NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

Wednesday, 24th November, 2021, 2.00 pm - 40 Cumberland Road, London, N22 7SG (watch it here)

Members: Please see list attached under item 2.

Quorum: 3 voting members, including one local authority elected member and one of the Clinical Commissioning Group Chair or the Healthwatch Chair (or substitutes).

1. FILMING AT MEETINGS

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

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

2. WELCOME AND INTRODUCTIONS (PAGES 1 - 2)

3. APOLOGIES

To receive any apologies for absence.

4. URGENT BUSINESS

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

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

7. MINUTES (PAGES 3 - 12)

To confirm and sign the minutes of the Health and Wellbeing Board meeting held on 22 September 2021 as a correct record.

8. PRIMARY CARE ACCESS

To receive an update on primary care access.

9. SPECIAL EDUCATIONAL NEEDS AND DISABILITIES (SEND) INSPECTION AND WRITTEN STATEMENT OF ACTION (PAGES 13 - 20)

To receive a verbal update on the Special Educational Needs and Disabilities (SEND) inspection. The Ofsted report is included as background information.

A briefing was circulated to Members of the Health and Wellbeing Board on 26 October 2021 and the OFSTED inspection is included in the agenda as background information.

10. SEMINAR FEEDBACK

To consider and receive feedback on the health and wellbeing seminars.

11. COVID-19 AND VACCINATIONS UPDATE

To receive a verbal update on the Covid-19 pandemic and the vaccination Programme.

12. UPDATE ON WORK TO TACKLE RACISM AND INEQUALITIES IN HARINGEY

To receive an update on work to tackle racism and inequalities in Haringey.

13. APPROVAL OF HARINGEY BETTER CARE FUND (BCF) 2020/21 SUBMISSION TO NHS ENGLAND (PAGES 21 - 84)

To consider and endorse the submitted Haringey Better Care Fund (BCF) Plan Narrative for 2021/22.

14. NEW ITEMS OF URGENT BUSINESS

15. FUTURE AGENDA ITEMS AND MEETING DATES

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

To note the dates of future meetings:

26 January 2022
16 March 2022

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Fiona Alderman
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Tuesday, 16 November 2021

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Agenda Item 2

Membership of the Health and Wellbeing Board

* Denotes voting Member of the Board

Organisation		Representation	Role	Name
Local Authority	Elected Representatives	3	* Cabinet Member for Health, Social Care, and Wellbeing – Chair	Cllr Lucia Das Neves
			* Cabinet Member for Early Years, Children, and Families	Cllr Zena Brabazon
			* Cabinet Member for Environment, Transport, and the Climate Emergency	Cllr Mike Hakata
	Officer Representatives	4	Director of Adults and Health	Beverley Tarka
			Director of Children's Services	Ann Graham
			Director of Public Health	Dr Will Maimaris
			Chief Executive	Zina Etheridge
NHS	North Central London Clinical Commissioning Group (CCG)	4	* Governing Board Member – Vice Chair	Dr Peter Christian
			Governing Board Member	John Rohan
			Chief Officer	Paul Sinden
			* Lay Member	*Vacancy*
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 HEALTH AND WELLBEING BOARD MEETING HELD ON WEDNESDAY, 22ND SEPTEMBER, 2021, 2.00 - 4.05 PM

PRESENT:

Cllr Lucia Das Neves, Chair – Cabinet Member for Health, Social Care, and Wellbeing*
Cllr Zena Brabazon – Cabinet Member for Early Years, Children, and Families* (until item 9)
Cllr Mike Hakata – Cabinet Member for Environment, Transport, and the Climate Emergency*
Ann Graham – Director of Children's Services
Dr Will Maimaris – Director of Public Health^
Dr Peter Christian – NCL Clinical Commissioning Group (CCG) Board Member*
Sharon Grant – Healthwatch Haringey Chair*
Geoffrey Ocen – Bridge Renewal Trust Chief Executive^
*Voting member

In attendance:
Christina Andrew – Strategic Lead, Communities and Equalities^
Kathryn Collin – CCG Assistant Director, Complex Individualised Commissioning^
Jonathan Gardner – Whittington Trust Director of Strategy^
Richard Gourlay – North Middlesex University Hospital Trust^
Michele Guimarin – Lead Commissioner for Autism and Learning Disabilities^
Georgie Jones-Conaghan – CCG Assistant Director, Complex Individualised Commissioning^
Deborah King – Mind^
Rachel Lissauer – Director of Integration, Clinical Commissioning Group (CCG)^
Sarah McDonnell-Davies – Executive Director of Borough Partnerships^
Charlotte Pomery – Assistant Director for Commissioning^
Fiona Rae – Principal Committee Co-ordinator
^Joining virtually

1. FILMING AT MEETINGS

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

2. WELCOME AND INTRODUCTIONS

The Chair welcomed those present to the meeting.

3. APOLOGIES

Apologies for absence were received from:

Dr John Rohan, NCL Clinical Commissioning Group (CCG) Board Member
David Archibald, Independent Chair Haringey Local Safeguarding Board
Lynette Charles, Mind in Haringey
Jo Sauvage, CCG Chair
Beverley Tarka, Director of Adults and Health

4. URGENT BUSINESS

There was no urgent business.

5. DECLARATIONS OF INTEREST

There were no declarations of interest.

6. QUESTIONS, DEPUTATIONS, AND PETITIONS

No questions, deputations, or petitions were received.

7. MINUTES

Richard Gourlay, North Middlesex Hospital Trust, drew attention to page six of the minutes where it stated that 'North Middlesex had Urgent Care from 12am (midnight) to 7am which included GPs and emergency nurse practitioners'. He noted that this should read 'there is an urgent care centre available at North Middlesex Hospital seven days a week that is staffed by both General Practitioners and also Emergency Nurse Practitioners'.

RESOLVED

That, subject to the amendment above, the minutes of the meeting held on 21 July 2021 were confirmed a correct record.

8. COVID-19 AND VACCINATION UPDATE

Dr Will Maimaris, Director of Public Health, provided a Covid-19 update. It was noted that there had been an acceleration of cases in mid-July due to the Delta variant, with nearly 200 cases per day. It was explained that this was concerning but that there had been lower levels of hospitalisations and deaths compared to January 2021 which seemed to show the impact of the vaccination programme. It was added that, over recent months, there had been a gradual decline in case rates across the borough but that there might be increases when the universities started in September and October.

It was noted that there were moderate numbers of people in hospital with Covid-19, with approximately 20 at Whittington and around 50 at North Middlesex. Hospitals were reporting that the majority of Covid-19 patients in intensive care were under 50 and unvaccinated which demonstrated the importance of encouraging vaccinations.

In relation to the uptake of the Covid-19 vaccine, it was explained that there was comparator data for London. Approximately 75% of those over 50 in Haringey had received two doses of the vaccine. It was noted that, although Haringey was rated as

the fourth most deprived borough in London, it had the eighth lowest vaccination rate which demonstrated good comparative results and which surpassed the uptake of previous vaccination programmes.

It was commented that, whilst there was good uptake of the vaccine in general, the was a plateau in all age groups over time and a dramatic reduction in uptake in younger age groups, both in Haringey and across London. It was noted that councils had been proactive in spreading communications about vaccinations but that there were still some disparities in uptake from certain communities.

It was explained that there had been two recent developments in the Covid-19 vaccination programme: the introduction of one vaccine for school children aged 12-15 and the booster vaccination programme for those over 50 and/ or in clinically vulnerable groups. It was noted that schools would be writing to parents and guardians shortly to inform them about the vaccination programme for school children.

Dr Peter Christian, CCG Board Member, noted that it was reassuring to hear that the vaccination programme was delivering positive outcomes in terms of reduced hospitalisations and deaths. He commented that the use of intensive care beds for unvaccinated patients was impacting hospital recovery plans and that the booster vaccination programme would put pressure on essential staff during the autumn and winter.

Sharon Grant, Healthwatch Haringey Chair, stated that residents wanted to know how the Covid-19 booster vaccination would operate and whether they would be contacted. She also noted that there were some concerns about the flu jab programme, including the arrangements and possible shortages. The Director of Public Health clarified that there would be an invitation system for the Covid-19 booster vaccinations as well as proactive outreach work. It was explained that Haringey was well placed to deliver booster vaccinations using pharmacies and primary care sites. Rachel Lissauer, CCG Director of Integration, stated that the flu jab would operate as per normal. It was noted that this would be primarily delivered through GPs and that there was currently no indication that there were capacity risks.

Sharon Grant, Healthwatch Haringey Chair, noted that Healthwatch had conducted some research about people's views of vaccinations, including the dual delivery of the Covid-19 vaccination and the flu jab. It was highlighted that people were broadly opposed to dual delivery and that the report could be circulated to members of the Health and Wellbeing Board for information. The Director of Public Health noted that it was very unlikely that there would be dual delivery except for, possibly, in care homes. It was added that the Healthwatch report would be circulated.

Geoffrey Ocen, Bridge Renewal Trust, noted that some people had been reluctant to get the vaccinations initially and that it would be important to actively encourage people to take up the Covid-19 booster vaccination. He added that targeted engagement worked well and that Community Protect should be extended. It was also noted that it was challenging to get younger people to take up the vaccinations.

RESOLVED

To note the update.

9. UPDATE ON WORK TO TACKLE RACISM AND INEQUALITIES IN HARINGEY

Charlotte Pomery, Assistant Director for Commissioning, and Geoffrey Ocen, Bridge Renewal Trust Chief Executive, provided an update on the nine actions agreed at the Health and Wellbeing Board meeting in May 2020.

1. **Data and evidence** – there had been good progress with the policy team and CCG colleagues to develop categories for ethnicity data collection which were more closely aligned with the categories used by the Office for National Statistics (ONS). It was reported that the new data was starting to be used in areas such as Early Years and that the data collection changes were being discussed with other partners.
2. **Funding** – it was stated that there had been successful bids to the CCG Inequalities Fund. It was noted that a number of awards were going through to grass roots organisations and that the approach for the next round of funding was being considered.
3. **Bereavement and Mental Health** – it was noted that the Mental Health Programme had been running since July, with a focus on resident engagement through initiatives such as Community Mental Health Champions.
4. **Domestic Violence** – it was commented that there had been 1,700 responses to the Safety at Night Survey; these had not yet been fully analysed but it was noted that domestic violence and Violence Against Women and Girls were key areas of focus.
5. **Communication and awareness raising** – the importance of language and use of a trusted voice was acknowledged. It was added that the web pages for Black History Month were now live on the Council's website and that this added to the bank of existing resources available through Haringey 365 (which celebrated Black history 365 days a year).
6. **Prevention and resilience building** – it was commented that there was some significant anxiety about the end of the government furlough scheme and about the reductions to Universal Credit.
7. **Shielding** – it was noted that the shielding programme for clinically (extremely) vulnerable people had been formally halted by the Department for Health and Social Care and that it was now important to ensure maximal uptake of the Covid-19 vaccinations across all communities.
8. **Access to services** – it was stated that officers were relying on the use of data, particularly more granular data, to monitor equity of access to services. It was noted that this had been used in a deep dive of the partnership programme plan on attainment. It was added that, through understanding the issues better, it was possible to provide a better response.
9. **Digital Exclusion** – it was acknowledged that many services and activities were still providing things digitally and that it would be important to ensure that people were as equipped as possible. It was added that digital inclusion would be a key underpinning factor for the local asylum seeker and refugee programme.

Geoffrey Ocen, Bridge Renewal Trust, noted that the digital inclusion work at Lea Valley Primary School was going well. It was highlighted that homework participation had increased from 10% to 98%. It was explained that this project provided devices and increased access but also involved support work with families to tackle wider determinants for educational outcomes. It was noted that improvements needed to be driven by funding and that the CCG Inequalities Fund was assisting in empowering community groups. It was explained that Council and CCG colleagues had attended the Voluntary Sector Forum in mid-September where thematic areas of intervention and appropriate mechanisms for delivery were discussed; this model was being developed with all partners.

The Chair noted that the Voluntary Sector Forum had discussed the importance of language, citing the anti-discrimination campaign as a strong example of incorporating those with lived experience. The Assistant Director for Commissioning explained that the campaign was in its early stages but would include a story-based approach, focusing on intersectionality, perceptions, and assumptions, as well as an information sharing approach to inform people how they could take action and when to contact the police.

Sharon Grant, Healthwatch Haringey Chair, noted that there was a project across North Central London to assist people in developing digital skills to access health and social care digitally. She explained that, although the project provided support to a number of people, it was suspected that many more people could be referred by GPs. Dr Peter Christian, CCG Board Member, suggested that he could mention the project at the next GP webinar.

In response to a question about the Welcome Strategy for refugees and asylum seekers, the Assistant Director for Commissioning explained that the support which could be provided depended on the resettlement scheme in question. It was noted that the Welcome Strategy provided a joined up approach and covered a wide variety of issues, including education, primary care, housing, and digital support.

RESOLVED

To note the update.

10. AUTISM STRATEGY

Kathryn Collin, Assistant Director for Complex Individualised Commissioning (Children and Young People), and Georgie Jones-Conaghan, Assistant Director for Complex Individualised Commissioning (Learning Disability and Autism), introduced the report which presented the Autism Strategy. They highlighted that the lived experience of those with autism and their families was central to the Autism Strategy. It was explained that this was a neurodiverse strategy which aimed to be inclusive and to move away from the focus on autism as a medical ‘disorder’. It was added that the NHS had recently released its Autism Strategy, which was helpful background, but that the local Autism Strategy aimed to be more holistic and would be developed further over the next 10 years.

It was noted that there were a number of key themes which underpinned the strategy, including workforce development and training, support and intervention, and transitions and handovers. Kathryn Collin explained that the Autism Strategy was ambitious in scope and that there would be three priorities per three year period to make delivery more manageable.

Georgie Jones-Conaghan explained that co-production underpinned the strategy and the delivery of the strategy. It was noted that Joint Commissioning had built a group of stakeholders over the last two years which included representatives from care, education, health, the Voluntary and Community Sector (VCS), as well as people with autism and carers. It was acknowledged that there had been limited input from children and young people and that, although there had been some advocating by proxy, there would be efforts to address this as part of the delivery of the strategy. It was also noted that the key performance indicators for the strategy included co-production to ensure its continued importance.

Kathryn Collin explained that the Health and Wellbeing Board was asked to sign off the overarching Autism Strategy, which was due to be published in October 2021. It was also proposed that an update would be presented to the Health and Wellbeing Board at least annually for input and challenge.

Sharon Grant, Healthwatch Haringey Chair, felt that it was useful that the Strategy mentioned the role of the Criminal Justice System. It was highlighted that it was important for the police and magistrates to be fully appraised of the circumstances of people with autism and that this should be a part of their training programmes.

Dr Peter Christian, CCG Board Member, noted that it was difficult for people to get diagnoses, particularly later in life. He acknowledged that diagnoses were very helpful for people, their families, and employers. Georgie Jones-Conaghan stated that the diagnosis issues were known and that there was currently a poor pathway for autism and ADHD diagnoses for adults. It was aimed to develop a neurodiverse diagnostics process which would be delivered by Barnet, Enfield, and Haringey Mental Health Trust with local peer support, including pre-diagnosis support which would be critical.

Cllr Hakata stated that the Autism Strategy was comprehensive and would lead to positive co-production. He noted some concerns that a number of young people from minority ethnic backgrounds who had additional needs had been excluded from schools. He stated that those with additional needs should not be excluded and enquired how knowledge sharing in schools could be encouraged. Georgie Jones-Conaghan stated that officers were aware that people from different areas of the system, such as education, would need to be involved in the delivery of the Autism Strategy. It was highlighted that the Strategy aimed to be as holistic and as broad as possible, particularly where there were disproportionate outcomes, and that this could include schools, alternative provision, and exclusions.

The Assistant Director for Commissioning noted that there had been a deep dive into exclusions in October 2020, during the first school term of the year and after the first lockdown. It was explained that there had been a learning event in schools to highlight the warning signs. It was noted that schools should not be excluding pupils with a diagnosis but that not all children and young people with additional needs had a

diagnosis. It was suggested that schools needed to become more autism friendly but that multiple parts of the system were involved.

Jonathan Gardner, Whittington Trust, thanked officers for including the Whittington in the production of the Autism Strategy. He noted that there was currently a backlog in assessments for children and young people. He acknowledged that there were a number of potential actions noted in the report but highlighted that there were limited resources and that the actions in the report would be unlikely to completely resolve this. The Director of Public Health noted that there were limited resources and added that it would be helpful to consider where to focus resources. He added that it was important to focus on Early Years inclusivity, identification, and interventions and as it was generally more difficult to intervene later on.

The Chair thanked officers for their presentation. The Health and Wellbeing Board formally recorded its thanks to those with autism and their families who had been involved in developing the Autism Strategy; it was acknowledged that they had made significant efforts to campaign and to ensure that services were more inclusive.

RESOLVED

1. To approve the draft All Age Autism Strategy 2021-2031 attached as Appendix 1 to the report.

2. To agree to updates on progress against the Strategy to come back to the Health and Wellbeing Board at regular intervals.

11. UPDATE ON INTEGRATED CARE SYSTEMS (ICS)

Rachel Lissauer, CCG Director of Integration, introduced the item which provided an update on the development of Integrated Care Systems (ICS). She noted that the government aimed to introduce ICS in April 2022 and that her presentation would focus on the range of different mechanisms and bodies which were being developed locally.

It was noted that the Integrated Care Board would be the NHS statutory body which would take over the key functions of the existing CCG and which would have responsibilities around delivery. It was explained that there would also be an Integrated Care Partnership which would be a statutory committee but would be determined locally, with members from local authorities, the NHS, and possibly others in North Central London (NCL). In addition, it was noted that there would be a Borough Partnership, which would incorporate existing place-based partnerships, and provider collaboratives, to connect provider organisations around delivery.

It was noted that there would be a lot of operational and development work for the ICS which would provide an opportunity to consider what would be most meaningful and to hear from local people; it was highlighted that this would continue after April 2022. Rachel Lissauer explained that there were a number of patient engagement forums in Haringey and that there would be a series of seminars which would allow

consideration of and input into the ICS plans. It was highlighted that partners would be important in developing the Borough Partnerships.

Members of the Health and Wellbeing Board enquired whether there had been any feedback from residents so far, whether residents understood the proposed changes, and how it could be ensured that residents' voices would be included within the ICS. It was also enquired whether private companies could be active and voting members within the ICS governance structure and it was noted that there were a number of concerns if this was possible.

Sarah McDonnell-Davies, CCG Executive Director of Borough Partnerships, stated that it was important to continue to develop the empowerment of communities. It was explained that the NHS, local government, and organisations such as Healthwatch had moved closer in recent years and during the Covid-19 pandemic and that this would continue through ICS; it was added that accountability would also continue to be crucial. It was stated that, through Borough Partnerships, there would be collective responsibility for improving outcomes as well as more diverse and integrated memberships. Sarah McDonnell-Davies, CCG Executive Director of Borough Partnerships, noted the concerns relating to private companies. It was stated that the ICS in NCL was currently a composition of Trusts, primary care, and local government, and that there was a strategy of bringing as much work as possible 'in house' within NCL. It was clarified that the ICS proposals did not include any changes to the statutory functions of the Health and Wellbeing Board but that it would be useful to consider how the five NCL Health and Wellbeing Boards worked together to create clear plans and priorities in the wider area.

The Assistant Director for Commissioning noted that there would be a series of ICS seminars over the next six months which would provide an opportunity to discuss the developments and priorities. It was added that the inclusion of the Community Health and Care Advisory Board would also be a helpful way to begin the process of communicating the changes to the public.

Sharon Grant, Haringey Healthwatch Chair, believed that seminars would be useful but that the staff running the system would not be included. She stated that some of the most innovative approaches involved working with staff to improve services. The Chair noted that the formal structures would be more prescribed but that coproduction could be used more flexibly with a wider range of participants.

RESOLVED

To note the update.

12. NEW ITEMS OF URGENT BUSINESS

There were no new items of urgent business.

13. FUTURE AGENDA ITEMS AND MEETING DATES

Following discussion, it was suggested that the following items should be considered at future meetings:

- Primary Care Access
- Winter planning.
- Children's Services items, including Special Educational Needs and Disabilities (SEND) update (inspection and key points of transition) and Start Well Board
- Outcomes from the Community Services and Mental Health review
- Long Covid (depending on Healthwatch progress)
- Better Care Fund Plan
- Child and Adolescent Mental Health Services (CAMHS)
- Joint Strategic Needs Assessments
- Draft Health and Wellbeing Strategy
- Integrated Care Systems
- Estates and Workforce
- Mental Health
- Digital Inclusion and Health

The Chair asked that members of the committee contact her with any additional items they wished to be put on the agenda for future meetings. It was also noted that the draft Special Educational Needs and Disabilities (SEND) Strategy had recently opened for consultation. It was agreed that the draft Strategy would be circulated to Health and Wellbeing Board members who were invited to comment before the closing date of 7 November 2021.

It was noted that the dates of future meetings were:

24 November 2021
26 January 2022
16 March 2022

CHAIR: Councillor Lucia das Neves

Signed by Chair ……..

Date ……

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01 October 2021

Ann Graham
Director of Children's Services, Haringey
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N22 8HQ

Rachel Lissauer, Director of Integration, Clinical Commissioning Group (CCG)
Mary Jarrett, Head of SEND, Local Area Nominated Officer

Dear Ms Graham and Ms Lissauer

Joint area SEND inspection in Haringey

Between 5 July 2021 and 9 July 2021, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Haringey to judge the effectiveness of the area in implementing the special educational needs and/or disabilities (SEND) reforms as set out in the Children and Families Act 2014.

The inspection was led by one of Her Majesty's Inspectors from Ofsted, with a team of inspectors including an Ofsted Inspector and a children's services inspector from the Care Quality Commission CQC.

Inspectors spoke with children and young people with SEND, parents and carers, and local authority and National Health Service (NHS) officers. They visited a range of providers and spoke to leaders, staff and governors about how they were implementing the special educational needs reforms. Inspectors looked at a range of information about the performance of the area, including the area's self-evaluation. Inspectors met with leaders from the area for health, social care and education. They reviewed performance data and evidence about the local offer and joint commissioning.

As a result of the findings of this inspection and in accordance with the Children Act 2004 (Joint Area Reviews) Regulations 2015, Her Majesty's Chief Inspector (HMCI) has determined that a Written Statement of Action is required because of significant areas of weakness in the local area's practice. HMCI has also determined that the local authority and the area's CCG are jointly responsible for submitting the written statement to Ofsted.

In reaching their judgements, inspectors took account of the impact of the COVID-19 (coronavirus) pandemic on SEND arrangements in the area. Inspectors considered a range of information about the impact of the pandemic and explored how the area's plans and actions had been adapted as a result.

This letter outlines our findings from the inspection, including some areas of strengths and areas for further improvement.

Main Findings

- Leaders have made insufficient progress in implementing the 2014 reforms. Recent leadership changes have ensured an increased sense of urgency in completing much needed improvements. Parents and providers have increasing confidence in leaders to work more closely with them, including newly appointed leaders. Leaders are aware of the deficiencies in SEND provision for children and young people in Haringey.
- Area leaders have produced a clear, fair and detailed self-evaluation which sets out the area's priorities in identifying, assessing and meeting the needs of children and young people with SEND. Accurate analysis carried out by leaders has highlighted areas of strength, but equally areas where further improvements are needed to embed the SEND agenda across the partnership.
- There is a developing culture of listening and learning, with operational staff telling leaders what they are experiencing on the ground.
- Parents told inspectors that they are concerned about the way that the SEND reforms are being delivered. There has not been a parent carer forum for some time. Leaders have worked hard to find a number of solutions in the absence of a parent carer forum and have recently awarded a contract for a new parent carer forum.
- Leaders know their community well. They understand the implications of increased demand and the challenge of meeting an increasingly broad range of needs. Leaders and front-line staff share an ambition for, and practise, integrated working.
- The quality of education, health, and care (EHC) plans is poor. Education, health and care professionals do not work together well enough to draw up these plans. Weaknesses in assessment and planning processes remain. Amendments made to EHC plans after annual reviews are often inaccurate. Inspectors identified too many errors and shortfalls in EHC plans.
- The CCG and local authority work in collaborative partnership to promote the SEND agenda and to deliver provision which meets the needs of children and young people with SEND and their families.

- Effective joint commissioning systems are in place in Haringey and are well embedded. The strong collaboration between partners is informing commissioning decisions and contributing to the redesign of services with increased capacity and sustainability.
- Strategic leaders understand the importance of co-production. However, in practice there is neither a culture nor practical systems in place for this to occur. Leaders are clear that more needs to be done to embed co-production with parents, children and young people in Haringey.
- Too many children and young people wait too long for assessments to identify autism spectrum disorder (ASD). There is little or, in most circumstances, no specific support available while waiting for assessment.

The effectiveness of the area in identifying children and young people's special educational needs and/or disabilities

Strengths

- Children and young people with SEND in schools benefit from knowledgeable and skilled special educational needs coordinators (SENCos). SENCos attend regular training to hear about best practice. They know about the support that is available to children, young people and their families. This equips them well to identify any emerging SEND.
- There is a coordinated approach to the sharing of information in the early years, so that children's needs can be identified in a timely way. Education, health and social care staff work together well to support the early identification of children's needs. Health visitors and other partnership services deliver an effective range of early interventions and support for families.
- Young people who become known to the youth justice service benefit from a variety of health assessments. These help to identify previously unmet speech and language needs and social, emotional and mental health needs.
- Leaders are determined that children and young people with SEND should have their needs met at the earliest possible stage. To support this aim, they have increased capacity in the statutory assessment team in recognition of increased demand and lack of timeliness and quality.

Areas for development

- The coordination of education, health and social care services and support across the area is inconsistent. Although some services work together well, this is not the case for all. Some children and young people with SEND do not experience a well-planned and consistent approach to identification of their needs. As a result,

some parents and school leaders are frustrated and have resorted to paying for assessments, for example speech and language assessments, to identify children and young people's needs.

- Leaders know who their most vulnerable children and young people with SEND are. They have effective systems in place to identify these children and young people. However, the processes for assessing and meeting these identified needs are not well communicated to families.
- Over time, leaders have not ensured that EHC plans are checked thoroughly. They have not tracked progress towards the outcomes identified in EHC plans well enough. Some outcomes are not specific to the child or young person's needs. Too often, health and care outcomes are missing from plans. A structured approach to assure the quality of new plans and improve existing plans is being implemented.
- Waiting times for assessment of ASD in Haringey are too long. This has more recently been exacerbated by the pandemic, with, for example, waiting times for assessment in the five to 12-year-old age group being up to, and in some circumstances more than, two years. In addition, some children are required to be assessed by speech and language therapists (SALT) as part of their ASD assessment process. Waiting times for SALT are high and these families are waiting too long for a potential diagnosis, with little or no support provided during the waiting period.

The effectiveness of the area in meeting the needs of children and young people with special educational needs and/or disabilities

Strengths

- Early years settings visited by inspectors have an ethos of inclusivity. Settings make reasonable adaptations to ensure that children, including those with the most complex needs, can access and enjoy mainstream settings. Early years practitioners ensure that children without additional needs interact with those who have SEND, which is helping to create a positive and inclusive culture.
- The Special Educational Needs and Disability Information and Advice (SENDIASS) service is well led and impartial. Leaders are aware of their function within the system. Parents who use the service value its high quality and appreciate the support provided.
- Health visitors advocate for children, families and the local community over and above the delivery of the healthy child programme. This includes work with families who find it hard to make their concerns known. For example, they assist

families with enquiries about housing issues, which helps improve environments for vulnerable babies and children.

- Parents value specialist provision in mainstream schools and special schools. They greatly appreciate the effective way these settings meet their children and young people's needs.
- Children and young people with SEND spoke positively about their schools and were able to identify professionals who help and support them. Children and young people, in non-COVID times, can attend a variety of inclusive after-school activities, such as sports clubs, swimming, music and social events. These activities help them to build their confidence and socialise.
- Leaders encourage innovation. There are some interesting examples of this, for example the five-day offer at college, including during the holidays, and the maintenance of contact with children and young people during lockdowns by some health, social care and education practitioners.

Areas for development

- The quality of EHC plans is weak. Plans do not tell the story of the whole child. The educational element is more detailed and insightful, but routinely information about health and social care needs is not included.
- Leaders have only recently started to check the quality of all EHC plans and ensure that all partners are contributing. This means that plans have not always been subject to a rigorous quality assurance process, and therefore their quality and timeliness are variable.
- The online local offer is not functioning effectively. It can be inaccessible and lacks clarity, ownership and credibility. Some health practitioners and parents spoken to were unaware of its existence. Some parents who have accessed the offer find it difficult to find and access short breaks, social activities for their children and respite provision within the area, for example. Also, for those who are older, there is limited short-break availability in the summer holidays.
- Leaders acknowledge the need to have a more joined-up approach to the planning of provision for those aged 19 to 25. Young people, including those with complex needs, are not supported well in making successful transitions into adult life. There is a limited choice of supported living opportunities, further education, and internship programmes to provide suitable options for those in this age group.
- There is more to do to embed co-production in the local area. Parents and professionals are ready to be part of the solution. An inclusive approach to young people's participation is required. Young people felt that listening did not always turn into action, and they want to participate in projects that change perceptions and attitudes towards young people with SEND and empower them.

- At the time of our inspection, some SALT provision into mainstream schools after Year 2 was focused on those children and young people with an EHC plan or those who were in the process of an EHC plan being provided. This means that children without an EHC plan might not receive the care and support that they require.
- Communication from staff to families between a referral being made for ASD assessment and the actual assessment taking place is weak, leaving some families wondering if an assessment will go ahead. Staff we spoke with agreed that communication could be improved so that families are better informed.
- Parents told inspectors that they were concerned that communication with professionals is poor, with many parents advising that they must 'tell their story' again and again. They also said that emails remain unanswered or delayed, which raises anxieties and promotes mistrust.

The effectiveness of the area in improving outcomes for children and young people with special educational needs and/or disabilities

Strengths

- Academic outcomes for children and young people with SEND are good and improving because of the effective identification of needs and the well targeted support in the early years. Settings and schools ensure that the curriculum is adapted to meet the needs of children and young people.
- Most pupils attend provision which has the confidence of children, young people and their parents. Most attend schools which have been judged to be good or better by Ofsted.
- Leaders across education, social care and health are ambitious for young people with SEND. Young people told inspectors that they know what they need to do to achieve their ambitions. Some young people spoke of their desire to attain qualifications, go to college and take university courses. A large proportion of young people with SEND leave school to attend further education, enter employment or begin apprenticeships. However, the options are limited and not always matched to the needs of young people.
- Attendance is good, and exclusions have reduced over the last three years because schools are vigilant.
- Young people not in education, employment, or training are relatively few as schools and settings develop innovative approaches and pathways to find placements.
- Health practitioners recognise the vast diversity of the population of Haringey and know how to adapt the SEND service provision to meet cultural needs and beliefs.

Areas for development

- Health practitioners do not always measure the impact of their work. This includes, for example, amended EHC plans not being routinely contained within health records. This not only means that those records remain incomplete, but also that health practitioners are not aware of key information that might be useful in their interactions with those children and young people.
- Area leaders have identified that some children and young people with ASD are not having their needs met quickly enough in appropriate provision. Parents expressed their concerns about the negative effect that delays in assessments can have on their children's long-term outcomes. This includes young adults with learning disabilities, as there is no dedicated 18+ autism service in Haringey. An autism hub is planned, but at the time of the inspection this was not in place.
- Annual reviews are not undertaken proficiently and EHC plans are not amended, even when the young person's needs have changed significantly. There is too much variation, particularly regarding health and care outcomes. This is impacting on transition for young people leaving college, because their needs are not accurately described.
- Preparation for adulthood is not planned well. There is a limited range of options for young people, particularly when moving into employment. Students and parents told inspectors that advice and guidance was limited and often too late. This limits their preparation for adult life and fails to match their needs.

The inspection raises significant concerns about the effectiveness of the area.

The area is required to produce and submit a Written Statement of Action to Ofsted that explains how the area will tackle the following areas of significant weakness:

- the poor quality of EHC plans and the annual review process, especially as children and young people prepare for adulthood
- the lack of partnership working and poor communication and co-production with parents, children and young people. This includes communication through the local offer
- unacceptable waiting times for ASD assessment.

Yours sincerely

Philip Garnham
Her Majesty's Inspector

Ofsted	**Care Quality Commission**
Michael Sheridan Regional Director	Victoria Watkins Deputy Chief Inspector, Primary Medical Services, Children Health and Justice
Philip Garnham HMI Lead Inspector	Daniel Carrick CQC Inspector
Claire Prince Ofsted Inspector	

Cc: Department for Education
Clinical commissioning group
Director of Public Health for the area
Department of Health
NHS England

Report for: **Health and Wellbeing Board**

Title: **Approval of Haringey Better Care Fund (BCF) 2020/21 Submission to NHS England**

Report authorised by: Beverley Tarka, Director of Adults and Health, London Borough of Haringey
Rachel Lissauer, Director of Integration, Haringey CCG

Lead Officer: Paul Allen, Head of Integrated Commissioning (Older People & Frailty), North Central London Clinical Commissioning Group (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. The Better Care Fund (BCF) Plan is a national programme to fund integration of services at a local level. It is underpinned through a Section 75 agreement to pool funds between the Clinical Commissioning Group (CCG) and London Borough of Haringey (LBH). The Department of Health & Social Care (DHSC) which runs the BCF Programme requested each local area to submit a full BCF Plan in 2021/22, as it is several years nationally since local BCF Plan Narratives were refreshed.

1.2. North Central London (NCL) CCG, the London Borough of Haringey (LBH) and our partners have worked together to construct and agree the BCF funding schedule to support integration, in particular the Ageing Well Strategy, as part of the Haringey Partnership Board's responsibilities. The Plan was discussed with partners at Haringey's multi-agency Ageing Well Board, a sub-group of the Haringey Integrated Care Partnership Board. The out-of-hospital targets and narrative summary were signed-off at recent North Middlesex University Hospital (NMUH) and Whittington Health Trust (WHT) A&E Boards.

1.3. As per DHSC mandated policy requirements, this report requests that the Health & Well-Being Board approve the Better Care Fund Plan Narrative, its funding schedule (confirming that the breakdown of the funding fulfils National Funding conditions for 2021/22) and the trajectories for the metrics included in its scope to March 2022.

2. Cabinet Member Introduction

2.1 Not applicable.

3. Recommendations

3.1. The Health and Wellbeing Board is asked to endorse the submitted Haringey Better Care Fund (BCF) Plan which includes:

3.1.1. the investment schedule in Appendix 1

3.1.2. the BCF Narrative for 2021/22 in Appendix 2

3.1.3. the trajectories for the metrics within its scope also in Appendix 2

4. Reasons for decision

4.1 The BCF Plan 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 aligns with the Borough Plan and is is key to delivering Haringey's multi-agency Ageing Well Strategy. The report is brought to the Health and Wellbeing Board as the National Conditions set out by the DHSC include a requirement that BCF Plans covering all mandatory funding contributions have been agreed by Health and Wellbeing Board areas.

4.1. The timing of this report and the recommendation to sign off the submitted Plan have been affected by the COVID pandemic which resulted in unprecendented challenges in the integrated health and care system locally, regionally and nationally. One consequence has been that the DHSC national policy requirements and guidance for the BCF Plan 2021/22 to local areas were delayed. The requirements, template and supporting documents were eventually released in September 2021 and all Boroughs needed to submit the Plan no later than 16th November 2021. As with many local areas, this has meant the CCG, LBH and its partners have had to submit the BCF Plan and the detals of its financial contribution prior to this submission to the Health and WellBeing Board. In such circumstances, the guidance requires local Health & WellBeing Boards to confirm the contents of the Plan and its compliance with the national conditions after the submission.

4.2. The information presented in the BCF Plan provides assurance to the Haringey Health and Wellbeing Board that Haringey is maintaining its commitment to 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. The Narrative submitted for Haringey's 2021/22 BCF Plan builds on progress made in previous years. It focuses on the local system's response to three national challenges:

- The need to respond to the legacy of the pandemic in the remainder of 2021/22, in particular managing a greater number of people whose underlying health

status and conditions may have worsened during the pandemic and who may seek medical attention in primary or secondary care. For example, we are seeing generally higher average acute daily A&E attendances in the autumn compared to the corresponding period pre-pandemic. At the same time the number of consultations in primary care increased by 14% across London, with NCL primary care showing a similar trend. The pandemic also changed our plans for development and delivery;

- Ensuring out-of-hospital systems are well prepared for increased activity in local Trusts to facilitate safe and timely hospital discharge in winter 2021/22;
- Addressing underlying issues associated with equity of access, outcomes and experience – and the resources to 'level to need' - across NCL and within the Borough. We know people living in more deprived (and often most diverse) neighbourhoods had around 17 years shorter healthy life expectancies than their most affluent peers pre-pandemic and there is good evidence nationally social gradients in inequality have worsened as a result of the pandemic.

6.2. In the Narrative Plan, partners set out how the BCF and its investment will address these multi-agency medium and longer-term challenges in as integrated a way as possible building a framework of support, called Haringey's integrated 'care cone', that tailors the needs of individuals to the best response in the system. The 'care cone' framework's aim is two-fold:

- To ensure the 'right joined-up solutions for the right person are delivered at the right time' to improve or maintain an individuals' physical and mental health, well-being and independence now and in the future - and best support their carers. Our framework emphasises the importance of a strength-based approach, prevention, self-management and personalisation, with delivery as close to home as possible, so people can stay as independent as possible;
- To help people avoid future health or social crises as far as possible and/or that people can recover as fully as possible after crises, ideally at home. We know some residents are at heightened risk of crises and hospitalisation that are avoidable through earlier detection, diagnosis and improved management of physical and mental health conditions, and this is a particular issue in deprived (and often diverse) communities.

6.3. Achieving these aims promotes system outcomes, including mitigating demand for intensive and costly interventions within the population. The framework of support achieves this is in 'the here and now' through reducing people's risk of crises and acute or non-acute hospitalisation. It also mitigates future demand by investing in early help and prevention to reduce the risk of individuals acquiring, or exacerbating existing, long-term conditions or adversely affecting their mental health and well-being. A key priority for 2022 is to address inequity of these outcomes (and the resources available to do so) in under-served communities within Haringey.

6.4. The BCF Narrative provides details of our approach but our Plans and investments categorises solutions within the care cone's levels of intervention:

- Feeling Healthy, Safe & Well: This element of the 'care cone' is closely linked to local and national public health messages/services to encourage people to

adopt, or get help with adopting, healthier lifestyles, e.g. smoking cessation, being active etc., and 'making every contact count';

- Early Help & Prevention: a targeted approach working with individuals to address issues or needs within communities, and/or those at 'rising risk' of needing more intensive or crisis-driven solutions soon. This includes encouraging people to come forward for earlier diagnosis, adopt healthy lifestyles, and better self-manage, their conditions, or get help to meet health, housing or social needs. We are planning a 'Healthy Neighbourhoods' collaboration between the statutory and voluntary sector to work together to engage and support communities, starting in the east of the Borough. The collaboration consists of a locally-based network of partners, including primary care, who will work to engage with communities and their representatives on local population health priorities, and develop community asset-based solutions to address them. The initiative is part-funded through the £5m NCL CCG Inequalities Fund aimed at 'levelling to need' across NCL and partly through the BCF Plan;
- Anticipatory Care & Support: people whose health, housing and social needs are more complex and/or intense, who need a tailored and often an integrated and multi-disciplinary response to these needs including care and support services. The two major initatives discussed in this section are development of the Multi-Agency Care & Coordination Team and Enhanced Care in Care Homes developments to plan with, and support, people proactively with frailty/multi-morbidity in the community and in care homes, respectively;
- Specialist/Emergency: people who need highly specialised health and social interventions and/or who are approaching or are at a social or health crises or need help recovering from crisis, ideally at home. This includes a particular focus on out-of-hospital solutions to meet demand, and we have expanded capacity of several of our existing schemes in 2021/22, partly through the BCF Plan and partly through other funding sources.

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

6.6. It should be noted the BCF Plan is just one investment 'pot' which promotes integration and out-of-hospital solutions – several other local and national funding streams are available in 2021/22, e.g. National Discharge Funding, NHSE CCG Ageing Well Programme Funding and CCG Inequalities and System Resilience funding. These investments and the joint work across partners should be seen as a developing an integrated respose across Haringey and NCL, and the BCF Plan discusses sets out some of the areas of particular development:

- How we intend to improve equity of access, outcomes and experience in terms of health, well-being and independence amongst our under-served communities;
- How we intend to improve our integrated health and care system in the Borough as part of our response to the NHS Long-Term Plan, including development of multi-disciplinary primary care and integrated care networks, to deliver health and care closer to home at a Borough and neighbourhood footprint;

- How we continue to work with our wider set of partners, such as Connected Communities, housing and the voluntary sector, to ensure our plans are aligned with wider planning to strengthen communities;
- How we will will ensure there is a 'golden thread' connecting care solutions across differing geographical footprints so there is a coherent picture of support across NCL, Borough and neighbourhood footprints.

6.7. The delivery of the Plan already had a positive impact on supporting people in Haringey to have healthy, long and fulfilling lives in 2020/21 and 2021/22, including:

a. Rising to the challenge of implementing robust COVID national hospital discharge guidance. During the pandemic, the proportion of people discharged from hospital who needed short-term care and support to recover increased significantly due to the impact of the condition and the surges in hospital admissions locally. The NHS, Council and voluntary sector worked together at WHT, NMUH and other NCL hospitals to discharge more patients, predominantly back home, more quickly than at any time pre-COVID, with staff working extended hours and 7 day working;

b. The proportion of patients who were in hospital for 21 days or more was decreased by 23% and 35%, respectively, between 2019/20 and 2020/21, far greater than the reduction in emergency admissions (both 15%), and this position has been maintained into the current financial year. The proportion of patients with 21+ day length of stays (15.5%) at Whittington Hospital was consistently one of the best Trusts in London at end Oct-21, with the corresponding proportion for NMUH being 21.5%;

c. Over 1,650 reablement episodes were completed in Aug-20-Jul-21 (a 15% increase on the corresponding figure pre-pandemic). LBH's Reablement Service and its partners provide short-term (<6 weeks) intensive therapy to help people recover their ability to undertake daily living, such as washing or getting around their home, after a crisis and/or hospital episode, e.g. due to a fall. This Council service now operates jointly with NHS community health therapists;

d. The majority of these individuals were aged 65+, and, of these, over 70% were at home for 91 days after hospital discharge, i.e. as opposed to returning to hospital or being admitted to a care home. We find that 73% of individuals need no further long-term Council-funded care after reablement, as they have recovered sufficiently;

e. Since the pandemic, a 40+ percentage increase in the typical month number of patients (to 140) accessing the multi-disciplinary Rapid Response service (usually responding within 2-4 hours) to treat people who are nearing, or at, a health crisis at home for up to 5 days following referral via a care professional. The service ensures people don't need to go to A&E unnecessarily;

f. Continued investment in for our Anticipatory Care solutions in 2021/22, with both our Multi-Agency Anticipatory Care & Coordination (MACC Team) and the community health element of our Enhanced Health in Care Homes (EHCH) model to manage the holistic (and often complex) needs of older residents/those with multi-morbidity in the community and in care homes. The EHCH service support residents and staff of care homes in Haringey to manage their needs. The BCF Plan matches similar National Health Service England (NHSE-I) investment in the primary care element of the EHCH to support each care home to have a named GP lead and routine 'Home Rounds', established in Haringey.

6.8. The national policy requirements state the Health & Well-Being Board must sign-off the schedule of investment for the Better Care Fund (BCF) Plan as part of a pooled Section 75 for 2021/22.

6.8.1 NCL CCG is expected to make a Minimum Contribution to the Haringey BCF Plan. Two of the national conditions are that:

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

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

- Improved Better Care Fund (iBCF) to meet the growing demand for care packages and reduce LBH's financial risk. The iBCF in 2021/22 incorporates the LA Winter Pressures, which is used to mitigate increased demand in the social care system particularly during the winter;
- Disabled Facilities Grant to fund major adaptations to LBH clients' properties (regardless of tenure type) to support them to live at home.

6.8.2 Table 1 shows the changes in BCF Plan funding between 2020/21 and 2021/22 and the proposed schemes are listed in Appendix 1. The majority of these schemes are existing services which we are continuing to fund in 2021/22.

6.8.3 There is a £1.1m uplift in the Minimum CCG Contribution between the two years. To conform to the national conditions above, £372k of this uplift must be spent on social care, including preventative solutions. Appendix 1 highlights schemes that are either newly BCF funded or in which the investment in an existing service from 2020/21 has been increased; collectively the additional investment in these rows make up the £1.1m uplift, including the £372k spend on adult social care.

Haringey BCF Plan Investment	**2020/21**	**2021/22**	**Change 21-22 v 20-21**	
			Increase	**% Increase**
Disabled Facilities Grant	£2,678,851	£2,678,851	£0	0%
iBCF, including WP Grant	£9,518,076	£9,518,076	£0	0%
Minimum CCG Contribution	**£19,892,808**	**£21,020,860**	**£1,128,052**	**5.7%**
Of which, minimum spend that must be on:				
- NHS commissioned Out-of-Hospital Spend	£5,652,972	£5,973,532	£320,560	5.7%

- Adult Social Care Services Spend	£6,534,023	£6,904,545	£370,522	5.7%
TOTALS	**£32,089,735**	**£33,217,787**	**£1,128,052**	**3.5%**

Table 1 – Requirements for Spend Haringey BCF Plan Funding 2020/21 and 2021/22

6.8.4 Table 2 confirms the schedule in Appendix 1 fulfils the 2021/22 National Conditions applied to Haringey.

Selected Health and Wellbeing Board: Haringey

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,678,851	£2,678,851	£0
Minimum CCG Contribution	£21,020,860	£21,020,860	£0
iBCF	£9,518,076	£9,518,076	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£33,217,787**	**£33,217,787**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£5,973,533	£13,929,577	£0
Adult Social Care services spend from the minimum CCG allocations	£6,904,545	£6,904,546	£0

Table 2 – Schedule of Funding v. National Requirements for BCF Plan 2021/22 (taken from BCF Spreadsheet, Expenditure Tab)

7. Contribution to strategic outcomes

7.1. The BCF Plan will contribute to objectives within both the Place and People Themes of the 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 Haringey's BCF Plan is one of the key plans for the London Borough of Haringey (LBH) and North Central London CCG. In particular it supports and helps deliver:

- North Central London Sustainability and Transformation Plan;
- North Central London Response to the NHS Long-Term Plan;
- LBH Joint Health and Well-being Strategy and is line with Haringey's Joint

Strategic Needs Assessment;
- Haringey Borough Partnership Delivery Plan.

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

8.1 Finance

8.1.1. The Better Care Fund (BCF) is a pooled budget of £33m between the London Borough of Haringey (LBH) and North Central London Clinical Commissioning Group (NCL CCG), as shown in Table 1. It is part of the overall Section 75 Agreement between both these parties.

8.1.2. Funding will be used for existing schemes that are rolled forward. There is an additional £371k (5.7% increase) funding allocation in 21/22 which will be spent on a combination of existing and new services (see Appendix 1).

8.1.3. The purpose of the fund is to enable integrated working across NCL 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.

8.1.4. The funding has been allocated jointly by LBH and NCL CCG in accordance with the aims and objectives of the plan.

8.2 Legal

8.2.1 The 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 Better Care Fund (BCF) policy framework here https://www.gov.uk/government/publications/better-care-fund-policy-framework-2021-to-2022 and planning requirements here https://www.england.nhs.uk/wp-content/uploads/2021/09/B0898-300921-Better-Care-Fund-Planning-Requirements.pdf parts of which are covered in this report, sets out the expectations of the local authority, CCG and the HWB. The BCF national conditions provides that *"The local authority and CCGs must agree a plan for their local authority area that includes agreement on use of mandatory BCF funding streams. The plan must be signed off by the HWB. BCF plans should set out a joined-up approach to integrated, person-centred services across local health, care, housing and wider public services. They should include arrangements for joint commissioning, and an agreed approach for embedding the current discharge policy in relation to how BCF funding will support this."* The recommendation to the Board to consider and approve the Haringey BCF Plan are in line with BCF policy and planning guidance."

8.3 Equality

8.3.1. An Equalities Impact Assessment (EIA) was completed for the whole BCF Programme in Dec 14. However, an EIA was undertaken as part of the wider Ageing Well Strategy in 2020 for which the BCF Plan is largely a funding vehicle.

8.3.2. The 2020 Ageing Well EIA indicates the Ageing Well (and by extension BCF Plan) programme has a number of perceived benefits to people with protected characteristics. The assessment highlighted a particularly positive impact on older people (over 65), disability (including mental health), gender and ethnicity.The same positive impact will occur in 2021/22, but we recognise that the EIA needs to be refreshed to better consider the impact of COVID-19 in particular on specific communities or groups in Haringey, hence the need for the updated EIA.

8.3.3. The positive impacts in the Ageing Well EIA were mainly due to: the cohort of patients and services users that will be the main beneficiaries; the delivery of services in people's homes; working in a service user centred way to define health and social care goals; and the intention to improve health and well-being. The development of specific aspects of the current Plan (particularly Healthy Neighbourhoods in the east of the Borough) will help tackle equity of access and outcomes within Haringey's more deprived (and diverse) neighbourhoods. No negative impacts were highlighted.

8.3.4. The BCF Plan EIA is currently being updated to reflect the impact of the pandemic on the population. For example, we know the pandemic was proportionately more likely to result in adverse health outcomes for some groups, including people from Black African and Caribbean, SE Asian and eastern European backgrounds, as well people living in more deprived neighbourhoods. The Bridge Renewal Trust report on the impact of the pandemic on specific ethnic groups recommended a number of actions, including better collection of ethnicity data, improved engagement, communication and shaping of solutions to improve equity of access and outcomes, and the need to address practical barriers, such as digital exclusion. These recommendations were absorbed into both the Ageing Well Strategy's, and many other, projects, such as working with communities to promote vaccine take-up and embedding statistical monitoring on equity of access. We will reflect these responses, as well as initiatives such as part BCF-funded Healthy Neighbourhoods in the east of the Borough (specifically designed to address social gradients associated with deprivation and ethnicity), in our updated EIA for the BCF Plan.

9. Use of Appendices

9.1. Appendix 1: Haringey's BCF Plan 2021/22 Completed Income and Expenditure Template, including schedule of schemes

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

Appendix 1 – BCF Plan 2021/22 Funded Schemes (including new proposals / increased investment in existing schemes funded via CCG Minimum Allocation in green cells)

Service Area	Description	TOTAL 21/22 Budget	Increase in BCF funding from 20/21
EARLY HELP & PREVENTION			
Health-orientated information, advice and guidance for citizens in Healthy Neighbourhoods	Voluntary sector provision of advice, information, signposting and guidance for people needing help	£55,000	
Local Area Coordination element of locality working and Healthy Neighbourhoods initiative	Voluntary sector coordinators to provide advice, information & signposting for people who need assistance and help develop community assets	£120,136	
Integrated Health, Housing, Finance & Care Early Intervention In Hospital - 'Healthy Neighbourhoods in Acute'	Advice and early help solutions for people to manage finances, housing, health, well-being & independence via integrating community solutions such as Connected Communities in health facilities	£159,000	
Integrated Health, Housing, Finance and Care Early Intervention Solutions to support Health Neighbourhoods in our Localities	Solutions to provide early help to people to help manage finances, housing, health, well-being & independence via integrating community-facing VCS solutions in HN collaboration	£128,801	£91,306
Self-Management Support	Structured programme of courses for patients interested in condition self-management or being expert patient	£91,600	
First Response Social Care Team	LBH posts to increase capacity in community first response, initial triaging & management of cases to support timely response	£230,000	
Strength and Balance Opportunities	Strengthening & balancing classes & exercises for people with a falls risk	£58,000	
Support for Dementia Friendly Haringey	Council funded Dementia Coordinator to take forward development of DFH (part-year funding)	£20,000	£20,000
Support for Community Navigation / Social Prescribing	Council commissioned support for community navigation/social prescribing network & community of practice (part-year funding)	£15,000	£15,000
ANTICIPATORY CARE AND SUPPORT			
COPD Exercise Programme	Community-based exercise groups for suitable COPD patients referred via health professionals	£13,000	

Service Area	Description	TOTAL 21/22 Budget	Increase in BCF funding from 20/21
Dementia Day Opportunities	LBH commissioned services to support people with dementia with facility- or wider home/ community-based day care/support	£475,000	
Nursing Services & WHT Contract Uplift*	District nursing for non-ambulant patients at home (* Increase is associated with uplift) and community matrons in MACC Team (see next line)	£7,070,798	£324,004
Multi-Agency Care & Coordination (MACC) Team	MACC Team multi-disciplinary team works in anticipatory care team working to screen, triage, assess & delivery solutions to people with frailty/ multi-morbidity	£1,226,993	£47,250
Investment in MSK Community Health & Primary Care services	Community health & primary care investment in MSK therapy services to improve people's health status & function (outside of IC)	£344,000	£344,000
Social work capacity to support complex case assessments	Investment in additional social worker to manage complex case assessments post-recovery, including joint Continuing Healthcare Assessments	£52,000	
Enhanced Health in Care Homes & Trusted Assessor	Implementation of EHCH Model and Trusted Assessor across Haringey to support care homes, their staff & residents	£216,000	
Palliative Care & Advanced Care Planning	NMUH-led multi-agency services to support range of community-, hospital- and bed-based palliative care	£766,000	
Expand End of Life nursing and other services	Investment in out-of-hours nursing services for end of life patients. This improves quality of life in last few days, supports advance care plan delivery & reduces risk of hospitalisation	£154,429	
Carer's Support	LBH commissioned range of solutions for carers: identifying carers, undertaking assessment of needs and support through to carers' respite.	£1,067,000	
Disabled Facilities Grant	LBH commissioned provider undertaking major adaptations of individuals' home to facilitate improvements in daily living functioning	£2,678,851	
IBCF*	Most of spend on providing long-term packages of care as part of social care clients' Personal Budgets. (**includes £1.15m on: care beds/step-down flats & care packages to support discharge in 2021/22*)	£9,518,076	
SUPPORTING DISCHARGE - RECOVERING AFTER CRISIS / ILLNESS			

Service Area	Description	TOTAL 21/22 Budget	Increase in BCF funding from 20/21
Integrated Discharge Team/Single Point of Access to support hospital discharge	Investment in teams involved in discharge (social work & nursing resources), including onward management & assessment of individual. Includes costs to cover extended hours and 7 day working	£266,093	
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	
Whittington Integrated Care Therapy Team	Multi-disciplinary therapy service in community and acute that supports older people (& other groups)	£3,268,293	
MH Discharge Coordinator	Social worker in MH service to support discharge & onward planning for patients with severe MH issues	£40,000	
Rapid Response	Multi-disciplinary nursing & therapies team to respond quickly when people are at crisis and/or need short-term rehabilitation at home or in A&E.	£410,000	
Enhanced Virtual Ward	Enhance existing EVW model through increased GP capacity for Haringey	£42,000	
Alcohol Liaison Services	Alcohol Liaison Nurses & Support Worker to support hospital patients with alcohol-related issues & coordinate support in community	£61,585	
Reablement Solutions	Community Reablement solutions to support people regain ability to undertake daily living skills, including patients with more complex needs	£3,274,785	£65,885
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	
MH Reablement Solutions	Investment in dedicated OT to support MH non-acute discharge development for people with complex physical & mental health needs	£52,000	£39,000
Enhanced bed-based intermediate care capacity	Intermediate care beds in care home to rehabilitate, assess individuals' needs and eligibility for CHC post-recovery as part of ASC contract with PWH	£155,000	
Nursing Intermediate Care	Nursing beds in care home with rehab MDT input & nursing outreach to patients' homes for those needing period of convalescence post-discharge	£413,523	£45,276

Service Area	Description	TOTAL 21/22 Budget	Increase in BCF funding from 20/21
Winter MDT capacity to support patient onward management of patients	Additional therapy & social worker resources to support for bed-based intermediate care patients in care homes in winter	£196,103	£96,331
Supporting people with challenging housing needs to return home post-hospital discharge	Investment in out-of-hospital housing liaision function to facilitate acute and non-acute hospital discharge of people with challenging housing environments to return home in a timely way	£40,000	£40,000
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		**£33,217,787**	
New or Increased Investments to BCF Plan Schemes from CCG Min. Allocation			**£1,128,052**

Title:	**Haringey Health & Well-Being Better Care Fund Narrative**
Report Authorised By:	**Beverley Tarka, Director of Adults and Health, London Borough of Haringey**
	Rachel Lissauer, Director of Integration, North Central London Clinical Commissioning Group
	Sarah Mansuralli, Director of Strategic Commissioning, NCL CCG

Bodies Involved in Developing Plan:	**North Central London CCG**
	London Borough of Haringey (including its housing function)
	North Middlesex University Hospital NHS Trust
	Whittington Health NHS Trust
	Barnet, Enfield and Haringey Mental Health NHS Trust
	Haringey GP Federation
	Bridge Renewal Trust (as strategic partner for voluntary sector in Haringey)
	Haringey Healthwatch
	This Narrative Plan and the supporting material was developed in partnership chiefly between the CCG and Council, but was shared more widely and discussed with clinicians and managers representing the range of bodies discussed above in its development. The direction in this Narrative builds on Haringey's multi-agency Ageing Well Strategy 2019-2023 developed in conjunction with partners, and the direction in the NHS Long-Term Plan. The Ageing Well Board, a multi-agency sub-group of the Haringey Integrated Care Partnership, reviewed the main elements of the Narrative, and proposed some changes. However, Ageing Well partners including all the bodies listed above broadly supported its contents and the approach of the Plan. Many of the bodies listed above have been key design and delivery partners for key integrated care solutions described in this Plan, e.g. implementation of anticipatory care/Enhanced Health Care in Care Homes and out-of-hospital services and the proposed Healthy Neighbourhoods collaboration in the east of the Borough. The latter is a proposed collaboration between the statutory and voluntary sector, and, with Bridge Renewal Trust, we have engaged a wider set of voluntary sector partners on the design and priorities for Healthy Neighbourhoods. We also presented the Plan to our partners involved in out-of-hospital services, particularly the acute Trusts (NMUH NHS and Whittington Health NHS Trusts), to discuss that element of the Plan, and to agree the metrics relating to hospital-based activity within the Plan.

Executive Summary

We will work together to ensure all adults are able to live healthy and fulfilling lives, with dignity, staying active and connected in their communities
Haringey Borough Plan 2019-2023, Priority 2

Our approach to the Better Care Fund Plan in 2021-22 reflects this aim, and extends the direction and achievements of the 2017-19 Haringey BCF Plan and Borough Plan, the changing landscape of local and national policy, strategy and delivery since 2019, and the unprecedented challenges of the pandemic.

We continue to build on the foundations of previous BCF Narratives in shaping a person-centred approach to integration on a multi-geographical footprint. Our 2021-22 approach aligns with the Integrated Care System responsibilities in the NHS Long-Term Plan/Innovation & Integration White Paper and its approach to implementation in North Central London (NCL), including emerging developments such as the NCL Community Health Review and Ageing Well Programme roll out across NCL ICS. This Plan explains the role of the BCF Plan in supporting this overall approach but is just one lever to promote multi-agency integration.

Similar to other systems nationally, our three main challenges are:

- Responding to the legacy of the pandemic in the remainder of 2021/22, in particular managing a greater number of people whose underlying health status and conditions may have worsened during the pandemic and who may therefore be coming through both community and hospital routes. For example, we are seeing generally higher average ED presentation rates in the autumn compared to the corresponding period pre-pandemic; at the same time the number of consultations in primary care increased by 14% across London, with NCL primary care showing a similar trend. The pandemic also changed our plans for development and delivery (see below);
- Ensuring out-of-hospital systems are well prepared for increased activity in local Trusts to facilitate safe and timely hospital discharge for the remainder 2021/22 (see Supporting Discharge);
- Addressing the underlying issues associated with equity of access, outcomes and experience across NCL and within the Borough. We know people living in more deprived (and often most diverse) neighbourhoods had around 17 years shorter healthy life expectancies than their most affluent peers pre-pandemic and there is good evidence nationally social gradients in inequality have worsened as a result of the pandemic (see below).

In this narrative, we also set out how we intend to use the BCF funding to address these multi-agency medium- and longer-term challenges in as integrated a way as possible.

Our Overall Approach: Haringey's Integrated 'Care Cone'

Our 'care cone' model, aligned with the NHS Comprehensive Personalised Care Framework, describes how we work with individuals and tailor an integrated and person-centred response to their needs. It

forms the structure of several local strategies, including Haringey's multi-agency Ageing Well Strategy 2019-2023. Our approach will help us address the above challenges and its aims for individuals are:

- To ensure the 'right joined-up solutions for the right person are delivered at the right time' to improve or maintain an individuals' physical and mental health, well-being and independence now and in the future - and best support their carers. Our model emphasises the importance of a strength-based approach, prevention, self-management and personalisation, with delivery as close to home as possible, so people can stay as independent as possible (see sections below);
- To help people avoid future health or social crises as far as possible and/or that people can recover as fully as possible after crises, ideally at home (see Supporting Discharge). We know some residents are at heightened risk of crises that are avoidable through earlier detection, diagnosis and improved management of physical and mental health conditions, and this is a particular issue in deprived (and often diverse) communities.

Achieving these aims promotes system outcomes, including mitigating demand for intensive and costly interventions within the population. The model achieves this is in 'the here and now' through reducing people's risk of crises and acute or non-acute hospitalisation. It also mitigates future demand by investing in early help and prevention to reduce the risk of individuals acquiring, or exacerbating existing, long-term conditions or adversely affecting their mental health and well-being. A key priority for 2022 is to address inequity of these outcomes (and the resources available to do so) in under-served communities within Haringey and across NCL.

The Integration section provides details of our approach but our plans relate to the care cone's levels of intervention:

- Feeling Healthy, Safe & Well: a 'universal' offer across the population to encourage people to be as healthy, independent as possible without need for additional intervention;
- Early Help & Prevention, a targeted approach working with people and communities;
- Anticipatory Care & Support: people whose health, housing and social needs are complex;
- Crisis Management & Recovery.

Along with other sources of investment (e.g. NHSE Age Well Programme Funding), our BCF-funded services particularly fit the latter three 'care cone' categories. As in the 2017-19 Plan, a small proportion of the BCF Plan funds infrastructure to support programme oversight and delivery, including joint Council/CCG commissioning, quality assurance and analytical posts.

Although the 'care cone' is a universal model across the population, BCF Plan investments focus on supporting people who are likely to, or who have, acquired specific long-term physical or mental health conditions, have multi-morbidity and/or frailty; or who need help to recover after a crisis. A significant proportion of those individuals (around 95%) with whom most of core BCF-funded services are likely to work are 50+, and the majority (>75%) are 65+. However, there is a significant social gradient in health outcomes across Haringey and in NCL, so there is no 'age restriction' on accessing

BCF-funded services. BCF Plan also provides a significant financial investment to support (all age) informal carers.

In addition, some elements of the approach described below – such as Healthy Neighbourhoods (and its accompanying investment in early help and prevention), which explicitly incorporates support for people with mental health issues – are common to the population as a whole. The BCF Plan also makes investments in out-of-hospital services to facilitate both acute and non-acute discharges and recovery.

The Impact of the Pandemic

The national pandemic had a significant impact on people's physical and mental health and well-being, but also on many services in 2020/21's BCF schedule and our pre-COVID plans. For example, it resulted in the redeployment of staff to meet demand during the pandemic, including into the vaccination programme, promoted new ways of (particularly virtual) working and the introduction of the NHSE revised Hospital Discharge arrangements and funding.

Whilst this meant disruption to some services, the pandemic did accelerate some plans for integration between partners, such as intermediate care, with an emphasis on ensuring as many people as possible can recover, ideally at home, after a spell in hospital. Despite the out-of-hospital pressures we faced (including managing Waves 1 & 2 of COVID), we have worked together to reduce acute lengths of stay, and managed to service demand for a higher number of people needing to recover through reablement/intermediate care post-crisis. We are currently planning for winter within our local system (see Supporting Discharge).

Our BCF Plan reflects some of these changes to delivery, with additional investment prioritised in key areas to balance the immediate need to support out-of-hospital services with investment to support longer-term early help and prevention to help people adopt healthier lifestyles and self-manage in the community as we emerge from the pandemic.

Improving Equity of Access and Outcomes (see Equality Section)

As a system, we know we need to do more to address inequities in access, outcomes and resources associated with health, care and life chances we know exist across NCL and within our Borough. A long-term commitment of the Integrated Care System is to have a more equitable NCL distribution of particularly NHS resources to meet underlying need, and Haringey is a Borough likely to benefit from 'levelling to relative need', a process that started as part of NHS Planning Guidance in 2021/22.

We know the legacy of the pandemic is likely to reinforce existing social gradients associated with inequalities unless we take a targeted approach to equity of access, outcomes and experience for under-served groups. In collaboration with the voluntary sector and as part of our long-term commitment to locality working, statutory sector partners developed a programme to engage and promote vaccine take up in the more deprived and often most ethnically diverse parts of Haringey. We intend to build on this engagement to develop a 'Healthy Neighbourhood within our localities'

collaboration in east Haringey to improve social and health-related outcomes and equity of access and experience. This collaboration, part funded through the BCF Plan, aims to bring together a network of statutory and voluntary sector partners, including primary care networks, to work together to engage with communities to tackle their identified health priorities and holistic needs. We intend to roll out a similar model across other localities.

Part of our approach is to continue to support particularly vulnerable or 'at risk' groups or those potentially under-served. However, our concept of equity of access, outcomes and experience goes beyond the expectations of the Protected Characteristics. It includes people living in deprived neighbourhoods, people at risk of homelessness, people with specific conditions, such as mental health, and carers. These are all particular groups for which the BCF partly of fully fund services.

Governance

The sign-off and governance of the Better Care Fund is a two-stage process to reflect the merger of 5 local CCGs into a single North Central London CCG since the last BCF Narrative Plan and the direction of travel in the NHS White Paper, in which it is proposed to place the BCF Plan on a statutory footing.

The first stage relates to the process of sign-off within Haringey and by the Health & Well-Being Board. We developed the Plan locally. The Director of Integration in the CCG's Haringey Directorate and LBH Director of Adults and Heath led development of the Plan locally. Local partners then reviewed the Plan at our multi-agency Ageing Well Board, a sub-group of the Haringey Integrated Care Partnership, and agreed its direction and approach. The Ageing Well Board includes representation from the partners described in the previous section, including housing colleagues.

We presented our Narrative Plan and out-of-hospital metrics to A&E Delivery Board via their Chairs at NMUH and Whittington Health to assure that the metric's targets, particularly for 14 and 21-day length of stay, were in line with local Trust and national ambitions.

We formally reviewed the Haringey Plan locally within the Joint Finance & Performance Partnership Board between Council and CCG commissioners. We will formally submit the Plan for sign off at the next Haringey Health & Well-Being Board in Q3 2020/21. As the next meeting occurs after the national submission deadline, the LBH Director of Adults and Health has delegated authority to sign-off the Plan on behalf of the Board.

The second stage relates to the BCF Plan as a Section 75 funding vehicle and aligning its contents with other neighbouring Boroughs (particularly in relation to out-of-hospital services) and the wider NCL Integrated Care System. The CCG holds the s75 pooled budget associated with the BCF Plan. We have formally constructed the pooled budget associated with the BCF Plan as a s75 agreement, and the investments in the s75 were reviewed and agreed between Council and CCG commissioners and finance leads at the Joint Finance & Performance Partnership Board.

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

Reviewing Progress

Partners remain committed to jointly monitoring progress of the BCF Plan, the initiatives within it and its impact. The main vehicles for this oversight remains Haringey's Ageing Well Board and Joint Finance & Performance Partnership Board.

The Ageing Well Board's role is to bring partners together to progress the Ageing Well Strategy - much of the Plan's contents and investments are within the existing scope of the Strategy. The Board acts as a Programme Board for the Strategy's and BCF Plan implementation and, as such, has oversight of integrated care solutions partners are developing and delivering together. The Ageing Well Board also receives report on the impact of these solutions, and this will include the revised BCF Plan metrics. As appropriate, other subgroups of the Haringey ICP will have over-sight of some of the other developments and investment within the Plan, e.g. Haringey's Place Board will oversee development of the Healthy Neighbourhoods collaboration discussed in the Plan. The A&E Boards will also receive reports on progress against out-of-hospital metrics included in the BCF Plan.

The Joint Finance & Performance Partnership Board has local oversight of the s75 agreement. It is responsible for reporting local allocated BCF spend against budget to Haringey-based CCG and Council commissioners and has oversight of the impact of the BCF Plan investments on the key metrics. This Board is also responsible for compiling year-end BCF Plan evaluation of individual schemes against a range of pre-agreed criteria based around national and local expectations of ongoing strategic fit, quality, integration, impact and value for money. Based on the evidence in this evaluation, it also recommends whether to continue with these investments (or not) the following year.

Overall Approach to Integration

The Summary discussed the 'care cone' model and its aims. Whilst the model recognises solutions should be person-centred and tailored around individual's needs, circumstances and preferences, the 'care cone' categorises the response into:

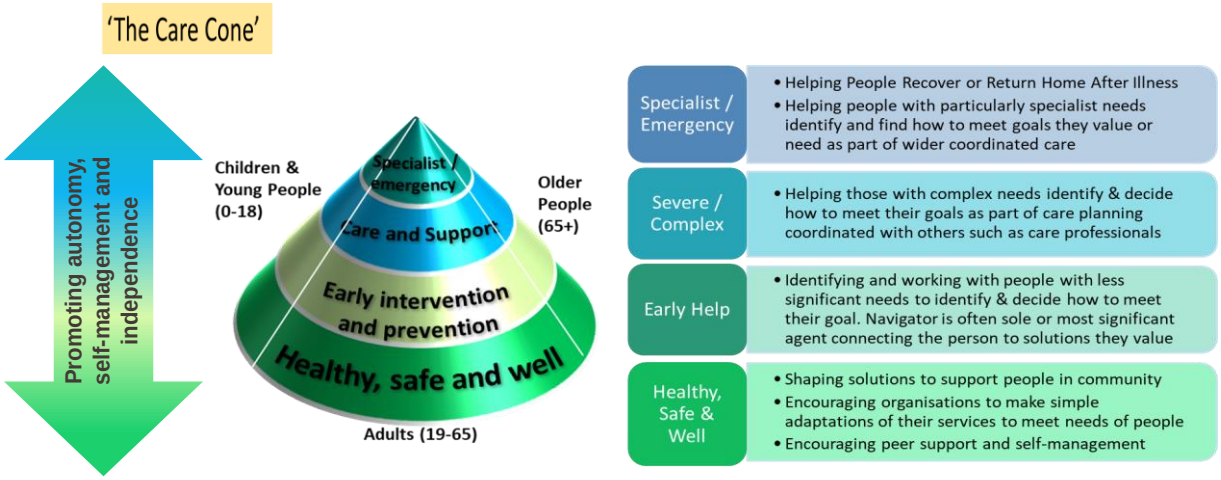
- Feeling Healthy, Safe & Well: This element of the 'care cone' is closely linked to local and national public health messages/services to encourage people to adopt, or get help with adopting, healthier lifestyles, e.g. smoking cessation, being active etc., and 'making every contact count';
- Early Help & Prevention: a targeted approach working with individuals to address issues or needs within communities, and/or those at 'rising risk' of needing more intensive or crisis-driven solutions. This includes encouraging people to come forward for earlier diagnosis, adopt health lifestyles, and better self-manage, their conditions, or get help to meet their health, housing or social needs;

- Anticipatory Care & Support: people whose health, housing and social needs are more complex and/or intense, who need a tailored and often an integrated and multi-disciplinary response to these needs including care and support services;
- Specialist/Emergency: people who need highly specialised health and social interventions and/or who are approaching or are at a social or health crises or need help recovering from crisis, ideally at home (see Supporting Discharge section for its priorities).

We provide examples of priorities we have identified for BCF funding within this framework in this, and the Supporting Discharge and Equalities, sections. We deliver many of our solutions in partnership across health, social care, housing and the voluntary sector. We also explain how our approach to integration and collaboration on a multi-geographical footprint builds on the 'care cone' framework. Specific changes to BCF Plan investment between 2020/21 and 2021/22 include:

- *Early help & prevention*: Expanding our investment pot to build community assets within the voluntary sector through our Healthy Neighbourhoods collaboration and to support our community navigators and coordinators and build multi-sectoral support for people living with dementia;
- *Anticipatory Care and Support:*
  - Further strengthening existing community health services, including in MSK;
  - Extending and consolidating our anticipatory care model for people with more significant frailty or multi-morbidity ('MACC Team' below);
- *Crisis Management:* Enhancing out-of-hospital services to facilitate acute and non-acute discharge to meet demand. This includes building 'Home First' capacity, enhancing our MDT to support P2 bedded patients and helping patients to address challenging housing issues to promote timely discharge (see Supporting Discharge).

At the end of each relevant section, we have included a table to describe how the investments we have listed in our spreadsheet relate to our model. The BCF Plan investment is part of a wider investment in these services and solutions (e.g. Ageing Well Programme funding, NCL Inequalities Fund, CCG and Council mainstream and Out-of-Hospital system resilience local and national funding).



Early Help & Prevention: 'Healthy Neighbourhoods in our Localities'

Building on our pre-existing locality working plans to co-locate staff from multiple agencies nearer communities they serve, we are planning a 'Healthy Neighbourhoods' collaboration to work together to engage and support communities. The collaboration consists of a locally based network of statutory and voluntary sector partners, including primary care, who will work to engage with communities and their representatives on local population health priorities. These priorities emerged from a combination of public-sector led intelligence (e.g. public health evidence base) and insight from communities and representative groups. The support will vary depending on the priorities identified, but the process of identifying and working with individuals (e.g. people living with frailty) includes:

- Primary care screening using an NCL-wide IT algorithm and local intelligence and networking between partner staff to identify residents who may need help;
- The voluntary sector working with statutory colleagues to 'in reach' into under-served communities, engage, connect and support individuals, help people work through needs and how they might self-manage; and help people address social issues that influence health and well-being outcomes, e.g. debt, access to benefits, housing issues etc. We also plan to support people to make positive lifestyle changes. For example, we recently launched our Ageing Well Guide and Resource Toolkit online, co-developed with a range of partners and representative groups. This provides hints, tips and contacts to help people ageing positively, e.g. eating well, looking after their mental well-being or support for carers. The Guide is online but we have distributed 5,000 copies to over 30 organisations working with older people in Haringey;
- The statutory sector working in localities to screen patients and provide diagnosis, professional advice, treatment and interventions, and connect them to voluntary sector partners. The statutory sector will work to improve partners' knowledge on issues such as LTC self-management.

Our 'Healthy Neighbourhoods' collaboration is designed to support people with physical and mental health needs. As part of this approach, we are piloting locality-based 'Mental Health Team Hubs' linked to two primary care networks working with the MH Trust and voluntary sector in our most deprived neighbourhoods to better support those with significant mental health needs.

Our collaboration emphasises the need to tailor our approach to individuals' needs, preferences and utilise their existing strengths and assets. As part of the collaboration, we are developing a joint 'Community Chest' as a funding vehicle to support community asset building in these localities partly funded through the BCF Plan, but also partly via other sources, e.g. CCG funding. The BCF also funds some of the infrastructure to promote early help and prevention, such as a new post in 2021/22 to support and promote our 120+ social prescribers and community navigation (some of whom are BCF-funded) operating in Haringey through our community-of-practice network, 'NavNet'.

We have captured how we anticipate locality working between statutory and voluntary sector and with communities through our multi-agency 'Haringey Way' set of principles, and Healthy Neighbourhoods collaboration is part of this overall approach. We are continuing our development of locality working in North Tottenham and North Middlesex Hospital as hub venues, and we intend to

roll out a similar model across Central and West localities in 2022/23. Some of the 'early help and prevention' funding is from the BCF Plan, some from our Inequalities Fund and other NHSE funding.

Alongside the health-orientated 'offer' of the 'Healthy Neighbourhoods' development, the North Tottenham hub already provides advice, guidance and help on issues such as debt, housing and care to the community via the voluntary sector, LBH's Connected Communities and DWP. The DFG section discusses the role of housing services in our model of collaboration.

Early Help & Prevention Funded Through BCF Plan (see also Spreadsheet; New or revised items in red font)		
Scheme ID	**Scheme**	**Reason for Change / Addition**
1	Health-orientated information, advice and guidance as part of wider advice model for citizens in Healthy Neighbourhoods	
4	Self-Management Support	
5	Local Area Coordination element of locality working and Healthy Neighbourhoods initiative	
9	Integrated Health, Housing, Finance and Care Early Intervention In Hospital as part of 'Healthy Neighbourhoods in Acute'	
10	Integrated Health, Housing, Finance and Care Early Intervention Solutions to support Health Neighbourhoods in our Localities	Increased investment to support VCS partnership development of Healthy Neighbourhoods collaboration
16	First Response Social Care Team	
18	Strength and Balance Opportunities	
24	Support for Dementia Friendly Haringey	**New:** investment in key area to rebuild post-pandemic Dementia Action Alliance
25	Support for Community Navigation / Social Prescribing	**New:** investment in infrastructure to support 120+ community navigators/social prescriber community of practice/problem-solving group in Haringey

Anticipatory Care & Support

We have continued with our substantial BCF funded investment in community health services as part of helping people to manage their long-term conditions. This includes a substantial investment in nursing and therapeutic intervention in the community, and supporting people with specific long-term conditions such as dementia, MSK or diabetes. Community health undertakes some of these interventions solely with primary care, but it may often be one organisational partner amongst several in an integrated model to manage people with complex cases of people with frailty and multi-morbidity through an anticipatory care model.

The development of our anticipatory care model for more complex cases is a good example of joint collaboration between partners. Haringey's Multi-Agency Care and Coordination Team (MACC) aim is manage the cases of people with moderate or severe frailty or multi-morbidity (including those with functional or organic mental health issues) living at home. MACC is a multi-agency and multi-disciplinary team led by a GP and consisting of nurses, therapists, pharmacists, mental health, adult social care and voluntary sector workers. It uses NCL-wide primary care tools and local intelligence from trusted referrers (such as GPs or people working in the community) to screen suitable patients across the Borough. The team triages individuals' health and social needs holistically:

- Those with less complex needs, who could work with voluntary sector social prescribers and/or a health professional, are supported to access solutions that could help and better understand and self-manage their condition, collaborating with locality-based colleagues if needed;

- Those with complex needs who could benefit from a 'full' MDT consultation between staff to develop an individual's person-centred plan summary.

The GP Federation, NMUH, WHT, CCG, LB Haringey and voluntary sector jointly developed the operational model, service specification, outcomes and investment requirements and planned roll out of the model in 2021/22, funded through the BCF Plan. Haringey's Over 50s Forum and feedback from patients helped inform the model's features, e.g. need for a named coordinator as part of planning.

Partners took a similarly collaborative approach to develop the BCF-funded Enhanced Health in Care Homes between community and primary care and care homes to support people with frailty/multi-morbidity living in these homes. We are currently expanding our MACC and EHCH models, both of which support Primary Care Network DES requirements, in terms of their scope. This is part of our commitment to place our PCNs at the heart of locality working as part of their new population health responsibilities and initiatives such as Healthy Neighbourhoods supports this. We also continue to improve our part BCF-funded services to support people nearing end of life to provide high-quality care and support in their last years and days of life so they can die in the place they want.

Anticipatory Care Funded Through BCF Plan (see also Spreadsheet; New or revised items in red font)		
Scheme ID	**Scheme**	**Reason for Change / Addition**
3	Dementia Day Opportunities	
7	Nursing services, including community matrons for MACC Team	
11-15	Multi-Agency Care & Coordination Team	Integrated model of multi-agency Anticipatory Care partly bringing together previous models of support and partly increased investment, e.g. in social care and MH
17	Social worker capacity for complex cases	
19	Enhanced Health in Care Homes & Trusted Assessor	
20	IBCF Supporting Social Care	
21	Palliative Care & Advanced Care Planning Facilitator	
22	Increased investment in End of Life Nursing Care and other EOL services	
45	Investment in MSK Community Health & Primary Care services	**New:** Brought into scope of BCF Plan
46	Carers' Support	

Collaboration and Integration across a Multi-Geographical Footprint

Our approach to integration assures a 'golden thread' to align system solutions between partners at a multi-geographical footprint – a seamless 'offer' of support for our population at an Integrated Care System, Borough and neighbourhood/primary care network footprint. One of our objectives is to ensure we deliver solutions, tailored to individuals' needs, as close to home as possible. This places a bias on delivering integrated care solutions in the places people live and can access services tailored to the way they want them delivered, particularly for those communities at risk of being under-served.

At the same time, our aspiration across the ICS is to provide a more equitable 'core' set of community health solutions to reduce unwarranted variations in outcomes and resources across NCL. There are also solutions and common delivery frameworks that can be best be delivered at an NCL footprint, e.g. primary care population health tools to identify frail patients.

We are collaborating across multiple Borough and across NCL to assure a more equitable level of resources to meet underlying needs across NCL and within each Borough. The CCG is currently planning to increase investment in community-based services in Haringey (outside BCF) through:

- An Inequalities Fund to target better outcomes in more deprived neighbourhoods (see Equalities section), of which Haringey has the most of any NCL Borough;
- Equitable distribution of the NHSE NCL Ageing Well Programme in solutions relating to urgent care response in the community and in anticipatory care for people with more complex health needs.

The development of anticipatory care is a good example of how our revised approach to commissioning and integration is emerging on a multi-geographical footprint. NCL CCG completed the national Frailty Network self-assessment audit on each Borough's current position on solutions to support people with frailty. Following the audit, a consensus emerged across NCL about the features of an anticipatory care model aligned to the emerging primary care network DES and NHSE AW Programme requirements. Together with an analysis of underlying level of needs across NCL, this review supported decisions and multi-agency planning on an 'equity-based' Borough allocation of the CCG AW Programme funding. Within Haringey, multi-agency partners then collaborated to consider how best they could work together to plan where best they could invest in improvements – and this led to additional investment in the east locality, in agreement with partners at the Ageing Well Board. Operationally, the MACC Team works closely with locality-based partners to identify and manage the cases. In turn, those working in localities are encouraged to identify and respond to priorities in their neighbourhoods, including co-production with communities as part of population health management. The development of Healthy Neighbourhoods will enhance this collaborative model.

Supporting Discharge (National Condition 4)

During the pandemic, we continued to build on strong pre-existing arrangements associated with hospital discharge and intermediate care between secondary care and community partners. Staff in each hospital in North Central London, in community health services, CHC teams, and Councils work together to triage the needs of those hospital patients approaching discharge who were identified as needing care and support to return home through the Integrated Discharge Team (IDT) model within each hospital. This network of partners includes NMUH and Whittington Hospital, the two hospitals that admit more than 85% of emergency Haringey patients, as well community health, mental health and adult social care.

We continued to facilitate hospital discharge via a D2A approach based around the national High-Impact Change Model in line with the National Discharge Guidance. Partners continue to have three broad aims to prevent admission and/to facilitate discharge for both acute and non-acute patients:

1. To reduce the number of people presenting to hospital and/or admitted to hospital in crisis through urgent interventions at home or within A&E. In response, we expanded our BCF-funded investment in our community health/social care Rapid Response service. Referrals to Rapid Response increased by 40% per month pre- and post-pandemic, as we redeployed staff during the pandemic. Given this increase represents previously unmet demand for the service, we are

planning an expansion of our BCF-funded community health Rapid Response 'offer' funded through the Ageing Well Programme in 2021/22 and 2022/23;

2. To ensure as many inpatients as possible can return directly home in a timely and safe way as soon as they are fit to do so – 'Home First' – and that there is support from the voluntary and statutory sector for those who need it;
3. To ensure as few decisions as possible about an inpatient's long-term take place in hospital. Our presumption is that every patient should be given every chance to recover post-discharge, ideally at home or, if not, in a community bed. The patient's long-term care needs should be assessed only at the end of the recovery period.

The above aims, D2A/HICM approach and out-of-hospital intermediate care were in place pre-pandemic. What has changed during the pandemic, in line with national guidance, is how we manage discharges in partnership with others, the configuration of some of the services across North Central London and additional funding available to support these processes in 2020/21 and 2021/22, partly funded through the BCF Plan.

LB Haringey social care, community health and housing needs partners and NCL CCG leads are part of the extended network of partners within the acute-based IDTs to prepare and support patients for discharge and help them recover. The IDTs operate 7 days a week, with additional surge capacity available to manage peak demand between partners. The social care element of these IDT-related resources is partly BCF-funded and partly via additional CCG-based funding in 2021/22, and we are planning to strengthen available resources this winter.

We are planning for the winter within our local system as we face the legacy of the pandemic and the BCF Plan is part of our system resilience investments across partners. We are already seeing a higher seasonal level of ED presentations within North Middlesex University Hospital, despite a higher level of consultations in primary care than pre-pandemic. The impact of the pandemic has been not just on those who acquired COVID19 or who live with post-COVID syndrome, but also on the wider population at risk of 'physical and mental health and social deconditioning', particularly amongst people with pre-existing long-term conditions or difficult social circumstances. This resulted in a greater proportion of people who needed 'care-aided' (i.e. P1-P3) solutions on discharge from hospital earlier pre- and post-pandemic, and these cases were typically more complex. In turn, this led to an increase in the number of reablement hours, with some people with more complex cases needing extended time (>4 weeks) to recover at home, both of which we anticipate will continue for at least the remainder of 2021/22. We have therefore increased our investment in reablement in the BCF Plan, alongside increased investment in housing-related support for discharge (see Equalities section), to promote timely and safe 'Home First' for more complex patients. We made a similar commitment to increase our investment in physical reablement for patients in our non-acute mental health wards, as we recognise we needed to enhance our D2A arrangements for these patients (see Equalities section).

The pandemic resulted in unprecedented pressures to discharge people safely and in a timely way from hospital, particularly during the two peak waves. Partners in Haringey utilised the national funding scheme to help cope with the enhanced level of demand associated with patients who needed 'care-aided' solutions on discharge. We used the national scheme to fund demand-led activity over-and-above the levels anticipated in the BCF Plan. For example, the number of Haringey reablement hours nearly doubled during and post-Wave 2 (January – June 2021) compared to pre-pandemic, as more people were discharged from hospital earlier. Demand for reablement remains high, and we increasingly utilised 'Home First' solutions (including 24-hour packages of care) rather than P2 rehab beds. We will continue to utilise the national scheme in 2021/22 (though the support is capped at 4 weeks for each individual), but are considering our investment opportunities as a partnership for the end of the scheme next year.

Multi-agency community organisations worked closely together to meet the enhanced demand on reablement during the pandemic. We are currently developing a project for 2021/22 to bring together a joint Urgent Care Response function across LBH and WHT to consolidate the improvements made in supporting people to recover at home, with therapists and reablement staff funded from the BCF Plan.

We continued to invest in our intermediate care community beds, and, as part of the move towards more integrated working, are utilising shared NHS P2 community beds across NCL. For several years, however, the CCG and LB Haringey commissioned BCF-funded short-term intermediate care beds to help people convalesce and recover their health and function at a local award-winning nursing home. A joint care home, community health and adult social care MDT (funded via the BCF Plan) augments the Enhanced Health in Care Homes Team to help individuals recover and decide on their next steps, including patients who may need a Continuing Health Care or social care assessment post-recovery. The number of these community beds increased over several years (now 18 during the pandemic) and we have stepped up investment in our MDT (not covered by national discharge funding) to reflect additional workload and throughput.

All of the above support for recovery is not only beneficial and valued by patients but also mitigates the need or the level of statutory Council or CCG-funded long-term. For example, 73% of discharged patients who had a short spell of reablement in their home subsequently did not need long-term care.

We also know the impact of the changes associated with the national guidance is that the number of people (both all aged and 65+) who stayed 21+ days in hospital decreased by 23% and 35% [SITREP-based figures], respectively, between 2019/20 and 2020/21, far greater than the reduction in emergency admissions (both 15%). This means patients, particularly those with complex needs, were discharged more quickly during the pandemic, with more needing care and support.

There is also evidence we were largely successful in pursuing our aims discussed above. Haringey complies well with the national expectations:

- *Home First*: 94% of inpatients were discharged home from hospital between Aug-20 and Jul-21 [SITREP-based figures], including those supported through voluntary sector BCF-funded Homes from Hospital services – this compares to 95% expected nationally;
- 1.8% of inpatients were admitted directly to long-term care home from hospital during the same period, compared to the 1% expected nationally.

The table below summarises our investment in Supporting Discharge from the BCF Plan, including our new or enhanced investments from the BCF Plan. (However, clearly the BCF Plan is only one of several sources of available local and national funding into out-of-hospital services in 2021/22). Taken collectively, these investments facilitate safe and timely multi-agency patient discharge with an emphasis either on Home First or in managing the flow of patients to recover in a community bed and move-on from these beds. In doing so, they have already, or will, improve our performance against the 14/21 day LOS targets (through avoiding unnecessary delays) and usual place of residence metrics (through promoting Home First), despite the increased activity in the hospital over H2 2021/22.

Out-of-Hospital Funded Through BCF Plan (see also Spreadsheet; New or revised items in red font)		
Scheme ID	**Scheme**	**Reason for Change / Addition**
8	Whittington Integrated Therapies and Therapeutic Support for Urgent Care Response	Increased investment in therapeutic interventions for people in community, including those with more complex cases
23	Alcohol Liaison Services in Hospital	
26	Increase Single Point of Access/IDT-support function to meet demand	
28	MH Discharge Coordinator	
29	Home from Hospital	
30 & 31	Rapid Response Service (inc at NMUH)	
32	Enhanced Virtual Ward - GP Element	
33	Reablement Solutions	Increased investment in out-of-hospital reablement particularly for complex cases to promote 'HomeFirst'
34	MH D2A Reablement	Increased investment in out-of-hospital reablement in non-acute hospital
36	Short-term intensive packages of care to support people to return home from hospital	
37	Additional Long Term Packages of Care for Individuals	
38	Step down flats	
39-41	Community-Based Care Home Intermediate Care and Convalescence Beds (iBCF & Min. CCG Contribution)	Increased investment in nursing support in the community element of this model to support people to recover
42 & 43	Enhanced MDT to support indivudals' recovery & move-on in (particularly care home) P2 beds	Increased investment in multi-agency MDT to support recovery and timely move-on of people from P2 beds
44	Supporting people with challenging housing needs to return home post-hospital discharge	**New:** Investment in out-of-hospital housing liaision function to facilitate acute and non-acute hospital discharge of people with challenging housing environments to return home in a timely way

Disabled Facilities Grant and Wider Services

Our partnership incorporates collaboration between health, social care and housing-related services, and we have provided a number of examples in other sections in how we work together to better support the holistic needs of individuals. We have shared and discussed our plans with our supported housing and housing needs colleagues, including our plans for DFGs, within the Council and Homes for Haringey, who we work with to shape strategy and deliver. Outside of the BCF Plan funding, we are investing heavily in assistive technology to complement all areas of the Plan set out here.

We know demand for adaptations across all housing tenures continues to be high against the available DFG allocation in the Borough, particularly within more deprived areas. Our level of demand for adaptations continues to mean our DFG allocation fully committed to fund adaptations annually. This means we have little opportunity to invest in alternative housing-based solutions such as remote monitoring through the DFG allocation. Given this context, we have therefore decided as a partnership to fund additional housing support roles to support hospital discharge from sources other than the BCF DFG allocation.

Our work with housing colleagues since the last BCF Plan Narrative includes:

- Working with Registered Social Landlords, particularly Homes for Haringey colleagues, to support their residents to better promote healthy living messages, address digital inclusion and improve access to healthcare and other solutions and services. For example, Homes for Haringey is an active member of our Dementia Action Alliance, and has agreed to act an ambassador for the work of our alliance with RSLs in the Borough;
- We intend to expand our pre-pandemic plans to use of supported housing facilities as 'community hubs' for activities for those living in these schemes and in the wider neighbourhood;
- We are currently planning how we can make better use of existing solutions, including Extra Care, and expand the range of supported housing for older people living with frailty over the next few years. We are also currently exploring how we can improve housing options for particularly people with disabilities or severe mental health issues as they age;
- We are working closing with housing colleagues to facilitate timely and safe hospital discharge for those with challenging housing issues, risk of homelessness and/or rough sleeping (see Equalities), with some of these solutions funded through the BCF Plan. We are currently working on a joint protocol to support multi-agency staff in acute and non-acute hospitals, in out-of-hospital services including IDTs and in housing needs to understand their and others' responsibilities for patients in these situations, and to share expectations around timescales.
- The BCF Plan will invest in a housing liaison role within the IDT system to help people who are inpatients and whose discharge is difficult because although they are not at risk of homelessness, they may live in challenging housing environments not conducive to recovery, e.g. they need blitz clean, issues of hoarding, minor repairs needed etc. The post-holder will work with these patients and their families to organise rapid improvements in their living environment (which the BCF Plan will also fund) to facilitate safe and timely discharge from acute and non-acute hospital.

Equality & Health Inequalities

We produced an Equality Impact Assessment based around the Protected Characteristics plus socio-economic deprivation for the Ageing Well Strategy, which is at the heart of the BCF Programme at the end of 2019/20. The EQIA highlighted areas for improvement that we built into the Strategy, including ensuring solutions were better able to reach into specific under-served communities and that we monitor the extent to which services were equitable to specific groups or communities in terms of access, outcomes and experience.

Professor Marmot's findings in Build Back Fairer: The COVID-19 Marmot Review suggested 'COVID-19 exposes the fault lines in society and amplifies inequalities…building for at least a decade', and this has broadly been our experience in Haringey. We know there is already a pre-pandemic social gradient of up to 17 years in healthy life expectancy between the least and most deprived (and often most ethnically diverse) neighbourhoods in Haringey. Our analysis also suggested residents from the most deprived (and ethnically diverse) neighbourhoods are more than twice as likely to be admitted as non-elective inpatients as their most affluent peers in the Borough, with notably higher rates amongst people from Black Caribbean, some SE Asian and eastern European backgrounds.

Inequalities is a national issue, and the NHS Planning Guidance for 2021/22 and Fenton Report highlighted the need to improve equity of access, outcomes and experience for under-served communities, particularly those living in deprived and diverse communities. In response, NCL CCG established a £5m Inequalities Fund up to 2022/23 to fund solutions to address these issues and improve the health, well-being and life chances of people in these communities. The planning and roll out of these solutions is ongoing in 2021/22, and, due to its high level of deprivation-related need, a significant proportion of this funding is targeted within Haringey.

We conducted research locally on the impact of the pandemic with our voluntary sector partners. This included, for example, a report commissioned via the Bridge Renewal Trust to help Haringey's partnership understand the impact of the pandemic on particular ethnic groups. Its recommendations focussed on better collection of ethnicity data, improved engagement, communication and shaping of solutions to improve equity of access and outcomes around the needs of communities and need to address practical barriers, such as digital exclusion. These recommendations were absorbed into both the Ageing Well Strategy projects many others, such as working with communities to promote vaccine take-up and locality working in deprived and diverse neighbourhoods.

We intend to build on our approach to:

- Build in 'equity ratios' across BCF-funded services to determine whether people within these services are or representative of specific communities or groups they intend to serve, e.g. reflective of diverse populations, and agree to improve this position. For example, our monitoring suggests our MACC Team *is* representative of people with complex needs: who are 50-64 and 85+; who are carers; and from most ethnic backgrounds other than white, but could further improve in reaching out to some groups;
- Put in place 'equity ratios' associated with the anticipated consequences of improving equity of preventative and anticipatory care solutions, e.g. mitigating higher levels of NEL admissions and avoidance admissions amongst specific groups;
- Ensure we improve our in-reach, engagement, communication and co-design of services and solutions into these communities through our 'Healthy Neighbourhoods' collaboration targeted in the deprived east of Haringey. The Inequalities Fund and BCF Plan (and other funding sources) will fund solutions to support communities to engage, design and deliver these solutions, and bring services closer to them;

- We will continue to be flexible about support for particular groups of individuals. For example, our WHT EHCH community health/geriatrician model commissioned in 2021/22 now provides support to MH/LD homes' MDT teams if the patient has frailty or multi-morbidity that needs their input.

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

- We are also currently refreshing our approach to better support *people with dementia* and families based on feedback from people with lived experience of dementia. We will invest in a BCF-funded Coordinator to work with organisations to grow our Haringey Dementia-Friendly Communities beyond the current 60 as we move out of the pandemic. The Coordinator will also work with deprived and diverse communities to improve awareness of the condition and connect people to solutions as part of the 'Healthy Neighbourhood' approach to engagement;

- We recognise the impact the pandemic had on residents' mental health, and are planning improvements in our support for *people with mental health and well-being issues*, including as part of the Inequalities Fund projects and 'Healthy Neigbourhoods' collaboration (see Integration section). Part of these investments focus on specific communities that are under-served, e.g. early support for people from black ethnic backgrounds. In 2021/22, the BCF Plan will increase its early help and prevention investment, including supporting solutions to address mental well-being.

  The 2021/22 BCF Plan also increased its investment in mental health services for people with more significant mental health needs, including within the MACC Team, and in reablement to support people with severe mental health issues with physical health needs in non-acute settings to return home and recover in the community.

- We developed a multi-agency Haringey Carers' Strategy that focusses on better *recognising and supporting carers* as a partnership, and better helping them access the solutions they need to continue in their caring role and to have a life of their own. The BCF Plan makes a substantial investment in carers' services and we intend to make roll out of the Strategy a priority in 2021/22 and 2022/23.

- We are seeing more people in either anticipatory care or in acute and non-acute hospitals with *challenging housing situations including those at risk of homelessness or rough sleeping in the community*. Although funded outside the BCF Plan (but via a DCLG Shared Outcomes bid), we established a Move-On Coordinator to support inpatients who are rough sleeping and/or at risk of homelessness. These Coordinators liaise with housing needs teams and other housing colleagues to ensure the transition from hospital to temporary or (ideally) long-term accommodation in the community is as smooth as possible. The DCLG bid also supported us to procure short-term accommodation for patients who are rough sleepers or at risk of homelessness. Haringey also has a GP-led Homeless Health Inclusion Team to work with reablement and rough sleepers in these

units to help them recover and address longer-term health issues. The work to improve discharge for this group will continue into 2021/22, e.g. improving housing needs protocols.

Better Care Fund 2021-22 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 blue 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 sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before 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 the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). 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 used 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.bettercarefundteam@nhs.net

5. 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 used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 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 text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned.
4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "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.
6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- 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.
7. 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.
8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. 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 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.
1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric
3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. 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 Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
5. Reablement 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.

7. 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 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.
1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM 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 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Haringey
Completed by:	Paul Allen
E-mail:	paul.allen14@nhs.net
Contact number:	07742 605254

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Director of Adults and Health, London Borough of Haringey
Name:	Beverley Tarka

Has this plan been signed off by the HWB at the time of submission?	No	
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Thu 25/11/2021	<< Please enter using the format, DD/MM/YYYY Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair		Lucia	Das Neves	lucia.dasneves@haringey.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Frances	O'Callaghan	frances.o'callaghan@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		Rachel	Lissaeur	r.lissauer2@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		John	Warlow	john.warlow@nhs.net
*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, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Haringey

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,678,851	£2,678,851	£0
Minimum CCG Contribution	£21,020,860	£21,020,860	£0
iBCF	£9,518,076	£9,518,076	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£33,217,787**	**£33,217,787**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£5,973,533
Planned spend	£13,929,577

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£6,904,545
Planned spend	£6,904,546

Scheme Types

Assistive Technologies and Equipment	£0	(0.0%)
Care Act Implementation Related Duties	£0	(0.0%)
Carers Services	£1,067,000	(3.2%)
Community Based Schemes	£278,801	(0.8%)
DFG Related Schemes	£2,678,851	(8.1%)
Enablers for Integration	£1,617,202	(4.9%)
High Impact Change Model for Managing Transfer of C	£346,093	(1.0%)
Home Care or Domiciliary Care	£7,561,793	(22.8%)
Housing Related Schemes	£160,866	(0.5%)
Integrated Care Planning and Navigation	£8,857,376	(26.7%)
Bed based intermediate Care Services	£1,304,562	(3.9%)
Reablement in a persons own home	£7,047,078	(21.2%)
Personalised Budgeting and Commissioning	£475,000	(1.4%)
Personalised Care at Home	£1,469,029	(4.4%)
Prevention / Early Intervention	£354,136	(1.1%)
Residential Placements	£0	(0.0%)
Other	£0	(0.0%)
Total	**£33,217,787**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	593.0	666.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	11.5%	11.1%
	LOS 21+	5.8%	5.5%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	92.0%

Residential Admissions

		20-21 Actual	21-22 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	360	385

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%

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: Plan for improving outcomes for people being discharged from hospital	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Haringey

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

iBCF Contribution	Contribution
Haringey	£9,518,076
Total iBCF Contribution	**£9,518,076**

Are any additional LA Contributions being made in 2021-22? 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	£21,020,860
Total Minimum CCG Contribution	**£21,020,860**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£21,020,860**	

	2021-22
Total BCF Pooled Budget	**£33,217,787**

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

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Haringey

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,678,851	£2,678,851	£0
Minimum CCG Contribution	£21,020,860	£21,020,860	£0
iBCF	£9,518,076	£9,518,076	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£33,217,787**	**£33,217,787**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£5,973,533	£13,929,577	£0
Adult Social Care services spend from the minimum CCG allocations	£6,904,545	£6,904,546	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	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	Health-orientated information, advice and guidance as part of wider advice model for citizens in Healthy Neighbourhoods	Voluntary sector provision of advice, information, signposting and/or guidance for people needing help	Prevention / Early Intervention	Social Prescribing		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	Personalised Care at Home	Physical health/wellbeing		Community Health		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, Charity / Voluntry Sector	Personalised Budgeting and Commissioning			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	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£91,600	Existing
5	Local Area Coordination element of locality working and Healthy Neighbourhoods initiative	Voluntary sector coordinators to provide advice, information and signposting for people who need assistance and to support best use of community assets	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	Minimum CCG Contribution	£120,136	Existing
6	Disabled facilities grant	LBH commissioned provider undertaking major adaptations of individuals' home to facilitate improvements in daily living functioning	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Private Sector	DFG	£2,678,851	Existing
7	Nursing services, including community matrons for MACC Team	District nursing for non-ambulant patients at home and community matrons to support anticipatory care (MACC Team)	Integrated Care Planning and Navigation	Support for implementation of anticipatory care		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£7,070,798	Existing
8	Whittington Integrated Therapies and Therapeutic Support for Urgent Care Response	Multi-disciplinary therapy to support patients, including intermediate care/reablement solutions	Reablement in a persons own home	Other	Therapeutic comn	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£3,268,293	Existing
9	Integrated Health, Housing, Finance and Care Early Intervention In Hospital as part of 'Healthy Neighbourhoods in Acute'	Solutions to provide early help to people to help manage finances, housing health, well-being & independence via integrating community-facing Connected Communities into acute hospital	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	Minimum CCG Contribution	£159,000	Existing

10	Integrated Health, Housing, Finance and Care Early Intervention Solutions to support Health Neighbourhoods in our Localities	Solutions to provide early help to people to help manage finances, housing, health, well-being & independence via integrating community-facing VCS solutions in HN collaboration	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£128,801	Existing
11	Multi-Agency Care & Coordination Team (GP Federation Commissioned Element)	MACC Team is GP-led multi-disciplinary team works in anticipatory care team working to screen, triage, assess & delivery solutions to people with frailty/ multi-morbidity	Integrated Care Planning and Navigation	Other	Integrated approach - undertakes all of functions listed	Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£397,000	Existing
12	Multi-Agency Care & Coordination Team (Additional Nursing & Therapies Element)	MACC Team multi-disciplinary team works in anticipatory care team working to screen, triage, assess & delivery solutions to people with frailty/ multi-morbidity.	Integrated Care Planning and Navigation	Other	Integrated approach - undertakes all of functions listed	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£341,348	Existing
13	Multi-Agency Care & Coordination Team (Mental Health Element)	MACC Team multi-disciplinary team works in anticipatory care team working to screen, triage, assess & delivery solutions to people with frailty/ multi-morbidity	Integrated Care Planning and Navigation	Other	Integrated approach - undertakes all of functions listed	Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£89,000	Existing
14	Multi-Agency Care & Coordination Team (Social Care Element)	MACC Team multi-disciplinary team works in anticipatory care team working to screen, triage, assess & delivery solutions to people with frailty/ multi-morbidity	Integrated Care Planning and Navigation	Other	Integrated approach - undertakes all of functions listed	Social Care		CCG			Local Authority	Minimum CCG Contribution	£146,198	Existing
15	Multi-Agency Care & Coordination Team (MDT Teleconference including primary care)	MACC Team multi-disciplinary team works in anticipatory care team working to screen, triage, assess & delivery solutions to people with frailty/ multi-morbidity	Integrated Care Planning and Navigation	Other	Integrated approach - undertakes all of functions listed	Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£253,447	Existing
16	Social Care Team	LBH posts to increase capacity in community first response, initial triaging & management of cases to support timely response	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum CCG Contribution	£230,000	Existing

17	Social worker capacity for complex cases	Enhanced social worker capacity to better assess and manage more complex cases including those eligible for CHC	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum CCG Contribution	£52,000	Existing
18	Strength and Balance Opportunities	Strengthening & balancing classes and exercises for individuals who professionals identify at risk of falling	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£58,000	Existing
19	Enhanced Health in Care Homes & Trusted Assessor	EHCH Model and Trusted Assessor across Haringey to support care homes, their staff & residents	Integrated Care Planning and Navigation	Support for implementation of anticipatory care		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£216,000	Existing
20	IBCF Supporting Social Care	Bulk of spend on providing packages of care (predominantly but not exclusively domiciliary care) as part of social care clients' Personal Budgets	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£7,114,393	Existing
21	Palliative Care & Advanced Care Planning Facilitator	NMUH-led multi-agency approach to support range of community-, hospital- & bed-based palliative care services. Other Providers - NHS Community Provider	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Acute Provider	Minimum CCG Contribution	£766,000	Existing
22	Increased investment in End of Life Nursing Care and other EOL services	Additional costs of community-based EOL care services in hospice	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£154,429	Existing
23	Alcohol Liaison Services	Council 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 navigation and planning		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£61,585	Existing
24	Support for Dementia Friendly Haringey	Council funded Dementia Coordinator to take forward development of DFH	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	Minimum CCG Contribution	£20,000	New
25	Support for Community Navigation / Social Prescribing	Council commissioned support for community navigation/social prescribing network & community of practice	Enablers for Integration	Community asset mapping		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£15,000	New

26	Increase Single Point of Access/IDT-support function to meet demand (ASC component)	Contribution to ASC component of IDT/associated discharge planning including extended working (7 day working)	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£266,093	Existing
28	MH Discharge Coordinator	Social worker in non-acute MH hospital to support discharge and onward planning for individuals with severe MH issues.	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		Social Care		LA			NHS Mental Health Provider	Minimum CCG Contribution	£40,000	Existing
29	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	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£150,000	Existing
30	Rapid Response Service (inc at NMUH) - Community Health Element	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.	Reablement in a persons own home	Other	Crisis management in <2 or <24 hours	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£339,000	Existing
31	Rapid Response Service - ASC Element	Funding for rapid access to packages of care to support individuals at home at crisis - part of RR model	Reablement in a persons own home	Other	Crisis management in <2 or <24 hours	Social Care		LA			Private Sector	Minimum CCG Contribution	£71,000	Existing
32	Enhanced Virtual Ward - GP Element	Access to 'virtual ward' to support admission avoidance & facilitate hospital discharge - funding to increase access to primary care	Personalised Care at Home	Physical health/wellbeing		Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£42,000	Existing
33	Reablement Solutions	LBH time-limited community-based enablement & therapist staff to facilitate improvements in peoples' ability with daily living tasks	Reablement in a persons own home	Reablement service accepting community and discharge referrals		Social Care		LA			Local Authority	Minimum CCG Contribution	£3,274,785	Existing
34	MH D2A Reablement	LBH community-based reablement to facilitate non-acute discharge of MH patients with physical health needs to improve their recovery in daily living tasks	Reablement in a persons own home	Reablement to support discharge - step down (Discharge to Assess pathway 1)		Social Care		LA			Local Authority	Minimum CCG Contribution	£52,000	Existing

36	Short-term intensive packages of care to support people to return home from hospital	Funding for high-intensity packages of care available to facilitate 'Home First' patient discharge in response to demand, particularly to support 7-day discharges	Reablement in a persons own home	Reablement to support discharge - step down (Discharge to Assess pathway 1)		Social Care		LA			Private Sector	Minimum CCG Contribution	£42,000	Existing
37	Additional Long Term Packages of Care for Individuals	Social care packages of care to facilitate hospital discharge over winter	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£447,400	Existing
38	Step down flats	Investment in step down flats for hospital discharge patients needing reablement & cannot return home	Housing Related Schemes			Social Care		LA			Local Authority	iBCF	£160,866	Existing
39	Care Home Intermediate Care Beds (iBCF-funded)	Intermediate care P2 beds at care home supported by MDT (see MDT line)	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	iBCF	£539,936	Existing
40	Care Home Intermediate Care Beds (Minimum CCG Contribution)	Intermediate care P2 beds at care home supported by MDT (see MDT line)	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Continuing Care		LA			Private Sector	Minimum CCG Contribution	£155,000	Existing
41	Community-Based Nursing & Care Home Intermediate Care (Convalescence) Beds	Intermediate care P2 beds focussed on convalescence at care home supported by MDT (see MDT line)	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		LA			Private Sector	Minimum CCG Contribution	£413,523	Existing
42	Enhanced MDT to support indivudals' recovery & move-on in (particularly care home) P2 beds - Community Health element	Multi-disciplinary team, including nursing, therapies and social workers, to work with EHCH CH/PCN & care homes to support patients to recover & move-on	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£103,876	Existing
43	Enhanced MDT to support indivudals' recovery & move-on in (particularly care home) P2 beds - LBH element	Multi-disciplinary team, including therapies and social workers, to work with EHCH CH/PCN & care homes to support patients to recover & move-on	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		CCG			Local Authority	Minimum CCG Contribution	£92,227	Existing
44	Supporting people with challenging housing needs to return home post-hospital discharge	LBH-commissioned Housing Liaison Worker & rapid deployment of housing-related services (e.g. blitz clean) to help timely discharge	High Impact Change Model for Managing Transfer of Care	Housing and related services		Social Care		LA			Local Authority	Minimum CCG Contribution	£40,000	New

45	Investment in MSK Community Health & Primary Care services	Community health & primary care investment in MSK therapy services to improve people's health status & function (outside of IC)	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£344,000	New
46	Carers' Support	Range of carers' solutions depending on intensity of need: identifying carers, undertaking assessment of needs and support through to carers' respite. Providers are Local Authority and Voluntary Sector	Carers Services	Other	Includes carers' advice, IAG, care planning, respite services & DPs	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,067,000	Existing
47	Principal Social Worker	To provide quality assurance and plan workforce development for social care	Enablers for Integration	Workforce development		Social Care		LA			Local Authority	Minimum CCG Contribution	£60,000	Existing
48	Commissioning & Analytics Support	To provide multi-disciplinary and multi-agency commissioning support for BCF Plan Programme	Enablers for Integration	Joint commissioning infrastructure		Social Care		Joint	50.0%	50.0%	Local Authority	Minimum CCG Contribution	£286,721	Existing
49	IBCF Market Management	Staff and other resources to manage brokerage and quality assurance of providers & contract management resources	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	iBCF	£1,255,481	Existing

2021-22 Revised Scheme types

Number	Scheme type/ services
1	Assistive Technologies and Equipment
2	Care Act Implementation Related Duties
3	Carers Services
4	Community Based Schemes
5	DFG Related Schemes

6	Enablers for Integration
7	High Impact Change Model for Managing Transfer of Care
8	Home Care or Domiciliary Care
9	Housing Related Schemes

10	Integrated Care Planning and Navigation
11	Bed based intermediate Care Services
12	Reablement in a persons own home
13	Personalised Budgeting and Commissioning
14	Personalised Care at Home

15	Prevention / Early Intervention
16	Residential Placements
17	Other

Sub type
1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other
1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other
1. Respite services 2. Other
1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other
1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other

1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other
1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other
1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other

1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other
1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other
1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other
1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other

1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other

Description
Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
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.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
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.
Provides support in your own home to improve your confidence and ability to live as independently as possible
Various person centred approaches to commissioning and budgeting, including direct payments.
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.

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.
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.
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.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Haringey

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	593.0	666.0	20/21 figure impacted by Wave 1 COVID E&D trends, likely to see increase in 21/22. Improvements in anticipatory care in community & care homes, enhanced Rapid Response & engagement with underserved groups, to impact in 21/22. Prevent-ative solutions will have longer-term impact

>> link to NHS Digital webpage

Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	11.5%	11.1%	Increase in 21+ more complex cases in Q3 anticipated to be higher % due to of increased number of non-COVID patients with more complex health (& social) issues. At same time anticipate additional funding & resources available in winter (partly BCF funded) will promote timely discharge and onward recovery, particularly in Q4. We have aligned our ambitions for targets with similar ambition on SITREP-based target for 2 local Trusts
	Proportion of inpatients resident for 21 days or more	5.8%	5.5%	

Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.3 Discharge to normal place of residence

	21-22 Plan	Comments
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.0%	Increased investment in OOH, inc. reablement & housing support, functions will improve ability to facilitate people to return home post-discharge in H1 2021/22 (see BCF Narrative). Our % discharged dipped in Spring 2020 post-wave, so 21/22 ambition to improve to pre-pandemic postiion in H2.

Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 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	468	443	360	385	Targets set v. 19/20 level. Represents 8% improvement on 19/20 position, which we believe realistic given in-year position. Achieved by ensuring even more people are helped at home for longer via more acessing out-of-hospital recovery and anticipatory care solutions (see Narrative)
	Numerator	130	124	103	114	
	Denominator	27,767	27,993	28,618	29,613	

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 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 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 (%)	80.0%	73.9%	80.0%	Position reflects ambition to return to pre-COVID levels and is supported through increased investment in reablement partly funded via BCF Plan in 2021/22, and closer alignment of Cmmunity Health & ASC services. Further details of our approach can be found in BCF Plan Narrative.
	Numerator	80	105	160	
	Denominator	100	142	200	

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 splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. 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)	Confirmed through	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? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	Ageing Well Strategy 2019-2023: https://www.minutes.haringey.gov.uk/documents/s111867/Ageing%20Well%20Strategy%20FULL%20V3.3.pdf Minutes of multi-agency Ageing Well Board Oct-21		
	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 describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes	Inequalities Fund - Healthy Neighbourhoods Proposal EQIA on AW Strategy Living Through Lockdown Report, Haringey Healthwatch: https://www.healthwatchharingey.org.uk/report/2020-08-19/living-through-lockdown		
	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?	Narrative plan Confirmation sheet	Yes	Narrative Plan		
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)?	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)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes			

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?**	• Do 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? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • 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?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes	Discussed at NMUH and WHT A&E Boards in Nov-21		