Report for:	**Health and Wellbeing Board – 25th June 2026**
Title:	**Approval of Haringey Better Care Fund (BCF) 2025/26 End of year submission**
Report authorised by:	Sara Sutton, Corporate Director, Adults, Health and Communities, London Borough of Haringey. Jo Baty, Service Director, Adults, Health and Communities, London Borough of Haringey.
Lead Officer:	Caroline Humphrey, Head of Service for Service, Improvement and Development, London Borough of Haringey.

Ward(s) affected: **All**
Report for Key/ Non Key Decision: **N/A**

1. Describe the issue under consideration

The Better Care Fund (BCF) is a national programme designed to support the integration of health and social care services through pooled funding arrangements between local authorities and NHS partners. Its purpose is to enable local systems to work together to deliver more person-centred care, improve outcomes for residents, support independence, reduce avoidable admission to hospital and improve discharge pathways. In Haringey, the BCF is a jointly managed pooled budget between the London Borough of Haringey and the North Central London Integrated Care Board, governed through a Section 75 agreement.

Performance for Quarters 1, 2 and 3 were previously reported to the Health and Wellbeing Board on 26 February 2026, where the Board reviewed the programme's progress and formally acknowledged performance.

This report builds on that position and provides an update for the full year, enabling the Board to consider and formally note the overall performance of the programme across 2025/26.

This report seeks formal approval from the Health and Wellbeing Board for the Better Care Fund (BCF) 2025/26 End of Year submission.

2. Cabinet Member Introduction

Not Applicable

3. Recommendations

3.1 The Health and Wellbeing Board is asked to approve the submission of the Haringey Better Care Fund End of year plan for 2025/26

3.2 The Health and Wellbeing Board is asked to note the performance and delivery against national BCF metrics for 2025/26.

4. Reasons for decision

4.1 Approval of the Better Care Fund (BCF) 2025/26 End of Year submission is required to ensure compliance with national programme requirements. These requirements mandate that all local areas formally submit their year-end position and obtain sign-off from the Health and Wellbeing Board. This process provides assurance to national partners that local systems have delivered against agreed plans, funding allocations, and performance metrics.

4.2 The information presented in the Plan should give the Health and Wellbeing Board the assurance Haringey is maintaining its commitment to health and social care integration to deliver its vision considering local and national strategies and plans, such as NHS Long-Term Plan, Haringey Deal and Haringey's Ageing Well Strategy.

5. Alternative options considered

5.1 No alternatives options considered on the basis that submission and approval of the Better Care Fund Plan is a mandatory national requirement.

6. Background information

6.1 Overview of the Better Care Fund

6.1.1 The Better Care Fund (BCF) was introduced nationally in 2015 to support closer integration between health and social care services. In Haringey, the BCF has become a central mechanism for delivering coordinated, person-centred care across the local system. It brings together funding from the Council and the NHS into a pooled budget, enabling joint commissioning and shared accountability for outcomes.

6.1.2 The core purpose of the BCF is to improve outcomes for residents by reducing avoidable hospital use, supporting timely discharge from hospital, and helping people to remain independent in their own homes for as long as possible.

6.1.3 The BCF for 2025/26 is structured around two overarching national policy objectives, which set the direction for both planning and delivery throughout the year. The first objective is the shift from sickness to prevention. This places a strong emphasis on preventing ill health before it escalates into more serious conditions requiring hospital treatment. It focuses on early intervention, supporting

residents to manage their health, and improving overall population health. By reducing the incidence of illness, this approach aims to ease pressure on acute services while delivering better long-term outcomes.

6.1.4 The second objective is supporting people to live independently and the shift from hospital to home. This reflects a move towards enabling residents to remain in their own homes wherever possible, supported by community-based care. It includes improving hospital discharge processes, expanding services that support recovery at home, and reducing the need for long-term residential care. This objective is central to the “home first” approach, where independence and community-based support are prioritised over institutional care.

6.2 Local Approach

6.2.1 Haringey’s BCF plan for 2025/26 reflects these national objectives and sets out a clear local approach focused on improving outcomes for residents through integrated, community-based care.

6.2.2 The plan builds on existing partnership arrangements between the Council, the NHS, and wider stakeholders, and aligns with the borough’s broader strategic priorities, including reducing health inequalities and improving population health. A strong emphasis is placed on delivering person-centred care that supports independence and responds to the needs of Haringey’s diverse communities.
6.2.3 Central to this approach is the “Home First” model, which aims to ensure that residents are supported to remain in their own homes wherever possible. This is supported by a range of services, including community reablement, discharge support, and preventative interventions. The plan also reflects the borough’s Age Well priorities, with a focus on prevention, dementia support, and out-of-hospital care.

6.2.4 The plan highlights the role of digital solutions, integrated working practices, and strengthened governance arrangements in supporting delivery.

6.3 Financial context

6.3.1 Financial delivery for the programme has been achieved in full. The total BCF allocation of £43,225,531 has been spent in line with plan, supporting the delivery of agreed services and priorities.

6.3.2 DFG allocation was £3,557,776; NHS contribution was £27,569,953 and Local authority better grant was £12,097,802

	2025-26
Source of Funding	Planned Income
DFG (including top-up)	£3,557,776
Minimum NHS Contribution	£27,569,953
Local Authority Better Care Grant	£12,097,802
Additional LA Contribution	£0
Additional NHS Contribution	£0
Total	**£43,225,531**

6.3.3 The total BCF funding allocation was deployed across 50 schemes, with 22 schemes delivered by the Integrated Care Board and 28 schemes delivered by the Local Authority.

6.3.4 Funding has been used effectively and that the programme has delivered value for money while maintaining focus on its strategic objectives

6.3.5 The year-end position also highlighted the importance of ensuring that future uplifts are targeted towards those areas of pathway pressure most closely linked to discharge, coordination and community resilience.

6.4 Delivery of outcomes against 25/26 objectives

6.4.1 The 2025/26 Better Care Fund was delivered against a narrative plan which set out a clear focus on prevention, independence, and a “Home First” model of care delivery. The plan prioritised reducing avoidable hospital admissions, improving discharge pathways, and supporting residents to remain independent within their communities.

6.4.2 In relation to prevention, the early part of the year saw reduced levels of avoidable admissions, indicating that community-based services and preventative interventions were having a positive impact. This reflects the system’s focus on early intervention and supporting residents to manage their health more effectively.

6.4.3 In terms of supporting independence, performance remained strong throughout the year for admissions to long-term residential and nursing care. The fact that this metric remained consistently on track across all quarters indicates that residents are being supported to live independently for longer, in line with the objectives of the programme.

6.4.4 Discharge performance was strong in the first half of the year, with performance exceeding the 92% target for discharge on the discharge ready date. However, performance declined during Quarter 4, falling to 89.6% in January, 87.4% in February and 88.5% in March. Similarly, the average number of days between discharge readiness and discharge increased to over 10 days in February and March, exceeding the 7.5-day target. This reflects the impact of increased winter pressures, greater discharge complexity, and capacity constraints across the system.

6.4.5 Taken together these outcomes show that while challenges emerged during the latter part of the year, the programme has made meaningful progress in delivering a more integrated, preventative, and community-focused model of care.

6.5 Performance against National Metrics

6.5.1 Performance against the national Better Care Fund (BCF) metrics provides a clear and consistent framework for assessing the extent to which the programme is delivering improved outcomes for residents and supporting the core objectives of prevention, independence, and reducing reliance on hospital-based care. These metrics form a central part of the national assurance process and are used to demonstrate local delivery against agreed plans.

6.5.2 Overall, performance across 2025/26 was stronger during the first three quarters of the year, with a number of key metrics performing in line with, or above, target. However, performance deteriorated in Quarter 4, reflecting sustained winter pressures, increased demand, and challenges relating to system flow and discharge capacity. This pattern is consistent with the wider position described throughout this report.

6.5.3 In relation to Emergency Admissions for people aged 65 and over, performance across the final quarter was 1.3% above target. While performance exceeded plan during several months earlier in the year, and Quarter 4 initially showed a positive trajectory, there was a deterioration in the final month. This reflects the impact of sustained winter pressures, including increased urgent care demand and flow challenges across the acute pathway. These pressures reduced the ability of the system to maintain earlier gains in admission avoidance.

6.5.4 Performance against the metric measuring the percentage of people discharged on their Discharge Ready Date was strong during the first half of the year, exceeding the 92% target. However, performance declined during Quarter 4, falling to 89.6% in January, 87.4% in February and 88.5% in March. This decline reflects increased discharge complexity, constraints in community service capacity, and wider system flow challenges, particularly during periods of heightened demand.

6.5.5 A similar trend is observed in the average number of days between Discharge Ready Date and discharge. Performance during the first part of the year remained well within the 7.5-day target, indicating effective discharge coordination and system flow. However, this deteriorated significantly during Quarter 4, with performance increasing to approximately 10.2 days in February and 10.1

days in March. This reflects delays in discharging residents who were clinically ready, particularly those with more complex needs and where onward care capacity was constrained.

6.5.6 Performance relating to admissions into long-term residential and nursing care remained more stable across the year and continued to indicate that residents were being supported to remain independent at home for longer. This is a key indicator of success for the BCF programme and aligns with the strategic objective of reducing reliance on long-term institutional care, although performance should continue to be closely monitored in the context of increasing demand and complexity.

6.5.7 Supporting metrics provide additional context to the overall performance position. Avoidable admissions fluctuated across the year but remained broadly in line with expected levels, with some improvement observed towards the end of the year. Falls among people aged 65 and over also improved towards year-end, with March performance recorded at 12, although variation across the year likely reflects changes in demand as well as improvements in data completeness and coding.

6.5.8 Taken together, these metrics demonstrate that the BCF programme delivered positive outcomes across much of 2025/26, particularly during Quarters 1 to 3, where performance was largely aligned with plan. While Quarter 4 presented challenges, driven by system-wide pressures, the overall position indicates that the programme has continued to support improved outcomes for residents. The issues identified through performance in the final quarter have directly informed both the risk profile and the priorities set out within the 2026/27 Better Care Fund plan.

6.6 Overall outcomes and Impact

6.6.1 The Better Care Fund has had a significant impact on how health and social care services are delivered in Haringey, supporting a more joined-up and person-centred approach to care. Using pooled funding and shared planning, the programme has enabled partners to work together more effectively to meet the needs of residents.

6.6.2 One of the most important outcomes has been the strengthening of community-based support. Services funded through the BCF have helped residents to remain independent in their own homes, reducing reliance on hospital care and long-term residential settings. This not only improves individual outcomes but also helps reduce pressure on the wider health and care system.

6.6.3 The programme has also supported improved hospital discharge processes, particularly during the first half of the year. More coordinated working between hospital teams, social care, and community services has helped to ensure that residents are discharged safely and more quickly, with appropriate support in place at home.

6.6.4 In addition, the BCF has contributed to a stronger focus on prevention. By investing in services that intervene earlier and support people before their needs escalate, the programme has helped reduce avoidable hospital admissions and improve long-term health outcomes.

6.6.5 While system pressures affected performance towards the end of the year, particularly during Quarter 4, this is evidenced by the deterioration in key discharge metrics, including the reduction in the proportion of residents discharged on their discharge ready date and an increase in delays to discharge, with average waiting times rising above 10 days in February and March. Despite these pressures, the overall impact of the programme remains positive, with strong performance across the first three quarters and sustained progress against core objectives.

6.7 Key learnings

6.7.1 Strong performance during the first three quarters of the year demonstrates that when capacity is available within community services, the system is better able to reduce avoidable hospital admissions and support timely discharge. Maintaining and strengthening this capacity will be critical going forward.

6.7.2 The challenges experienced during Quarter 4 also highlight the impact of system-wide pressures. The deterioration in discharge performance, including a reduction in discharges on the discharge ready date to below 90% and an increase in delays exceeding 10 days, demonstrates how increased demand, higher patient complexity, and workforce constraints can significantly affect performance.

6.7.3 Another key learning is the value of integrated working. Where services worked closely together across organisational boundaries, outcomes for residents were improved, particularly in supporting independence and reducing delays in care. Continued focus on strengthening partnerships and joint working arrangements will therefore remain a priority.

6.7.4 The importance of data and performance monitoring has also been highlighted. Regular reporting throughout the year has enabled early identification of issues and supported timely responses. Further strengthening of performance frameworks and analytical insight will help to improve decision-making and support continuous improvement.

6.7.5 These learnings have directly informed planning for 2026/27, with a clear focus on strengthening community capacity, improving discharge pathways, enhancing integration, and building a more resilient system that can respond effectively to future pressures.

6.8 Key Risks and Mitigation

6.8.1 Delivery of the Better Care Fund (BCF) programme in 2025/26 has highlighted a number of key risks which have directly informed the development of the 2026/27 BCF plan and submission. This is particularly important in the context of Quarter 4, where performance deteriorated against a number of core metrics following stronger delivery across the first three quarters of the year. This reflects the overall position already set out in the report, namely that system pressures in Quarter 4 impacted emergency admissions and discharge-related performance.

6.8.2 One of the principal risks relates to emergency admissions for people aged 65 and over. Across the quarter, Haringey was 1.3% above

target, with performance exceeding plan in several months during the year. Although Quarter 4 started strongly, performance deteriorated in the final month. This reflects sustained winter pressures, including high urgent care demand and wider flow challenges across the acute pathway.

6.8.3 A second key risk relates to the percentage of people discharged on their discharge ready date. Performance was above the 92% target during the first half of the year, but fell below target in Quarter 4, with delivery at 89.6% in January, 87.4% in February and 88.5% in March. This decline is linked to increased discharge complexity, capacity constraints in community services, and ongoing system flow issues.

6.8.4 A related risk is reflected in the average number of days from discharge ready date to discharge. Performance was strong during the first half of the year and remained well below the 7.5-day target, but worsened significantly in Quarter 4, reaching approximately 10.2 days in February and 10.1 days in March. This reflects delays for people who were not discharged on their ready date, particularly those with more complex needs and limited onward capacity.

6.8.5 Wider supporting metrics also reinforce the need for continued system focus. Avoidable admissions fluctuated across the year but remained broadly in line with expected levels, with some improvement towards year end. Falls among people aged 65 and over also improved towards the end of the year, although variation across the year suggests the influence of changes in demand and coding completeness. These indicators provide important context and demonstrate that, while some pressures intensified, there were also areas where performance remained stable or improved.

6.8.6 In response to these risks, a number of mitigating actions have been built into the 2026/27 BCF submission. These include:

- strengthening admission avoidance initiatives, including expansion of community-based alternatives to hospital care
- increasing virtual ward capacity, to support more people safely at home and reduce avoidable hospital attendance and admission
- targeting support through neighbourhood teams, to improve early intervention and coordinated local care
- strengthening discharge pathways through improved brokerage and better coordination with system partners
- increasing step-down capacity, to improve patient flow and reduce discharge delays
- improving pathway management and escalation arrangements, particularly for people with more complex needs
- increasing community capacity to reduce delays and strengthen resilience during periods of sustained demand

6.8.7 These mitigating actions provide assurance that the issues identified through 2025/26 delivery and highlighted through the HWB end-of-year reporting process, have been fully considered and translated into concrete actions within the 2026/27 plan.

6.9 Next steps and priorities for 2026/27

6.9.1 The 2026/27 Better Care Fund (BCF) plan has been developed in direct response to the delivery, performance and system pressures identified during 2025/26, and forms part of the wider Health and Wellbeing Board (HWB) partner planning framework for the coming year. This ensures that the priorities set out within the BCF submission are fully aligned with both local system objectives and national BCF policy requirements.

6.9.2 A key priority for 2026/27 will be strengthening prevention and admission avoidance, reflecting both the national BCF objective of shifting from sickness to prevention and the deterioration in emergency admissions performance for people aged 65 and over during Quarter 4 of 2025/26. The plan includes the expansion of community-based alternatives to hospital care, increased virtual ward capacity, and more targeted delivery through neighbourhood teams to support earlier intervention and reduce escalation into acute services.

6.9.3 Improving hospital discharge performance and system flow will be a central focus of the 2026/27 plan, in response to the decline in performance against discharge metrics observed in Quarter 4. This includes addressing the reduction in the proportion of residents discharged on their discharge ready date and the increase in time between discharge readiness and discharge. The plan sets out actions to strengthen brokerage, increase step-down capacity, and improve coordination between acute, community and social care services.

6.9.4 The 2026/27 BCF submission also places a strong emphasis on reducing delays for residents with more complex needs, recognising the impact this cohort had on performance in the latter part of 2025/26. This will be supported through improved pathway management, enhanced escalation arrangements, and increased capacity within community services to support more timely discharge.

6.9.5 In line with wider HWB and North Central London priorities, the programme will continue to support the development of neighbourhood-based and integrated models of care, ensuring that services are more closely aligned around local populations and that care is delivered in a more coordinated, person-centred way.

6.9.6 Strengthening data, performance oversight and system intelligence will also be a key priority. Building on learning from 2025/26, there will be a continued focus on improving data quality and reporting across core metrics, including emergency admissions, discharge performance, avoidable admissions and falls, to enable earlier identification of emerging pressures and more responsive system management.

6.9.7 Addressing health inequalities remains a core component of both the HWB partner report and the 2026/27 BCF plan. Services will continue to target those residents and communities with the highest levels of need, supporting the delivery of equitable outcomes and improved population health.

6.9.8 These priorities are reflected within the 2026/27 Better Care Fund submission presented to the Health and Wellbeing Board for approval, providing assurance that the programme is evolving in response to delivery experience and system pressures. They are also aligned with the wider HWB strategic framework,

ensuring that the BCF continues to play a central role in delivering integrated, preventative and community-based care across Haringey.

7 Contribution to strategic outcomes

The Better Care Fund Plan plays a central role in delivering the objectives of the Adults, Health and Wellbeing priorities within the Haringey Deal, supporting residents to live healthy, independent and fulfilling lives within their communities.

Through targeted investment in integrated services, the BCF contributes to:

- Reducing avoidable hospital admissions
- Improving discharge outcomes and system flow
- Supporting residents to remain independent at home
- Reducing reliance on long-term institutional care

The plan directly supports the delivery of key local and system strategies, including:

- The Haringey Deal and Corporate Plan
- The Joint Health and Wellbeing Strategy
- North Central London system priorities and the NHS Long-Term Plan

The BCF also contributes to reducing health inequalities by:

- Targeting services toward populations with higher levels of need
- Supporting earlier intervention in more deprived communities
- Improving access to coordinated, community-based care

Overall, the Better Care Fund supports a shift towards earlier intervention, improved coordination of care and reduced reliance on hospital services, ensuring that residents receive the right support at the right time in the most appropriate setting

8 Finance

8.1 The allocated Better Care Fund for 2025/26 was £43,225,531, however the outturn spend position for 2025/26 was £43,771,970, a variation against the budget of £546,259. The breakdown of the spend is detailed in the table below:

Activity	Number of Schemes	Sum of Expenditure for 2025-26 (£)
Assistive technologies and equipment	2	£2,389,645
Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	5	£1,885,465
Disabled Facilities Grant related schemes	1	£3,324,019
Discharge support and infrastructure	14	£24,956,149
End of life care	1	£766,000
Evaluation and enabling integration	2	£355,424
Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	2	£3,706,100
Housing related schemes	1	£99,768
Long-term home-based community health services	1	£651,988
Long-term residential/nursing home care	1	£216,000
Other	6	£1,205,731
Personalised budgeting and commissioning	2	£854,975
Support to carers, including unpaid carers	1	£1,491,238
Wider local support to promote prevention and independence	11	£1,869,468
Grand Total	**50**	**£43,771,790**

8.2 The budget assigned to the assistive technology and community equipment, tends to be an indicative budget as the final year-end allocation is determined by demand, the needs of individuals and cost. In 2025-26, there were additional cost of £545,259 over the budget due to:

- Increased demand in the need for equipment following discharge from hospital back into the community.
- the additional cost pressure arising from the liquidation of NRS Healthcare in August 2025. The health and social care system had to seek and put in place alternative providers at increased cost to the system.
- This was an increase charge to the ICB and recharged accordingly as part of community equipment service.

8.3 **Legal**

The Better Care Fund requires local authorities and Integrated Care Boards to agree joint plan, owned by the Health and Wellbeing Board. These joint plans, funded by a pooled budget, supports integration governed by an agreement under s75 National Health Service Act 2006.

The Better Care Fund Policy Framework 2025 to 2026 updated March 2025 sets out the objectives, funding and conditions for the BCF 2025 to 2026. Local areas should review and develop plans to support 2 policy objectives: Objective 1 is reform to support the shift from sickness to prevention. Objective 2 is reform to support people living independently and the shift from hospital to home.

Health and Wellbeing Boards are expected to produce plans, supporting a 'home first' goal with a systematic adoption of best practice in preventing avoidable hospital and care home admissions.

The Policy Framework also confirms the conditions and funding for the BCF in 2025 to 2026, and the steps Health and Wellbeing Boards must take to deliver on the BCF objectives. The conditions are:

- Jointly agreeing a plan
- Implementing the objectives of the BCF
- Complying with the grant conditions and the BCF funding conditions
- Complying with the oversight and support processes

Within the 4 conditions, local areas have flexibility to decide how best to spend the fund across health, social care and housing schemes or services and agree how much spending will improve performance against the BCF metrics for 2025 to 2026.

The 3 headline metrics are:

- Emergency admissions to hospital for people aged over 65
- Average length of discharge delay for all acute patients
- Long term admissions to residential care homes and nursing homes for people aged 65 and over

This report sets out the area's performance against these metrics.

10. Equality

The Council and its NHS partners have a Public Sector Equality Duty (PSED) under the Equality Act 2010 to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between groups.

The Better Care Fund Plan supports these duties by:

- Targeting services toward residents with higher levels of need, including older people, those with disabilities and people living in more deprived communities

- Supporting earlier intervention and prevention to reduce inequalities in health outcomes
- Improving access to coordinated and integrated care for vulnerable groups

While the BCF primarily operates as a funding mechanism, its delivery is closely aligned with the Ageing Well Strategy and wider system priorities, which aim to reduce inequalities and improve outcomes across protected characteristics.

An Equalities Impact Assessment (EIA) was previously undertaken as part of the Ageing Well Strategy. The impact of the 2025/26 Better Care Fund programme and its continued delivery model has been reviewed against this framework to ensure that services continue to support equitable access and outcomes. This assessment has also informed the development of the 2026/27 plan.

11. Use of Appendices

- Appendix 1: Haringey Better Care Fund 2025/26 End Of Year Return

HM Government

NHS England

Better Care Fund 2025-26 EOY Reporting Template

2. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

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

Health and Wellbeing Board:	Haringey	
Completed by:	Caroline Humphrey / Maitress Murdoch	
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Contact number:	07976346023 /07867372591	
Has this report been signed off by (or on behalf of) the HWB Chair at the time of submission?	No	
If no, please indicate when the report is expected to be sig	Thu 25/06/2026	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion – when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income & Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet – tab 1.

<< Link to the Guidance sheet

Haringey LONDON

NHS North Central London Integrated Care Board

Better Care Fund 2025-26 EOY Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Haringey

Confirmation of Nation Conditions			Checklist Complete:
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 condition:	
1) Plans to be jointly agreed	Yes		Yes
2) Implementing the objectives of the BCF	Yes		Yes
3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) and Section 75 in place	Yes		Yes
4) Complying with oversight and support processes	Yes		Yes

Better Care Fund 2025-26 EOY Reporting Template

4. Metrics for 2025-26

Selected Health and Wellbeing Board: Haringey

For metrics time series and more details: BCF dashboard link

For metrics handbook and reporting schedule: BCF 25/26 Metrics Handbook

4.1 Emergency admissions

Plan		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,478.9	1,593.2	1,394.9	1,694.1	1,475.6	1,371.4	1,458.8	1,599.9	1,613.4	1,596.6	1,462.1	1,344.5
	Number of Admissions 65+	440	474	415	504	439	408	434	476	480	475	435	400
	Population of 65+	29,751.0	29,751.0	29,751.0	29,751.0	29,751.0	29,751.0	29,751.0	29,751.0	29,751.0	29,751.0	29,751.0	29,751.0

Assessment of whether goal has been met in Q4:	Not on track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	Haringey was 1.3% over target on activity across the quarter. Over the last quarter, progress in managing 65+ emergency admissions in Haringey has been supported by closer system working across intermediate care and discharge pathways. This has included stronger alignment between Adult Social Care, Whittington Health and community partners, alongside development of a joint therapy and reablement offer (including D2A and Home from Hospital). Strengthening intermediate care pathways through joint Health and ASC therapies and reablement remains a key focus. This has included mapping existing provision, identifying gaps and duplication, and beginning to design a more integrated offer aligned to Haringey's population needs. This will support clearer pathways, reduce handoffs between services, and ensure people receive support more quickly, with the aim of improving outcomes, reducing length of stay, and supporting independence at home. We have also taken steps to increase D2A and therapy capacity, including recruitment approvals for additional occupational therapy and physiotherapy roles to support discharge to assess and community rehabilitation. While early in delivery, this is expected to improve access to timely assessment and follow-up care, strengthen system resilience, and reduce the risk of readmissions. Overall while some elements remain in development there is clear progress in building a more joined-up and responsive intermediate care system in Haringey to tackle the emerging demand related to 65+ admissions. The focus now is on embedding these improvements, strengthening data quality and oversight, and ensuring that increased capacity and pathway changes translate into measurable reductions in avoidable admissions and improved outcomes for residents in Haringey.

4.2 Discharge Delays

Original Plan	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60
Proportion of adult patients discharged from acute hospitals on their discharge ready date	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	7.50	7.50	7.50	7.50	7.50	7.50	7.50	7.50	7.50	7.50	7.50	7.50

Assessment of whether goal has been met in Q4:	Not on track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	Over the last few months, discharge delay improvement in Haringey has been supported by clearer case oversight, defined escalation routes, and closer partnership working with acute services and the Transfer of Care Hub. This has included structured tracking of delayed patients, clearer ownership of actions, and regular joint reviews to resolve barriers. As a result hospital partners are identifying and progressing discharge actions earlier, reducing escalation of delays and improving the timeliness and consistency of discharge processes. The learning from this will then be applied to the other hospital sites such as North Middlesex and Royal Free Group, UCLH and others. The regular Hospital Discharge Huddle has provided a consistent forum to review risks, agree actions and update partners, improving communication between Adult Social Care, hospital teams and community services. This has enabled quicker decision-making on complex cases and strengthened shared ownership of delays. In parallel, "action required" lists from the Transfer of Care Hub have improved the timeliness and clarity of local authority updates, reducing delays caused by unclear actions or gaps in communication. Work is underway to embed updated discharge pathways and a shared operating model across Haringey. This is supporting greater consistency in how cases are managed and reducing variation across teams, with further work planned to strengthen this approach. Capacity is also being strengthened through recruitment approvals for additional occupational therapy and physiotherapy roles to support Discharge to Assess and community rehabilitation. This will improve the timeliness of functional assessments, reduce delays linked to equipment and adaptations, and support safer, more sustainable discharges. Recent case reviews have identified gaps at the A&E interface, in referral quality, and in escalation and out-of-hours processes. These are being actively addressed with partners through strengthened NCL referral standards, clearer escalation routes, and improved weekend arrangements, demonstrating a proactive approach to reducing repeat delays. Training was also delivered to ensure that referral qualiy and standards were aligned accross Haringey and Hospital teams. This is open to regular reviews incase gaps are identified so these can be mitigated earlier. Despite this progress delays continue to reflect system-wide challenges, including care placement bed availability for nursing and residential, increasing complexity of need, and capacity pressures across health and social care. Ongoing collaboration across Haringey and the wider system remains key to sustaining progress and reducing delays further and to ensure that the metric continues to deliver as it should. Challenges in data quality and reporting for discharge ready date (including inconsistencies across sites and pathways) reduce confidence in performance analysis and limit the ability to fully evidence impact and target improvement.

4.3 Residential Admissions

Actuals + Original Plan		2023-24 Full Year Actual	2024-25 Full Year CLD Actual	2025-26 Plan Q1 (April 25-June 25)	2025-26 Plan Q2 (July 25-Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 Plan Q4 (Jan 26-Mar 26)
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	343.2	504.2	121.0	121.0	121.0	121.0
	Number of admissions	100.0	150.0	36.0	36.0	36.0	36.0
	Population of 65+*	29751.0	29751.0	29751.0	29751.0	29751.0	29751.0

Assessment of whether goal has been met in Q4:	On track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	This metric continues to perform well and is on track to meet the year end target, with progress consistent across all quarters.

Better Care Fund 2025-26 EOY Reporting Template

5. Income & Expenditure

Selected Health and Wellbeing Board: Haringey

Source of Funding	2025-26 Planned Income	2025-26 Updated Total Income for 25-26	DFG EOY Actual Expenditure
DFG (including top-up)	£3,557,776	£3,557,776	£3,557,776
Minimum NHS Contribution	£27,569,953	£27,569,953	
Local Authority Better Care Grant	£12,097,802	£12,097,802	
Additional LA Contribution	£0	£0	
Additional NHS Contribution	£0	£0	
Total	**£43,225,531**	**£43,225,531**	

		% of Planned Income
End of Year Actual Expenditure	£43,225,531	**100%**

If expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.	n/a

Better Care Fund 2024-25 EOY Reporting Template

6. Year End Impact Summary

Selected Health and Wellbeing Board: Haringey

Confirmation of Statements		
Question statements	**Confirmation**	**If the answer is "No" please provide an explanation:**
Overall delivery of BCF has improved joint working between health and social care	Yes	
Our BCF schemes were implemented as planned in 2025-26	Yes	
The delivery of our BCF plan 2025-26 has had a positive impact on the integration of health and social care in our locality.	Yes	

Highlight success and challenges within reference to the most relevant enablers from SCIE logic model:	
Logic model for integrated care - SCIE	
Success and Challenges	**Narrative**
2 key successes observed towards driving the enablers for integration	Increased joint working with acute partners through forums such as the Tuesday & Friday patient flow meeting - Magnolia unit has strengthened shared accountability for flow and discharge planning. Collaborative system discussions (e.g. Re-grouping on Hospital Discharge (including Brokerage) and DAG call) have supported alignment of priorities across ASC, brokerage, and NHS partners. Continued focus on Discharge to Assess (D2A), reablement, and therapy-led support has improved the ability to discharge patients earlier and more safely. Work to align and map intermediate care pathways across the system has supported a clearer and more consistent offer.
2 key challenges observed towards driving the enablers for integration	Challenges in data quality and reporting (including inconsistencies across sites and pathways) reduce confidence in performance analysis and limit the ability to fully evidence impact and target improvement. Ongoing constraints in care market capacity, therapy provision, and community support continue to delay discharge for patients with complex needs. Demand remains high, particularly within the 65+ population, with increasing complexity and acuity. Cases requiring multi-agency input (health, ASC, housing) continue to experience delays due to coordination challenges and dependency on multiple services. Housing-related barriers and sourcing appropriate placements remain a key driver of delays.