Appendix 3 – BCF 24/25 Quarter 2 Submission

Better Care Fund 2024-25 Q2 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board:	Haringey

Has the section 75 agreement for your BCF plan been finalised and signed off?	No
If it has not been signed off, please provide the date section 75 agreement expected to be signed off	29/11/2024
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.	On going discussion to finalise aspects of the section 75 agreement

Confirmation of Nation Conditions		
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the**
1) Jointly agreed plan	Yes	
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes	
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes	
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes	

Better Care Fund 2024-25 Q2 Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Haringey

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning				For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs *Please:* *- describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans* ***- ensure that if you have selected***	Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*
		Q1	Q2	Q3	Q4						
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	153.0	139.0	158.0	138.0	149.1	On track to meet target	The NCL core offer for Virtual Ward includes providing care calls three times a day as a standard requirement, to help expedite patients' return home if they do not meet the clinical criteria for hospital residency. Progress in this area has been slow due to ongoing local discussions between Health and Social Care regarding the management of case handovers once patients are in the community, and the delivery of in-house Health Care Assistant (HCA) support.	The Long Term Condition (LTC) and Local Community Services (LCS) program has been implemented across North Central London (NCL) to support patients who are at the highest risk. Haringey's Rapid Response Team has consistently achieved a 90% success rate for responding within 2 hours, which helps reduce reliance on the London Ambulance Service (LAS) for transport. This service includes a falls pick-up option, providing an alternative to calling LAS. Referrals to the Rapid Response Team come from Haringey's connected care responders (such as pendant alarms and telecare) and the 111 service. The team aims to have a paramedic available every day. Although some paramedics have already been recruited for permanent positions, the recruitment process is ongoing to ensure sufficient coverage for this essential service. Each month, the team manages and triages over 180 patient referrals. Additionally, Silver Triage refers patients to the Rapid Response Team as an alternative to being taken to Accident & Emergency (A&E). North Middlesex Hospital reports that frequent attendees make up around 10% of all visits to the emergency department. A High-intensity user focused project was launched at the NMUH Emergency Department to address this issue. This project aims to provide multi-professional and agency-led support for patients dealing with physical, mental health, and social challenges, thereby tackling the underlying causes of high-intensity emergency presentations. As a result, the project has enabled the profiling of both younger and older patients, with the majority being younger	A full Virtual Ward offer against the required criteria is not yet available to Haringey patients, due to the absence of 3x daily care provision within the pathway. Based on quarter 1 avialable information.	This issue concerning Virtual Ward delivery has been escalated and is scheduled to be addressed within the governance of Haringey's Age Well Board.

Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	95.0%	95.0%	95.0%	95.0%	91.96%	Not on track to meet target	A new systemwide P2 digital solution is being developed, with plans for implementation in the upcoming year. This solution will enhance the data set to reflect variations at the acute site, borough, and unit levels.	The implementation of a single point of access (SPA) through the ICE hub represents a significant opportunity to enhance patient care. By effectively screening a greater number of eligible patients for health beds, we can help them rehabilitate and regain their independence in a multidisciplinary team (MDT) setting, which includes input from Adult Social Care. This approach greatly increases the likelihood of patients being discharged to their own homes, thus avoiding the high costs and loss of autonomy associated with formal care placements. Additionally, the streamlined process promotes greater efficiency throughout the system. The positive uptake of NCL P2 from local acute sites, particularly at North Middlesex Hospital, highlights its effectiveness. With the average wait time for triage to transfer reduced to under four days, patients can access P2 provisions	There is a need to improve access to an accurate dataset for P2 provisions.	The new digital tool will also address validity issues and provide a level of data granularity that is currently not feasible to obtain manually.
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,200.0	336.5	Not on track to meet target	There was no falls service in Haringey prior to 23/24. Workforce challenges have impacted progress in this area.	Support for falls in Haringey is part of a wider frailty network that focuses on multifactorial risk assessment, care planning, primary and secondary prevention, and interventions for complex needs. This support includes close collaboration with Voluntary and Community Sector (VCS) providers to create resource guides and accessible e-learning materials. There is a falls hotline, virtual frailty wards, and ongoing collaboration between the Rapid Response team and the London Ambulance Service (LAS) for a falls pick-up option as an alternative to calling LAS. Additionally, this service receives referrals from Haringey pendant alarm responders and the 111 service.	Support for falls in Haringey is part of a wider frailty network that focuses on multifactorial risk assessment, care planning, primary and secondary prevention, and interventions for complex needs. This support includes close collaboration with Voluntary and Community Sector (VCS) providers to create resource guides and accessible e-learning materials. There is a falls hotline, virtual frailty wards, and ongoing collaboration between the Rapid Response team and the London Ambulance Service (LAS) for a falls pick-up option as an alternative to calling LAS. Additionally, this service receives	At present, Haringey has established a falls working group, which is guided by a designated clinic lead and also offers online resources and a Age Well Guide designed to support our community. A dedicated falls hotline is also in operation, providing essential guidance on accessing falls services. Furthermore, the locality has implemented an educational program through the Better Care Fund (BCF) to equip healthcare providers and professionals with the knowledge and tools necessary to prevent falls and enhance support for individuals at risk. The Rapid Response service is operational, and the local
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				523	not applicable	On track to meet target	Demand for long-term care is rising beyond what is expected based on the population's socio-demographic characteristics, and the complexity of cases is also increasing. This means that more individuals require long-term care, including those supported by the Council and those with more complex needs.	Invested in home first and reablement based care as first approach to enable better wrap around care to facilate the resident staying at home to meet outcome 2	On track to meet target	On track to meet target

5.1 Assumptions

1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include any learnings from the last 6 months.

Estimates for the demand for P1 provisions were based on previous data, which indicated that 90% of P1 cases originated from hospitals and 10% from the community. However, current data reveals that only 1% of P1 cases come from the community, while 99% come from hospitals. Additionally, actual P1 figures are currently lower than expected due to the introduction of a localities model in the last three months. Efforts are underway with the Locality teams to raise awareness about the Reablement service and its ability to support service users coming through the Front Door, not just those transitioning from the hospital.

As for UCR, September's validated data is not yet available on CSDS, so a zero has been entered in the September field. The variance from the plan is being investigated but likely results from various factors, including changes in reporting from 2-hour only to all standard UCR referrals, a change in reporting source from local to CSDS for both 2-hour and all standardized referrals per 100,000 population. Additionally, workforce challenges have impacted activity, and the launch of the NCL UCR community coordination hub has been delayed; it is now scheduled to roll out borough by borough starting in December, affecting planned activities.

The VCS numbers have remained steady in the first half of the year, though they are slightly below our ambitious target. However, we anticipate an increase in numbers over the winter, which will help alleviate the demand for discharges through Bridge Renewal Trust.

2. How have system wide discussions around winter readiness influenced any changes in capacity and demand as part of proactive management of winter surge capacity?

To support planning, coordination, and insight during winter, the system has undertaken a preparedness workshop to test scenarios and share good practice across NCL. As part of the approach, actions include:
-System level scenario and evidence-based modelling to test and assure plans
-Put in place leading indications to be tracked weekly and guide system oversight and week to week operational decision making
-Systematise the use of Raidr (electronic real-time data) for operational pressures to support real-time relief for sites

These will be supported by local ways of working:
-Refreshed UEC governance with links to place
-New system-wide OPEL frameworks to support rapid escalation
-CNO led IPC forum to support the management of risk and capacity closure
These actions will contribute to the capacity and demand moving forward during winter.

System-wide discussions on winter readiness have led to a collaborative approach between Haringey, NHS, VCS, and other stakeholders to manage the anticipated winter surge. We've aligned on increasing interim care placements, utilising reablement services to maximise patient flow, and prioritising support for high-need discharges to reduce hospital stay duration during these upcoming months.

The Haringey discharge teams have taken a proactive approach by enhancing coordination with brokerage and community partners. This initiative ensures smoother discharge pathways and effective contingency planning for surge periods. By balancing demand and optimising available resources, this approach enhances responsiveness to the fluctuating needs of the residents, enabling them to be discharged quickly and to receive the right care at the right time.

3. Do you have any capacity concerns or specific support needs to raise for the winter ahead?

There is a pressing need for additional capacity in high-dependency residential care and specialised homecare services to efficiently manage complex discharges. To address this, we propose increased support for rapid equipment delivery and enhanced workforce capacity through our Discharge to Assess (D2A) support. However, this initiative's success is contingent upon the NRS system's reliability.

Moreover, ensuring continuous support, especially for after-hours and weekend discharges, is critical to maintaining patient flow and reducing bed pressures. To further alleviate demand during peak winter months, we are reviewing expanded provisions for community-based step-down facilities.

Additionally, we have strategically aligned staff leave in the hospital discharge service to ensure sufficient coverage throughout the winter period, thereby maintaining service quality and availability.

4. Where actual demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?

Haringey's Adult Social Care operates an out-of-hours Emergency Duty Team (EDT) that supports emergency care requests when the brokerage service is unavailable. This ensures that urgent care needs are promptly addressed, even outside regular working hours.

In addition, a dedicated hospital social work discharge team operates seven days a week, including weekends. This team is crucial in managing urgent discharges and alleviating delays that could negatively affect patient flow and bed availability. Adult Social Care actively participates in weekly Multi-Disciplinary Team (MDT) meetings in collaboration with the GP federation to identify patients at risk of hospital admissions. This proactive approach enables us to provide comprehensive support that helps mitigate the risk of admissions or prevents patients from needing to visit the Emergency Department (ED).

The Home from Hospital Service, funded through BCF and delivered by our VCS providers onsite with the Trust site, is essential to our multidisciplinary hospital discharge planning. This service collaborates closely with health and social care teams in emergency departments and medical assessment wards to prevent unnecessary admissions and to support effective discharge planning. '

Furthermore, community navigation and social prescribing networks are promoted to assist residents in accessing the appropriate services and support within their local wards in Haringey. This community-based approach ensures that individuals receive the necessary care and resources to maintain their health and well-being, thereby reducing the likelihood of hospital admissions.

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan						Actual activity (not including spot purchased capacity)					
Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	139	144	176	162	146	208	113	78	97	109	112	84
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	58	59	55	47	58	73	39	54	52	59	43	51
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	2	2	2	2	2	2	2	2	2	2	2	2
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	2	2	2	2	2	2	2	2	2	2	2	2
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	14	19	20	20	13	13	16	20	12	17	16	18
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	5	5	5	5	5	5	5	5	5	5	5	5

Actual activity - Community		Prepopulated demand from 2024-25 plan						Actual activity:					
Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Social support (including VCS)	Monthly activity. Number of new clients.	50	50	50	50	50	50	44	44	44	44	44	44
Urgent Community Response	Monthly activity. Number of new clients.	146	156	159	163	180	154	108	115	79	111	100	0
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	13	11	7	2	4	7	5	4	3	1	3	4
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	1	1	1	1	1	1	1	0	0	0	0	0
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0