**4.43%**	**4.19%**

Proposed financial principles

- The starting point for a single CCG will be the borough based allocations of funding and services they have now. The budgets will be set for 20/21 on this borough basis ahead of the merger through the current CCG governance structures.
- The future NCL CCG will not disinvest in non-acute services in any boroughs and will over time look to increase investment in these areas where it can reduce or support lower levels of growth in acute budgets and reduce health inequalities within and across boroughs. This will support the delivery of the medium term financial strategy.
- This is the starting point for future system planning, detailed work on this is taking place through local director leads and governing bodies and system plans should be agreed with regional teams, in consultation with National Programme Directors by 15 November 2019.
- This strategic planning, completed by the current NCL CCGs before April 2020 will support and inform operational planning in 2020/21 and strategic plans provide the basis for agreeing indicative contract values for 2020/21 and activity levels as well as setting out clear direction of travel for the next four years.
- Borough teams will continue to commission enhanced primary care services under an agreed framework.
- The NCL CCG will continue to meet the mental health investment standard in line with national guidance. This will be on an NCL wide basis in line with national guidance, to allowing for differential approaches by provider in line with the Medium Term Financial Strategy (MTFS) to ensure new investment supports lower levels of growth in acute hospitals and delivers value for money across the system. It should be noted that this principle is complementary to the principle of not disinvesting in mental health services across boroughs.

The above principles will continue to be worked on and developed over the time ahead of merger. With input from both the current CCGs and any shadow arrangements for the new CCG. It is proposed that a schedule is included in the new constitution for the NCL CCG which will provide assurance that these principles will be honoured.

CCG Accumulated Deficits and Surpluses

The following approach for treatment of historical deficits / surplus has been agreed with the Director of Operational Finance (SW, SE and NW London), and the Interim Regional Director of Finance (London), on behalf of NHS England / Improvement:

- The **priority for all CCGs (and hence for the merged NCL CCG) is to return to financial sustainabilit**y - i.e. recurrent run rate balance;
- The minimum planning cumulative surplus requirement for CCGs is currently 1% of allocation. However, **for CCGs moving back into financial sustainability from deficit positions there will be discussions with local system leaders to agree what is reasonable to deliver within plans** and over what length of time;
- Given the existing underlying deficit across the NCL CCGs for 2019/20, returning to recurrent run rate balance is likely to take some years and recovery to a 1% surplus therefore a bit longer. **Accumulated deficits would only start to be addressed once the merged NCL CCG moves back into surplus;**
- NHS London will discuss and agree with NCL the **planning assumptions to ensure the trajectory back to run-rate balance and then to modest surplus is deliverable, reasonable, fair and does not penalise investment in key LTP priority areas.** This could include consideration of 'freezing' an element of the accumulated deficit, particularly where deficits were incurred at a time when CCGs were funded below target allocation;

- Additionally, the impact of mergers on deficit repayment profiles should be made 'neutral' – what that effectively means is that the merged CCG should not be required to deliver any additional improvement to the financial position of the merged CCG than could have been delivered if the CCGs did not merge;
- The national finance team is currently reviewing the impact that the future repayment profiles may have on mergers, and are keen to make sure that an equitable approach is taken which is also supportive of the current programme of CCG merger. Further details in the policy proposal will be available in due course.

Ensuring Strong Financial Management

The new CCG will work to ensure it meets its key financial duties set out by the NHS England for CCGs as a statutory body through:

- Clear and effective arrangements setting out the financial duties of the new governing body and statutory role holders within this;
- Robust financial procedures and controls;
- Effective financial management and financial planning arrangements; and
- Comprehensive financial systems, operated by well-managed, adequately resourced and suitably trained staff.

As an example of this, the Finance Committee and Governing Body will receive regular reports on the financial performance of the CCG to provide assurance and documentary evidence of performance for contractual elements of performance. This will also include regular reviews of, but not limited to: Draft Financial Plan, Final Financial Plan, monthly QIPP reports, risk registers and ad-hoc reports and information as required. The CCG will also submit monthly and quarterly information as required to NHS England as part of the CCG assurance processes.

The Finance Committee will meet on a regular basis to review the financial position and identify mitigating actions to ensure we deliver our financial plan.

Alongside this, the NCL CCG will have an Audit Committee whose role will centre on ensuring the adequacy and effectiveness of the organisation's overall internal control systems. The Audit Committee operates on behalf of the Governing Body and through the work of the Audit Committee, the Governing Body will be assured that effective internal control arrangements are in place.

The remits of these Committees are further detailed in Appendix C below.

Appendix C: Further Governance Arrangements

Committee Remits

The key remits of the respective Committees of the Governing Body are as follows:

Strategy and Commissioning Committee (excluding primary care):

- Development and oversight of commissioning strategy for the CCG;
- Approval of strategic business cases- outcomes and financial envelope;
- Approval of statutory commissioning plans;
- Approval of annual operating plans;
- Commissioning at a system level;
- Oversight of contracting round;
- Acute commissioning;
- Strategic and specialist mental health commissioning;
- Arrangements for commissioning of Specialist Services delegated to the CCG by NHS England;
- Commissioning activity not overseen by the borough groups / sub-committees or future partnership boards;
- Development of QIPP commissioning strategy.

Primary Care Commissioning Committee:

- Development and oversight of primary care strategy for the CCG;
- Exercises delegated authority from NHS England for primary care commissioning;
- GP core contracting;
- Approval of Locally Enhanced Services and Local Incentive Schemes that fall within the remit of the Committee;
- Considers recommendations with regards to primary care from partnership boards.

Individual Funding Request Panel and Individual Funding Request Appeals Panel:

- Makes decisions on individual funding requests applications;
- Considers and follow the CCG's IFR Policy when determining the outcome of individual funding requests applications;
- Remits decisions for individual funding requests over the panel's financial authority limits to the appropriate decision makers.

Finance Committee:

- Oversight of finance and financial management arrangements for the CCG;
- Oversight of strategic performance that impacts the finances of the CCG;
- Approval of budgets and oversight and assurance of financial performance and budget monitoring;
- Oversight of contract performance and contract negotiations

- Oversight of QIPP development and delivery;
- Oversight and assurance of commissioner and provider performance against Constitutional and contractual targets.

Quality and Safety Committee:

- Oversight and assurance of the quality and safety of commissioned services;
- Oversight and assurance that patients have effective and safe care with positive experience of services;
- Oversight and assurance of safeguarding and complaints;
- Oversight of patient related provider performance (individual cases and aggregated performance)
- Oversight of CDOP activity.

Patient & Public Engagement and Equalities Committee:

- Oversight and assurance that effective engagement and involvement is taking place across NCL and throughout the CCG and that the CCG is meeting its statutory duties and the IAF criteria;
- Oversight of the CCG's engagement/involvement strategy, action plan and activity;
- Ensures that meaningful engagement is undertaken to help inform commissioning and commissioning decisions and that the CCG is acting on the feedback from local communities;
- Supports and helps to ensure co-ordination and consistency of local engagement activity undertaken through borough-based partnership working;
- Sharing good practice and successes in local engagement work with other parts of NCL;
- Advocates to ensure the CCG's engagement and involvement approach follows best practice, is streamlined and enables the CCG to demonstrate the value and benefits to residents;
- Oversight of the CCG's equality, diversity and inclusion strategy, action plan and activity;
- Ensuring the CCG is successfully holding providers to account for their engagement and equalities duties.

Audit Committee:

- Reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the CCG's activities that supports the achievement of its objectives;
- Ensures that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2013 and provides appropriate independent assurance to the audit committee, Accountable Officer and Governing Body;
- Reviews and monitors the external auditors' independence and objectivity and the effectiveness of the audit process;
- Reviews the findings of other significant assurance functions, both internal and external to the CCG, and consider the implications for the governance of the CCG;
- Satisfies itself that the CCG has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority's standards and reviews the outcomes of work in these areas;
- Monitors the integrity of the financial statements of the CCG and any formal announcements relating to its financial performance;

- Reviews the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

Remuneration Committee:

- Approve Governing Body and Clinical Lead pay levels;
- Approve organisational pay policy;
- Make recommendations on pay levels for Very Senior Managers (in line with the NHS England guidance for the new Model Constitution).

Medicines Management sub-committee:

The proposed governance structure includes a Medicines Management sub-committee – reporting into the Quality and Safety Committee. The proposed remit of the Medicines Management sub-committee is:

- Oversight and assurance of the CCG's statutory functions on medicines;
- Oversight and assurance on medicines and that safe, effective and value for money medicines are available and their proper use is promoted;
- Ensures appropriate treatments are available and appropriate governance and systems are in place to support decisions on the funding of treatments and drugs;
- Approval of medicines policies, prescribing guidelines, clinical pathways and any other information involving medicines for clinicians and patients within the CCG's commissioning responsibilities;
- Identification of QIPP opportunities and monitoring of prescribing spend to inform budgets.

The work of the Medicines Management sub-committee will need to be considered in the context of borough-based activity on Medicines Management.

Core Governance Principles

A significant amount of work has already been undertaken to ensure the NCL CCGs work to common governance arrangements. In the last year, this has included the CCGs all agreeing a single strategic approach to Risk Management and a range of single Governance Policies. Substantial work has also been undertaken to draft a single set of Standing Financial Instructions for NCL – and a common Constitution. Work is also currently being undertaken to harmonise all HR policies. All of this work very much supports the move to a single CCG for North Central London.

Going forward, the CCG will have a comprehensive governance and risk management framework which includes:

- Operating under a robust set of governance principles representing best practice;
- A Constitution based on the new NHS England Model CCG Constitution;
- Supporting Constitutional documents - including Standing Orders, Scheme of Reservation and Delegation, Prime Financial Policies and Standing Financial Instructions;
- A robust risk management framework, supporting policies and documents;
- A full suite of governance policies such as:
    - Conflicts of Interest;
    - Gifts, Hospitality and Sponsorship;

- Counter Fraud, Bribery and Corruption;
- Information Governance and Security;

A membership vote will be undertaken to approve the new Constitution for the NCL CCG. It is proposed that this work will be undertaken immediately after the Governing Bodies' decision to submit the merger application to NHS England – with a view to the voting process being concluded by 25th October 2019.

Local decision-making and Integrated Care Partnerships

Without compromising the robustness of the governance arrangements in place, it is recognised that some flexibility will be required as the commissioning / provider landscape evolves across North Central London (in the context of meeting the requirements of the NHS Long Term Plan and the introduction of an Integrated Care System (ICS) and Integrated Care Partnerships (ICPs)).

Under the proposed operating model for the single CCG, with borough-based teams working on:

- primary care commissioning;
- joint community (including children's and some elements of learning disability joint commissioning) and mental health commissioning;
- local medicines management activity;
- local safeguarding work;
- local transformation programmes.

It will be important for local decision-making arrangements to be developed alongside the Governing Body Committee arrangements as set out above. This will need to be reflected in the Scheme of Delegation and Standing Financial Instructions. The proposed borough-based decision-making arrangements are set out in Appendix B of this document – and may take the form of borough-based groups or sub-committees of the NCL Strategy & Commissioning Committee. The associated governance arrangements will be developed ensuring robust levels of accountability and transparency.

It is envisaged that, in time, much of this delegated borough-based decision-making will be through Integrated Care Partnerships.

Clinical Leadership

In addition to elected representatives on the Governing Body, the provision of strong specialty clinical leadership, is a key part of the CCG's commissioning role to improve health outcomes.

As part of preparing for the proposed single CCG for North Central London – a full schedule of all Clinical Lead roles has been produced – including those working with individual CCGs and those involved in progressing STP-level priorities across the NCL footprint. The latter has demonstrated, from both a consistency and efficiency perspective, the benefit of Clinical Lead roles across the wider footprint.

As part of our governance work to prepare for a single CCG we are undertaking an immediate priority to review and agree:

- A strategic approach for identifying the portfolio areas that require specialist Clinical Lead capacity;
- The optimum balance between NCL-wide clinical lead roles and roles required to support borough-based integrated care partnerships;
- Clear and consistent paths of accountability for, and oversight of, clinical lead activity;
- A model that, where required, allows flexibility in clinical lead arrangements as new priorities develop;

- Consistency of approach for clinical leads' terms and conditions.

In anticipation of a potential merged CCG from April 2020 – current terms for existing CCG Clinical Leads are being extended up to 31 March 2020, thereby allowing the outputs from the above review work to be introduced in a timely and value-added manner.

Appendix D: Governance Transition Plan

The merger of the North Central London CCGs in April 2020 will mean adopting new governance structures across NCL with an aim of reducing unnecessary and duplicative decision-making. The key governance milestones through transition will include:

No.	Steps	Dates
1	Attend NHS England Formal Assessment Panel	9 October 2019
2	Complete membership vote on new Constitution	25 October 2019
3	Complete review of Clinical Leadership	30 November 2019
4	Secure NHS England support to merge NCL CCGs	30 November 2019
5	Plan and launch elections for elected Governing Body roles with new GB members being selected by early February 2020: a) Planning and preparation b) Election launched c) Ballot d) Ratification of process and results at Governing Body meetings	November 2019 – March 2020 4 November 2019 2 December 2019 20 January - 9 February 2020 March 2020
6	Recruitment of appointed Governing Body members	2 December 2019 – 7 February 2020
7	Commence process to elect / appoint GB Chair, Deputy (lay) Chair, Clinical Vice Chair	10 February
8	Deliver new Governing Body member induction sessions	17 February – 31 March 2020
9	Governing Body shadow arrangements in place and operating (for decisions solely relating to the future CCG)	24 February 2020 – 31 March 2020
10	Alignment check of all corporate governance policies	2 December 2019 – 31 January 2020
11	Development of Terms of Reference for Governing Body committee structure	4 November 2019 – 18 December 2020
12	First Governing Body meeting with approval of governance documentation	Post 1 April 2020

Appendix E: Letters of Support

NHS
Royal National
Orthopaedic Hospital
NHS Trust

RNOH Stanmore
Brockley Hill
Stanmore
Middlesex
HA7 4LP

RNOH Bolsover Street
45 Bolsover Street
London
W1W 5AQ

Tel: 020 3947 0100
www.rnoh.nhs.uk

3rd September 2019

Helen Pettersen
Accountable Officer - North Central London STP
River Park House
225 High Road, Wood Green
N22 8HQ

Dear Helen

Further to our telephone conversation, I am writing to confirm my organisation's support for the North Central London clinical commissioning groups' proposal to merge from 1 April 2020.

In line with the conclusions of the "Inter-great" simulation events, this merger will support the development of a streamlined NCL health commissioning function and a single set of system-level commissioning decisions, while assisting the development of strong borough partnerships and NCL Integrated Care System.

We look forward to working with you to build on the collaborative approach developed in NCL over the last two years, through our STP and most recently between partners on planning for an integrated system to deliver benefits for our residents and patients.

I am happy for this letter to be included within your merger application submission to NHS England.

Yours sincerely

Rob Hurd
Chief Executive

NHS
Whittington Health
NHS Trust

Executive Offices
Magdala Avenue
London
N19 5NF

Tel: 020 7288 3636
020 7272 3070
siobhanharrington@nhs.net
Web: www.whittington.nhs.uk

10 September 2019

Helen Pettersen
Accountable Officer and STP Convener
Haringey CCG
River Park House
225 High Road
Wood Green N22 8HQ

Dear Helen

Following recent liaison with you and other senior NCL CCGs staff, I am writing to confirm my organisation's support for the North Central London clinical commissioning groups' proposal to merge from 1 April 2020.

In line with the conclusions of the "Inter-great" simulation events, this merger will support the development of a streamlined NCL health commissioning function and a single set of system-level commissioning decisions, while assisting the development of strong borough partnerships and NCL Integrated Care System.

We look forward to working with you to build on the collaborative approach developed in NCL over the last two years, through our STP and most recently between partners on planning for an integrated system to deliver benefits for our residents and patients.

In order for us to focus on key priorities and deliver models of integrated care that will support the changes needed in NCL, reducing bureaucracy and transactional meetings and tasks will be most important. We need as a system to reduce duplication and to challenge ourselves to work smarter.

I am happy for this letter to be included within your merger application submission to NHS England.

Yours sincerely,

Siobhan Harrington

Siobhan Harrington
Chief Executive

NHS
Camden and Islington
NHS Foundation Trust

Executive office
4th Floor, East Wing
St Pancras Hospital
4 St Pancras Way
London NW1 0PE
Tel: 020 3317 7016
www.candi.nhs.uk

4 September 2019

Helen Pettersen
NCL CCGs Accountable Officer
River Park House
225 High Road, Wood Green
LONDON N22 8HQ

Dear Helen

Further to our telephone conversation, I am writing to confirm Camden and Islington Foundation Trust's full support for the North Central London clinical commissioning groups' proposal to merge from 1 April 2020.

In line with the conclusions of the "Inter-great" simulation events, this merger will support the development of a streamlined NCL health commissioning function and a single set of system-level commissioning decisions, while assisting the development of strong borough partnerships and NCL Integrated Care System.

We look forward to working with you to build on the collaborative approach developed in NCL over the last two years, through our STP and most recently between partners on planning for an integrated system to deliver benefits for our residents and patients.

The merger will support consistent development of models in Mental Health and the system planning for effective support to the seriously mentally ill. It will also help streamline the delivery of the estates development programme at St Pancras.
I am happy for this letter to be included within your merger application submission to NHS England.

Yours sincerely,

Angela McNab
Chief Executive

NHS
Central and
North West London
NHS Foundation Trust

Executive Office
Tel: 020 3214 5760

5 September 2019

Helen Pettersen
Accountable Officer – Barnet, Camden, Enfield, Haringey and Islington Clinical Commissioning Groups and STP Convenor for North Central London
14th Floor, Euston Tower
286 Euston Road
NW1 3DP

Dear Helen,

Further to our telephone conversation, I am writing to confirm Central and North West London NHS Foundation Trust's support for the North Central London clinical commissioning groups' proposal to merge from 1 April 2020.

In line with the conclusions of the "Inter-great" simulation events, this merger will support the development of a streamlined NCL health commissioning function and a single set of system-level commissioning decisions, while assisting the development of strong borough partnerships and NCL Integrated Care System.

We look forward to working with you to build on the collaborative approach developed in NCL over the last two years, through our STP and most recently between partners on planning for an integrated system to deliver benefits for our residents and patients.

I am happy for this letter to be included within your merger application submission to NHS England.

Yours sincerely,

Claire Murdoch
Chief Executive

Central London
Community Healthcare
NHS Trust

Office of the Chief Executive
Ground Floor
15 Marylebone Road
London NW1 5JD
Tel: 020 7798 1300
Web: www.clch.nhs.uk

Helen Pettersen
NCL CCGs Accountable Officer
River Park House
225 High Road, Wood Green
N22 8HQ

2nd September 2019

Dear Helen

Further to our telephone conversation, I am writing to confirm my organisation's support for the North Central London clinical commissioning groups' proposal to merge from 1 April 2020.

In line with the conclusions of the "Inter-great" simulation events, this merger will support the development of a streamlined NCL health commissioning function and a single set of system-level commissioning decisions, while assisting the development of strong borough partnerships and NCL Integrated Care System.

We look forward to working with you to build on the collaborative approach developed in NCL over the last two years, through our STP and most recently between partners on planning for an integrated system to deliver benefits for our residents and patients.

I am happy for this letter to be included within your merger application submission to NHS England.

Yours sincerely

Andrew Ridley

Andrew Ridley
Chief Executive Office
Central London Community Healthcare NHS Trust

Great Ormond Street Hospital for Children
NHS Foundation Trust

Great Ormond Street
London WC1N 3JH

Tel: 020 7405 9200

Helen Petterson
Central London Community Healthcare NHS Trust

By Email: h.pettersen@nhs.net

2nd September 2019

Dear Helen,

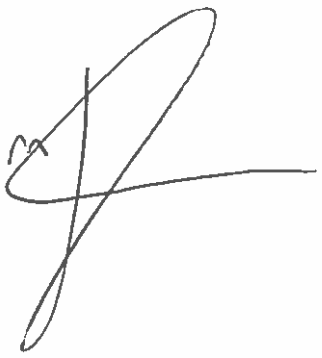
Further to our telephone conversation, I am writing to confirm my organisation's support for the North Central London clinical commissioning groups' proposal to merge from 1 April 2020.

In line with the conclusions of the "Inter-great" simulation events, this merger will support the development of a streamlined NCL health commissioning function and a single set of system-level commissioning decisions, while assisting the development of strong borough partnerships and NCL Integrated Care System.

We look forward to working with you to build on the collaborative approach developed in NCL over the last two years, through our STP and most recently between partners on planning for an integrated system to deliver benefits for our residents and patients.

I am happy for this letter to be included within your merger application submission to NHS England.

Yours sincerely,



Mr Matthew Shaw
Chief Executive

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

A University Teaching Trust

Helen Pettersen
Accountable Officer
Barnet, Camden, Enfield, Haringey and
Islington Clinical Commissioning Groups and
STP Convenor for North Central London

h.pettersen@nhs.net
Via email only

Barnet, Enfield and Haringey Mental Health Trust
Trust Headquarters
Orchard House
St Ann's Hospital
St Ann's Road
London N15 3TH

Tel: 020 8702 6010
Email: beh-tr.chiefexecutive@nhs.net

Dear Helen,

Further to our telephone conversation, I am writing to confirm my organisation's support for the North Central London clinical commissioning groups' proposal to merge from 1 April 2020.

In line with the conclusions of the "Inter-great" simulation events, this merger will support the development of a streamlined NCL health commissioning function and a single set of system-level commissioning decisions, while assisting the development of strong borough partnerships and NCL Integrated Care System.

We look forward to working with you to build on the collaborative approach developed in NCL over the last two years, through our STP and most recently between partners on planning for an integrated system to deliver benefits for our residents and patients.

I am happy for this letter to be included within your merger application submission to NHS England.

Yours sincerely,

David Griffiths, Chief Finance & Investment Officer
On behalf of Jinjer Kandola, Chief Executive

NHS
University College London Hospitals
NHS Foundation Trust

Professor Marcel Levi
Chief Executive
2nd Floor Central
250 Euston Road
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NW1 2PG

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3 September 2019

Helen Pettersen
Managing Director
NHS Haringey CCG
River Park House
225 High Road
Wood Green
London. N22 8HQ

Dear Helen

Further to our telephone conversation, I am writing to confirm my organisation's support for the North Central London clinical commissioning groups' proposal to merge from 1 April 2020.

In line with the conclusions of the "Inter-great" simulation events, this merger will support the development of a streamlined NCL health commissioning function and a single set of system-level commissioning decisions, while assisting the development of strong borough partnerships and NCL Integrated Care System.

We look forward to working with you to build on the collaborative approach developed in NCL over the last two years, through our STP and most recently between partners on planning for an integrated system to deliver benefits for our residents and patients.

I am happy for this letter to be included within your merger application submission to NHS England.

Yours sincerely

PROFESSOR MARCEL LEVI
CHIEF EXECUTIVE

North Middlesex University Hospital NHS Trust

Sterling Way
London N18 1QX
Direct Line 020 8887 XXXX
Email: maria.kane@nhs.net

3 September 2019

Dear Helen

I thought it would be helpful to confirm my organisation's support for the North Central London clinical commissioning groups' proposal to merge from 1 April 2020.

This is in accord with the conclusions of the 'Inter-great' simulation events, whereby merger will support the development of a streamlined NCL health commissioning function and a single set of system-level commissioning decisions, while assisting the development of strong borough partnerships and an NCL Integrated Care System.

We look forward to working with you to build on the collaborative approach developed in NCL over the last two years, through our STP and most recently between partners on planning for an integrated system to deliver benefits for the residents and patients of Enfield, Haringey and beyond.

We hope that this will now address some historic funding anomalies, reduce commissioning fragmentation and enhance potential economies of scale.

I am happy for this letter to be included within your merger application submission to NHS England.

Yours sincerely,

Maria Kane

Maria Kane
Chief Executive

Royal Free London NHS
NHS Foundation Trust

Royal Free Hospital
Pond Street
London
NW3 2QG

Tel: 020 3758 2000

4 September 2019

Helen Pettersen
Accountable Officer
NCL CCGs
River Park House
225 High Road, Wood Green
London
N22 8HQ

Dear Helen

Further to our conversation, we are writing to confirm our organisation's support for the North Central London clinical commissioning groups' proposal to merge from 1 April 2020.

In line with the conclusions of the "Inter-great" simulation events, this merger will support the development of a streamlined NCL health commissioning function and a single set of system-level commissioning decisions, while assisting the development of strong borough partnerships and NCL Integrated Care System.

The potential gains of this approach, such as better health outcomes, improved patient experience, coupled with reducing demand on health and social care services are essential goals for our area. The way we manage and deliver health and social care services do not meet the current, and will not meet the future, health and care needs of our population in a sustainable way. We must change our approach to achieve these. The Royal Free Group is committed to this work and we will support this as best we can.

We look forward to working with you to build on the collaborative approach developed in NCL over the last two years, through our STP and most recently between partners on planning for an integrated system to deliver benefits for our residents and patients.

We are happy for this letter to be included within your merger application submission to NHS England.

Yours sincerely

Caroline Clarke
Group chief executive
Royal Free London Group of Hospitals

Kate Slemeck
Chief executive
Royal Free hospital

Steve Shaw
Chief executive
Barnet hospital

Barnet Hospital

NHS
Royal Free London
NHS Foundation Trust

Barnet Hospital,
Wellhouse Lane,
Barnet,
EN5 3DJ

Tel: 020 8216 4600

2nd September 2019

Helen Pettersen
Accountable Officer for North Central London CCGs
Ground Floor, Building 2
North London Business Park
Oakleigh Road South
London N11 1NP

Dear Ms Pettersen

Further to our telephone conversation, I am writing to confirm my organisation's support for the North Central London clinical commissioning groups' proposal to merge from 1 April 2020.

In line with the conclusions of the "Inter-great" simulation events, this merger will support the development of a streamlined NCL health commissioning function and a single set of system-level commissioning decisions, while assisting the development of strong borough partnerships and NCL Integrated Care System.

We look forward to working with you to build on the collaborative approach developed in NCL over the last two years, through our STP and most recently between partners on planning for an integrated system to deliver benefits for our residents and patients.

I am happy for this letter to be included within your merger application submission to NHS England.

Yours sincerely,

Dr Steve Shaw
Chief Executive
Barnet Hospital
Royal Free London NHS Foundation Trust

Moorfields Eye Hospital NHS Foundation Trust

NHS

Moorfields Eye Hospital
NHS Foundation Trust
162 City Road, London EC1V 2PD
Phone: 020 7253 3411

Helen Pettersen
Chief accountable officer
NCL CCG

9 September 2019

Dear Helen

Further to our telephone conversation, I am writing to confirm my organisation's support for the North Central London clinical commissioning groups' proposal to merge from 1 April 2020.

In line with the conclusions of the "Inter-great" simulation events, this merger will support the development of a streamlined NCL health commissioning function and a single set of system-level commissioning decisions, while assisting the development of strong borough partnerships and NCL Integrated Care System.

We look forward to working with you to build on the collaborative approach developed in NCL over the last two years, through our STP and most recently between partners on planning for an integrated system to deliver benefits for our residents and patients.

I am happy for this letter to be included within your merger application submission to NHS England.

Yours faithfully

David Probert
Chief executive

September 10, 2019

Dear Helen,

Following recent liaison with you and other senior NCL CCGs staff, we are writing to confirm our organisation's support for the North Central London clinical commissioning groups' proposal to merge from 1 April 2020.

In line with the conclusions of the "Inter-great" simulation events, this merger will support the development of a streamlined NCL health commissioning function and a single set of system-level commissioning decisions, while assisting the development of strong borough partnerships and NCL Integrated Care System.

We look forward to working with you to build on the collaborative approach developed in NCL over the last two years, through our STP and most recently between partners on planning for an integrated system to deliver benefits for our residents and patients.

Islington GP Federation (IGPF) is wholly-owned by Islington GPs. Our vision is to enable all Islington registered patients to have free and equitable access to good, safe, value for money primary care well into the future. This letter is aligned with this vision and, as such, represents the views of IGPF's board of directors on behalf of its shareholders.

IGPF recognises and respects the role of the LMC in representing its members in Islington, whose GP practices are almost all IGPF shareholders. We are committed to collaborating with the LMC, driven by a shared vision to support general practice sustainability and strength of voice in this changing health and wellbeing landscape. We also acknowledge that the two organisations may on occasion have differing priorities and agendas, on the basis that they have different jobs to do. We remain committed to always seek a shared purpose and close allegiance.

In May 2019, Jonty Heaversedge presented at a North London Partners event. In it he described London's model Integrated Care System: a key component of that system, he said, was a 'Large-scale General Practice Organisation', operating at borough level and he cited GP federations as that type of organisation. This contrasts with March 2019's second Inter-great event summary, which contained no meaningful reference to such 'at scale' GP organisations that had featured heavily in the outputs of late 2018's first Inter-great event.

IGPF's support in this letter assumes that you see IGPF as a LGPO and, as such, as key to the development of NCL's ICS as in the model described by Jonty on behalf of NHS, HLP and NCL in May. On that basis we will commit energy, time and

resources into our continued participation in Islington's borough partnership design process. We will also expect to play an active and material role within the governance structure under development for NCL's ICS, in support of and in addition to Islington PCN representation by PCN clinical directors. We believe that it is imperative that the emerging system recognises the critical role that LGPO's will play in the development of PCNs over the next 5 to 10 years. This recognition needs to be built into NCL's strategic communication and operational governance in order to be clear to all organisations participating in this exciting system change opportunity.

Additionally, IGPF has been working collaboratively with the other 5 federations in NCL and is committed to doing so as the system develops towards an ICS.

We are happy for this letter to be included within your merger application submission to NHS England.

Yours sincerely,

Dr Benedict Smith, Chair, The Islington GP Group Ltd (Islington GP Federation)

Mike Clowes, CEO, The Islington GP Group Ltd (Islington GP Federation)

Enfield GP Federation

Enfield Healthcare Cooperative Limited
1 Smythe Close
London
N9 0TW

9.9.19

Helen Pettersen
North London Partners in Health and Care
c/o Camden Council
5th Floor
5 Pancras Square
London
N1C 4AG

Dear Helen,

I am writing to confirm my organisation's support for the North Central London clinical commissioning groups' proposal to merge from 1 April 2020.

We believe the merging of financial and governance resources through this route with collective accountability has the potential to support the development of a consistent health commissioning function through a single set of system-level commissioning decisions, facilitating the development of borough partnerships and a NCL Integrated Care System.

We look forward to working with you to build on the collaborative approach developed in NCL over the last two years, through our STP and most recently between partners on planning for an integrated system to deliver benefits for our residents and patients.

I am happy for this letter to be included within the merger application submission to NHS England.

Yours sincerely

Alpesh Patel
Director EHCL

FEDERATED 4 HEALTH
THE PAN HARINGEY GP FEDERATION

Hornsey Central Neighbourhood Centre
151 Park Road
London
N8 8JD

www.federated4health.com
harccg.enquiries.f4h@nhs.net

5th September 2019

Dear Helen

Following recent liaison with you and other senior NCL CCGs staff, I am writing to confirm Federated4Health's (Haringey's GP Federation) support for the North Central London clinical commissioning groups' proposal to merge from 1 April 2020.

In line with the conclusions of the "Inter-great" simulation events, this merger will support the development of a streamlined NCL health commissioning function and a single set of system-level commissioning decisions, while assisting the development of strong borough partnerships and NCL Integrated Care System.

We look forward to working with you to build on the collaborative approach developed in NCL over the last two years, through our STP and most recently between partners on planning for an integrated system to deliver benefits for our residents and patients.

I am happy for this letter to be included within your merger application submission to NHS England.

Yours sincerely

Cassie Williams
Chief Executive Officer
Federated4Health

Chief Executive
Zina Etheridge

Haringey LONDON

Helen Pettersen
Accountable Officer
North Central London CCGs

Date: 09 September 2019

Dear Helen

Following discussion with you and other North Central London (NCL) CCG officers, I am writing to confirm Haringey Council's support for the North Central London clinical commissioning groups' proposal to merge from 01 April 2020.

Over recent months we have discussed in detail how we can create a stronger and more integrated health and care system across North Central London. The plans for more streamlined commissioning at system-level for NCL can helpfully support this change.

We look forward to working with you to further build on the collaborative approach developed in the NCL over the last two years, including through our STP and more recently between partners, to plan for a more integrated system to deliver important benefits for our residents.

I am of course happy for this letter to be included with your merger submission to NHS England.

Yours sincerely

Zina Etheridge

Zina Etheridge
Chief Executive

Chief Executive
5th Floor, River Park House
225 High Road
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Helen Pettersen
Accountable Officer for
North Central London CCGs

9 September 2019

Dear Helen,

I am writing to confirm my organisation's support for the North Central London clinical commissioning groups' proposal to merge from 1 April 2020.

In line with the conclusions of the "Inter-great" simulation events, this merger will support the development of a streamlined NCL health commissioning function and a single set of system-level commissioning decisions, while assisting the development of strong borough partnerships and NCL Integrated Care System.

We look forward to working with you to build on the collaborative approach developed in NCL over the last two years, through our STP and most recently between partners on planning for an integrated system to deliver benefits for our residents and patients. The key priorities for our residents include strengthening Primary Care and Mental Health services, ensuring the viability and quality of North Middlesex Hospital and Chase Farm Hospital, responding to youth violence and reducing stalk health inequalities in the Borough. As you are aware as a Council, we are very keen to use our significant influence and resource to ensure through a 'placed based' approach these issues are address in partnership with the NHS.

I am happy for this letter to be included within your merger application submission to NHS England.

Yours sincerely,

Cllr Nesil Caliskan
Leader of Enfield Council

Nesil Caliskan
Leader of the Council
Enfield Council
Civic Centre, Silver Street
Enfield EN1 3XA

Phone: 020 8379 4116
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Website: www.enfield.gov.uk

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Report for:	**Health and Wellbeing Board**
Title:	Adoption of Haringey Ageing Well Strategy 2019-2022
Report authorised by:	Beverley Tarka, Director of Adults and Health Rachel Lissauer, Director of Commissioning, Haringey CCG
Lead Officer:	Paul Allen, Head of Integrated Commissioning (Older People & Frailty), Haringey CCG and Council 0203 6881173
Ward(s) affected:	**All**
Report for Key/ Non Key Decision:	

1. Describe the issue under consideration

1.1. This report asks the Board to endorse the Haringey's Ageing Well Strategy.

1.2. The Strategy represents one of the key emerging priorities as we develop a refreshed Health and Wellbeing Strategy, alongside other priorities including: Children, Young People and Families, Vulnerable Adults and people experiencing poor mental health. The multi-agency Haringey Borough Partnership will lead on the delivery and development of the Ageing Well work as part of an integrated health and care system in Haringey.

1.3. This Strategy is central to delivery of Haringey's Borough Plan (and CCG commissioning intentions), as it describes how we will work collaboratively to support predominantly older people who have or might have health and care needs now or in the future in the Borough. In particular it will contribute to the People priorities in the Plan that relate to making individuals, families and communities stronger and more resilient.

1.4. An Equalities Impact Assessment (EIA) has been completed for the Ageing Well Strategy. The overall outcome was positive because of the perceived benefits to people with protected characteristics particularly in terms of issues associated with older people, disability (including mental health), gender, ethnicity and social inclusion. In particular, it supports development of 'age-friendly' communities and Borough.

2. Cabinet Member Introduction

2.1. Not applicable.

3. Recommendations

3.1. The Health and Wellbeing Board is asked to endorse the Ageing Well Strategy 2019-2022 (Appendix 1) which sets out:

- The Haringey vision to support people with frailty to age well and what successful delivery of the Strategy will look like;
- The needs of the population, including how we're building on solutions that already exist, and scope of the Strategy;
- How the Strategy has been structured and its governance and how it supports Haringey-wide strategies such as the Borough Plan;
- What individual elements of the Strategy will deliver;
- The first of an annual Roadmap (a set of actions) to support delivery;

4. Reasons for decision

4.1. A number of health and care partners have come together with residents, patients and carers to produce this Ageing Well Strategy for Haringey and to commit to a common vision: *"We will work together to support people with frailty to live and age well"*.

4.2. Partners who have collaborated on this Strategy include the London Borough of Haringey, Haringey CCG, Whittington Health NHS Trust, North Middlesex University Hospital NHS Trust, Barnet, Enfield & Haringey NHS Trust, Federated 4 Health (Haringey's GP Federation) and a number of voluntary sector and charitable organisations, such as Bridge Renewal Trust, Public Voice and the 50+ Forum and North London Hospice. Patients, residents and carers and their representative groups have helped us design the Strategy.

4.3. The nascent multi-agency Borough Partnership is developing an approach currently based around four priority population groups, of which one is Living and Ageing Well. The Partnership will lead development of an integrated care system in Haringey (and contribute to that across North Central London), involving a wide set of partners who contribute to health and wellbeing. It is suggested the Ageing Well Strategy in its development and scope is an exemplar of how to develop and deliver such a system.

4.4. The Strategy complements Haringey's existing strategies or plans about its population health and well-being, such as Haringey's Health & Well-Being Strategy and the Borough Plan, as well as individual partners' own plans, such as Haringey's Clinical Commissioning Group (CCG) commissioning intentions.

4.5. This Strategy sets out how we build on what we know is working well in Haringey and identifies a number of improvements we can make to move us towards our aim and aspirations. It also supports our plans for integration of health and social care and therefore supports implementation of the NHS Long-Term Plan.

4.6. The scope of the Strategy chiefly focusses on ensuring our older population can 'age well' and what this means for people with frailty (or those who could become frail in the medium-term). This latter population is predominantly, but not exclusively, aged 65 and over - but we also consider the needs of specific groups of people more likely to become frail at a younger age. The solutions we describe in the Strategy are those which focus on health and well-being prevention, such as keeping fit and active, and primarily on health, care and housing-related support for this older population.

4.7. ‘Frailty’ is not a single medical condition but rather a state of health. It refers to the impact of a combination of medical issues and symptoms on our body as we age - around 10% of people aged 65+ years are frail, but this proportion increases to 25-50% for those aged over 85. It means people are more likely to struggle to recover mentally and physically if they have an illness, accident or crisis, and may need help to do so.

4.8. The needs section of the Strategy indicates that there are at least 13,500 people aged 65+ with some degree of frailty living in Haringey. This represents half the 65+ population, and one-third of the population (8,700) have mild frailty, with 5% (1,350) having severe frailty. Although only 18% of Haringey’s older population have moderate or severe frailty, their often complex needs mean they use 30%+ of all available health and care resources. It is important to ensure these individuals are supported – and can support themselves – to maintain or improve their health, well-being, independence and other goals important to them. In addition, the number of older people is set to increase in Haringey over the next 10 years, with the number of 85+ year olds increasing by 5% per annum. This is welcome but will place pressures on resource capacity and on future health and social care budgets.

4.9. A key project underway with partners is to shape our revised integrated model of care tailored around the differing complexity of needs of individuals in Haringey in light of the emerging changes described in the NHS Long-Term Plan and being implemented in Haringey. This will lead to, for example, integrated health and social care teams of professionals working more closely in neighbourhood footprints to support populations of 30-50,000 people, as part of integrated and primary care networks operating locally.

4.10. Partners have agreed to develop a three-year programme and action plan (a Roadmap) setting out how we will make the changes we think we need to implement the Strategy. We will look back at what we’ve achieved at the end of every year to see if it’s making a difference and to refresh our plans.

4.11. The Strategy and its Delivery Programme are divided up into several projects that take a ‘life course’ approach to supporting people as they age, as outlined in the structure below. Each of these projects has its own section in the Strategy:

- Ageing Well, i.e. how we can adopt healthier and fulfilling lifestyles as we age and monitor our health status;
- Living Well with Long-Term Conditions, including dementia: A separate strategy will be developed for LTCs, but this section gives a view about the general approach taken. A specific section in the Ageing Well Strategy discusses Living Well with Dementia;
- Living Well when Becoming Frail: This describes the need for targeted help and support when individuals become frail, typically those with mild frailty;
- Living Well when Frailer: This describes the needs of people with more complex needs and how we will provide a coordinated response to best manage these needs. These individuals are those most likely to need a coordinated, often statutory sector, support
- Planning for, and Nearing, End of Life: This describes how as partners we will support people to die with dignity in the place of their choosing;

- Supporting People to Recover after Illness or Crisis including crisis and short-term support in, and discharge from, hospital or to avoid hospitalisation;
- Supporting Carers to continue in their caring role and have a life of their own.

4.12. The Strategy discusses next steps and how the Borough Partnership and the Integrated Care (Group) will oversee implementation of the Roadmap.

5. Alternative options considered

5.1. Not applicable.

6. Policy Implication

6.1. The Ageing Well Strategy is one of the key plans of the Borough Partnership between partners. It supports and helps deliver:

- North Central London Sustainability and Transformation Plan;
- LBH Joint Health and Well-being Strategy and is line with Haringey's Joint Strategic Needs Assessment;
- Priority 2 (People) of Haringey's Borough Plan 2019-2023;
- Haringey CCG Operating Plan
- Priority 2 (Integration) of Haringey CCG's Strategic Priorities
- National NHS Long-Term Plan within Haringey.

7. Contribution to strategic outcomes

7.1. The Strategy will contribute to objectives within both the Place and People Themes of the new Borough Plan:

7.2. Place Theme: *A place with strong, resilient & connected communities where people can lead active and healthy lives in an environment that is safe, clean and green.*

7.3. People Theme: *Our vision is a Haringey where strong families, strong networks and strong communities nurture all residents to live well and achieve their potential.*

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

8.1 Finance

8.1.1 Adoption of this strategy will have no discernable financial consequence in and of itself. However, each of the projects the strategy influences will have its own cost stucture which will be budgeted for.

8.2 Legal

8.2.1 The Health and Wellbeing Board duties include to advance the health and wellbeing of people in its area and for this purpose, to encourage persons who arrange for the provision of any health or social care services in its area to work in an integrated manner. The Strategy has been developed in collaboration between Health and Social Care and is intended to improve the health and wellbeing of the people in Haringey. Therefore, the Board under this duty to encourage integrated working can endorse the Strategy.

8.3 Equality

8.3.1 An Equalities Impact Assessment (EIA) has been completed for the Ageing Well Strategy. This EIA drew on evidence from a wider variety of sources. This included quantitative data on protected characteristics groups in the population and on service utilisation (including intelligence from the State of the Borough needs analysis, the Borough Plan and national data sources, such as those from ONS; and from the Ageing Well Strategy's own Needs Analysis section). The EI assessment also incorporated qualitative feedback from residents directly or their representative groups at engagement sessions such as the CCG's patient forums. This engagement included people with one or more of the protected characteristics, including age, gender, disabilities and ethnicity.

8.3.2 The overall outcome was positive because of the perceived benefits to people with protected characteristics. The assessment highlighted a particularly positive impact on issues associated with older people (over 65), disability (including mental health), gender, ethnicity, human rights, socio-economic group, social inclusion and community cohesion.

8.3.3 These positive impacts were mainly due to: the cohort of patients and services users that will be the main beneficiaries including potentially disadvantaged or under-served groups; the delivery of services in people's homes; working in a person- centred way to define health and social care goals; and the intention to improve health and well-being. No negative impacts were highlighted.

9. Use of Appendices

9.1. Appendix 1: Ageing Well Strategy 2019-2022.
9.2. Appendix 2: Strategy Gant Chart

10. Local Government (Access to Information) Act 1985

10.1. Not applicable.

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Ageing Well Strategy for Haringey 2019 – 2023

Version no: V3.2
Status (Draft/Final): Final
Issue date: Sep-19

Document Author:
Paul Allen

Revision History

Name	Version	Date	Summary of changes
Yewande Sangowawa	V2.0	17.09.19	Alterations to figures numbering throughout the document
Yewande Sangowawa	V3.0	26.09.19	Alteration to Ageing Well high level actions – start/end date and owners
Paul Allen	V3.1	29.09.19	Final alterations to Strategy
Yewande Sangowawa	V3.2	03.10.19	Additional information on Long Term Conditions included
Paul Allen	V3.3	08.10.19	Final amends to sections

Summary

A number of health and care partners as well as patients, residents and carers have come together to produce this Ageing Well Strategy for Haringey and to commit to a common vision: ***"We will work together to support people with frailty to live and age well".***

The Strategy is a plan adopted by the multi-agency Borough Partnership and supports one of 4 population groups – older people – the Partnership identified as a priority to support. The Partnership will also oversee delivery implementation, outcomes and impact of the Strategy and report to the Health & Well-Being Board. It is closely aligned to national and local policy direction, including the Borough Plan and NHS Long-Term Plan, particularly those sections of the latter which relate to integrating health and care services at a Borough and local footprint.

The scope of the Strategy chiefly focusses on ensuring our older population can 'age well' and what this means for people with frailty (or those who could become frail in the medium-term). This population is predominantly, but not exclusively, aged 65+ - but we also include the needs of specific groups of people more likely to become frail at a younger age in its scope. We know there are at least 13,500 people aged 65+ with some degree of frailty living in Haringey. This represents half of the 65+ population, and one-third (8,700) have mild frailty, with 5% (1,350) having severe frailty. It is important to ensure these individuals are supported and can support themselves to maintain or improve their health, well-being and independence. The number of older people is set to increase in Haringey over the next 10 years, with the number of 85+ year olds increasing by 5% per annum. This is welcome but will place future pressures on health and care budgets and capacity of the system. For example, only 18% of the population have moderate or severe frailty, but they use 30%+ of all available health and care resources due to their complex needs.

In response, partners have agreed to develop a three-year programme and action plan (a Roadmap) setting out how we will make the changes we need to implement the Strategy. The Roadmap is included in the Annex. Every year, we will look back at what we've achieved to see if it's making a difference and refresh our plans. We've taken a 'life course' approach to the structure of the Strategy:

- Ageing Well, i.e. how we can adopt healthier and fulfilling lifestyles as we age;
- Living Well with Long-Term Conditions, including dementia: A separate strategy will be developed for LTCs, but this section gives a view about the general approach taken. A specific section in the Ageing Well Strategy discusses Living Well with Dementia;
- Living Well when Becoming Frail: This describes the need for targeted help and support when individuals become frail, typically those with mild frailty;
- Living Well when Frailer: This describes the needs of people with more complex needs and how we will provide a coordinated response to best manage these needs. These individuals are those most likely to need a coordinated, often statutory sector, support
- Planning for, and Nearing, End of Life: This describes how as partners we will support people to die with dignity in the place of their choosing;
- Supporting People to Recover after Illness or Crisis including crisis and short-term support in, and discharge from, hospital or to avoid hospitalisation;

- Supporting Carers to continue in their caring role and have a life of their own.

Introduction: Our Aims And Principles

" We will work together to support people with frailty to live and age well"

A number of health and care partners have come together to produce this Ageing Well Strategy for Haringey and to commit to the above statement. The Strategy complements Haringey's existing strategies or plans about its population health and well-being, such as Haringey's Health & Well-Being Strategy and the Borough Plan, as well as individual partners' own plans, such as Haringey's Clinical Commissioning Group (CCG) commissioning intentions.

Partners who have collaborated on this Strategy under the remit of Haringey's Health and Well-Being Partnership include the London Borough of Haringey, Haringey CCG, Whittington Health NHS Trust, North Middlesex University Hospital NHS Trust, Barnet, Enfield & Haringey NHS Trust, Federated 4 Health (Haringey's GP Federation) and a number of voluntary sector and charitable organisations, such as Bridge Renewal Trust, Public Voice, the 50+ Forum and North London Hospice. Patients, residents and carers have helped us design the Strategy. We are very grateful for their contribution, time and knowledge.

As part of its development, partners decided to set out goals and principles we felt were important in making improvements to which this Strategy aspires. Working together, partners will commit to:

- Having a common way of identifying people with frailty as early as possible;
- Carrying out timely and shared assessments to understand people's needs;
- Involving the individual and their carers – their friends and families - in care planning and in promoting self-care;
- Working together with people and their carers to plan and deliver care and treatment and thus reduce the risk of someone needing more intensive and/or crisis-driven interventions later;
- Delivering care in the setting and living environment most suitable to the needs and wishes of people and their carers;
- Providing a timely, co-ordinated and multi-disciplinary response, where this is needed, to manage care, treatment and independence tailored to an individual's need;
- Improving people's functional ability to undertake daily living activities important to them;
- Respecting and protecting patients and carers from harm, neglect or abuse;
- Assessing and delivering care to support advance care planning for the last phase of life;
- Developing a single shared care record/plan available to patients, carers and care providers.

This Strategy will set out how we build on what we know is working well in Haringey and identifies a number of improvements we can make to move us towards our aim and aspirations.

What Success will Look Like

A number of Council and CCG strategies set out to improve the health, well-being and quality of life of the population within, and across, the Borough. The Ageing Well Strategy supports these aims through promoting a structured approach to helping as they become older and may become more dependent on others often due to the impact of multiple health conditions as they age.

This Strategy recognises there will need to be a number of key improvements to our current system. These improvements include how we will translate the goals and principles in the Aims section into reality. For example, we will know our Strategy is successful if we are able to identify people more readily who may need help earlier, provide better and more targeted information and advice to them, better assess their needs and work with and across partners to plan and deliver care in a coordinated and timely way.

The Strategy's implementation will support a number of outcomes older people tell us are important to them regardless of their level of need. This includes being as healthy, well and independent as they can for as long as possible and feeling well-supported to do so: for example, they can recover as far as possible after illness or crises. However, older people tell us they also value other outcomes, such as feeling they can contribute to their families and wider community, whilst their housing environment is also important to them.

Helping people to achieve these outcomes in the short-, medium- and longer-term will be beneficial to them and reduces their risk of having health or social crises. In turn, this will reduce pressures on our services, such as hospital A&E departments, because people's care can be better planned and delivered at home for more people in a more effective and efficient way.

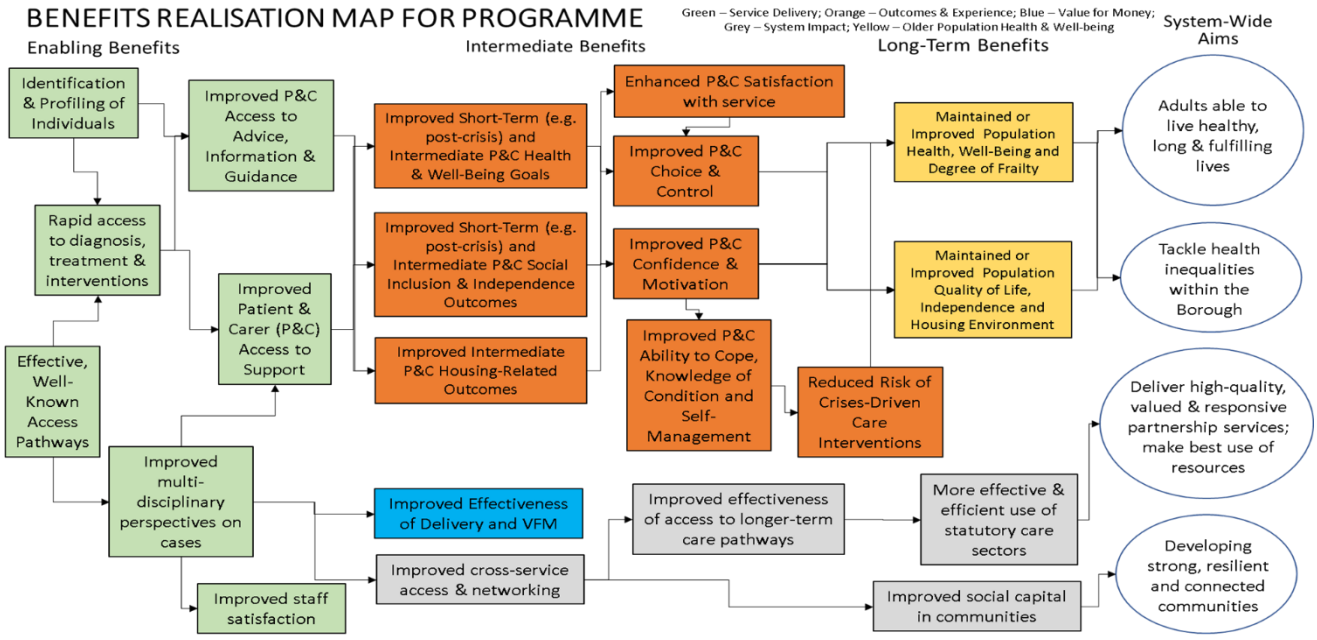


Figure 1 – Benefits Realisation Map for Strategy & Programme

Figure 1 combines all these types of outcomes to show what success might look like as a result of implementing this Strategy and how it relates to other strategies:

- A set of tangible service delivery objectives: improvements in access, planning and delivering the information and help that's available to people consistently across the Borough;
- Person-centred short- and longer-term outcomes about the expected benefits of this Strategy;
- Care system outcomes such as making best use of resources and improved value for money;
- An indication of how this Strategy contributes to wider strategic aims in Haringey.

A full set of system measures will be developed in 2019/20 to assure progress against the above outcomes is being made and that the Strategy implementation is having the impact intended.

Our Model of Networked Care

We are currently finalising our intended model of care for people as they age, including those that acquire long-term conditions and frailty, with both front-line professionals and older people. Our summary of this model will show the practical differences in care and support against which the success of the Strategy can be judged. We plan to make sure that individuals benefit from:

- Ensuring information, advice and guidance is simpler to access and more consistent between partners. Where needed, those with health and care needs will have access to community navigators to help steer them through a care and support system to solutions that's right for them;
- Simplified initial access points for health and care support for individuals, their families and professionals so that they get access to the right support they need quickly;
- Ensuring the assessment, care planning, delivery and review process is better tailored around an individuals' needs more effectively closer to home and in a way that's described in our principles;
- A range of high-quality services are available to them in the community that are tailored to their needs, so that individuals can decide with others which solutions are the ones right for them;
- Working in an increasingly multi-disciplinary and multi-agency way as individuals' needs become more complex. This means an individual may be working with one or two professionals, such as a GP or community nurse, if their needs are less complex but that those with more complex needs will have access to a more comprehensive multi-disciplinary team with a care coordinator;
- Seamless pathways of care and support to return home or to a suitable alternative, such as supported living, following a spell in hospital. Our services will continue to help people recover and regain their abilities if that's what they need;
- All of the above solutions is delivered in such a way that we are promoting prevention, individuals' autonomy and independence, encouraging them to manage their conditions and situations.

Strategy and Programme Structure and Governance

Partners have agreed to develop a three-year programme and action plan (a Roadmap) setting out how we will make the changes we think we need to implement the Strategy. We will look back at what we've achieved at the end of every year to see if it's making a difference and to refresh our plans.

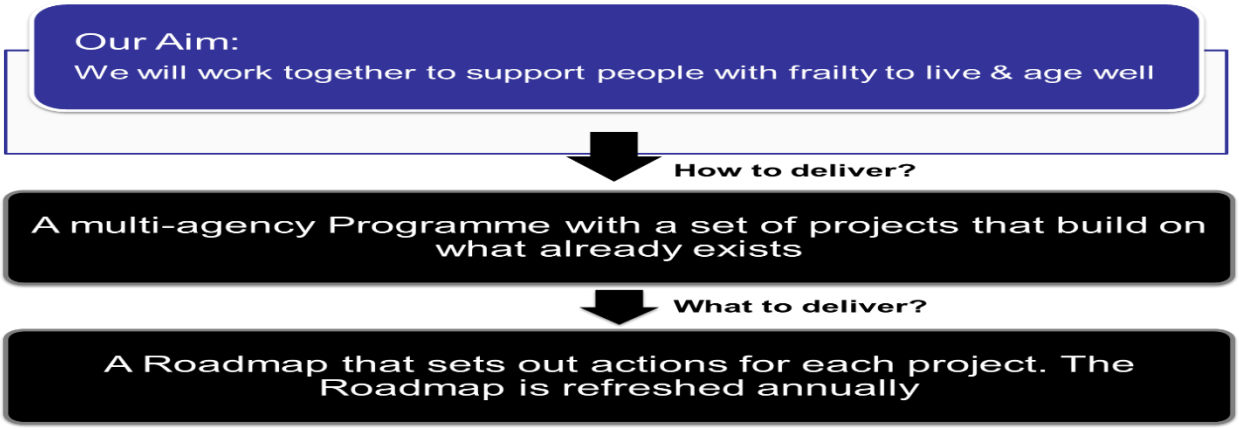


Figure 1 – Summary of Approach to Development and Implementation

A summary of the Roadmap for 2019/20 is included in Appendix 1.

Our Focus

The scope of the Strategy is far-reaching as it needs to consider:

- *Those who it will benefit* which is for the older population to 'age well' and what this means for people with frailty (or those who could become frail in the medium-term). This population is predominantly, but not exclusively, aged 65 and over - but we also consider the needs of specific groups of people more likely to become frail at a younger age;
- *The type of solutions* which focus on health and well-being prevention, such as keeping fit and active, and primarily on health, care and housing-related support for this older population;
- *How it integrates with other plans* to make sure the Strategy is aligned with national and local policy and plans, such as Haringey's Borough Plan or North Central London's Care Partners implementation of the NHS Long-Term Plan, and individual agency's own improvement plans. We have incorporated expectations of these strategies into our Ageing Well Strategy.

Governance

Haringey's Health & Well-Being Board has overall responsible for this Strategy and delivery of its Programme, as governance needs to be multi-agency to reflect the improvements we want to make to the integrated care model. The Board will discharge its responsibility through Haringey's multi-agency Borough Partnership that will be responsible for oversight of, and support for, delivery of the Strategy's Programme. This Partnership Board contains executives from the partners involved in forming this Strategy including patient/service user and carer representative groups.

The Head of Service for Integrated Care Commissioning (Older People & Frailty), a joint appointment between the CCG and Council, acts as the Programme Manager for the Strategy reporting on issues,

risks, progress and impact of implementation to the Board. The Programme Manager is supported to do so through a multi-agency programme group (Integrated Care Adults Group), which includes leads (from different agencies) responsible for different aspects of the Programme as well as patient/user representative groups. In turn, a number of multi-agency project groups support the work of the leads to make the improvements necessary.

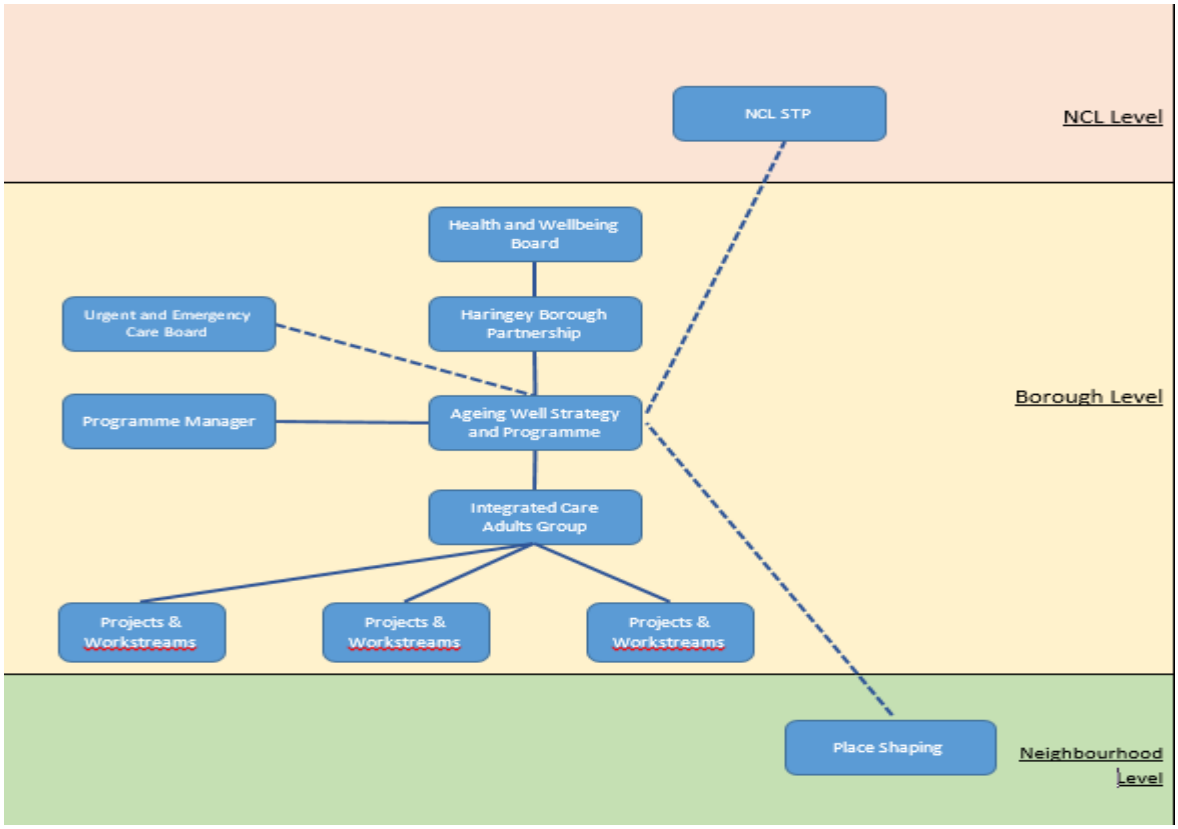


Figure 2 - Governance for Ageing Well Strategy in Haringey

An integrated care model needs to incorporate partners across North Central London, at Borough and local neighbourhood footprints. We need to align our plans across these levels:

- Haringey's Borough Partnership is one of 5 such partnerships in North Central London – one in each Borough. We are liaising with North London Health & Care Partners to ensure this Strategy aligns with NCL plans being revised in light of the expectations in the recently published NHS Long-Term Plan. Where it makes sense to do so, we are working across NCL to deliver these improvements, e.g. in progressing an IT solution for shared records;
- We are working closely with our local acute Trusts, Whittington Health and NMUH, Urgent & Emergency Boards to ensure our proposals are aligned with their plans. In practical terms, this will include ensuring our improvements align with similar to those planned for Enfield (NMUH) and Islington (WHT) and fully engage with our partners. A senior level multi-agency Transformation Leadership Group is overseeing development of those aspects of the integrated care model for older people that can be aligned across Enfield and Islington – a 'Frailty Network';
- We are working closely with partners at a neighbourhood level to deliver care closer to home for people with frailty, e.g. through our Integrated Care and Primary Care Networks discussed in this Strategy. These improvements support our wider partnership approach to working

collaboratively with local communities to make them stronger and more resilient. We are currently piloting our approach to partnership working in North Tottenham.

The Structure of the Strategy

Partners decided to take a life-course approach as a way of organising the Strategy and its Roadmap. Figure 3 below outlines a total of 8 projects in our improvement Programme:

- Five projects describe our life-course as we age (from simply needing to eat and drink well, take exercise and so on) through to supporting people if they develop a long-term condition, then becoming gradually more frail, and, finally, approaching the end of our lives;
- Another project focusses on making sure people are as well-prepared as possible and then well-supported should they have a health or social crisis, including needing to go to hospital, and that they can recover afterwards as quickly as possible;
- A project recognises the vital role family and friends (carers) play in supporting someone with health and care needs;
- A final section discusses some of the enablers to support staff deliver the improvements partners want. This includes issues like joint workforce development and IT development, which is being considered across North Central London (see Next Steps);
- The entire Strategy helps make sure we successfully develop and sustain age-friendly communities as a whole as part of partners' commitment to the Borough Plan. The Ageing Well Strategy, and partners' commitment to it, will help make this a reality, but the concept of age-friendly communities is much wider than the scope of this Strategy.

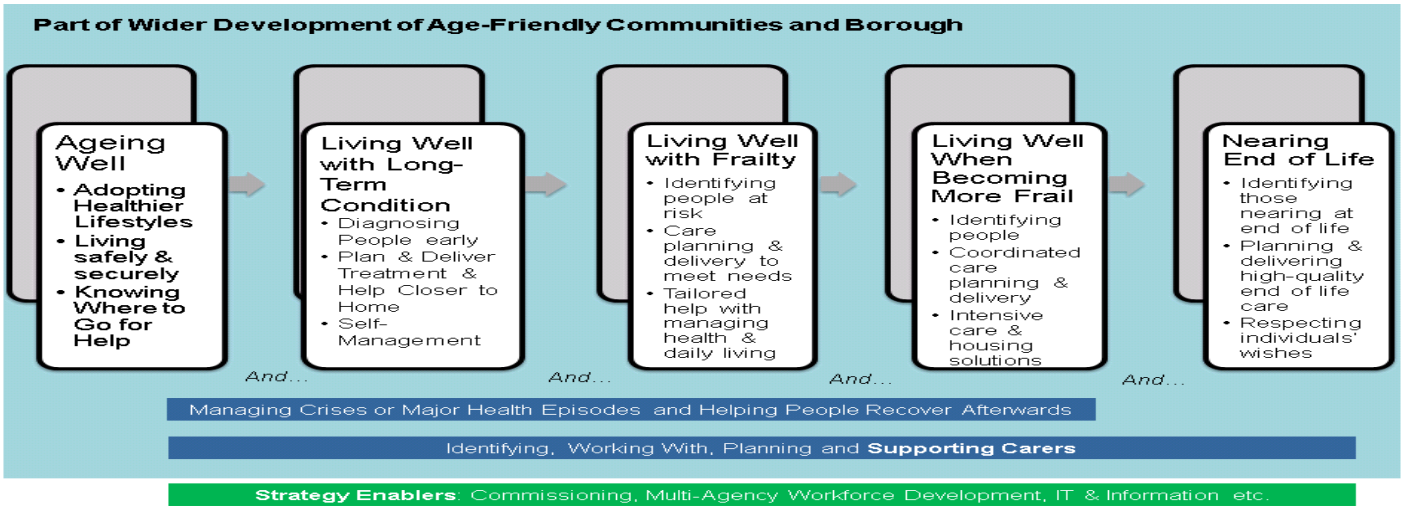


Figure 3 - A Life Course Approach to the Strategy

One of the Strategy's elements, **Living Well with a Long-Term Condition**, is the subject of a dedicated Long-Term Conditions (LTC) Strategy currently being developed within the CCG. However, a section in the Ageing Well Strategy outlines the improvements anticipated for people with LTC. However, one section of the current Strategy focusses on '**Living Well with Dementia**' given the importance of this condition on ageing well. We will make sure the Ageing Well and LTC Programmes are aligned so that we can provide joined-up plans for care and support to people with long-term conditions as they age, particularly for those who have more than one medical condition.

Each of the projects has its own section in this Strategy that sets out what's already in place, what our aspirations are in this Strategy and what our priorities for joint improvement are. A set of resulting improvement actions for each section are included in the Roadmap in Appendix 1.

Our Needs Now and in the Future

Figure 4 provides facts and figures about Haringey's older population, to which this Strategy is predominately aimed, and the services they utilise. There are 60,100 people aged 50+ living in the Borough, of whom 27,320 are aged 65+. These numbers represent 25% and 10% of Haringey's population. White British is the single largest ethnicity group in Haringey's older population (42%), with White Other making up another 24%, and Black and Asian ethnicities accounting for a further 18% and 10%.

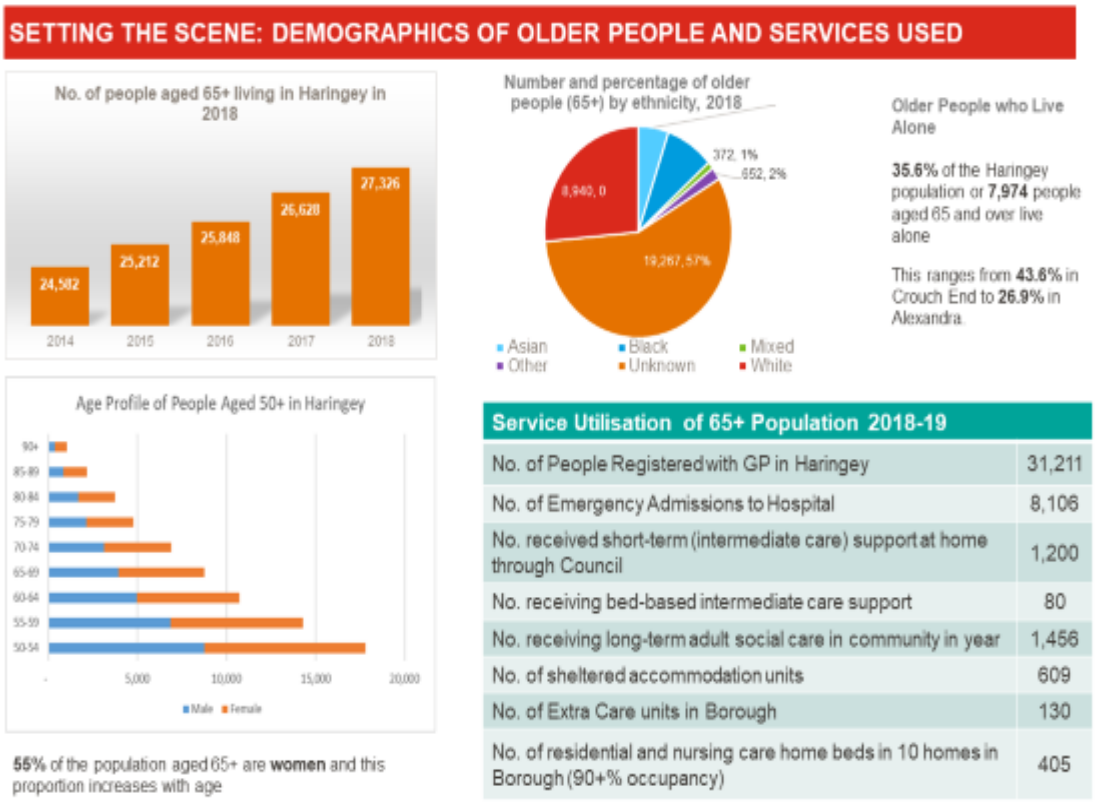


Figure 4 – Demographics and Service Utilisation for Haringey's Older Population

The population is ageing: it's estimated there will be 35,310 older people living in Haringey in 2028, an increase of 30% in ten years, with those aged 85+ increasing by 5% each year. As it's more likely older people will need more intensive health and care services than the general population, this is one reason why this Strategy is important.

Figure 5 shows there's a greater number of older people living in the west wards in Haringey. However, the more deprived wards are in the east and central wards (Figure 6). Average life expectancies for both men (81 years) and women (84) are the same as London. However, there's a big variation in overall and healthy life expectancies associated with deprivation in Haringey: people

in the 20% most deprived wards can expect to be in good health until, on average, 54 years, whilst their counterparts in the least deprived live in good health, on average, until 70.

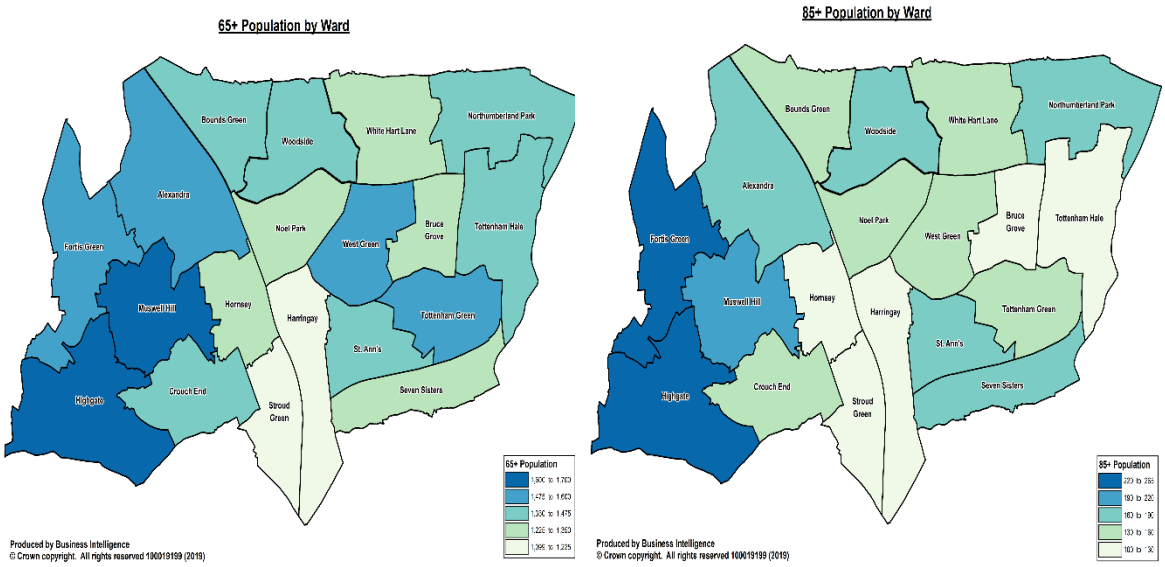


Figure 5 – Older Population in Haringey

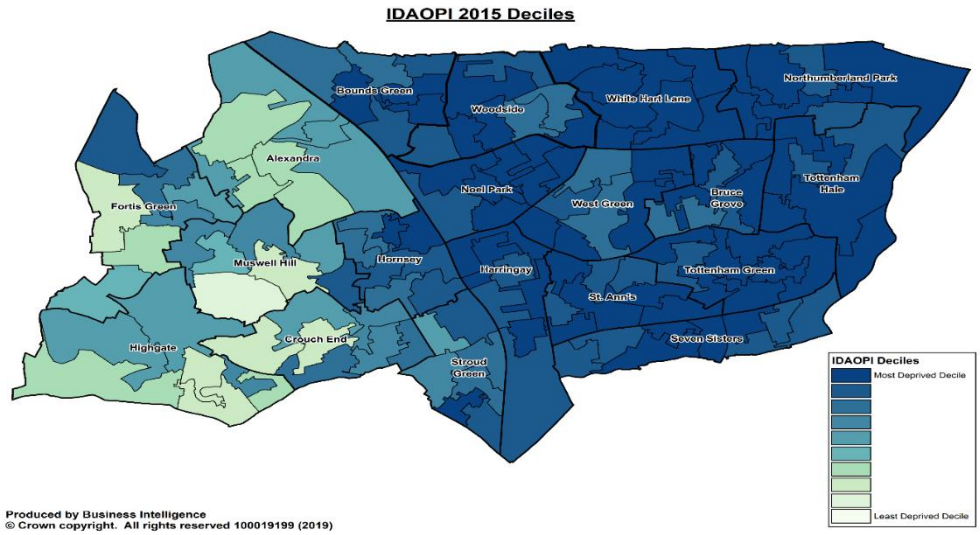


Figure 6 –Deprivation affecting older people index 2015 in Haringey

A vital part of this Strategy is to make sure older people are as in control over their own lives as autonomously as they can. We want to encourage and support people to lead fulfilling lives and develop meaningful social interactions and relationships as we know one benefit of making a contribution to the community is improved quality of life. This means that far from being passive recipients of health and social care, older people have a sense of purpose and feel valued by family,

friends, professionals with whom they work and their communities. To further this approach, older people have, and will be, active participants in shaping and taking forward this Strategy.

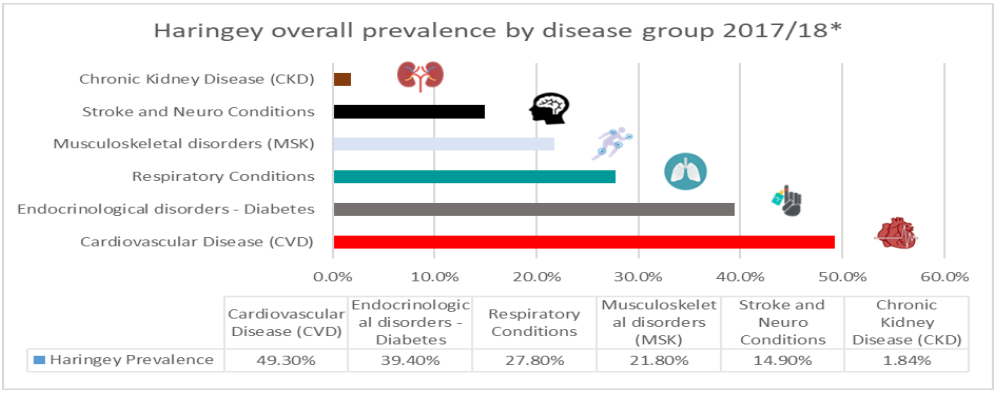


Figure 7 – Condition Prevalence in Haringey

We are developing a Long-Term Conditions (LTC) Strategy in parallel with this Strategy, and this will include a more comprehensive needs analysis. However, it does highlight that:

- A number of chronic conditions are known to impact significantly on individuals' health and life expectancy as they age in Haringey, including heart disease, diabetes and respiratory conditions. The LTC and Ageing Well Strategies have chosen to highlight 6 conditions (Figure 7) plus dementia on which Haringey needs to improve over the next few years;
- Individuals are more likely to have multiple long-term conditions ('multi-morbidity') as they get older: 30% of people aged 65-69 in Haringey have 2+ long-term conditions: this increases to 60% for those aged 85+: there's a greater risk people with multi-morbidity will be frailer.

The Ageing Well Strategy complements the LTC Strategy by focussing more precisely on the needs of (predominantly older) people with 'frailty', who often have multi-morbidities, and dementia.

Frailty

'Frailty' is not a single medical condition but rather a state of health. It refers to the impact of a combination of medical issues and symptoms on our body as we age - around 10% of people aged 65+ years are frail, but this proportion increases to 25-50% for those aged over 85.

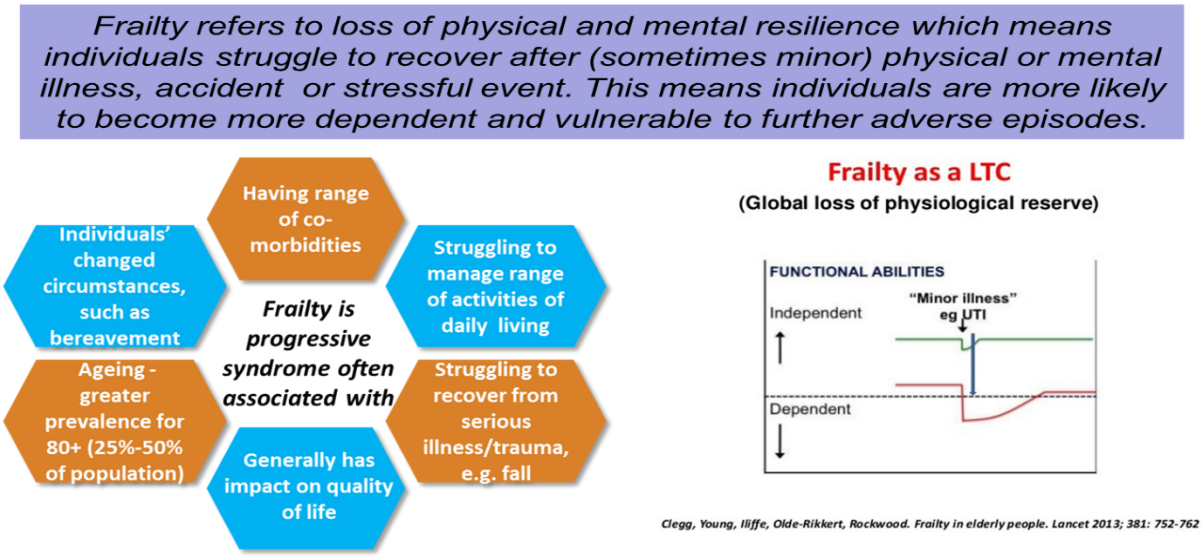


Figure 8 – Summary of Issues associated with Frailty

There are a complex range of medical, social and environmental factors that mean particular individuals are more or less likely to be frail. Figure 9 provides an insight into some of these factors. For example, there are conditions most often associated with frailty, such as musculoskeletal conditions like arthritis, respiratory conditions (e.g. Chronic Obstructive Pulmonary Disease) and falls/fractures, but the list in Figure 9 is by no means exhaustive.

Social factors are also known to influence whether someone is, or at risk of becoming, frail or frailer. For example, a recent national study[1] found older people who felt socially isolated were 75% more likely to become physically frail, whilst those living on low incomes are nearly twice as likely to be frail than wealthier individuals at the same age[2]. Trigger events such as bereavements and low mood are also known to impact on individuals underlying frailty and ability to recover after crises.

[1] Catharine R Gale, Leo Westbury, Cyrus Cooper, Social isolation and loneliness as risk factors for the progression of frailty: The English Longitudinal Study of Ageing, Age and Ageing, Volume 47, Issue 3, May 2018
[2] Watts PN, Blane D, Netuveli G Minimum income for healthy living and frailty in adults over 65 years old in the English Longitudinal Study of Ageing: a population-based cohort study BMJ Open 2019

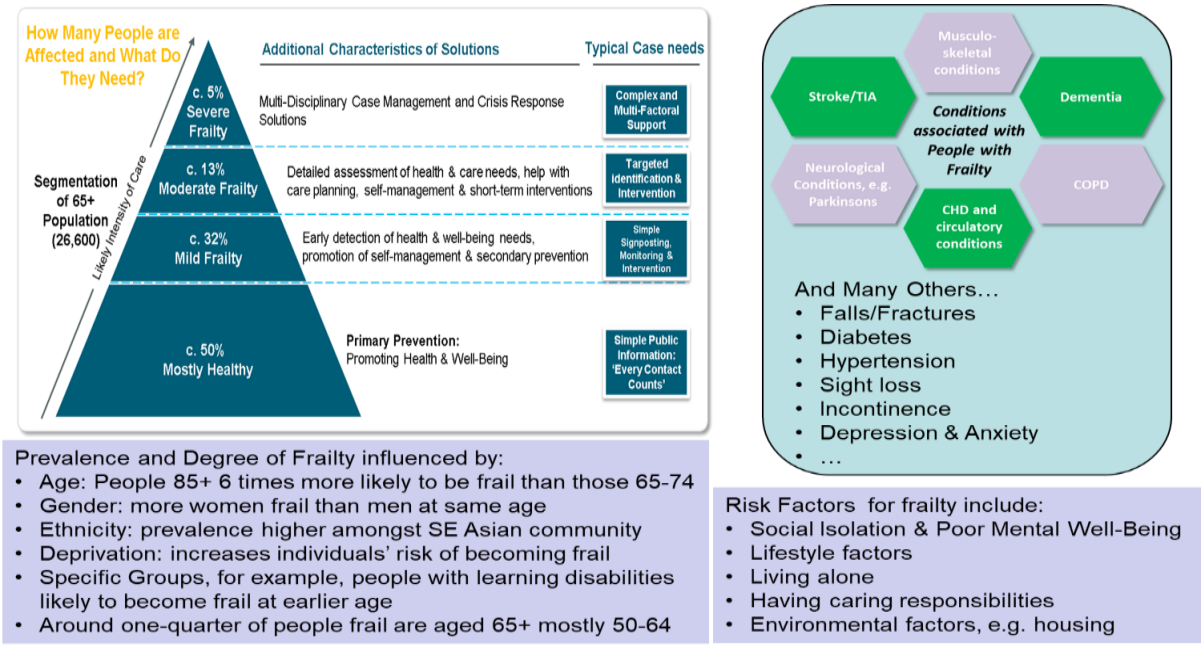


Figure 9 – Characteristics of People with Frailty and Response

People also have different degrees of frailty depending on their underlying needs. Figure 9 summarises the degree of frailty amongst the 65+ population in the Borough. It is estimated half of this population has some degree of frailty – **around 13,500 older people in Haringey**. One-third of the population (8,700) have mild frailty, with 5% (1,350) having severe frailty.

However, the 18% of people with moderate and severe frailty are estimated to utilise 40% of health and care resources, such as the costs of hospital admission and adult social care due to their underlying needs[3]. There is evidence locally and nationally[4] that up to 15% of older people who attend A&E could be better managed at home, such as people presenting with common respiratory conditions or urinary tract infections. In addition, we know some individuals, and those who care for them, could also be encouraged to better manage their conditions, or access help earlier, to avoid crises.

However, the same study suggested many older people presenting to A&E nationally are sicker and are more likely to need admission. One reason is that one-third of patients admitted to hospital as an emergency now have 5+ conditions, such as heart disease, stroke, diabetes, dehydration, hip fracture or dementia, and this proportion trebled in 10 years. Many patients are now older, with the proportion of 85+ patients admitted increasing by nearly 60% over the last decade. This mirrors our experience in Haringey in which we've seen a greater proportion of older people admitted to hospital once in A&E. Many are frail and could benefit from a more joined-up and multi-agency approach between hospital and community to coordinate and deliver their care, thus mitigating future crises.

[3] Vernon, M., Hopper, A. and Thompson, A.: NHS RightCare Frailty Pathway: An optimal frailty system
[4] Steventon, A., Deeny, S., Freibel, R., Gardner, T. and Thorlby, R., Emergency hospital admissions in England: Which may be avoidable and how?, Healthcare Foundation, May 2018. A local audit of recent A&E attendances indicated similar results

Haringey's Borough Partnership has developed a 'care cone' to summarise the level of need amongst Haringey's population and partners anticipated response to meet this need. Figure 9 uses this approach to describe the degree of support an individual will need will vary according to their underlying frailty. For example, those older people who are mostly healthy may simply need encouragement and signposting to preventative solutions to keep them as healthy, independent and connected as possible. Those with more severe frailty are likely to need complex and multi-disciplinary support facilitated through person-centred coordination of their care – as well as being encouraged and supported to be as healthy and independent as possible in their situations.

Although this Strategy chiefly focusses on older people, some people who are frail are under 65, mostly aged 50-64. It's estimated around one quarter of people with frailty are **under 65, i.e. 4,500 people in Haringey,** the majority with mild to moderate frailty, but up to 225 live with severe frailty. Particular 'at risk' groups amongst this younger population include:

- Those with chronic and enduring physical disabilities or severe mental health issues;
- Those with learning disabilities who are known to become frailer at a younger age than the general population, particularly those with Downs Syndrome;
- Those who are subject to severe and multiple disadvantage, such as those who may be homeless.

The solutions discussed in this Strategy apply to these groups and partners are working to ensure these solutions join up with specialist pathways, e.g. to support those with disabilities as they age.

Falls

As people get older and/or become frailer, they are more likely to fall. As well as the potential impact injury such as a fracture, older people who fall are also more likely to suffer longer-term consequences, such as a loss of independence, confidence and potential development of further long-term conditions or complications, all of which can lead to physical and mental deterioration and the risk of becoming frailer. It can also increase their risk of further falls and fractures.

The causes of a fall are often a result of the interplay of multiple risk factors associated with an individuals' underlying health conditions, medical history and its management, their environment and the event itself, e.g. the activity they were trying to undertake when falling. People with specific conditions, such as visual impairment, arthritis, Parkinson's disease, diabetes, stroke, delirium or dementia, are at greater risk of falls. Other risk factors include having a previous history of falls, muscle weakness, poor balance, alcohol consumption, incontinence and use of particular or multiple medication(s). Falls and fractures are included in this Strategy as they therefore often represent particular events or triggers that have an adverse effect on an older person's overall health and wellbeing and a sign of underlying or deteriorating health issues.

Figure 10 contains some facts and figures about falls and hip fractures in Haringey. It's estimated one in three people over the age of 65 and one in two over the age of 85 fall every year. Care home residents are 3 times more likely to fall than those living in the community and 10 times more likely to sustain a significant injury – this is often because these residents are particularly frail. The short- and long-term costs to the health and social care system of a fall are substantial, as they result in an

injury or fracture that often needs treatment and hospitalisation and in the need for further long term support.

Falls, together with low bone mineral density, are the main cause of hip fractures, a particularly devastating injury for the older population because nearly half of people with these fractures are not able to recover their ability to walk and half may require need care in a residential or nursing home.

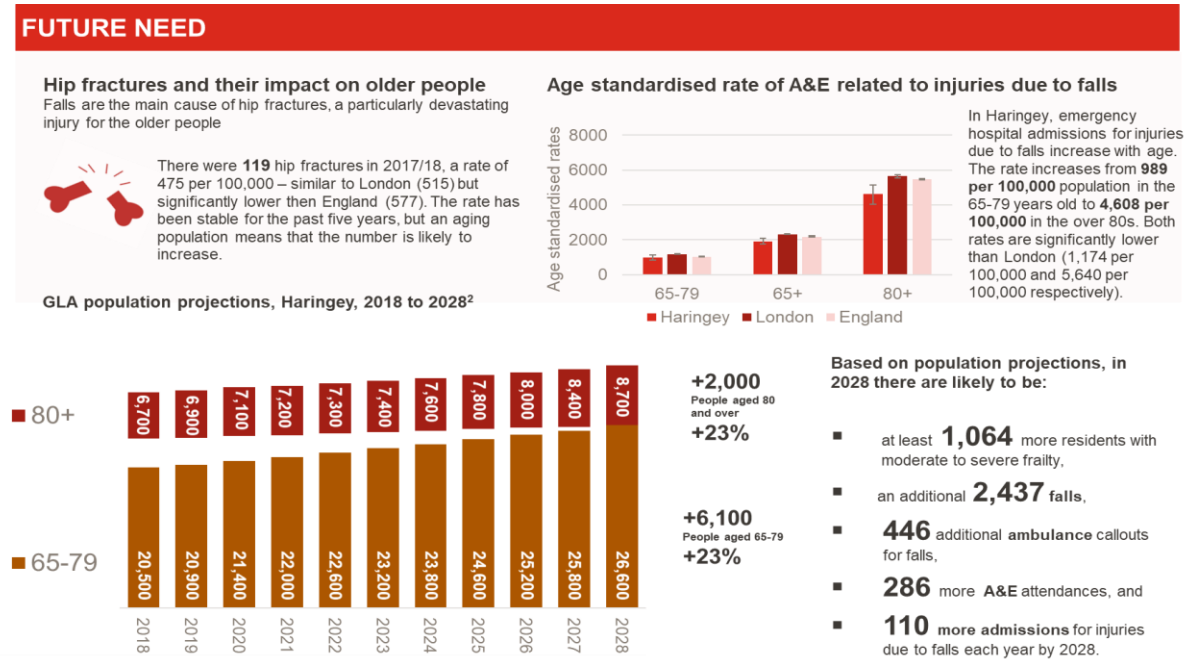


Figure 10 – Falls and Fractures in Haringey now and in the future

Tackling falls and fractures requires a whole system multi–agency approach. Reducing risk factors is crucial to preventing falls. Whilst the public, private and voluntary sector has a key role in reducing risk factors (e.g. reducing the risk of people falling in care homes or in hospital), older people can often reduce their own risks themselves by making sure there are fewer slips/trips hazards in their home and eating and drinking well, maintaining physical activity. Activities such as Tai Chi are known to be particularly effective in and improving strength and balance as people age. Haringey's Strength and Balance Scheme is a 12-week programme open to all residents at risk of falls or repeat falls and it aims to support people to undertake strength, balance, stamina and flexibility exercises. Similar activities are available in care homes.

Our aspiration is that all older people at risk of falling or those who have presented to services with a fall should be offered a falls risk assessment. Our Integrated Community Therapy Team (ICTT) in Whittington Health Trust undertake such assessments which recommend appropriate interventions to other professionals and individuals themselves, such as optimising an individual's medication regime, highlighting slips/trips hazards or recommending small items of equipment that can make a difference to people. ICTT will also refer people onto relevant services, e.g. where a risk of fracture due to low bone mineral density has been identified.

Dementia

'Dementia' is a term describing a set of conditions associated with the brain. They affect individual's memory, ability to undertake everyday tasks, communication, problem-solving and perception.

Some people may develop behavioural and psychological symptoms such as depression, anxiety or even hallucinations as their conditions develop. One in three aged 65+ will develop dementia as they age with the risk of acquiring the condition increasing as they get older. As Haringey will see a welcome increase in the number of older people over the next decade, there will also be an increase in the number of people affected by dementia.

Figures 11 and 12 contains some facts and figures about dementia. Alzheimer's disease is the most common form of dementia. A further 20% of people with dementia have vascular dementia, which is caused by reduced blood flow to the brain and is associated with conditions such as strokes.

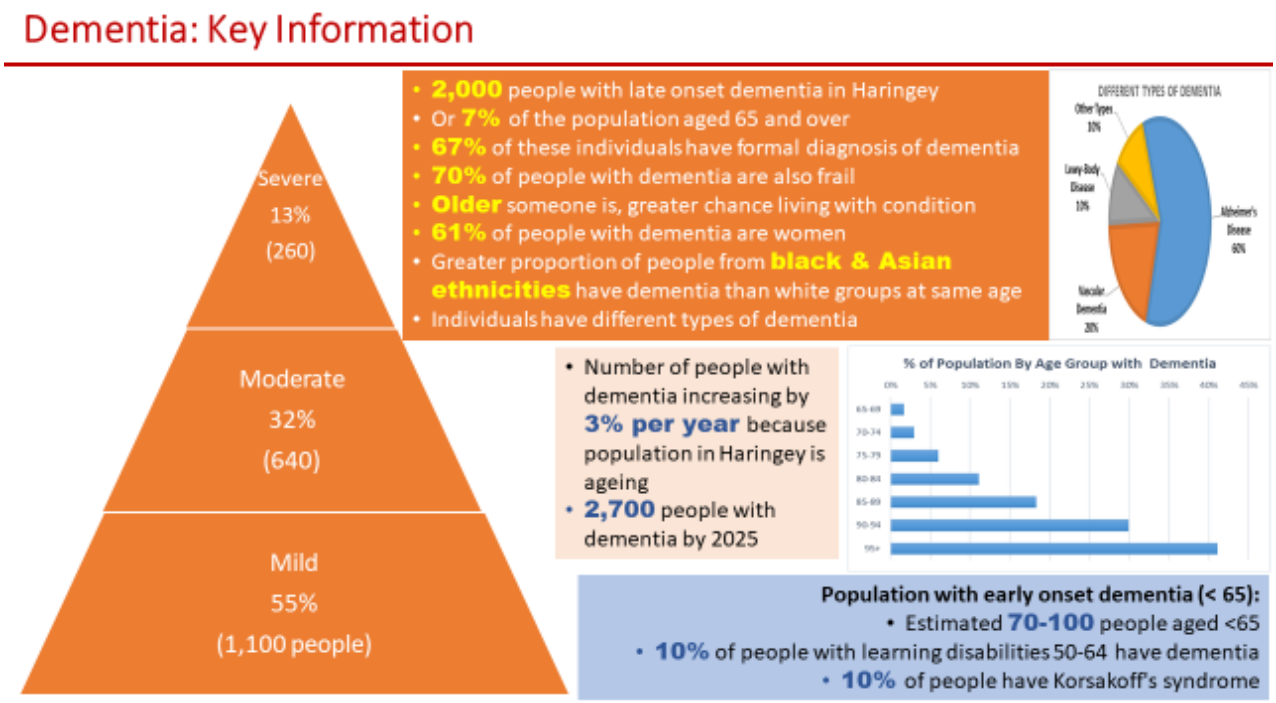


Figure 11 – Facts & Figures on Prevalence of Dementia in Haringey

Sadly, dementia is progressive condition, which means symptoms gradually get worse and we know that getting a diagnosis can therefore be devastating. However, people can live well with dementia for a number of years if they get access the treatment and support they need early enough, such as the right medication, helping people remember their life stories and continuing to be physically active. There's evidence leading a healthy lifestyle – being active, eating well and managing your weight – can reduce your risk of acquiring dementia. Conversely, particular medical conditions – such as high blood pressure and obesity – increase this risk, particularly for vascular dementia.

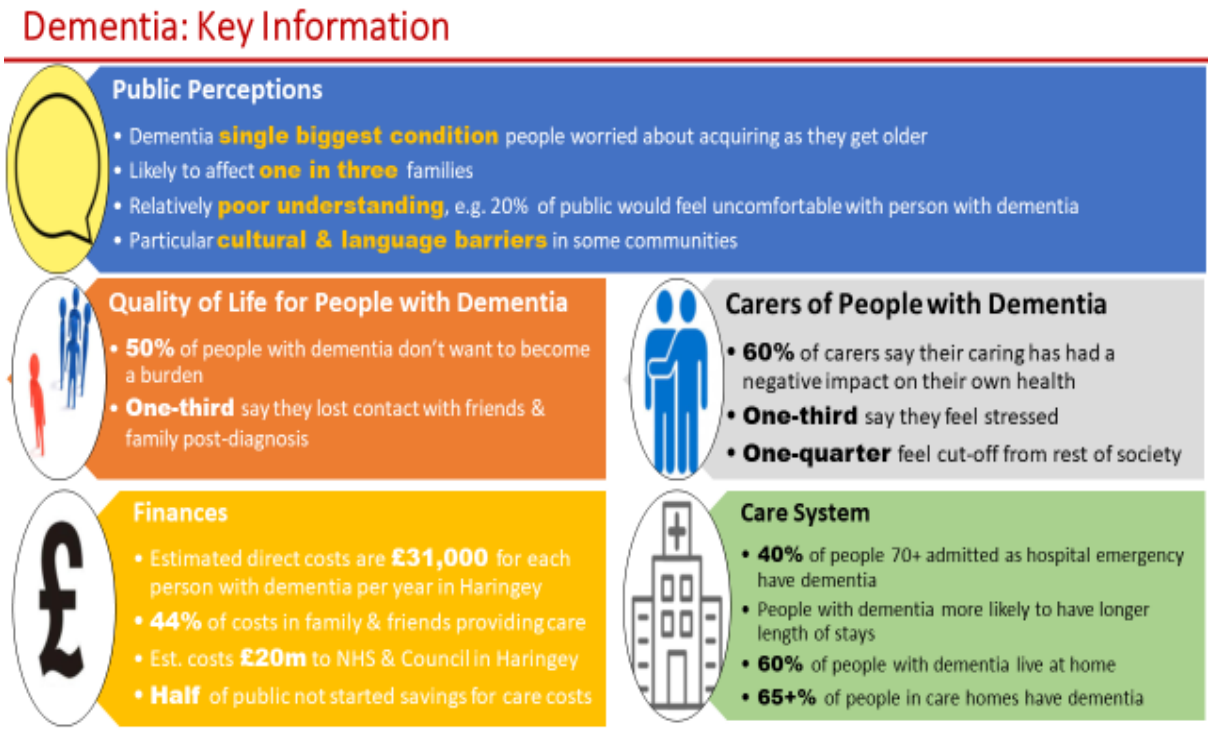


Figure 12 – Intelligence about Dementia

We know most people living with dementia often have other conditions and this means they are more likely to be frail. The impact on individuals and families may be compounded by personal circumstances, such as living alone. We want to encourage people with dementia and their families to plan for the future and avoid preventable crises, such as being admitted to hospital or care home or carers feeling unable to cope any more. Working together to support people to live well with dementia is vitally important and has its own section in this Strategy.

We also know there needs to be a step-change in how people think about dementia. Through our Dementia-Friendly Haringey, we want to mobilise our communities to play their part in tackling these issues as we know simple changes can make a big difference to people's lives.

Carers

'Unpaid carers' – family and friends who support someone with personal, social or health care needs ('cared for') – provide a vital contribution to supporting older people. It's estimated 60% of us will become a carer at some point in our lives, and the single largest group are caring for people with frailty, physical disabilities or dementia.

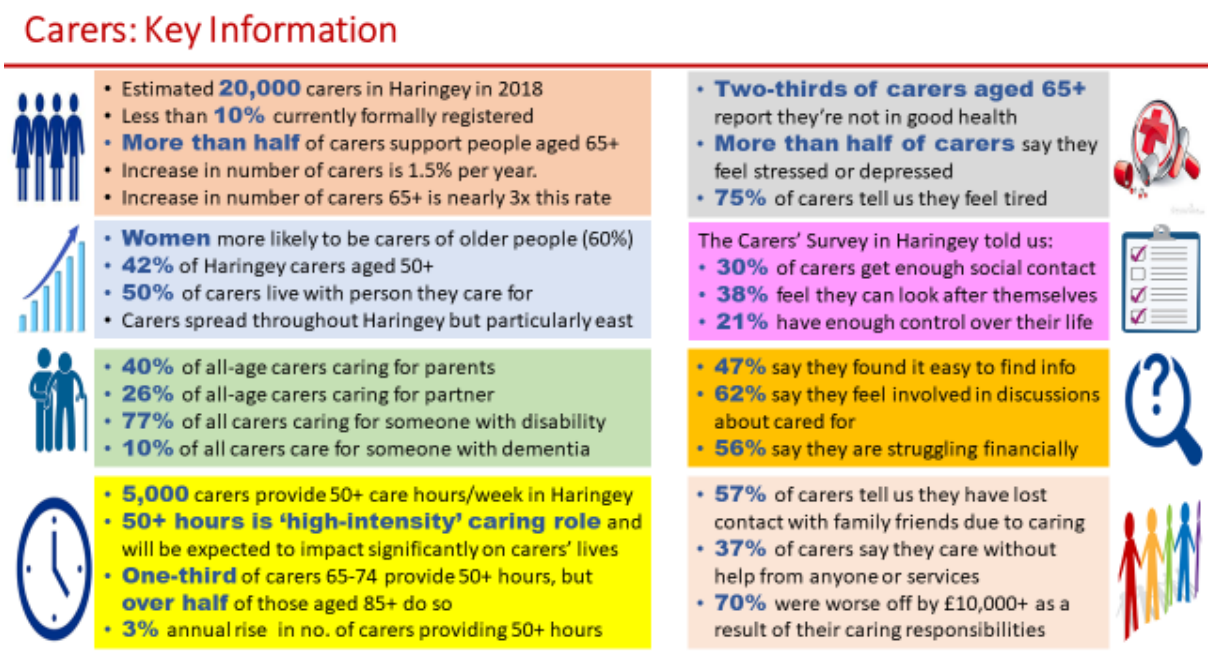


Figure 13 – Facts & Figures about Carers

Figure 13 provides some facts and figures about carers in Haringey. There are estimated to be 20,000 carers (for people of all ages) in Haringey and we need to improve the number of people formally registered as such on the Council's Carers' Register which is an important step to getting help.

For all age groups, carers at greatest risk of adverse outcomes are those providing more than 50+ hours informal care per week – around 5,000 people in Haringey. These individuals are at particular risk because their caring role impacts on their capacity to be in work, participate in social activities, and on their physical and mental health and well-being. Many of these carers are older and could be in poor health, e.g. the majority of carers aged 85+ provide 50+ hours care per week for someone else.

It's important we identify and support carers to continue in their caring role, particularly those with high-intensity caring responsibilities, those carers who are frail (and/or older) themselves and those living with someone with dementia. This support includes direct solutions to help people continue to care, for example providing respite care to the cared for to help carers to take a short-break, but also advice and help to improve their finances and access to benefits and to have a life of their own.

Services for Older People and What People tell us about them

A range of services already support the needs of older people, those with frailty or dementia and their carers. A list of these services broadly categorised into the structure of the Strategy can be found in Figure 13. These services provide a platform on which to build our plans for are integrated approach to supporting people.

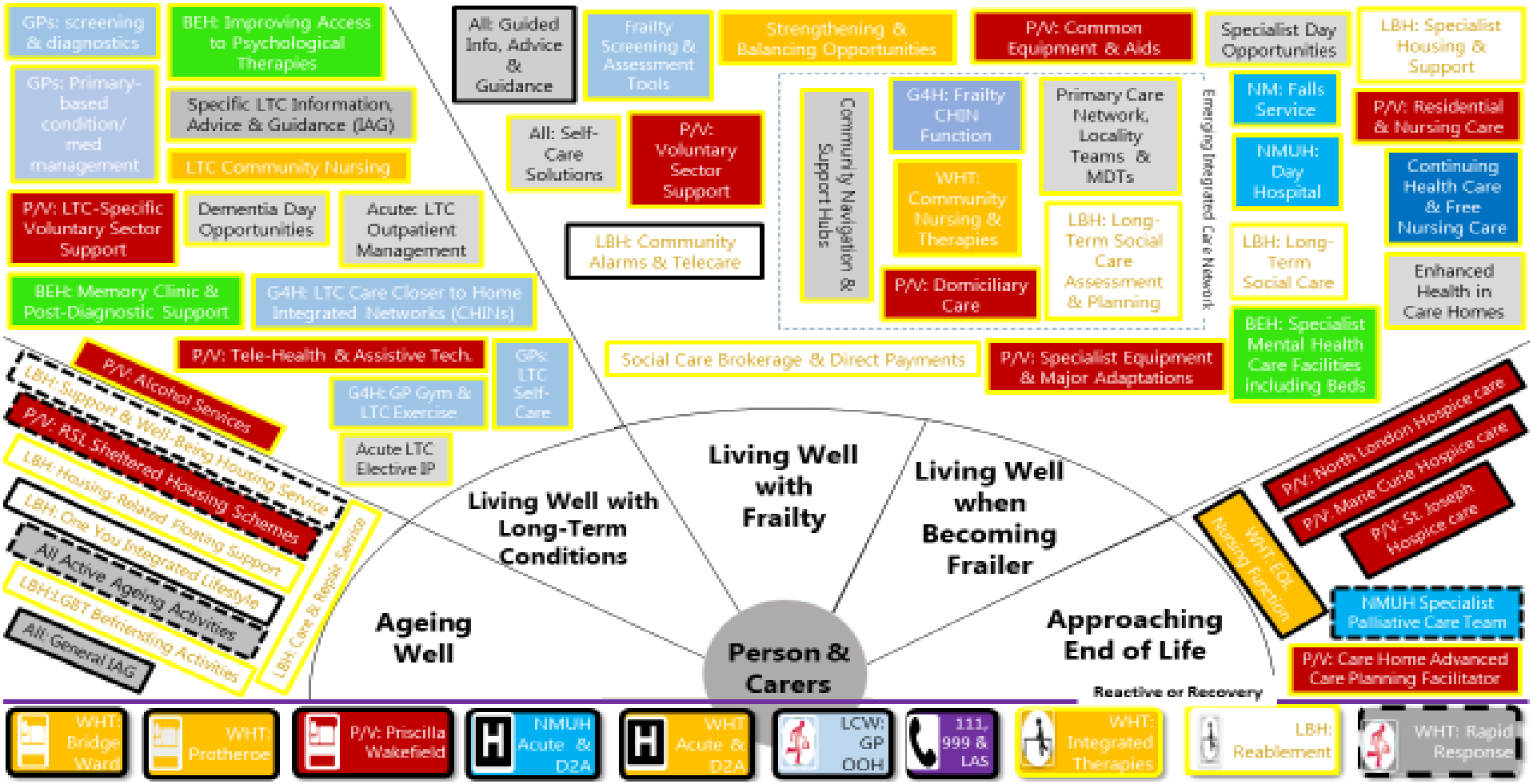
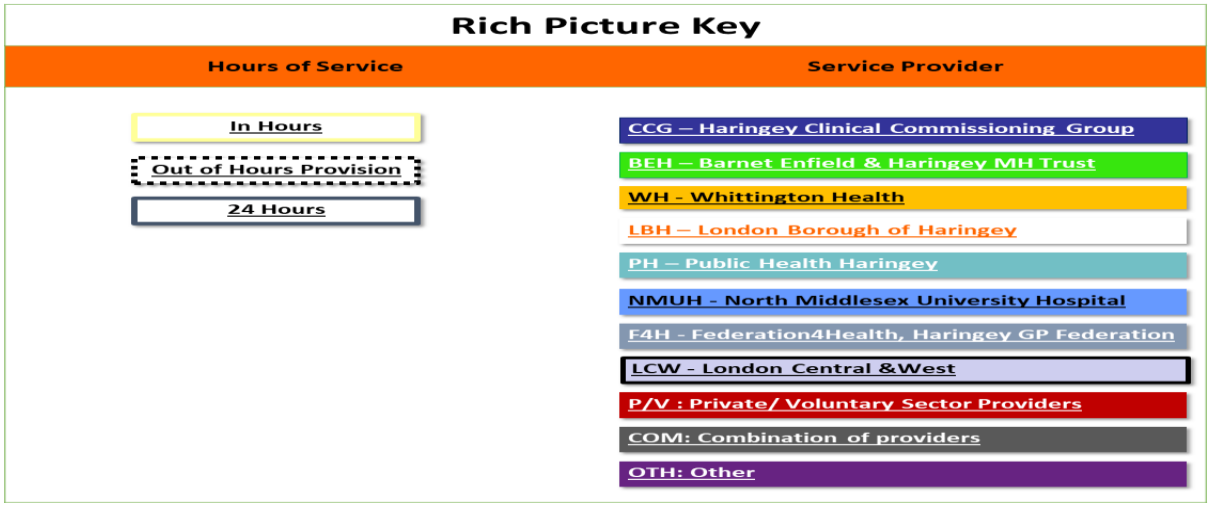


Figure 13 – Existing Services to Support People as They Age



We know many people value the support services offer but we have also listened to people about the things we could improve. Relevant sections of the Strategy discuss the services we have in more detail and our proposed improvements. Some common feedback from older people and carers include:

- Older people should be seen as an asset, rather than a burden, to the community. People could be encouraged to self-manage their care, be as independent as possible and to support others.
- Information about, and access to, services could improve and be more timely across the Borough. For example, only half of carers reported they found it easy to find out information and advice about services, support and benefits in the Council Carers' Survey;
- Many people valued the services they received. However, this was not true of everyone and there needs to be a greater level of consistency of support particularly within GP practices;
- Individuals' care and support could be more joined up and better coordinated particularly if the case was complex. At times, this support could be delivered in a timelier way to help them. Older people particularly welcomed the idea of more localised services with more time to discuss their cases and help to navigate the care system;
- People and carers could be better treated as 'experts by experience' and professionals could better listen and respect their views. For example, three-fifths of carers felt professionals consulted them in the care of the individual whom they cared in the Carers' Survey.

Ageing Well and Supporting an Age-Friendly borough

Current Position

An important part of our Strategy is to make sure older people can lead as healthy, fulfilling and independent lives as possible as they age. This will help reduce people's risk of acquiring, or worsening, their long-term conditions and becoming frail. But we also need to make sure Haringey is an age-friendly Borough, that is our communities and services that we all use can support people with particular needs as they age – sometimes simple changes can make a big difference to people's lives. This section of the Strategy focusses on both of these issues.

A range of solutions are already available in Haringey broadly aimed at supporting people to age well:

- Provision of information, advice and guidance across a range of national and local partners about the benefits of, and how to, adopt healthier and more active lifestyles in older age. We continue to encourage people to, for example, eat and drink well, take more exercise and stay connected and join in social activities they might enjoy as they get older;
- 'Living well' solutions particularly targeted at older people to age well. This includes, for example, providing them with opportunities to undertake social and physical activities they might enjoy such as Silverfit, which provides activities such as yoga, badminton and Nordic walking sessions for middle-aged and older people in Haringey. I's equally important solutions are in place for people less able to access such sessions: for example, many care homes provide chair-based exercises for residents. The London Borough of Haringey recently published 'Active Together', its Physical Activity & Sport Strategy for Haringey, to promote physical activities for all ages;
- There are many voluntary and community services and resources available that promote ageing well in Haringey, both statutory and commissioned services and those in the voluntary and community sector. For example, the North Tottenham pilot mapped over 100+ organisations providing a huge range of solutions to the diverse community in this relatively small area, many that relate to older people such as luncheon clubs. The 50+ Forum recently produced a directory of Haringey services older people might find useful and LBH's website has a similar list of such opportunities;
- Voluntary and public-sector partners are increasingly working together to create community and information hubs in local communal building or facilities such as libraries or sheltered accommodation. Connected Communities, one of our information hubs, for example, can help older people with housing, financial and benefits matters and we plan to expand their work geographically and in terms of the help and advice they can offer to better promote, for example, healthy lifestyles or support for carer. More generally, we are increasingly looking at how we can use all of our community assets – people, places and services – to better support older people, e.g. making the best use of green spaces, such as parks, allotments etc. so people can have the opportunity to be as physically active as possible;
- We want to build on the approach taken by Haringey's award of Dementia-Friendly Status to consider how the Borough could become more Age-Friendly (see Living Well with Dementia).

Despite all of these positive improvements, we know there's more we could do:

- Some people tell us they can find it difficult to find out about the resources and opportunities available, whilst others have difficulties accessing them;
- People tell us that sometimes the various opportunities and solutions are not as well-connected as they could be and professionals working with people, such as GPs, don't always know about these opportunities;
- There's likely a differing resources to help people age well in different areas of Haringey. Whilst this might simply reflect the needs of the population in particular neighbourhoods, there's an opportunity to build on these solutions.

Aspirations

Our aim is to ensure people to work together to support people to age well. We will do so through working with our partners, including older people and the community and voluntary sector, and this will include strengthening individuals, families and communities so that by 2022:

- Our places, services and communities will be better shaped around the needs of people as they age, including people who might need varying degrees of help to access them. We will have made significant strides towards implementing an age-friendly Haringey through strengthening individuals and communities and, as partners, we will support our communities to build their assets. This will include more older people volunteering in their communities;
- Our information, advice and guidance across partners provided will be more consistent and accessible to people who need it to help them age well and will be suitably tailored to the needs of these individuals. Consistent messages about how to do so will be delivered across partners who will be able to signpost people to others that could help them. Information, advice and guidance will be available locally across the Borough tailored to the community needs and using local facilities. This will be part of a wider information 'offer' for older people about their housing, finances, income and so on;
- More older people have adapted their lifestyles to make them healthier and more independent because they are more knowledgeable about the changes they can make, such as eating or drinking well, and it is straightforward for them to make simple adjustments to their lives;
- Health and social needs of older people and their carers will be better screened consistently across the Borough to support earlier access to advice, diagnosis or treatment through our local care and support partners working together. Support for older people will transition seamlessly between community and voluntary sector and statutory sector support as their needs change.

Key Priorities

Working with older people and their carers, our main priorities are to build on our solutions including those already in place, or could be mobilised, in local communities and services within them. This will mean:

- Improving our understanding and knowledge of existing services in communities. We will work with these communities and services to develop and nurture future capabilities, and support volunteering and peer support opportunities;
- Partners will increasing integrate and use available resources and facilities for use within the wider community, e.g. expansion of the 'community hub' concept within Homes for Haringey in which the wider community can use their facilities for activities. The aim is to have a network of 'ageing well hubs' across Haringey;
- Improve and streamline information, advice and guidance across partners working in local communities and tailor this around the needs of the population they serve. This should improve the range and utilisation of solutions available in communities as knowledge of them is more widely available to older people and those who can connect them to these solutions. They will also increasingly integrate with wider advice and help available through Connected Communities and others on issues, such as financial matters, also important for older people;
- Improve the screening of older people's health and well-being needs and make this more consistent within our GP practices and local integrated care networks; and ensure there's an integration between community and voluntary sector and statutory sectors as individuals needs change. This includes, for example, ensuring people can better plan for their future needs and know what to do if they are feel unwell.

High Level Actions				
#	**Milestones**	**Start Date**	**End Date**	**Owner**
	Improve the use of Housing Hubs/Community Hubs as community facilities/meeting place, with care navigators aiming to improve engagement Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar -21 PIII: Mar-22	Ageing Well Project Group
	Increase prevention and self-care, as well as self-referral to GP/system (as appropriate) especially in those with long term conditions. Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar-21 PIII: Mar-22	Ageing Well Project Group
	Join up existing services by improved signposting between services and by mapping of complementary services by GPs Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar-21 PIII: Mar-22	Ageing Well Project Group
	Normalise consideration of 'financial health', including sign posting to address financial concerns and encourage financial planning. Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar-21 PIII: Mar-22	Ageing Well Project Group
	Increase use of green spaces, allotments and interactions with nature to improve physical activity levels and wellbeing Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar-21 PIII: Mar-22	Ageing Well Project Group
	Improve awareness & uptake of volunteering opportunities (all ages) Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar-21 PIII: Mar-22	Ageing Well Project Group

	Raise awareness/improve transport options for older people Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar-21 PIII: Mar-22	Ageing Well Project Group
	Actively promote carer's health and wellbeing Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar-21 PIII: Mar-22	Ageing Well Project Group
	Provide guidance about the setting up of community lunch clubs Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar-21 PIII: Mar-22	Ageing Well Project Group

Living Well with Dementia

Current Position

'Dementia' is an umbrella term for a range of progressive conditions affecting the brain. It results in a decline in multiple areas of brain functions, including memory, reasoning, communication skills and the skills needed to carry out daily activities. Its impact on individuals and their families may be compounded by other conditions and by personal circumstances such as living alone. A small number of people aged 50-64 years may develop early onset dementia. The intention is these individuals should have access to the same solutions as discussed below and in the wider Strategy. This is particularly important as some groups at particular risk, such as those with learning disabilities, are also at risk of being frail at an earlier age.

A range of solutions are already available in Haringey to treat people with dementia and help them and their families live as well as possible with the condition:

- The Alzheimer's Society awarded Haringey Dementia-Friendly Status to recognise the work of 60 organisations to raise awareness of dementia amongst the population to promote a dementia-friendly Borough. This alliance encourages organisations to make simple adjustments to their services to better accommodate people with dementia live as normal a life as possible. These organisations include health and care commissioners and providers, but also a wider range of services, such as arts and community groups, housing organisations, leisure centres, banks and schools;
- Individuals are screened for cognitive impairment initially within their GP practices and those cases of patients that need further investigation are referred to a consultant-led Memory Service for a formal diagnosis. This is important to ensure people receive the medical treatment and support that's right for their condition and circumstances. The Memory Service also provides short-term services to help people come to terms with, and adjust to living with, their condition. The Service will discharge the care of the individual to their GP practice to continue with their treatment;
- Individuals are already able to access a range of community-based support for people with dementia and their carers provided by the voluntary and private sector and Council. Some of these services provide advice, information and support for people to live well with the condition, whilst others are Council-funded services available to people (often with more advanced dementia and/or other needs) to help them live at home, such as dementia day opportunities at the Haynes Day Centre;
- We know that 70% of those with dementia are also frail and have multi-morbidities. The services discussed in other sections of this Strategy in relation to frailty, such as Care Closer to Home Integrated Network (CHINs) and Enhanced Health in Care Home models, provide support to a significant number of people with dementia in the community and in care homes who have other care needs;
- There are a range of services that support people with dementia who have more advanced dementia and/or behavioural issues. This includes nursing and residential care home provision in the Borough, as well as specialist mental health bed-based facilities for those with dementia.

We know individuals and families who use these services value the support on offer, but we recognise there are challenges which this Strategy can address. In particular:

- Using the Dementia-Friendly status of the Borough as a launch pad, we need to continue to raise awareness in the Borough about cognitive impairment and dementia, particularly across Haringey's diverse communities to ensure people are diagnosed as early to plan their subsequent treatment, care and support;
- We need to improve, and provide earlier access to, diagnosis, in particular ensuring that GP practices more consistently check the cognitive abilities of their patients;
- We need to improve post-diagnostic care and support more consistently for patients and families returning to the care

of their GP practices following discharge from the Memory Service;

- We need to strengthen our existing crisis resolution support to better support people and families better manage significant and unexpected changes in their health status or circumstances;
- We need to improve how services are coordinated to better support individuals and their families as their condition gradually advances and/or they become frailer including as they plan for end of life.

Aspirations

Our aim is to ensure people with dementia are diagnosed as early as possible and that they and their carers get the right treatment, care and support for them that will help them live as long, fulfilling and healthy lives as possible as they age.

In order to achieve this, we need to improve a range of services that work together to improve outcomes for people living with the condition – to improve our dementia pathway. Our services will form a coherent network that responsively support individuals and their families as their conditions and/or circumstances become more complex and that their views will be central to planning and delivery. We want to avoid people being diagnosed at an advanced stage with the condition or who present to services at crisis because there is support isn't available early enough. All of this will mean making sure we are making the best use of our collective resources.

Working with patients and carers, we intend to improve our dementia pathway. Key improvements include:

- Development of Dementia-Friendly Haringey in which more, and a greater range of, organisations commit to learning more about dementia and being better able to shape their services around the needs of people with dementia;
- Effective public awareness-raising about the condition, its impact and the importance of early diagnosis, particularly amongst those communities who are currently under-represented in terms of diagnostic rates. This awareness-raising will include how particularly older people can adopt healthier lifestyles to mitigate the risk of developing the condition;
- This awareness-raising will be strengthened through ensuring cognitive screening being part of the annual health checks available to older patients within their GP surgeries to better identify individuals with mild cognitive impairment or the early signs of dementia. In turn, the long-term development of primary care networks (in which GP practices will come together with partners to better support 50–80,000 populations in Haringey) will facilitate the sharing of good practice, working closely with the Memory Service. This will lead to timely diagnosis of more people at the early stages of the condition in which treatments can be most effective.
- The opportunity for people to have a navigator/coordinator from the time they are referred onto specialist service for diagnosis onwards. The navigator's role is to provide tailored advice, information, guidance, signposting and/or support coordinated across the care and support system, if the person wishes. This is particularly important to support individuals to initially come to terms with any diagnosis and to help them consider how to live as well as they can with the condition in the longer-term. The navigator will support planning for individuals and families within the Memory Service and provide continuity and coordination of support following the individual's discharge from the Service back to primary care. An individual's named navigator may change over time as their condition becomes more advanced and/or needs are more complex, but the individual and their carers should have always known who this person is;
- Part of the navigator and other professionals' roles will be to ensure individuals and families have a better understanding of the condition and how it, and the treatment and support provided, may impact on them and how they can live as healthy and fulfilling a life as possible. This includes how to mitigate crises and plan for the future;

- A tiered approach to community-based opportunities for people with dementia will be available in the Borough, ranging from access to more dementia-friendly universal services available to everyone (such as leisure centres or community groups), locality-based 'hub' models of more targeted support for individuals and a small number of more specialist day opportunities for people with advanced dementia. Life reminiscence and other approaches, building on what we know works, such as singing for the brain, will be more widely available through these opportunities. Part of this tiered approach includes establishing and sustaining peer support networks for carers;
- People will access specialist care and support to ensure we deliver a holistic and person-centred approach to care planning and delivery across sectors and disciplines. Examples include better coordinated care for people with dementia with moderate or severe frailty between primary, community health and secondary care and social care through locality-based integrated networks described in other sections of this Strategy; and access to psychological support solutions for people living with dementia and their carers;
- People with dementia and carers will increasingly benefit from both widely available digital solutions and more specialist technology, aids and adaptations to continue to live as independently and as safely as possible as the Council and other providers continue to improve their digital 'offer';
- More carers will be identified and benefit from a wider range of support opportunities as part of the planning for the support of the individual with dementia and will, in turn, get the help and support they need in their own right and to continue in their caring role; this will include wider access to respite care;
- Better coordination between services and their closer liaison with the person with dementia and carers often facilitated through the navigator/coordinator will help mitigate crises arising. However, effective resolution services will be available quickly if crises do arise, including to those individuals or carers needing unplanned hospital attendance or admissions and who need to return home in a timely and safe way;
- A geriatrician-led Enhanced Health in Care Home model will provide effective care for people with dementia living in residential or nursing care homes. This will support staff in care home to better manage the cases of particular residents with complex needs including those in the advanced stages of the condition;
- People with advanced dementia, including those with behavioural issues, will be benefit from assessment and long-term treatment beds within specialist mental health beds to help understand and treat them. Patient's referral, admission to, and discharge from, these facilities into the community will be well-coordinated between agencies;
- Professionals will provide opportunities for people living with dementia to consider their options about what will happen when their conditions become more advanced and their cognitive capacity to make decisions becomes impaired and/or they approach end of life. Individuals will have the opportunity to create their own advanced care plans to capture these choices and be confident that professionals will respect these wishes.

Key Priorities

Working with people with dementia and their carers, our main priorities are:

- Ensure we are able to better and more systematically screen and identify people who may have cognitive impairment and improve subsequent medical management of patients;
- Continue to improve diagnostic rates and reducing waiting times for medical diagnosis and subsequent treatment;
- Help people come to terms with diagnosis and improving post-diagnostic support to ensure people are able to continue their lives as long as possible including access to community navigators;
- Improve information, advice and guidance not just to individuals & families living with dementia, but also professionals' knowledge of available services and dementia pathways in Haringey (included in Becoming Frail);
- Implement a tiered approach to day opportunities for people with dementia and use of Haynes Day Centre and other facilities in as personalised way as possible depending on needs of individuals;

- Improve holistic care and support planning and delivery of care for people with dementia across agencies, particularly for those with more severe dementia and/or complex needs, who may also be frail;
- Improve care planning and support for people with dementia living in care homes and support for staff working in these care homes (included in Becoming More Frail Section);
- Better identify and support carers of people with dementia in their caring role (included in Supporting Carers);
- Continue to build Dementia-Friendly Haringey across different organisations

High Level Actions				
#	Actions for Priorities	Start Date	End Date	Owner
2.1	Continue to build on Dementia-Friendly Haringey and work across partners to engage more organisations, raise awareness amongst more staff and support more people to become Dementia Friends	May-19	Mar-22	Dementia-Friendly Haringey Leadership Group: specific targets to be set for each year
2.2	Improve and disseminate end-to-end cross-agency dementia pathways for people with dementia and their carers and develop outcomes framework to monitor progress	Apr-19	Dec-19	Dementia Reference Group
2.3	Work between HCCG, BEH MHT and Primary Care Networks to improve screening & diagnostic pathways for people with cognitive impairment	Jan-20	Sep-20	Paul Allen, HCCG/LBH as commissioner lead with providers
2.4	Work with Haringey's Primary Care Networks, BEH MHT other health partners to improve, and share good practice on, medical and clinical management of patients from diagnosis and onward management of patients • Phase I: Agreement on protocols & future management • Phase II: Implementation	P I: Dec-19 P II: Jul-20	P I: Jun-20 P II: Mar-21	Paul Allen, HCCG/LBH as commissioner lead with providers
2.5	Work with BEH MHT and partners to improve support available to people and carers to help them come to terms with diagnosis and begin to plan for the future	Sep-19	Mar-20	Uttara Mandal, BEHMHT
2.6	Establish network of appropriately trained community navigators across partners who can advise & support people with dementia and carers, to connect them with services and to be a contact and liaison point for them	Sep-19	Mar-20	Paul Allen, HCCG/LBH as commissioner lead with providers
2.7	Across partners, improve clinical and practice knowledge and skills in managing people with dementia and knowledge to support people through dementia pathways Phase I: Planning and development (2019/20) Phase II: Implementation across workforce (2020/21)	Nov-19	Mar-21	Dementia Reference Group lead to be identified
2.8	Improve access to day opportunities for people with dementia and carers, including those with more complex needs; work on developing a 'hub' approach so that workers in services for more complex needs can support staff in other services work with people with dementia Phase I: Planning and initial development (2019/20) Phase II: Implementation (2020/21)	Oct-19	Mar-21	Dementia Reference Group

2.9	Ensure wider frailty network under development, incorporating Integrated Care Networks and joint intermediate care, is able to plan, assess, manage and review the cases of people with dementia, particularly those with more severe dementia and/or complex needs Phase I: Planning and initial development (2019/20) Phase II: Full implementation of ICNs (2020/21)	Oct-19	Mar-21	Paul Allen, HCCG/LBH as commissioner lead with providers
NOTE Action relating to training community navigators who can advise on dementia can be found in *Becoming Frail*				
NOTE Action relating to cognitive screening check in routine GP annual health screening & reviews for those aged 75+ can be found in *Becoming Frail*				
NOTE Actions relating to improving and bring together available public information, advice and guidance about dementia and services to support them can be found in *Becoming Frail*				
NOTE Actions relating to ensuring Enhanced Health in Haringey Care Homes model adequately supports needs of people with dementia can be found in *Becoming More Frail*				

Living Well with a Long Term Condition

Current Position

Better management of people with long-term conditions will be one of our key priorities as a partnership. We want to move to a situation in which the health system is organised around managing individuals' needs holistically rather than services or specific conditions as they age. We also know that people with long-term conditions could be better managed in the community and want to enjoy a good quality of life free from frequent crises and unnecessary hospitalisation.

Prevention and early detection of a potential long-term condition is key to reducing the risk of people acquiring a LTC or this condition becoming worse. A range of high-quality community and secondary care services already exist and work closely with primary care to diagnose, treat and manage a wide range of conditions such as:

- Endocrinology: Diabetes
- Respiratory: Asthma and COPD
- Cardiovascular: high blood pressure etc.
- Musculoskeletal: Osteoporosis, Arthritis, etc.
- Chronic Kidney Conditions
- Stroke and Neuro conditions including Atrial fibrillation

People are living longer, with males now expected to live 80 years and females 85. Whilst welcome, increasing life expectancy can mean people will live longer with multiple long-term conditions ('multi-morbidity') and this can adversely impact on their health and well-being: multi-morbidity is associated with the wider determinants of health such as including unemployment, mortality and quality of life. Multi-morbidity is more common in deprived areas, and some of our Haringey population are at substantially higher risk of poor health and early death, particularly in the east of the Borough. We know nearly 70% of the total health and care expenditure in England is attributed to caring for people with long-term conditions, including multi-morbidity.

Some issues we know we need to improve on are:

- We could better promote and support people to adopt healthier lifestyles so they are less at risk of acquiring long-term conditions, such as high blood pressure or diabetes;
- More people living with particular conditions could be diagnosed and treated earlier; and we could improve the advice, information and support we provide about living with these conditions and what do if they are getting worse;
- We know there are variations across the Borough in screening, diagnosis and early treatment in care and support across the Borough that need to be addressed;
- The support provided for people between partners is not as joined up as it could be and this is a particular issue for people with multi-morbidity;
- The population with multi-morbidity continues to grow as people get older; but we know there are already constraints on capacity to respond within the current configuration of the health and care system.

Aspirations

Our aim is to offer care and services that enables the people of Haringey with long-term conditions to live longer and healthier lives with access to safe, well-co-ordinated and high quality services.

We want to ensure that as far as possible people with LTCs are able to maintain or enhance their quality of life through high quality services and supported self-management. Partners across North Central London (NCL), including Haringey Health and Well-Being Partnership Board, recognises the need to intensively challenge the way we support people with LTCs through a more Integrated, coordinated and holistic personalised person centred approach. To enable this, the LTC Strategy currently under-development will focus on four areas for delivery: **prevention, early detection, treatment and support.** The scope of this strategy will align with Haringey Mental Health Strategy as well as Ageing Well Strategy.

Our response is founded on working in partnership with stakeholders involved in patient care to transform how services are developed and delivered. We want people with LTCs and their carers to be at the heart of how we plan, design and deliver treatment and care; and we want to support professionals to work with individuals and together across the voluntary and public-sector sectors to improve services and health outcomes. This will enable us to integrate services further, move care closer to home and improve the information and support people can access, making use of resources available in communities to fully develop a more holistic way of delivering care and support.

We recognise the need to support and develop primary care to deliver services that address population needs in a sustainable way. Our newly established local primary care networks will work closely with our multi-disciplinary, multi-agency integrated care networks to identify, diagnosis, treat and support individuals with long-term conditions to meet their needs depending on their complexity (both networks are discussed in the next sections). These developments will be supported by key enablers such as making the best use of estates, joint workforce development and IT developments to better screen and track individuals' needs as they change over time and to identify those most at risk of acquiring specific long-term conditions, such as heart disease, or multi-morbidity.

We will work towards reducing unwarranted variation in care and better utilise our joint resources to make the best use of, or expand, current services whilst at the same time flexing resources to ensure we serve those parts of the Borough with residents at the highest level of risk.

Key Priorities

Short-term (Year 1)

In 2019/20, we will…

- Set out a multi-agency Long Term Conditions Strategy that addresses the population main health and social needs, and which includes relevant priorities from the NHS Long Term Plan
- Engage with patients and general public and agree strategic direction for the LTCs in Haringey
- Map all existing services and establish key priorities according to NHS RightCare recommended pathways and identify how we will take forward improvements
- Produce a LTC Roadmap to help us identify the actions we can take as partners to improve our 'offer'
- Improve diagnostic rates of key conditions within primary care, such as hypertension and diabetes; and better support people to manage their own conditions.

Long-term (Year 2 & 3)

From 2020, we will…

- Develop our LTC model and progress its implementation in line with our priorities including improved prevention, early diagnosis and self-management;

- Introduce new work streams and pathways, including integrating primary, community and secondary care further through development of our primary care and integrated care networks (see next sections);
- Align our priorities with existing NCL work
- Further progress our enablers within our LTC model such as work development and IT systems.

High Level Actions				
#	**LTCs strategy milestones**	**Start Date**	**End Date**	**Owner**
1	Decrease number of patients at risk of developing LTCs by improving prevention programmes and early detection	2019	Ongoing	Juliana Da Silva
2	Support GPs closing the gap between recorded prevalence and exception reporting through LCS and QIST teams	2019	Ongoing	Juliana Da Silva
3	Increase number of patients self-managing their LTCs through self-management programmes	2019	Ongoing	Juliana Da Silva
4	Align care/pathways across the Borough for all LTCs patients by redesigning current services model.	2019	Ongoing	Juliana Da Silva
5	Increase services offer at primary care level to avoid unnecessary pressures in secondary care outpatient services, A&E attendances and consequent admissions.	2019	Ongoing	Juliana Da Silva
6	Decrease variation and duplication of care provided to patients across Haringey	2019	Ongoing	Juliana Da Silva

Becoming Frail

Current Position

As they age, we know people are more likely to acquire one or more long-term and chronic conditions that affects their physical and mental well-being and daily living. Some will become frail, i.e. they lose physical and mental function and resilience. People can therefore find it more difficult to recover after illness, accident or stressful event and are at heightened risk of increased dependency, poor health or further adverse episodes.

This section discusses how people living with frailty can be identified as early as possible so they can be provided with advice and information about how to best to manage their health and social needs and the opportunities that may be available to them. The section goes on to discuss plans partners have developed to better support people with frailty, with the next section focussing on additional solutions for people with more significant needs.

Solutions that already exist in Haringey to help people live as well and safely as possible as they become frail include:

- Identification of people who may be frail either as part of pro-active management of patients within GP surgeries (for example, as a result of annual health checks or identified from case-finding tools based on national models for frailty) or because their frailty is recognised and assessed if they present to A&E;
- Provision of information, advice and signposting on websites or through trusted sources such as the Over-50s Forum. Examples include AskSara, an online system to provide guided user questions and answers to help people identify solutions, such as equipment, that could help meet people's needs;
- Simple items of equipment, aids and adaptations that's available to people to help them with daily living, such as medication dispensers, grab sticks or chair/bed adaptors. This also includes the Council's Safe & Sound service, that provides personal or housing alarms for people who may feel vulnerable and, if pressed, has a 24/7 response from service operatives;
- Primary care-based support for people with moderate frailty to undertake a comprehensive assessment (including a community navigator) of their health and social needs in preparation for future development of a wider integrated care network in local neighbourhoods. This medical assessment will result in a set of follow-on actions to be undertaken by their GP or other professionals to better manage their healthcare needs;
- Support from health professionals, such as district nurses and therapists, to help people manage their long-term conditions or recover after illness in their home as part of the care available via their GP;
- A range of community and voluntary sector opportunities to support people with frailty tailored to their needs and interests in a range of settings across Haringey and which includes support in people's homes;
- Support for residents who may be frail through Homes from Haringey and other Registered Social Landlords to ensure these residents have the support in suitable housing they need and are able to continue to pursue social opportunities important to them. These community facilities also act as 'hub' for the wider community;
- Voluntary sector community navigators, with their roles tailored to specific individuals' needs and circumstances, e.g. those who with mental health issues. Navigators work with people on a time-limited 1:1 basis to help them navigate the Council and NHS systems, understand their needs and connect them to the right solutions to meet goals important to them. Some of these navigators work in the community, but others are based within care settings, such as GP practices and hospitals;

We know many individuals who use these services value the support on offer but we know there are number of improvements that can be made. In particular:

- Not everyone living with frailty becomes known to services early enough to help and their needs are not always consistently recognised and addressed. This means people don't always get the access to the advice, help and support they need to improve their health, well-being and independence. We know these individuals are more likely to present to services later with more significant needs and/or at crisis, such as hospitalisation if their needs are not addressed early;
- The information, advice and guidance different agencies provide could be improved, joined up and better targeted at people with frailty;
- The process by which individuals find the right aids or equipment for them and the range of the equipment and technology available could be improved;
- One issue in the Borough remains the number of people who have falls due to their frailty – often these falls result in adverse outcomes for people and may result in them becoming more frail. The services we have to reduce the risk of falls or repeat falls could be improved and more people could benefit from them;
- Our existing community navigation services have proved popular and successful amongst people who are using them. We need to make these services are more consistently known amongst, and accessible to, people and professionals, such as GPs, so more people can benefit;
- We could provide a more joined-up response to planning and delivering and between agencies to the health and social needs of people with frailty in local communities and these could be better tailored to individuals.

Aspirations

Our aim is to work together to support people with frailty to live well. This. and the next, section (which focusses on supporting people with more complex needs) describe some of the key improvements we intend to make as people age to make the best use of collective resources. This will mean:

- As partners, we will use a single, simple screening tool across the Borough to assess the frailty and underlying needs of individuals as they present to services such as GP practices, hospitals or community health. This will help identify the differing degree of frailty people are likely to have and ensure more people at earlier stage of frailty can be identified and supported appropriately;
- Information, advice and guidance will be targeted to people who are likely to be frail and we will make the best use of solutions such as AskSara. Health, Council and voluntary sector staff, such as GPs or community navigators, will acted as trusted sources to ensure people are aware of this information and support them to access it. Individuals will therefore know a lot more about how best to manage their conditions for themselves and what to do if these conditions become worse suddenly;
- Older people's care and support will be managed through Local Integrated Care Networks. These Networks are groups of care professionals such as GPs, nurses, therapists, social workers and pharmacists working together to help identify and manage the health and social needs of people with frailty in local neighbourhoods.
- The Networks will incorporate our community navigators to support social prescribing in local GP practices and other facilities and connect people to solutions they may value. There will a wide range of voluntary sector opportunities targeted at people for frailty and tailored to their specific needs and interests;
- There will be a wide range of accessible technology, equipment, aids and adaptations available for people with frailty to help them manage their health and well-being and daily living as part of these solutions. The

'offer' will include the Council's Safe & Sound service with devices tailored to the specific needs of people with frailty;

- People's housing environments will be adapted to support people as they age and become frailer, and social housing facilities will be hubs to support the wider community;
- People's risk of falls or repeat falls will reduce as a result of improved knowledge and management of individuals' risks, their mobility through exercise referrals as part of a comprehensive falls service in the Borough.

Key Priorities

Working with people living with frailty, our key improvements are:

- Adopt a single, simple screening tool across all services in the Borough to assess the frailty and individuals' needs;
- Streamline our information, advice and guidance targeted at people who are likely to be frail;
- Improve awareness of staff across all sectors who are working with people with frailty about how to connect them to solutions from which they could benefit and to actively promote these solutions to individuals. This includes promoting and encouraging self-care, self-management and peer support amongst people with frailty;
- Improve and promote the range of equipment, aids and adaptations and digital solutions available to those with frailty and simplify access to these solutions, including the Council's Safe & Sound service;
- Expand and better join up our social prescribing and community navigation roles across the Borough and make sure they are part of our development of local Integrated Care Networks;
- Work with the voluntary sector to improve and better market the range of solutions targeted at people with frailty;
- Develop more adaptable social housing solutions to better support individuals as they age and expand use of their facilities to become community hubs;
- Improve the falls service and associated solutions in the Borough.

High Level Actions

#	Actions for Improvement	Dependencies	Start Date	End Date	Owner
3.1	Establish a single screening tool for use across all care and support services in the Borough to assess frailty and individuals' needs; and build use of these tools as basis to identify and review individuals' needs across sectors		July 2019	March 2020	Leadership Team
3.2	Work with Primary Care Networks to ensure cognitive screening and screening for frailty are part of the annual health checks for those aged 75+ and other vulnerable groups	*Living Well With Dementia*	September 2019	March 2021	HCCG Primary Care Team
3.3.	Across partners, improve and bring together available public information,	• *Living Well with*	PI: September 2019	PI: August 2020 PII: September	Paul Allen

	advice and guidance about living well with frailty, dementia, community navigators and services and support to help people do so; whilst promoting improved self-care, self-management and self-determination of these solutions Phase I – Develop and initial implementation Phase II – Full Implementation	• *Dementia* • *Becoming More Frail*	PII: September 2020	2021	
3.4	Work across Haringey's health and care partners to set out joint staff development programme, and share good practice, on: • Identification and management of people with frailty; • How to promote of self-care & self-management; • Improve staff knowledge on the network of services available for people and how to access them. Phase I – Plan and agree delivery of workforce development Phase II - Implementation workforce development		PI: October 2019 PII: April 2020	PI: March 2020 PII: September 2021	Leadership Team
3.5	Establish network of appropriately trained community navigators across partners who can advise & support people with frailty, dementia and carers and to connect them with services	*Living Well with Dementia*	July 2019	March 2020	Paul Allen
3.6	Work across partners to improve the 'community support offer' available to carers, people with frailty and/or who need early help: • Develop a joint Design & Outcomes Framework to map assets and develop future community services; • Make better use of identified existing services & facilities; • Use existing social housing facilities as community 'hubs' across Haringey; • Improve access to, and range of, community service including through stimulating development of peer support and community groups; • Pilot this approach within North Tottenham as part of place-shaping		July 2019	March 2021	Paul Allen / Gill Taylor / Marco Inzani

	solutions				
3.7	Evaluate existing Frailty Care Closer to Integrated Network (CHINs) and explore how to absorb its function to support people with moderate frailty into emerging Integrated Care Network model		April 2019	November 2020	Paul Allen
3.8	Review and improve falls pathways and associated solutions in the Borough, including the Falls Service, as part of the wider development of a Frailty Network Phase I – Develop and initial implementation Phase II – Full Implementation		PI: September 2019 PII: April 2020	PI: March 2020 PII: March 2021	Priyal Shah with Providers
3.9	Improve and better promote the range and type of equipment, aids and digital solutions available to those with frailty and more complex needs including the Council's Safe & Sound Service		October 2019	March 2021	Adult Social Care

Becoming Frailer

Current Position

This section discusses the needs and solutions for people who have more significant frailty and more complex needs. These individuals are likely to be in poor health, have problems with daily living (such as washing or getting around the house) and are at risk of further crises. Many may need a coordinated and often multi-disciplinary ongoing health and/or care response to plan and help meet their needs, including access to nursing, therapies and/or personal care. The aim is to support individuals for as long and as safely as possible in their own homes and maintain or improve their health, well-being and independence.

In addition to those discussed in the previous section, a range of solutions already exist in Haringey:

- A number of multi-disciplinary teams (MDTs) identify, plan, assess and organise long-term or ongoing care for people with more complex needs. For example:
    - MDT case tele-conferences between GPs, acute geriatricians and other health professionals discuss individual cases of patients recently discharged from hospital and who need medical follow-up;
    - The cases of people with more complex needs or severe frailty (identified through a range of health and social care professionals such as GPs) are managed within a Borough-wide multi-disciplinary Locality Team, a dedicated multi-agency team with a community matrons, social workers and therapists, who coordinate, plan, case manage and organise individuals' longer-term care;
- A range of support from health professionals, such as community matrons and specialist condition nurses, to help manage individuals' ongoing health conditions sometimes as part of a multi-agency team;
- Access to a range of specialist aids, equipment and major adaptations to help people to live in their home for as long as possible at home and meet their health needs;
- Access to adult social care assessment and care planning to decide how to meet an individual's personal and social care needs, with many eligible (thorough a national framework) to receive Council-funded Personal Budgets. Some people may choose to receive the Budget as a Direct Payment to arrange care themselves; whilst others may choose to work with the Council's Brokerage Team to arrange these services. The most common services people choose to support them to live at home are personal care, day opportunities and short breaks;
- Some people have such complex needs they need to have more specialised accommodation within the community. There are over 130 Extra Care flats in housing schemes in Haringey, which provide individuals with their 'own front door' but in which care and support is available 24/7. There are also 11 long-term residential and nursing care homes for older people, including those with dementia, across the Borough for those with the most complex needs.

We know many people who use services value the available support, but we know there are number of improvements that can be made:

- Our multi-disciplinary long-term care and support 'offer' for patients could be better coordinated and more people with complex needs could benefit from this integrated support. This includes more consistent management of these patients' medical needs across practices and better access to mental health support;
- Handovers between services, e.g. those between intermediate care to help people recover and long-term care could be made more consistent and people better supported to navigate what can feel like a complex process;
- Some people wait too long to access longer-term community health or adult social care across the Borough and we need to make sure our reviews of their care are more timely. Some of the available services could also

be better tailored to individuals' needs more consistently across the Borough;

- More people could benefit either from major adaptations to their homes to help them live there or access to more specialised housing;
- There is only limited number of nursing care home beds in Haringey which often means people with the most complex needs are often placed outside the Borough, and there can be delays to assess and review individuals for Continuing Health Care outside of hospital for some people.

Aspirations

Our aim is to work together to support people with frailty, including those who are have more complex needs, to live well. As well as the actions identified in the previous section, our key aspirations for those group of people are:

- People will benefit from responsive and consistent long-term community health and care services they need, eliminating unnecessary delays or duplications within the health and care assessment, planning, delivery and review process in a more person-centred way;
- People will benefit from a multi-disciplinary approach to coordinating the planning and delivery of health and care needs for more people through development of our Local Integrated Care Networks. Each person with complex needs will have a named professional, such as a GP, community matron or social worker, to act as a coordinator and each person will have an integrated care plan summary that is assessed and reviewed routinely;
- The joint support provided will incorporate greater access to mental health services, including specialist advice, information and support to individuals and other care professionals from specialist mental health workers;
- The recently formed Primary Care Networks in Haringey will develop as part of our Integrated Care Networks. PCNs mean local GP practices will collaborate to share good practice and expertise, and deliver proactive, personalised and coordinated medical services to specific groups. People with significant frailty are one group who will benefit from this improved 'offer';
- There will be a greater range of care services tailored to meet individuals' outcomes and needs in the community that they can access directly or be helped to do so;
- People with complex needs will be supported at home because they have greater access to specialised digital technology and major adaptions to help people manage health condition or in their environment; and a greater range of specialist living solutions;
- Residential and nursing care home staff will be better supported to manage the cases of residents through an Enhanced Health in Care Homes model, which will see health professionals, such as GPs, geriatricians and community nurses, work within the homes on a planned and urgent basis to help manage the cases of more complex residents and develop skills amongst care home staff to better manage cases.
- More people who need it will be accommodated in nursing care home in, rather than out of, Borough.

Key Priorities

Working with people living with frailty, our key improvements are to:

- Streamline access to and join up existing community health and social care services to improve assessment, planning, delivery and review of care and support for more people with complex needs across the Borough;
- Developing a more multi-agency approach to care coordination through development of local multi-agency

Integrated Care Network in parallel with development of Primary Care Networks to manage the cases of people with frailty;

- Improve our mental health 'offer' to older people with frailty, including tailoring our Improvements to Access to Psychological Therapies (iAPT) services to this group, and ensuring information, advice and support about mental health issues is available to them and other health and care professionals;
- Work with care providers to ensure they have a more consistent and outcomes-based focus to their work with people with more significant frailty and this is more joined up with other professionals working with the individual, e.g. in an Integrated Care Network; and that there is adequate provision of available high-quality services across the Borough;
- Explore how we could improve and promote a greater range of digital technology to those with more significant frailty, such as tele-care and tele-health monitoring;
- Ensure there's greater access to major adaptations available to individuals' homes; and re-provide a greater range of specialist living solutions through working with Registered Social Landlords to expand Extra Care facilities and using 'step-down' flats to better support people who need to recover;
- Roll out our planned Enhanced Health in Care Homes model to support care homes in Haringey;
- Re-provide one of our nursing care homes as a partnership between the Council and NHS to increase nursing care bed capacity in the Borough.

	High Level Actions				
#	**Milestones**	**Dependencies**	**Start Date**	**End Date**	**Owner**
4.1	Across partners, work towards developing local multi-agency Integrated Care Networks (ICNs) across Haringey: • Further develop further multi-agency health, social care and voluntary sector team models and care pathways in localities to support Primary Care Networks; • Improve agency's joint capacity and responsiveness to address to assess, plan, deliver & review needs of patients; • Deploy multi-agency team as part of North Tottenham place-shaping pilot to better support people with more significant frailty who need care coordination; • Integrate work of Locality Team, joint Intermediate Care and Care Closer to Home (CHINs) into emerging ICNs <u>Phase I</u> – Develop and agree ICN <u>Phase II</u> – Implement ICN		PI: August 2019 PII: October 2020	PI: September 2020 PII: September 2021	Leadership Team
4.2	Work with GP Federation and other partners to develop Haringey's Primary Care Networks and integrate ICNs and PCNs to improve care				GP

	pathways for people with significant frailty and/or high-risk patients Phase I – Develop and initially form 8 PCN Phase II – Full implementation of PCN functions		PI: April 2019 PII: October 2019	PI: September 2019 PII: September 2021	Federation with Partners
4.3	Roll out multi-agency Enhanced Health in Care Homes model to support care home staff & residents including those with dementia.	Living Well with Dementia	April 2019	March 2020	Paul Allen with Providers
4.4	Work with Registered Social Landlords towards increasing the range of supported living solutions such as Extra Care or 'step-up' flats as a means of supporting people in the community		September 2019	September 2021	Aphrodite Asimakopoulou
4.5	Council to work with partners to explore re-providing Osborne Grove as a nursing care home to increase capacity of available beds		April 2019	September 2022	Charlotte Pomery
4.6	Work with partners to re-provide locality-based community social care, such as home care, available to everyone with significant frailty, including Council-funded services. Phase I – Develop Phase II – Testing in North Tottenham and evaluating impact Phase III – Full Implementation if successfully evaluated		PI: July 2019 PII: April 2020 PIII: April 2021	PI: March 2020 PII: March 2021 PIII: March 2022	Charlotte Pomery
4.7	Improve support for mental health & well-being issues for people with changed and/or significant frailty through improving access to therapies such as IaPT Phase I - Develop and initial improvement Phase II – Full implementation		PI: October 2019 PII: April 2020	PI: March 2020 PII: March 2021	Tim Miller
4.8	Improve Continuing Health Care pathway including CHC processes and timescales for assessments and reviews for older people with frailty Phase I - Develop and initial improvement Phase II – Full implementation		PI: July 2019 PII: April 2020	PI: March 2020 PII: March 2021	Nigel Evason

	Note Action relating to information, advice and guidance and promote improved self-care, self-management and self-determination can be found in *Becoming Frail*

Approaching End of Life Care

Current Position

End of Life Care (EOLC) is the comprehensive care of those with serious or life-threatening illnesses with a focus on the improvement of quality of life through alleviating pain and suffering ('palliative care').

Older people and adults approaching end of life receive care and support from the Specialist Palliative Care Team, GPs, District Nurses, acute hospitals and hospices. The care and support may include (but is not limited to) assessment and management of physical, psychological and spiritual symptoms to reduce symptoms, suffering and distress; analysis of complex clinical decision-making challenges where medical and personal interests are finely balanced by applying relevant ethical and legal reasoning alongside clinical assessment; and providing specialist advice and support to the wider care team who is providing direct core level palliative care to the person. Our Advance Care Planning Facilitator project within care homes enables residents to discuss and express their wishes in relation to the type of care they would like to receive in the future and has recently been aligned with our Enhanced Health in Care Homes model (see previous section).

A recent review of services suggested the following improvements to the care and support 'offer':

- There is limited palliative care capacity. Access to the service could be improved at an earlier stage.
- Integration and coordination between specialist palliative care services and community teams could be improved to provide a multi-disciplinary approach.
- Training in end of life care, advanced pain management and communication skills should be provided to a wider range of community staff.
- Need to augment Advanced Care Planning to better support patient preference and wellbeing.
- Increase uptake and use of Coordinate My Care (CMC) within primary care and wider community teams.

Aspirations

Our aim is to improve the quality of life and wellbeing towards end of life and provide holistic planning and delivery of care and support to the patient and the people close to them. Health and care partners in North Central London will develop an NCL-wide EOLC Strategy, but this section focusses on priorities for Haringey. By 2022, we expect to achieve the following (subject to discussion and agreement with key EOLC partners in Haringey and NCL):

- With patients, families, local authorities and our voluntary sector partners at both a national, regional and local level, including specialist hospices, Haringey residents will be offered personalise cared to improve end of life care planning and delivery. This will be underpinned by an End of Life Care strategy.
- By rolling out training to help staff identify and support relevant patients, we will introduce proactive and personalised care planning (Advance Care Planning) for everyone identified as being in their last year of life.
- With support from Primary Care Networks and Quality Improvement Support Teams within Primary Care, quality of end of life care will be improved with a corresponding increase in the number of CMC records.
- Through support of the wider community and voluntary sector, social, befriending and bereavement support will be expanded.
- Through review of data, we will gather a better understanding of, and reduction in inequalities in End of Life Care, for vulnerable groups, for example, people who are homeless, people from Black, Asian and Minority Ethnic groups, people living with mental health conditions, Learning Disability, dementia.

Key Priorities

Short-term (Year 1)

- Develop a North Central London End of Life Care Strategy in collaboration with partners across the sector.
- Embed the expanded Specialist Palliative Care Service in the Community (started Q4 2018-19) to increase capacity.
- Learn from the Advance Care Planning Facilitator (ACP) project in the two care homes and decide on future provision.
- Review Hospice at Home Nursing service provision. The service is aimed at enabling people approaching end of life to be cared for and die in their preferred place of care.
- Improve EOLC in Primary Care as part of the Quality Improvement project (GP contract).

Long-term (Year 2 & 3)

From 2020, we will

- Improve the number and quality of Coordinate My Care records (which is a marker for ACP) in Haringey.
- Improve education, training and facilitation on Advance Care Planning and End of Life Care for wider community staff.
- Review models of hospice commissioning to create a sustainable solution for commissioners and hospices.

High Level Actions

#	Milestones	Start Date	End Date	Owner
5.1	Embed the expanded Specialist Palliative Care Service in the Community (started Q4 2018-19).	Jan 2019	May 2019	Priyal Shah / Patrick Schrijnen
5.2	Learn from the Advance Care Planning Facilitator (ACP) project in the two care homes and decide on future provision.	March 2019	May 2019	Priyal Shah
5.3	Review Hospice at Home Nursing service provision.	April 2019	July 2019	Priyal Shah
5.4	Develop North Central London End of Life Care Strategy.	April 2019	December 2019	Priyal Shah / Patrick Schrijnen
5.5	Improve EOLC in Primary Care through Quality Improvement in EOLC	April 2019	March 2020	Priyal Shah
5.6	Update on this project once North Central London EOLC strategy has been decided	Jan 2020	March 2020	Priyal Shah / Patrick Schrijnen

Major Health Episodes, Crisis and Recovery

Current Position

'Major health episodes or health or social crises' refers to a sudden, significant deterioration in a person's physical, mental and/ or social needs resulting either from planned surgery or from unforeseen illness, accident, injury or significant life event or circumstance (e.g. bereavement). This is a particular risk for people who are already frail. 'Recovery' refers to those interventions in which an individual can regain physical, mental and psychological capacities and independence post-crisis, often after a spell in hospital. Helping people with frailty recover is therefore particularly crucial in helping them maximise their health, independence and quality of life.

A range of high-quality short-term recovery and recuperation services (collectively called 'intermediate care') provide this support already exist in Haringey. Access to these intermediate care services is managed via a Council-run Single Point of Access (SPA) to support patients' hospital discharge if they need ongoing care and support. The SPA simplifies hospital discharges for people, offers therapeutic triage to support decision-making and facilitates same-day and next-day discharges to all residents needing this service. The SPA's 'discharge to assess' response increasingly makes sure decisions about people's long-term care needs are made out-of-hospital and after people have recovered (mostly at home), greatly improving residents' experience of support as well as their medium and long-term rehabilitation and health outcomes.

As part of the referral services locally as part of the NHS 111 system, Haringey has an effective Rapid Response service that operates seven days per week, providing short-term care and nursing interventions to Haringey residents in crisis in their own homes within 2 hours of call-out (or same day if less urgent) as an alternative to prevent people having to go to A&E unnecessarily. A highly successful pilot of the trusted assessors for care homes model, alongside additional clinical support to residential and nursing homes, has been running for some time, improving patient experience by both facilitating hospital discharges and reducing admissions. The CCG and Council already commission a range of bed-based solutions for people to recover or recuperate depending on the complexity and nature of their medical and functional care needs.

These services provide an excellent base from which the integrated intermediate care offer in Haringey have also improved. The SPA, for example, will screen individuals who need short-term help post-crisis, e.g. following hospital discharge, into the right care solutions to help continue their recovery over several weeks. This might mean, for example, access to therapeutic interventions to help them get about within their home via the Council's Reablement service or more medically-orientated home- or bed-based rehabilitation, with the latter in specialist facilities across the Borough.

Despite these positive outcomes, we know there are some issues to address:

- More people could benefit from our intermediate care services particularly those that could be referred before they may need a hospital episode ('step-up'), those with particularly short-term and intensive nursing needs at home and those who may need continuing health care in the community in the longer-term. This may also include expanding the times some services operate;
- We could better bring together some of the staff working in our intermediate teams to streamline assessment and planning processes for individuals with whom they work;
- We know we could improve the forward and onward planning post-intermediate care for some individuals based on good practice we have developed around MDT planning in other parts of the system.
- We need to support joint service development through delivery of key enablers such as more joined-up

commissioning between the Council and CCG and further development of joint IT and information-sharing solutions.

Aspirations

Our aim is to ensure that older adults experiencing major health episodes or crises receive treatment and social support in the most efficient and effective way possible. We aim to prioritise care outside acute hospital wherever possible, to maximise opportunities for Haringey residents to remain as independent as they can for as long as they can, and to support them to remain in their homes for as long as possible.

We are proud of the current services that help recover, but we know we could do more to improve and better align our joint intermediate care services and the capacity of community organisations to respond effectively to more complex clinical and social care and support needs at home. This will entail ensuring collaboration and joint accountability, seamless handovers between acute and crisis teams and longer-term care management teams, and the capacity to respond rapidly to individual's changing circumstances. Our services will form a coherent network that responsively supports all individuals and their families as their conditions and/or circumstances become more complex.

It will also mean a shift in resourcing from acute to community services as we are able to support more people with more complex needs outside of hospital. We will:

- Improve the care and support of older patients within our hospitals more generally from A&E onwards;
- Better join-up Health and ASC teams planning and delivering intermediate care together and planning next steps, including for a wider group of people, such as those who need short-term intensive nursing input or convalescence. This will mean staff, such as therapists, in different agencies will work more closely and jointly assess and review patients and streamlining individuals' access to services;
- Continued good management of hospital discharge for patients (e.g. transport, discharge before lunch, discharge summaries, early discharge planning, choice policy and so on). We will deliver 'home-first' approach to all hospital discharges and move-on from bed-based intermediate care placements, i.e. assume the first preference is that people can return home even if they need care and support to do so;
- Provide a 'trusted assessor' model for hospital patients who need to be discharged, or need to return, to a care home, and link this to Enhanced Health in Care Home model which we are rolling out to Haringey care homes (see Becoming More Frail);
- An improved focus on triage and redirection to community services from A&E (including statutory and voluntary sector interventions) – this will allow more people to return home quickly after a minor episode and reduces the risk of being admitted to hospital unnecessarily;
- Increased hours of operation of some of our intermediate care services to make sure they are more accessible throughout the day and week for Haringey residents;
- Integrated Health and ASC IT records and information-sharing will be available to support joint work and transition of cases between hospital and intermediate care and between intermediate care and any long-term support services the individual needs, respectively.

Key Priorities

In 2019/20, we will…

- 'Scale up' the existing trusted assessors for care homes input from pilot to full service.
- Ensure full utilisation of the trusted assessors for care homes service in acute hospitals.
- Develop and implement the community trusted assessor model between therapies and social work; and in doing improve the overall joint intermediate care 'offer' in Haringey. This includes expand the scope of and consolidate the Haringey Single Point of Access.
- Pilot the transfer administration of simple medications from district nursing to reablement.
- Implement early discharge planning.
- Implement the discharge choice policy.
- Ensure more patients are able to benefit from existing intermediate care services, including 'step-up' patients, those who need intensive nursing input and those who may be eligible for long-term health care

From 2020, we will…

- Move the administration of simple medications to all community care providers.
- Offer 7-day GP support to care homes as part of the GP contract;
- Implement joint Health and ASC records for intermediate care.
- Significantly reduce delays to hospital discharge caused by TTAs, transport and discharge after lunch.
- Integrate Health in the Haringey Single Point of Access.
- Implement improvements to the flow of residents between intermediate care and long-term care.
- Implement urgent diagnostic and treatment 'hubs' in the community.

High Level Actions				
#	**Milestones**	**Start Date**	**End Date**	**Owner**
6.1	Improve NHS-and Council Joint Intermediate Care pathways incorporating: • Integrated Point of Access across agencies and improved handover (e.g. from hospital) into intermediate care; • Trusted therapies assessment model between NHS and Council and streamlined access & management of people using pathway; • Improved handover to onward management of cases post-intermediate care across Integrated Care & Primary Care Networks; • Establish supporting infrastructure to support joint working, e.g. workforce development, information governance, IT etc. Phase I – Develop and initial implementation Phase II – Full Implementation	P1 - July 2019 P2 - April 2020	P1 - March 2020 P2- September 2021	Anita Marsden / Alison Kett
6.2	Work with partners to deploy Trusted Assessor model to support hospital discharge of patients to care homes in Haringey at NMUH and WHT and link with new Enhanced Care Home Model	April 2019	January 2020	Robert Cass

6.3	NMUH and WHT hospitals to work with partners to improve management of people with frailty from A&E attendance to discharge including: - interfacing with revised intermediate care and Integrated Care and Primary Care Networks for patients with delirium - improving access to intermediate care pathways as part of 'step-up' strategies to avoid or mitigate crises Phase I – Develop and initial implementation Phase II – Full Implementation	P1 - July 2019 P2 - April 2020	P1 - March 2020 P2 - September 2021	Richard Robson / Clarissa Murdoch
6.4	Develop an 'intermediate care nursing model' to support people with frailty who need recuperation after crisis or hospital episode	July 2019	December 2019	Robert Cass
6.5	Improve nurse-led rapid response and virtual ward functions to better support people approaching at crisis at home or to return home from A&E Phase I – Improvements with the existing resources Phase II – Potential expansion of model	P1 - July 2019 P2 - April 2020	P1 - March 2020 P2 - March 2021	Leadership Team
6.6	Work across partners to improve seven day and out-of-hours services to better support patients and increase urgent GP appointment and diagnostic capacity, including through development of Primary Care Networks Phase I – Explore options for improvement Phase II – Phase implementation of improvements	P1 - October 2019 P2 - April 2021	P1 - March 2021 P2 - March 2022	Leadership Team
6.7	Work to improve mental health crisis resolution services for older people with dementia with BEHMHT Phase I - Develop and agree improvement Phase II - Full implementation	P1 - October 2019 P2 - April 2020	P1 - March 2020 P2 - March 2021	Paul Allen / Tim Miller
6.8	Work across partners to improve emergency care planning arrangements for people with frailty involved in Frailty Network and sharing of information between partners Phase I - Develop and agree improvement Phase II - Full implementation	P1 - October 2019 P2 - April 2020	P1 - March 2020 P2 - March 2021	Leadership Team

Supporting Carers

Current Position

We know that (unpaid) 'carers' – family and friends of someone who has personal, social or health care needs (the 'cared for') – provide a vital and often unrecognised contribution to supporting people with health and care needs. We know 60% of us will become a carer at some point and the single largest group of people for whom they care are people with frailty. Most of these carers are themselves older and often have their own health issues, with the majority of more elderly carers (85+) having intensive caring responsibilities for someone else such as a spouse or close relative.

A range of support already exists in Haringey for carers to help them in their caring roles and to lead as health, well and fulfilling a life as possible. This includes:

- Information, advice and signposting on websites or through trusted sources such as the Over-50s Forum. The Council and CCG commission Carers FIRST in Haringey to provide first response, information to, and registration for, carers, as well as linking carers up to a range of opportunities to stay in touch and be supported. This includes providing tailored advice, advocacy and help to carers navigate the care and benefits systems and help to better plan their caring role, such as connecting them to services they might value. There are currently 1,000+ carers of all ages registered with Carers' FIRST. Frequent queries relate to financial support for carers such as eligibility for the DWP Carers Allowance;
- Some voluntary local groups and activities are available to support carers and often those they care for. These are tailored to specific needs, for example, local groups of carers of older people are enabled to come together and socialise via Carers FIRST;
- Carers benefit from the Council's free Emergency Carers' Alert Card scheme. This is a small card with a unique PIN and contact details to the Council's Safe & Sound Service, LBH's 24/7 Community Alarm Service Its purpose is for the Safe & Sound to mobilise the emergency plan they hold for that carer, e.g. who to contact to continue in the caring role, emergency support etc., in the event of someone ringing the contact number and quoting the relevant PIN;
- Health and care professionals consider the views and role of carers in joint assessment, planning and delivery of services to meet the care and support needs of the person cared. However, carers can also request a separate Carers' Assessment (or review) of their needs from the Council to look at their needs as a carer and how caring affects them. Some carers may be eligible for Council-funded support following assessment and planning;
- Council-funded planned or emergency respite care supports carers to take a short break from their caring role with professionals supporting the individual during the day or overnight either within an individuals' home or in a suitable housing environment, such as Extra Care or residential or nursing care;
- North Middlesex Hospital have a Carers' Passport Scheme for carers who are regular visitors to ward which has a range of advantages such as free parking and flexible visiting hours. whilst those they care for are in hospital and

We know many individuals who use these services value the support but we know improvements could be made:

- More carers of people with frailty could be better identified and registered in Haringey, and the advantages of registration could be better promoted. Registration is particularly important, for example, to make sure more people are subsequently able to access emergency planning with the Safe & Sound service;
- Care planning and delivery between agencies to the needs people with frailty and their carers could be better joined up - and more consistently accommodate carers' views as 'experts in the care of those they care for' and to support them in their own right;
- Information, advice and guidance that different agencies provide could be better coordinated and targeted at the needs of carers of people with frailty and their likely needs. This includes advice about income maximisation for

carers;

- A greater range of local support activities, including peer support, better tailored to carers could be developed and promoted across the Borough;
- More carers could benefit from support to address their own physical and mental health and well-being particularly in terms of social isolation and anxiety as part of a more joined up 'offer' for carers;
- More people could benefit from Carers' Assessments and subsequent help with planning their caring role;
- There's significant demand on respite care which could therefore help more carers and those for whom they care;
- The needs of some group of carers, such as such as those caring for people with dementia or elderly carers, could be better understood and supported.

Aspirations

Our aim is to work together to support carers of people with frailty to live well and continue in their caring role. To achieve this, we need to identify carers early, and as their circumstances change, help them find solutions tailored to them. The key improvements we intend to make which will make the best use of collective resources include:

- Organisations available to all will be encouraged to make simple changes to services to become more 'carer friendly';
- We will work together to identify carers, including those within high-risk groups, and better promote the benefits of registration. A wider range of organisations, including GP practices, hospitals, voluntary sector organisations and pharmacists, will more consistently promote the carers registration and support solutions across the Borough;
- Information, advice and guidance targeted at carers will be well-coordinated across multiple organisations as part of the wider network of information available locally. This will include access to information and support to improve carers' employment or finances to maximise household incomes;
- Carers will have good access to community navigators to help them identify their goals and connect them to solutions they might value. This, and the parallel development of multi-disciplinary Integrated Care Networks (ICNs), will provide a local response to meeting individuals' needs; both community navigation and ICNs are discussed in other sections;
- A range of local community services will increasingly become available to support the needs of carers including peer support opportunities. This will mean navigators or others can refer carers to improve their physical health and well-being, improve social inclusion and mental well-being or financial or employment opportunities, tailored to individuals' circumstances;
- Health staff working in Integrated Care and Primary Care Networks will address carers' physical and psychological health needs consistently across the Borough. This will include advice and support to better manage underlying cared for or carers' own health conditions and what do if they feel unwell. Older and frailer carers or those with particular intensive caring roles will be well-supported as part of a coordinated care response across these Networks;
- A greater number of Carers' Assessments will be undertaken to support carers to better plan their caring role and consider how to manage in a crisis targeted at those most at need. A range of home- and facility-based respite solutions will be available to carers;
- A range of digital technology will be available to support carers' role or help them 'keep in touch' if they live remotely.

Key Priorities

Working with carers, our key priorities are:

- Staff across multiple care organisations will be better trained to identify and work with carers including treating them as 'experts by experience' for those they care for. This will lead to jointly agreed and more personalised plans and care delivery, and help them carers plan their caring role and involved in managing the care of those they care for;
- Business intelligence will support us to target specific high-risk groups of carers of people with frailty and work towards improving the 'offer' of support for these individuals. Improvements will be developed with carers to better support these high-risk groups, such as those who are supporting people who have dementia, significant multi-morbidities and those with intensive caring roles;
- Streamline our information, advice and guidance better targeted at carers of people with frailty so that we have consistent messages across different organisations about the support on offer for carers;
- Work with a range of organisations, particularly health, care, housing and voluntary sector services, to promote carers' registration and free emergency planning with the Council's Safe & Sound service and Rapid Response;
- Incorporate the need to help carers navigate around the care and support system into the expectations of our Borough-wide development of social prescribing/community navigation, and as part of Community First development;
- Expand the range of community and voluntary sector solutions available to carers as part of the wider work on improving these solutions for vulnerable people, including through place-shaping work starting at North Tottenham;
- Improve the health and well-being 'offer' available to carers through their GP practice and as part of their Primary Care and Integrated Care Networks particularly for those with the most intensive caring roles;
- Expand the number of professionals who can undertake assessment of carers and plan with carers to support their role through development of the Integrated Care Networks;
- Expand the range of carers' respite opportunities in the Borough.

High Level Actions

#	Priority Actions	Start Date	End Date	Owner
7.1	Work across Haringey's health & care partners to set out joint staff development programme, and share good practice, on: • Identification, registration and working with carers of people with frailty; • How to promote 'carer management of person cared for' and looking after yourself; • Improve staff knowledge on the network of services available for carers and how to access them including helping them plan support; • Improve ability to undertake joint carers/cared for and specific carers assessments, planning & reviews <u>Phase I</u> – Plan and agree delivery of staff development <u>Phase II</u> - Implementation of staff development	Oct 2019 April 2020	March 2020 March 2021	Sebastian Dacre and Paul Allen
7.2	Establish a business intelligence tool to consistently identify where there are carers known (or potentially 'hidden	July 2019	March 2020	Charlotte Pomery / Community First

	carers') across Haringey, particularly high-risk groups			working with providers
7.3	Expand range of carers' respite opportunities in the Borough	October 2019	March 2021	Sebastian Dacre
NOTE Action relating to helping carers navigate around the care and support system into Haringey-wide social prescribing/community navigation can be found in *Becoming Frail*				
NOTE Action relating to screening for carers as part of the annual health checks & reviews for those aged 75+ can be found in *Becoming Frail*				
NOTE Actions relating to improving and bring together available public information, advice and guidance about caring and support can be found in *Becoming Frail*				
NOTE Actions relating to community and voluntary sector solutions available to carers as part of the place-shaping work starting at North Tottenham can be found in *Becoming More Frail*				

Our Next Steps

This Strategy has discussed how we will build on the solutions we already have in place to develop an integrated model of care to support people as they age more effectively and consistently in Haringey. It explains what our priorities for improvement will be for 2019/20 and beyond to make this happen.

We have set up a number of multi-agency projects to ensure the improvements we need to make are progressed and that they make a difference to individuals' lives and how we manage our health and care system. To help us, we are developing a set of outcome-based measures based on the benefits realisation map in this Strategy – and will continue to listen to feedback from individuals and carers.

We will also work with other health and care partners in North Central London to put in place a number of enablers for the Strategy. These include:

- *Joint Governance, Leadership and Network Collaboration* to help ensure our projects are delivered effectively and the right resources and infrastructure are available to support development;
- *Joint Commissioning and Finance* to help ensure the proposed improvements build on our revised approach to collaborative commissioning and financial management between partners;
- *Joint IT and Information Sharing, Reporting & Analytics* to help ensure the IT and informatics infrastructure needed to support these improvements, such as shared care records, is delivered;
- *Joint Workforce Development* to ensure our workforce is supported to work together in a more person-centred way; and that professionals know what their own responsibilities are, and who to contact when, to support individuals and carer;
- *Joint Estates Management* to help we make the best use of our buildings and facilities to develop a network of support closer to home for individuals and carers;

Our plans will therefore incorporate these enablers as part of the Roadmap.

Our intention is to update our Roadmap of actions and improvements annually over the next 3 years. We will therefore report progress on the Strategy's development, with a revised Roadmap and the impact on key outcomes, to the Health & Well-Being Board and Borough Partnership over this period.

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AGEING WELL STRATEGY ROADMAP 2019/20 AND BEYOND

SROs: Rachel Lissauer, Director of Commissioning, Haringey CCG

SRO: Charlotte Pomery, Director of Commissioning, LBH

Programme Lead: Paul Allen, Head of Integrated Commissioning (Frailty & Integrated Care)

Project Start: Oct-19

Display Week: 1

NO.	TASK	ASSIGNED TO	START	END
1	**Ageing Well**	Mary Orhewere		
1.1	Improve the use of Housing Hubs/Community Hubs as community facilities/meeting place, with care navigators aiming to improve engagement	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
1.2	Increase prevention and self-care, as well as self-referral to GP/system (as appropriate) especially in those with long term conditions	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
1.3	Join up existing services by improved signposting between services and by mapping of complementary services by GPs	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
1.4	Normalise consideration of 'financial health', including sign posting to address financial concerns and encourage financial planning	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
1.5	Increase use of green spaces, allotments and interactions with nature to improve physical activity levels & wellbeing	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
1.6	Improve awareness & uptake of volunteering opportunities (all ages)	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
1.7	Raise awareness/improve transport options for older people	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
1.8	Actively promote carer's health and wellbeing	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
1.9	Provide guidance about the setting up of community lunch clubs	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
2a	**Living With Long-Term Conditions**			

Display Week: 1

NO.	TASK	ASSIGNED TO	START	END
2a.1	Work in partnership with PHE to decrease number of patients at risk of developing LTCs by improving prevention programmes and early detection	Juliana Da Silva	Jul-19	Mar-20
2a.2	Support GPs and PCNs closing the gap between recorded prevalence and exception reporting through LCS and QIST teams	Juliana Da Silva	Jul-19	Mar-22
2a.3	Support patients self-managing their LTCs through self-management programmes by working closely with providers. Extend the self-management support to all LTCs and patients with multi morbidity across Haringey.	Juliana Da Silva	Jul-19	Dec-19
2a.4	Align care/pathways across the Borough for all LTCs patients by redesigning current services model.	Juliana Da Silva	Jul-19	Mar-22
2a.5	Increase services offer at primary care level to avoid unnecessary pressures in secondary care outpatient services, A&E attendances and consequent admissions.	Juliana Da Silva	Jul-19	Mar-22
2a.6	Work with wider commissioning teams and providers to review current services provision and decrease variation and duplication of care provided to patients across Haringey.	Juliana Da Silva	Jul-19	Mar-20
2a.7	Complete services mapping exercise related for the 6 identified areas for improvement, which includes an overview of type of services we should be providing to our population according to NHS Right Care Pathways.	Juliana Da Silva	Apr-19	Jul-19
2b	**Living With Dementia**	Paul Allen & Dementia Reference Group		
2b.1	Continue to build on Dementia-Friendly Haringey and work across partners to engage more organisations, raise awareness amongst more staff and support more people to become Dementia Friends	Dementia-Friendly Haringey Leadership Group	May-19	Mar-22
2b.2	Improve and disseminate end-to-end cross-agency dementia pathways for people with dementia and their carers and develop outcomes framework to monitor progress	Dementia Reference Group	Jun-19	Jun-19
2b.3	Work with BEH MHT and Primary Care Networks to improve diagnostic pathways for people with cognitive impairment	Paul Allen, HCCG/LBH as commissioner lead with providers	Jan-20	Sep-20
2b.c	Work with Haringey's Primary Care Networks, BEH MHT other health partners to improve, and share good practice on, medical and clinical management of patients from diagnosis and onward management of patients	Paul Allen, HCCG/LBH as commissioner lead with providers	Dec-19	Mar-21
	• Phase I: Agreement on protocols & future management		Dec-19	Jun-20
	• Phase II: Implementation		Jul-20	Mar-21
2b.d	Work with BEH MHT and partners to improve support available to people and carers to help them come to terms with diagnosis and begin to plan for the future	Uttara Mandal, BEHMHT	Sep-19	Mar-20
2b.e	Establish network of appropriately trained community navigators across partners who can advise & support people with dementia and carers, to connect them with services and to be a contact and liaison point for them	Paul Allen, HCCG/LBH as commissioner lead with providers	Sep-19	Mar-20
2b.f	Across partners, improve clinical and practice knowledge and skills in managing people with dementia and knowledge to support people through dementia pathways	Dementia Reference Group lead to be identified	Nov-19	Mar-21
	Phase I: Planning and development (2019/20)		Nov-19	Jun-20
	Phase II: Implementation across workforce (2020/21)		Jul-20	Mar-21
2b.g	Improve access to day opportunities for people with dementia and carers, including those with more complex needs; work on developing a 'hub' approach so that workers in services for more complex needs can support staff in other services work with people with dementia	Dementia Reference Group	Oct-19	Mar-21
	Phase I: Planning and initial development (2019/20)		Oct-19	Jul-20
	Phase II: Implementation (2020/21)		Aug-20	Mar-21

Display Week: 1

NO.	TASK	ASSIGNED TO	START	END
2b.h	Ensure wider frailty network under development, incorporating Integrated Care Networks and joint intermediate care, is able to plan, assess, manage and review the cases of people with dementia, particularly those with more severe dementia and/or complex needs	Paul Allen, HCCG/LBH as commissioner lead with providers	Oct-19	Mar-21
	Phase I: Planning and initial development (2019/20)		Oct-19	Jul-20
	Phase II: Full implementation of ICNs (2020/21)		Aug-20	Mar-21
2b.i	Ensure Enhanced Health in Care Homes model available to support Haringey's care homes adequately supports needs of people with dementia and that care home staff have adequate training on dementia	Paul Allen, HCCG/LBH as commissioner lead with providers	Jul-19	Mar-20
3	**Becoming Frail**			
3.1	Establish a single screening tool for use across all care and support services in the Borough to assess frailty and individuals' needs; and build use of these tools as basis to identify and review individuals' needs across sectors	Leadership Team	Jul-19	Mar-20
3.2	Work with Primary Care Networks to ensure cognitive screening and screening for frailty are part of the annual health checks for those aged 75+ and other vulnerable groups	HCCG Primary Care Team	Sep-19	Mar-21
3.3	Across partners, improve and bring together available public information, advice and guidance about living well with frailty, dementia, community navigators and services and support to help people do so; whilst promoting improved self-care, self-management and self-determination of these solutions	Paul Allen	Sep-19	Sep-21
	Phase I – Develop and initial implementation		Sep-19	Aug-20
	Phase II – Full Implementation		Sep-20	Sep-21
3.4	Work across Haringey's health and care partners to set out joint staff development programme, and share good practice, on: • Identification and management of people with frailty; • How to promote of self-care & self-management; • Improve staff knowledge on the network of services available for people and how to access them.	Leadership Team	Oct-19	Sep-21
	Phase I – Plan and agree delivery of workforce development		Oct-19	Mar-20
	Phase II - Implementation workforce development		Apr-20	Sep-21
3.5	Establish network of appropriately trained community navigators across partners who can advise & support people with frailty, dementia and carers and to connect them with services	Paul Allen	Jul-19	Mar-20
3.6	Work across partners to improve the 'community support offer' available to carers, people with frailty and/or who need early help:	Paul Allen / Gill Taylor / Marco Inzani	Jul-19	Mar-21
3.6.1	• Develop a joint Design & Outcomes Framework to map assets and develop future community services;			
3.6.2	• Make better use of identified existing services & facilities;			
3.6.3	• Use existing social housing facilities as community 'hubs' across Haringey;			
3.6.4	• Improve access to, and range of, community service including through stimulating development of peer support and community groups;			
3.6.5	• Pilot this approach within North Tottenham as part of place-shaping solutions			
3.7	Evaluate existing Frailty Care Closer to Integrated Network (CHINs) and explore how to absorb its function to support people with moderate frailty into emerging Integrated Care Network model	Paul Allen	Apr-19	Nov-20
3.8	Review and improve falls pathways and associated solutions in the Borough, including the Falls Service, as part of the wider development of a Frailty Network	Priyal Shah with Providers	Sep-19	Mar-21
	Phase I – Develop and initial implementation		Sep-19	Mar-20
	Phase II – Full Implementation		Apr-20	Mar-21
3.9	Improve and better promote the range and type of equipment, aids and digital solutions available to those with frailty and more complex needs including the Council's Safe & Sound Service	Adult Social Care	Oct-19	Mar-21

NO.	TASK	ASSIGNED TO	START	END
4	**Becoming Frailer**			
4.1	Across partners, work towards developing local multi-agency Integrated Care Networks (ICNs) across Haringey:	Leadership Team	Aug-19	Sep-21
4.1.1	• Further develop further multi-agency health, social care and voluntary sector team models and care pathways in localities to support Primary Care			
4.1.2	• Improve agency's joint capacity and responsiveness to address to assess, plan, deliver & review needs of patients;			
4.1.3	• Deploy multi-agency team as part of North Tottenham place-shaping pilot to better support people with more significant frailty who need care coordination;			
4.1.4	• Integrate work of Locality Team, joint Intermediate Care and Care Closer to Home (CHINs) into emerging ICNs			
	Phase I – Develop and agree ICN		Aug-19	Sep-20
	Phase II – Implement ICN		Oct-20	Sep-21
4.2	Work with GP Federation and other partners to develop Haringey's Primary Care Networks and integrate ICNs and PCNs to improve care pathways for people with significant frailty and/or high-risk patients	GP Federation with Partners	Apr-19	Sep-21
	Phase I – Develop and initially form 8 PCN		Apr-19	Sep-20
	Phase II – Full implementation of PCN functions		Oct-20	Sep-21
4.3	Roll out multi-agency Enhanced Health in Care Homes model to support care home staff & residents including those with dementia.	Paul Allen with Providers	Apr-19	Mar-21
4.4	Work with Registered Social Landlords towards increasing the range of supported living solutions such as Extra Care or 'step-up' flats as a means of supporting people in the community	Aphrodite Asimakopoulou	Sep-19	Sep-21
4.5	Council to work with partners to explore re-providing Osborne Grove as a nursing care home to increase capacity of available beds	Charlotte Pomery	Apr-19	Sep-22
4.6	Work with partners to re-provide locality-based community social care, such as home care, available to everyone with significant frailty, including Council-funded services	Charlotte Pomery	Jul-19	Mar-22
	Phase I – Develop		Jul-19	Mar-20
	Phase II – Testing in North Tottenham and evaluating impact		Apr-20	Mar-21
	Phase III – Full Implementation if successfully evaluated		Apr-21	Mar-22
4.7	Improve support for mental health & well-being issues for people with changed and/or significant frailty through improving access to therapies such as IaPT Phase I - Develop and initial improvement Phase II – Full implementation	Tim Miller	Oct-19	Mar-21
	Improve Continuing Health Care pathway including CHC processes and timescales for assessments and reviews for older people with frailty	Nigel Evason	Jul-19	Mar-21
	Phase I - Develop and initial improvement		Jul-19	Mar-20
	Phase II – Full implementation		Apr-20	Mar-21
5	**Approaching End of Life**			
5.1	Embed the expanded Specialist Palliative Care Service in the Community (started Q4 2018-19).	Priyal Shah / Patrick Schrijnen	Jan-19	May-19
5.2	Learn from the Advance Care Planning Facilitator (ACP) project in the two care homes and decide on future provision.	Priyal Shah	May-19	May-19
5.3	Review Hospice at Home Nursing service provision.	Priyal Shah	Apr-19	Jul-19
5.4	Develop North Central London End of Life Care Strategy.	Priyal Shah / Patrick Schrijnen	Apr-19	Dec-19
5.5	Improve EOLC in Primary Care through Quality Improvement in EOLC	Priyal Shah	Apr-19	Mar-20

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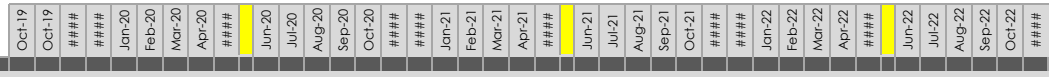

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NO.	TASK	ASSIGNED TO	START	END
5.6	Update on this project once North Central London EOLC strategy has been decided	Priyal Shah	Jan-20	Mar-20
6	**Recovering From Crises or Illness**			
6.1	Improve NHS-and Council Joint Intermediate Care pathways incorporating:			
6.1.1	• Integrated Point of Access across agencies and improved handover (e.g. from hospital) into intermediate care in line with D2A processes			
6.1.2	• Trusted therapies assessment model between NHS and Council and streamlined access & management of people using pathway;	ınita Marsden / Alison Ke	Jul-19	Sep-21
6.1.3	• Improved handover to onward management of cases post-intermediate care across Integrated Care & Primary Care Networks;			
6.1.4	• Establish supporting infrastructure to support joint working, e.g. workforce development, information governance, IT etc.			
	Phase I – Develop and intial implementation		Jul-19	Mar-20
	Phase II – Full Implementation		Apr-20	Sep-21
6.2	Work with partners to deploy Trusted Assessor model to support hospital discharge of patients to care homes in Haringey at NMUH and WHT and link with new Enhanced Care Home Model	Robert Cass	Apr-19	Jan-20
6.3	NMUH and WHT hospitals to work with partners to improve management of people with frailty from A&E attendance to discharge including: - interfacing with revised intermediate care and Integrated Care and Primary care Networks for patients with delirium - improving access to intermediate care pathways as part of 'step-up' strategies to avoid or mitigate crises	Richard Robson / Clarissa Murdoch	Jul-19	Sep-21
	Phase I – Develop and intial implementation		Jul-19	Mar-20
	Phase II – Full Implementation		Apr-20	Sep-21
6.4	Develop an 'intermediate care nursing model' to support people with frailty who need recuperation after crisis or hospital episode	Robert Cass	Jul-19	Dec-19
6.5	Improve nurse-led rapid response and virtual ward functions to better support people approaching at crisis at home or to return home from A&E	Leadership Team	Jul-19	Mar-21
	Phase I – Improvements with the existing resources		Jul-19	Mar-20
	Phase II – Potential expansion of model		Apr-20	Mar-21
6.6	Work across partners to improve seven day and out-of-hours services to better support patients and increase urgent GP appointment and diagnostic capacity, including through development of Primary Care Networks	Leadship Team	Oct-19	Mar-22
	Phase I – Explore options for improvement		Oct-19	Mar-21
	Phase II – Phase implementation of improvements		Apr-21	Mar-22
6.7	Work to improve mental health crisis resolution services for older people with dementia with BEHMHT	Paul Allen / Tim Miller	Oct-19	Mar-21
	Phase I - Develop and agree improvement		Oct-19	Mar-20
	Phase II - Full implementation		Apr-20	Mar-21
6.8	Work across partners to improve emergency care planning arrangements for people with frailty involved in Frailty Network and sharing of information between	Leadership Team	Oct-19	Mar-21
	Phase I - Develop and agree improvement		Oct-19	Mar-20
	Phase II - Full implementation		Apr-20	Mar-21
7	**Supporting Carers**			
7.1	Work across Haringey's health & care partners to set out joint staff development programme, and share good practice, on:			
7.1.1	• Identification, registration and working with carers of people with frailty;			
7.1.2	• How to promote 'carer management of person cared for' and looking after yourself;		Oct-19	Mar-21
7.1.3	• Improve staff knowledge on the network of services available for carers and how to access them including helping them plan support;	Sebastian Dacre and Paul Allen		

Display Week: 1

NO.	TASK	ASSIGNED TO	START	END
7.1.4	• Improve ability to undertake joint carers/cared for and specific carers assessments, planning & reviews			
	Phase I - Plan and agree delivery of staff development		Oct-19	Mar-20
	Phase II - Implementation of staff development		Apr-20	Mar-21
7.2	Establish a business intelligence tool to consistently identify where there are carers known (or potentially 'hidden carers') across Haringey, particularly high-risk groups	Charlotte Pomery / Community First working with providers	Jul-19	Mar-21
7.3	Expand range of carers' respite opportunities in the Borough	Sebastian Dacre	Oct-19	Mar-21
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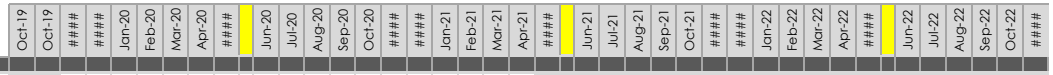

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This template provides a simple way to create a Gantt chart to help visualize and track your project. Simply enter your tasks and start and end dates - no formulas required. The bars in the Gantt chart represent the duration of the task and are displayed using conditional formatting. Insert new tasks by inserting new rows.

Guide for Screen Readers

There are 2 worksheets in this workbook.

TimeSheet
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The instructions for each worksheet are in the A column starting in cell A1 of each worksheet. They are written with hidden text. Each step guides you through the information in that row. Each subsequent step continues in cell A2, A3, and so on, unless otherwise explicitly directed. For example, instruction text might say "continue to cell A6" for the next step.

This hidden text will not print.

To remove these instructions from the worksheet, simply delete column A.

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Report for: **Health and Wellbeing Board – 16 October 2019**

Title: 2019 Child and Adolescent Mental Health Services (CAMHS) Transformation Update including the Trailblazer and Schools Link Programmes

Report Authorised by: Rachel Lissauer, Director of Commissioning and Integration, NHS Haringey CCG

Lead Officer: Michele Guimarin, Joint Commissioner for Vulnerable Children, London Borough of Haringey and NHS Haringey CCG

Kathryn Collin, Head of Children's Commissioning, NHS Haringey CCG

1. Describe the issue under consideration

This paper provides an update of Haringey's CAMHS Transformation Programme. This includes some exciting new developments, funded externally by NHS England to develop mental health support teams in schools in the east of Haringey and a project to forge better relationships and communication between CAMHS practitioners and all Haringey schools.

The purpose of this paper is to provide the Board with an overview of current issues, strengths and challenges for children and young people's (CYP) mental health as an introduction and background to the CAMHS Transformation Plan 2019, which will be submitted to the next Health and Wellbeing Board for final sign off.

Each year, the CCG is required to undertake an annual refresh of its CAMHS transformation plan and submit to NHS England for assurance. The plan is currently a working draft and the final date for submission is the 31st October. In previous years, this has been published as a draft on the CCG and council websites until final sign off at the Health and Wellbeing Board.

2. Recommendations

The board is asked to note:

- the key issues, strengths and areas for development outlined in the paper
- the new developments within the Haringey CAMHS Transformation Programme, particularly Haringey's national *Trailblazer* status

- that the final draft of the CAMHS Transformation Plan 2019 Annual refresh will be produced in draft form by the end of October and will be submitted to the next Board for final sign off.

3. Background Information

3.1 Haringey's CAMHS Transformation Programme

The importance of good emotional health and the wellbeing of our children and young people cannot be underestimated. It is a national priority with the publication of the 2018 *Transforming Children and Young People's Mental Health Provision* Green Paper[1] and is a key strategic local priority in the 2019-2023 Borough Plan which articulates a clear vision for strong families and networks which are resilient and have access to early help and support. This contributes to our aim for children and young people to have the best start in life in Haringey and to lead happy and fulfilling lives.

A significant number of Haringey children and young people require mental health support services. Our Joint Strategic Needs Assessment (JSNA) projected that around 4,800 Haringey children and young people aged 5-15 have a diagnosable mental health condition. There are an additional 5,700 young people aged 16-24 years with the same.

Indeed 50% of mental health problems (except for dementia) are established by age 14 and 75% by age 24. Risk factors such as having four or more adverse childhood experiences (ACEs) indicate that a person may experience mental health problems. ACEs include homelessness, physical or emotional neglect, physical or sexual abuse or experienced domestic violence. Other risk factors such as having long term disabilities or a diagnosis of autism mean these groups are more likely to suffer from poor mental health.

In view of these stark statistics, and the principle of parity of esteem between mental and physical health that is enshrined in law under the 2012 Health and Social Care Act, NHS England has set targets for local areas to improve access to mental health services. We must ensure that a minimum of 35% of under-18s with a diagnosable mental health condition are accessing mental health services by 2021. Nationally and locally this is a challenge as recording of activity on the correct system that allows data to be counted by NHS England has proven problematic. Although we are on track to meet this target and are currently achieving access for around 31% of children with a diagnosable mental health condition, many of the simple process redesigns and quick wins have already been undertaken so increasing and then maintaining our access figures even by just 1-2% will require significant effort across all local partners. It is a concerning statistic that 65% of our children and young people may still not be accessing the support they need.

[1] https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper/quick-read-transforming-children-and-young-peoples-mental-health-provision

The Haringey CAMHS Transformation Programme and the associated annual transformation plan outlines the borough's approach to addressing concerns of access and inequality and demonstrates how local partners will work together to make the necessary improvements. NHS England has provided external funding for the five year programme and spend is scrutinised closely to ensure Haringey is delivering its objectives.

Table 1 CAMHS Transformation Plan Investment per annum 2018/19- 20/21 after which funding will be mainstreamed within CCG baseline funding.

	18/19	19/20	20/21
CAMHS Transformation NHS England	£977,000	£1,075,000	£1,174,000
Trailblazer Pilot and Four Week Waiting time Initiative NHS England	£489,594	£1,339,130	£1,294,063
Health Education England Funding for Trailblazer Pilots		£66,990	£267,960
Schools Link Programme		In-kind support from Anna Freud Centre who are funded by DfE	
Suggested additional funding provided through the Five Year Forward Plan, NHS England		88,873	£328,887

A CAMHS Review was undertaken in 2015 by the council and CCG which assessed access to and take up to services by GP catchment areas and ethnicity. This data showed that the population of west Haringey was using services far greater than those in the east of the Borough. The variation by ethnicity was not conclusive. This review led to specific, needs led commissioning of mental health provision in east Haringey and a series of recommendations which are being implemented through the CAMHS Transformation Plan.

4. The Trailblazer Project and Four Week Waiting Time Initiative[2]

In 2018, following the publication of the Green Paper on *Transforming Children and Young People's Mental Health Provisio*n, the government and NHS England invited

[2] Trailblazer Pilot

bids for areas to *trailblaze* new initiatives to support improved access to services and the development of mental health teams in schools.

Haringey submitted its application and was chosen as a Wave 1 *Trailblazer Pilot* which included a commitment to deliver a Four Week Waiting Time for CAMHS.
Haringey is one of four London areas delivering the four week waiting time pilot (4WW). The Haringey pilot involves Open Door and Barnet Enfield Haringey Mental Health Trust. The purpose of the waiting list work is to test various methods aimed at reducing waiting times, particularly for first assessment.

The Trailblazer is being delivered through a strong partnership led by the Clinical Commissioning Group (CCG) including: Haringey CAMHS (BEH-MHT); Haringey Local Authority including Early Help, Educational Psychology, Public Health lead Anchor Project; Haringey Education Partnership; Tottenham Hotspur Foundation; Community Links (More than Mentors); deep:black; and Open Door – Young People's Counselling and Psychotherapy. The Children and Young People's (CYP) Transformation Executive chaired by the LBH Assistant Director for Commissioning oversees the governance of Trailblazer and the Four Week Waiting Initiative as part of the overall CAMHS Transformation Programme.

The pilot work is an exciting opportunity for the borough and enables us to test new ideas on behalf of the rest of the UK. It has brought over £1 million of much needed investment into our area and the success of the bid is testament to the strong partnerships that already exist in Haringey.

Two multi-disciplinary Trailblazer Mental Health Support Teams (MHSTs) will be providing support and interventions. The MHSTs are skill mixed to ensure best use of resource and comprise of a senior CAMHS practitioner, a speech and language therapist, an educational psychologist, two children's wellbeing practitioners[3] and two education mental health practitioners[4]. These professionals are further supported by teams from the council's highly regarded Anchor Project[5] and the voluntary and charitable sector including the Tottenham Hotspur Foundation. A booklet which explains the structure and work of the MHSTs is currently under development for publication locally.

Each team will cover half of the 36 east Haringey schools (5 secondary, 30 primary and 1 special primary) and will offer interventions including support for mild to moderate anxiety.

5. The Haringey Schools Link Programme

In addition to Haringey's trailblazer status, Haringey has recently been awarded the Schools Link Programme, which is a four year DfE programme to train a member of

[3] https://cypiapt.com/cwp-services/

[4] https://cypiapt.com/2019/03/13/educational-mental-health-practitioner-2019-update/

[5] https://local.gov.uk/anchor-project-haringey-council

the Senior Leadership Team as a Mental Health lead within the every school in England.

Haringey will be one of the first Local Authorities to deliver the Schools Link programme which will support the implementation of the CAMHS Transformation Programme. The Schools Link Programme will also assist with the recommendations arising out of the Council's Alternative Provision Review and recommendations on reducing exclusions (please see section 6.2).

The aim of the programme is to bring together education and mental health professionals so that more children and young people get the help and support they need, when they need it. For Haringey this means 72 schools and colleges will attend two workshops through the existing Networked Learning Communities led by head teachers. The model they use is CASCADE which is a useful method for ensuring there is a whole borough/school approach to supporting mental health needs. This work builds on the excellent work of The Anchor Project which provides educational settings with information, advice and support to strengthen whole-school wellbeing and resilience.[6]

6. Key Issues in Haringey for Children and Young People's Mental Health

The above sections of the paper have outlined context to the improvement programme and described some new developments that are in the early stages of implementation. This section outlines some of the key issues with services at present before describing some key achievements to date and the areas for development.

6.1 Access to services for more vulnerable groups and Children and Young People who do not attend appointments

Overall, young men and women access CAMHS in line with expected rates, which is very positive however more can be done. The introduction of a new digital support programme, Kooth[7] may attract greater numbers of young men and others who would not normally sit and talk to someone face to face.

The 2015 CAMHS Review stated there were few local services for young people identifying as LGBTQ+. Within CAMHS there is not a specific service for LGBTQ+ but CAMHS are trained to work with young people questioning their sexuality, sexual identity and gender issues. Given the vulnerability of young LGBTQ+ further support in school, youth groups and Early Help, still needs to be considered as with other vulnerable groups.

The CAMHS Learning Disability team is a very experienced team and has recently expanded. This has allowed them to provide some more intensive input for this cohort

[6] https://www.haringey.gov.uk/social-care-and-health/health/public-health/anchor-approach/anchor-approach-information-schools

[7] Kooth is an online counselling and emotional well-being platform for children and young people, accessible through mobile, tablet and desktop and free at the point of use. https://www.kooth.com/

of vulnerable children and young people but there is still not enough capacity overall and this is an area for development.

It can be difficult to identify and to work with vulnerable young people. Training in Adverse Childhood Experiences (ACEs) has been shown to be helpful in changing attitudes and increasing confidence in responding to vulnerability by adopting a trauma-informed approach. Currently, the Trailblazer Pilot work, Virtual Head, Youth Offending Service and the Anchor Project use a trauma-informed approach. This can be cascaded across services.

The Trailblazer Pilot partnership includes More than Mentors, Tottenham Hotspurs Foundation and deep:black because engaging with a mental health practitioner can be frightening. Each of these organisations is offering activities and in turn their sports/arts/youth workers are being supported by CAMHS practitioners. This provides a therapeutic approach to the intervention. Increasingly, youth clubs have trained therapists within their teams/activities

6.2 Lack of Early Intervention and Limited School Offer

The 2015 CAMHS Review showed that there were few early intervention programmes and those that existed were not coordinated. At any one time, schools will be able to identify a number of vulnerable pupils whose learning needs, medical needs, behavioural challenges, social difficulties or family circumstances combine to have an impact on their ability to fully participate in, and benefit from, the curriculum. A proportion of these pupils may at some point, therefore, require additional support or alternative provision to be made for their education.

Haringey schools and colleges do not have a comprehensive social emotional mental health offer. NHS England's Trailblazer Pilot and the DfE's Schools Link Programme will assist schools and colleges in recognising mental health issues and improving communication.

6.3 Waiting Times

Waiting times for services have been very long although this is now starting to improve thanks to additional investment, the role of Open Door (a local voluntary sector provider) and internal service improvements at Barnet, Enfield and Haringey Mental Health Trust (BEH). Parents report that this is a particular concern for them, especially the lack of support received while waiting.

Reducing long waits

- In October 2018, 21% of young people were waiting over 18 weeks for a first appointment.
- As of July 2019, this had reduced to 4% of young people waiting over 18 weeks.

Delivering 4wk waiting times

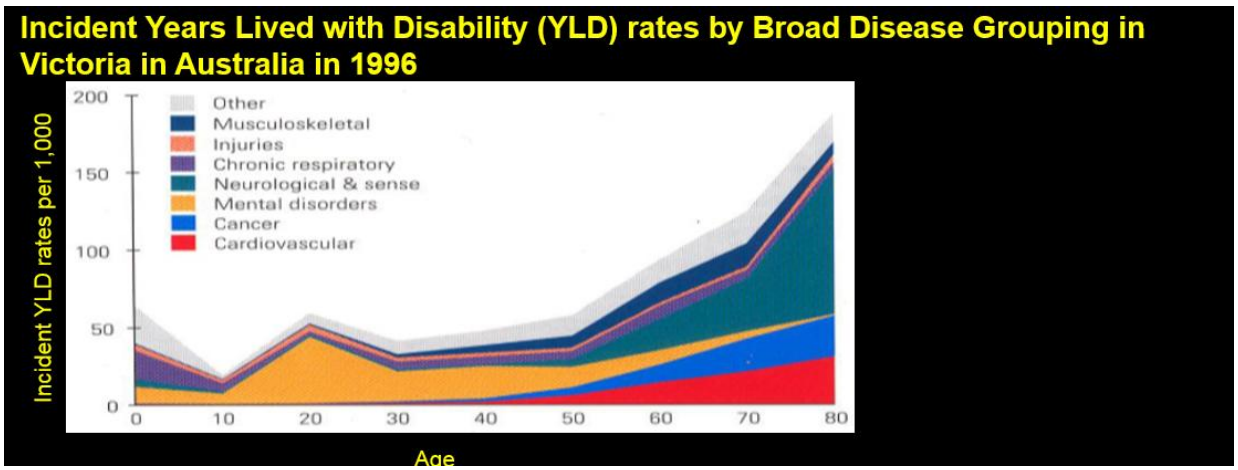
- In October 2018, 60% of young people were seen within four weeks for a first appointment.
- By July 2019 this had increased to 67%.

As part of the Trailblazer pilot, service redesign is underway to make sure no-one waits more than 4-6 weeks for an appointment. However, it is unclear if this can be

achieved within the existing financial envelope. Additional non-recurrent investment poses a risk for sustainability of meeting this target in the longer term and so the focus is on transformational pathways. The Kooth digital support online programme will support young people who may not meet the threshold for a CAMHS service but nevertheless wish to talk and to explore any problems they are encountering. It can also meet some of the needs of young people on a waiting list.

6.4 Transitions and lack of 0-25 services

There is an increased drive nationally towards greater focus on early intervention and prevention for those children and young people with long-term mental health needs. Major psychological changes and life transitions may happen together during young adulthood including mental health disorders and other physical injuries. In Australia, a study of incidence of a range of physical and mental health conditions showed the incidence of mental health disorders appeared highest when young people are 15 to 25 years old. This indicates that mental health services need to be ready to meet the demand during this time period. Services need to be developed and targeted appropriately to meet the challenges which people under 25 face in order to reduce the risk of these issues manifesting further into adulthood.



For services targeting 0-25 year olds there needs to be an integrated approach across health, social care, education and the voluntary sector. There is now a recognition of the benefit of an all age approach to commissioning, especially for mental health and SEND. This is a key priority in the NHS Long Term Plan.

Parents and young people report that there is a ‘cliff edge’ at transition from children’s to adult services at the age of 18.

There is also a particular issue for our young people with autism without a learning disability. These young people do not often meet the threshold for adult metal health services or adult services feel they cannot meet their needs (young adults with autism and a learning disability would be seen by the Haringey Learning Disability Partnership).

Open Door provides a service for 18-25 year olds but waiting times are significant. There is specific further work to do on transition services for mental health and for

autism, breaking down the arbitrary divide between adults' and children's commissioning to deliver better outcomes

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7. Some Key Strengths/Achievements to date

- A strong Haringey CAMHS Transformation Partnership has brought together all key stakeholders to drive change. The CYP Transformation Executive is chaired by the Assistant Director for Commissioning and supported by Educational Psychology, Special Educational Needs and Disabilities (SEND), public health, Healthwatch, a GP, a head teacher and a parent representative.
- Overall achievements have been made in the CYP mental health workforce being able to offer a greater number of evidence-based therapies through appointing new members of staff, implementing further staff training and introducing a better skills mix.
- Patient reported outcomes (PROMs) have also improved.
- Excellent work has been undertaken in engaging young people and parents to help redesign and improve services and a parent/carer rep sits on the Transformation Board. Healthwatch children and young people and parent/carer events are taking place from September 2019.
- Mental Health Support Teams are now present in all East Haringey Trailblazer schools.
- More Than Mentors (year 7 peer to peer support for 11 year olds transitioning to secondary school has been extended in partnership with 10 schools and Bruce Grove Youth Centre.
- Deep:black are providing creative arts sessions held at Woodside High School
- Exam stress reduction sessions held for young people as part of the Trailblazer.
- A pilot project for autistic young people is now run by Tottenham Hotspurs Foundation to help provide therapeutic interventions while undertaking sports activities
- Parent training held and there are plans to extend training for parents of autistic young people

8. Key Areas for Development

- Continued focus on access targets and reducing waiting lists
- Roll-out of school and college programme
- Development of 0-25 services within existing resources. Currently services are fragmented and commissioned and delivered for children and young people 0-17 and then 18+. This does not sit well with responsibilities for SEND (Special Educational Needs and Disabilities) which extend to 25. This will involve bringing together adult and children's commissioners to work differently across a pathway

- More local support for young people with autism/LD and challenging behaviour to reduce out of borough residential placements. This includes specialist training and evidence- based interventions. Key to supporting young people to stay locally is improved day and overnight respite provision and there is a programme of work planned for respite and short breaks to improve our local offer.
- Implement a whole system approach to thinking differently about emotional health and wellbeing- focussed on early intervention (this is the i-THRIVE model)[8]
- The future of the CHOICES service and how we make this work. https://www.haringeychoices.org/. This service is open access offering brief intervention and signposting to services but uptake/ number of contacts is still quite poor, even when the service is now in schools. We need to think about new ways of working e.g. a helpline, therapeutically informed youth services/clubs which are already in place in some areas e.g. Camden.
- Finding investment for the expectations set out in the Ten Year Plan - home treatment, Out of hours, 18-25 year old services and transition.

9. North Central London Sustainability and Transformation Partnership Programme - CAMHS (NCL STP)

Haringey CCG leads on the Crisis and Urgent Care workstream on behalf of North Central London (NCL). The Out of Hours Service for children presenting in mental health crisis (usually at an A&E department who then have to be admitted inappropriately to a children's medical ward with specialist support) began in July 2019 and will be expanded to all hospitals in NCL by December 2019. This will make a significant difference in reducing inappropriate admissions to beds in hospitals and enable more effective use of resource.

10. CAMHS Transformation Programme- Some Key risks

Although there have been some significant achievements in the early stages of the Trailblazer pilot, there are ongoing risks to delivery of our CAMHS Transformation Programme. There is a need to bear in mind the changing landscape of both the NHS and Social Care systems and the demands and pressures therein that need a coordinated response. Seemingly small funding changes can have a detrimental effect on another part of the local social emotional mental health support offer.

Staff recruitment is a key risk and this can be mitigated through the strong CAMHS Partnership Board members who can support recruitment. Increased referrals to services (rising demand) and increasing complexity are also risks to delivery of our programme, particularly the 4 week waiting time initiative.

Collaboration between schools, Early Help, Youth Services, CAMHS, traded services such as Haringey Education Partnership (HEP), Anchor Project, Educational

[8] http://implementingthrive.org/

Psychology and voluntary sector are needed to effectively implement and coordinate programmes.

11. Contribution to strategic outcomes

The CAMHS Transformation, Schools Link Programme and the Trailblazer Pilot work contributes to the delivery of the Borough Plan 2019-2023 *People* priority ensuring our children and young people have the best start in life, a happy childhood and that, 'every young person, whatever their background has a pathway to success for the future'. The aims of the emotional social and mental health work supports outcome 6: educational achievement, school exclusion, first time entrants in the criminal justice system and young people who are not in education, employment or training.

The trailblazer project in particular realises our ambition to provide early support and responses to our children and young people before escalation of need.

12. Statutory Officer Comments (Legal and Finance)

12.1 Legal

The contents of the report do not present any direct legal implications to the council. The projects detailed in the report are directly funded by NHS England, the CCG and DfE.

12.2 Finance

The contents of the report do not present any direct financial implications to the council. The projects detailed in the report are directly funded by NHS England, the CCG and DfE.

13. Environmental Implications

There are none.

14. Resident and Equalities Implications

The CAMHS Review undertaken in 2015 by the council and CCG assessed access to and take up of services by GP catchment areas and ethnicity. This data showed that the population of west Haringey was using services far greater than those in the east of the Borough. The variation by ethnicity was not conclusive. This review led to specific, needs led commissioning of mental health provision in the east of the borough and has shaped our CAMHS Transformation Programme. Many vulnerable young people are unable to engage with a variety of services including mental health for a complexity of reasons. The Trailblazer Pilot work was specifically established to overcome such barriers to access by partnering CAMHS practitioners with sports clubs, arts and peer mentors. NHS England has fed back that our pilot bid was successful because of the strength of partnerships with voluntary sector and charitable organisations. The pilot work is aimed at addressing health inequalities in the eastern part of the borough.

The Schools Link Programme will benefits all Haringey Schools, alternative provision and Colleges.

15. Use of Appendices

None

16. Background Papers

None

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Report for:	**Health and Wellbeing Board**
Title:	**Approval of Haringey Better Care Fund (BCF) 2019-20 Submission to NHS England**
Report authorised by:	Beverley Tarka, Director of Adults and Health Rachel Lissauer, Director of Commissioning, Haringey CCG
Lead Officer:	Paul Allen, Head of Integrated Commissioning (Older People & Frailty), Haringey CCG and Council 0203 6881173
Ward(s) affected:	**All**
Report for Key/ Non Key Decision:	**N/A**

1. Describe the issue under consideration

1.1. This report seeks ratification of the nationally mandated submission of the Haringey Better Care Fund 2019-20 Plan to NHS England no later than 27th September 2019. As a result of the statutory timescales, the submission has been signed-off in advance by the Chair of behalf of the Health & Well-Being Board.

1.2. Haringey CCG, the London Borough of Haringey (LBH) and their partners are working together to construct and agree plans for integrating health and social care for 2019-20 and beyond, including those discussed as part of the NHS Long-Term Plan. This has led to the development of a number of proposed strategies, including Haringey's Ageing Well Strategy, which is the subject of a separate paper.

1.3. The BCF Plan is one of the main vehicles to fund plans for integration, as it is underpinned through a Section 75 agreement to pool funds between CCG and LBH to support integrated schemes. The current plan and the schemes included within them (Appendices 1 & 2) were developed through the BCF Plan governance structure (which includes health and social care providers, clinicians, voluntary and community sector and public representatives) and the emerging Haringey Borough Partnership.

1.4. The narrative for the BCF Plan for 2019/20 builds on progress in previous years and discusses how:

- We will apply an agreed set of principles to joint development and delivery of integrated health and care solutions to deliver a more person-centred approach to care. This includes implementation of an approach to care that matches the health and care needs of individuals to the anticipated response. We will encourage and facilitate access to improved advice, information or early help via community-based solutions for the larger pool of people whose needs are less complex; and, at the same time, we will also ensure the smaller group of patients with more complex needs have a more coordinated multi-disciplinary response to care planning and delivery. However, both of these approaches will be delivered in a more person-centered and targeted way.
- We will improve our integrated health and care system in the Borough as part of Haringey's response to the NHS Long-Term Plan, such as development of multi-disciplinary primary care and integrated care networks, which will deliver health and care closer to home at a Borough and neighbourhood footprint.
- We will also work with our wider set of partners, such as Connected Communities, housing and the voluntary sector, to ensure our plans are aligned with wider planning to strengthen communities. To enable this, we have increased investment in early help and prevention in the 2019/20 BCF Plan, as we intend to work with health partners to better target and work with people with care and support needs.
- We will ensure there's a 'golden thread' connecting care solutions across differing geographical footprints so there's a coherent picture of support across North Central London, Borough and neighbourhood footprints;

1.5. As part of the 2019/20 commitments, we have increased investment in:

- An early intervention and prevention project between Connected Communities and NMUH to provide targeted advice, information and support to patients, families and visitors on a variety of issues, such as improving health and well-being, finance and housing;
- Multi-agency intermediate care services to 'step-up' particularly older people to prevent hospitalisation as they approach a crisis or facilitate timely discharge of hospital patients ('step-down') to home or in a care home placement to recover their health and functional abilities;
- Joining up and improving the quality of care and support for care home residents in Haringey's care homes through an Enhanced Care Home Model.

2. Cabinet Member Introduction

2.1 Not applicable.

3. Recommendations

3.1. The Health and Wellbeing Board is asked to approve the Haringey Better Care Fund (BCF) 2019-20 Plan attached as Appendix 2 and which sets out:

- The Haringey vision for integration of health and social care, how this is aligned with the Borough Plan and with NHS Long-Term Plan;
- How Haringey meets the four national BCF Plan Conditions;
- The list of schemes fully or partly funded through the BCF Plan that have been agreed across Haringey CCG and the London Borough of Haringey (LBH) to deliver the vision for health and social care;
- That Haringey is meeting all of the BCF Funding Contributions
- Confirmation that targets for the 4 BCF outcome measures have been set and how the Plan will positively influence these measures.

4. Reasons for decision

4.1. The Better Care Fund (BCF) is a national programme to support integration of health and social care, to protect the independence of residents and to improve outcomes for local people. It is welcome, and in line with the Borough Plan and the discussions to shape a borough partnership for Haringey, that there is an increased focus on prevention, early intervention and community solutions in the guidance. This emphasis has been taken through into the development of the Plan to reflect local partners' view that these elements are of critical importance in creating a sustainable health and care integrated offer, which goes beyond transfers in an out of hospital.

4.2. The Plan is also a well-established vehicle for integration in Haringey. It has made a number of positive impacts on supporting people in Haringey to have healthy, long and fulfilling lives, including:

a. Over 1,000 reablement episodes were available to adults in 2019/20. LBH's Reablement Service provides short-term (<6 weeks) intensive therapy to help people recover their ability to undertake daily living, such as washing or getting around their home, after a crisis and/or hospital episode, e.g. due to a fall;
b. The majority of these individuals were aged 65+, and, of these, 75% were at home for 91 days after hospital discharge, i.e. as opposed to returning to hospital or being admitted to a care home – a national BCF Plan metric. We anticipate both the number of people using the service and the proportion of people at home will increase as part of our plans for 2019/29;
c. Improvements in access to support for those patients who need public-sector health or social care support after a spell in hospital through the Council-run Single Point of Access (SPA). SPA works with multi-agency acute, CCG, Community Health and LBH staff to triage patients into a 'discharge and assessment pathway' according to their need so they can then access

solutions such as bed- or community-based short-term intermediate care/reablement to help them recover their health and functional abilities;

d. A 21% reduction in the rate (per 100,000 people) of delayed days for the transfer of care (discharge) from hospital – a national BCF Plan metric. This measures the extent to which, for whatever reason, a patient's discharge is delayed. The further improvement to our integrated multi-agency discharge pathways (including SPA) in 2019/20 and investment from BCF Plan (and System Resilience funding to help winter planning) supported this improvement;
e. A 21% reduction in the rate of injuries due to falls in people aged 65+ per 100,000 population. This was due to a greater preventative solutions in the community and in care homes, e.g. increased access to strengthening physical activities as part of LBH's Strategy;
f. Over 1,000 people accessing the multi-disciplinary Rapid Response service (usually responding within 4 hours) to treat people who are nearing, or at, a health crisis at home for up to 5 days following referral via a care professional. The service ensures people don't need to go to A&E unnecessarily;
g. 475 people were supported to community-based solutions that might help them through Local Area Coordinators operating in 2 areas of the Borough. The Coordinators' role is to connect vulnerable people to these services and provide support to them. This model has recently been independently and positively evaluated, and the Council is about to expand to other areas in the Borough.

4.3. Haringey CCG, the London Borough of Haringey (LBH) and its partners have been working together to construct and agree plans for integration of health and social care for 2019-20 and beyond, including those discussed as part of the NHS Long-Term Plan, and this has led to the development of a number of proposed strategies, including Haringey's Ageing Well Strategy. The BCF Plan has been developed through the BCF Plan governance structure (which includes health and social care providers, clinicians, voluntary and community sector and public representatives) and the emerging Haringey Borough Partnership. Haringey's BCF Plan 2019/20 has therefore been informed by this engagement. The Plan was presented to the Finance & Performance Partnership Board (of which the Health & Well-Being Board Chair is a member) on 18th September for formal sign-off prior to the submission date (27th September) on behalf of the Health & Well-Being Board.

4.4. The information presented in the BCF Plan should give the Haringey Health and Wellbeing Board the assurance Haringey is maintaining its commitment to progress health and social care integration to deliver the vision of the Haringey

BCF Plan in light of local and national strategies and plans, such as NHS Long-Term Plan, Borough Plan and Haringey's Ageing Well Strategy.

5. Alternative options considered

5.1 Not applicable.

6. Background information

6.1. Haringey must submit a Better Care Fund (BCF) Plan for 2019-20 and this must be approved by the Health and Wellbeing Board even if post-submission (given the timescales for HWB meeting), as per NHS England guidance.

6.2. As part of national guidance, Haringey CCG is expected to make a Minimum Contribution to the Haringey BCF Plan. This minimum contribution to the BCF Plan must spend a certain amount on out-of-hospital services and support for adult social care as part of the national conditions. These figures are £5.343m for out of hospital services and £6.175m to support social care for 2019/20. Collectively, the schedule of schemes funded or proposed to be funded through the BCF Plan in 2019/20 meet this criteria (Appendix 3).

6.3. There are also additional grants, which represent LBH's contribution, within the overall BCF Plan, namely:

- Improved Better Care Fund (iBCF) which is used to meet the growing demand for care packages and reduce the financial risk for LBH;
- LA Winter Pressures which is used to mitigate increased demand within the social care system particularly during the winter;
- Disabled Facilities Grant which is used to fund major adaptations to LBH clients' properties (regardless of tenure type) to support them to live at home for as long as possible.

6.4. Table 1 shows the changes in each element of the BCF Plan between 2018/19 and 2019/20.

BCF Plan Element	2018/19	Revised 2019/20	Increase 2019/20 - 2018/19
DFG	£2,187,962	£2,360,942	£172,980
iBCF	£7,097,300	£8,369,874	£1,272,574
Winter Pressures Grant	£1,148,202	£1,148,202	-
Minimum CCG Contribution	£17,699,598	£18,800,956	£1,101,358
TOTALS	**£28,133,062**	**£30,679,974**	**£2,546,912**

Table 1 - Uplifts in Haringey BCF Plan Funding 2018/19 and 2019/20

6.5. Areas must meet four national conditions in order for their BCF plans to be approved. Haringey meets all the national conditions:

Condition	Definition
1. Jointly agreed plan	The Haringey BCF Plan 2019/20 and its related strategies such as the Ageing Well Strategy has been developed with the engagement of all stakeholders including LBH, Haringey CCG, health and social care providers, community and voluntary sector, and public, service users and carers via governance structures.
2. Social care maintenance	Nationally, a certain proportion of the Minimum CCG Contribution should be used to support adult social care. In Haringey, this equates to a minimum of £6.175m to support social care for 2019/20. The total spend on the schemes in Appendix 3 exceeds the minimum level.
3. NHS commissioned out-of-hospital services	Nationally, a certain proportion of the Minimum CCG Contribution should be used to support adult social care. In Haringey, this equates to a minimum of £5.343m to out-of-hospital services for 2019/20. The total spend on the schemes in Appendix 3 exceeds the minimum level to emphasise the importance of hospital interface and community services.
4. Implementation of the High Impact Change Model for Managing Transfers of Care	The Haringey BCF Plan 2019/20 articulates a range of actions in line with the High Impact Change Model to reduce Delayed Transfers of Care from North Middlesex Hospital; Whittington Hospital; and Barnet, Enfield and Haringey Mental Health Trust. This builds on existing progress Haringey has made in implementing discharge and assessment processes.

6.6. The schemes proposed to be funded through the BCF Plan are listed in Appendix 3 divided into sections associated with Haringey's Ageing Well Strategy. The majority of these schemes are existing services which we are continuing to fund in 2019-20.

6.7. However, Appendix 3 also includes a number of additional schemes (in green highlighted cells) Haringey CCG and LBH executives have proposed could be funded through the £1.1m uplift in the Minimum CCG Contribution between 2018/19 and 2019/20. As part of national guidance, £258k of this £1.1m uplift must be spent on supporting adult social care.

6.8. In agreeing these new investments, Council and CCG executives discussed proposals, with each one considered against a number of criteria for inclusion, namely the extent to which each proposal fitted with national conditions, promoted local integration of services and was able to be mobilised quickly or was an

expansion of an existing service/contract arrangement. Proposals the CCG and Council agreed were the best fit to the above criteria are included in Appendix 3 (green cells). Given the short-term nature of the BCF Plan funding, all of the proposals are only up to the end of March 2020.

6.9. The Haringey BCF 2017-19 Plan outlines the targets NHSE has set Haringey or Haringey's executives has set for the four national outcomes BCF is expected to deliver. They are in line with individual Council and CCG existing targets:

Outcome	2019-20 Target
Non-Elective Admissions (NEAs) – All Ages	2% reduction in rates (NB: Provisional Target set by NHSE)
Delayed Transfers of Care (DTOC)	<17 delays per day (set by NHSE)
Council-Funded Residential/Nursing Care Home Admissions of People 65+	0% increase
Reablement effectiveness – 91 days still at home for people 65+	80% for 2019/20, i.e. a +5% improvement on 2018/19 out-turn

6.10. The Plan and its investments will support two particular performance areas:

- *Reducing the number of non-elective (emergency) admissions to hospital per 100,000 population*. Haringey was unable to meet its target in 2018/19 – the outturn was a 4% increase compared to 2017/18. This was largely driven by increased admissions of older people (particularly at NMUH). Action was taken to improve this position from January with partners through additional investment from System Resilience funding, and this will continue into 2019/20 through improvements and additional BCF Plan investment in specific areas, such as expanding Rapid Response. The latest development is NMUH's 'Frailty Hot Floor' with partners to better triage and address the needs of older people presenting to A&E to avoid admission to a hospital bed. As a result of these improvements, there was a 4% and 3% decrease in the number of all-age and 65+ admissions, respectively, between April – June 2018 and 2019;
- *Reducing the need for Council-funded residential and nursing care home per 100,000:* This increased by 11% between 2017/18 and 2018/19. This was largely due to a larger proportion of (particularly 85+) people admitted at a later stage in life than in 2017/18 because they were better supported at home for longer. This meant that whilst their overall utilisation remained the same, more people were being admitted to local care homes. The BCF Plan in 2019/20 will increase investment in intermediate care services and SPA. This will increase capacity to support individuals to access convalescence and

rehabilitation services first to increase their likelihood of being able to return home. As a result, the number of residential and nursing care home admissions has already started to decrease in 2019/20.

6.11. Haringey BCF Plan is governed through the BCF governance structure. This includes monthly highlight reports to the Integrated Care (Adults) Group and Programme Board and quarterly finance and performance reports to the Finance and Performance Partnership Board who provide oversight and scrutiny.

7. Contribution to strategic outcomes

7.1. The BCF Plan will contribute to objectives within both the Place and People Themes of the new Borough Plan

7.2. Place Theme; *A place with strong, resilient & connected communities where people can lead active and healthy lives in an environment that is safe, clean and green.*

7.3 People Theme; *Our vision is a Haringey where strong families, strong networks and strong communities nurture all residents to live well and achieve their potential.*

7.4 Policy Implication:

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

- North Central London Sustainability and Transformation Plan;
- LBH Joint Health and Well-being Strategy and is line with Haringey's Joint Strategic Needs Assessment;
- Priority 2 (People) of Haringey's Borough Plan 2019-2023;
- Haringey CCG Operating Plan
- Priority 2 (Integration) of Haringey CCG's Strategic Priorities
- National NHS Long-Term Plan within Haringey.

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

8.1 Finance

- The Better Care Fund (BCF) is a pooled budget of £30.7m between the London Borough of Haringey (LBH) and Haringey Clinical Commissioning Group (CCG), as shown in Table 1.
- The purpose of the fund is to enable integrated working across Haringey CCG, LB Haringey and its partners to ensure the best value for money is

achieved, across the agreed projects, as listed in the BCF Planning template.

- The funding has been allocated jointly by LBH and Haringey CCG in accordance with the aims and objectives of the plan.

8.2 Legal

8.2.1 The Health and Wellbeing Board responsibility include promoting and coordinating joint commissioning and integrated provision between the NHS, social care and related children's and public health services in Haringey.

8.2.2 The 2019-20 Better Care Fund: Policy Framework (April 2019) requires that the local BCF Plans for 2019-20 are signed off by the Health and Wellbeing Board as part of the assurance and approval process (Paragraph 2.19).

8.3 Equality

8.3.1. An Equalities Impact Assessment (EIA) was completed for the whole BCF Programme in December 2014. However, this is currently being updated in October 2019 in view of the revised BCF Plan and accompanying Ageing Well Strategy.

8.3.2. The overall outcome is to continue with the programme as there were a number of perceived benefits to people with protected characteristics. The assessment highlighted a particularly positive impact on older people (over 65), disability (including mental health), gender and ethnicity.

8.3.3. These positive impacts were mainly due to: the cohort of patients and services users that will be the main beneficiaries; the delivery of services in people's homes; working in a service user centred way to define health and social care goals; and the intention to improve health and well-being. No negative impacts were highlighted.

9. Use of Appendices

9.1. Appendix 1: Record of the Committee Chair's Urgent Action;
9.2. Appendix 2: Haringey's BCF Plan 2019-20 Completed Planning Template;
9.3. Appendix 3: List of Schemes Funded through BCF Plan 2019-20.

10. Local Government (Access to Information) Act 1985

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

RECORD OF COMMITTEE CHAIR'S URGENT ACTION

Title of Report: **Approval of Haringey Better Care Fund (BCF) 2019-20 Submission to NHS England**

1. Reason for urgency or Relevant paragraph for authority under scheme of delegation

1.1. Part 3 Section E, - Scheme of delegation section 5, indicates that where action need to be taken on an urgent matter between meetings of the Cabinet, or any Committee or Sub Committee of the Cabinet or Council this can be taken forward by the Leader for Executive functions and in the case of non Executive functions, the director can take the decision in consultation with the Chair of the Committee.

1.2. The Better Care Fund (BCF) 2019-20 Plan is part of the national administration of the BCF as set out in the Integration and Better Care Fund Planning Requirements for 2019-20 ("BCF Policy Guidance") (NHS England, Department of Health and Department for Communities and Local Government).

1.3. The BCF Policy Guidance requires the BCF Plan to be submitted no later than 27 September 2019 to NHS England, having been approved or set to be approved by the Health and Wellbeing Board (HWB). The HWB must agree the final template submission containing the Strategic Narrative, schemes that support the plan and their funding, compliance with national conditions required and the financial contributions confirmed. The next scheduled meeting of the HWB is 16th October 2019, and this does not allow for the BCF Plan to be submitted before the deadline date. Therefore, an urgent decision is required to approve the BCF Plan to allow for submission to NHS England.

2. Decision of the Director for Adults Social Services

2.1. I approve the recommendation as set out in the attached report having consulted with the Deputy Chief Executive and the Chair of the Health and Wellbeing Board.

Signature B. F Taylor **Date** 18/9/19

3. Concurrence of the Chair of Health and Wellbeing Board

3.1. I confirm that I have been consulted in the making of this decision.

Signature Sarah James **Date** 18.9.2019

Once signed by the Chief Officer this cover sheet together with the substantive report must be forwarded to the Committees Team - Level 5, River Park House - for processing.

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Better Care Fund 2019/20 Template

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.
3. The checker column will appear 'Red' and contain the word 'No' if the information has not been completed. Clicking on the corresponding 'Cell Reference' column will link to the incomplete cell for completion. Once completed the checker column will change to 'Green' and contain the word 'Yes'

4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

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

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net
3. Please note that in line with fair processing of personal data we collect email addresses to communicate with key individuals from the local areas for various purposes relating to the delivery of the BCF plans including plan development, assurance, approval and provision of support.
We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.
Please let us know if any of the submitted contact information changes during the BCF planning cycle so we are able to communicate with the right people in a timely manner.

4. Strategic Narrative (click to go to sheet)

This section of the template should set out the agreed approach locally to integration of health & social care. The narratives should focus on updating existing plans, and changes since integration plans were set out until 2020 rather than reiterating them and can be short. Word limits have been applied to each section and these are indicated on the worksheet.

1. Approach to integrating care around the person. This should set out your approach to integrating health and social care around the people, particularly those with long term health and care needs. This should highlight developments since 2017 and cover areas such as prevention.
2 i. Approach to integrating services at HWB level (including any arrangements at neighbourhood level where relevant). This should set out the agreed approach and services that will be commissioned through the BCF. Where schemes are new or approaches locally have changed, you should set out a short rationale.
2 ii. DFG and wider services. This should describe your approach to integration and joint commissioning/delivery with wider services. In all cases this should include housing, and a short narrative on use of the DFG to support people with care needs to remain independent through adaptations or other capital expenditure on their homes. This should include any discretionary use of the DFG.
3. How your BCF plan and other local plans align with the wider system and support integrated approaches. Examples may include the read across to the STP (Sustainability Transformation Partnerships) or ICS (Integrated Care Systems) plan(s) for your area and any other relevant strategies.

You can attach (in the e-mail) visuals and illustrations to aid understanding if this will assist assurers in understanding your local approach.

5. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's Better Care Fund (BCF) plan and pooled budget for 2019/20. On selected the HWB from the Cover page, this sheet will be pre-populated with the minimum CCG contributions to the BCF, DFG (Disabled Facilities Grant), iBCF (improved Better Care Fund) and Winter Pressures allocations to be pooled within the BCF. These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from Local Authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be utilised to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact England.bettercaresupport@nhs.net

6. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and utilised to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Condition 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.
On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is free text field to include a brief headline description of the scheme being planned.
4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available at the end of the table (follow the link to the description section at the top of the main expenditure table).
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- While selecting schemes and sub-types, the sub-type field will be flagged in 'red' font if it is from a previously selected scheme type. In this case please clear the sub-type field and reselect from the dropdown if the subtype field is editable.
5. Planned Outputs
- The BCF Planning requirements document requires areas to set out planned outputs for certain scheme types (those which lend themselves to delivery of discrete units of delivery) to help to better understand and account for the activity funded through the BCF.
- The Planned Outputs fields will only be editable if one of the relevant scheme types is selected. Please select a relevant unit from the drop down and an estimate of the outputs expected over the year. This is a numerical field.

6. Metric Impact
- This field is collecting information on the metrics that a chem will impact on (rather than the actual planned impact on the metric)
- For the schemes being planned please select from the drop-down options of 'High-Medium-Low-n/a' to provide an indicative level of impact on the four BCF metrics. Where the scheme impacts multiple metrics, this can be expressed by selecting the appropriate level from the drop down for each of the metrics. For example, a discharge to assess scheme might have a medium impact on Delayed Transfers of Care and permanent admissions to residential care. Where the scheme is not expected to impact a metric, the 'n/a' option could be selected from the drop-down menu.
7. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
8. Commissioner:
- Identify the commissioning entity for the scheme based on who commissions the scheme from the provider. If there is a single commissioner, please select the option from the drop-down list.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns alongside.
9. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

10. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop-down list
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
11. Expenditure (£) 2019/20:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
12. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2019/20 and will inform the understanding of planned spend for the iBCF and Winter Funding grants.

7. HICM (click to go to sheet)

National condition four of the BCF requires that areas continue to make progress in implementing the High Impact Change model for managing transfers of care and continue to work towards the centrally set expectations for reducing DToC. In the planning template, you should provide:
- An assessment of your current level of implementation against each of the 8 elements of the model – from a drop-down list
- Your planned level of implementation by the end March 2020 – again from a drop-down list

A narrative that sets out the approach to implementing the model further. The Narrative section in the HICM tab sets out further details.

8. Metrics (click to go to sheet)

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2019/20. The BCF requires plans to be agreed for the four metrics. This should build on planned and actual performance on these metrics in 2018/19.

1. Non-Elective Admissions (NEA) metric planning:
- BCF plans as in previous years mirror the latest CCG Operating Plans for the NEA metric. Therefore, this metric is not collected via this template.

2. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from ONS subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
- Please include a brief narrative associated with this metric plan

3. Reablement (REA) planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.
- Please include a brief narrative associated with this metric plan

4. Delayed Transfers of Care (DToC) planning:
- The expectations for this metric from 2018/19 are retained for 2019/20 and these are prepopulated.
- Please include a brief narrative associated with this metric plan.
- This narrative should include details of the plan, agreed between the local authority and the CCG for using the Winter Pressures grant to manage pressures on the system over Winter.

9. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2019/20 for further details.

The Key Lines of Enquiry (KLOE) underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

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

10. CCG-HWB Mapping (click to go to sheet)

The final sheet provides details of the CCG - HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity figures.

Better Care Fund 2019/20 Template

2. Cover

Version 1.2

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2019/20.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Haringey
Completed by:	Paul Allen
E-mail:	paul.allen14@nhs.net
Contact number:	2036881173
Who signed off the report on behalf of the Health and Wellbeing Board:	Beverley Tarka
Will the HWB sign-off the plan after the submission date?	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	16/10/2019

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Sarah	James	Sarah.James@haringey.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Tony	Hoolaghan	t.hoolaghan@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		Rachel	Lissauer	r.lissauer@nhs.net
	Local Authority Chief Executive		Zina	Etheridge	zina.etheridge@haringey.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Beverley	Tarka	beverley.tarka@haringey.gov.uk
	Better Care Fund Lead Official		Paul	Allen	Paul.allen14@nhs.net
	LA Section 151 Officer		Dan	Hawthorn	dan.hawthorn@haringey.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Complete:
2. Cover	Yes
4. Strategic Narrative	Yes
5. Income	Yes
6. Expenditure	Yes
7. HICM	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

<< Link to the Guidance sheet

Checklist

2. Cover

^^ Link back to top

	Cell Reference	Checker
Health & Wellbeing Board	D13	Yes
Completed by:	D15	Yes
E-mail:	D17	Yes
Contact number:	D19	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	D21	Yes
Will the HWB sign-off the plan after the submission date?	D23	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	D24	Yes
Area Assurance Contact Details - Role:	C27 : C36	Yes
Area Assurance Contact Details - First name:	F27 : F36	Yes
Area Assurance Contact Details - Surname:	G27 : G36	Yes
Area Assurance Contact Details - E-mail:	H27 : H36	Yes

Sheet Complete	Yes

4. Strategic Narrative

^^ Link back to top

	Cell Reference	Checker
A) Person-centred outcomes:	B20	Yes
B) (i) Your approach to integrated services at HWB level (and neighbourhood where applicable):	B31	Yes
B) (ii) Your approach to integration with wider services (e.g. Housing):	B37	Yes
C) System level alignment:	B44	Yes

Sheet Complete	Yes

5. Income

^^ Link back to top

	Cell Reference	Checker
Are any additional LA Contributions being made in 2019/20?	C39	Yes
Additional Local Authority	B42 : B44	Yes
Additional LA Contribution	C42 : C44	Yes
Additional LA Contribution Narrative	D42 : D44	Yes
Are any additional CCG Contributions being made in 2019/20?	C59	Yes
Additional CCGs	B62 : B71	Yes
Additional CCG Contribution	C62 : C71	Yes
Additional CCG Contribution Narrative	D62 : D71	Yes

Sheet Complete	Yes

6. Expenditure

^^ Link back to top

	Cell Reference	Checker
Scheme ID:	B22 : B271	Yes
Scheme Name:	C22 : C271	Yes
Brief Description of Scheme:	D22 : D271	Yes
Scheme Type:	E22 : E271	Yes
Sub Types:	F22 : F271	Yes
Specify if scheme type is Other:	G22 : G271	Yes
Planned Output:	H22 : H271	Yes
Planned Output Unit Estimate:	I22 : I271	Yes
Impact: Non-Elective Admissions:	J22 : J271	Yes
Impact: Delayed Transfers of Care:	K22 : K271	Yes
Impact: Residential Admissions:	L22 : L271	Yes
Impact: Reablement:	M22 : M271	Yes
Area of Spend:	N22 : N271	Yes
Specify if area of spend is Other:	O22 : O271	Yes
Commissioner:	P22 : P271	Yes
Joint Commissioner %:	Q22 : Q271	Yes
Provider:	S22 : S271	Yes
Source of Funding:	T22 : T271	Yes
Expenditure:	U22 : U271	Yes
New/Existing Scheme:	V22 : V271	Yes

Sheet Complete	Yes

7. HICM

^^ Link back to top

	Cell Reference	Checker
Priorities for embedding elements of the HCIM for Managing Transfers of Care locally:	B11	Yes
Chg 1) Early discharge planning - Current Level:	D15	Yes
Chg 2) Systems to monitor patient flow - Current Level:	D16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Current Level:	D17	Yes
Chg 4) Home first / discharge to assess - Current Level:	D18	Yes
Chg 5) Seven-day service - Current Level:	D19	Yes
Chg 6) Trusted assessors - Current Level:	D20	Yes
Chg 7) Focus on choice - Current Level:	D21	Yes
Chg 8) Enhancing health in care homes - Current Level:	D22	Yes
Chg 1) Early discharge planning - Planned Level:	E15	Yes
Chg 2) Systems to monitor patient flow - Planned Level:	E16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Planned Level:	E17	Yes
Chg 4) Home first / discharge to assess - Planned Level:	E18	Yes
Chg 5) Seven-day service - Planned Level:	E19	Yes
Chg 6) Trusted assessors - Planned Level:	E20	Yes
Chg 7) Focus on choice - Planned Level:	E21	Yes
Chg 8) Enhancing health in care homes - Planned Level:	E22	Yes
Chg 1) Early discharge planning - Reasons:	F15	Yes
Chg 2) Systems to monitor patient flow - Reasons:	F16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Reasons:	F17	Yes
Chg 4) Home first / discharge to assess - Reasons:	F18	Yes
Chg 5) Seven-day service - Reasons:	F19	Yes
Chg 6) Trusted assessors - Reasons:	F20	Yes
Chg 7) Focus on choice - Reasons:	F21	Yes
Chg 8) Enhancing health in care homes - Reasons:	F22	Yes

Sheet Complete	Yes

8. Metrics

^^ Link back to top

	Cell Reference	Checker
Non-Elective Admissions: Overview Narrative:	E10	Yes
Delayed Transfers of Care: Overview Narrative:	E17	Yes
Residential Admissions Numerator:	F27	Yes
Residential Admissions: Overview Narrative:	G26	Yes
Reablement Numerator:	F39	Yes
Reablement Denominator:	F40	Yes
Reablement: Overview Narrative:	G38	Yes

Sheet Complete	Yes

9. Planning Requirements

^^ Link back to top

	Cell Reference	Checker
PR1: NC1: Jointly agreed plan - Plan to Meet	F8	Yes
PR2: NC1: Jointly agreed plan - Plan to Meet	F9	Yes
PR3: NC1: Jointly agreed plan - Plan to Meet	F10	Yes
PR4: NC2: Social Care Maintenance - Plan to Meet	F11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Plan to Meet	F12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Plan to Meet	F13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F15	Yes
PR9: Metrics - Plan to Meet	F16	Yes
PR1: NC1: Jointly agreed plan - Actions in place if not	H8	Yes
PR2: NC1: Jointly agreed plan - Actions in place if not	H9	Yes
PR3: NC1: Jointly agreed plan - Actions in place if not	H10	Yes
PR4: NC2: Social Care Maintenance - Actions in place if not	H11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Actions in place if not	H12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Actions in place if not	H13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H15	Yes
PR9: Metrics - Actions in place if not	H16	Yes
PR1: NC1: Jointly agreed plan - Timeframe if not met	I8	Yes
PR2: NC1: Jointly agreed plan - Timeframe if not met	I9	Yes
PR3: NC1: Jointly agreed plan - Timeframe if not met	I10	Yes
PR4: NC2: Social Care Maintenance - Timeframe if not met	I11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Timeframe if not met	I12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Timeframe if not met	I13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I15	Yes
PR9: Metrics - Timeframe if not met	I16	Yes

Sheet Complete	Yes

^^ Link back to top

Better Care Fund 2019/20 Template

3. Summary

Selected Health and Wellbeing Board: Haringey

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,360,942	£2,360,942	£0
Minimum CCG Contribution	£18,800,956	£18,800,956	£0
iBCF	£8,369,874	£8,369,874	£0
Winter Pressures Grant	£1,148,202	£1,148,202	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£30,679,974	£30,679,974	£0

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£5,342,699
Planned spend	£12,666,875

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£6,175,392
Planned spend	£6,355,442

Scheme Types

Assistive Technologies and Equipment	£0
Care Act Implementation Related Duties	£0
Carers Services	£1,067,000
Community Based Schemes	£1,299,000
DFG Related Schemes	£2,360,942
Enablers for Integration	£1,602,202
HICM for Managing Transfer of Care	£406,000
Home Care or Domiciliary Care	£7,561,793
Housing Related Schemes	£160,866
Integrated Care Planning and Navigation	£1,178,578
Intermediate Care Services	£5,949,169
Personalised Budgeting and Commissioning	£0
Personalised Care at Home	£8,655,688
Prevention / Early Intervention	£438,736
Residential Placements	£0
Other	£0
Total	£30,679,974

HICM >>

		Planned level of maturity for 2019/2020
Chg 1	Early discharge planning	Established
Chg 2	Systems to monitor patient flow	Established
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Established
Chg 4	Home first / discharge to assess	Established
Chg 5	Seven-day service	Established
Chg 6	Trusted assessors	Established
Chg 7	Focus on choice	Established
Chg 8	Enhancing health in care homes	Established

Metrics >>

Non-Elective Admissions
Delayed Transfer of Care

Go to Better Care Exchange >>

Residential Admissions

		19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	468.1843354

Reablement

		19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	0.8

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
	PR8	Yes
Metrics	PR9	Yes

Better Care Fund 2019/20 Template

4. Strategic Narrative

Selected Health and Wellbeing Board: Haringey

Please outline your approach towards integration of health & social care:

When providing your responses to the below sections, please highlight any learning from the previous planning round (2017-2019) and cover any priorities for reducing health inequalities under the Equality Act 2010.

Please note that there are 4 responses required below, for questions: A), B(i), B(ii) and C)

Link to B) (i)
Link to B) (ii)
Link to C)

A) Person-centred outcomes

Your approach to integrating care around the person, this may include (but is not limited to):

- Prevention and self-care
- Promoting choice and independence

Remaining Word Limit: 1

Our approach builds on progress in implementing our Design Framework outlined in our 2017-19 BCF Narrative which laid the foundations for a person-centred approach to health/care integration. Our vision in Haringey's Borough Plan is to ensure strong families, networks & communities help people live well and have healthy and fulfilling lives, stay active and connect to their communities. Delivering these solutions will mean different things to different people depending on their needs and circumstances. This is why our approach is tailored to differing levels of needs and founded on prevention and person-centred planning.

In 2017-19, our successes associated with BCF Plan investment were:
• Improvements in preventative services such as falls prevention and self-management schemes for people with LTCs, e.g. COPD, which reduced long-term dependence on services and mitigated crises;
• Development of our integrated and person-centred health and care teams (e.g. Locality Team) that enable people to improve or maintain their health, independence at home as long as possible;
• Collaborating across the system to improve community- and bed-based intermediate care and support to regain independence after hospital discharge with a 'Home First' policy;
• Improvements in end of life services to support people in their last days, including helping those in care homes develop advance care plans.

Building on our Design Framework and in line with the NHSE Comprehensive Personalised Care Framework, we've introduced a Haringey 'care cone' model to match an individual's need to an expected 'system' level of response:
• 'Healthy, safe & well' describes how universal services in the community, such as leisure centres, could better accommodate more vulnerable adults as part of age-/disability-friendly communities and thus build social capital in communities. Our approach will build on the success of Dementia-Friendly Haringey in which 60 organisations from a range of sectors are collaborating to make simple improvements to services for people living with dementia;
• Early Help describes how community-based solutions can be specifically tailored for those with some, but less complex, health and care needs, and how people can be matched and connected to solutions through community navigation/social prescribing;
• People with complex needs need a more holistic multi-agency, multi-disciplinary and coordinated response to assessing, planning, delivering and reviewing their care, such as that offered through our Locality Team;
• People who need a well-coordinated crisis or post-crisis response to help avoid unnecessary hospitalisation or to help them recover post-hospitalisation.

Our health and care 'offer' to all residents will be built around the 'care cone' for 4 population groups (older people, children & young people, mental health and vulnerable adults) so individuals can access the right care in the right setting at the right time. It incorporates our original Design Framework to guide system-wide transformation:
• Prevention: taking every opportunity to promote the need for people to manage their health, well-being and independence to mitigate the risk of needing complex or crisis-driven interventions;
• Community asset-based approach to development, i.e. working with residents, the voluntary sector and providers to ensure people's needs can be better met in a greater range of sustainable community solutions and individuals can connect to solutions, e.g. via community navigation;
• Integrating health & care to develop solutions jointly, so partners can plan and deliver person-centred care in a joined-up and effective way to deliver on agreed goals. We are developing integrated care networks, the heart of which will be primary care networks, incorporating, community health services, acute services, mental health, social care and voluntary sector;
• Promoting a fairer Borough and recognising the diversity of our communities and how different groups experience health & well-being inequalities. For example, there's a greater level of deprivation and a younger population in the east than in the west of Haringey. This means, for example, differing community-based solutions will emerge in different neighbourhoods in response to underlying need alongside a 'core' offer for people with complex needs. Our resources will be tailored appropriately (see B(i) on North Tottenham);
• Co-design: ensuring we actively engage and work with stakeholders, including patients, users, carers and their representative groups, in designing and delivering solutions in a transparent and evidence-based way.

The development of Haringey's Ageing Well (AW) and Long-Term Conditions (LTC) Strategies illustrates how we intend to realise these aspirations. They are targeted at groups - older people, those with frailty or LTCs - likely to benefit from solutions the BCF Plan funds. Our AW Strategy sets out our

B) HWB level

(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):

- Joint commissioning arrangements
- Alignment with primary care services (including PCNs (Primary Care Networks))
- Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)

^^ Link back to top

Remaining Word Limit: 1

The BCF Plan a joint CCG/LBH commissioning arrangement. Its budget and use is overseen via multi-layered governance arrangements so partners are engaged with its development (see (C)). Haringey has well-established joint commissioning arrangements and S75 funding for MH and learning disabilities services. We are building our new partnership arrangements across commissioners & providers to support integration: this includes CCG, Council, GP Federation, Whittington Health (integrated acute-community) and NMUH Trusts, BEHMHT, hospices and voluntary sector and patient representative groups.

We're developing our approach across STP, Borough and Neighbourhood footprints to ensure there's a 'golden thread' to align system solutions. In (A), we've described how we're developing integrated care solutions: some services are Borough-wide, whilst others are at neighbourhood footprint, but they're expected to work together to form a seamless pathway. For example, our single multi-agency point of access for patients needing support post-discharge is Borough-wide, and some may need (HWB-level) bed-based intermediate care. However, patients rehabilitated and discharged from the latter will benefit from a 'warm handover' and coordinated care planning & delivery via our integrated care and primary care networks at a Neighbourhood footprint. This will mean patients can access a range of professionals as appropriate locally and based around their GP.

Specific developments for our population include:

• Establishing our 8 primary care networks in Haringey as part of the NHS Long-Term Plan changes. PCNs will be at the heart of the wider development of our neighbourhood Integrated Care Networks which will bring together GPs, pharmacists, nurses, therapists, social workers, mental health specialists and voluntary sector navigators to work together as ICN teams to support people. Support will be tailored to individuals' needs through the 'care cone', with people with complex needs having a coordinator and care plan summary to describe the support they receive;

• Working with the voluntary sector to expand the range and uptake of community navigation and community-based solutions available to people with health and care needs, and to support the voluntary sector to build community social capital. This includes, for example, encouraging carers/former carers of people with dementia to form support networks to share their experiences and expertise; or using the expertise of staff working with people with severe dementia in our Borough-wide 'dementia hub' to facilitate voluntary or social housing sector staff working in communities to support those with less severe dementia. One way we intend to connect the Borough & Neighbourhood footprints is to support the practical development of voluntary or community solutions in neighbourhoods, but to shape developments according to a common Borough-wide Design Framework, co-developed with voluntary sector representatives. This will set out the outcomes people tell us they want to achieve and assure these services can respond to needs appropriately;

• Partners are increasingly committed to sharing resources and facilities within neighbourhoods. This approach, for example, facilitated development of a MH Well-Being Hub run by the voluntary sector in a RSL facility which also hosts NHS services. In 2019/20, we will map such opportunities geographically to form a flexible Borough-wide plan about estate utilisation to ensure synergy between the Borough and Neighbourhood footprint, which will facilitate co-location of teams.

We will implement these approaches across Haringey but are piloting an integrated outcomes-based approach in North Tottenham (one of our more deprived areas), in which a number of statutory and voluntary sector teams have agreed to collaborate as a test-bed for what can be achieved locally. This initiative is based on our design principles and has progressed through intensive engagement with residents, an emphasis on strengthening early intervention, and enabling frontline staff to design and test new ways of working together that address local needs, all built on an asset-based approach. This North Tottenham development will result in:

• Improved universal and targeted advice, guidance and early intervention on issues such as debt, housing and care, including via LBH's Connected Communities teams that operate within public facilities such as libraries. We will ensure opportunities to access these teams is expanded so people with care needs and carers can benefit from these solutions, e.g. via GP Link Worker;

• A Neighbourhood team of nurses, social workers, therapists, housing officers and navigators who work with GP practices and the PCN to support people with care and support needs, and link individuals into services from which they could benefit or to promote behaviour change or self-care. The team's practical development will inform wider ICN development in Haringey. The resulting greater local knowledge of residents gained by staff (and inter-connectedness of the virtual network) will help identify people whose needs are complex or are approaching crisis to mitigate these issues earlier;

• Understanding and mapping the 100+ voluntary schemes working in this diverse neighbourhood, connecting people with care needs into these solutions and working with services to align and build their 'offer'.

(ii) Your approach to integration with wider services (e.g. Housing), this should include:	
- Your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the	^^ Link back to top
Remaining Word Limit:	18

The approach discussed in (A) incorporate integration with a variety of wider services in the Borough that the BCF Plan supports right across the 'care cone'. For example:
• Universal Solutions: The AW Strategy contains plans to extend the number of organisations who have signed up to Haringey Dementia-Friendly Communities beyond the current 60. Current members include a diverse range of voluntary-, public- and private-sector organisations such as those working in health and social care, including hospices and VCS organisations, retail, hospitality, social housing, funeral services, leisure and sport, and arts and museums across Haringey. This means staff employed in these organisations have an understanding of dementia, whilst some have purposefully shaped their 'offers' around the needs of people with dementia, e.g. Tottenham Hotspur Foundation run 'sporting stories' to help people recall their past.

Our strategies plans to extend this concept to make Haringey an age- and disability-friendly Borough as part of our commitment to the Borough Plan. For example, we've specific actions in the AW Strategy to make better use of green spaces, allotments and interactions with nature and to encourage older people to volunteer in local communities, both of which will improve people's physical activity levels, wellbeing & quality of life. The application of this concept will mean an individuals' needs will be better accommodated through accessing services available to all of us and feeling part of the community;

• Early Help: We are working with our Registered Social Landlord (RSL) providers to ensure individuals with life-limiting physical or mental health conditions or frailty and who may have support needs can be better helped within housing environments. For example, many of our 130 Extra Care units are situated in wider supported housing complexes so people can be supported without having to move from their communities.

We are increasingly using supported housing facilities as 'community hubs' for activities for those living in these schemes and in the wider neighbourhood, e.g. knitting clubs, exercise classes etc., as part of making the best use of local assets. These hubs are concentrated mostly in the deprived areas, which are in the east of the borough, as this will help address health inequalities. LBH has also recently funded a number of community navigators who can connect vulnerable people to these 'hubs' (see B(i)).

LBH is planning to make a number of improvements to its Safe & Sound service, its in-house 24/7 community alarm service, with the aim of improving its service and technology 'offer' to potential customers, which older people and those with life-limiting conditions. We are discussing how health colleagues can best promote this revised offer to their patients and carers. This will provide reassurance help is available quickly if an alarm is triggered and which will can also help reduce unwarranted LAS call-outs.

We are also working with LBH's community-based services in public building, e.g. Connected Communities, which provide information, advice and guidance on a range of issues – an example can be found in the previous section. This will include providing advice and information to people with support needs, e.g. providing this information in hospital.

• Complex Needs: With our RSL partners, we are currently exploring how to add additional Extra Care and specialist accommodation in Haringey. LBH reviewed its DFG Allocation Policy in 2018/19 and improved its administration and delivery processes. We have improved the timescales for delivering adaptations between 2017/18 and 2018/19 (with the average time for delivery reducing by 2 weeks) and we are committed to continuing this improvement in 2019/20. To do so, we are progressing a 'trusted therapy assessment' model between the Council and our Community Health provider whereby relevant therapy recommendations identified by the latter could be accepted as a trigger for DFG adaptations by LBH without a new therapy assessment being needed. This will further reduce timescales for assessment and delivery of DFGs. We're also exploring how we might use part of our DFG allocation to fund assistive technology solutions to keep people as independent as possible, particulary for those with advanced dementia, one of our priority areas over the next 18 months.

• Needs at Crisis: Part of bed-based intermediate care 'offer' funded through the BCF is based within an RSL facility already, with the nursing and therapies input provided by our Community Health provider. This facility is well-used, and patients' stay provides an opportunity to decide and progress longer-term RSL housing options with them if they cannot return home. We are also working with our RSL partners on increasing the number of 'step-up/step-down' flats for vulnerable people who do not need a hospital bed or care home placement, but nonetheless cannot immediately return home

C) System level alignment, for example this may include (but is not limited to):	
- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans - A brief description of joint governance arrangements for the BCF plan	^^ Link back to top
Remaining Word Limit:	29

The BCF Plan and LTC and AW Strategies are aligned with ICS/STP initiatives. We have adopted a three-tier approach as per NHS Long-Term Plan to planning and governance.

STP/ICS:
North London Partners in Health & Care, on which North Central London CCGs, Council and health providers are represented, is responsible for coordinating STP-wide plans. As part of the development of a single ICS for Mar-20, NCL CCGs are finalising which services could be commissioned or provided at STP, and which at a Borough, footprint.

Those services likely to be commissioned at a STP footprint include elective health services in which there's likely to be a common NCL care pathway, particularly those for which there are opportunities to reduce unwarranted variation and economics of scale in commissioning across Boroughs. A number of our existing LTC pathways and end-of-life care pathways fall into this category. We have also well-established joint commissioning arrangements between Haringey and Islington CCG, e.g. for community health services, where it makes sense to do so.

Even for services likely to need to a tailored Borough solution, such as those associated with integrated care between local partners, there's a need to establish a set of multi-agency design principles across NCL to which Borough partnerships adhere. For example, a set of such principles and support materials has recently been established across NCL to support PCNs to establish social prescribing. This work informed the approach to community navigation more generally in Haringey and was delivered on the ground in Neighbourhoods (see (A)). In turn, our approach influenced the NCL-wide principles. This provides consistency of approach and assures alignment between STP, Borough and Neighbourhood footprints.

There are several examples of how the interaction at STP and Borough levels has already provided opportunities to align solutions via Haringey's BCF Plan investment:
• Common NCL-wide hospital discharge processes were implemented over the last 2 years. These processes contributed to Haringey's significant improvement in DTOCs and the introduction of gradually converging acute-community care processes and structures, e.g. move to single point of access, across NCL to reduce unwarranted variation, e.g. implementation of a common NCL Choice Policy for patients needing care home admission (see (A));
• Haringey commissioned its Trusted Assessor/Enhanced Health in Care Home model via established Enfield & Islington procurement arrangements rather than introducing its 'own' model. This means a single TA for Haringey & Enfield operates within NMUH rather than 2 different ones and models of onward support. This has simplified operational arrangements for the provider, care homes and for the acute staff.

Borough Level:
The Ageing Well Strategy is in the process of being agreed at Haringey's Borough Partnership and HWB Board. It and services listed in this BCF Plan which make a significant contribution to the Strategy, is chiefly at the Borough or Neighbourhood footprints.

Our solutions in the BCF Plan are comprehensively aligned with LBH's Borough Plan and Haringey CCGs existing commissioning plans. For example, the BCF Plan includes investment in early intervention/prevention in 2019/20. This supports the AW Strategy, which includes actions to better consolidate and target information, advice and guidance across partners to residents and patients in the Borough and in neighbourhoods, and how an asset-based approach to commissioning community solutions will be adopted to support older people with care needs. In turn, both approaches reinforce the People section of the Borough Plan.

Where it makes sense to do so, we are designing Haringey's integrated care solutions to align with those in Islington and Enfield to provide a consistent approach. We are collaborating with staff from the GP Federations, acute and community health providers and Enfield & Islington CCG to develop a frontline-led Frailty Network. This taps into expertise to establish and operationalise common solutions, such as professionals using the same frailty screening tool, within our Strategy. This will support a set of solutions that improves the acute/community interface at NMUH and WHT, and facilitates

Better Care Fund 2019/20 Template

5. Income

Selected Health and Wellbeing Board: Haringey

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Haringey	£2,360,942
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,360,942**

iBCF Contribution	Contribution
Haringey	£8,369,874
Total iBCF Contribution	**£8,369,874**

Winter Pressures Grant	Contribution
Haringey	£1,148,202
Total Winter Pressures Grant Contribution	**£1,148,202**

Are any additional LA Contributions being made in 2019/20? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Haringey CCG	£18,800,956
Total Minimum CCG Contribution	**£18,800,956**

Are any additional CCG Contributions being made in 2019/20? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Total Addition CCG Contribution	**£0**	
Total CCG Contribution	**£18,800,956**	

	2019/20
Total BCF Pooled Budget	**£30,679,974**

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

Better Care Fund 2019/20 Template

6. Expenditure

Selected Health and Wellbeing Board: Haringey

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance

Link to Scheme Type description

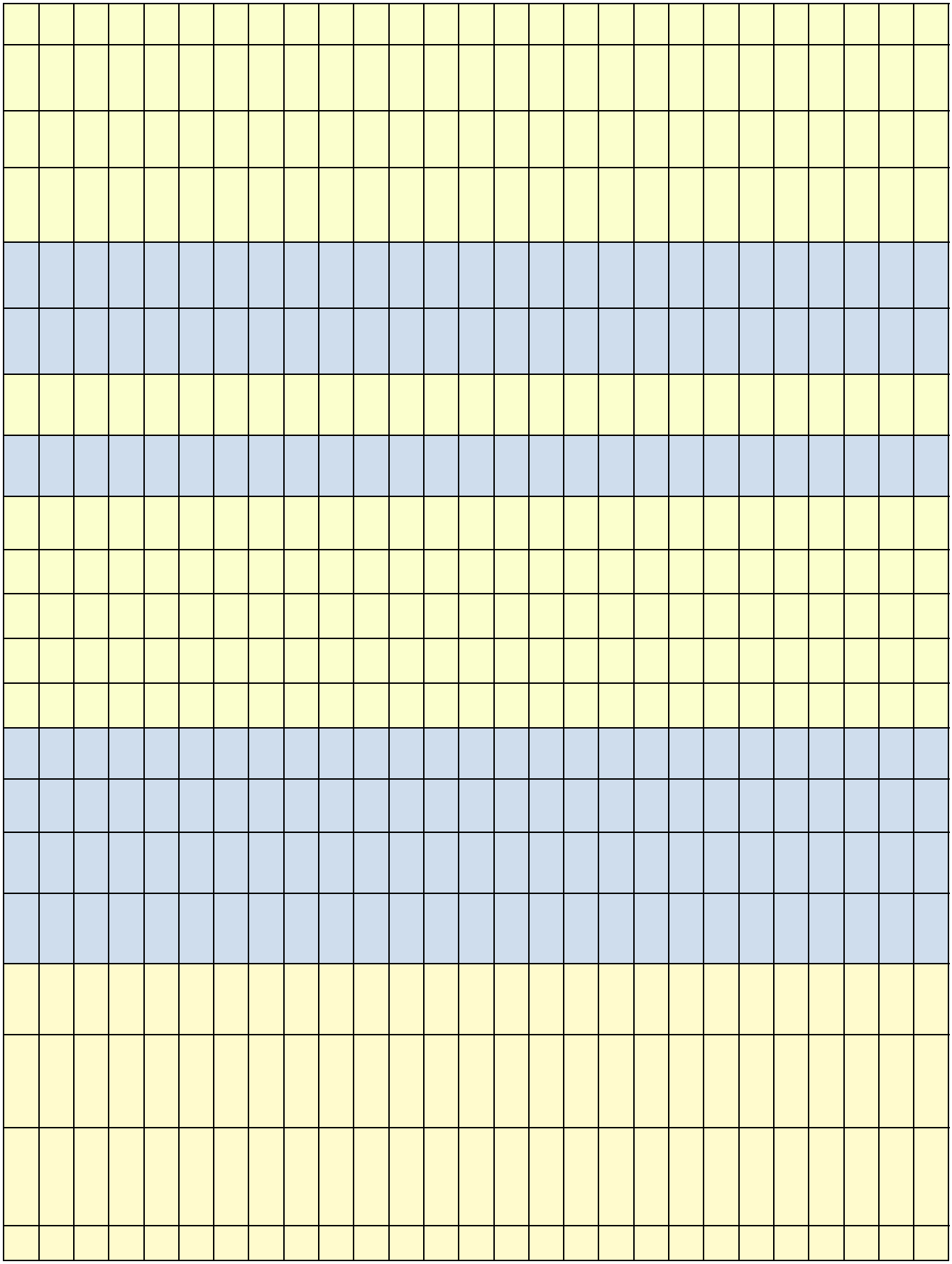
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Outputs		Metric Impact				Expenditure								
						Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Information, Advice and Guidance (IAG	Voluntary sector provision of advice, information, signposting and/or guidance for people needing help	Prevention / Early Intervention	Social Prescribing				Low	Not applicable	Low	Low	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£55,000	Existing
2	COPD Exercise Programme	Community-based exercise groups for suitable COPD patients referred via health professionals	Prevention / Early Intervention	Other	Self-management training for people with COPD			Low	Not applicable	Not applicable	Not applicable	Other	Secondary Prevention	CCG			NHS Community Provider	Minimum CCG Contribution	£13,000	Existing
3	Dementia Day Opportunities	LBH commissioned services to support people with dementia with facility- or wider home/ community-based day care/support. Other Providers - NHS Mental Health Provider,	Community Based Schemes					Low	Not applicable	Low	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£475,000	Existing
4	Self-Management Support	Structured programme of courses for patients interested in condition self-management or being expert patient	Prevention / Early Intervention	Other	Self Management courses for diabetes and long term health conditions			Low	Not applicable	Not applicable	Not applicable	Other	Secondary Prevention	CCG			NHS Community Provider	Minimum CCG Contribution	£91,600	Existing
5	Local Area Coordination	Voluntary sector coordinators to provide advice,	Prevention / Early Intervention	Social Prescribing				Low	Not applicable	Low	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£120,136	Existing
6	Disabled facilities grant	LBH commissioned provider undertaking major adaptations of	DFG Related Schemes	Adaptations				Low	Low	Medium	Not applicable	Social Care		LA			Private Sector	DFG	£2,360,942	Existing
7	Nursing Services	District nursing for non-ambulant patients at home	Personalised Care at Home			Packages	14,000.0	Medium	Medium	Medium	Medium	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£6,529,807	Existing
8	Whittington Integrated Care Therapy Team	Multi-disciplinary therapy service that supports older people (& other groups)	Personalised Care at Home			Packages	7,700.0	Medium	Medium	Medium	High	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£2,014,000	Existing
9	Locality Team (Nursing)	Multi-disciplinary clinical, nursing, therapy & social work team to care plan, support & review people with severe frailty. Other Providers - NHS Mental Health Provider, Local Authority	Integrated Care Planning and Navigation	Care Coordination				High	Medium	High	Medium	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£341,348	Existing

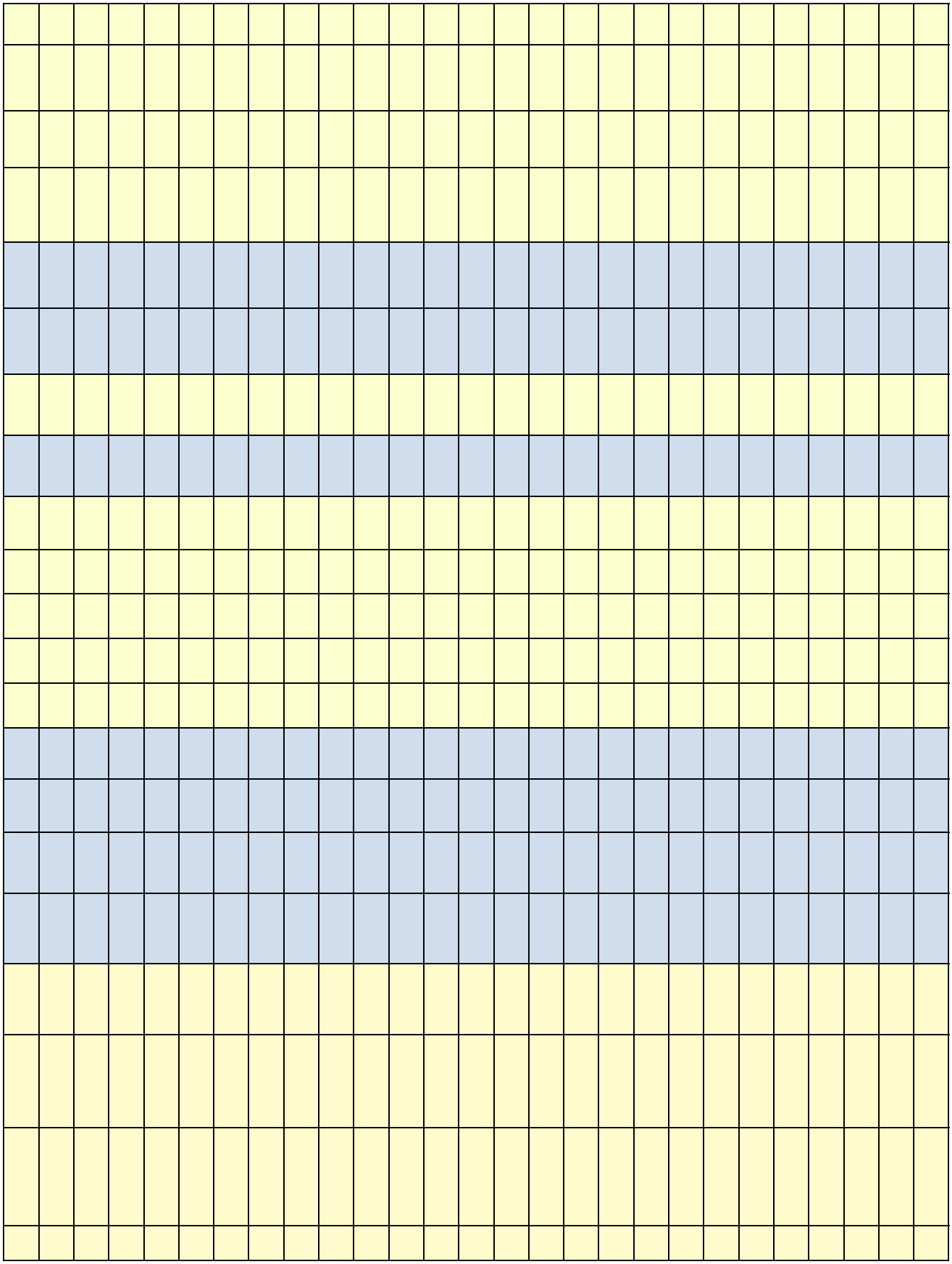
9	Locality Team (Mental Health Support)	Multi-disciplinary clinical, nursing, therapy & social work team to care plan, support & review people with severe frailty. Other Providers - NHS Mental Health Provider, Local Authority	Integrated Care Planning and Navigation	Care Coordination				High	Medium	High	Medium	Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£94,198	Existing
9	Locality Team (Social Worker)	Multi-disciplinary clinical, nursing, therapy & social work team to care plan, support & review people with severe frailty. Other Providers - NHS Mental Health Provider, Local Authority	Integrated Care Planning and Navigation	Care Coordination				High	Medium	High	Medium	Social Care		CCG			Local Authority	Minimum CCG Contribution	£78,000	Existing
10	MDT Teleconfernce	Weekly calls between geriatricians, GPs and others about complex cases to facilitate good patient management	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				High	Not applicable	Medium	Medium	Other	Mutiple spend across acute health, primary care, community health	CCG			NHS Community Provider	Minimum CCG Contribution	£253,447	Existing
11	Social Care Team	LBH posts to increase capacity in Single Point of Access and initial triaging of cases to support timely hospital discharge & facilitate access to intermediate care.	Integrated Care Planning and Navigation	Single Point of Access				Medium	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£230,000	Existing
12	Strength and Balance Opportunities	Strengthening & balancing classes and exercises for individuals who professionals identify at risk of falling	Community Based Schemes					Medium	Not applicable	Low	Medium	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£58,000	Existing
13	Enhanced Health in Care Homes & Trusted Assessor	Implementation of EHCH Model and Trusted Assessor across Haringey to support care homes, their staff & residents	HICM for Managing Transfer of Care	Chg 8. Enhancing Health in Care Homes				High	High	Low	Low	Other	Multiple spend across acute health and community health providers	CCG			NHS Community Provider	Minimum CCG Contribution	£216,000	New
14	IBCF Supporting Social Care	Bulk of spend is on providing packages of care (predominantly but not exclusively domiciliary care) as part of social care clients' Personal Budgets	Home Care or Domiciliary Care			Packages	1,576.0	High	Medium	High	High	Social Care		LA			Local Authority	iBCF	£7,114,393	Existing
15	Palliative Care & Advanced Care Planning Facilitator	NMUH-led multi-agency approach to support range of community-, hospital- and bed-based palliative care services. Other Providers - NHS Community Provider	Community Based Schemes					Medium	Low	Low	Low	Other	Multiple spend across acute health and community health (hospice) providers led by NMUH	CCG			NHS Acute Provider	Minimum CCG Contribution	£766,000	Existing

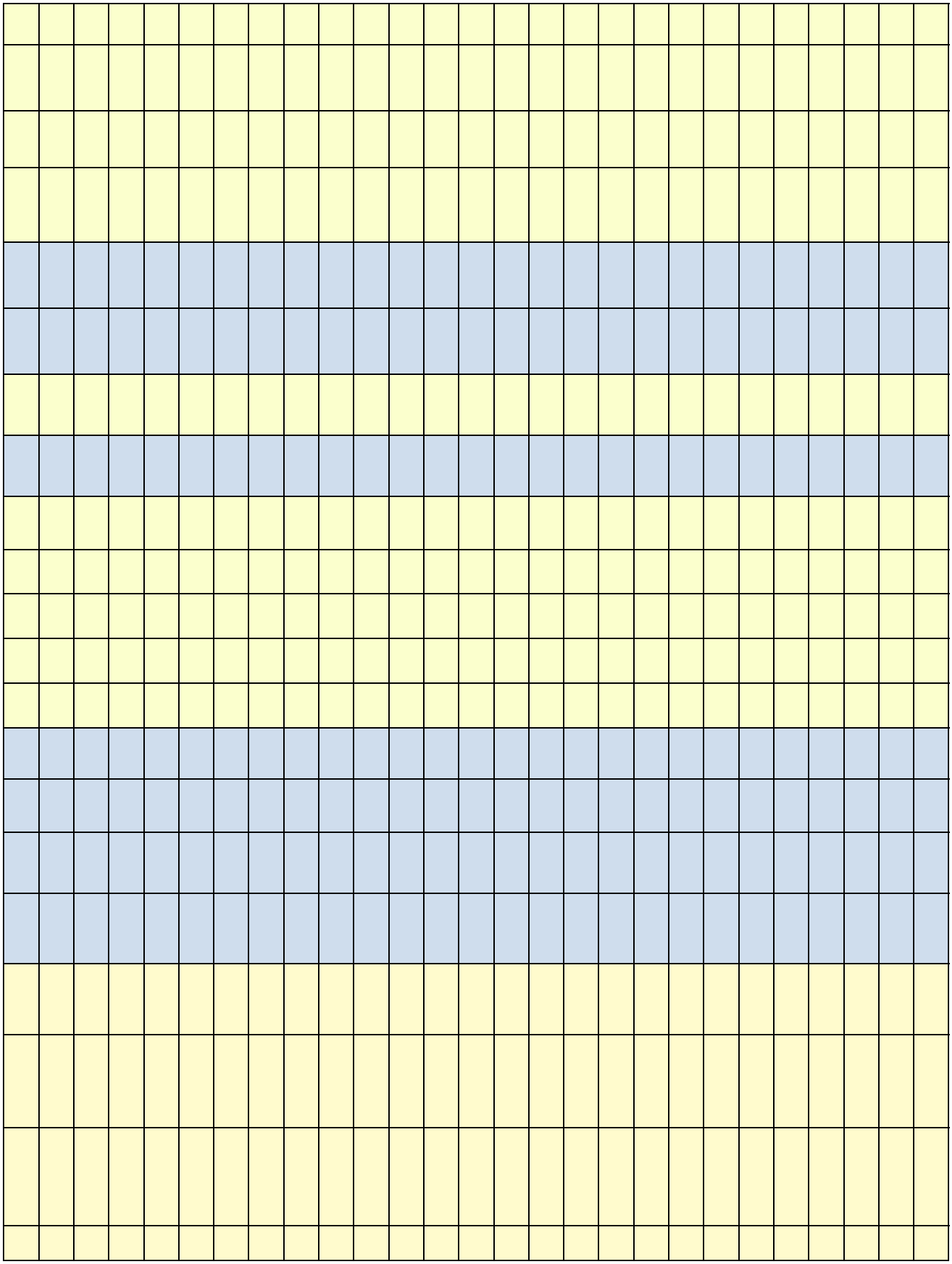
16	Alcohol Liaison Services	Public Health commissioned Alcohol Liaison Nurses & Support Worker to support patients in hospital with alcohol-related issues & to coordinate support in community	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Low	Medium	Low	Not applicable	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£61,585	Existing
17	Bed Based Intermediate Care @ Protheroe House	Bed-based time-limited rehabilitation service to facilitate people's recovery after illness	Intermediate Care Services	Bed Based - Step Up/Down		No. of beds	10.0	Medium	High	High	High	Social Care		LA			NHS Community Provider	Minimum CCG Contribution	£625,000	Existing
18	Bridges Rehab	Bed-based specialist nursing & therapies for patients requiring 24/7 rehabilitation	Intermediate Care Services	Reablement/Rehabilitation Services		Packages	180.0	Medium	High	High	Medium	Community Health		CCG			NHS Acute Provider	Minimum CCG Contribution	£1,254,233	Existing
19	Rapid Response Service - Community Health	Multi-disciplinary nursing & therapies team to respond quickly when people are at crisis and/or need short-term rehabilitation either at home or in A&E. Other Providers - Local Authroity	Intermediate Care Services	Rapid / Crisis Response				High	Low	High	Medium	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£303,000	Existing
19	Rapid Response Service - LBH	Funding for rapid access to packages of care to support individuals at home at crisis - part of RR model	Intermediate Care Services	Rapid / Crisis Response				High	Low	High	Medium	Social Care		LA			Private Sector	Minimum CCG Contribution	£71,000	Existing
20	Reablement Solutions	LBH time-limited community-based enablement &	Intermediate Care Services	Reablement/Rehabilitation Services		Packages	1,440.0	High	High	Medium	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£2,596,000	Existing
21	Home from Hospital	Voluntary sector scheme to support hospital patients (who do not need public-sector intervention) return home and settled if they need it	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Low	Low	Low	Not applicable	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£150,000	Existing
22	MH Discharge Coordinator	Social worker in MH service to support discharge and onward planning for individuals with severe MH issues.	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				Not applicable	High	Low	Not applicable	Social Care		LA			NHS Mental Health Provider	Minimum CCG Contribution	£40,000	Existing
23	Nursing Intermediate Care	Nursing beds with rehabilitative MDT input and nursing outreach to patients' homes for those needing a period of convalescence post-discharge	Intermediate Care Services	Bed Based - Step Up/Down		No. of beds	4.0	Low	High	High	Medium	Community Health		CCG			Private Sector	Minimum CCG Contribution	£327,000	New
24	Carers' Support	Range of carers' solutions depending on intensity of need: identifying carers, undertaking assessment of needs and support through to carers' respite. Providers are Local Authority and Voluntary Sector	Carers Services	Other	Includes carers' advice, information & support, care planning for carers, respite services and Carers' Direct Payments			Medium	Low	Medium	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,067,000	Existing

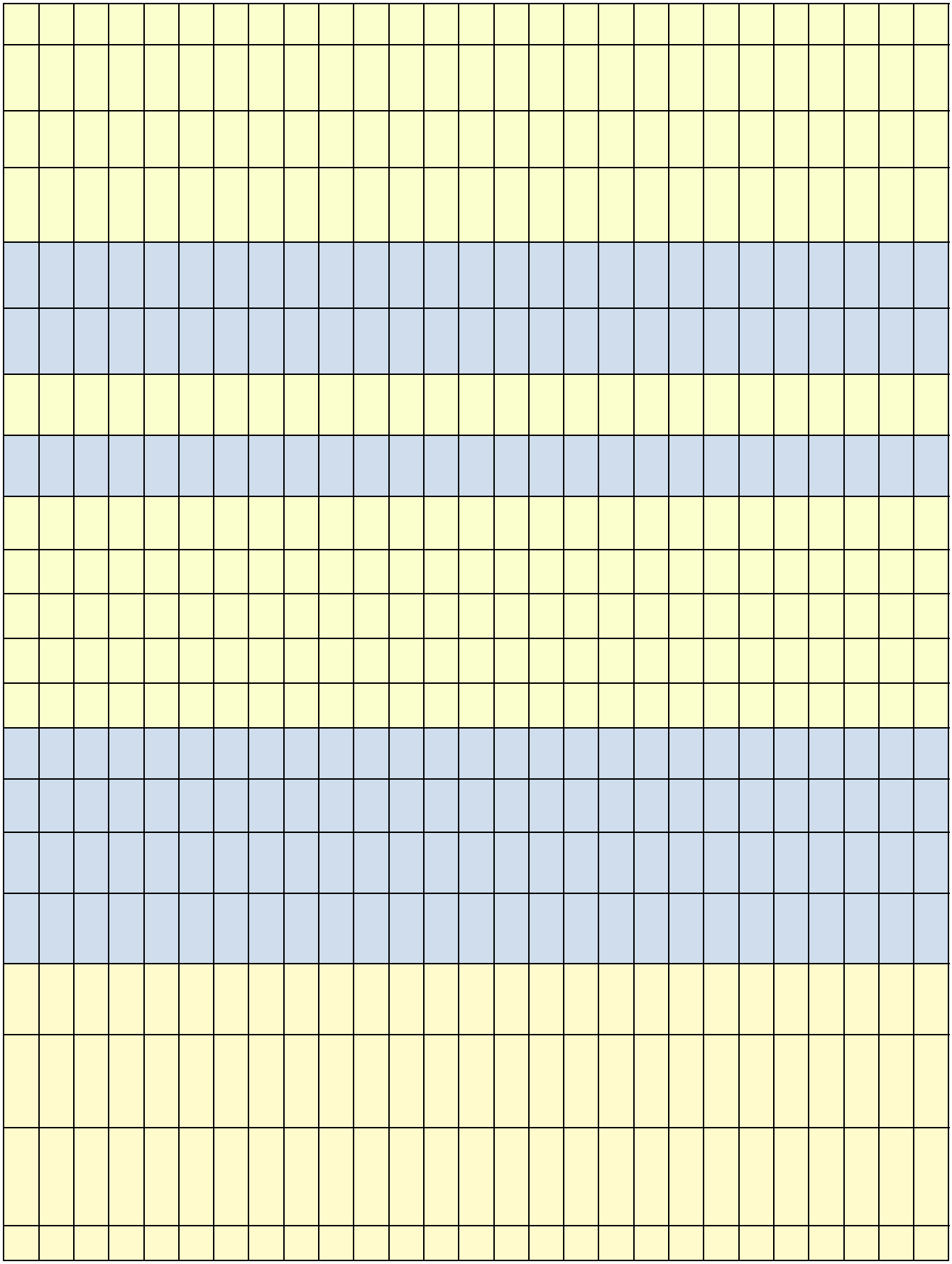
25	Principal Social Worker	To provide quality assurance and plan workforce development for social care	Enablers for Integration	Implementation & Change Mgt capacity				Not applicable	Low	Low	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£60,000	Existing
26	Commissioning & Analytics Support	To provide multi-disciplinary and multi-agency commissioning support for BCF Plan Programme	Enablers for Integration	Implementation & Change Mgt capacity				Medium	Medium	Medium	Medium	Social Care		Joint	50.0%	50.0%	Local Authority	Minimum CCG Contribution	£286,721	Existing
27	Increase bed-based capacity in intermediate care	Additional intermediate care beds in care home to better rehabilitate and assess move on of individuals' needs via MDT approach	Intermediate Care Services	Bed Based - Step Up/Down		No. of beds	2.0	Medium	High	High	Medium	Social Care		LA			Private Sector	Minimum CCG Contribution	£155,000	New
28	Expand Rapid Response service via dedicated worker in NMUH Frailty Team & ED	Embed Rapid Response Nurse in NMUH to support their 'Frailty Hot Floor' model to ensure patients return home from A&E quickly avoiding admission.	Intermediate Care Services	Rapid / Crisis Response				High	Low	High	Medium	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£36,000	New
29	Additional short-term intensive packages of care to support people to return home from hospital	Increase number of high-intensity packages of care available to facilitate 'Home First' patient discharge in response to demand, particularly to support 7 day discharges	Intermediate Care Services	Rapid / Crisis Response				Low	High	High	Low	Social Care		LA			Private Sector	Minimum CCG Contribution	£42,000	New
30	Increase Single Point of Access function to meet demand	Two additional social care professionals in SPA to support increased demand from hospital	Integrated Care Planning and Navigation	Single Point of Access				Low	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£58,000	New
31	Simplified Discharge Nurse working in Single Point of Access	Embed CHC nurse into integrated SPA to support clinical triaging and oversight of cases, including in terms of managing CHC cases	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Low	High	High	Low	Continuing Care		CCG			NHS Community Provider	Minimum CCG Contribution	£36,000	New
32	Increased social worker capacity for complex cases	Increase social worker capacity to better assess and manage more complex cases including those eligible for CHC	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Low	Medium	High	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£26,000	New
33	Increased investment in End of Life Nursing Care and other EOL services	Investment in out-of-hours nursing services for end of life patients to support advance care plan delivery and reduce risk of individuals attending hospital	Personalised Care at Home			Hours of Care	2,230.0	Medium	Low	Medium	Not applicable	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£111,881	New

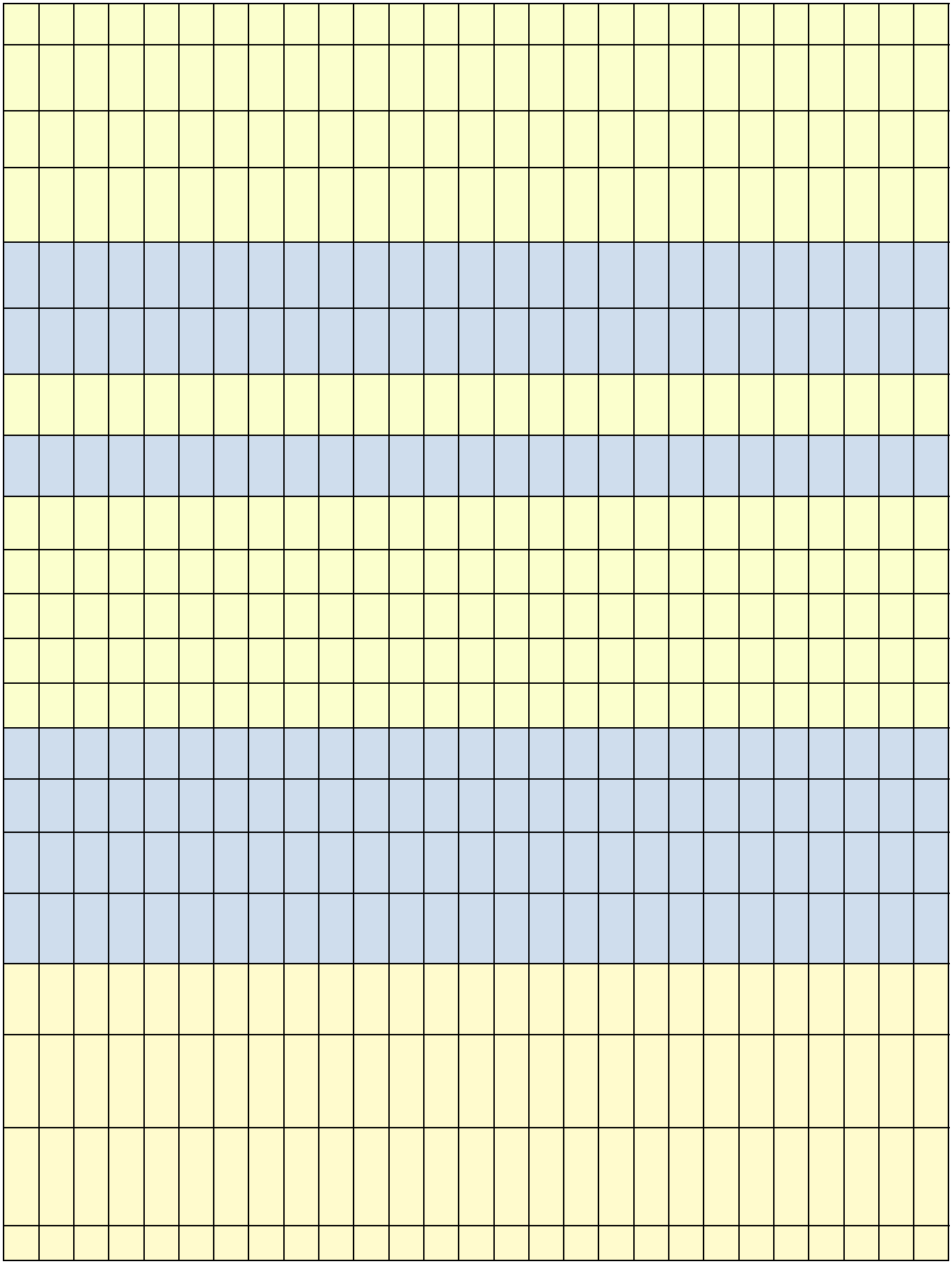
34	Integrated Health, Housing, Finance and Care Early Intervention Solutions	Solutions to provide early help to people to help manage finances, housing health, well-being & independence via integrating community-facing solutions such as Connected Communities in health facilities, e.g. acute	Prevention / Early Intervention	Social Prescribing				Low	Not applicable	Low	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£159,000	New
35	Funding for step down flats	Investment in increase capacity for step down flats for hospital discharge patients needing reablement and cannot return home	Housing Related Schemes					Not applicable	Medium	Medium	Medium	Social Care		LA			Local Authority	Winter Pressures Grant	£160,866	Existing
36	Additional intermediate care beds	Intermediate care rehab beds at care home supported by	Intermediate Care Services	Bed Based - Step Up/Down		No. of beds	10.0	Low	High	High	Medium	Social Care		LA			Private Sector	Winter Pressures Grant	£539,936	Existing
37	Additional Long Term Packages of Care for Individuals	Social care packages of care to facilitate hospital discharge over	Home Care or Domiciliary Care			Packages	100.0	Medium	High	High	Not applicable	Social Care		LA			Private Sector	Winter Pressures Grant	£447,400	Existing
38	IBCF Market Management	Staff and other resources to manage brokerage and quality	Enablers for Integration	Market development (inc Vol sector)				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£1,255,481	Existing

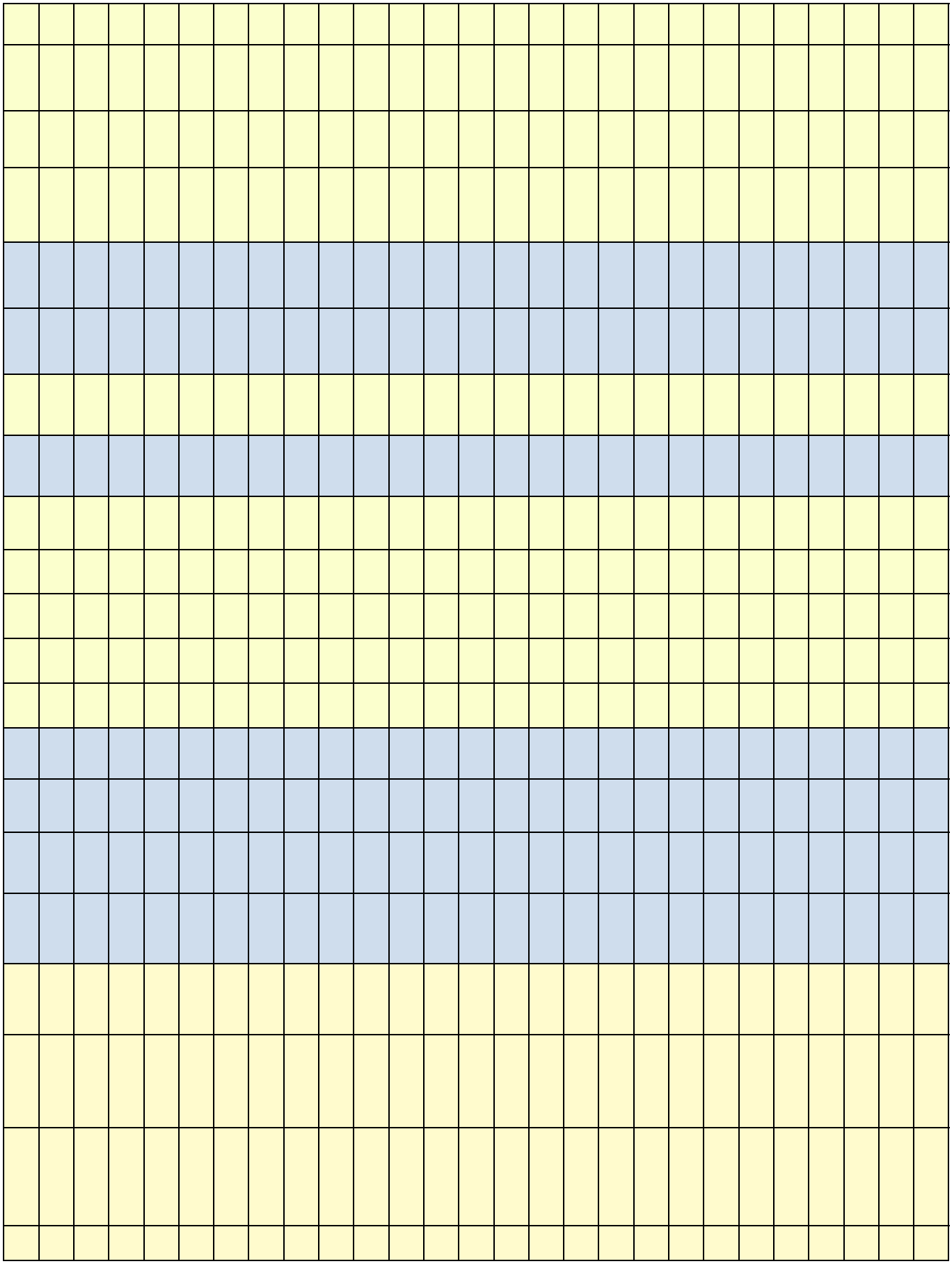


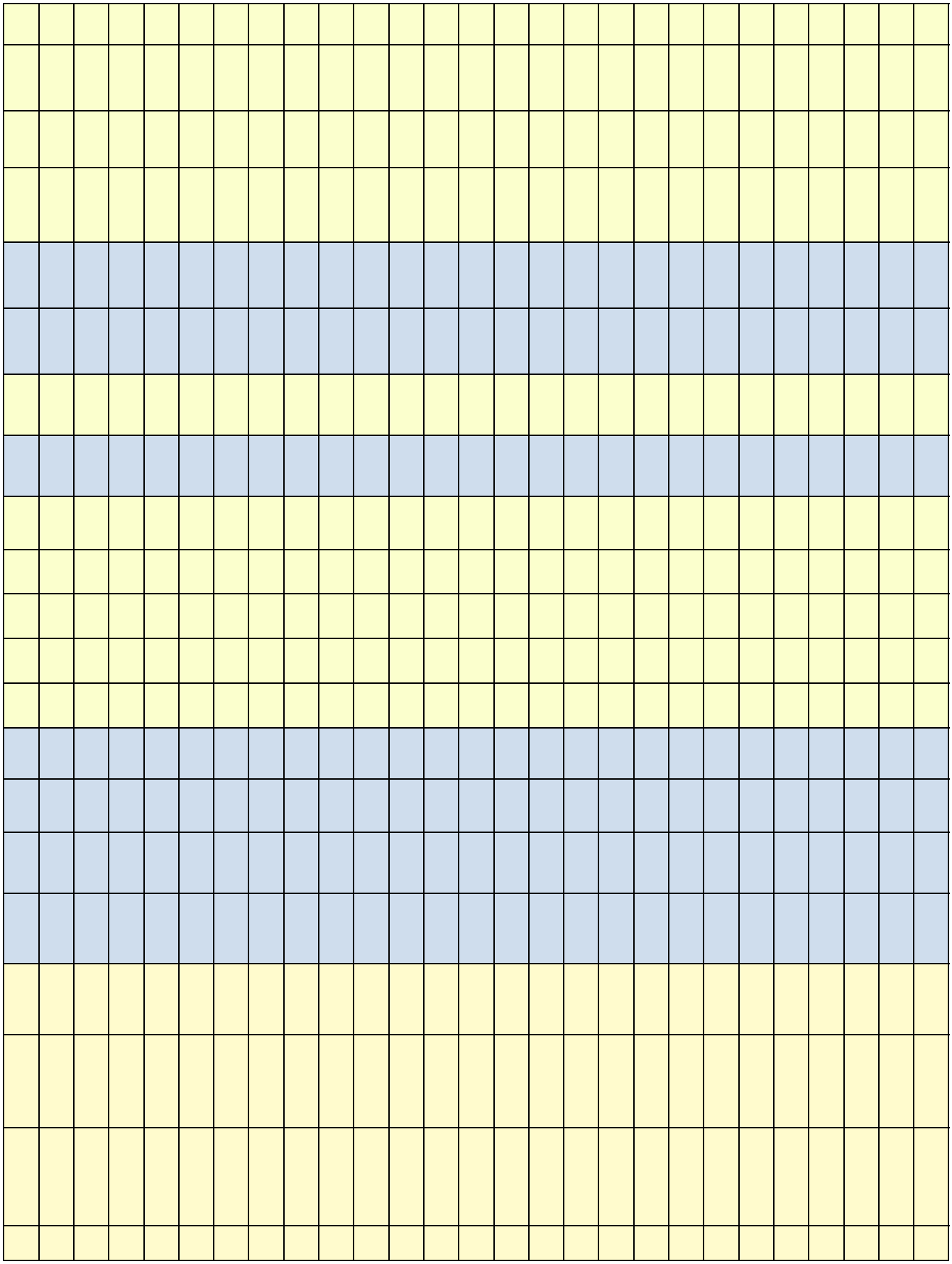


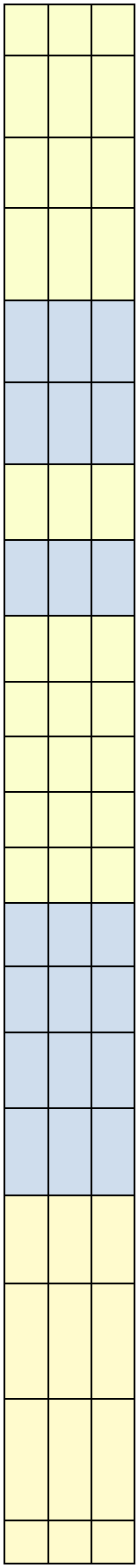












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Scheme Type	Description	Sub Type
Assistive Technologies and Equipment	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Digital participation services).	Telecare Wellness Services Digital Participation Services Community Based Equipment Other
Care Act Implementation Related Duties	Funding planned towards the implementation of Care Act related duties.	Deprivation of Liberty Safeguards (DoLS) Other
Carers Services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. This also includes the implementation of the Care Act as a sub-type.	Carer Advice and Support Respite Services Other
Community Based Schemes	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood level (eg: Integrated Neighbourhood Teams)	
DFG Related Schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.	Adaptations Other

Enablers for Integration	Schemes that build and develop the enabling foundations of health and social care integration encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.	
High Impact Change Model for Managing Transfer of Care	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM as such, is included in this section.	Chg 1. Early Discharge Planning Chg 2. Systems to Monitor Patient Flow Chg 3. Multi-Disciplinary/Multi-Agency Discharge Teams Chg 4. Home First / Discharge to Access Chg 5. Seven-Day Services Chg 6. Trusted Assessors Chg 7. Focus on Choice Chg 8. Enhancing Health in Care Homes Other - 'Red Bag' scheme Other approaches
Home Care or Domiciliary Care	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.	
Housing Related Schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	

Integrated Care Planning and Navigation	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches like Single Point of Access (SPoA) and linking people to community assets. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams and the HICM for managing discharges, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.	Care Coordination Single Point of Access Care Planning, Assessment and Review Other
Intermediate Care Services	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.	Bed Based - Step Up/Down Rapid / Crisis Response Reablement/Rehabilitation Services Other

Personalised Budgeting and Commissioning	Various person centred approaches to commissioning and budgeting.	Personal Health Budgets Integrated Personalised Commissioning Direct Payments Other
Personalised Care at Home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.	
Prevention / Early Intervention	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.	Social Prescribing Risk Stratification Choice Policy Other
Residential Placements	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.	Supported Living Learning Disability Extra Care Care Home Nursing Home Other
Other	Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.	

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Better Care Fund 2019/20 Template

7. High Impact Change Model

Selected Health and Wellbeing Board: Haringey

Explain your priorities for embedding elements of the High Impact Change Model for Managing Transfers of Care locally, including: - Current performance issues to be addressed - The changes that you are looking to embed further - including any changes in the context of commitments to reablement and Enhanced Health in Care Homes in the NHS Long-Term Plan - Anticipated improvements from this work
Our acute Trusts, NMUH and WHT, supported by their health & care partners, led Winter Reviews in 2019/20 to better understand what went well last winter and how we could plan for summer and winter 2019. We identified a number of improvements that form part of our plans in our AW Strategy, including investment in several schemes funded via BCF Plan. These improvements will be progressed as part of the wider development of the Frailty Network NMUH Urgent & Emergency Board will oversee (see

		Please enter current position of maturity	Please enter the maturity level planned to be reached by March 2020	If the planned maturity level for 2019/20 is below established, please state reasons behind that?
Chg 1	Early discharge planning	Plans in place	Established	
Chg 2	Systems to monitor patient flow	Plans in place	Established	
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Established	Established	
Chg 4	Home first / discharge to assess	Established	Established	
Chg 5	Seven-day service	Plans in place	Established	
Chg 6	Trusted assessors	Plans in place	Established	
Chg 7	Focus on choice	Plans in place	Established	
Chg 8	Enhancing health in care homes	Plans in place	Established	

Better Care Fund 2019/20 Template

8. Metrics

Selected Health and Wellbeing Board: Haringey

8.1 Non-Elective Admissions

	19/20 Plan	Overview Narrative	
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.	There was a greater increase in 65+ admissions in 2018/19 than any other population. Development of our system-aligned and multi-agency care network, particularly our Frailty Network, should impact on NEL admissions in 2019/20 (see Narrative). Three elements of our plans will impact on NEA: - Our early intervention & preventative solutions targeted at 'at risk' patient groups (e.g. older people) at a neighbourhood footprint will mean a greater number of people will be identified and connected into community solutions to keep them fit, well and stimulated. We will focus on supporting self-care, and help them to better	**Please set out the overall plan in the HWB area for reducing Non-Elective Admissions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

Plans are yet to be finalised and signed-off so are subject to change; **for the latest version of the NEA CCG operating plans at your HWB footprint please contact your local Better Care Manager (BCM)** in the first instance or write in to the support inbox:
ENGLAND.bettercaresupport@nhs.net

8.2 Delayed Transfers of Care

	19/20 Plan	Overview Narrative	
Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	17.0	Haringey has a well-integrated and effective solution to reducing delayed transfers of care. Our Discharge-to-Assess (D2A) process has been successful and resulted in a consistent year-on-year reductions in delays over the last 2 years, e.g. there was a 21% reduction in DTOC days between 2017/18 and 2018/19. In 2019/20, we will expand resources to support discharge planning and onward patient management including System Resilience/WG funding. Improvements include: • Hospital Discharge Preparation: The planned development of NMUH's 'Frailty Hot Floor' will better manage patient flow for older people. NMUH has also invested in additional resources to support its internal discharge processes and liaison with patients for those patients who with the most complex needs (and are most likely to	**Please set out the overall plan in the HWB area for reducing Delayed Transfers of Care to meet expectations set for your area. This should include any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric. Include in this, your agreed plan for using the Winter Pressures grant funding to support the local health and care system to manage demand pressures on the NHS, with particular reference to seasonal winter pressures.**

Please note that the plan figure for Greater Manchester has been combined, for HWBs in Greater Manchester please comment on individuals HWBs rather than Greater Manchester as a whole.
Please note that due to the merger of Bournemouth, Christchurch and Poole to a new Local Authority will mean that planning information from 2018/19 will not reflect the present geographies.

8.3 Residential Admissions

		18/19 Plan	19/20 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	476	468	In 2019/20 we have or intend to: - Work with NMUH and WHT and our Trusted Assessors as part of our continued improvement to Simplified Discharge to better identify the optimum solution for older patients with complex needs with potential to return home with support rather than be placed in a
	Numerator	130	130	
	Denominator	27,326	27,767	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2016 based Sub-National Population Projections for Local Authorities in England;

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

8.4 Reablement

		18/19 Plan	19/20 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	81.8%	80.0%	In 2019/20 we will continue to invest in reablement services funded via the BCF Plan. We will: - Work with NMUH and WHT as part of our continued improvement to Simplified Discharge to better identify the optimum solution for older patients who have the potential to return home as part of our 'Home First'
	Numerator	82	80	
	Denominator	100	100	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

Better Care Fund 2019/20 Template

9. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Haringey

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	**Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted?** Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Do the governance arrangements described support collaboration and integrated care? Where the strategic narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure, metric and HICM sections of the plan been submitted for each HWB concerned?	Yes	Ageing Well Strategy (Draft) BCF Plan Narrative 2017-19		
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that covers:** - Person centred care, including approaches to delivering joint assessments, promoting choice, independence and personalised care? - A clear approach at HWB level for integrating services that supports the overall approach to integrated care and confirmation that the approach supports delivery at the interface between health and social care? - A description of how the local BCF plan and other integration plans e.g. STP/ICSs align? - Is there a description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? This should include confirmation that equality impacts of the local BCF plan have been considered, a description of local priorities related to health inequality and equality that the BCF plan will contribute to addressing. Has the plan summarised any changes from the previous planning period? And noted (where appropriate) any lessons learnt?	Yes	Ageing Well Strategy (Draft)		
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home. In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Yes			
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Yes			
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Yes			
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	**Is there a plan for implementing the High Impact Change Model for managing transfers of care?**	**Does the BCF plan demonstrate a continued plan in place for implementing the High Impact Change Model for Managing Transfers of Care?** Has the area confirmed the current level of implementation and the planned level at March 2020 for all eight changes? Is there an accompanying overall narrative setting out the priorities and approach for ongoing implementation of the HICM? Does the level of ambition set out for implementing the HICM changes correspond to performance challenges in the system? If the current level of implementation is below established for any of the HICM changes, has the plan included a clear explanation and set of actions towards establishing the change as soon as possible in 2019-20?	Yes	Ageing Well Strategy (Draft)		

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Have the planned schemes been assigned to the metrics they are aiming to make an impact on? Expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (tick-box) Is there an agreed plan for use of the Winter Pressures grant that sets out how the money will be used to address expected demand pressures on the Health system over Winter? **Has funding for the following from the CCG contribution been identified for the area?** - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Yes			
	PR8	**Indication of outputs for specified scheme types**	Has the area set out the outputs corresponding to the planned scheme types (Note that this is only for where any of the specified set of scheme types requiring outputs are planned)? (auto-validated)	Yes			
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric? Is there a proportionate range of scheme types and spend included in the expenditure section of the plan to support delivery of the metric ambitions for each of the metrics? Do the narrative plans for each metric set out clear and ambitious approaches to delivering improvements? **Have stretching metrics been agreed locally for:** - Metric 2: Long term admission to residential and nursing care homes - Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement	Yes	Finance & Performance Partnership Board Performance Update Q4 2018/19 (which set out proposed targets for 2019/20) - Jun-19 papers & minutes		

CCG to Health and Well-Being Board Mapping for 2019/20

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	90.7%	87.4%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	6.9%	8.3%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.4%	0.6%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.5%	3.5%
E09000002	Barking and Dagenham	08W	NHS Waltham Forest CCG	0.1%	0.1%
E09000003	Barnet	07M	NHS Barnet CCG	91.1%	92.1%
E09000003	Barnet	07P	NHS Brent CCG	2.0%	1.8%
E09000003	Barnet	07R	NHS Camden CCG	1.0%	0.7%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000003	Barnet	07X	NHS Enfield CCG	3.0%	2.4%
E09000003	Barnet	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000003	Barnet	08D	NHS Haringey CCG	2.2%	1.6%
E09000003	Barnet	08E	NHS Harrow CCG	1.2%	0.8%
E09000003	Barnet	06N	NHS Herts Valleys CCG	0.0%	0.1%
E09000003	Barnet	08H	NHS Islington CCG	0.2%	0.1%
E09000003	Barnet	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.6%	98.1%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.4%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.4%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11E	NHS Bath and North East Somerset CCG	93.5%	98.3%
E06000022	Bath and North East Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.9%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	99N	NHS Wiltshire CCG	0.1%	0.3%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.7%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	04G	NHS Nene CCG	0.2%	0.6%
E09000004	Bexley	07N	NHS Bexley CCG	93.4%	89.8%
E09000004	Bexley	07Q	NHS Bromley CCG	0.1%	0.1%
E09000004	Bexley	09J	NHS Dartford, Gravesham and Swanley CCG	1.4%	1.5%
E09000004	Bexley	08A	NHS Greenwich CCG	7.2%	8.4%
E09000004	Bexley	08L	NHS Lewisham CCG	0.1%	0.1%
E08000025	Birmingham	15E	NHS Birmingham and Solihull CCG	78.4%	81.7%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05J	NHS Redditch and Bromsgrove CCG	3.1%	0.4%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	39.2%	17.8%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	88.9%	95.8%
E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.7%	1.7%
E06000009	Blackpool	00R	NHS Blackpool CCG	86.4%	97.6%
E06000009	Blackpool	02M	NHS Fylde & Wyre CCG	2.1%	2.4%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.5%
E08000001	Bolton	00V	NHS Bury CCG	1.5%	1.0%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%
E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%
E06000058	Bournemouth, Christchurch and Poole	11J	NHS Dorset CCG	52.4%	99.7%
E06000058	Bournemouth, Christchurch and Poole	11A	NHS West Hampshire CCG	0.2%	0.3%
E06000036	Bracknell Forest	15A	NHS Berkshire West CCG	0.5%	2.0%
E06000036	Bracknell Forest	15D	NHS East Berkshire CCG	26.1%	96.9%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.0%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.2%	0.1%
E08000032	Bradford	02N	NHS Airedale, Wharfdale and Craven CCG	67.2%	18.4%
E08000032	Bradford	02W	NHS Bradford City CCG	98.9%	23.9%
E08000032	Bradford	02R	NHS Bradford Districts CCG	98.0%	56.3%
E08000032	Bradford	02T	NHS Calderdale CCG	0.2%	0.0%
E08000032	Bradford	15F	NHS Leeds CCG	0.9%	1.4%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.2%	0.0%
E09000005	Brent	07M	NHS Barnet CCG	2.3%	2.4%
E09000005	Brent	07P	NHS Brent CCG	89.7%	86.4%
E09000005	Brent	07R	NHS Camden CCG	3.9%	2.8%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.3%	0.7%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	0.6%	0.4%
E09000005	Brent	08E	NHS Harrow CCG	5.9%	4.0%
E09000005	Brent	08Y	NHS West London (K&C & QPP) CCG	4.3%	2.7%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.9%	99.7%
E06000043	Brighton and Hove	09G	NHS Coastal West Sussex CCG	0.1%	0.2%
E06000043	Brighton and Hove	99K	NHS High Weald Lewes Havens CCG	0.3%	0.1%
E06000023	Bristol, City of	11E	NHS Bath and North East Somerset CCG	0.1%	0.0%
E06000023	Bristol, City of	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	49.3%	100.0%
E09000006	Bromley	07N	NHS Bexley CCG	0.2%	0.1%
E09000006	Bromley	07Q	NHS Bromley CCG	94.6%	95.1%
E09000006	Bromley	07V	NHS Croydon CCG	1.2%	1.4%
E09000006	Bromley	08A	NHS Greenwich CCG	1.4%	1.2%
E09000006	Bromley	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000006	Bromley	08K	NHS Lambeth CCG	0.1%	0.2%
E09000006	Bromley	08L	NHS Lewisham CCG	1.9%	1.8%
E09000006	Bromley	99J	NHS West Kent CCG	0.1%	0.2%

E10000002	Buckinghamshire	06F	NHS Bedfordshire CCG	0.6%	0.5%
E10000002	Buckinghamshire	14Y	NHS Buckinghamshire CCG	94.4%	94.9%
E10000002	Buckinghamshire	15D	NHS East Berkshire CCG	1.4%	1.2%
E10000002	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E10000002	Buckinghamshire	08G	NHS Hillingdon CCG	0.7%	0.4%
E10000002	Buckinghamshire	04F	NHS Milton Keynes CCG	1.3%	0.7%
E10000002	Buckinghamshire	04G	NHS Nene CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.6%	0.7%
E08000002	Bury	00T	NHS Bolton CCG	0.8%	1.2%
E08000002	Bury	00V	NHS Bury CCG	94.0%	94.3%
E08000002	Bury	01A	NHS East Lancashire CCG	0.0%	0.2%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	14L	NHS Manchester CCG	0.6%	2.0%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.9%
E08000033	Calderdale	02R	NHS Bradford Districts CCG	0.4%	0.6%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.4%	98.9%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.3%	0.3%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.7%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	71.8%	96.7%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.8%	0.7%
E10000003	Cambridgeshire	99D	NHS South Lincolnshire CCG	0.3%	0.0%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07J	NHS West Norfolk CCG	1.6%	0.4%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	4.0%	1.4%
E09000007	Camden	07M	NHS Barnet CCG	0.2%	0.3%
E09000007	Camden	07P	NHS Brent CCG	1.3%	1.9%
E09000007	Camden	07R	NHS Camden CCG	83.9%	88.9%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	5.6%	4.8%
E09000007	Camden	08C	NHS Hammersmith and Fulham CCG	0.4%	0.3%
E09000007	Camden	08D	NHS Haringey CCG	0.5%	0.6%
E09000007	Camden	08H	NHS Islington CCG	3.2%	3.0%
E09000007	Camden	08Y	NHS West London (K&C & QPP) CCG	0.3%	0.2%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.6%	95.0%
E06000056	Central Bedfordshire	14Y	NHS Buckinghamshire CCG	0.8%	1.5%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.9%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.3%	1.9%
E06000056	Central Bedfordshire	04F	NHS Milton Keynes CCG	0.1%	0.1%
E06000049	Cheshire East	15M	NHS Derby and Derbyshire CCG	0.1%	0.3%
E06000049	Cheshire East	01C	NHS Eastern Cheshire CCG	96.4%	50.2%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.1%	0.6%
E06000049	Cheshire East	01R	NHS South Cheshire CCG	98.6%	45.8%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.2%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02D	NHS Vale Royal CCG	0.6%	0.2%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	02F	NHS West Cheshire CCG	1.9%	1.2%
E06000050	Cheshire West and Chester	01C	NHS Eastern Cheshire CCG	1.2%	0.7%
E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	01R	NHS South Cheshire CCG	0.5%	0.2%
E06000050	Cheshire West and Chester	02D	NHS Vale Royal CCG	99.4%	29.5%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	02F	NHS West Cheshire CCG	96.9%	69.1%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.3%
E09000001	City of London	07R	NHS Camden CCG	0.2%	7.0%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.1%	2.5%
E09000001	City of London	07T	NHS City and Hackney CCG	1.8%	70.4%
E09000001	City of London	08C	NHS Hammersmith and Fulham CCG	0.0%	1.2%
E09000001	City of London	08H	NHS Islington CCG	0.1%	3.6%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.4%	15.0%
E09000001	City of London	08Y	NHS West London (K&C & QPP) CCG	0.0%	0.2%
E06000052	Cornwall & Scilly	15N	NHS Devon CCG	0.3%	0.6%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000047	County Durham	00D	NHS Durham Dales, Easington and Sedgefield CCG	97.0%	52.4%
E06000047	County Durham	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.0%
E06000047	County Durham	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.1%	0.0%
E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	00J	NHS North Durham CCG	96.7%	46.3%
E06000047	County Durham	00P	NHS Sunderland CCG	1.2%	0.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.5%	99.8%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.4%	0.2%
E09000008	Croydon	07Q	NHS Bromley CCG	1.6%	1.3%
E09000008	Croydon	07V	NHS Croydon CCG	95.3%	93.2%
E09000008	Croydon	09L	NHS East Surrey CCG	2.9%	1.3%
E09000008	Croydon	08C	NHS Hammersmith and Fulham CCG	0.2%	0.0%
E09000008	Croydon	08K	NHS Lambeth CCG	3.0%	3.0%
E09000008	Croydon	08R	NHS Merton CCG	0.8%	0.4%
E09000008	Croydon	08T	NHS Sutton CCG	0.8%	0.4%
E09000008	Croydon	08X	NHS Wandsworth CCG	0.5%	0.5%

E10000006	Cumbria	01K	NHS Morecambe Bay CCG	54.0%	36.6%
E10000006	Cumbria	01H	NHS North Cumbria CCG	99.9%	63.4%
E06000005	Darlington	00C	NHS Darlington CCG	98.2%	96.1%
E06000005	Darlington	00D	NHS Durham Dales, Easington and Sedgefield CCG	1.2%	3.2%
E06000005	Darlington	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.2%
E06000005	Darlington	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.6%
E06000015	Derby	15M	NHS Derby and Derbyshire CCG	26.5%	100.0%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	15M	NHS Derby and Derbyshire CCG	70.9%	92.6%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	7.9%	1.4%
E10000007	Derbyshire	01C	NHS Eastern Cheshire CCG	0.3%	0.0%
E10000007	Derbyshire	04E	NHS Mansfield and Ashfield CCG	2.1%	0.5%
E10000007	Derbyshire	04L	NHS Nottingham North and East CCG	0.3%	0.0%
E10000007	Derbyshire	04M	NHS Nottingham West CCG	5.1%	0.6%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.4%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	13.9%	4.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.5%	0.2%
E10000008	Devon	15N	NHS Devon CCG	65.7%	99.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.3%	0.3%
E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.5%	0.6%
E08000017	Doncaster	02X	NHS Doncaster CCG	96.8%	97.8%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.2%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.2%
E06000059	Dorset	11J	NHS Dorset CCG	46.0%	95.6%
E06000059	Dorset	11X	NHS Somerset CCG	0.6%	0.9%
E06000059	Dorset	11A	NHS West Hampshire CCG	1.7%	2.5%
E06000059	Dorset	99N	NHS Wiltshire CCG	0.7%	1.0%
E08000027	Dudley	15E	NHS Birmingham and Solihull CCG	0.1%	0.6%
E08000027	Dudley	05C	NHS Dudley CCG	93.3%	90.7%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	3.9%	6.9%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.8%	1.5%
E08000027	Dudley	06D	NHS Wyre Forest CCG	0.8%	0.3%
E09000009	Ealing	07P	NHS Brent CCG	1.8%	1.6%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000009	Ealing	07W	NHS Ealing CCG	86.9%	90.4%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.5%	3.1%
E09000009	Ealing	08E	NHS Harrow CCG	0.4%	0.3%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.7%	0.5%
E09000009	Ealing	07Y	NHS Hounslow CCG	4.7%	3.5%
E09000009	Ealing	08Y	NHS West London (K&C & QPP) CCG	0.7%	0.4%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.3%	85.1%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	9.2%	7.9%
E06000011	East Riding of Yorkshire	03M	NHS Scarborough and Ryedale CCG	0.7%	0.2%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.6%	6.8%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.0%	0.6%
E10000011	East Sussex	09F	NHS Eastbourne, Hailsham and Seaford CCG	100.0%	34.7%
E10000011	East Sussex	09P	NHS Hastings and Rother CCG	99.7%	33.3%
E10000011	East Sussex	99K	NHS High Weald Lewes Havens CCG	98.1%	29.6%
E10000011	East Sussex	09X	NHS Horsham and Mid Sussex CCG	2.8%	1.2%
E10000011	East Sussex	99J	NHS West Kent CCG	0.8%	0.7%
E09000010	Enfield	07M	NHS Barnet CCG	1.0%	1.2%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E09000010	Enfield	07X	NHS Enfield CCG	95.2%	90.9%
E09000010	Enfield	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000010	Enfield	08D	NHS Haringey CCG	7.7%	6.9%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%
E09000010	Enfield	08H	NHS Islington CCG	0.2%	0.1%
E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.1%	0.0%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.2%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.2%	11.5%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.6%	0.6%
E10000012	Essex	08F	NHS Havering CCG	0.3%	0.0%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.5%
E10000012	Essex	06T	NHS North East Essex CCG	98.6%	22.7%
E10000012	Essex	08N	NHS Redbridge CCG	2.9%	0.6%
E10000012	Essex	99G	NHS Southend CCG	3.3%	0.4%
E10000012	Essex	07G	NHS Thurrock CCG	1.4%	0.2%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	07H	NHS West Essex CCG	97.1%	19.8%
E10000012	Essex	07K	NHS West Suffolk CCG	2.3%	0.4%

E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	38.5%	97.7%
E08000037	Gateshead	00J	NHS North Durham CCG	0.9%	1.2%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.8%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E08000037	Gateshead	00P	NHS Sunderland CCG	0.0%	0.1%
E10000013	Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.1%	0.1%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.6%	98.6%
E10000013	Gloucestershire	05F	NHS Herefordshire CCG	0.5%	0.1%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.6%	0.2%
E10000013	Gloucestershire	05T	NHS South Worcestershire CCG	1.1%	0.5%
E10000013	Gloucestershire	99N	NHS Wiltshire CCG	0.2%	0.2%
E09000011	Greenwich	07N	NHS Bexley CCG	5.1%	4.2%
E09000011	Greenwich	07Q	NHS Bromley CCG	1.1%	1.3%
E09000011	Greenwich	08A	NHS Greenwich CCG	89.2%	89.3%
E09000011	Greenwich	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000011	Greenwich	08L	NHS Lewisham CCG	4.4%	4.9%
E09000011	Greenwich	08Q	NHS Southwark CCG	0.1%	0.1%
E09000012	Hackney	07R	NHS Camden CCG	0.7%	0.7%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.2%	93.8%
E09000012	Hackney	08C	NHS Hammersmith and Fulham CCG	0.5%	0.4%
E09000012	Hackney	08D	NHS Haringey CCG	0.6%	0.7%
E09000012	Hackney	08H	NHS Islington CCG	4.6%	3.7%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.5%	0.6%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.5%
E06000006	Halton	01J	NHS Knowsley CCG	0.2%	0.3%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E06000006	Halton	02E	NHS Warrington CCG	0.7%	1.1%
E06000006	Halton	02F	NHS West Cheshire CCG	0.6%	1.1%
E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07R	NHS Camden CCG	0.1%	0.1%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.5%	2.5%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.6%	1.1%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	82.8%	87.6%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.7%
E09000013	Hammersmith and Fulham	08X	NHS Wandsworth CCG	0.2%	0.3%
E09000013	Hammersmith and Fulham	08Y	NHS West London (K&C & QPP) CCG	6.5%	7.2%
E10000014	Hampshire	15A	NHS Berkshire West CCG	1.7%	0.6%
E10000014	Hampshire	09G	NHS Coastal West Sussex CCG	0.2%	0.1%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	15D	NHS East Berkshire CCG	0.2%	0.0%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.5%	14.3%
E10000014	Hampshire	09N	NHS Guildford and Waverley CCG	2.9%	0.5%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.5%	12.4%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.2%	15.9%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.4%	0.7%
E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.6%	14.6%
E10000014	Hampshire	10X	NHS Southampton CCG	5.1%	1.0%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.8%	0.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.1%
E10000014	Hampshire	99N	NHS Wiltshire CCG	1.3%	0.4%
E09000014	Haringey	07M	NHS Barnet CCG	1.0%	1.4%
E09000014	Haringey	07R	NHS Camden CCG	0.6%	0.6%
E09000014	Haringey	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.1%	3.2%
E09000014	Haringey	07X	NHS Enfield CCG	1.3%	1.4%
E09000014	Haringey	08C	NHS Hammersmith and Fulham CCG	0.4%	0.3%
E09000014	Haringey	08D	NHS Haringey CCG	87.7%	91.0%
E09000014	Haringey	08H	NHS Islington CCG	2.5%	2.1%
E09000015	Harrow	07M	NHS Barnet CCG	4.3%	6.4%
E09000015	Harrow	07P	NHS Brent CCG	3.6%	4.8%
E09000015	Harrow	07W	NHS Ealing CCG	1.3%	2.1%
E09000015	Harrow	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000015	Harrow	08E	NHS Harrow CCG	89.7%	84.1%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.5%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.8%	2.0%
E09000015	Harrow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%

E06000001	Hartlepool	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.6%
E06000001	Hartlepool	00K	NHS Hartlepool and Stockton-On-Tees CCG	32.4%	99.4%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	3.5%	2.9%
E09000016	Havering	08F	NHS Havering CCG	91.7%	96.2%
E09000016	Havering	08M	NHS Newham CCG	0.1%	0.2%
E09000016	Havering	08N	NHS Redbridge CCG	0.6%	0.7%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.0%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	0.9%
E06000019	Herefordshire, County of	05F	NHS Herefordshire CCG	98.2%	97.3%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	05T	NHS South Worcestershire CCG	0.8%	1.3%
E10000015	Hertfordshire	07M	NHS Barnet CCG	0.2%	0.0%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000015	Hertfordshire	14Y	NHS Buckinghamshire CCG	0.2%	0.1%
E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	97.0%	46.5%
E10000015	Hertfordshire	07X	NHS Enfield CCG	0.5%	0.1%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.6%	0.1%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.0%	50.7%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.2%	0.6%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.8%	0.2%
E09000017	Hillingdon	14Y	NHS Buckinghamshire CCG	0.0%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.2%	6.9%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.2%	1.8%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.3%	89.8%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.1%	1.0%
E09000018	Hounslow	07W	NHS Ealing CCG	5.4%	7.4%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.2%	0.9%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.2%	87.1%
E09000018	Hounslow	09Y	NHS North West Surrey CCG	0.3%	0.4%
E09000018	Hounslow	08P	NHS Richmond CCG	5.7%	3.8%
E09000018	Hounslow	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07R	NHS Camden CCG	4.9%	5.4%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.5%	0.5%
E09000019	Islington	07T	NHS City and Hackney CCG	3.4%	4.2%
E09000019	Islington	08C	NHS Hammersmith and Fulham CCG	0.5%	0.5%
E09000019	Islington	08D	NHS Haringey CCG	1.2%	1.5%
E09000019	Islington	08H	NHS Islington CCG	89.1%	87.9%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	07R	NHS Camden CCG	0.2%	0.3%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.0%	5.4%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	1.2%	1.7%
E09000020	Kensington and Chelsea	08Y	NHS West London (K&C & QPP) CCG	63.9%	92.5%
E10000016	Kent	09C	NHS Ashford CCG	100.0%	8.3%
E10000016	Kent	07N	NHS Bexley CCG	1.3%	0.2%
E10000016	Kent	07Q	NHS Bromley CCG	0.9%	0.2%
E10000016	Kent	09E	NHS Canterbury and Coastal CCG	100.0%	14.1%
E10000016	Kent	09J	NHS Dartford, Gravesham and Swanley CCG	98.3%	16.5%
E10000016	Kent	09L	NHS East Surrey CCG	0.1%	0.0%
E10000016	Kent	08A	NHS Greenwich CCG	0.2%	0.0%
E10000016	Kent	09P	NHS Hastings and Rother CCG	0.3%	0.0%
E10000016	Kent	99K	NHS High Weald Lewes Havens CCG	0.6%	0.0%
E10000016	Kent	09W	NHS Medway CCG	6.1%	1.1%
E10000016	Kent	10A	NHS South Kent Coast CCG	100.0%	12.9%
E10000016	Kent	10D	NHS Swale CCG	99.8%	7.1%
E10000016	Kent	10E	NHS Thanet CCG	100.0%	9.1%
E10000016	Kent	99J	NHS West Kent CCG	98.7%	30.4%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.4%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	90.8%	98.6%
E09000021	Kingston upon Thames	08J	NHS Kingston CCG	86.9%	95.9%
E09000021	Kingston upon Thames	08R	NHS Merton CCG	1.1%	1.3%
E09000021	Kingston upon Thames	08P	NHS Richmond CCG	0.7%	0.8%
E09000021	Kingston upon Thames	99H	NHS Surrey Downs CCG	0.7%	1.2%
E09000021	Kingston upon Thames	08T	NHS Sutton CCG	0.1%	0.1%
E09000021	Kingston upon Thames	08X	NHS Wandsworth CCG	0.3%	0.7%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02R	NHS Bradford Districts CCG	1.0%	0.7%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.4%	0.7%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.6%	54.7%
E08000034	Kirklees	15F	NHS Leeds CCG	0.1%	0.3%
E08000034	Kirklees	03J	NHS North Kirklees CCG	98.9%	42.4%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.5%	1.3%

E08000011	Knowsley	01F	NHS Halton CCG	1.0%	0.8%
E08000011	Knowsley	01J	NHS Knowsley CCG	86.8%	88.2%
E08000011	Knowsley	99A	NHS Liverpool CCG	2.4%	8.0%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.1%	0.1%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.8%
E09000022	Lambeth	07R	NHS Camden CCG	0.2%	0.1%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	0.9%	0.6%
E09000022	Lambeth	07V	NHS Croydon CCG	0.7%	0.8%
E09000022	Lambeth	08C	NHS Hammersmith and Fulham CCG	0.6%	0.4%
E09000022	Lambeth	08K	NHS Lambeth CCG	85.5%	92.2%
E09000022	Lambeth	08R	NHS Merton CCG	1.0%	0.6%
E09000022	Lambeth	08Q	NHS Southwark CCG	1.9%	1.6%
E09000022	Lambeth	08X	NHS Wandsworth CCG	3.5%	3.7%
E09000022	Lambeth	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.0%
E10000017	Lancashire	02N	NHS Airedale, Wharfdale and Craven CCG	0.2%	0.0%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.1%	1.5%
E10000017	Lancashire	00R	NHS Blackpool CCG	13.6%	1.9%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01A	NHS East Lancashire CCG	99.0%	30.0%
E10000017	Lancashire	02M	NHS Fylde & Wyre CCG	97.9%	13.8%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	16.6%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.9%	0.2%
E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Morecambe Bay CCG	44.1%	12.1%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.2%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.5%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	96.9%	8.7%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.7%	0.2%
E08000035	Leeds	02N	NHS Airedale, Wharfdale and Craven CCG	0.1%	0.0%
E08000035	Leeds	02W	NHS Bradford City CCG	1.1%	0.2%
E08000035	Leeds	02R	NHS Bradford Districts CCG	0.5%	0.2%
E08000035	Leeds	15F	NHS Leeds CCG	97.7%	98.8%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.6%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.4%	0.6%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	2.1%	1.8%
E06000016	Leicester	04C	NHS Leicester City CCG	92.8%	95.5%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.8%	2.7%
E10000018	Leicestershire	03V	NHS Corby CCG	0.5%	0.0%
E10000018	Leicestershire	15M	NHS Derby and Derbyshire CCG	0.4%	0.6%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.5%	39.8%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.2%	4.1%
E10000018	Leicestershire	04N	NHS Rushcliffe CCG	5.4%	1.0%
E10000018	Leicestershire	04Q	NHS South West Lincolnshire CCG	5.6%	1.1%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	53.1%
E09000023	Lewisham	07Q	NHS Bromley CCG	1.4%	1.5%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000023	Lewisham	08A	NHS Greenwich CCG	2.1%	1.9%
E09000023	Lewisham	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000023	Lewisham	08K	NHS Lambeth CCG	0.3%	0.4%
E09000023	Lewisham	08L	NHS Lewisham CCG	91.5%	92.0%
E09000023	Lewisham	08Q	NHS Southwark CCG	3.9%	3.9%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.3%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.2%	0.1%
E10000019	Lincolnshire	03T	NHS Lincolnshire East CCG	99.2%	32.0%
E10000019	Lincolnshire	04D	NHS Lincolnshire West CCG	98.6%	29.9%
E10000019	Lincolnshire	04H	NHS Newark & Sherwood CCG	2.4%	0.4%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	4.9%	1.1%
E10000019	Lincolnshire	99D	NHS South Lincolnshire CCG	90.8%	19.6%
E10000019	Lincolnshire	04Q	NHS South West Lincolnshire CCG	93.3%	16.1%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.5%	2.7%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.4%	96.3%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.3%	1.0%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.3%	4.5%
E06000032	Luton	06P	NHS Luton CCG	97.3%	95.5%
E08000003	Manchester	00V	NHS Bury CCG	0.4%	0.1%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	14L	NHS Manchester CCG	90.9%	95.6%
E08000003	Manchester	00Y	NHS Oldham CCG	0.9%	0.4%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01W	NHS Stockport CCG	1.7%	0.8%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	4.0%	1.6%

E06000035	Medway	09J	NHS Dartford, Gravesham and Swanley CCG	0.2%	0.2%
E06000035	Medway	09W	NHS Medway CCG	93.9%	99.5%
E06000035	Medway	10D	NHS Swale CCG	0.2%	0.0%
E06000035	Medway	99J	NHS West Kent CCG	0.2%	0.3%
E09000024	Merton	07V	NHS Croydon CCG	0.5%	0.9%
E09000024	Merton	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000024	Merton	08J	NHS Kingston CCG	3.4%	2.9%
E09000024	Merton	08K	NHS Lambeth CCG	1.0%	1.7%
E09000024	Merton	08R	NHS Merton CCG	87.7%	80.9%
E09000024	Merton	08T	NHS Sutton CCG	3.3%	2.6%
E09000024	Merton	08X	NHS Wandsworth CCG	6.6%	10.8%
E06000002	Middlesbrough	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.2%	0.2%
E06000002	Middlesbrough	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.3%
E06000002	Middlesbrough	00M	NHS South Tees CCG	52.3%	99.5%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.2%
E06000042	Milton Keynes	04G	NHS Nene CCG	0.6%	1.3%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	58.9%	95.2%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	5.9%	4.0%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.8%	0.8%
E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.5%	0.3%
E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.0%
E09000025	Newham	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000025	Newham	08M	NHS Newham CCG	96.6%	97.3%
E09000025	Newham	08N	NHS Redbridge CCG	0.3%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.2%	0.2%
E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.4%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.7%	0.7%
E10000020	Norfolk	06M	NHS Great Yarmouth and Waveney CCG	47.7%	12.2%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000020	Norfolk	06V	NHS North Norfolk CCG	100.0%	18.6%
E10000020	Norfolk	06W	NHS Norwich CCG	100.0%	25.2%
E10000020	Norfolk	99D	NHS South Lincolnshire CCG	0.2%	0.0%
E10000020	Norfolk	06Y	NHS South Norfolk CCG	98.9%	24.1%
E10000020	Norfolk	07J	NHS West Norfolk CCG	98.4%	18.5%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.6%	0.7%
E06000012	North East Lincolnshire	03T	NHS Lincolnshire East CCG	0.8%	1.2%
E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.6%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.2%	0.2%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.2%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.1%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.1%
E06000013	North Lincolnshire	04D	NHS Lincolnshire West CCG	1.0%	1.3%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	94.9%	96.9%
E06000024	North Somerset	11E	NHS Bath and North East Somerset CCG	1.6%	1.5%
E06000024	North Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	21.8%	98.3%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.6%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.2%	96.3%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E10000023	North Yorkshire	02N	NHS Airedale, Wharfdale and Craven CCG	32.5%	8.3%
E10000023	North Yorkshire	00C	NHS Darlington CCG	1.3%	0.2%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.1%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.4%	0.7%
E10000023	North Yorkshire	03D	NHS Hambleton, Richmondshire and Whitby CCG	98.3%	22.8%
E10000023	North Yorkshire	03E	NHS Harrogate and Rural District CCG	99.8%	26.2%
E10000023	North Yorkshire	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.1%
E10000023	North Yorkshire	15F	NHS Leeds CCG	0.9%	1.3%
E10000023	North Yorkshire	01K	NHS Morecambe Bay CCG	1.9%	1.0%
E10000023	North Yorkshire	03M	NHS Scarborough and Ryedale CCG	99.3%	19.2%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.6%	18.8%
E10000023	North Yorkshire	03R	NHS Wakefield CCG	2.0%	1.2%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.6%	1.9%
E10000021	Northamptonshire	03V	NHS Corby CCG	99.2%	9.8%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	2.0%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.1%	1.2%
E10000021	Northamptonshire	04G	NHS Nene CCG	98.8%	84.9%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.1%	1.0%
E10000021	Northamptonshire	99D	NHS South Lincolnshire CCG	0.9%	0.2%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.5%
E06000057	Northumberland	01H	NHS North Cumbria CCG	0.1%	0.1%
E06000057	Northumberland	00J	NHS North Durham CCG	0.2%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	0.9%	0.6%
E06000057	Northumberland	00L	NHS Northumberland CCG	97.9%	98.7%

E06000018	Nottingham	04K	NHS Nottingham City CCG	89.9%	95.4%
E06000018	Nottingham	04L	NHS Nottingham North and East CCG	4.6%	2.0%
E06000018	Nottingham	04M	NHS Nottingham West CCG	4.1%	1.1%
E06000018	Nottingham	04N	NHS Rushcliffe CCG	4.3%	1.5%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	97.1%	13.5%
E10000024	Nottinghamshire	15M	NHS Derby and Derbyshire CCG	1.5%	1.8%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.6%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	04D	NHS Lincolnshire West CCG	0.4%	0.1%
E10000024	Nottinghamshire	04E	NHS Mansfield and Ashfield CCG	97.9%	22.5%
E10000024	Nottinghamshire	04H	NHS Newark & Sherwood CCG	97.6%	15.6%
E10000024	Nottinghamshire	04K	NHS Nottingham City CCG	10.1%	4.6%
E10000024	Nottinghamshire	04L	NHS Nottingham North and East CCG	95.1%	17.2%
E10000024	Nottinghamshire	04M	NHS Nottingham West CCG	90.8%	10.2%
E10000024	Nottinghamshire	04N	NHS Rushcliffe CCG	90.3%	13.6%
E10000024	Nottinghamshire	04Q	NHS South West Lincolnshire CCG	0.7%	0.1%
E10000024	Nottinghamshire	04V	NHS West Leicestershire CCG	0.1%	0.0%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.5%	1.4%
E08000004	Oldham	14L	NHS Manchester CCG	0.8%	2.1%
E08000004	Oldham	00Y	NHS Oldham CCG	94.5%	96.3%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E10000025	Oxfordshire	15A	NHS Berkshire West CCG	0.5%	0.3%
E10000025	Oxfordshire	14Y	NHS Buckinghamshire CCG	2.4%	1.8%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	04G	NHS Nene CCG	0.1%	0.1%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.4%	96.5%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.6%	0.2%
E10000025	Oxfordshire	12D	NHS Swindon CCG	2.7%	0.9%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	23.0%	96.3%
E06000031	Peterborough	99D	NHS South Lincolnshire CCG	5.1%	3.7%
E06000026	Plymouth	15N	NHS Devon CCG	22.1%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.5%	1.4%
E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.6%	98.4%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.2%	0.2%
E06000038	Reading	15A	NHS Berkshire West CCG	35.3%	99.4%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.2%	0.6%
E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	4.9%	3.3%
E09000026	Redbridge	08C	NHS Hammersmith and Fulham CCG	0.1%	0.1%
E09000026	Redbridge	08F	NHS Havering CCG	0.8%	0.7%
E09000026	Redbridge	08M	NHS Newham CCG	1.4%	1.7%
E09000026	Redbridge	08N	NHS Redbridge CCG	92.3%	89.4%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.3%	3.1%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.7%
E06000003	Redcar and Cleveland	03D	NHS Hambleton, Richmondshire and Whitby CCG	1.1%	1.1%
E06000003	Redcar and Cleveland	00M	NHS South Tees CCG	47.3%	98.9%
E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.5%	0.5%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	4.9%	7.0%
E09000027	Richmond upon Thames	08J	NHS Kingston CCG	1.6%	1.5%
E09000027	Richmond upon Thames	08P	NHS Richmond CCG	91.7%	90.3%
E09000027	Richmond upon Thames	99H	NHS Surrey Downs CCG	0.0%	0.1%
E09000027	Richmond upon Thames	08X	NHS Wandsworth CCG	0.4%	0.7%
E08000005	Rochdale	00V	NHS Bury CCG	0.7%	0.6%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.5%	96.6%
E08000005	Rochdale	14L	NHS Manchester CCG	0.6%	1.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.9%	1.0%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.3%	3.1%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	1.0%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.1%	1.2%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.8%	1.7%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.3%
E06000017	Rutland	03V	NHS Corby CCG	0.2%	0.5%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	9.9%	86.3%
E06000017	Rutland	99D	NHS South Lincolnshire CCG	2.6%	11.5%
E06000017	Rutland	04Q	NHS South West Lincolnshire CCG	0.4%	1.4%
E08000006	Salford	00T	NHS Bolton CCG	0.2%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.8%	1.4%
E08000006	Salford	14L	NHS Manchester CCG	1.1%	2.5%
E08000006	Salford	01G	NHS Salford CCG	94.1%	94.6%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.2%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.1%
E08000028	Sandwell	15E	NHS Birmingham and Solihull CCG	1.9%	7.0%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.7%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	55.1%	88.6%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.7%	1.3%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000014	Sefton	01J	NHS Knowsley CCG	1.8%	1.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.3%
E08000014	Sefton	01T	NHS South Sefton CCG	96.0%	51.6%
E08000014	Sefton	01V	NHS Southport and Formby CCG	96.8%	41.9%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.3%	0.1%

E08000019	Sheffield	02P	NHS Barnsley CCG	0.8%	0.4%
E08000019	Sheffield	15M	NHS Derby and Derbyshire CCG	0.2%	0.4%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.4%	0.2%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.5%	99.1%
E06000051	Shropshire	05F	NHS Herefordshire CCG	0.4%	0.3%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.5%	0.3%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.7%	95.4%
E06000051	Shropshire	01R	NHS South Cheshire CCG	0.4%	0.3%
E06000051	Shropshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.2%	0.9%
E06000051	Shropshire	05T	NHS South Worcestershire CCG	1.0%	1.0%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.3%	1.4%
E06000051	Shropshire	02F	NHS West Cheshire CCG	0.1%	0.1%
E06000051	Shropshire	06D	NHS Wyre Forest CCG	0.8%	0.3%
E06000039	Slough	14Y	NHS Buckinghamshire CCG	1.8%	6.2%
E06000039	Slough	07W	NHS Ealing CCG	0.0%	0.1%
E06000039	Slough	15D	NHS East Berkshire CCG	33.8%	93.4%
E06000039	Slough	08G	NHS Hillingdon CCG	0.0%	0.1%
E06000039	Slough	07Y	NHS Hounslow CCG	0.0%	0.1%
E06000039	Slough	09Y	NHS North West Surrey CCG	0.0%	0.1%
E08000029	Solihull	15E	NHS Birmingham and Solihull CCG	17.0%	98.9%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05J	NHS Redditch and Bromsgrove CCG	0.4%	0.3%
E08000029	Solihull	05L	NHS Sandwell and West Birmingham CCG	0.0%	0.1%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.4%	0.4%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E10000027	Somerset	11E	NHS Bath and North East Somerset CCG	3.1%	1.1%
E10000027	Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.3%
E10000027	Somerset	15N	NHS Devon CCG	0.2%	0.5%
E10000027	Somerset	11J	NHS Dorset CCG	0.5%	0.7%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.3%
E10000027	Somerset	99N	NHS Wiltshire CCG	0.1%	0.1%
E06000025	South Gloucestershire	11E	NHS Bath and North East Somerset CCG	0.8%	0.6%
E06000025	South Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	28.2%	97.5%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.8%	1.8%
E06000025	South Gloucestershire	99N	NHS Wiltshire CCG	0.0%	0.1%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.2%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.2%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E06000045	Southampton	10X	NHS Southampton CCG	94.9%	99.5%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.5%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.8%	4.7%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.7%	95.3%
E09000028	Southwark	07R	NHS Camden CCG	0.3%	0.3%
E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.5%	1.6%
E09000028	Southwark	08C	NHS Hammersmith and Fulham CCG	0.7%	0.5%
E09000028	Southwark	08K	NHS Lambeth CCG	6.6%	7.7%
E09000028	Southwark	08L	NHS Lewisham CCG	2.1%	2.0%
E09000028	Southwark	08Q	NHS Southwark CCG	94.1%	87.9%
E09000028	Southwark	08X	NHS Wandsworth CCG	0.1%	0.1%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.1%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.6%	2.3%
E08000013	St. Helens	01X	NHS St Helens CCG	91.2%	96.3%
E08000013	St. Helens	02E	NHS Warrington CCG	0.1%	0.1%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.7%	1.2%
E10000028	Staffordshire	15E	NHS Birmingham and Solihull CCG	0.3%	0.4%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.3%	14.9%
E10000028	Staffordshire	15M	NHS Derby and Derbyshire CCG	0.5%	0.5%
E10000028	Staffordshire	05C	NHS Dudley CCG	1.4%	0.5%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	92.1%	14.7%
E10000028	Staffordshire	01C	NHS Eastern Cheshire CCG	0.6%	0.1%
E10000028	Staffordshire	05G	NHS North Staffordshire CCG	95.1%	23.4%
E10000028	Staffordshire	05N	NHS Shropshire CCG	1.0%	0.3%
E10000028	Staffordshire	01R	NHS South Cheshire CCG	0.5%	0.1%
E10000028	Staffordshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	96.2%	23.6%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.5%	16.7%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	8.8%	2.9%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%
E10000028	Staffordshire	05Y	NHS Walsall CCG	1.6%	0.5%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.1%	0.2%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.6%	0.8%
E10000028	Staffordshire	06D	NHS Wyre Forest CCG	0.2%	0.0%
E08000007	Stockport	01C	NHS Eastern Cheshire CCG	1.6%	1.1%
E08000007	Stockport	14L	NHS Manchester CCG	1.1%	2.2%
E08000007	Stockport	01W	NHS Stockport CCG	94.9%	96.5%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E06000004	Stockton-on-Tees	00C	NHS Darlington CCG	0.4%	0.2%
E06000004	Stockton-on-Tees	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.4%	0.6%
E06000004	Stockton-on-Tees	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.1%
E06000004	Stockton-on-Tees	00K	NHS Hartlepool and Stockton-On-Tees CCG	66.9%	98.4%
E06000004	Stockton-on-Tees	00M	NHS South Tees CCG	0.4%	0.7%

E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.3%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.5%	0.3%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	91.2%	97.1%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.2%
E10000029	Suffolk	06M	NHS Great Yarmouth and Waveney CCG	52.3%	16.3%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.9%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.4%	0.6%
E10000029	Suffolk	06Y	NHS South Norfolk CCG	1.1%	0.3%
E10000029	Suffolk	07H	NHS West Essex CCG	0.1%	0.0%
E10000029	Suffolk	07K	NHS West Suffolk CCG	91.1%	29.7%
E08000024	Sunderland	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.9%	0.9%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.9%
E08000024	Sunderland	00J	NHS North Durham CCG	2.2%	1.9%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.5%	0.3%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	96.0%
E10000030	Surrey	07Q	NHS Bromley CCG	0.4%	0.1%
E10000030	Surrey	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000030	Surrey	09H	NHS Crawley CCG	6.6%	0.7%
E10000030	Surrey	07V	NHS Croydon CCG	1.3%	0.4%
E10000030	Surrey	15D	NHS East Berkshire CCG	3.4%	1.2%
E10000030	Surrey	09L	NHS East Surrey CCG	96.6%	14.1%
E10000030	Surrey	09N	NHS Guildford and Waverley CCG	94.0%	16.9%
E10000030	Surrey	09X	NHS Horsham and Mid Sussex CCG	1.5%	0.3%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.7%	0.2%
E10000030	Surrey	08J	NHS Kingston CCG	4.5%	0.7%
E10000030	Surrey	08R	NHS Merton CCG	0.3%	0.0%
E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	23.0%	4.2%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	09Y	NHS North West Surrey CCG	99.4%	29.5%
E10000030	Surrey	08P	NHS Richmond CCG	0.7%	0.1%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	99H	NHS Surrey Downs CCG	97.4%	23.8%
E10000030	Surrey	10C	NHS Surrey Heath CCG	98.9%	7.6%
E10000030	Surrey	08T	NHS Sutton CCG	1.2%	0.2%
E10000030	Surrey	99J	NHS West Kent CCG	0.2%	0.0%
E09000029	Sutton	07V	NHS Croydon CCG	1.0%	1.9%
E09000029	Sutton	08J	NHS Kingston CCG	3.5%	3.4%
E09000029	Sutton	08K	NHS Lambeth CCG	0.1%	0.2%
E09000029	Sutton	08R	NHS Merton CCG	6.3%	6.7%
E09000029	Sutton	99H	NHS Surrey Downs CCG	1.3%	1.9%
E09000029	Sutton	08T	NHS Sutton CCG	94.7%	85.6%
E09000029	Sutton	08X	NHS Wandsworth CCG	0.2%	0.3%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.0%	0.2%
E06000030	Swindon	12D	NHS Swindon CCG	96.0%	98.2%
E06000030	Swindon	99N	NHS Wiltshire CCG	0.7%	1.5%
E08000008	Tameside	14L	NHS Manchester CCG	2.2%	5.8%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.9%
E08000008	Tameside	01W	NHS Stockport CCG	1.8%	2.3%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.2%	88.0%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.8%	2.9%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.7%	97.1%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.3%	0.3%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.3%
E06000034	Thurrock	08F	NHS Havering CCG	0.2%	0.4%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.5%	99.0%
E06000027	Torbay	15N	NHS Devon CCG	11.7%	100.0%
E09000030	Tower Hamlets	07R	NHS Camden CCG	1.1%	0.9%
E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.5%	0.3%
E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	0.9%	0.9%
E09000030	Tower Hamlets	08C	NHS Hammersmith and Fulham CCG	0.8%	0.5%
E09000030	Tower Hamlets	08H	NHS Islington CCG	0.2%	0.1%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.2%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.9%	96.9%
E08000009	Trafford	14L	NHS Manchester CCG	2.7%	7.0%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.1%
E08000009	Trafford	02A	NHS Trafford CCG	95.7%	92.7%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%
E08000036	Wakefield	02P	NHS Barnsley CCG	0.9%	0.6%
E08000036	Wakefield	15F	NHS Leeds CCG	0.4%	1.0%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.5%	98.0%
E08000030	Walsall	15E	NHS Birmingham and Solihull CCG	1.1%	4.8%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.7%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.6%	3.1%
E08000030	Walsall	05Y	NHS Walsall CCG	92.8%	90.4%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.4%	1.4%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.4%	0.4%
E09000031	Waltham Forest	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000031	Waltham Forest	08D	NHS Haringey CCG	0.1%	0.1%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.3%	1.7%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.4%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.3%	96.1%

E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	0.9%	0.6%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	1.0%	0.6%
E09000032	Wandsworth	08J	NHS Kingston CCG	0.1%	0.0%
E09000032	Wandsworth	08K	NHS Lambeth CCG	3.2%	3.5%
E09000032	Wandsworth	08R	NHS Merton CCG	2.8%	1.6%
E09000032	Wandsworth	08P	NHS Richmond CCG	1.3%	0.7%
E09000032	Wandsworth	08X	NHS Wandsworth CCG	88.3%	92.6%
E09000032	Wandsworth	08Y	NHS West London (K&C & QPP) CCG	0.7%	0.4%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.2%	2.0%
E06000007	Warrington	02E	NHS Warrington CCG	97.6%	97.0%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.2%
E10000031	Warwickshire	15E	NHS Birmingham and Solihull CCG	0.2%	0.5%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.2%	21.5%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	04G	NHS Nene CCG	0.2%	0.2%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	05J	NHS Redditch and Bromsgrove CCG	0.7%	0.2%
E10000031	Warwickshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.1%	45.8%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.7%	30.7%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E06000037	West Berkshire	15A	NHS Berkshire West CCG	30.0%	97.6%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.7%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	99N	NHS Wiltshire CCG	0.1%	0.4%
E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.1%	0.4%
E10000032	West Sussex	09G	NHS Coastal West Sussex CCG	99.5%	57.5%
E10000032	West Sussex	09H	NHS Crawley CCG	93.4%	14.0%
E10000032	West Sussex	09L	NHS East Surrey CCG	0.3%	0.0%
E10000032	West Sussex	09N	NHS Guildford and Waverley CCG	3.1%	0.8%
E10000032	West Sussex	99K	NHS High Weald Lewes Havens CCG	1.1%	0.2%
E10000032	West Sussex	09X	NHS Horsham and Mid Sussex CCG	95.7%	25.9%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.1%	1.0%
E10000032	West Sussex	99H	NHS Surrey Downs CCG	0.6%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	2.0%
E09000033	Westminster	07R	NHS Camden CCG	3.0%	3.4%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	79.3%	71.3%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	0.6%	0.6%
E09000033	Westminster	08K	NHS Lambeth CCG	0.1%	0.2%
E09000033	Westminster	08Y	NHS West London (K&C & QPP) CCG	23.1%	22.6%
E08000010	Wigan	00T	NHS Bolton CCG	0.2%	0.1%
E08000010	Wigan	01G	NHS Salford CCG	0.8%	0.6%
E08000010	Wigan	01X	NHS St Helens CCG	3.8%	2.2%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.2%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.8%	1.0%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.7%
E06000054	Wiltshire	11E	NHS Bath and North East Somerset CCG	0.9%	0.4%
E06000054	Wiltshire	15A	NHS Berkshire West CCG	0.2%	0.2%
E06000054	Wiltshire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.5%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.3%	0.4%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.5%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.3%	0.4%
E06000054	Wiltshire	12D	NHS Swindon CCG	1.3%	0.6%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.2%
E06000054	Wiltshire	99N	NHS Wiltshire CCG	96.7%	96.8%
E06000040	Windsor and Maidenhead	15A	NHS Berkshire West CCG	0.4%	1.3%
E06000040	Windsor and Maidenhead	14Y	NHS Buckinghamshire CCG	0.3%	1.1%
E06000040	Windsor and Maidenhead	15D	NHS East Berkshire CCG	34.1%	96.9%
E06000040	Windsor and Maidenhead	09Y	NHS North West Surrey CCG	0.2%	0.5%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.2%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.1%	0.0%
E08000015	Wirral	02F	NHS West Cheshire CCG	0.4%	0.3%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.7%
E06000041	Wokingham	15A	NHS Berkshire West CCG	31.5%	97.0%
E06000041	Wokingham	15D	NHS East Berkshire CCG	1.0%	2.6%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.4%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.3%	1.5%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.1%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.8%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.4%	3.5%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	93.8%	93.4%
E10000034	Worcestershire	15E	NHS Birmingham and Solihull CCG	0.9%	2.0%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.7%	0.4%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	05F	NHS Herefordshire CCG	0.9%	0.3%
E10000034	Worcestershire	05J	NHS Redditch and Bromsgrove CCG	95.8%	27.7%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.3%	1.1%
E10000034	Worcestershire	05T	NHS South Worcestershire CCG	97.2%	49.3%
E10000034	Worcestershire	06D	NHS Wyre Forest CCG	98.3%	18.6%
E06000014	York	03E	NHS Harrogate and Rural District CCG	0.2%	0.1%
E06000014	York	03Q	NHS Vale of York CCG	60.2%	99.9%

Produced by NHS England using data from National Health Applications and Infrastructure Services (NHAIS) as supplied by NHS Digital.

Appendix 2 – Full List of Schemes Funded through BCF Plan 2019/20 (including proposals)

Service Area	Description	TOTAL 2019/20 Budget
Information, Advice and Guidance (IAG)	Voluntary sector provision of advice, information, signposting and/or guidance for people needing help	£55,000
LIVING WELL WITH LONG-TERM CONDITION/DEMENTIA		
COPD Exercise Programme	Community-based exercise groups for suitable COPD patients referred via health professionals	£13,000
Dementia Day Opportunities	LBH commissioned services to support people with dementia with facility- or wider home/ community-based day care/support	£475,000
Self-Management Support	Structured programme of courses for patients interested in condition self-management or being expert patient	£91,600
LIVING WELL WITH FRAILTY AND BECOMING MORE FRAIL		
Local Area Coordination	Voluntary sector coordinators to provide advice, information and signposting for people who need assistance and to support best use of community assets	£120,136
Disabled facilities grant	LBH commissioned provider undertaking major adaptations of individuals' home to facilitate improvements in daily living functioning	£2,360,942
Nursing Services	District nursing for non-ambulant patients at home	£6,529,807
Locality Team	Multi-disciplinary clinical, nursing, therapy & social work team to care plan, support & review people with severe frailty. Other Providers - NHS Mental Health Provider, Local Authority	£513,546
MDT Teleconference	Weekly calls between geriatricians, GPs and others about complex cases to facilitate good patient management	£253,447

Service Area	Description	TOTAL 2019/20 Budget
Social Care Team	LBH posts to increase capacity in Single Point of Access and initial triaging of cases to support timely hospital discharge & facilitate access to intermediate care.	£230,000
Strength and Balance Opportunities	Strengthening & balancing classes and exercises for individuals who professionals identify at risk of falling	£58,000
Whittington Integrated Care Therapy Team	Multi-disciplinary therapy service that supports older people (& other groups)	£2,014,000
Enhanced Health in Care Homes	Implementation of EHCH Model and Trusted Assessor across Haringey to support care homes, their staff & residents	£60,000
Further investment in Enhanced Health in Care Homes & Trusted Assessor	Relates to current part-year investment in Enhanced Health in Care & Trusted Assessor models rolled out across Haringey using existing Enfield & Islington contracts	£150,000
IBCF	Bulk of spend is on providing packages of care (predominantly but not exclusively domiciliary care) as part of social care clients' Personal Budgets	£8,369,874
Integrated Health, Housing, Finance and Care Early Intervention Solutions	Solutions to provide early help to people to help manage finances, housing health, well-being & independence via integrating community-facing solutions such as Connected Communities in health facilities, e.g. acute	£159,000
NEARING END OF LIFE		
Palliative Care & Advanced Care Planning Facilitator	NMUH-led multi-agency approach to support range of community-, hospital- and bed-based palliative care services. Other Providers - NHS Community Provider	£766,000
Expand End of Life nursing and other services	Increased investment from BCF Plan in out-of-hours nursing services for end of life patients. This will improve quality of life in last few days, support advance care plan delivery and reduce risk of individuals attending hospital	£111,881
REACTIVE SOLUTIONS: RECOVERING AFTER CRISIS		

Service Area	Description	TOTAL 2019/20 Budget
Alcohol Liaison Services	Public Health commissioned Alcohol Liaison Nurses & Support Worker to support patients in hospital with alcohol-related issues & to coordinate support in community	£61,585
Bed Based Intermediate Care	Bed-based time-limited rehabilitation service to facilitate people's recovery after illness and/or spell in hospital	£625,000
Increased bed-based intermediate care capacity (CHC contribution)	Fund intermediate care beds in care home to better rehabilitate, assess individuals' needs and eligibility for CHC outside hospital as part of ASC contract with PWH.	£155,000
Bridges Rehab	Bed-based specialist nursing & therapies for patients requiring 24/7 rehabilitation	£1,254,233
Rapid Response	Multi-disciplinary nursing & therapies team to respond quickly when people are at crisis and/or need short-term rehabilitation either at home or in A&E. Other Providers - Local Authority	£374,000
Expand Rapid Response via nurse in NMUH 'Frailty Hot Floor'	Embed 1.0 WTE Rapid Response Nurse for 6 months in NMUH to support their 'Frailty Hot Floor' to ensure patients return home from A&E quickly avoiding admission.	£36,000
Reablement Solutions	Multi-disciplinary nursing & therapies team to respond quickly when people are at crisis and/or need short-term rehabilitation either at home or in A&E. Other Providers - Local Authority	£2,596,000
Home from Hospital	Voluntary sector scheme to support hospital patients (who do not need public-sector intervention) return home and settled if they need it	£150,000
MH Discharge Coordinator	Social worker in MH service to support discharge and onward planning for individuals with severe MH issues.	£40,000
Nursing Intermediate Care	Nursing beds with rehabilitative MDT input and nursing outreach to patients' homes for those needing a period of convalescence post-discharge	£177,000

Service Area	Description	TOTAL 2019/20 Budget
Increased investment in Nursing Intermediate Care Solution	Convalescence solution to provide nursing at home or in care homes for patients discharged from hospital with specific needs (e.g. non-weight bearing). Provides a short-term period of recuperation prior to rehabilitation	£150,000
Increase number of 24-hour packages of care at home	Increase number of high-intensity packages of care available to prevent hospitalisation or facilitate 'Home First' hospital discharge of patients to meet demand, particularly to support 7 day discharges	£42,000
Expand Single Point of Access (SPA), social work and CHC Clinical Nursing resources to support demand	Relates to increasing capacity for teams involved in point of access and onward management of patient, including Continuing Healthcare (CHC) to meet demand	
	- Additional social care professionals in SPA	£58,000
	- Embed D2A nurse in SPA;	£36,000
	- Social worker to support complex cases	£26,000
SUPPORTING CARERS		
Carer's Support	LBH commissioned range of solutions for carers depending on intensity of need; ranging from identifying carers, undertaking assessment of needs and support through to carers' respite. Other Provider -Local Authority, Private Provider	£1,067,000
ENABLERS		
Commissioning & Analytics Support	To provide multi-disciplinary and multi-agency commissioning support for BCF Plan Programme	£286,721
Principal Social Worker	To provide quality assurance and plan workforce development for social care	£60,000
	Total	**£30,679,947**