BCF Narrative Template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Islington Health and Wellbeing Board

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils), and how have you engaged these stakeholders?

The Islington Borough Partnership Board is the group that drives integration in Islington. We have used the plans of the Borough Partnership to inform this document.

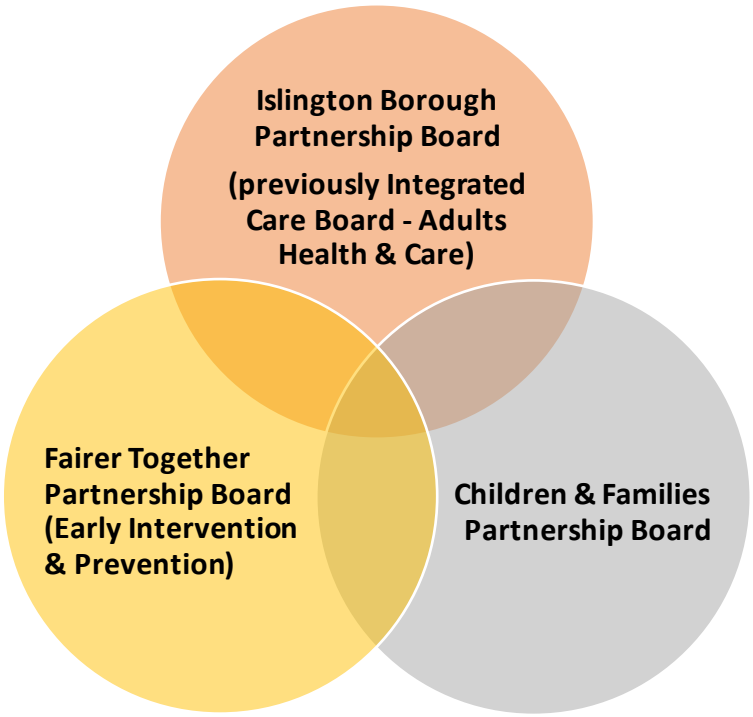
The members of the Borough Partnership include North Central London ICB, the London Borough of Islington (including Housing and Social Care), UCLH NHS Trust, Whittington Health NHS Trust, Camden and Islington NHS Trust, the Islington GP Federation, Voluntary Action Islington, Age UK and Islington Healthwatch.

The Borough Partnership have agreed a broad range of high-level priorities and outcomes to deliver real impact for residents. These have been developed through collaboration and co-production with our resident voice, resulting in a consistent set of "I Statements" that we use to describe our aspirations, and a set of "Problem Statements" that we use to focus our attention in delivering improvement. We use multiple methods and organisations to continue to prioritise our residents as stakeholders.

As a Borough Partnership, we have established a Joint Shared Vision and a Partnership Agreement which underpin our ways of working together.

Please briefly outline the governance for the BCF plan and its implementation in your area.

As above, our key governance structure is the Borough Partnership. It is this group that is driving service integration, is setting priorities and improving services for our residents. This group meets monthly and is co-chaired by the Islington DASS and the Director for Integration at the ICB.

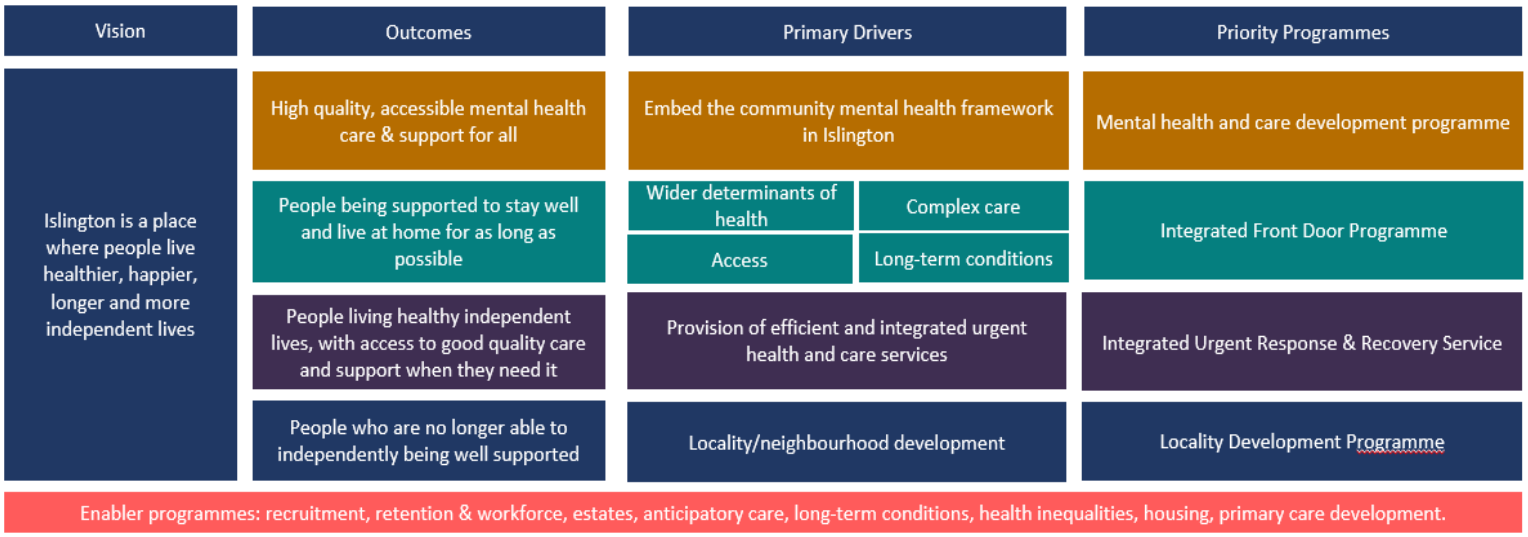


The board works collaboratively with the emerging partnership boards focusing on early intervention and prevention and children and young people to ensure join up on key shared priorities relating to health and care. Separately to the Board, we also have a Section 75 group (detailed below) which monitors delivery, progress against targets and addressing operational delivery issues as required.

However, each area has their own strategic programme plans to support delivery of broader agreed outcomes.

There will be overlap between programmes, where integrated working across partners and consistent communications will be delivering even greater impact (e.g. locality working).

Executive Summary: Priorities for 23-25



Our Four Priority Programmes are set out above. These Priority Programmes have been identified collectively by the Borough Partnership, informed by all our organisations and a borough wide engagement programme. This was informed by our Islington 'I Statements' that describe resident needs and expectations of health and care, and clarified the agreed 'Problems we are trying to solve' list.

The I-statements underpin the ambitions and priorities of the Islington Borough Partnership and are central in shaping our approach to Islington borough partnership programmes and ensuring the resident voice is central to the work we do. We have set these out in more detail below to describe our person centred approach.

This process formed a clear set of problem statements

Problem…	This means…
We work in places but aren't always collaborating with each other	People end up getting passed from service to service
Locality working happens in some but not all parts of the system	People have an inconsistent user experience across the borough partnership
We aren't necessarily building and strengthening networks in localities	People feel disconnected from their communities
We aren't always present and visible in our communities	People are unaware or don't feel connected to local services
Demand across the system is increasing	People find it hard to access services when needed

The problem statements were a significant aspect of driving our four priority areas which are set out in more detail below

Mental Health and Care (BCF schemes 7, 19, 20, 28, in tab 6a of the Planning Template)

A focused operational group across the council, ICB and C&I has been developed to support the mental health programme, including:

- Focusing embedding the community mental health framework – including employment support offers, crisis prevention pathway and SMI health checks.
- Delivery of the community mental health transformation – via expansion of the core teams.
- Delivery of the community mental health service review core offer.

Integrated Front Door (BCF schemes 4, 8, 16, 17, 18, 40, 48 in tab 6a of the Planning Template) / (HICM Change 1, 3)

- A single place to jointly screen and triage urgent health and all social care referrals.
- Introduction of a single referral form, which will combine the current 6 individual health and care referral forms and screening processes.
- This streamlined approach will improve processes and ensure efficiencies within the system, enabling better outcomes for residents.
- The programme's future ambition includes integration with mental health & housing within the Front Door.

Integrated Urgent Response and Recovery Service (BCF schemes 5, 6, 11, 12, 15, 51 in tab 6a of the Planning Template) / (HICM 3, 4, 5, 6, 8)

- Effectively aligning urgent health services and social care professionals to prevent hospital admission and support hospital discharge.
- Refreshed processes, pooled resources which will enable joint risk management and response.

Locality Development (BCF schemes 13, 14, 19, 20, 21, 22, 23, 24, 25, 29, 30 in tab 6a of the Planning Template) / (HICM 3, 9)

Islington already delivers many of the locality functions outlined in the recent Fuller report: MDT working, services operating on locality footprints etc.

- A true locality approach needs to be cohesive and integrated, providing systematic case finding, care and review – all done with appropriate leadership, infrastructure and support.
- We can use our existing structures and examples of good-practice to further Islington locality development and define our approach.
- The front door programme, includes exploring the option of creating 3 integrated locality hubs for health and social care professionals to support those with longer term more complex needs.

National Condition 1: Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- **Joint priorities for 2023-25**
- **Approaches to joint/collaborative commissioning**
- **How BCF funded services are supporting your approach to continued integration of health and social care.**

Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Our joint priorities are set out above in the previous section. These are

- *Mental Health and Care (BCF schemes 7, 19, 20, 28, in tab 6a of the Planning Template)*
- *Integrated Front Door (BCF schemes 4, 8, 16, 17, 18, 40, 48 in tab 6a of the Planning Template) / (HICM Change 1, 3)*
- *Integrated Urgent Response and Recovery Service (BCF schemes 5, 6, 11, 12, 15, 51 in tab 6a of the Planning Template) / (HICM 3, 4, 5, 6, 8)*
- *Locality Development (BCF schemes 13, 14, 19, 20, 21, 22, 23, 24, 25, 29, 30 in tab 6a of the Planning Template) / (HICM 3, 9)*

As set out in the executive summary, we coproduced a set of Islington "I Statements" with Islington residents / patients who told us what is important to them.

These underpin our priorities, but importantly, are central in our person centred approach and ensure the voice of the resident is central to the work we do. The "I Statements" are;

Islington has a long tradition of joint and collaborative commissioning. This is supported by pooled budgets but also by strong partnership approaches. LBI and NCL ICB currently have 6 pooled budgets with a total shared spend of over £90m p/a. The partners work closely together, with overall responsibility for the embedding integrated, person centred health and social care held by the Borough Partnership. This group is co-chaired by the Islington DASS and the ICB Director for Integration, and is supported by the Section 75 group as above.

Both partners are continually and collaboratively reviewing their approaches to joint working; LBI has recently completed a restructure of its functions to better align to the Borough Partnership and local priorities, and the ICB is restructuring in Sep-23 in response to national changes and to further support our partnership working. This has resulted in an NCL vision for a consistent aligned model (between the ICB and Local Authorities) that will further strengthen our partnership arrangements and ensure we are in the best possible position to deliver for our residents. A shared workplan across the LA and NCL teams will ensure that collaborative, joint working is strengthened.

National Condition 2: Use this section to describe how your area will meet BCF objective 1: Enabling people to stay well, safe and independent at home for longer.

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- **steps to personalise care and deliver asset-based approaches**
- **implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches**
- **multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake**
- **how work to support unpaid carers and deliver housing adaptations will support this objective.**

Our approach in this area is focussed on prevention; either preventing hospital admissions or preventing long term care needs following a hospital admission.

Proactive care and co-ordination

The BCF funds key services in this space. This includes

- PAWS; the Proactive Ageing Well Service *(BCF scheme 13)*. This multi-organisational service, working across primary, secondary, community, voluntary sector organisations works on a population health, preventative approach aimed at identifying unmet need and preventing further deterioration of moderately frail adults. Working from our population health tools (specifically Healtheintent and use of the EFI scores) the team identifies moderately frail adults and provides a wide range of preventative health and care interventions informed by a Comprehensive Geriatric Assessment. This could include support from social prescribers, medicines optimisation, ophthalmology referrals, mobility support and transport referrals, etc.
    - Development in 2023-24 include; optimising the screening processes to ensure we do this as efficiently and effectively as possible, further integration with existing frailty services across the borough with a focus on the locality model
- Integrated Networks (*BCF schemes 20, 21 and 22)*. These MDT's cover Islington, supporting around 1,200 people a year with complex, cross-organisational needs. The teams take referrals from across our system, including voluntary sector services, and co-ordinate personalised care around the individual. This helps join up our

services at the resident level, and enables our professionals (across primary, social care, community, acute, mental health and the voluntary sector) to work together on a locality footprint to co-ordinate support for our most complex cohort.
    - Developments in 2023-24 include integration with the Islington locality model, exploring efficiencies with the primary care intervention, building on the review completed in 2022 to ensure consistent take up of the services across all populations
- Carers services (detailed below in the carers section) (*BCF schemes 22 and 23)*
- District Nursing services *(BCF scheme 14)*. These teams provide ongoing health interventions in people's homes to help keep people well, at home and safe, preventing need for more intensive interventions and providing care closer to home. This could include temporary support for things like wound management or medication management, or supporting residents with long term conditions like diabetes. The services has a significant self care component ensuring that residents are supported to look after their own health care needs where possible. We have restructured our DN services to deliver the ambitions in the Fuller Report and provide care on a PCN level.
    - Developments in 2023-24 include closer integration with the Islington Single Front door model to bring DN services closer to social care models of delivery, and continuing to embed the approach with the redesigned Locality Model.
- Vital support for our social care provision. *(BCF schemes 1, 2, 3, 44, 45)*, This includes care at home (dom care) and residential and nursing care, helping residents to remain living in the community with as much independence as possible
- Support for community equipment *(BCF schemes 29 and 30)*, helping people to remain living at home independently with appropriate support

Responding to urgent need

The BCF funds several key services that can support people with urgent care needs in the community. This include

- Rapid Response teams *(BCF scheme 15)*; delivering the national 2 hour mandate to support people at home with urgent health and care needs. We are joining these services up to form an integrated front door as set out above. We have seen a substantial increase in activity in our rapid response services (over 40% increase in 2022-23). Our capacity and demand section (tab 4 on the Planning template) sets

out a small gap between demand and capacity. This is due to inappropriate referrals but also occasional short term capacity issues. We are working across NCL to address this through reviewing our service against the NCL Core Offer to identify specific gaps. The service in Islington is part of a broader model that works across Haringey and several other key services in the borough, and part of our approach to a co-ordinated rapid response offer is to ensure that we are able to flex our capacity across key services like Reablement to ensure a more responsive offer.

- Reablement *(BCF schemes 5 and 6)*; supporting people in the community to remain at home and become increasingly independent. This supports preventing admission as well as responding to hospital discharge needs. This team has been newly restructured, with increased capacity and ability to respond quickly to referrals using a new 'Take home and settle' approach that supports Discharge to Assess approaches
    - For 2023-24, our priorities include the Islington Integrated Urgent Response and Recovery Service set out above.

D2A (BCF schemes 8, 16, 17, 18, 46, 47, 48) and Care after Hospital (schemes 11, 12, 31 and 32) / (HICM 1, 3, 4, 5, 6, 7, 8)

- Our D2A and Reablement offer are being further integrated in Islington. We are joining up key services like virtual wards, our P2 offer and care at home to provide a broad range of support following hospital admission.
- The BCF supports our therapy teams in Islington, including our neuro and stroke rehabilitation services, helping people to continue their recovery
- During 2022-23, we jointly reviewed our discharge processes and pathways across NCL, working alongside all 5 Local Authorities and the ICB in a jointly commissioned piece of work. This has led to several recommendations regarding our discharge processes and ways of working that we will be implementing through 2023-25. For example, we are exploring the footprints of our transfer of care hubs, our ways of working across our system, our borough based P1 offer and reviewing our NCL approach to P2.
- We have established a comprehensive approach to people with housing and homeless needs in hospital. We have a pan-NCL offer providing dedicated housing support to our Transfer of Care Hubs, dedicated homeless P2 offers, and joined up approaches with our housing colleagues. We are continuing this work into 2023-25

In terms of developing our locality offer, the Borough Partnership has agreed the following strategic and operational framework which inform how we will grow and develop our locality functions

Locality Functions	
Strategic	**Operational**
Population health improvement – analytically reviewing local data to understand population needs and areas of unwarranted variation and health inequalities *(HICM 2)*.	• Led by population health data, operationally delivering service transformation and test and learn pilots to meet population health needs across the population health triangle - from early intervention through to complex care for cohorts of patients. • Using data to case find those at risk and to ensure systematic call and recall so that residents can be managed in a proactive way
Connecting and mobilising local communities to supplement quantitative population health data and develop an in depth understanding of population needs.	• Delivery of meaningful engagement and co-production with residents to support locality priorities and programmes. • Working with communities and the VCSE to design responses that will work for people Holding knowledge of the locality footprint, in terms of: • Assets – eg care homes, community centres, schools, Fairer Together Hubs, Family Hubs etc. • Estates - use and capacity across partners • Service provision - statutory and voluntary
Supporting a mixed programme of local priorities, as defined by the population health data and the Islington Integrated Care Board.	• Being clear of our priorities and ensuring that our front line staff understand those

	• Facilitating multi-disciplinary team working and drawing in required expertise from partners to deliver required transformation - e.g. secondary care consultants, voluntary sector roles.
Co-working alongside system partners and PCNs to deliver locality, PCN and borough partnership priorities.	• Having the right infrastructure that can support knowledge management – similar to a business manager role
Workforce planning, including developing flexible workforce models (*HICM 5)* and OD and development support.	• Systematic approach to workforce development and OD across localities • Opportunities for staff to come together to learn and share ideas • Ensuring we hear the voice of our communities in OD – using experts by experience or the VCSE to "make it real"
Driving improvement via monitoring impact and benefits realisation of locality work and adopting quality improvement methodology. Sharing learning across localities.	• Having the infrastructure that enables leadership teams to understand impact and areas for QI • Developing distributed leadership to ensure that all front line workers are considering impact and continuous quality improvement and have a degree of autonomy to act

In terms of learning from 2022-23, we have identified several areas for development. These include

- Continuing to grow our Personal Health Budget offer post hospital (*HICM 7)*. We launched successful pilots last year, with additional funding from the ASC discharge fund, that supported innovative ways to help people leaving hospital. We are continuing this into 2023-25
- Evolving our Locality Model in Islington. This is a substantial area of focus and is set out above.

- We have seen continued growth in our rapid response services, including expansion of the virtual ward model in Islington. We have doubled the capacity available to Islington residents, and are planning to have 40-50 virtual beds in 2023.

Finally, in relation to our capacity and demand models and learning in 2022-23, we have the following findings

- At a high level, our P0/1/2/3 demand numbers remain highly accurate. We work across NCL to develop this model and have established effective, daily reporting mechanisms that we use to track our flow in these pathways. We are exploring ways of improving this following the recommendations from our recent joint review, and are testing the OPTICA system in May-23

- While our demand model has worked well, our main areas of pressure across all pathways are in terms of the complexity of patient need that we continue to see.

  This manifests across all pathways and can include

  - P1: Complex housing and homeless needs, complex mental health needs, high clinical demand including delirium. We have launched a substantial, NCL wide approach to housing and homeless needs that has become embedded into our transfer of care hubs. We have also increased our virtual ward capacity which continues to support patients to receive care at home. Finally, we have a specific hospital discharge support offer from SHP, our VCS partner, that can provide a variety of interventions to support residents leaving hospital (e.g. shopping, topping up pre-paid meters, supporting minor home adjustments, enabling keys and other access issues). We have recorded this as P0 on the planning template.
  - P2: Increasing complex rehabilitation needs, including bariatric complexity, substance misuse, patients with criminal justice needs, complex braces and nuerological needs
  - P3: As well as a restricted provider market in general, we have increasing volumes of patients requiring 1:1 care, behaviours that challenge and other high levels of care needs that challenge our market

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as

- **where number of referrals did and did not meet expectations**
- **unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)**
- **patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);**
- **approach to estimating demand, assumptions made and gaps in provision identified**
- **where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?**

how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Our approach to demand and capacity modelling for 2023-24 draws on three key sources

- Hospital discharge data; both 2022-23 and the NCL ICB Operating Plan for 2023-24. We work across the ICS to develop the agreed operating plan; this means confirming expected hospital activity with all acute providers and breaking this down into P0/1/2/3. This is informed by the activity delivered in the previous year and our ICS wide planning approaches for the coming year.
- The service activity for 2022-23 and for the coming year. Intermediate Care is a sub-set of all P0/1/3 activity and so we monitor Islington services activity. We also need to adjust the figures in the operating plan to account for hospital discharges for Islington residents from out of sector hospitals; this is a relatively small % but an important area with key non NCL hospitals for Islington residents including Homerton and the Royal London.
- Finally, we review against our ambitions for 2023-24. For Islington, key changes in our hospital discharge approach are set out above, but include continued expansion of our rapid response service, establishing our Integrated Front Door, continuing to grow our reablement and hospital discharge pathways and seeking to maintain our level of care home admissions. In terms of P2, we are also launching a single clinical model across NCL and refreshing our LOS and occupancy ambitions.

We then take our demand modelling and review against our capacity. For 2022-23 we have largely been able to deliver against expected demand, however, we have recognised the following issues in our pathways

- For P1, we continue to relaunch our Reablement service. *(HICM 3, 4, 5)* We expect to be able to further increase our activity in 2023-24 as set out in the metrics section in the planning template. We want more Islington residents to benefit from Reablement at home. We are also reviewing our housing support pathways, in particular taking learning from the Discharge Fund in 2022-23 to review how our blitz cleans work and consider how we can build further capacity in this area.
- For P2, we are reviewing some of lower intensity units and considering how we can support Islington residents currently using these services to return home instead, in line with our residents preferences to be cared for at home. Our approach to managing capacity is set out in the assumptions section of the Planning Template, but a key mitigation to respond to seasonal or other spikes in demand is our approach to using P2 capacity across NCL. This means that all NCL residents have access to all NCL beds allowing us to smooth demand and ensure a consistent occupancy rate across the sector. This has had different impacts for boroughs depending on their historical use of bed bases and where those beds are. For Islington, the main rehab unit has been in Camden and delivered by CNWL *(BCF scheme 11)* however, the pathways are well established from the Camden unit to Islington, social workers are co-located on the site and MDT processes are effective with support and oversight from the IDT. Where Islington residents are placed in other P2 units, we are developing a consistent clinical model for the P2 units which includes interfaces and discharge pathways to optimise flow from, say, Barnet units, back to Islington.
- For P3, *(HICM 8)* as an inner London borough we have limited care home capacity and are unlikely to be able to grow this further. Our local beds have been under pressure following some temporary pauses in capacity longstanding remedial works required that are now resolving so we plan to be able to support more residents to access care homes closer to family and friends. We have an NCL wide market management group, and a key ambition of the ICS is to increase the capacity in our more complex care home beds as we see increased demand against this cohort. It is important to understand our approach to the Capacity and Demand template as set out in the assumptions section of the Planning Template. Our key issue is not a mis-match of demand and capacity, but the ability to place safely and quickly. We adopt a spot purchasing approach to placing residents where our local capacity is full; this means that we will always eventually be able to find a bed but the key issue is about how quickly we can do this.

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 struggled to reach an 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.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- **unplanned admissions to hospital for chronic ambulatory care sensitive conditions**
- **emergency hospital admissions following a fall for people over the age of 65**
- **the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.**

In terms of reducing unplanned admissions for chronic ambulatory care sensitive conditions, our key intervention remains the Rapid Response service. *(BCF schemes 5, 6, 11, 12, 15, 51 in tab 6a of the Planning Template) / (HICM 3, 4, 5, 6, 8)* This service has seen more Islington residents than ever in 2022-23, and we plan for this capacity to grow further in 2023-24. Key improvements we are making to this pathway include

- Further focus on the 2 hour target, improving our current performance
- Increasing referral pathways and opportunities, including exploring Single Points of Access across NCL, better working with LAS and with 111
- Locally, joint work between Whittington Health and London Borough of Islington to better integrate our Single Front Door approach which will increase capacity, responsiveness and resilience of the offer (*HICM 4, 5).*

In terms of care homes admissions, our ambitions are set out in the Planning Template. As noted above, we intend for our admissions to remain stable in 2023-24 though note this is in the context of growing older adults population and increasing complexity in the support needs across our borough. We are finding increasing numbers of patients requiring more intensive support such as 1:1 care and this is a challenge for our market as noted above. As noted above, we plan for local provision to come back online in increasing volumes in 2023-24 as specific capacity issues at local care homes are resolved and admissions can restart. This will enable up to 50 further P3 block beds in Islington to be reopened to support our residents.

Islington's BCF funds key services across this pathway, preventative services such as our community frailty teams, services to care for adults at home such as domiciliary care and district nurses, integrated co-ordination services to support multi-disciplinary working such as our Integrated Networks, support for hospital discharge teams, P1 and P2 services to help Islington residents recover and regain independence.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: Provide the right care in the right place at the right time.

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and

social care services are being delivered to support safe and timely discharge, including:

- **ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.**
- **How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.**
- **Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.**

Our approach to a home first approach is described above in some detail. Our priority areas to support home first within the BCF are *D2A (BCF schemes 8, 16, 17, 18, 46, 47, 48) and Care after Hospital (schemes 11, 12, 31 and 32).* The priorities for 2023-24 are set out above in page 10 above.

This approach is embedded across our organisations, and we use all available checkpoints in planning discharge to ensure that we are continuing to support people to go home (*HICM4)*. We have set a further improvement in our BCF metric for supporting people to return home following a hospital admission aiming to improve Islington delivery to above the national average.

A major focus in 2022-23 has been on standardising our P2 approaches across NCL. We have had a cross-provider project, working under our Community Services Transformation Board, to ensure a single clinical and operational model, a single demand and capacity approach (*HICM 2)*, and drive the benefits of a scaled approach.

For example, we have created a single point of access to our P2 beds across NCL. By launching the ICE (Intermediate Care Escalation) hub in 2022-23 we are able to have a consistent check and challenge approach to all requests for a P2 bed. By doing this, we have been able to divert 7% of all referrals (Q4 2022-23) to home first. This enables us to address any variation in referrer behaviour or expectation, and ensure that we support people to have rehabilitation and recovery at home.

This work is underpinned by the development of the 'NCL Core Offer'. This is a standard set of expectations that we expect all community providers to deliver. A key area of focus is P1

(HICM 4); we are working to ensure that all NCL residents have a consistent P1 approach, that they can manage the same levels of complexity, provide optimal referral response times, deliver a consistent intensity of offer; all of which will support our complex acute system to make best use of P1 offers where possible.

In terms of responding rapidly to discharge pressure, and preventing delayed discharges, we have effective local services that can respond as needed. Where required, we have local and ICS wide escalation routes so that we can respond to pressures and address complex situations. This includes daily calls with our hospitals, regular, structured escalation routes and an NCL wide SILVER call to address any complex delays.

Our NCL wide Discharge Operational Group is a key opportunity to drive best practice in discharge. This supports our Islington system by bringing together a larger group of discharge professionals and enabling system conversations with organisations like UCLH and Whittington where we need to work on a larger footprint. This group has led substantial improvements in our discharge flow in 2022-23, including

- Updating and re-launching the NCL wide Choice and Facilitated Discharge policy. *(HICM 7).* These policies support our patients and system when we are working with residents to exercise choice at the point of discharge. We are holding a Choice Summit in Jun-23, and for the first time have secured a consistent approach to choice and facilitated discharge across all acute, community, mental health and social care partners. This means we can be much more consistent in our approaches to managing choice delays in NCL. Importantly, the policy sets out a clear focus for home first approaches across our ICS.
- Working on a consistent and best practice led approach to early identification. *(HICM 1)* We have shared models across our system and developed our learning on the critical need to identify patients with likely care needs after discharge as early as possible. This has included checklists, scoring systems and other tools which allow us to get as 'upstream' in the discharge process as possible and to give residents the best chance of being discharged home as we identify any issues and barriers as early in the process as we can.
- Providing assurance frameworks, like a single discharge alert model, that enables our system to have confidence in sharing information about discharges where there are opportunities to improve. This has been launched across NCL in Jun-23 and will allow greater shared learning and best practice when responding to alerts and issues that

required support post discharge. As above, we want to develop a learning community of discharge leads that enables us to work consistently for our residents.

- Closer working with our mental health system *(HICM 3)*. We are aligning and reducing duplication wherever possible; this means a single escalation framework, shared approaches to resolving complex discharges, joint working with our MH beds and acute beds, and shared approaches across our community beds. We have launched a consistent approach to visibility of our long stayers, discussing them at the same NCL Silver and FOG senior meetings to support parity of esteem, and to demonstrate our shared commitments to home first approaches.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

Many areas of the High Impact Change model have been described above, such as our approach to early discharge planning, Home First, our approaches to Multi-Disciplinary working in the hospital discharge and community pathways, and our work on choice and engagement. Our narrative plan shows where we have specifically referenced the *HICM* and the work that we are planning to further develop our model.

The following table gives our current self assessment against the maturity model

1	Early Discharge Planning	Established/Mature
2	Monitoring and responding to system demand and capacity	Established
3	Multi-disciplinary working (MDTs)	Mature
4	Home First Discharge to Assess	Plans in place / Established
5	Flexible working patterns	Established/Mature
6	Trusted assessment	Established
7	Engagement and choice	Mature
8	Improved discharge to care homes	Established/Mature
9	Housing and related services	Mature

The following sections provide additional narrative in terms of developing the HICM where this has not been covered above, though we would emphasise that our approach to the HICM is referenced throughout the Narrative Plan.

In terms of our approaches to Monitoring Demand and System Capacity (*HICM 2)*, we have conducted a review of our approach across NCL in 2022-23, and are currently exploring tools to improve our operational and data approaches to discharge. One of our key limitations is the inconsistent approaches to the 'days delayed' data across our acute system in NCL. This has led to discussions to implement OPTICA across NCL which will meet our requirements to develop a 'single source of the truth' in terms of describing the discharge pathway where we work across multiple organisations and data systems. This is a national programme which sits on the Palantir framework, and has demonstrated impact in other areas in terms of improving joint working and supporting flow.

In terms of early identification (*HICM 1)*, we work as a system in NCL to support best practice in discharge. For Early Identification, this has meant peer reviewing and joint learning by bringing each acute trusts early identification processes to our Operational Group for in-depth review and exploration. This has led to increased consistency and delivery of best practice, for example in testing checklist based approaches, working with London Ambulance Service to identify housing issues in a more consistent way, and developing better approaches to early alerting to community and local authority services where residents are likely to need support to go home.

Finally, we have a developed Housing approach that works across NCL (*HICM 9)*. In practical terms, this has meant embedded housing officers working in each acute trust. These people support a wide range of housing needs, and are closely integrated with their local housing providers including the local authority. We also have dedicated P2 housing pathways, and wide ranging approaches to resolving housing issues, which has included increasing take-up of our personal health budget offer to support discharge. Our key local hospital IDT's have access to pre-paid cards where they can rapidly order items and services to support discharge (up to £400) and we see increasing take-up of this service.

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that <u>duties</u> under the Care Act are being delivered?

The workstreams and funding priorities identified across this report have been created to ensure that the Islington Borough Partnership can deliver our statutory duties in a safe and effective way whilst offering our residents choice and control.

The Partnership are committed to **promoting individual wellbeing** to ensure Islington residents can live healthy, fulfilling, and independent lives – connected to their community and with appropriate care and support as required.

Our approach to **preventing needs for care and support** is supported through investment in social prescribing services using the local VCS to deliver universal services and minimise the need for statutory services where possible. VCS partners also form part of our approach to **providing information and advice** which is being developed across the partnership and includes targeted support for carers services.

We have committed to invest BCF funding to **promote diversity and quality in provision of services** and ensure that the provider market for community and accommodation-based services is maintained. High quality Adult Social Care is a crucial contributor to the Council's Fairness Agenda – whether due to our work as part of Fairer Together, the Challenging Inequalities programme, or our contributions to the Community Wealth Building movement as an employer and a commissioner.

Safeguarding adults is a core function of all our organisations and this is supported through the Safeguarding Adults Board. Funding across all the streams ensures that providers and operational teams have the resources for effectively **co-operating** and deliver safeguarding duties in line with the Making Safeguarding Personal principals.

Promoting integration of care and support with health services has been supported through the BCF via joint commissioning functions across the Partnership and the ICB. This work is now being extended to include more operational functions from the shared front door for community services to the integrated rapid response teams.

Local authorities must **involve people in decisions about their care and support**, and **provide an independent advocate** where the person has substantial difficulty being involved and has no appropriate individual to support them. Commissioning integrated advocacy offers benefits including easier access to multi-skilled advocates, improved working relationships, and better communication. The duty to provide advocacy in the Care Act applies equally to those people whose needs are being jointly assessed by the NHS

together with the local authority, or where a 'joint package' of support is planned, commissioned or funded.

How the BCF supports unpaid carers, including carers breaks and implementation of Care Act duties

Islington Carer population

According to data from the 2021 Census, 15,000 residents in Islington providing unpaid care (7.2% of population), 7,400 residents self-identify as providing 20+ hours of unpaid care per week, with 3,900 residents provide 50 or more hours of unpaid care per week. The proportion and number of people providing unpaid care fell between 2011 and 2021, but unpaid carers tended to provide more hours of care in 2021. However, it is important to note, it is unlikely that the number of carers have reduced over the last 10 years, it is more likely many carers have not identified themselves as carers in the census. This is echoed in the recent publication by The Health Foundation that suggests one reason nationally only 8% of carers are currently making contact with local authority services for support, is low levels of carer identification. This suggests that few carers appreciate their status, eligibility and even the impact caring is having on them. They also cite the typical support available is not perceived by carers as attractive/impactful to them as another reason for low up take.

As of March 2023, 849 carers (aged 18+) were known to Adult Social Care directly; 3,723 carers were registered with Islington Carers Hub; and according to the GP Patient Survey in 2022, 449 patients registered with an Islington GP practice reported that they care for someone. In 2022/23, on average 744 carers accessed support from Islington Carers Hub per quarter and 11,000 carers accessed information and online support (delivered in partnership with Mobilise) over the year.

Islington already has a broad range of services and support available for carers, with a few key elements of the offer detailed below.

Adult Social Care

Residents have an entitlement to a carer's assessment if they are over 18 and provide unpaid care to someone over 18 living in Islington. The person they care for doesn't need to be getting support from social services. The assessment shows if there's extra support that can make caring easier for example respite, carers groups, benefits advice and carers emergency card.

Adult Social Care promote Direct Payments which enable carers, who have been assessed as needing care and support services, to choose and buy the care and support themselves.

Islington Carers Hub

Islington Carers Hub provides advice, information and support to all carers aged 18 or over who live or work in Islington or care for someone living in Islington. They do this either directly or through their work with other organisations. The Hub acts as a one stop shop for carers in the borough and offers up to two years support for people once their caring role has ended. Islington Carers Hub provides strategic leadership on Carers' issues across the local health, social care private and voluntary sectors.

A digital offer provided by Mobilise, enables carers to access information and connect with others for peer support online, including connecting with carers who live beyond Islington but share similar experiences, strengths, ideas and challenges. Services provided by the Hub include

- Information pack about the kinds of help for carers in Islington
- Advice and Information sessions at a range of venues
- Support groups for carers to meet and share ideas
- Programme of activities, social connection and training opportunities
- Counselling, delivered in partnership with Islington Mind
- Help with getting the Carers Emergency Card
- Flexible Breaks Fund
- A quarterly newsletter called Carers News
- Events and activities like Carers Rights Day
- Carers Assessment
- Promotion of the right to a statutory Carers Assessment and the benefits from this
- Support with benefit claims to maximise income
- Information on carers rights, including rights as employees
- Carers Providers Forum to share updates and good practice

Camden & Islington NHS Foundation Trust

- Services for Ageing and Mental Health support carers of people living with Dementia.
- Better Lives Family Service supports carers affected by someone's alcohol or drug use.

Whittington Health NHS Trust

- Training on long term conditions is provided for both patients with long term conditions and their carers.
- Dementia care plans - 'What matters to me' include support for carers

Voluntary and community sector organisations

Many voluntary and community organisations in Islington have specialist services for carers or that can support carers. For example.

- Centre 404 Parent Carer and Family Carers Group offers person-centred support to people with learning disabilities and autism, and their families.
- Islington Mind Mother to Mother carers support project offers support to mothers whose children have mental health problems.
- Islington & Camden Young Carers service, delivered by Family Action works with young carers, their families and professionals offering whole family support, advice, guidance and resources. Young Carers service and Islington Carers Hub work together to support transitions.

Carers Pooled Budget

Islington has a dedicated S75 pooled budget to provide support to unpaid carers, which is part funded by the NHS minimum contribution to the BCF. The main objectives of the pool are to ensure that there is joined up health and social care support for unpaid carers and that the needs of carers are recognised and understood by health and social care statutory agencies, the wider voluntary sector and the community at large.

The main function of the pool is to commission the Islington Carers Hub, which is the central service for supporting carers in the Borough. Islington Carers Hub (ICH) service was commissioned in April 2009 to provide a comprehensive information, advice and guidance service to all unpaid carers living in Islington or with a caring responsibility for someone with care and support needs living in the Borough. The service was recommissioned in 2022. The incumbent provider, Age UK Islington, was successful. The contract started in March 2022 and runs for a period of 3+2+2 years.

The pool is also held for the funding of carers personal budgets across all customer groups i.e. older adults, learning disability, mental health and physical disability, including access to carers breaks.

Adult Carers Strategy

An Islington Adult Carers Strategy 2023-2030 is currently in development to build on the good practice and offer for carers, driving better outcomes for carers. The strategy is being co-developed in partnership with carers and key partners across Islington, including Adult Social Care and other Council departments, Health colleagues and Voluntary and Community Sector.

There is already a Camden and Islington joint young carers strategy but this strategy includes a priority on Transitions to adulthood.

Strategic Approach to using housing support and DFG funding to support independence

The 2022/3 allocation for the Disabled Facilities Grant (DFG) for Islington Council is £1,177k. This is from the £1,940k DHSC funding allocated to Islington, with remainder going to ASC for minor adaptations. This grant is for the provision of adaptations to disabled people's homes to help them to live independently for longer. The DFG is part of the Better Care Fund (BCF).

The aim is to use home aids/adaptations and technologies to support people in their own homes to improve outcomes across health, social and housing.

Our private sector Housing team in Homes and Neighbourhoods have responsibility for administering DFGs, under the Service Director for Community Safety in the Council, in partnership with our housing and adult social care service to ensure that they support continued independence in the home. Applications come through our access service in adult social care and are processed by a dedicated team which includes occupational therapy. There is close collaboration on policy and case work between the services, including supporting discharge from hospital.

We review spend and take up annually and commit to full spend of the budget given by central government. As mentioned previously, grants below £10,000 are not means tested. This decision, using the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002, was taken after evaluating why people did not take up their offer as we found that the means test was having an adverse effect on those with small pensions or savings pot who did not pursue the DFG because of cost they would incur after means testing. DFGs are available to all in the private sector – homeowners, social housing providers and

private rented. Our housing service has its own disabled adaptation scheme for residents who would otherwise have been grant applicants.

In 2022-23, there have been 139 grants completed, assisting with greater independence for Islington residents. The majority of the grants (66%) are between £5k and £15k, with the majority (58%) for residents aged over 65. Our largest grants are around the £25-£30k range. Six of the grants were for residents aged under 18, and the remainder were for adults. In addition, we have about 130 grants currently 'live' and working towards completion. We have had some supplier issues in the last year, but there are other stages of the process such as application, planning, estimation, or resident led delays (including hospital admissions) that impact delivery. The budget can also be used for low-cost adaptations managed within social care and associated operational costs. These grants average 70% to housing association tenants and 30% to owner occupier or tenanted properties.

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- **Changes from previous BCF plan**
- **How equality impacts of the local BCF plan have been considered**
- **How these inequalities are being addressed through the BCF plan and BCF funded services**
- **Changes to local priorities related to health inequality and equality and how activities in the document will address these**
- **Any actions moving forward that can contribute to reducing these differences in outcomes**
- **How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.**

Addressing health inequalities is a key focus of the Borough Partnership and is a thread running through each of the core and enabler work programmes. This work is supported by a well developed Health Inequalities Strategy across NCL ICB. 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 to fund solutions to address these issues and improve the health and life chances of people in the 20% most deprived neighbourhoods.

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. This includes, for example, Learning Disability and Autism as they form part of the Core20Plus5 cohort, and we have various initiatives (not BCF funded) to support addressing health inequalities here.

Our key Population Health Management tool is HealtheIntent. This tool allows us key insights to drive our inequalities approaches; for example segmenting our population by diagnoses, deprivation, ethnicity and being able to break this down at a practice, PCN and borough level.

In terms of our BCF, we work with individual services to ensure that they have a clear plan to understand and address health inequalities. This is necessarily service specific, but is underpinned by the ICS approach to health inequalities and utilisation of consistent tools like Healtheintent. For example, our NCL wide P2 beds programme has approaches to understand utilisation of the beds at a granular level to work against expected take-up and population ratios. This approach has informed, for example, development of patient information packs and engagement with referrers to consider where we are best able to ensure appropriate access and optimal outcomes from our services. This has included development of specific offers and services across NCL to focus on groups that may have challenges in accessing effective P2 rehabilitation (BCF schemes 11, 31 and 32). Similarly, we are working with Long Term Condition services with a focus on referral and access at a Primary Care level. This has identified opportunities with different practices to ensure that our referral pathways are working as expected. We have also trialled alternative pathways for access to specialist support for long term conditions where residents may have challenges in accessing Primary Care in the first instance. For example, we have developed a homeless health service, where we work with street homeless residents to ensure they have access to support through resident appropriate pathways. Finally, we have reviewed our Integrated Networks model recently (BCF schemes 19, 20 and 21) with a focus on ensuring that our demographic take up matches population expectations; this has led to a

focus on broadening referral pathways and ensuring that our voluntary sector has a consistent and equitable approach to bringing patients for discussion at the Networks.

We look to build on local Place-based initiatives to complement and develop existing statutory and voluntary sector initiatives within Boroughs. The Borough Partnership is supporting a range of local integrated projects focused on targeting our most deprived communities. These are based on local inequalities data, fostering collaboration between partner organisations. In total, £681,166 will be allocated to Health Inequalities projects in Islington in 23/24.

	Project Name	Provider Leads	Funding allocation
Existing projects	Community Research & Support Programme	Healthwatch Islington	22/23: £93,910 23/24: £69,958
	Hand in Hand Islington: A Volunteer Peer Buddy Scheme	Camden and Islington NHS Foundation Trust	22/23: £105,505 23/24: £97,624
	Islington Homelessness Health Inclusion Programme	Islington Council & Islington GP Federation	22/23: £83,250 23/24: £107,780
	Early Prevention Programme - Black Males & Mental Health	Islington Council	22/23: £260,518 23/24: £130,000
New Projects (23/24)	Childhood Immunisation	ICB Primary Care, Islington GP Federation, Public Health VCS Partners	£81,000
	Cancer Screening	Public Health, VCS Partners	£66,000
	Leaving Care Counselling and Psychotherapy	Brandon Centre	£19,000
	Progression to Adulthood	Brandon Centre	£65,000
	Learning Disabilities and Severe Mental Illness Cafes	Islington Council, Islington GP Federation, VCS Partners	£60,000
	Mental Health Inequalities Tool Kit	Healthwatch Islington and Islington MIND	£35,000

Delivery highlights from 2022-23 include

Community Research and Support Programme:

A community engagement project, talking to residents about their experiences of cancer screening and COPD services. The aim is to help services and commissioners to better understand barriers to uptake within specific communities where uptake is lower. Healthwatch Islington together with commissioners has developed specific questions for the engagement, and a bank of materials to help inform residents of what's available. These

resources have been used by the Diverse Communities Health Voice, a partnership of 12 community organisations across Islington, to engage with communities in Islington.

- 100+ residents supported to access appropriate interventions report improved well-being and/or access
- 500+ residents report knowing more about what services to access when, and share this with 800+ indirect beneficiaries (family, neighbours, friends)

Hand in Hand Islington: A Volunteer Peer Buddy Scheme

Hand in Hand Islington is a Volunteer Peer Travel Buddy scheme that has recruited, trained and supported 19 volunteers with lived experience of mental ill-health to accompany vulnerable residents to other locations in the borough for appointments, courses, services, green spaces, social activities and events.

The service aims to improve access to Islington's health and social opportunities for residents of the borough that experience substantial levels of inequality, stigma, and isolation as well as support peer buddies by creating a step towards meaningful activity and employment, building confidence, and gaining work readiness through volunteering.

- 26 peer buddies recruited and 19 peer buddies trained
- 273 peer buddy journeys completed

Islington Homeless Health Inclusion Programme

Identifying and treating the health needs of people experiencing homelessness (PEH) in Islington using a combination of engagement, diagnostic tools, health navigation, outreach nursing, and the provision of flexible GP appointments. The service offers a mixture of hub-based healthcare support; hostel outreach and drop-in sessions via Homeless Resource Centres and community facilities.

- 91 consultations have been conducted
- 55 health record reviews and 32 holistic health checks completed
- 17 individuals have been registered with a GP
- 50 onward referrals have been made

Early Prevention Programme – Black Males and Mental Health

The young Black men and mental health programme is an innovative programme designed to improve mental health and wellbeing outcomes for young Black men, and to improve their life chances is Islington. It has 4 workstreams:

- Early Intervention: Becoming a Man (BAM) – counselling and 1-1 mentoring in three secondary schools.
- Elevate Innovation Hub – Community hub which delivers therapeutic solutions based on culturally competent practice. There is a Senior Psychologist and Lead Psychologist as well as trained Elevate Coaches who support young black men aged 16-25 at risk of poor health, serious youth violence and exclusion from school.
- The Barbers Round Chair Project: Equips Islington Barbers as community mental health ambassadors.
- A cultural competency and anti-racist practice training programme for partners including GPs, social care and schools.
- 3 Islington Schools signed up for BAM
- 200-225 pupils supported via BAM this year
- 6 Barber shops engaged in programme and 10 Barbers completed Mental Health Ambassador training.