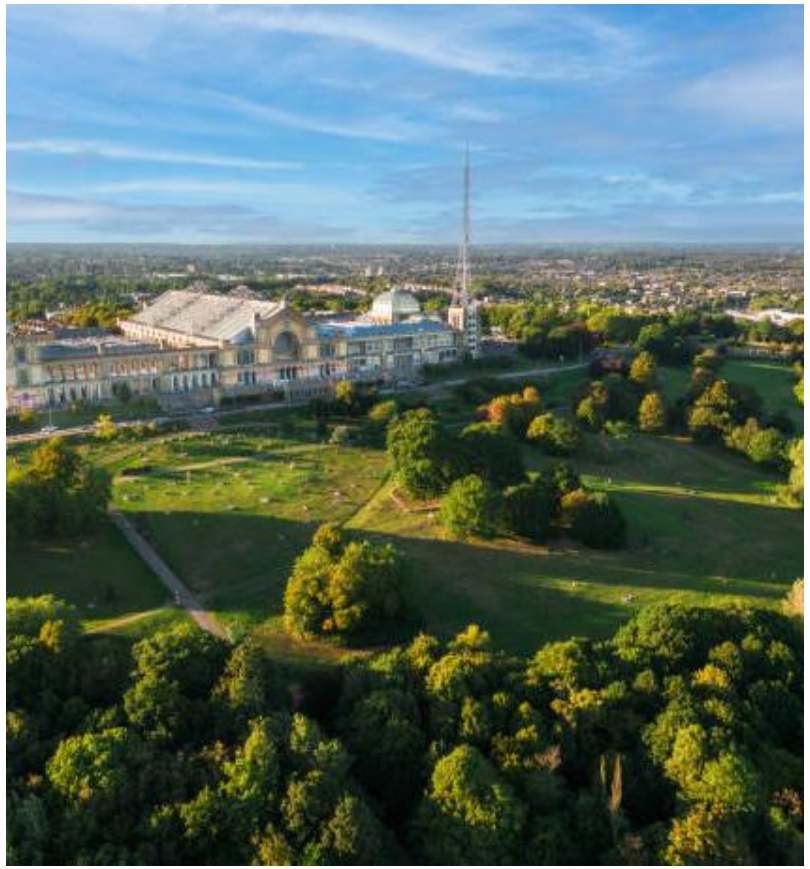

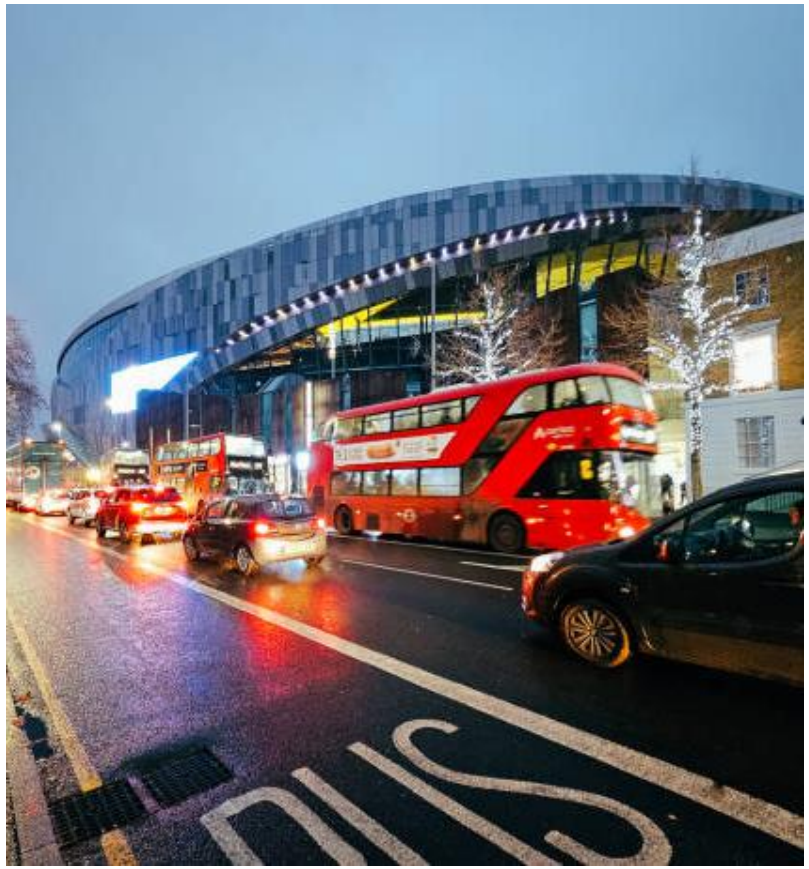

Haringey Test Bed Programme

Haringey Health & Wellbeing Board

17th September 2026

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Haringey
LONDON

HARINGEY GP FEDERATION

NHS
Whittington Health
NHS Trust

Why neighbourhood health, and why now?

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National plans driving…

- The *NHS 10 Year Plan* recognises public services are financially unsustainable, satisfaction is in decline, and that the way we deliver health and care must change
- The plan sets out three "shifts" which must happen to address these issues: hospital → community, treatment → prevention, analogue → digital
- Related and specific ambitions are reflected in the *Neighbourhood Health Framework*, guidance on *Neighbourhood Health Centres*, and the 2026/27 GP contract

health systems to act differently…

- The newly-merged West and North London integrated care system has set out the intent to invest 1% of its total annual budget (~£120m) into neighbourhood health and care over the next five years
- To understand what works to support "left shift" of resources, Haringey has been selected to pioneer the "test bed" – building on the strength of people, plans, and partners already in the borough

to connect & improve care in Haringey

- As well as investing in an expanded MACC team, we are also progressing wider initiatives including resident engagement, work well and employment, and targeting inequalities
- We are also strengthening our local health and care partnership – including building a shared "Team Haringey" approach across frontline teams

Haringey testbed – an overview

- ✓ Put simply, the **“test bed”** is a pioneering initiative to better join up and connect teams and services providing health and care for some of the most vulnerable people living in Haringey – those with several long-term conditions, and at ‘rising risk’ in their health & wellbeing status

- ✓ The “test bed” builds upon the successful **multi-agency care coordination** (MACC) **team** in the borough – that brings together GPs, social workers, mental health practitioners, occupational therapists, physiotherapists, pharmacists, and nurses as a multi-disciplinary team. In this way, people receive **“whole person”** support for their needs – be they medical, psychological, and/or social (e.g. linked to relationships, housing, benefits, employment)

- ✓ This means people referred to the service – including those who are living with **frailty** and a number of **long-term conditions** – are supported by a single team through comprehensive assessment, care planning, a range of health & care interventions, and review . As well as providing a more joined-up experience, the team also offers more proactive and preventative support – addressing people’s health and care needs before they increase or become more complex; when hospital referral may be the only option

What This Means to Haringey

Reading the national and regional drivers onto our own population and patch

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Demographics

264,300 residents; 21% aged 0–17 alongside a fast-growing over-65 population. One of London's most ethnically diverse boroughs, which shapes need and how services must be designed.

Geography

A marked east–west divide. Three neighbourhoods — East, Central and West Haringey — form the testbed's operating footprint.

Inequalities

4th most deprived borough in London. Up to a 15-year gap in healthy life expectancy between the richest and least well-off parts of the borough.

Existing Assets

A successful foundation to build on, MACCT, 7 established PCNs, aligned district nursing teams, and a mature Federation / Whittington Health / Council partnership

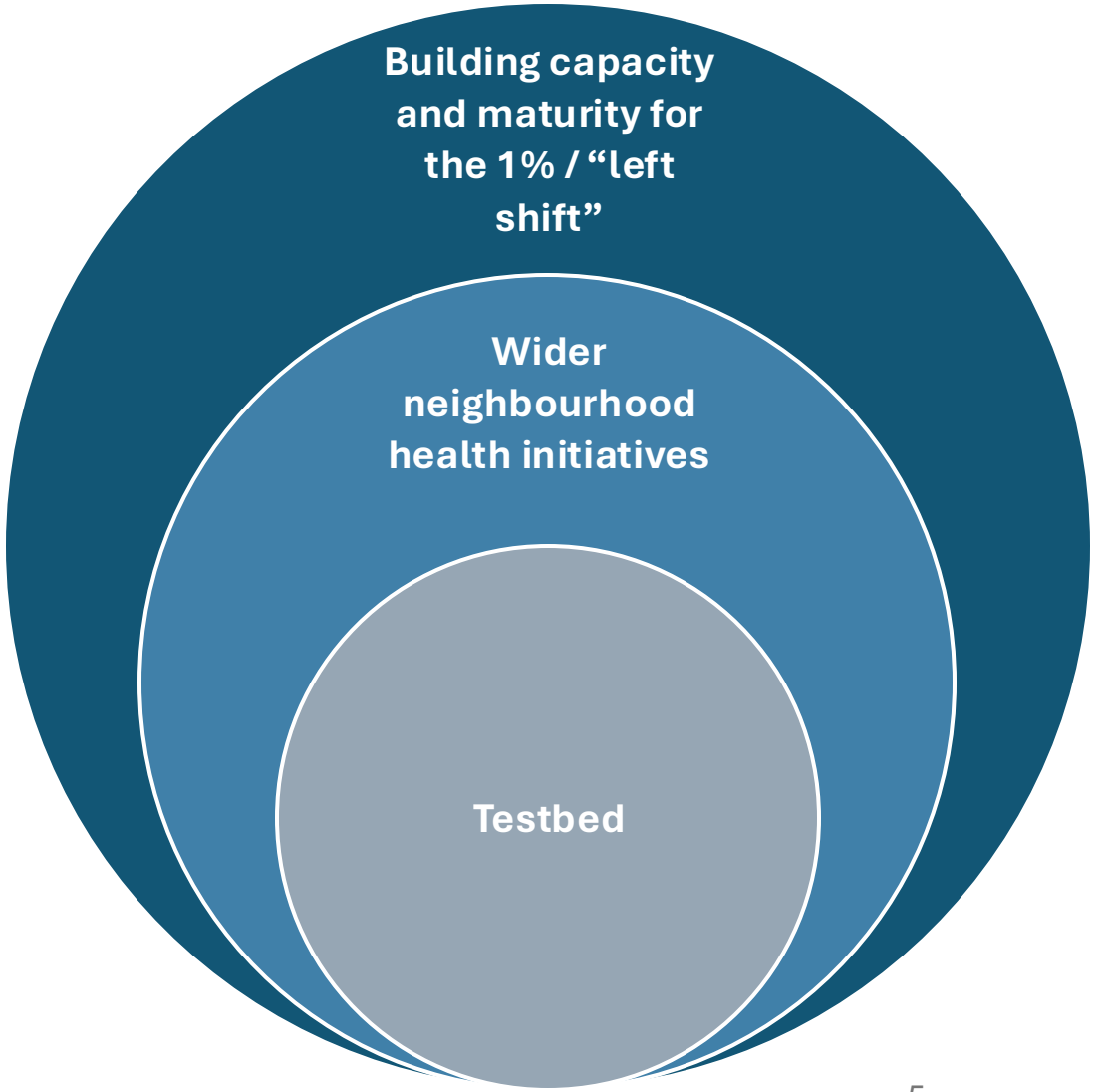
Our neighbourhood ambitions

Refreshing our neighbourhood governance is grounded in shared current priorities, and future ambitions as borough partners.

The **neighbourhood testbed** is our current focus. We're mobilising an expanded MACC team, providing greater capacity and service user throughput, to deliver system impact (by e.g. reduced non-elective demand). Getting this right demonstrates the value proposition for neighbourhood health in Haringey, and potential benefit across W&NL.

The testbed is anchored in pillars 3 + 4 of the W&NL approach, and primarily represents a change initiative between NHS partners (primary, community, mental health, secondary care). In Haringey, we are also working with the Council & wider borough partners (VCSE, Public Voice) to mobilise and expand **wider neighbourhood health initiatives** which deliver against pillar 1 + 2, and that are tackling health inequities on a neighbourhood / hyper-local footprint.

By mobilising across all four pillars, we are aiming to better manage today's demand, respond to needs holistically, and to free up system capacity. This sets the foundations – and the enabling infrastructure – to focus on prevention and addressing the needs of tomorrow. For us in Haringey, that means demonstrating we are perfectly-placed to use system investment to expand capacity, rebalance system pressures, to bend the future demand curve, and to improve the value and efficacy of public sector.



What We're Doing to Get the Testbed Up and Running

Six moves underway right now across the partnership

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MACCT into INT

Widening multidisciplinary team membership across health, care and VCSE partners.

Proactive MDT + Psychiatric MDT

Shifting from reactive case discussion to proactive, risk-based outreach.

LTC / LES High Risk & Complex plus Frailty

New long-term condition and local enhanced service offers targeting frailty and complex need.

Teleconference to Neighbourhood Health MDT

Scaling virtual consultation routes to widen access and cut unnecessary travel.

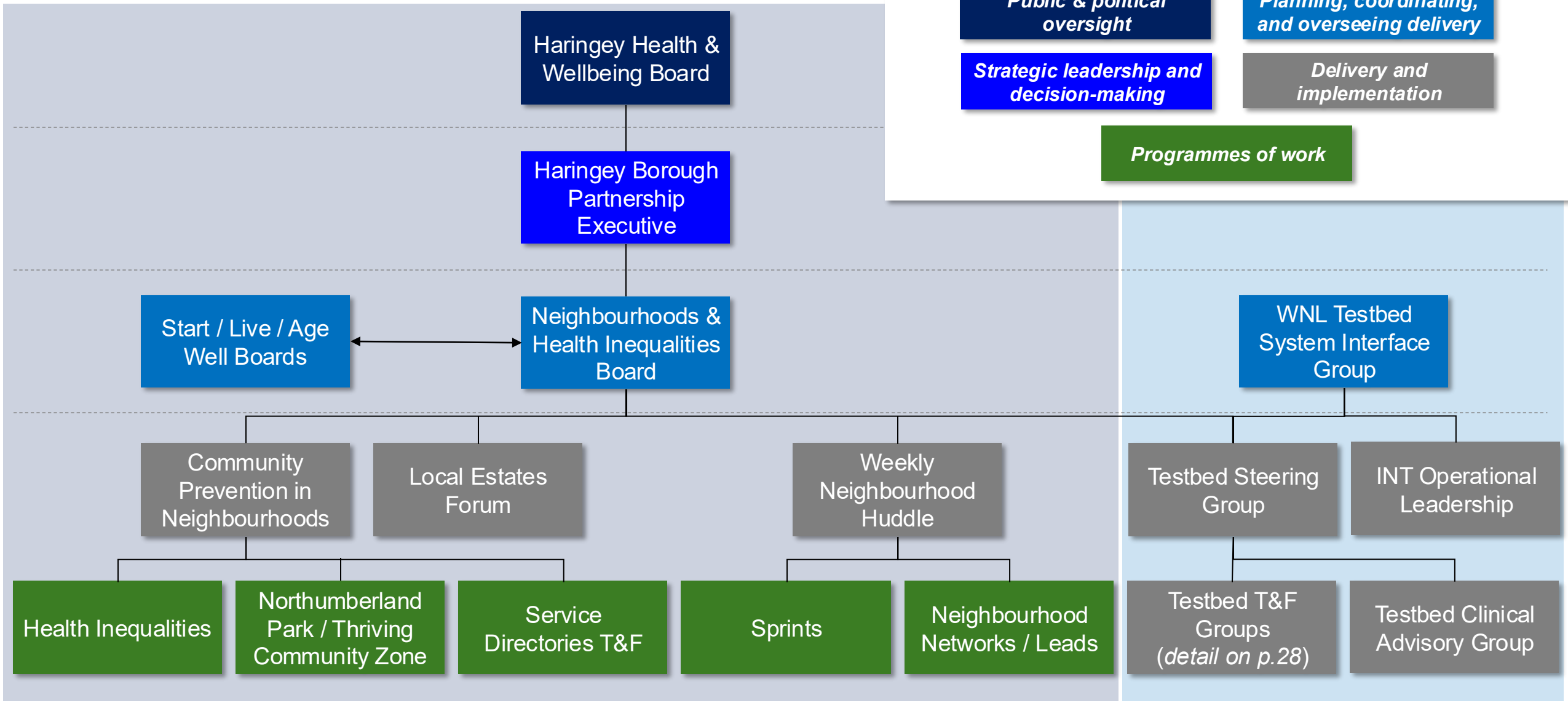
Increasing Run Rate

Accelerating referral throughput and caseload capacity as the model beds in -(3,200 per annum, 266 monthly run rate))

Team Haringey

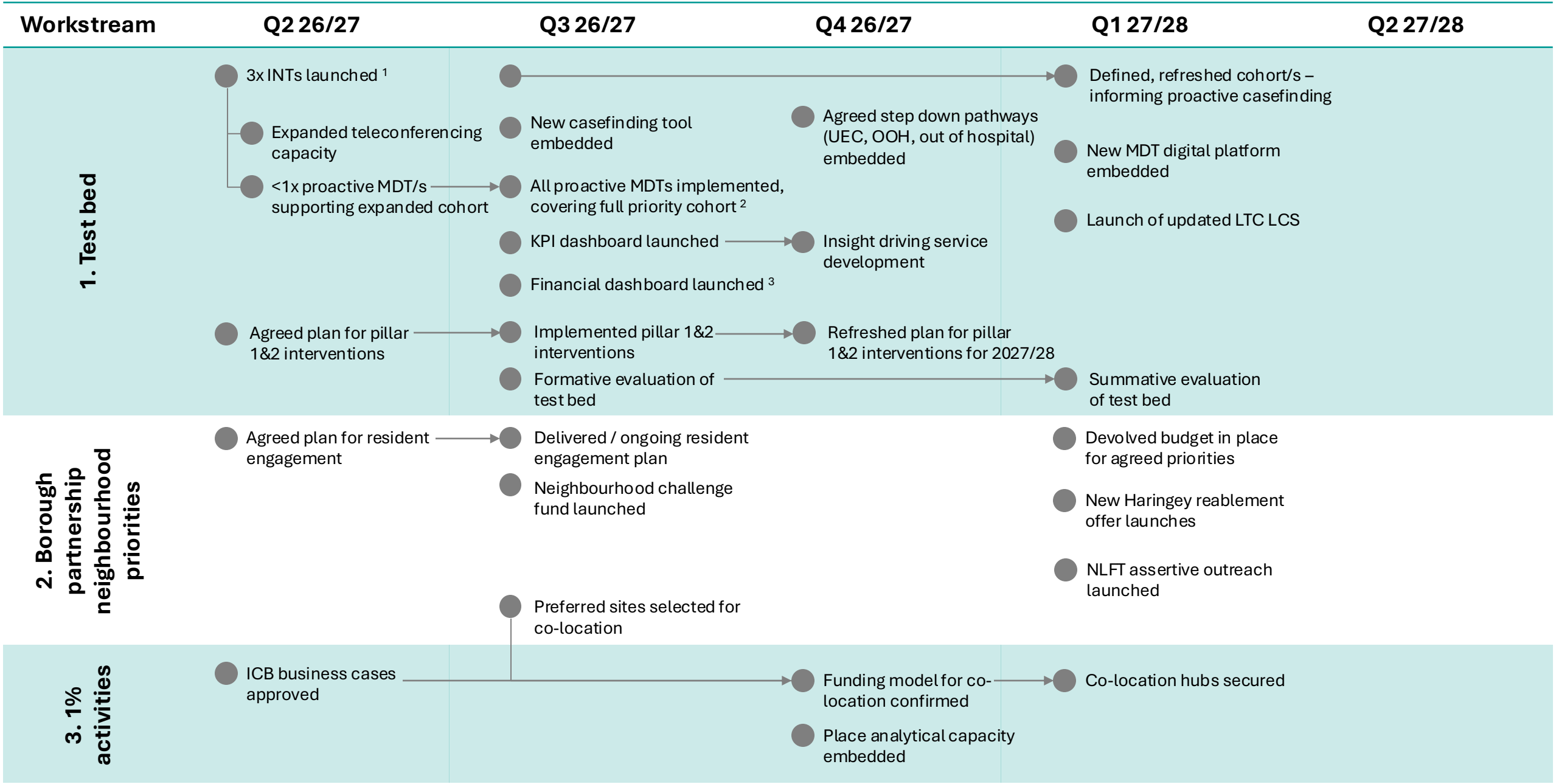
One shared identity and culture across the integrator partners delivering the testbed.

Haringey Neighbourhood Health Governance



Note: this governance schematic sets out fora which influence delivery of neighbourhood health across all four pillars of the system-wide model

Haringey neighbourhood health – medium term plan and deliverables



NOTES: 1. With expanded skill mix (psych, geriatrician, GP), fed by current data. **2.** Hitting target run rate of 266 pts pcm. **3.** tracking run rate, supported by a proactive spend plan

Test bed – our impact and learning so far

OUR IMPACT TO DATE

- Testbed mobilisation in converting MACCT into 3 INT teams & with expansion/additionality with focusing of estates/workflows and OD
- Recruitment to clinical/operational roles as well securing PMO support
- Proactive MDT went live & Psychiatric MDT to go live early September
- INT OD workshops planned to be held in September
- Data Dashboard demonstrating our impact will start reporting from Mid-September
- Delivering the expected run rate

WHAT'S WORKED WELL

- ✓ Making this an explicit shared endeavour – “Team Haringey” spirit
- ✓ Pump priming to lead transformation alongside BAU
- ✓ Building on existing infrastructure
- ✓ Dedicated neighbourhood leadership
- ✓ Clear and focussed success criteria
- ✓ Focussing on drivers of change, as well as pure service capacity

NEEDS FURTHER EFFORT

- ! Time needed to agree, plan for, & mobilise complex change
- ! Delivering change/additionality on top of BAU
- ! Ensuring parity of esteem and equitable contribution from involved partners
- ! Managing concerns about workload shift – adult social care, primary care, mental health
- ! Community engagement
- ! Technical barriers – casefinding tool, workforce passport, system interoperability, EPR access, estates

What the Testbed Means for Haringey Residents

Designed around what patients have already told us, and shaped further by residents as we Test & Learn this year

Where this started: in designing the testbed and our 3 neighbourhood teams, we drew directly on feedback from MACCT patient surveys, what residents told us mattered most about their care. Inside Haringey's MACCT- https://youtu.be/jmBOrylRxe0?si=tnesxdfrp2LnJJfF

Also through our recent LTC workshops (Heart Failure & Diabetes) held in summer 2026

What You Can Expect

Tell Your Story Once

Right now, care can feel disjointed — repeating yourself to different teams. Coordinated MDT care means your GP, community and social care teams work from one shared picture.

Support to Stay Home

We know most residents want to stay independent at home. Proactive, joined-up support is designed to spot problems early and avoid unnecessary hospital admissions.

Care That's Personal to You

Bespoke health coaching tailored to your own goals and circumstances — not a one-size-fits-all care plan.

Fair Care Across the Borough

We're analysing need at each neighbourhood level (East, Central, West) so support is adjusted to close equity gaps, not applied evenly regardless of local need.

How We'll Keep Listening and Improving through our communication and engagement activities

Clear Comms for Residents

Patient-facing materials explaining the testbed are being designed now.

Resident Focus Groups

We're setting up focus groups so residents can shape the testbed directly.

Test, Learn, Improve

A continuous test-and-learn approach — adjusting as we find out what works.

Patient Experience KPI

A new patient experience measure is being added to track how care actually feels.

MACCT = Haringey's Multi-Agency Care and Coordination Team. MDT = Multi-Disciplinary Team. INT = Integrated Neighbourhood Team.

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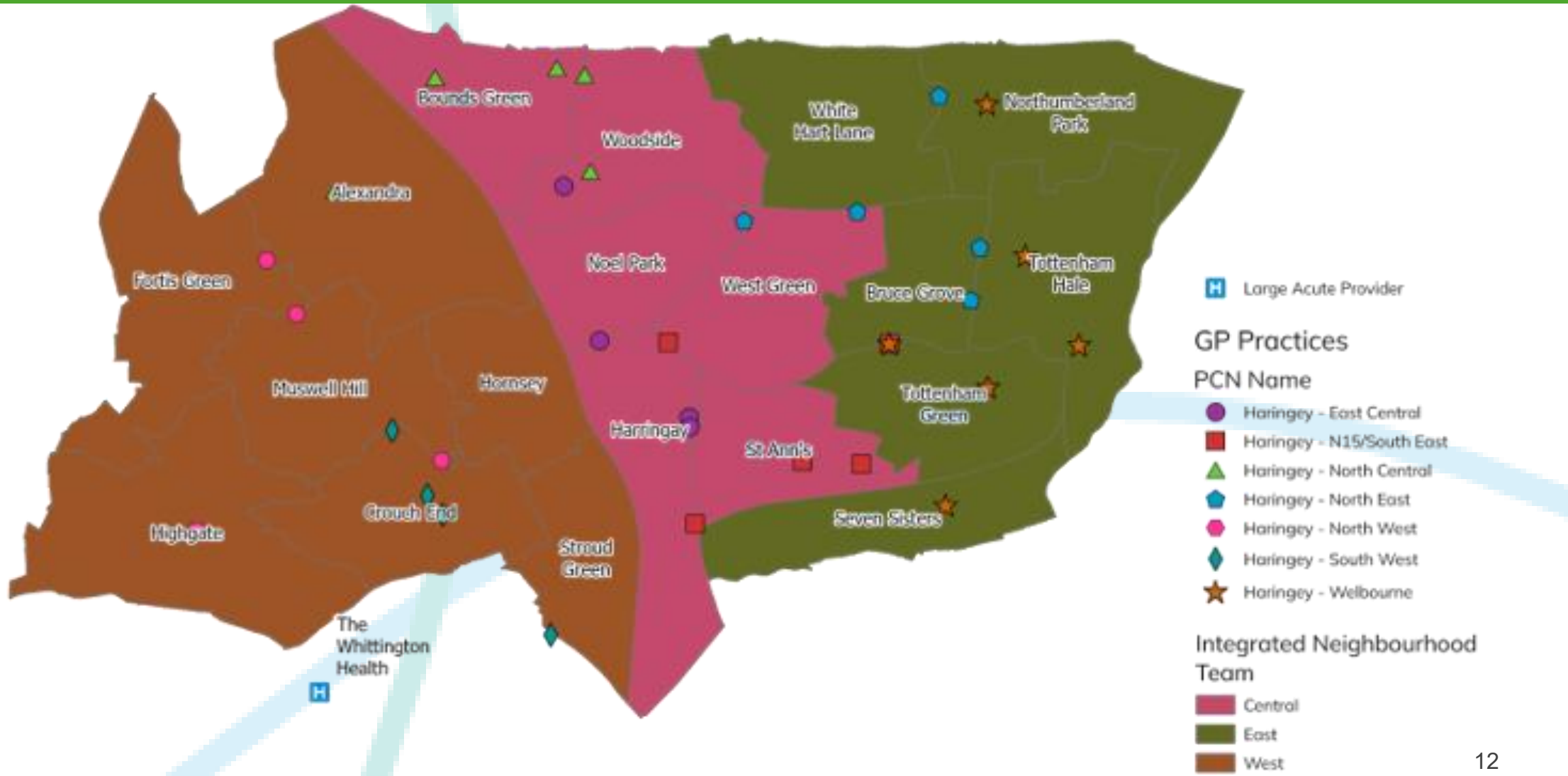
Haringey Integrator

Appendix

About Haringey: Neighbourhood Geographies



About Haringey Integrator: what the partner orgs provide

Organisation	Strategic Implication
Council	Operational integration of social care, public health, and prevention services into neighbourhoods Convening and linking role into VCS and grass roots community organisations
HGPF	Deepened role in borough-wide coordination, hosting functions, aligning clinical services
Whittington Health	Leading MDTs, supporting left-shift from acute to community, hosting neighbourhood teams

Board/Exec Commitment

- All three organisations have ratified the proposal at their executive levels.
- Named senior leaders (e.g. Michael Fox, Nadine Jeal, Sara Sutton, Will Maimaris) are actively involved.
- Staff are being aligned to neighbourhoods with dedicated time and leadership roles.

Resources Being Pivoted

- **Council**: 5 Neighbourhood Connector roles, adult social care locality teams, convening power, transformation resources.
- **HGPF**: COO (0.2 WTE), DoP (0.2 WTE), neighbourhood development team, QI, digital, workforce, comms.
- **Whittington**: Programme manager (Sana Burney), MACC team, district nursing, LTC leads, OD and analytics support.

About Haringey Integrator: Commitments as partners

Commitments made Sept 25 as part of integrator assurance

- Board commitment to partnership
- Transparency and joint delegating decision making (through HBP) into any released left shift funds and the service delivery models
- A commitment all bids aligned to neighbourhood model rooted through partnership (i.e. that no party pursues opportunity independently without first engaging and routing through the partnership if it has a direct impact on the neighbourhood model)
- Visibility on community contract streams/shared approach on any new funding to neighbourhoods)

Commitments proposed Jan 26 to ensure success of test-bed across integrator partners – to be written into a Partnership MOU with goal to sign off Mar 26

a. Central co-located PMO and joint SROs from HGPF & Whitt
b. Specific focus on Pillar 4 and benefits realisation for 3200 residents in scope, whilst recognising and amplifying wider neighbourhood work across all pillars with partners
c. Substream enabler groups (Comms, Digital & PHM, workforce) alongside existing estates focus
d. Behaviours – collaboration, honesty, commitment to moving towards shared decision making/accountability
e. Shared strategic risk management approach (financial, delivery, political)
f. Formalise roles & responsibilities & embed resilience if personnel change
g. Describe input/dedicated resource from each partner (with an eye to future state)
h. Embed population needs based resourcing and approach to ensuring equality
i. Strengthen need to manage/influence collectively at place
j. Move towards shared decision making over ‘community/neighbourhood contracts’
k. Align/be conscious of partnership arrangements in neighbouring Boroughs / Trusts that span Places
l. Ensuring community engagement/VCSE commissioning is integrated alongside clinical health & care elements