Title:	**Haringey Health & Well-Being Better Care Fund Narrative**
Report Authorised By:	**Beverley Tarka, Director of Adults and Health, London Borough of Haringey**
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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:

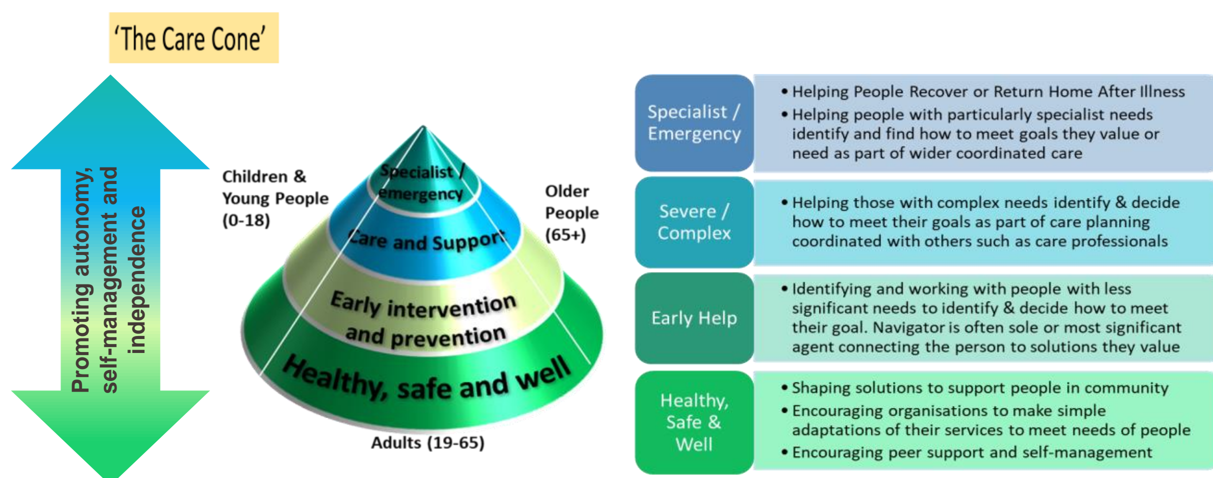
- Feeling Healthy, Safe & Well: This element of the 'care cone' is closely linked to local and national public health messages/services to encourage people to adopt, or get help with adopting, healthier lifestyles, e.g. smoking cessation, being active etc., and 'making every contact count';
- Early Help & 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.