Title:	**Haringey Health & Well-Being Better Care Fund (BCF) Narrative**
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Bodies Involved in Developing Plan:	**North Central London Integrated Care Board**
	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 BCF Plan was developed in partnership chiefly between NCL ICB and Council and its executives and clinicians. It is an extension of the 2022/23 Plan and reflects our progress. The Narrative builds on Haringey's multi-agency Ageing Well Strategy developed in conjunction with partners, and direction of the NHS Long-Term Plan. The Age Well Board, a multi-agency sub-group of the Haringey Integrated Care Partnership (Haringey's Borough Partnership), endorsed the Plan prior to submission to the Health & Well-Being Board. The above organisations, represented at the Board, supported the Narrative's integrated care approach and many are delivery partners for solutions discussed below, e.g. the Healthy Neighbourhoods collaboration in east Haringey between the statutory and voluntary (VCSE) sectors. This oversight included our partners involved in out-of-hospital services, including our acute Trusts (North Middlesex University Hospital (NMUH) NHS and Whittington Health (WHT) NHS Trusts), with whom we reviewed our High Impact Change Model self-assessment and out-of-hospital metric targets in this Plan.

Executive Summary
Our ambition is to work with residents of all ages so they can have the best start in life, live more years in good physical and mental health in a sustainable environment, to age within a connected and supportive community and to have a dignified death. North Central London Integrated Care Board's (NCL ICB's) Population Health Strategy & Health Inequalities 2023-25

Our vision is for Haringey to be a place where everyone can live healthy and fulfilling lives and feel connected and safe in communities where people support each other. Haringey Council Corporate Delivery Plan 2023/24, Adults, Health & Welfare.

Our approach to the 2023-25 BCF Plan reflects these aims, extends the direction of previous Plans and incorporates more recent changes to local and national policies and strategies. Our Plan aligns with the Integrated Care System and Council responsibilities in the NHS Operating Plan (including those relating to inequalities), Health & Care Bill, the NHS Long-Term Plan and Putting People at the Heart of Care, as well as NCL ICB's recently published Population Health Strategy and Haringey Council's Delivery Plan. This Narrative explains how the BCF supports NCL ICS and Haringey to take forward these requirements, including emerging developments such as our response to the Fuller Report or NCL Community Services Review; it should be noted the BCF is just one lever to promote integration. We continue to build on our foundations in shaping a person-centred approach to integration on a multi-geographical footprint.

Our three main priorities relate to challenges in our system:

- *Managing Demand-Led Pressures:* Managing a greater number of people whose underlying health status and social conditions worsened as a legacy of the pandemic, with consequences for the system. Although emergency admissions of older people decreased in 2022/23 compared to pre-pandemic, the typical acuity of individuals' cases, particularly those aged 50+, is more complex.
- *Ensuring our hospital/out-of-hospital systems are well-prepared and sufficiently resilient* to manage patient flow, including how we address financial and workforce constraints (such as recruitment and retention), to facilitate safe and timely hospital discharge and recovery post-hospitalisation.
- *Addressing underlying issues associated with equity* of access, outcomes and experience and the systemic consequences of inequality in Haringey; people living in deprived (and often more diverse) neighbourhoods have 17 years shorter healthy life expectancies than their most affluent peers.

Our Approach: Haringey's Integrated 'Care Cone' (see Integration Section)

Our 'care cone' model (aligned to the NHS Comprehensive Personalised Care Framework) is the framework we use to organise our response to the individuals' presenting needs. Our model informs the structure of several strategies, such as Haringey's Ageing Well Strategy and NCL ICS's Population Health & Inequalities Strategy. It aims to:

- Emphasise the importance of a strength-based approach, prevention, self-management of health conditions and personalisation, so people can stay as healthy, well and independent as possible.
- Ensure where people do need help, the 'right joined-up solutions for the right person are delivered at the right time' as close to home as possible, to improve or maintain their physical and mental health, well-being and independence now and in the future and best support carers.
- Help people avoid future health or social crises as far as possible and/or people can recover as fully as possible after crises, ideally at home. We can mitigate the risk of some crises for residents via earlier detection, diagnosis and improved management of physical and mental health conditions, particularly in more deprived (and diverse) communities.

The 'care cone' is a population-wide model though BCF investments chiefly focus on supporting people who are likely to, or who have, acquired long-term physical or mental health conditions, have multi-morbidity and/or frailty; or who need help to recover post-crises. Most individuals (>90%) likely to benefit from BCF schemes are aged 50+, but there is no 'age restriction' on services. Some BCF schemes *do* support an 'all age' approach, e.g. Haringey's Healthy Neighbourhoods model or carers' support.

Achieving these aims promotes positive system outcomes, including mitigating demand for intensive and costly interventions within the population. The model achieves this is in short- to medium-term by reducing people's risk of crises and acute or non-acute hospitalisation or supports their recovery. There is evidence we were successful in doing so: a 20+% reduction in 1+ day non-elective (NEL) admissions for Haringey 65+ residents in 2023/24 v. 2019/20 (pre-pandemic), due to better managing complex patients in primary and proactive care in the community, including in under-served communities.

Delivery of our 'care cone' model mitigates future demand by investing in early help to reduce the risk of people acquiring, or exacerbating existing, long-term physical or mental health conditions, including a greater level of engagement and investment to tailor our response to better support under-served communities. The BCF includes preventative schemes particularly targeted to:

- Address Borough-wide physical and mental well-being/health-related issues, the latter including social isolation, bereavement and support for those with lived experience of dementia, and carers.
- Tackle inequalities in Haringey's deprived east locality and responding to the Fuller report, including via our Healthy Neighbourhoods model, focussing on our most deprived areas in east Haringey.

Improving Planned Care & Out-of-Hospital Support to Help People Recover After Crisis/Hospitalisation
The pandemic's legacy and 'system shocks', such as rising cost-of-living, led to significant deconditioning in many people's physical and mental health and well-being and increased demand on the care system, particularly amongst older people with existing long-term conditions (LTCs)[1]. This group are typically now more likely to be frailer, less physically active and isolated, and more likely for existing conditions to exacerbate than pre-pandemic. We estimate a 20% increase in the number of Haringey residents with moderate/severe frailty aged 50+ post-Wave 1 due to deconditioning[2]. We also know that there is a significant increase in the number of younger adults with complex health and care needs in the Borough also.

Our community system responded well to these issues: for example, the number of Haringey GP consultations increased by a third between 2019/20 and 2022/23. This helped mitigate the number of older people with crises resulting in ED attendances over this period, with NEL admissions decreasing; but it meant there was an increase in the typical acuity of older people now admitted to hospital needing community and acute care, e.g. average length of stay for those aged 75+ at NMUH hospital increased from 10 to 13 days between Mar-21 and Mar-23, with consequences for short- and long-term

[1] Public Health England: Wider impact of COVID-19 on physical activity, deconditioning & falls in adults, Aug-21
[2] Based on an 18% increase in the number of people on GP lists with 3+ LTCs pre- & post-pandemic and a 20% increase in the proportion of older people presenting to EDs with moderate/severe frailty over this period.

care system utilisation and resources. Similarly, we see more people in our system in poor housing environments or at risk of homelessness.

Partners in Haringey and across NCL worked together to shape our resulting solutions and plans, including those contained with the 2023-25 BCF Plan (including the pooled Discharge Fund), to meet rising demand and acuity, particularly in relate to several new or expanded out-of-hospital schemes to ensure people can mitigate crisis, avoid hospitalisation or support people to recover post-hospitalisation, ideally at home. Investments, linked to integrated discharge/intermediate care and NCL Community and Mental Health Service Reviews, to which the BCF contributes include:

- Expanding our planned and proactive care network to better manage people with LTCs, including falls, dementia, multi-morbidity, frailty and end of life, improve our neighbourhood care 'offer' to respond to the Fuller report across Haringey and enhance our statutory-sector community response to patients and residents, e.g. in terms of timely delivery of assessments, community equipment or adaptations/improvements/repairs to property.
- Sustaining our investment in joint Discharge Teams to support patient discharge from acute or non-acute hospitals locally and across NCL; and enhance our investment in support for P2 bedded and particularly joint P0/P1 Home First pathways in Haringey and across NCL. This includes additional support for discharge for people with challenging home environments and those at risk of homelessness/rough sleeping; and investing in admission avoidance services.
- Investing to address financial and workforce pressures associated with complexity and rising costs of short- and particularly long-term care in Councils, NHS and private providers in a range of settings.
- The above support includes enhanced investments for patients/residents known to be vulnerable, including those with severe and enduring mental health issues, those part of inclusion health or those more generally from under-served communities or groups.

Improving Equity of Access and Outcomes (see Equality Section)

A long-term commitment of the Integrated Care System is to provide a more equitable NCL allocation of resources to tackle inequalities in access, outcomes and resources that impact on health, care and life chances. For example, NCL ICB plan to increase investment in health and care services in Haringey in response to the Community and Mental Health Services Reviews to reduce unwarranted NCL variation in service provision. Haringey will be a 'net beneficiary' of this 'levelling to need' over the next 5 years, as it is a less well-resourced Borough for its relative needs. Initial investment priorities in Haringey for 2023-25 include planned and proactive care (improved falls prevention pathways and pain management services) and intermediate care (expanded Rapid Response/P1 Home First pathways).

The pandemic's legacy and other 'system shocks' will continue to reinforce existing population social gradients of outcomes without a more targeted approach to investment within under-served groups across Haringey and NCL. This forms part of NCL ICB's Population Health Strategy, incorporating our response to the Core20Plus5 requirements.

The ICB continued to commit an annual £5m Inequalities Fund Programme across NCL in 2023/24 (with c. £1.8m in non-BCF IF projects in Haringey alone). Haringey's BCF part-funds Healthy Neighbourhoods, our IF prevention model into under-served communities, and this model will be expanded in 2023-25 as part of our response to the Fuller report and need to build resilience and infrastructure in the voluntary and community (VCSE) sector as one of our key stakeholders.

Our 'Healthy Neighbourhoods' model is a locality-based collaboration between the Council, NHS/primary care, VCSE sectors and residents/patients focussed in deprived and diverse east Haringey wards to improve social and health-related equity of access and outcomes. The collaboration brought together a network of statutory and voluntary sector partners to engage with communities to tackle and find solutions to specific population physical and mental health and social needs around a set of key themes. We will expand the scope of our work in east Haringey, increase IF Programme investment to deprived communities around our NMUH system. We will support residents living in these communities to decide on, and build, the solutions and community assets right for these communities, as part of building an approach to community empowerment. We also intend to expand our approach to engagement, codesign and community-asset building to our central and west localities in 2023-225 with different demographic profiles as part of our response to the Fuller report and Core20Plus5 requirements within our Population Health Strategy and PCN DES requirements.

Our Healthy Neighbourhoods model supports particularly vulnerable groups, including people at risk of homelessness, those with specific conditions and carers. This goes beyond the expectations of the Protected Characteristics to acknowledge even in deprived communities there are especially vulnerable individuals who needed support. The BCF Plan includes schemes to support such individuals.

Governance

BCF Plan governance is a two-stage process involving oversight of Narrative and contract development, respectively, with oversight across NCL's multi-geographical Integrated Care System structure. The governance structure is shown below, with those Boards heavily involved in creating and agreeing the BCF Plan 2023-25 in orange boxes.

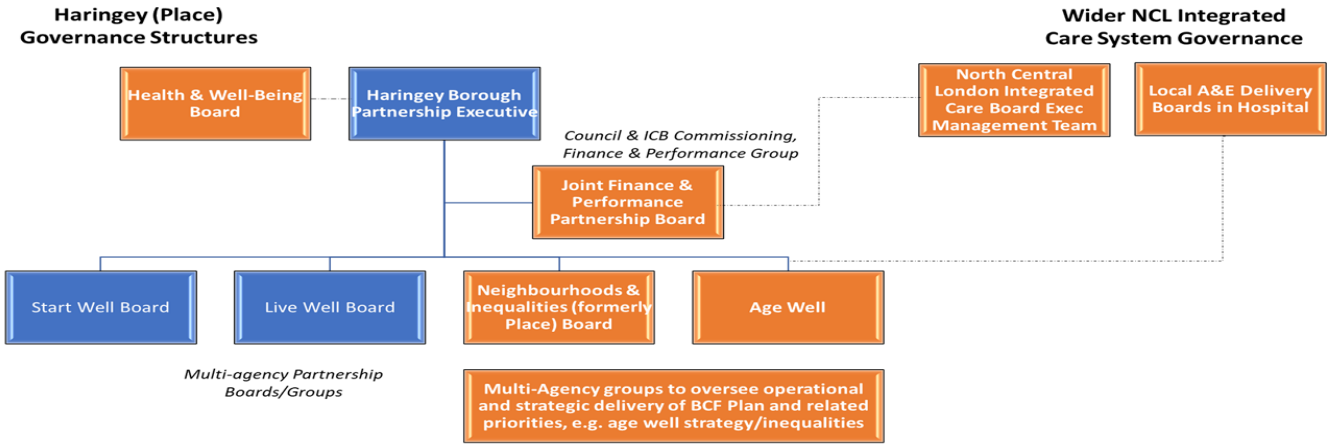


Figure 1 – Summary of Governance Structure for BCF Plan 2023-25

The Plan's content will be signed off by Haringey's Health & Well-Being Board in Q2 2023/24, but the Chair has signed-off submission in June in consultation with partners. The Director of Integration in the ICB's Haringey Directorate and LBH Director of Adults and Heath oversaw local Plan development, including its investment schedule. We agreed the Plan locally via Haringey's Joint Finance & Performance Partnership Board which these Council/ICB executives oversee. The latter Board is a local Haringey executive commissioning, performance and finance group which has responsibility for shaping and agreeing joint s75 agreements (including BCF investments), liaising with individual organisational directorates in Council and ICB, and joint monitoring and reviewing progress, performance and impact of the BCF (see below).

Partners listed in the first section endorsed the Plan at the Age Well Board and agreed its direction and approach, and over time helped shape investments in the BCF Plan, e.g. additional investment in supporting people with dementia and prevention. This involvement includes our secondary care partners: we included the High Impact Change Model (HICM) self-assessment review, capacity & demand and metric targets to our A&E Delivery Board to provide assurance the plans were in line with the NCL Operating Plan and national ambitions.

The BCF is a pooled Section 75 agreement between Council and NHS held by the ICB and includes investments in out-of-hospital services including via both ICB and Local Authority Discharge Fund components. The budget and its allocation – including assuring compliance with minimum Council and out-of-hospital spend – was provisionally agreed between commissioners and finance leads at the Joint Finance & Performance Partnership Board locally.

The ICB's Strategy and Development Committee then reviewed and gave the ICB's commitment to the Plan contents, metrics and s75 investments, alongside the other 4 Borough BCF submissions. NCL ICB's Governing Body will 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 managing the BCF Plan, the initiatives within it and its impact. The main vehicles for this are Haringey's Age Well Board and Joint Finance & Performance Partnership Board. A small proportion of the BCF Plan funds infrastructure continues to support commissioning programme oversight, including joint Council/CCG commissioning and workforce development.

The Age Well Board's role is to bring partners together to progress its Strategy which this Plan largely underpins. The Board acts as the Strategy's Programme Board and BCF Plan implementation and has oversight of integrated care solutions partners are developing and delivering together. The Board also receives report on the impact of these solutions, and this includes the BCF Plan metrics on a routine basis. Our NMUH and WHT A&E Boards receive reports on progress against out-of-hospital metrics, including those included in the BCF Plan. We will incorporate routine updates associated with the new

demand and capacity requirements into these integrated reports with each organisation responsible for reporting on their individual out-of-hospital services (e.g. LBH for reablement).

The Joint Finance & Performance Partnership Board is responsible for compiling year-end BCF Plan evaluation of individual schemes against a range of pre-agreed criteria based on 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. This Board has local oversight of the s75 agreement and is responsible for reporting on allocated BCF budgetary spend and has oversight of the impact of the BCF investments on metrics. It will have oversight of the quarterly returns to the national and regional BCF Teams in 2023-25, and oversight of the process to produce the fortnightly ASC Discharge returns.

Reviewing the BCF Plan commitments in 2023/24

As noted in the Provide Right Support at Right Place at Right Time section later in this report, partners have agreed to review key aspects of the BCF/Discharge Fund investments in 2023/24, with a view to making agreed changes to the proposed BCF schedule included in this Plan. Partners anticipate our current schedule of investments in the BCF Plan particularly for 2024/25 will be subject to change, and we will commit to update this schedule post-review.

Our Approach to Integration and Collaborative Commissioning

Our 'care cone' tailors solutions to individual's needs and circumstances and categorises solutions into:

- *Feeling Healthy, Safe & Well* aligned 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, and 'making every contact count'. This is a 'universal' offer across the population, with greater investment/promotion to groups or communities most under-served, e.g. addressing higher levels of smoking prevalence amongst specific groups. Investment in these solutions is non-BCF.
- *Early Help & Prevention*, a targeted approach working to address issues or needs amongst people at 'rising risk' of needing more intensive solutions, e.g. those at risk of acquiring or living with existing LTCs and/or those in under-served communities or groups. Our objectives are to encourage people to come forward for earlier diagnosis, adopt healthy lifestyles, better self-manage their conditions, get help to meet their health, housing or social needs and avoid or mitigate crises.
- *Planned and proactive care* for 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 care including discharge/intermediate services* to support people who need highly specialised health and social interventions and/or who are approaching or are at crises or need help recovering from crisis, ideally at home.

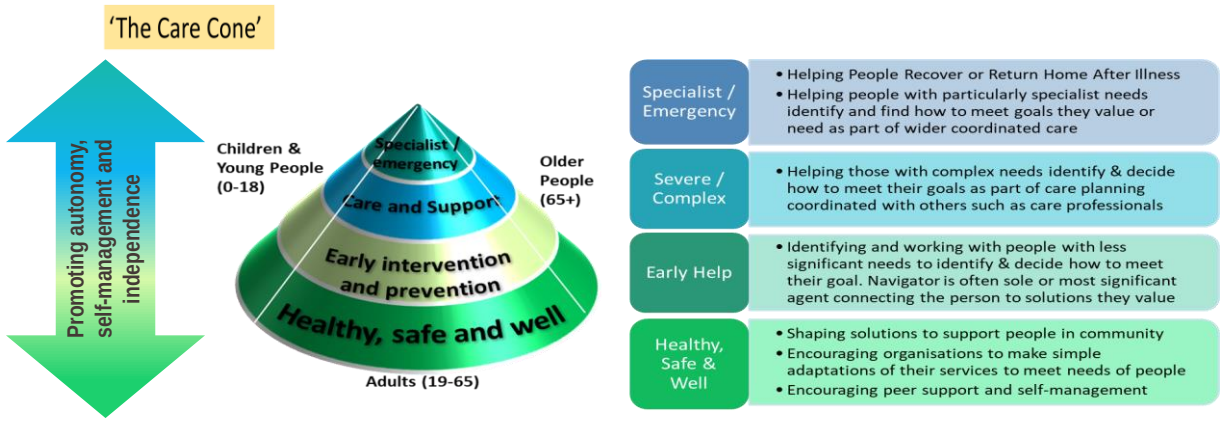


Figure 2 – Haringey Care Cone Framework

Our priorities for enhanced 2023-25 BCF Plan delivered in partnership across health, social care, housing and VCSE includes the following investment in this framework (details in each relevant section).

Early help & prevention

- Consolidate and expand our IF and BCF investment in building locality-based, coproduced community assets through our Healthy Neighbourhoods collaboration and tackle inequalities in east Haringey around our NMUH acute hospital which serves the most deprived populations in Haringey and Enfield, including responding to the Fuller report. Our locality approach, and response to the Fuller report, will then be rolled out across central and west Haringey in 2023-25, partly utilising existing BCF Plan resources (see Right Care at Right Time section).
- Respond to the support our Borough Partnership Executive's Haringey-wide priority focus on mental health, social isolation and bereavement, including for carers of people with terminal conditions.
- Increase our BCF investment in delivering early help for carers and people aged 50+ as part of our locality working, including supporting community navigation and asset-building and developing our approach to dementia-friendly Haringey and improving support for people living with dementia.

Planned and Proactive Care

- Consolidate and expand our planned and proactive care network to facilitate better management of people with LTCs, including in relation to Core20Plus5 LTCs, dementia, multi-morbidity, frailty and falls, and build our neighbourhood care 'offer' to respond to the Fuller report, and ICB and PCN Direct Enhanced Services requirements.
- Enhance our re-procured joint community equipment service between Council and NHS, partly funded via the BCF Plan, and establish a handyperson scheme funded via BCF DFG investment and bring Wheelchair Services into the scope of BCF planning.
- Respond to financial and workforce pressures associated with acuity of care and rising costs of short- and long-term care within Councils, NHS and private providers in a range of settings.

Specialist/emergency care including discharge/intermediate services (including investment from DF)

- Build our investment in joint Discharge Teams across Haringey, our local acute and non-acute hospitals and NCL, including through our NCL-wide Transfer of Care Hub which organises cross-boundary discharges. This will ensure we have sufficient capacity and capabilities to promote safe and timely discharges within the HICM framework, tailored to the patients' underlying needs.
- Significant additional investment in our P0/P1 Home First 'offers' for admission avoidance (particularly to expand our 2-hour response) and post-discharge across social care and community health and virtual wards to meet rising demand.
- Build investment in our NCL-wide P2 intermediate care beds and the need they fulfil (e.g. rehabilitation/reablement/step-down) for community, non-acute and acute patients, as well as the MDT support to prevent deconditioning and plan timely move-on.
- Enhance our approach to support people with challenging housing environment and those at risk of homelessness in secondary care: a dedicated post to coordinate discharge and temporary move-on arrangements for patients with our housing colleagues; step-down flats to help people recover physically and from homelessness, and support move-on to longer-term housing solutions.

Investments in the above lines include key groups of individuals known to be vulnerable, such as those with severe and enduring mental health issues living in the community or who are in acute or non-acute settings, those who are part of inclusion health or those from under-served communities, e.g. within the Healthy Neighbourhoods model or the above investment in discharge arrangements.

Collaborative Commissioning Between Partners 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. This approach to integration is supported through our collaborative approach to joint commissioning, which in turn in under-pinned through the multi-agency governance structures described above.

The BCF Plan promotes joint ICB/Council commissioning across all population groups to better understand population health needs holistically across partners and engage a range of statutory- and voluntary-sector partners to jointly develop and fund solutions built around the structure of the 'care cone' across the health, housing and social care system. This led to joint commissioning of individual multi-agency services, such as our proactive care model with, for example, a single agreed specification for services even if there are multiple contracts with individual providers.

Our collaborative approach helps us synthesise the needs of multi-geographical developments across neighbourhoods, Boroughs and the ICS. For example, one objective is to ensure we deliver solutions, tailored to individuals' needs, as close to home as possible. This places a bias on codesigning local 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 between Boroughs.

These two drivers can be reconciled, and the development of our multi-agency proactive care model is a good example of how our approach to strategic commissioning and integration brings together NCL standardisation and local shaping. A consensus emerged across NCL Boroughs on a 'proactive care blueprint': the key features of, and outcomes for, a proactive care model based on that emerging from the PCN DES and NHSE requirements. This led to an 'equity-based' Borough allocation of additional NCL ICB funding to support development, with local Borough partners working together to plan where best they should invest and agree those elements of the model best developed across the ICS, e.g. NCL-wide development of an algorithm to help identify those patients at risk. In Haringey, this led to additional non-BCF ICB investment, alongside existing BCF funding, agreed between partners at the Borough's Age Well Board. Our proactive care model is now being further localised and developed to align with our neighbourhood models to respond to the Fuller report.

We continue to collaborate across multiple Borough and across NCL to assure a more equitable level of resources to meet underlying needs across NCL and in each Borough as part of the ICB's commitment to 'level to need' in community services, some of which are part-BCF funded. For example:

- Haringey commissioners and partners at the Haringey Borough Partnership deciding on which NCL Inequalities Programme schemes are funded in the Borough in partnership with the ICS.
- The NCL Community Services and Mental Health Reviews seek to ensure there's a common 'core offer' for individual services designed locally, such as proactive care, across the ICS, and to enhance existing services in less well-resourced Boroughs (including Haringey) over the next 5 years.

National Condition 2: Enable People to Stay Well, Safe and Independent

In this and the next section, we utilise our 'care cone' to describe our response and investments to address underlying demand and need. We have included a table at the end of each section to describe how BCF investments relate to the relevant 'care cone' tier, and influence metric delivery. However, the BCF Plan is simply part of a wider investment in solutions as outlined in this Narrative.

Early Help & Prevention including 'Healthy Neighbourhoods'

We continued to invest in our 'Healthy Neighbourhoods' collaboration in the east of the Borough and now see this as a blueprint for the approach in other localities in Haringey in bringing together partners to build engagement, community assets and deliver planned and proactive care within these neighbourhoods. The neighbourhood-based approach has proved successful and is being

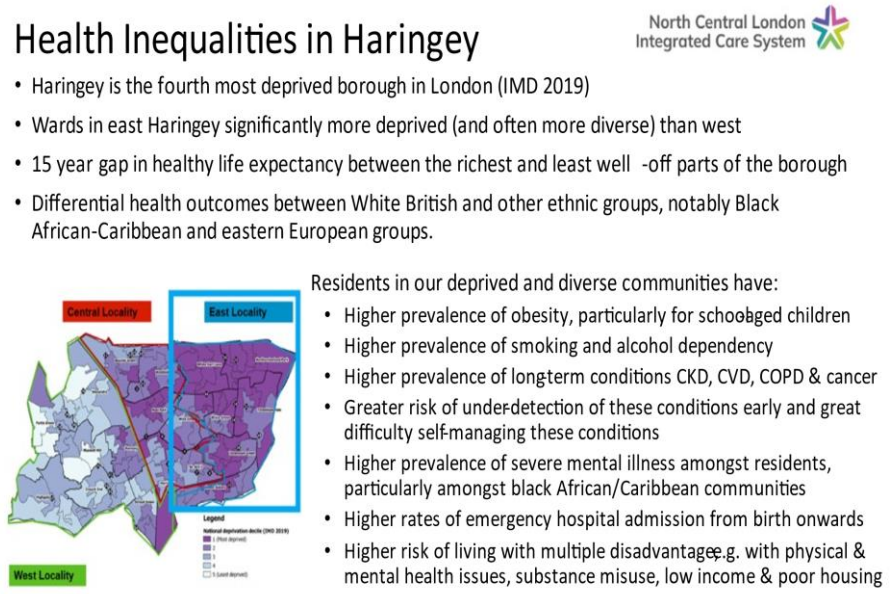
Healthy Neighbourhoods is a multi-agency collaboration between NHS, primary care, Council and VCSE partners working with under-served communities living in the east of the Borough to design and deliver a range of preventative and planned care solutions across the population to improve their health, well-being and life chances. Priorities agreed by partners from a combination of public health evidence, insight from communities and representative groups in our more deprived communities were:

- Ensuring a Best Start in Life (largely focussed on children and families)
- Improving Prevention, Diagnosis and Management of Acquired LTCs (part-BCF funded)

- Improving Mental Health/Well-Being (fully BCF funded)
- Supporting Vulnerable People including those with severe & multiple disadvantage/inclusion health to recognise even within deprived communities, there are individuals who have greater need (part-BCF funded).

A cross-cutting theme, part-BCF funded Community Empowerment, ensures there is sufficient VCSE engagement and investment to support community asset-building and co-design in the emerging models, and people in under-served communities feel better able to 'have their say' on local services.

The above priorities for east Haringey were identified from quantitative and qualitative intelligence in collaboration between partners, including public health, Council, NHS and VCSE partners in collaboration with residents, as key issues partners at the Place Board agreed to focus on in that locality (see summary below). (A similar exercise has recently started in the two other localities – see below).



The support available within the Healthy Neighbourhoods model varies depending on the theme, but, for example, the process of identifying and working with individuals living with LTCs 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.
- A range of partly BCF-funded VCSE organisations 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 their condition; and help people address social issues they value help with that influence health and well-being outcomes, e.g. debt, access to benefits, housing issues etc., and this includes investment from Haringey's Community Chest.
- 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.

There is some evidence that our approach is beginning to deliver outcomes for participants and the system as a whole and is supporting improvements in several key metrics (see Equalities section).

To promote Healthy Neighbourhoods, the Council, ICB and our voluntary sector umbrella partners established a part-BCF funded 'Community Chest' in 2022/23 (which will be expanded in 2023-25) to provide grants to VCSE partners to support community asset-building linked to a 'call to action' for each

theme. We awarded funding to schemes to provide local activities and services, for example a local breakfast and activities club with part-BCF funded community health/primary care staff providing advice about diet, nutrition, help with physical activation and healthcare issues. The club works will people with LTCs, such as CVD/hypertension and COPD (both part of Core20Plus5 priorities), identified by health professionals as part of the LTC HN Theme, to help them better self-manage their conditions.

The Healthy Neighbourhoods funding is part of a wider investment in locality working which will be closely aligned to the development of our response to the Fuller report in 2023-25. This will ensure our locality models – east, west and central - will be developed with primary care clinical leadership and oversight from our Primary Care Networks (PCNs) and GP Federation as major partners working alongside NHS, Council and community and voluntary sector organisations to help shape preventative and proactive care solutions with our residents and patients.

We continue to enhance our part-BCF funded multi-agency locality hub working at North Tottenham and 'lifestyle hubs' at our NMUH system, both serving deprived communities in east and central Haringey. The hubs provide health-orientated information and advice, but also guidance and help with issues such as debt, housing and care to the community with the VCSE, the Council's Connected Communities and DWP.

Our housing colleagues are partners in our locality working and the Council, NHS, primary care and VCSE developed an action plan to improve the health, well-being and independence of particularly older residents living in supported accommodation such as sheltered housing. This will form part of the locality working, and we will utilise these housing facilities as 'community hubs' to support older people in nearby neighbourhoods as well as residents. The Council (non-BCF) funds a range of supported housing, including Extra Care, for older people living with frailty, with several developments planned over the next few years. The iBCF continues to fund step-down/step-up flats to facilitate discharge in conjunction with the Council's housing department.

Our response to the physical and mental health needs of individuals in our more deprived neighbourhoods also includes our non-BCF funded locality-based 'Mental Health Team Hubs' linked to primary care networks working with the MH Trust and VCSE to better support those with significant mental health needs with their conditions and physical health as part of our response to the transformation of mental health services.

One priority is to ensure people, particularly those who need early help including older people or those with LTCs, have access to the information they need to help them make positive decisions about their lifestyles and conditions. For example, our (non-BCF funded) multi-agency and online Ageing Well Guide and Resource Toolkit, co-developed with partners and residents, provides hints, tips and contacts to help people age positively, e.g. eating well, looking after mental well-being etc.. The Guide is online, but 5,000 paper copies were distributed to 50+ organisations working with older people in 2022/23.

Many people tell us they would like someone to help them connect, navigate or coordinate access to opportunities or solutions they may value to improve their health, social or housing outcomes and life-chances. 'NavNet' is our innovative community-of-practice and collaborative practical problem-solving Community Navigation network amongst volunteers and professionals who act as community navigators (including our social prescribers and care coordinators in primary care), and acts as a dynamic resource directory. NavNet members are employed by many different organisations, with different functions, job titles and specialisms, e.g. a VCSE Somali Community Navigator, Council Local Area Coordinators or Connected Communities (both part-BCF funded). NavNet members are people whose role is likely to involve 'connecting' residents/patients, help each other problem-solve individual cases, alert each other to opportunities and activities and feedback about improvements that could be made to support– a key community asset and invaluable 'eyes and ears' in local communities. The BCF funds a dedicated post to coordinate the development and infrastructure of 'NavNet', which currently has 220 members, a 30% increase in membership since the postholder started in Q3 2022/23.

In 2023-25, we intend to:

- Consolidate our existing BCF investment in building NavNet as our Community Navigation network (to over 400+ members) and wider VCSE infrastructure and community asset building and development initiatives over the next 18 months.
- Non-BCF support VCSE and statutory sector staff, including NavNet members, to better help people aged 50+ by developing and rolling out a tiered approach to ageing well and frailty awareness-raising and training based on the Guide's content; and encouraging greater sign-up to NavNet.
- Continue to develop our multi-agency approach to locality working in the east of the Borough including with primary care and community, as part of our response to the Fuller report. This includes sustaining and joining up our existing BCF investments in strength and balance, self-management and expert patient programmes as part of the wider development of the ageing well training and awareness-raising described and of locality developments. This includes further investment in our Community Chest-related solutions in 2023-25.
- Ensure the ICS requirements relating to the Fuller response are delivered within Haringey, with development and implementation achieved through collaborative commissioning (see previous section). We will develop our multi-agency approach around the needs of specific localities/neighbourhoods or on specific issues, including reducing risk of acquiring or improving self-management of LTCs, mental health (some of '5' priorities in 'Core20Plus5') and PCN 'Plus' priorities identified as part of our primary care clinical leadership. For example, we will progress plans to:
    - Develop non-BCF funded hubs to that in North Tottenham across Haringey in our central and west localities, including working with our housing colleagues as noted above. The priority in central Haringey is to better and more joined-up support for people with mental health issues, which reflects the Borough Partnership Executive focus on this issue and demographics in this locality. This support includes our part-BCF funded network of Local Area Coordinators that already exist across the Borough to support people with more complex health and social needs.

- Work with Primary Care Networks (PCNs) in west Haringey to better support people with frailty as part of their 'Plus' responsibilities in 'Core20Plus5' as part of community asset building. People with significant frailty are well-served through our BCF-funded proactive care solutions, so west PCNs will work with community partners and residents to codesign early help to support people with mild frailty to manage their condition/risks and age well.
- Expand development of multi-agency solutions and integration into locality working to support people with mental health issues and its root causes across Haringey, e.g. social isolation or a significant change in life circumstances such as bereavement. Particularly vulnerable groups we will focus on include those with inclusion health or severe mental health needs and those with lived experience of dementia, and carers. For example, we intend to continue to build our membership of, and community assets within, our BCF funded Dementia Friendly Haringey via our Dementia Coordinator and improve support in our BCF funded dementia 'hub-and-spoke' model linked to localities. Similarly, we intend to establish a BCF funded Carers' Support Network within our localities in response to the needs of carers of all ages as part of roll out of our Carers' Strategy.

- Continue to consolidate our approach with, and investment in, the VCSE through the next phases of our partly BCF funded Community Chest and encourage other partners to utilise this framework.
- Continue to develop our partly BCF-funded Inequalities Fund Programme in Haringey through additional investment in the schemes associated with the NMUH system (see Equalities section). We will also continue our early help investment at NMUH hospital – our BCF Funded 'Healthy Neighbourhoods in Acute' scheme.

Early Help & Prevention Funded Through BCF Plan (see also Spreadsheet; New or revised items in red font)			
Scheme ID	**Scheme**	**Reason for Change / Addition**	**Metrics**
1	Health-orientated information, advice and guidance as part of wider advice model for citizens in Healthy Neighbourhoods		All investments have potential impact on avoidable admissions & falls metric
5	Local Area Coordination to support people with complex needs in localities		
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	Includes investment in Community Chest in 2023/24	
24	Support for Dementia Friendly Haringey	Increased investment in 2023/24	
25	Support for Community Navigation / Social Prescribing ('NavNet') & wider VCSE infrastructure to support engagement	Increased investment in 2023/24	
46	Carers' Support Services	Increased funding to develop locality Carers' Support Network	

Proactive and Planned Care & Support

We have substantial BCF funded investment in community health services as part of helping people to manage their LTCs. This includes significant investment in nursing and therapeutic intervention in the community and supporting people with specific LTCs such as dementia, MSK, COPD or diabetes. Community health undertakes some of these interventions solely with primary care, but several organisational partners may be needed in an integrated model to manage people with complex cases of people with frailty or multi-morbidity. We have recently re-procured our joint community equipment service between Council and NHS, partly funded via the BCF Plan. We fund an admission avoidance (Rapid Response) scheme for people in crisis to avoid hospitalisation, along with intermediate care

services such as reablement which also support people to avoid hospitalisation as long as post-discharge. Further details of this scheme can be found in Condition 3: Right Place, Right Time section.

The development of our early help and proactive care solutions are part of our commitment to place our Primary Care Networks (PCNs) at the heart of locality working as part of their new population health responsibilities and as part of our response to the Fuller report.

Haringey's mainly BCF-funded Multi-Agency Care & Coordination Team (MACCT) is our WHT/Haringey GP Federation-led proactive care model and it supported 2,000 people with moderate or severe frailty or multi-morbidity living at home over the last year. MACCT is a multi-agency and multi-disciplinary team led by a GP with nurses, therapists, pharmacists, mental health, social care and voluntary sector workers. Our model incorporates many of the features of NHSE's Proactive Care Framework. This includes utilisation of NCL-wider primacy algorithms from a common data platform (as well as referrals from trusted sources such as GPs, nurses or social workers) to triage individuals' needs into the right support stream: work with the voluntary sector or single professional to support access to the right personalised care and support and opportunities; or people with complex needs who could benefit from a 'full' MDT consultation to develop an individual's person-centred plan summary and care coordinator.

Our proactive care approach is supplemented through non-BCF funded multi-agency 'Proactive Intervention Teams' operating in PCNs in conjunction with VCSE and acute Trusts to manage the health and social needs of patients who were on the elective waitlist for some time and who are particularly vulnerable (e.g. those with severe mental health issues).

Our BCF-funded Enhanced Health in Care Homes (EHCH) model is a coloration between community health and primary care and care homes supports people with frailty or multi-morbidity living in these homes in line with NHSE's and the PCN DES's requirements for the support available. This model proved successful, and we now cover all care homes across NCL. We intend to extend the model of support for older adults living in our LD care homes through additional non-BCF investment.

We continue to improve our part BCF-funded services to support people nearing end of life to provide high-quality palliative and end-of-life care and support in their last years and days of life so they can die in the place they want, and we actively promote Advanced Care Planning in our proactive care services, including MACCT and our EHCH model.

The above more proactive solutions supported the absolute number of people admitted to hospital due to chronic ambulatory care sensitive conditions gradually decreased, including those living in the most deprived 20% areas, over the last 5 years. We also know some individuals approach crises quickly and we invested in our admission avoidance services to provide an urgent response at home (next section).

In 2023-25, we will build on our planned and proactive care response:

- Roll out our part-BCF funded reprocured community equipment service across NHS and Council. We also brought ICB funding of our Wheelchair Services into the BCF Plan for the first time in 2023/24.
- Continue to 'get the basics right': improve our response and workforce capacity to ensure people can benefit from high-quality and timely statutory assessments (e.g. Care Act, Carers', Mental Health Care Act, Continuing Health Care Assessments) to help to plan to meet their needs, with some roles being funded through the BCF Plan.
- Work across partners to improve our personalised planning and delivery of care, including further developing our model of support for people with dementia (partly BCF-funded). We will also ensure there is sufficient capacity and BCF investment to fund increases in demand and costs of public sector-funded long-term care provision across our care markets, particularly in care homes, and improve our partnership arrangements to better manage the market.
- Working with our housing partners, we will better support the physical and mental health needs of people in supported accommodation, such as sheltered housing or Extra Care, and intend to pilot an 'enhanced care in supported living' model as part of our BCF ECH/MACC Teams as a collaboration between the Council, community health and primary care in 2023-25
- Strengthen our falls pathway, including additional non-BCF investment in community health in relation to improving bone health and physical activation of patients at risk of falls or repeat falls
- Improve our proactive approach to better managing the increasingly complex adult social care and health needs of a greater number of younger adults (aged 18-64 years) living in the community in Haringey through strengthening both case management and care and support solutions.
- Integrate relevant social care, housing, community health teams, MACC and PIT Teams into locality working, alongside the early help solutions discussed above, starting in east Haringey as part of our response to the Fuller report. We will further extend the role of the MACC Teams to incorporate the needs of people with more complex LTCs (but not necessarily frail) as part of roll out of our non-BCF funded LTC Local Enhanced Service with primary care.
- Continue to develop our partly BCF-funded Inequalities Fund Programme improving Core20Plus5 LTCs. Our approach will also support early diagnosis and better utilisation of community services.
- Reprocure and further develop some of our BCF-funded carers' services in 2023/24 (see Carers' Section).

Planned & Proactive Care Funded Through BCF Plan (see also Spreadsheet; New or revised items in red font)			Influences Which Metrics				
Scheme ID	Scheme	Reason for Change / Addition from 2022/23 / Additional Comments	Admission Avoidance	Falls	Usual Place (Home)	Res/Nursing Adms	Reablement Home Outcome
3	Dementia Day Opportunities					Y	
7	Nursing services, including community matrons for MACC Team		Y	Y	Y	Y	
60	Community Health Specialised LTC Services	**New:** Investment in LTC/falls Community Health services as part of Community Services Review in 2023/24	Y	Y	Y	Y	
11-15	Multi-Agency Care & Coordination Team (multiple elements)		Y	Y	Y	Y	Y
16 & 17	First Response Social Care Team and managing complex cases	L16 combines 2 lines to support SW Teams in 2022/23 (at same funding).	Y	Y		Y	
2	COPD Exercise Scheme		Y				
4	Self-Management Support		Y				
18	Strength and Balance Service		Y	Y			
19	Enhanced Health in Care Homes & Trusted Assessor		Y	Y			
20	IBCF Supporting Long-Term Community Social Care		Y	Y		Y	Y
21	Palliative Care & Advanced Care Planning Facilitator	Services can access bereavement support	Y	Y	Y	Y	
50	Community Equipment Service (ICB Funded Only)		Y	Y	Y		
6	Disabled Facilities Grant (Major Adaptations)		Y	Y		Y	
62	Complex Case Management of Younger (18-64) Adults	**New:** Investment in case management & care solutions for ASC clients with complex needs living in community	Y	Y		Y	
52	Wheechair Services	**New:** Brought into scope of BCF Plan	Y	Y			
46	Carers' Support Services	Increased funding to develop locality Carers' Support Network	Y			Y	

Provide Right Support at Right Place at Right Time: National Condition 3
Admission Avoidance, Supporting Safe & Timely Discharge and Helping People Recover

Partners have three aims to prevent admission and/to facilitate discharge for secondary care patients:

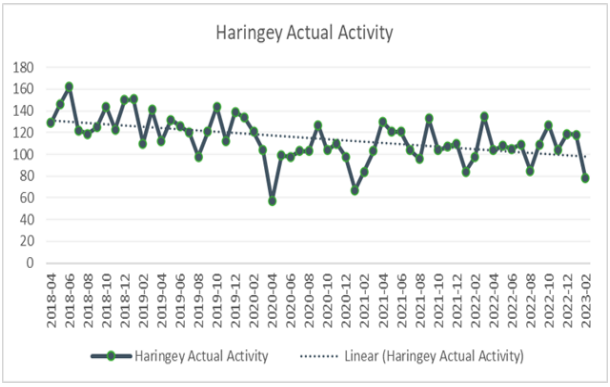
1. **Reduce the number of people presenting to hospital and/or admitted to hospital in crisis through urgent interventions at home or within A&E.** Many planned and proactive care services in the Supporting People to Remain at Home section are designed so partners working together in a coordinated and integrated way can support this aim. For example, our current review of the MACC Team suggests its intervention has a positive impact on reducing avoidable ED attendances/NEL admissions, including falls admissions, due to better managing escalating needs before a patient crisis - our estimates suggested a reduction in hospitalisation rates by as much as 25%.

   BCF-funded investments also include our community admission avoidance service, Rapid Response, connected to 111 which responds every month to c. 185 patients at crises at home in 2-24 hours (depending on urgency) without the need for avoidable ED attendance/admission – a 80% increase in the numbers pre-pandemic. We plan to further non-BCF investment in this service in 2023/24.

2. **Ensure as many patients as possible can return directly home in a timely and safe way as soon as they are fit to do so – 'Home First' – and there's support to recover health and independence.** Typically, 93% of people are discharged 'home' - to their usual place of residence. Our figures show 76% of people with reablement remain at home post-hospital discharge, and that we have increased the number of people seen in our P1 'Home First' pathways via hospital by 15% in 2022/23 compared to pre-pandemic partly enabled through Discharge Funding investment. These home-based intermediate care solutions also support admission avoidance (if patients with escalating needs are identified in the community), including falls prevention. We have set a target for this metric to reflect our improved range of P1 Home First solutions to manage more complex health and care needs at home and better support those at risk of homelessness/with challenging housing.

   We need to improve the proportion of people who receive reablement and who remained at home 91 days post-discharge. This figure needs to improve towards its pre-pandemic levels; this proportion decreased during the pandemic as there were more complex cases who were more likely to either be moved to P2/P3 long-term care and/or have longer-term admissions/readmissions.

3. **Ensure as few decisions as possible about an inpatient's long-term care take place in hospital. Every patient should be given the chance to recover post-discharge, ideally at home** or, if not, in an intermediate care bed. Individuals' long-term care needs should be assessed post-recovery. We know 1-1.5% of our patients are admitted to long-term care placements in care homes. This approach to ensuring as many people as possible can recover either pre- or post-hospitalisation has ensured we reduce the number of people admitted to Council-funded long-term care homes.



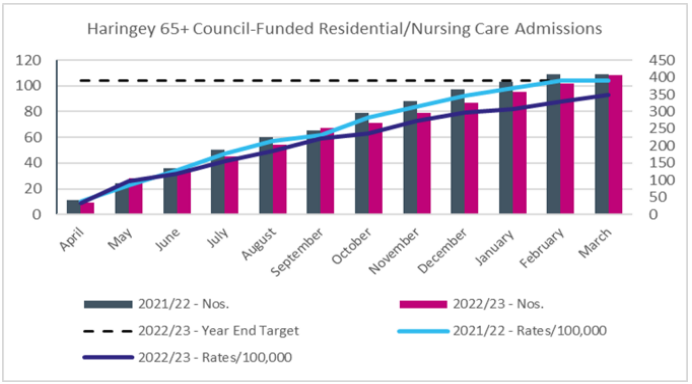


Figure 3 – Trend data for Avoidance Hospital Admissions and (b) 65+ Council-Funded Long-Term Care Home Admissions for Haringey

These objectives are beneficial for patients and mitigate the need for, and intensity of, Council or ICG-funded long-term care for individuals. We have utilised our routine monitoring of metric data in 2022/23 to inform target setting (examples in Figure 3), with our targets (once adjusted for standardised rates) adjusted to take account of the likely impact of the additional improvements in the previous and this sections. For example, expanding our planned and proactive care services (e.g. better utilising our MACC Team or expanding Rapid Response) will influence both our falls admission and avoidable admission rates *and* our long-term admissions to care homes. The table at the end of this section summarises our in BCF Admission Avoidance/Supporting Discharge investments in 2023-25. It, and the table in the Supporting People at Home section, also indicates whether these services contribute significantly to which BCF metrics.

Planning Discharges and High-Impact Change Model

We have strong arrangements for hospital discharge and intermediate care between secondary care and community partners. Staff in secondary care, in community health services, CHC teams and Councils work together to triage the needs of those hospital patients approaching discharge identified as needing care to return home through the Integrated Discharge Team (IDT) model in each hospital. This network of partners includes North Middlesex University Hospital (NMUH) and Whittington Hospital Trusts (WHT), two hospitals that admit 80+% of emergency Haringey patients, as well community health, mental health, Council social care and housing services. As system partners, we facilitate discharge via a D2A approach based on the national High-Impact Change Model (HICM). Appendix 1 summarises our progress against our HICM self-assessment in 2022/23 across NMUH and WHT with our neighbouring Boroughs and plans to make further improvements in 2023-25. The BCF partly funds the

adult social care staff working as one of these out-of-hospital discharge partners. All IDTs and partners operate 7 days a week, with additional capacity to manage surge demand.

Haringey's Council and community health services also work with IDTs in other NHS Trusts on a case-by-case basis, particularly for more complex cases, to plan and manage the discharge and ongoing recovery, care and support needs of Haringey residents in other hospitals. In addition, a non-BCF funded NCL Transfer of Care Hub (TOCH) supports the management of patients cross-Borough particularly to support discharge to, and move-on from, P2 NHS Rehab facilities access to which is open to patients from 5 Boroughs in NCL under our ICS bed-sharing agreement.

The majority of inpatients are discharged home without statutory sector care and support, i.e. P0 pathways; however, some P0 patients may value time-limited support to return and settle home via our part BCF-funded VCSE Home from Hospital schemes operating in NMUH and WHT. These schemes helped 750+ Haringey residents discharged on P0 pathways from acute hospitals to return home in 2022/23, the highest number recorded. This support provides a vital contribution to ensuring people can be discharged to their usual place of residence and we want to strengthen this support in 2023/24.

Supporting People to Recover Post-Crises – Step-Up and Step-Down Intermediate Care
The Summary highlighted the legacy of the pandemic, including the significant increase in the number of people with moderate/severe frailty in Haringey due to health and social deconditioning, particularly amongst people with pre-existing LTCs and/or difficult social circumstances. This had consequences for demand in our community system, with the community and primary care sectors, including those proactive and planned care services, absorbing a significantly increased level of activity (particularly amongst older people) in the community during the pandemic. Due to this community response, the number of people hospitalised as an emergency *decreased* pre- and post-pandemic, e.g. 30%+ decrease in NEL admissions for all ages between Apr–Mar-23 compared to Apr–Mar-19, though our data tells us this decrease has now levelled off the last 12 months.

However, we had rising acuity amongst those admitted to hospital – for example, the average number of diagnoses of conditions per patient increased by 30% at NMUH, whilst the proportion of Haringey patients who stayed longer than 14+ days increased from 12% to 14% between 2019/20 and 2022/23. This also means there are significant pressures in terms of our NHS and Council intermediate care P1-P3 'offers', with more people needing more complex support to recover (e.g. a 15% increase in P1 Home First reablement cases between 2019/20 & 2022/23), despite reductions in admissions. Our forecasts suggest these trends will continue, and much of the LA/ICB Discharge Fund will be utilised to support community and bedded intermediate care, alongside other BCF/non-BCF funding sources (see below).

We continue to ensure our discharge model emphasises 'Home First' and have extended our community-based models of support. For example, our Trusts provide a largely non-BCF funded Virtual Ward 'offer' to support acute patients with frailty/delirium to return home but under the care of an acute/community health team. The number of patients supported through our WHT Virtual Ward

service is 20 at any one time, and we are planning to extend the service capacity in response to demand. As part of this our approach, we continue to invest in remote monitoring assistive technology to support people to live as healthy, safe and independent lives as possible including within Virtual Wards.

The increased complexity of patient cases also relates to their social and environmental circumstances. For example, we know typically 20%-30% of Haringey discharge delays are due to patients living in challenging housing environment (e.g. hoarding, deep cleans etc.) or who are at risk of homelessness, and both these circumstances are more prevalent now than pre-pandemic amongst our non-acute and acute patients. We are working with housing colleagues to increase investment to address these issues:

- A joint protocol setting out housing and care staff respective responsibilities in supporting the discharge of patients at risk of homelessness through the NMUH/WHT IDTs and their partners, including shared expectations around timescales.
- BCF-funded investment in a housing liaison function in our IDT systems in 2022/23 to help coordinate, plan and support the discharge of cases of individuals living in challenging housing environments, together with procurement of an urgent deep clean/environmental service to organise rapid improvements in their homes to facilitate safe and timely discharge.
- Non-BCF-funded NCL Move-On Co-ordinators support inpatients who are rough sleeping and/or at risk of homelessness. The Co-ordinators liaise with housing needs teams and other housing colleagues to ensure smooth transition from hospital to temporary or long-term accommodation.
- Part BCF-funded (including Discharge Funding in 2024/25) short-term accommodation for secondary care patients who are rough sleepers or risk of homelessness.
- Non-BCF-funded GP-led Homeless Health Inclusion Team to work with rough sleepers in these units to help them recover physically and from homelessness and address longer-term health issues.

Much of the Discharge Fund (and BCF ICB Minimum Allocation/iBCF) was focussed on supporting P1-P3 pathways in 2022/23. We will continue to increase capacity in out-of-hospital interventions in 2023-25. The Discharge Fund has helped ensure that our capacity for intermediate care better matches the call on demand we experience across our Trusts. We know current demand for P1 Home First solutions were slightly higher than anticipated capacity in Q1 2023/24 (see Demand & Capacity spreadsheet), and the following investments in 2023-25 has enabled us to assure that demand matches capacity from Q2 2023/24:

- Partly Discharge Funded, reablement and domiciliary care and support to aid patient's recovery as part of P1 'Home First' or admission avoidance, including within Rapid Response or Virtual Wards.
- Partly Discharge Funded, health-orientated/D2A pathways prior to CHC assessments in individuals' home.
- P2 intermediate care beds including:
  - Part BCF-funded/part-ASC Discharge funded 225 P2 NCL NHS Rehabilitation beds pooled for the 5 Boroughs, with these beds shared across the 5 Boroughs (NB: see Demand & Capacity section).
  - BCF-funded short-term Haringey-based intermediate care ('P2 with reablement') beds to help people convalesce and recover their health and function in a care home, with a joint community health and adult social care MDT to support individuals recovery and move-on.

- Partly Discharge Funded, Council and NHS residential/nursing care home interim step-down/assessment for secondary care patients who cannot return home for health, social or environmental reasons, partly funded via Discharge Funding.
- Partly Discharged Funded support for ASC workforce initiatives designed to support hospital discharge, case management, review and move-on post-discharge.

In 2023-25, we will look to improve our commitment to support patients' admission avoidance and safe and timely discharges and onward recovery in the community:

- Strengthen the interface between our admission avoidance, hospital ED and discharge functions, and our planned and proactive care 'offers' post-recovery in the community. This includes expanding the MACC and EHCH Teams and falls prevention and how we make best use of both our newly opened diagnostic centre in Wood Green as a facility to triage escalating health or social needs of individuals quickly to mitigate escalating crises through responding in localities.
- Continue to invest in improving our partly BCF-funded admission avoidance solutions, particularly expanding Rapid Response functions capacity to respond in 2 hours, and further integration with our wider Urgent Care Response network including 111 to avoid conveyancing to ED, e.g. better use of the non-BCF funded NCL Frailty Car Service to care home residents as part of our 111 response.
- Progress improvements identified in the High Impact Change Model table over the next 12-18 months as system partners across our local acute and non-acute hospitals (Appendix 1).
- Reprocure our part-BCF funded Home from Hospital schemes to support the needs of P0 pathway patients, including strengthening how we help more individuals recover their health, well-being and independence once home and connect them to our wider early help and proactive care systems.
- Respond to an ICS-wide joint Council and NHS review of our future discharge interface between acute and community and onward intermediate care 'offer' and implement improvements in our joint Discharge Team (with BCF partly-funding ASC staff) models around our NCL acute and non-acute systems. This includes improving our capacity and capabilities to better identify, prepare/plan for discharge and triage the needs of people in integrated P1-P3 pathways across the ICS.
- Continue to develop and expand our BCF/DF-funded P1 NHS/Council Home First intermediate care/reablement 'offers' to ensure more patients with a greater range of needs have the support they need to return to their usual place of residents.
- Continue to progress NCL-wide improvements to NCL part-funded BCF/DF-funded P2 bedded intermediate care, interim care home step-down and fast-track arrangements. This includes funding to reduce unwarranted variation in resources across NCL acute and non-acute hospitals, expanding P2 NHS Rehabilitation bed complement and improving our MDT arrangements to best support move-on.
- Expand our part-BCF funded investment in housing-related support for patients with challenging housing behaviours or risk of homelessness to be discharged from acute or non-acute hospitals in a safe and timely way and to recover their health and address their circumstances.

Proposals for 2024/25 Discharge Fund Allocations and ICB Minimum Allocation

Our submitted plan does not include schemes and commissioner for the ICB DF for 24/25. We have agreed a process summarised below that will support the development of schemes – note that both schemes, commissioner and funding per borough for the ICB DF for 24/25 is subject to change. In developing our approach, we have engaged with our regional Better Care Manager and whilst it means we cannot identify our 24/25 spend at this stage, we are confident that our approach is fully aligned with meeting the BCF principles and outcomes.

The process we are working to locally is: The councils and the ICB in NCL have not reached agreement on the use of the discharge funding for 23/24 and 24/25. To move this forward, an alternative approach will be taken in accord with the principle we agreed for open book transparency between partners. The ICB will agree to the allocation to social care of 50% of the ICB ADF allocation as a one off in 2023-24 (£3.4m).

This is agreed on condition that we jointly appoint and fund an independent financial expert, to review both the ADF, BCF and all budgets within both social care and the ICB that the independent financial expert and CFOs feel necessary to resolve this issue, with open book financial reporting and activity counting on both sides.

This independent expert's work will report jointly to a nominated council CFO and Phill Wells as ICB CFO and they will be able to make binding recommendations to inform how the 2024-25 BCF and ADF are spent in an equitable way.

Terms of Reference, a specification and principles for the work including definitive timescales for completion will need to be jointly agreed between CFOs and the independent financial advisor before the final stages of BCF sign-off including the s75 sign offs are completed and the £3.4m one off for 23-24 is transferred to councils.

Out-of-Hospital Funded Through BCF Plan (New or revised items in red font)			Influences Which Metrics					Additionality to Capacity? (New Services)			
Scheme ID	Scheme	Reason for Change / Addition from 2022/23 / Additional Comments	Admission Avoidance	Falls	Usual Place (Home)	Res/Nursing Adms	Reablement Home Measure	P0	P1	P2	P3
8	Integrated Therapies and Therapeutic Support for Urgent Care Response including support for P1 Home First recovery	Uplifted investment in community health services. ICTT supports P1 Home First and 'step-down'	Y	Y	Y	Y	Y				
23	Alcohol Liaison Services in Hospital		Y	Y	Y						
26	Invest in Single Point of Access/IDT-support function to meet demand	Line 26 combines several lines in 2022/23 (at same funding). Supports funding of ASC staff in discharge process and 7 day working	Y	Y	Y						
29	Home from Hospital (P0 Support)		Y	Y	Y						
30 & 31	Rapid Response Service & Virtual Ward (Community Health & ASC components)	Line 30 combines 2 lines in 2022/23 (at same funding). Included here as intermediate care but is N2: Support at Home offer ('step-up')	Y	Y		Y					
33 & 36	P1 Home First Reablement Solutions & Packages of Care (iBCF & Min. NHS Contribution)	Line 33 (& seperately Line 36) consolidates several lines in 2022/23 (at same funding). Included here as intermediate care but supports 'step-down' and some 'step-up' (N2) clients	Y	Y	Y	Y	Y				
38	P1 Home First Step down flats		Y	Y	Y						
39-41, 51	P2 Community-Based Care Home Intermediate Care & Convalescence Beds (iBCF & Min. NHS Contribution)	Provides 'bedded reablement' and dedicated multi-agency MDT to support recovery & move-on	Y	Y		Y					
42 & 43	Enhanced MDT to support indivudals' recovery & move-on in (particularly care home) P2 beds		Y	Y		Y					
44	Supporting people with P1 Home First challenging housing needs to return home post-hospital discharge	DF investment in 2023/24	Y	Y	Y	Y					
54	D2A Pre-CHC Assmt P1 Home First Pathway	DF investment in 2023/24 and 2024/25 to meet demand	Y	Y	Y	Y			Y		
55	D2A Pre-CHC Assmt Interim Residential/Nursing Care Step-down beds	DF investment in 2023/24 and 2024/25 to meet demand	Y	Y						Y	Y
67	Discharge Funding for care provision to support P1 HomeFirst hospital discharge pathways	Investment from ICB element of ICB Discharge Fund to meet ASC P1 HomeFirst demand in 2023/24	Y	Y	Y	Y	Y		Y		
68	Discharge Funding to support Council-funded short-term/interim P2/P3 care placements post-hosptal discharge	Investment from ICB element of ICB Discharge Fund to meet ASC bedded intermediate care demand in 2023/24	Y	Y		Y				Y	Y
64	Discharge Funding to support workforce initiatves to support hospital discharge & post-intermediate care review	DF investment from ASC Discharge Fund to meet demand in 2023/24 & 2024/25	Y	Y	Y	Y	Y		Y	Y	Y
65	Discharge Funding for care provision to support P1 HomeFirst hospital discharge pathways	DF investment from ASC Discharge Fund to meet demand in 2023/24 & 2024/25	Y	Y	Y	Y	Y		Y		
63	Discharge Funding 2024-25 - To Be Determined	Additional investment to be agreed. NCL ICB and LAs plan to agree the final application of the Discharge Fund during 2023-24.	To Be Determined					To Be Determined but likely to add capacity to P1-P3			

Approach to Demand and Capacity Modelling – Community and Hospital

Our approach to demand and capacity modelling draws on four key data sources/methodologies:

1. Hospital discharge data from 2022/23 and 2023/24 NCL ICS Operating Plan which reflects acute demand for P0-P3 discharge pathways. We utilised the Plan's forecasts, based on historical activity projected forward which disaggregates into P0-P3 pathways.
2. Existing capacity and demand activity for intermediate care in 2022-23 and use this as the basis for an interim projection for 2023/24. We know the number of Haringey patients (demand-side) utilising, for example, P2 pathways sub-categories utilised in 2022-23. We can utilise these proportions, applied to P0-P3 projections in (1), to estimate likely demand within each sub-category.
3. (2) provides estimates of likely demand in 2023/24 without any further intervention, e.g. our additional BCF/non-BCF investments. We therefore consider how the investments in intermediate care listed in the previous section will influence demand figures along P0-P3 pathways. For example, non-BCF added investment in Rapid Response will increase the number of people who are diverted into such schemes rather than in ED; or additional capacity from BCF/DF into P1 Home-First/care home step-down schemes will draw activity into, and between, these pathways. This 'additionality' also informs our capacity calculations, e.g. further Rapid Response investment increases its capacity. As noted above, this showed that our demand was slightly greater than capacity in Q1 2023/24 prior to implementation of our additional solutions funded through 2023-25 BCF Plan investments. This helped inform our BCF schedule for the Discharge Funding to assure that our capacity better matched demand from Q2 2023/24 onwards.

4. Some services are linked to admission avoidance (community), others to discharge. However, others (e.g. reablement) are utilised by both routes, and where this is the case, a simple pro-rota estimate of cases from community/hospital is used to estimate demand and capacity.

The above considerations were included in the BCF Demand and Capacity profile for Haringey. The BCF schemes in the table in the previous section shows where they impact as 'additionality'.

We continue to work with partners as part of an NCL ICS, rather than simply Borough-based, development of intermediate care solutions. However, this ICS-wide approach leads to some issues in terms of matching P2 demand to capacity, particularly for rehab beds. Haringey has never had rehab beds in its Borough boundaries, with its patients utilising nearby P2 NHS rehab facilities in 3 other NCL Boroughs. Boroughs in NCL agreed to report their Rehab capacity in the spreadsheet in terms of the facility's geographical host Borough (though demand comes from multiple Boroughs), which means Haringey is reporting a '0' capacity in the template. Any analysis regionally of demand/capacity should pool information on bedded rehab across 5 NCL Borough returns to fully understand the ICS position.

We reviewed our learning from our 2022/23 ASC Discharge Fund scheduled investment across both acute and non-acute systems. We were largely able to deliver against targets as reported in Year End submission. Key learning points are the need to improve and invest via BCF/non-BCF/DF in:

- Admission avoidance/Home First solutions in 2023-25 including expanding Rapid Response, and our P1 'offers' such as reablement, health-orientated solutions and case management, including Virtual Wards. We saw rising levels of complexity of cases, which meant we were under-target for the number of reablement cases delivered – due to higher costs per case.
- NCL-wide bedded support in several ways (see previous section):
  - Currently reviewing our NCL-wide P2 bed capacity and bed-sharing arrangements and the oversight via TOCH to ensure beds are utilised in a more effective way to increase throughput.
  - Patients awaiting P2/P3 provision had a greater complexity of rehabilitation needs, long-term health issues and complex social and housing situations. This made these individuals difficult to place sometimes within our local systems, e.g. step-down to care homes, which slowed discharge.
  - Continue to invest in supporting interim care home step-down arrangements, but to preferentially to better utilise other MDT-supported P2 options to help patients recover and prevent long-term deconditioning – particularly as occupancy in care homes is 95%+.
- Our homelessness and housing needs solutions (see previous section).
- Governance and oversight between parties of sign-off of returns and submissions to the BCF Team for the fortnightly returns in 2023-25 – progress now formally agreed.

Support for Unpaid Carers

The BCF Plan continues to invest in solutions to identify and support unpaid carers as part of Haringey's wider multi-agency Adult Carers' Strategy. Its aim is to ensure that *all carers, of all ages, are recognised, respected and supported* to ensure anyone who provides unpaid care and support is:

- Able to identify themselves and recognised as carer
- Supported to continue to be a carer
- Supported to maintain or improve health & wellbeing
- Supported to have a life of their own

- Provided with information, advice and guidance, with priorities relating to housing and finances.

We continue to progress the resulting action plan, but have made progress since the last BCF Narrative:

- Council and NHS partners have improved their engagement, identification and support for carers as part of wider NCL development of 'anchor institutions' approach to enhance care and support organisations' roles as civic leaders. For example, the Dementia Reference Group, which brings together people with lived experience with dementia including carers with statutory partners, held a series of 'You Say, We Do' workshops in 2022/23 on topics such as safeguarding and post-diagnostic support. This proved a successful and popular approach with carers.
- Increased the number of people supported through activities facilitated through our VCSE carers partners' activities, including 1:1 support including on topics such as health, well-being, managing caring role etc., and improving awareness of the support available for carers in Haringey through 'NavNet' and via regular newsletters to carers known to the Council.
- A focus on supporting carers from under-served communities to shape solutions and opportunities with them – these specific requirements are integrated into the Strategy's action plan.

The BCF Plan funds key services to support carers in Haringey including:

- Carers' First contract as our key VCSE carers' partner to hold the Councils' Carers' Register and identify and support carers. In 2023-25, we will re-procure our VCSE carers' service. We will ensure that the needs of carers are integrated into our locality-based development and plan additional BCF investment in carers' support workers in localities during 2023-24
- Short-break care for carers to provide them with respite from caring responsibilities, and provision of Direct Payments (which increased by 80+% over the last 3 years) to support them in their role. BCF investment in carers' breaks is significant (highest of 5 NCL Boroughs).
- In 2023-25, we intend to increase our investment in supporting carers by over one-third. We will utilise the funding to establish a Carers' Support Network to better support and assess the needs of carers for all client groups as part of our roll out of locality working as part of our response to the Fuller report.

Disabled Facilities Grant and Wider Housing Services

Disabled Facilities Grant

One of overall aims in terms of housing-related support is to better utilise home aids/adaptations and technologies to support people in their own homes to improve outcomes across health, social and housing. This includes partly BCF-funded community equipment and wheelchair services (included in Supporting People to Remain Home) and provision of major adaptations of people's homes to help them to live independently for longer, funded through the DFG via the Better Care Fund.

Demand for DFG funded adaptations across all tenures and for residents of all ages continues to be high, particularly in deprived areas, and we have utilised the funding flexibly in the way the RRO offers for several years. The Council administers all aspects of the DFG process, including OT assessments, following referral, working in conjunction with housing, Registered Social and private landlords, and a

delivery provider framework. We routinely review delivery, quality, performance and spend during the year, but, as in previous years, we anticipate funding will be fully committed in 2023/24.

We are exploring setting up a Handyperson Service from the DFG allocation in 2023/24 to support people living in the community who need minor adaptations or repairs. We will utilise the service to support people to live at home and as part of our overall housing hospital discharge 'offer' (see below).

Engagement with Housing Services

Our partnerships incorporate health, social care and housing-related services. We shared our plans with our supported housing and housing needs colleagues within the Council's housing department, who we work with to shape our approach and delivery as part of our plans for locality working and support to promote discharges and move-on for people with challenging housing environments/at risk of homelessness. Our wider work with housing colleagues since the last BCF is included in previous sections of the Narrative.

Equality & Health Inequalities

As noted last year, we conducted an Equality Impact Assessment based around the Protected Characteristics plus socio-economic deprivation for the BCF/ Ageing Well Strategy and the impact of the pandemic on amplifying social gradient of inequalities, which helped shaped our delivery plans.

There was pre-pandemic social gradient of up to 17 years in healthy life expectancy between the least and most deprived (and often most ethnically diverse) areas. Residents from the 20% most deprived neighbourhoods are 2-3x as likely (from birth to 75 years) to be hospitalised as their affluent peers, with notably higher rates amongst people from Black Caribbean/African and eastern European backgrounds. We know the impact of the pandemic and other 'system shocks' such as the rising cost of living and energy prices affected people in under-served communities than other groups. For example, our local intelligence and national reporting tells us people in under-served communities are now more at risk of being moderate/severe frailty than their age peers in better-served communities. As the Summary notes, there is good evidence our Haringey community services have responded well to rising demand, and this helped people manage their conditions. For example, the number of Haringey GP consultations increased by one-third between 2019/20 and 2022/23, with the number for people living in the 20% most deprived areas/from the above ethnic backgrounds rising by a similar proportion.

NCL ICS reaffirmed its commitment to improve equity of access and outcomes to under-served communities, particularly those living in deprived neighbourhoods in 2023/24. The ICB committed non-BCF £5m Inequalities Fund Programme (c. £1.8m targeted at Haringey's under-served communities) to fund solutions to address these issues and improve the health and life chances of people in the 20% most deprived neighbourhoods. The Programme's most significant investment is in Haringey's Healthy Neighbourhoods collaboration between NHS, Council, VCSE and residents in our deprived communities. Our BCF partly funds VCSE activities in the model through our Community Chest (see Early Help section).

The table below shows the full distribution of funding within the Inequalities Fund Programme projects and additional BCF Plan investment.

The Programme was focussed largely on addressing the 'Core20Plus5' issues within the 20% most deprived neighbourhoods: alongside other sources of funding, such as the MH Transformation Fund, the Programme includes investments in projects supporting people living with SMI, those with or at risk of LTCs, such as cancer, COPD, CVD/hypertension, and inclusion health. We have engaged with PCNs to support the 'Plus' component, including frailty in the west (see previous sections).

A stock-take of the Programme undertaken in 2022/23 was promising. For example, one non-BCF project supporting 150 people with heart failure living in the 20% most deprived neighbourhoods through an MDT approach including the VCSE, markedly improved health outcomes, including self-management, for participants. It also reduced re-admissions for its participants by 22% with overall HF admissions in these deprived communities reducing by 6%.

Due to the improvements in engagement and support between residents/patients, VCSE and statutory services in the community, including within the IF Programme, over the last 2 years, we have seen a *decrease* in the number of people living in Haringey's 20% most deprived communities NEL admissions to hospital – a reduction of over 30% between 2019/20 and 2022/23.

We continue to roll out our approach to determine the extent to which BCF and ICB-funded services are equitable for those patients and residents they serve including through:

- Ensuring we incorporate the views of particularly under-served communities and groups in the delivery or involve people in co-design of solutions. For example, partners, led by the VCSE, collaborated with specific communities (e.g. people from black African/Caribbean groups) as part of the (entirely BCF-funded) mental well-being theme of our Healthy Neighbourhoods to shape solutions they might value. This led to an approach in which people engaged with a range of arts and sports activities they might value *before* discussing their underlying mental health issues.
- We used our IF Programme funded community ambassador network into specific under-served groups and wider engagement network led through our VCSE partners to improve delivery of healthcare services. For example, we recently engaged with the Turkish/Kurdish community on a range of healthcare-related issues, including ensuring services the support people with LTCs receive (e.g. in BCF-funded nursing or proactive care services) is culturally sensitive and in settings closer to the community. We will continue to build our social capital network and infrastructure in 2023-25
- We continue to roll out monitoring equity of access and outcomes of key services through 'equity ratios'. These ratios measure the extent to which services, such as our MACCT, are accessible to residents with particular characteristics, e.g. defined by age, ethnicity or circumstance (e.g. those living alone, carers etc.), with the expectation action will be taken to address under-representation with those groups under-served. We have started to create deprivation, age and ethnicity-based equity ratios for our performance metrics, including BCF metrics, in line with HIID's proposed approach to metric development.

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

- A BCF-funded Coordinator to work with organisations to grow our Haringey Dementia-Friendly Communities. The Co-ordinator works with deprived and diverse communities to improve awareness of the condition and connect people to solutions they may value.
- BCF part-funded IF projects in a range of communities and collaborations in our most deprived communities - many focus on specific under-served groups, e.g. improved support for young people from black ethnic backgrounds with mental health issues, including those recovering from crisis.
- The BCF part funds a model to support discharge of people with severe mental health needs from non-acute secondary care to return home and recover in the community as part of our MH IDT.
- Support for people with multiple disadvantage and those at risk of homelessness as part of our Healthy Neighbourhoods IF, BCF Discharge Fund investments and other funding to:
    - Help up to 50 people per annum with complex physical and mental health issues better manage their lives and health needs in the community as part of locality working, including non-BCF Department for Levelling Up, Housing & Communities Rough Sleeping Initiative funding to support care coordinators in 2023-25 and a substantial non-BCF funded Health Homelessness Inclusion Team to manage the health needs of people at risk of homelessness.
    - Support c. 120 people per annum who are High-Impact Users within our local ED acute hospital to better manage their lives and health through a dedicated multi-professional MDT led by a dedicated care coordinator, a non-BCF IF project with promising outcomes for patients. We estimate a 15% reduction in ED attendances so far from this group, with over 800 ED attendances and 80 NEL admissions mitigated per year.
    - Support c. 30 people per annum admitted to non-acute or acute hospital to recover their health and from homelessness through extending the number of non-BCF-funded step-down provision and supporting their subsequent move-on into long-term accommodation.

In 2023-25, we intend to continue our focus on addressing equity of access, outcomes and experience:

- Continue with our Healthy Neighbourhoods and IF Programme projects as part of the locality working in east Haringey in 2023/24 and beyond.
- Continue to extend and develop our BCF and non-BCF investments for people with dementia, mental health and people living with severe and multiple disadvantage.
- With Enfield, look to extend our non-BCF IF Programme around our NMUH system reaching jointly into east Haringey & Enfield. This system was selected for additional investment as it is the acute hospital, whose patients live in the most diverse and deprived NCL neighbourhoods.
- Ensure our future developments in this Narrative proactively consider equity as part of their codesign and implementation, including engaging with under-served residents and patients (e.g. in locality development). We will then utilise 'equity ratios' and resident/patient feedback to monitor the success and impact of these services/projects, including those relating to BCF and its metrics.

APPENDIX 1 - SUMMARY OF HARINGEY HIGH-IMPACT CHANGE MODEL LOCAL SELF-ASSESSMENT UPDATE

High-Impact Change Model Self-Assessment Summary

Impact change	Maturity Status	Position in Sep-22	Actions to improve	Updated Position May-22	Actions to improve in 2023-25
Change 1: Early discharge planning	**Established** but needs to be more systematically embedded	Flow meetings take place daily led by the respective Integrated Discharge Teams (IDTs) in NMUH, WHT and other acute sites. Patients placed on the discharge list for care-aided (P1-P3) support includes patients who are pre-medically optimized to facilitate early discharge planning including virtual ward.	More consistent identification of patients: introduce RAG rating for discharge needs based on complexity in 48 hours of admission; and to embed EDD as planning tool within wards NMUH trialed ED admission identification tool & intend to implement systematically	Criteria to reside approach (inclusive of MDT ward rounds) rolled out in training across acute Trusts	Creation of detailed CTR dashboard in development to manage & track patients and support with identifying complex discharges early.
Change 2: Monitoring and responding to system demand and capacity	**Established** & working towards more sophisticated operational real-time & strategic models to become Mature	All NCL acute Trusts and IDTs have robust mechanisms in place to monitor & share operational pre-MO/MO cases on a patient-by-patient basis with partners.	Continue to refine patient-level information and information-sharing between partners	Patient-level information & information sharing between partners shared twice daily as 'pre-MO/MO list' and discussed on daily calls but continued recognition solutions need to improve.	To identify and develop a robust centralised system for sharing information to minimise patient delays. NCL ICS will review options for partners to improve real-time sharing/tracking of information, assigning case management & progress on discharge preparation, including through the Optica platform in local Trusts.
		Partners utilise & share aggregated data from all NCL Trusts to understand flow across system, including discharge pathway utilization, bed utilization, LOS and delays, and this is utilised operationally & by executives to understand acute & out-of-hospital capacity & demand. Strategic analysis & predictive modelling supports decision-making on capacity including future system resilience.	Continue to refine strategic analysis and predictive modelling on discharge pathways and support in community	Forecast Modelling reporting now taking place at NCL and local level with regular submission and presentation to AEDB.	Further refinement of modelling including scenario-building in event of continued deconditioning due to legacy of pandemic and 'system shots'
Change 3: Multi-disciplinary working	**Well-Established** & planning to work towards more mature models as part of NCL Review	Our Community Health-led multi-disciplinary IDTs in each acute Trust manage cases jointly between NHS acute and community health, CHC and adult social care partners. Each P1-P3 case is allocated to the most appropriate professional to oversee the planning for discharge.	Review current model between partners to ensure we are identifying potential barriers to discharge early; with senior management oversight and to support frontline led review of ways of working	Completed a joint Council/NHS ICS-wide review of discharge arrangements between parties and parties are planning implementation of findings. This includes redevelopment of IDTs to have a multi-agency Borough base and development of a NCL ICS-wide multi-disciplinary Transfer of Care Hub (TOCH) to manage cross-boundary/P2 cases. Quick win improvements also made: LBH social care are now onsite in acutes/P2 facilities	Implement recommedations of review and set up revised Discharge Teams/TOCHs across Haringey and across ICS, and further progress quick win opportunities
			Build on existing partnership safeguarding & quality of care framework to implement NCL ICS response to 'potential harm' events as reportable incidents associated with delayed transfers prior to winter in our local system	DATIX reporting and statutory safeguarding procedures in place across partners involved in discharge, with lessons learnt discussed in partnership	Need to continue to strengthen safeguarding & quality of care arrangements & training and onward learning across partners, including as part of redesign of IDTs
Change 4: Home first	**Well-Established** & planning to work towards more mature models as part of NCL Review	Discharge-to-Assess policies and processes are well-established in all our NCL acute systems, and in WHT and NMUH. IDTs have a pivotal role in working across partners to decide the next steps for the patient post-discharge with a clear 'Home First' policy via our D2A.	Make best use of existing solutions (e.g. Virtual Wards) and increase BCF investment in reablement to manage demand in 2022/23 Progress development of the joint Community Health/LBH Urgent Care Response project to better manage the cases of 'Home First' discharged patients. Review current model of case management between partners (Change 3)	Increased investment and operational improvements in reablement pathways in 2022/23 and health-orientated P1 HomeFirst pathways (including VWs) now operating. This led to changes in case management responsibilities for some cases between ASC and Health. NCL-wide improvements relating to UCR/111 response, e.g. Frailty Car etc. also in	Redesign P1 HomeFirst triaging and HomeFirst streaming into best fit for patient needs as part of ICS joint review. Continue to invest in reablement and increased investment in VW/Rapid Response and health-orientated P1 Home First offer between Council and community health.
Change 5: Flexible working patterns	**Established** & planning to work towards more mature systematic approach	IDT model in each Trust operates 7 days per week and has daily meetings at the weekend. Community partners also operate 7 days/week	Increase discharge rates more consistently at weekend including via community projects (e.g. Virtual Wards) to support flexible working.	7 day working across partners in place but could be strengthened/modified in response to NCL-wide review	Part of NCL-wide review includes stregnthening DTs/TOCHs on multi-agency 7-day basis
Change 6: Trusted assessment	Working towards **Established** & planning to work towards more mature systematic approach as part of NCL Review	IDT model in each Trust assigns case to the most appropriate agency to undertake the relevant assessment. Where more than one partner's input is needed, this is facilitated in discussion between partners with the lead responsible for coordination, so the case is as well-coordinated as possible Trusted Assessor role for care home assessments funded via the BCF Plan (see Change 8) and their assessments are	Review current model of case management for more complex discharges and move-on between partners as part of frontline led improvements, and revise processes and procedures to support approach (Change 3)	Trusted Assessor model strengthened in 2022/23 through full implementation of Enhanced Health in Care Homes model which includes TA role in Haringey and its local system linked to other Boroughs TA solutions	Strengthen multi-disciplinary, multi-agency discharge teams/TOCHs and P1 HomeFirst case management across local system & ICS in response to review, including case management responsibilities (see Home First)
Change 7: Engagement and choice	**Established** & planning to work towards more mature systematic approach to choice	Our systems have information packs for patients and families to help explain the discharge process and 'what happens next'. We have also revised our Choice Policy for those patients who need care solutions so that we can work with them and their families to find the right community services, but which emphasises the need to proactively make timely and reasonable decisions with those professionals managing the discharge	Ensure more consistent engagement and application of the policy across our acute systems. Implement updated Choice Policy and enhance training for ward staff on engagement with patients and families, including on policy.	Choice Policy rolled out across NCL. Process being refined by each individual Trust. Improvements to Policy currently being trialled at NMUH.	Learning and development including upskilling acute staff in local system on applying the NCL Choice Policy will continue into 2023/24 - seen as important element of changes to discharge processes
		Voluntary sector Home from Hospital scheme in place to facilitate discharge and return home on P0 pathways	Ensure we make best use of our VCSE 'offer' within NMUH and WHT hospitals in winter	750+ Haringey residents helped to return home via Home from Hospital in 2023/24, highest ever recorded	Reprocure and redesign Home from Hospital schemes in Haringey in 2023/24 in light of NCL-wide review
Change 8: Improved discharge to care homes	**Well-Established** & planning to work towards more mature models	BCF-funded Enhanced Health in Care Homes (EHCH) Teams operate alongside the relevant GP clinical lead in all older people's care homes as outlined in the EHCH Framework. Our model includes a nurse Trusted Assessor within our acute hospitals to assess the needs of patients who are scheduled to move to care homes, with assessments generally accepted by the care home.	Actively engaging with homes to recognise need to increase abilities of homes to place/return more complex patients in homes via Complex Care Project across NCL. This will include ensuring our trusted assessor arrangements are more widely accepted and robust.	Complex Care/in reach nurse post at NMUH to link with EHCH Teams and care homes to better manage seamless discharge to care homes. See TA update above	Strengthen TA/care home support for triaging the needs of people who will be discharged to care homes. Strengthen join up with EHCH Teams working in community to improve follow up
Change 9: Housing and related services	Well-Established & planning to work towards more mature models	Our systems identify people with challenging housing situations or at risk of homelessness as part of early discharge planning. We have housing liaison care coordinators in each our NCL acute systems, developed protocols with Borough housing needs teams & expanding our challenging housing function (see DFG Section).	Better identify people with complex housing needs as part of Early Discharge Planning (Change 1)	Pilot for Challenging Housing Environment Coordinator concluded successfully - continuing investment agreed	Strengthen model of support for people living in challenging housing environment in 2023/24
			Progress planning and utilisation of our available resources to support discharged patients with housing issues in community for winter	Move-on Coordinator for people post concluded in 2023/24 - plan to continue to investment from ASC Discharge Fund schemes in 2022/23	Continue investment and strengthen model of support for people at risk of homelessness in 2023/24