Meeting
Health & Wellbeing Board
Date and time
Thursday 29th September, 2022 **At 9.30 am**
Venue
Colindale Communities Trust, The Old Library, The Concourse, London, NW9 5XA

Dear Councillors,

Please find enclosed additional papers relating to the following items for the above mentioned meeting which were not available at the time of collation of the agenda.

Item No	Title of Report	Pages
7	Forward Work Programme	3 - 8
13	Better Care Fund	9 - 58
15	Combating Drugs Partnership	59 - 74

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London Borough of Barnet
Health and Wellbeing Board
Forward Work Programme
2022 / 2023

Contact: Allan Siao Ming Witherick (Governance) allan.witherick@barnet.gov.uk

AGENDA ITEM 7

Subject	Decision requested	Report Of	Contributing Officer(s)
19 January 2023			
Reference items			
List of abbreviations	The Board to note the list	Chair of the HWB Board	Governance Officer
Forward Work Programme	The Board to note the Programme	Chair and Vice Chair of the HWB	Governance Officer
Deep Dive			
Neighborhood Conversation – Health and Wellbeing in Edgware	The Board listens to the experience of residents, and the work currently underway to improve health and wellbeing in the area	Chair and Vice Chair of the HWB	
Business items			
North Central London Integrated Care Partnership Update	The Board notes and comments on the update	Director of Integration (Barnet), North Central London Integrated Care Board Executive Director for Adults and Health	
Better Care Fund	The Board agrees the sign off process	Executive Director for Adults and Health	Health and Care Commissioner (Shirley Regan)
Dementia Strategy	The Board to note and comment on the draft Dementia Strategy.	Executive Director for Adults and Health	Senior Commissioning Officer (Jo Kamanu)

**A key decision is one which: a key decision is one which will result in the council incurring expenditure or savings of £500,000 or more, or is significant in terms of its effects on communities living or working in an area comprising two or more Wards*

Subject	Decision requested	Report Of	Contributing Officer(s)
Progress on Dementia Friendly Borough	The Board to note progress.	Director of Public Health and Prevention	Seher Kayikci, Senior Health Improvement Officer
Enhanced Care in Care Homes	The Board to note and comment on the update.	Executive Director of Adults and Health	Head of Joint Commissioning - Older Adults & Integrated Care (Muyi Adekoya)
Migrant Health Needs Assessment	The Board to note and comment on the Needs Assessment	Director of Public Health and Prevention	Consultant in Public Health (Rachel Wells) and Public Health Registrar
16 March 2023			
Reference items			
List of abbreviations	The Board to note the list	Chair of the HWB Board	Governance Officer
Forward Work Programme	The Board to note the Programme	Chair and Vice Chair of the HWB	Governance Officer
Deep Dive			
Neighborhood Conversation – Health and Wellbeing in Burnt Oak	The Board listens to the experience of residents, and the work currently underway to improve health and wellbeing in the area	Chair and Vice Chair of the HWB	
Business items			
Director of Public Health Annual Report 2022-23	The Board notes and comments on the report	Director of Public Health and Prevention	

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Subject	Decision requested	Report Of	Contributing Officer(s)
Fit and Active Barnet (FAB) – Year 2 Delivery	The Board notes and comments on the Year 2 Action Plan	Executive Director for Adults and Health	Service Manager – Sport & Physical Activity (Courtney Warden)

Items to be assigned

Suggested future items	Source	Report of	Contribution Officer(s)
Sustainability Strategy, including Air Quality	Public Health/Environmental Health to confirm	Deputy Chief Executive, London Borough of Barnet	
Children and Young People's Plan	Ben Thomas/Lee Robinson, Family Services	Executive Director, Children and Families, London Borough of Barnet	
Barnet Borough Partnership: Fuller Report and Neighbourhood model development in Barnet (in around 6 months time)	NCL ICB	Director of Integration (Barnet), North Central London Integrated Care Board Executive Director for Adults and Health	
Community Services Review	NCL ICB		

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Primary Care Update: Bi-annual report	NCL ICB	Director of Integration (Barnet), North Central London Integrated Care Board Executive Director for Adults and Health	
Delegation of Dental, Ophthalmology and Pharmacy Contracting	NCL ICB		
Suicide Prevention Plan Update	To approve additional actions	Director of Public Health and Prevention and Executive Director of Children and family Services	Public Health consultant
Better Care Fund Plan	To endorse approved plan	Executive Director of Adults and Health	Head of Joint Commissioning - Older Adults & Integrated Care (Muyi Adekoya)
NCL ICB Forward Plan,	To note and comment on the Forward Plan	Director of Integration (Barnet), North Central London Integrated Care Board	
ICB Annual Report	To note and comment on the Annual Report	Director of Integration (Barnet), North Central London Integrated Care Board	
ICB Performance Assessments	To note and comment on the performance assessments presented	Director of Integration (Barnet), North Central London Integrated Care Board	

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ICB Joint Capital Resource Strategy	To note and comment on the strategy	Director of Integration (Barnet), North Central London Integrated Care Board	

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	Health & Wellbeing Board **29th September 2022**
Title	**Barnet BCF Plan 2022/23**
Report of	**Executive Director – Communities, Adults and Health**
Wards	**All**
Status	**Public**
Urgent	**Yes. Formal permission for the BCF spend will not be given until the plan has been approved by the Health & Wellbeing Board.**
Key	**Yes**
Enclosures	Appendix A – BCF narrative plan 2022/23 Appendix B – BCF Finance Planning Template 2022/23 Appendix C – Intermediate Care Capacity and Demand
Officer Contact Details	Shirley Regan, Health & Social Care commissioner- Older Adults & Integrated Care Shirley.Regan@Barnet.gov.uk Muyi Adekoya, Head of Joint Commissioning – Older Adults and Integrated Care Muyi.adekoya@nhs.net

Summary

The Better Care Fund (BCF), launched in 2015, is the current national policy approach for integrating health and adult social care. Spanning the NHS and local government the BCF seeks to join-up funding streams for health and social care services, so that people are supported to both manage their own health and wellbeing and live independently in their own home for as long as possible. The policy stipulates that local plans are overseen and approved by each Health and Wellbeing Board (HWB) across England.

Our local BCF plan has a total pooled budget of £41,850,245 for the financial year 2022-23, covering schemes that support the core work programmes for delivering person centred care, adaptations to the home environment, safely managing transfers of care between hospital and home, and prevention of health deterioration.

The Better Care Fund policy guidance and associated financial uplift was only released to local authorities on 19th July 2022. Barnet's BCF plan therefore, reflects arrangements that

are to a significant extent already committed and in existence, since we are now six months into the financial year.

The BCF Plan 2022-23 was approved by the HWB Chair on 23 September 2022 and was submitted to NHSE in accordance with the BCF requirements on 26 September 2022.

This report presents the 2021-22 BCF Plan for endorsement by the Board.

Officers Recommendations

1. **That the Health and Wellbeing Board endorses the Chair's decision to approve the BCF Plan for submission to NHSE.**
2. **That the Health and Wellbeing Board notes the contents of the Barnet BCF Plan 2022/23**
3. **That the Health and Wellbeing Board delegates approval for any required changes from NHSE to the Barnet Better Care Fund plan for 2022-23, to the Executive Director-Communities, Adults and Health in consultation with the Chair of the Health and Wellbeing Board.**

1. WHY THIS REPORT IS NEEDED

1.1. One of the National Conditions for the BCF Submission is that it should be approved by the Health and Wellbeing Board. This report presents the BCF narrative plan 2022-23 and associated finance and capacity documents, for endorsement by the Barnet Health and Wellbeing Board.

1.2. The BCF Plan 2022-23 submission was delivered to NHS England on 26 September following Chair's action to approve, subject to endorsement by the full Health and Wellbeing Board. The Board is asked to confirm their endorsement of the submission.

2. REASONS FOR RECOMMENDATIONS

2.1. The Better Care Fund was established in 2015 by the Government to provide funds to local areas to support the integration of health and social care, and to seek to achieve delivery of the National Conditions and Local Objectives of the BCF requirements.

2.2. The Government's aims around integrating health, social care, and housing through the BCF, have played a key role in the journey towards person-centred integrated care through pooled budget arrangements. The aims have provided a context in which the NHS and local authorities work together as equal partners, with shared objectives in the provision of support in the right place, that enables the person to continue living in their own home from a holistic approach. The plans produced are required to be presented and agreed by the Health and Wellbeing Board (HWB) and represent a single, local, spending plan for the delivery of integrated health and social care.

2.3. In accordance with the Government's legislation for health and social care, Barnet is now part of the North Central London Integrated Care System (ICS) across 5 local authority areas. The Integrated Borough Based Partnership and Integrated Care Board (ICB)have been established in July 2022.

2.4. The BCF Plan 2022-23 was approved by the HWB Chair on 23 September 2022 and was submitted to NHSE in accordance with the BCF requirements on 26 September 2022.

2.5. The Council and NCL ICB will deliver and monitor their BCF schemes for 2022-23 as part of the s75 partnership agreements, through the HWB Joint Executive Group (JEG) and in accordance with Government requirements.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1. Not Applicable

4. POST DECISION IMPLEMENTATION

4.1. The timeframe for assurance of the BCF plan from this point is as set out below:

BCF planning requirements published	19/07/2022
Optional draft BCF planning submission (including capacity and demand plan) submitted to BCM and copied to the BCF team	18/08/2022
BCF planning submission from local HWB areas (agreed by ICBs and local government).	26/09/2022
Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	26/09/2022 - 24/10/2022
Regionally moderated assurance outcomes sent to BCF team	24/10/2022
Cross-regional calibration	01/11/2022
Approval letters issued giving formal permission to spend (NHS minimum)	30/11/2022
All section 75 agreements to be signed and in place	31/12/2022

4.2. The JEG will provide an update to HWB in January 2023 to confirm that the approval process for 2022-23 is complete.

5. IMPLICATIONS OF DECISION

5.1. Corporate Priorities and Performance

5.1.1. The BCF plan aligns with the overarching aims of the Barnet Joint Health and Wellbeing Strategy 2021 to 2025 and the Council's Corporate Plan for 2021 to 2025

5.2. Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.2.1. In accordance with BCF conditions, all funding elements have been jointly agreed by local authority and NHS ICB partners with the relevant amounts included in the respective organisational budgets for 2022-23.

5.2.2. The value of the schemes pooled within the BCF in 2022-23 totaled £41,850,245. The funding sources are as presented in the table below:

Disabled Facilities Grant (DFG)	£2,884,527
Minimum NHS Contribution	£29,344,000
iBCF	£9,621,518
Additional LA Contribution	£0
Additional ICB Contribution	£0
Total	**£41,850,245**

5.2.3. Oversight of expenditure throughout the financial year will be monitored on behalf of the HWB, by delegation to the HWB Joint Executive group.

5.2.4. There are no procurement, staffing, IT, or property implications from this decision.

5.3. Legal and Constitutional References

5.3.1. The Better Care Fund (BCF) governance requirement requires the NHS and local government to create a local single pooled budget to incentivise closer working around residents, placing their increased wellbeing as the focus of health and care services, and building resources in social care and community services for the benefit of the people, communities and health and care systems.

5.3.2. Under the Council's constitution Responsibility for Functions (Article 7), the Health and Wellbeing Board has the following responsibility within its Terms of Reference:

- *Item 3*: 'To work together to ensure the best fit between available resources to meet the health and social care needs of the population of Barnet (including children), by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental, and social well-being. Specific resources to be overseen include money for social care being allocated through the NHS; dedicated public health budgets; the Better Care Fund; and Section 75 partnership agreements between the NHS and the Council.'

- *Item 9:* Specific responsibility for:
  - Overseeing public health
  - Developing further health and social care integration

5.3.3. The National Conditions for the operation of BCF in 2022 / 2023 include that a jointly agreed BCF plan between local health and social care commissioners is prepared and approved by the Health and Wellbeing Board.

5.4. Insight

5.4.1. Our Better Care Fund Plan for 2022-223 is informed by the:

- Barnet Joint Strategic Needs Assessment (JSNA)
- ICB and Council performance management data
- The NHS Long Term Plan
- Health and social care integration: joining up care for people, places and populations

5.5. Social Value

5.5.1. The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic, and environmental benefits.

5.5.2. Our plans clearly recognise the importance of addressing wider factors such as education, employment, housing, environment, and welfare. These wider factors can both impact on and be impacted by the health and wellbeing of an individual or population and will be considered as part of sustainable improvements to health and wellbeing.

5.5.3. Social Value will be considered by commissioners during any service procurement and review of activity detailed in the BCF plan for 2022-23.

5.6. Risk Management

5.6.1. In agreeing the BCF spending plan, the strategic partners have considered the overall system pressures and the appropriate level of investment needed in 2022/23 to meet the BCF metrics and national conditions.

5.6.2. The HWB Joint Executive Group (HWBJEG) is the executive body with delegated oversight for the BCF pooled budget and delivery of the BCF Plan. The HWBJEG therefore receives and scrutinises performance updates, finance expenditure and risk reports from each of the BCF scheme lead officers, as part of the monitoring function for the delivery of all Section 75 arrangements on a quarterly basis.

5.6.3. The HWBJEG monitoring reports are submitted to the HWB records, with updates provided to the HWB on a bi-annual basis or as requested.

5.7. Equalities and Diversity

5.7.1. Decision makers should have due regard to the public sector equality duty in making

their decisions. The statutory grounds of the public sector equality duty are found at section 149 of the Equality Act 2010 and are as follows.

5.7.2. A public authority must, in the exercise of its functions, have due regard to the need to:

a) Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under this Act.
b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

5.7.3. The BCF plan 2022/23 contains a particular focus on tackling health inequalities in Barnet and outlines a range of schemes to address where an inequity of access to health and social care support in a timely manner, may have a detrimental effect on the health & wellbeing of certain groups.

5.8. **Corporate Parenting**

5.8.1. There are no implications for Corporate Parenting in relation to this report.

5.9. **Consultation and Engagement**

5.9.1. The content of our BCF plan has been discussed with acute and community commissioners and service providers as an integral part of our strategic planning processes.

5.10. **Environmental Impact**

5.10.1. There are no direct environmental implications from noting the recommendations**.**

6. Background papers

6.1. 2022-23 Better Care Fund: Policy Framework
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2022-to-2023

6.2. Better Care Fund Planning Requirements for 2022-23
https://www.england.nhs.uk/wp-content/uploads/2022/07/B1296-Better-Care-Fund-planning-requirements-2022-23.pdf

BCF narrative plan 2022-23

Health and Wellbeing Board

BARNET

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

Barnet Adult Social Care -Head of Transformation NCL ICB- Urgent & Emergency Care Board NCL -Out Of Hospital care Public Health DFG -Housing and ASC leads Admissions Avoidance service Royal Free Hospital/Barnet Hospital Central London Community Healthcare Trust

Stakeholder involvement

BCF Category leads and strategic partners have been invited to contribute to the narrative based on their area of expertise and knowledge of local activity current or planned. Other key stakeholders have been invited to comment on the plan content and provide additional information on current work in progress to support delivery of the BCF objectives.

A virtual workshop of senior managers across the system working in the areas of supported hospital discharge or admissions prevention/avoidance, was held to review the HICM self-assessment and inform the Intermediate Care demand & capacity data.

CONTENTS

1. Executive summary

Barnet Health and Well-being Board plays a key role in the local commissioning of health care, social care, and public health through developing and overseeing a Joint Strategic Needs Assessment (JSNA) that informs the Joint Health & Wellbeing Strategy (JHWS) 2021-25.

Barnet's shared vision for health and care over these 4 years is set out around 3 key areas:

- Creating a healthier place and resilient communities
- Starting, living, and ageing well
- ensuring delivery of coordinated and holistic care when people need it

The schemes within our 2022-23 Better Care Fund (BCF) plan are intended to support the delivery of programmes of work that are based on the changing health and social care landscape, and acknowledging lessons learnt during the pandemic over the past two years.

Key changes in 2021/22

Schemes within the BCF plan played a pivotal role during the covid pandemic in supporting the local health and care system in delivering the capacity required to manage the demand for services. This is especially true of those services involved in supporting the system to manage the transfer of patients being discharged from hospital into community settings in a timely and safe way, or those community-based services delivering care and support to residents in their own homes to reduce the need for hospital admission.

An example is the One Care Home team which was introduced during the pandemic to provide clinical in-reach to care homes in the borough, to facilitate supported hospital discharge.

Reablement services have also been enhanced with additional capacity, and the planned introduction of a therapy led service model.

Barnet has recently launched a Frailty MDT across all seven PCNs. The service model provides personalised, proactive, and holistic care for patients over 65 years who are identified as frail, with the aim to reduce the risk of harm requiring hospitalisation. The Frailty Working Group has now reviewed various models across the system and engaged with stakeholders to design a finalised model and workforce structure to take forward.

Priorities for 2022-23

The national BCF objectives for 2022-23 are to:

- Enable people to stay well, safe, and independent at home for longer.
- Provide the right care in the right place at the right time.

National condition four of the BCF has been amended to reflect these two objectives and requires HWB areas to agree an approach within their BCF plan to make progress against these objectives in 2022-23. There is also an additional focus this year on whether Intermediate Care capacity reflects local demand levels for services.

Barnet's BCF allocation has been aligned with delivery against these objectives and the impact of each funded scheme will be reviewed during 2022-23 to ensure on-going relevance to achieving the required BCF objectives. There is a particular focus this year on services that prevent/reduce the number of hospital admissions by maintaining the person in their own home.

Work with Housing colleagues has commenced at both a strategic level as part of the ASC reforms implementation to integrate the housing, health, and social care response; and at an operation level by integrating housing officer expertise in the IDT planning from hospital for people without permanent housing.

The detailed BCF planning template demonstrates the breadth of our current BCF plan in investing in commissioned out of hospital services including:

- The plan funds not only NHS community services and social care services, but a range of prevention services such as the delivery of the Ageing Well programme and the Enhanced Health in Care Homes (EHCH).
- Specific local services such as the development of Dementia Hubs and dementia friendly communities; carers assessment, support, advice, and respite services; assistive technology in the home and work to promote digital inclusion; and the provision of dignity in palliative/end of live services.
- 'Access to Care' pilot as a new joint initiative between CLCH and the ASC admissions avoidance team to provide a holistic response to reduce hospital ED activity
- iBCF continues to play a crucial part in enabling the system to mobilise services to support more people to be discharged from hospital when they are medically ready, by ensuring that the social care provider market has the capacity and the clinical support to facilitate safe transfer.

2. BCF Governance

The Health and Wellbeing Board (HWB) continues to oversee the Better Care Fund and sponsors the Barnet Joint Health and Wellbeing Strategy to tackle local population health challenges and drive forward work to reduce inequalities in the borough.

In addition, our local HWB takes a leadership role in the Barnet Borough Partnership to promote the integration of services across health and care and improve outcomes for the borough's population

The HWB has delegated the oversight and delivery of the BCF plan to the Health and Wellbeing Board Joint Executive Group (HWBJEG). This includes monitoring the overall budget management, decision making and problem solving about funding allocation, ensuring delivery of metrics and reporting requirements and other key governance decisions. The Health and Wellbeing Board has also approved a scheme of delegation for the management of pooled budgets within an overarching Section 75 agreement.

The HWBJEG is co-chaired by the Director of Adult Social Services and the Director of Integration, North Central London ICB, and is made up of commissioning and operational colleagues at Director level to provide strategic oversight and scrutiny.

The HWBJEG meets quarterly and has a well-established and effective programme of work structure, designed to ensure that there is transparency and momentum in the delivery and review of the agreed BCF funded schemes. Reporting attendees include finance and BCF scheme leads (including the DFG lead) as set out within the BCF planning template.

BCF Scheme leads will be responsible for linking with local system partners (i.e. Acute, Community health services, Primary care, Voluntary and Community Sector, and Housing) to monitor progress either directly with service providers or via established system meetings such as the Barnet Borough Partnership, A & E Delivery Board, Housing Integration Group, and scheduled service provider contract meetings within the ICB Governance.

Finance and performance are monitored monthly against the BCF spending plan, alongside regular highlight reports from scheme leads to reflect on performance data, demand and capacity pressures and potential areas for future investment based on emerging best practice.

The Joint commissioning team (*BCF scheme 33)* provide the co-ordinating, monitoring, and support function to the BCF scheme leads and HWB Joint Executive Group, to enable integration at both a strategic and operational level.

During 2022-23 as part of the work on the implementation of the ASC Reforms, Barnet has established work to integrate Housing into local health and care strategies, with a focus on increasing the range of new supported housing options available. This will include the commissioning of accommodation and support for single homeless with MH needs, who are one of the complex care groups which result in delayed transfers of care from acute hospital settings.

The HWBJEG has committed to review current levels of investment and allocation of BCF funding in Q3/4 2022-23, to ensure continued relevance of schemes to delivery against the BCF objectives, and to identify prioritisation for future investment based on new service demand and evidence of impact.

3. BCF plan 2022-23

3.1. Barnet approach to integration

Integrated care is about providing people with the support they need, in the right place and at the right time, and delivered through joined up working across partners. The Covid-19 pandemic has underlined the importance of collaboration between health and care organisations, local authorities, and voluntary sector partners.

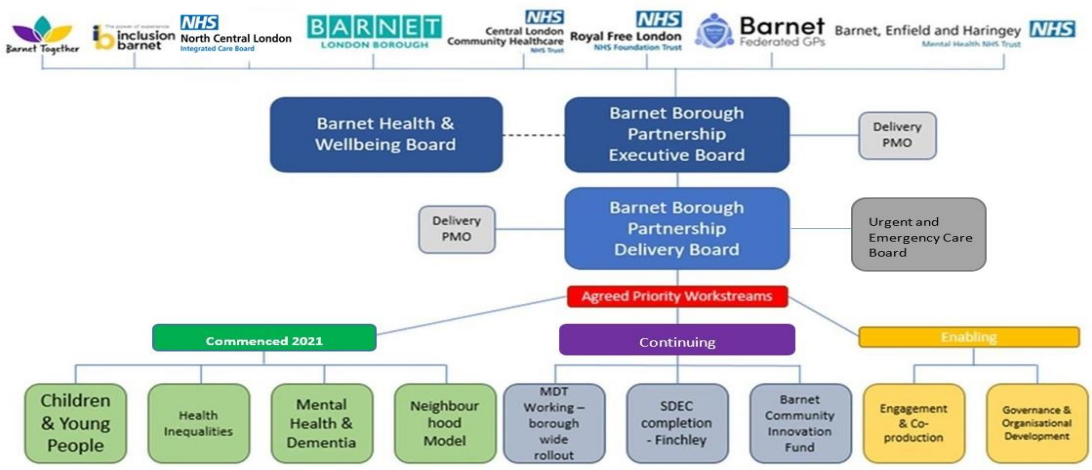
The Barnet Joint Health & Wellbeing strategy sets out our whole system place-based vision until 2025 for improving the health and wellbeing for those who live, study and work in Barnet around three key areas of focus. These key areas are:

- Creating a healthier place and resilient communities, which includes commitments to; integrate healthier places in all policies, create a healthier environment and strengthen community capacity and secure investment to deliver healthier places.
- Starting, living, and ageing well, which includes commitments to improve children's life chances, promote mental health and wellbeing, get everyone moving, support a healthier workforce and prevent long term conditions.
- Ensuring delivery of coordinated and holistic care, when we need it, which includes commitments to; support digital transformation of services, enable carers health and wellbeing and deliver population health integrated care.

Barnet works closely with strategic partners across North Central London (NCL) ICB to develop a strategic system-wide plan for transforming the health and social care system. Joint working on this wider footprint will help in addressing the complex challenges we each face and improve the health of the population, and the NCL Population Health Plan is currently being developed. This will form a central driver for commissioning and provision of services via our emerging Barnet Borough partnership.

The Barnet Borough partnership will enable the health and social care organisations to tackle complex challenges through collaboration on key issues including:

- Supporting those with long-term health conditions or mental health issues
- Acting sooner to help those with preventable conditions
- Caring for those with multiple needs as populations age
- Getting the best from collective resources so people receive care as quickly as possible
- Improving the health of children and young people
- Supporting people to stay well and independent



The on-line Joint Strategic Needs Assessment (JSNA) is the evidence base for understanding population-level need in Barnet. It is designed to inform joined up decision making and commissioning by the Barnet Health and Wellbeing Board, Barnet ICB & Borough Partnership, Adult Social care, Public health, Voluntary & Community Sector, and private sector service providers. The information within the JSNA was last refreshed in November 2021 and will continue to be refreshed on a routine basis.

3.2. Achievements in 2021-22

BCF funding continues to support an integrated approach to the effective management of patient transfer in Barnet between acute and community settings and has increased the system's ability to enable residents to be supported in their own home, through the delivery of the right care at the right time.

Reablement

National statistics evidence that reablement is an effective strength-based approach to supporting the successful delivery of the right care in the right place.

In 2021-22 Barnet has further developed the reablement offer and now all clients discharged from hospital requesting social care support are offered a reablement service for up to six weeks giving them support during the recovery period. In total 1,859 reablement episodes were provided (an increase of 85% compared to previous years 1,002 episodes) of which 62% of clients did not need any further support beyond the six-week provision, and a further 20% required decreased support of care provision.

The reablement service pathway (D2A Pathway 1) has therefore been enhanced through BCF investment (*BCF scheme 21)* to provide additional resources to extend the support offer of a home-based response post-discharge rather than transfer to a bedded facility. This enabled the commissioning of 200 additional hours of reablement provision per week from one local provider to support the safe discharge of residents from hospital back into community settings.

A new service model for reablement has also been planned for implementation from September 2022. This model proposes that occupational therapists are based within the

Assessment & Early Intervention Team (AEIT) to facilitate a reablement ethos at all stages in the customer journey. It is also proposed that the reablement support provider will employ one or more lead practitioners who will be directly supported by the AEIT OTs to fulfil key functions both during hospital discharge and in the 91 days post discharge.

Prevention/Early Intervention

The BCF funds the Barnet Age UK Neighbourhood Services contract (*BCF scheme 8)* to support older people in Barnet (both those that are Care Act eligible and those who are not) to remain well and living independently ay home for as long as possible.

It provides four key service elements:

- Neighbourhood Services - localised activities for older people to support their mental and physical wellbeing by reducing isolation and keeping people active and connected
- Handyman Service- small building repairs, minor adaptations + general home safety checks
- Falls Prevention Activities– exercise classes, including strength, balance and Tai Chi and advice about falls prevention
- Later Life Planning - helps people plan for later life and for life after retirement

The introduction of the CLCH One Care Home inreach team during the covid pandemic, has enabled residential care providers to feel able to consider new admissions/readmissions from hospital for residents with complex health needs.

3.3. Joint priorities for 2022-23

The Barnet Borough partnership has agreed 4 key workstreams for focus during 2022-23:

- Mental Health and dementia
- Frailty
- Tacking Inequalities
- Neighbourhood model

The implementation of Adult Social Care reforms this year, will also impact on how integrated working with health and housing partners will need to be revised to ensure a co-ordinated response to the commissioning and delivery of provision outside of hospital.

Key milestones for the ASC reforms work include:

- Updated Adult Social Care Outcomes Framework (Autumn 2022)
- Development of sustainable care markets that includes conducting a Fair cost of care exercise (submission October 2022)
- New adult social care assurance regime – inspections begin October 2023

As services begin to emerge from the covid pandemic, it has been decided to not adjust the BCF scheme allocation in 2022-23. The intention is to review all current schemes over winter 2022 with regards scrutiny of the impact of delivery against the key BCF objectives, in preparation for the planning of the expected two-year BCF investment plan from 2023-24.

4. Implementing BCF Policy Objectives (national condition four)

National condition four requires Barnet to agree an overarching approach to meeting the BCF policy objectives as follows:

4.1. Objective 1: Enable people to stay well, safe, and independent at home for longer

(Barnet BCF schemes: 4,5,7,8,9,13,14,19,23,24,25,26,27,28,29,31,32,33,34)

BCF continues to support Barnet to diversify its accommodation related support offer to enable more people to live independently through increasing local supported living options for younger adults and developing new extra-care facilities for older adults.

Assistive Technology (*BCF scheme 32*) & Community Equipment (*BCF scheme 31)*

In support of Barnet's prevention agenda and to maximise independence, the partners work hard to promote the use of assistive technology and equipment. BCF is utilised to implement assistive technology services and evidence-based preventative support including the provision of community equipment, to reduce the risk of people requiring inpatient hospital care and enable them to continue living in their own home. At the end of Q4 2021/22, the following numbers of residents were supported:

Assistive technology	**Full year 2021/22**
Installations	1,798
Total number of live connections	3,722
Community Equipment	
No of residents supported	6,316

Integrated Service Delivery

The work on integration of health and social care delivery to provide a holistic response continues to develop in different ways to ensure we best meet the needs of local people. This includes the BCF funded single point of access (SPA) (*BCF scheme 28*) to community health services provided by Central London Community Healthcare Trust (CLCH) multi-disciplinary team working with frail elderly clients; and facilitating seven-day working in both acute and community teams to support safe hospital discharge. This is also demonstrable through the integrated work delivered by the Care Quality Team (*BCF scheme 4*) in conjunction with the CLCH care homes in-reach team.

In primary care, BCF supports the PCNs in delivering the Frailty MDT (*BCF scheme 34*), and the Locally Commissioned Service (LCS) for Enhanced Health in care homes programme (*BCF scheme 7*).

At a system level, the Barnet Borough Partnership Neighbourhood model aims to bring about a shift in the culture of how people approach health and care, making the offer more person-centred and enabling residents to develop more personal resilience and increased confidence in self-management of their health & wellbeing.

Community based support

The BCF Community based Support (*BCF scheme 13*) offer includes the Barnet Urgent Community Response (previously known as the Rapid Response service) works closely with the commissioned care technology provider to facilitate pendant alarm referrals for falls pickup, supporting the delivery of care in a community/home setting rather than a London Ambulance Service (LAS) conveyance to acute settings (where appropriate).

The North Central London ICB Silver Triage services delivered by consultant geriatricians working in acute and community locations, is a system wide initiative across the NCL footprint with shared clinical operational and information governance. It is a new model of pre-hospital emergency care, that aims to work in partnership with the LAS to reduce the number of hospital conveyances for older people living with frailty, especially those who live in residential care or nursing homes. Based on the principles of shared decision making, advance care planning and risk benefit analysis to determine whether somebody needs to be conveyed to the emergency department, it promotes that their care needs can be met through an alternative intervention. *BCF schemes 15 and 34* complement and enable this approach.

The fracture liaison service (*BCF scheme 14)* works with frail elderly to prevent fractures as a result of osteoporosis and provides direct referrals to the specialist falls clinic.

Mental Health advocacy services (*BCF scheme 27)* provide access to independent support for someone to:

- Find out the views / feelings / beliefs of the person.
- Represent and support the person in relation to their 'best interests'.
- Make sure that the person can participate in the decision-making process

Steps to personalise care and deliver asset-based approaches

Barnet is committed to a strength-based approach and identifying ways to make people's lives significantly richer and more rewarding as a result. Every social care member of staff is expected to demonstrate practice that is person-centred, reflective, creative, and informed by the wide range of ways in which residents of the borough can have greater choice and control of how their support needs are met.

The Neighbourhood model supported by direct payments/self-directed support (*BCF scheme 9*), will adopt a strength and asset-based approach across all teams working within localities so that health, housing, and social care collaboratively identify the resources that both people and places have, and gain a better understanding of what a 'good life' means for local communities. The neighbourhood programme group and governance structure will lead this programme of work, supporting local providers as they plan and implement changes and ensure consistent quality across the various projects being undertaken.

The BCF Barnet Integrated Frailty MDT model provides the foundations of a neighbourhood model. It will deliver personalised, proactive, and holistic care for patients over 65 years who are (or at risk of) moderately and severely frail. The Frailty Working Group have now reviewed various service models across the local system and engaged with stakeholders to design a finalised model and workforce to take forwards.

CLCH trust are developing new roles to provide a dedicated pan-Barnet Frailty multi-disciplinary team (*BCF scheme 34),* including dementia nurses and advisors, and frailty nurses/ case managers and therapists. The team will contribute to the Frailty MDT meetings and case management and deliver proactive care in the community, with the continued engagement and support from secondary care and the voluntary care sector to ensure a holistic, integrated model which is intended to launch during 2022.

Integrated Frailty MDT Service-building foundations of neighbourhood model working

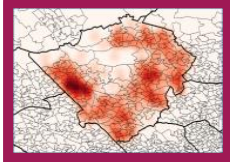
NCL ICB are in the final planning stages of implementing a generalised Long-Term Conditions Locally Commissioned Service (LCS) which aims to radically change the local approach of PCNs to population health management, focussing on secondary prevention of respiratory and metabolic long-term conditions at a neighbourhood level. This work will start with a partial baseline year in 2022/23 focussing on preventing hospital admissions in those with multiple morbidities and reducing ambulatory care sensitive condition admissions.

A particular focus of the Barnet HWB is to use a community asset based approach in an area of the borough with high levels of deprivation. This is a project targetting the reduction of hospital admissions for residents on the Grahame Park estate who substance misuse,through increasing outreach services and co-producting the planning of interventions with the local residents.

Grahame Park Neighbourhood Model

2022-23

Case Study: Substance Misuse Outreach Services



Hospital Admissions for Alcohol-attributable Harm (SAR), 2019

Hospital admissions for alcohol -attributable harm are high in Grahame Park.

1. The *Health Needs Assessment* identified higher rates of substance misuse in Grahame Park.
2. We approached stakeholders, who complained that the monthly outreach services provided by Change, Grow, Live were too infrequent.
3. A *Mental Health Deep Dive* was completed for Grahame Park, which investigated substance misuse further to determine whether more outreach was equitable and justified.
4. Public Health looked at the feasibility of increasing the frequency of outreach services.
5. Change, Grow, Live will visit Grahame Park on a weekly basis going forwards, and are being hosted by Colindale Communities Trust, an organisation based on the Concourse.

Next Steps for the Neighbourhood Model

- Building relationships with the community. We are working (in forums like the Grahame Park Strategy Group) to build trust.
- Confirming our priorities for the Neighbourhood Model. We are confident that this will include mental health and wellbeing and preventing cardiovascular diseases.
- Coproducing interventions with residents. After confirming our priorities (i.e. mental health), we will engage with residents to understand, for instance, the barriers to accessing existing mental health services, whether crisis support or early intervention is more appropriate, and which groups struggle most with stigma around mental health, etc.
- Working closely with the Barnet Borough Partnership to refine neighbourhood working.

Health & Wellbeing Board will visit Grahame Park in September, and we will go into greater depth at this meeting.

4.2. BCF Objective 2: Provide the right care in the right place at the right time

(Barnet BCF schemes 1,2,3,6,10,11,12,15,16,17,18,20,21,22,28)

The commissioning priorities in Barnet for adults (including those with dementia) during 2022/23 are as follows:

Prevention & early intervention

The Barnet memory clinic (*BCF scheme 10)* provides an early intervention function through earlier identification of the signs of dementia that enables the provision of timely advice and planned interventions in the community to support the person and their family.

Intermediate Care

The approach to safely managing patient discharge from hospital continues to be based on a home first approach, or where that is not possible to discharge to assess once the person is medically optimised to a step-down rehabilitation bed where their recovery can be supported. BCF *scheme 6* provides the oversight for those decisions, with *BCF scheme 17* facilitating the bed-based provision to enable the longer term of assessment of support needs to happen in an enabling environment.

Supported Accommodation

Barnet will continue to work with the service provider market to develop new models of accommodation and support, ensuring that there is sufficient and diverse housing and support provision to meet the needs of adults, enabling them to be appropriately supported to remain independent and to maximise their wellbeing. The new Supported Living (*BCF scheme 16*) framework has gone live from April 2022.

Residential Care

Despite the ageing population, current policy recognises that the number of care homes in Barnet may decline, as people are supported to continue living in their own homes for longer. This is reflected in Barnet's Housing Strategy which aims to make it easier for older residents to plan ahead to ensure that they have choices when their current home no longer meets their needs. Residential Care Home Provision (*BCF scheme15*) forms part of the support offer to the system to facilitate the delivery of step down and short-term step-up care in the community.

Nursing care

A growing demand has been identified for care homes that can provide complex care for conditions such as dementia and nursing services. Work is underway at an ICB level (between providers and commissioners) to co-design/co-produce a pathway model, with the aim of going live with a support offer to support the wider avoidable admissions avoidance work.

The plan is to increase the number of registered nursing care beds available within the borough, so that there is sufficient capacity in our local market to provide the right support to adults for older people with complex needs needing nursing care in a care home setting.

Extra care schemes

Barnet will continue to develop more extra care housing and support services in the Borough to support independence and provide flexibility for residents with increasing support needs to live in their own home. Two new schemes are expected to be available for 2023-24: Atholl House in Burnt Oak is due for completion in January 2023, and Cheshire House in Hendon is due for completion in March 2024.

Live in Care

The commissioning framework for provision to establish the option of 'Live-In care' to provide 24hours support within the person's own home is currently in the development. This support

option is especially aimed at residents with more complex support needs who wish to continue living in their own home and should be available in 2023.

Community support

Further opportunities are being considered to strengthen support in our communities for adults with dementia or with extreme frailty, preventing support needs from escalating, and thereby reducing the numbers of preventable admissions into hospitals or nursing care.

Adult social care has transformed traditional day care provision (*BCF scheme12***)**, so that people have more support to access employment and volunteering to support social inclusion and economic well-being. We are working to improve personal outcomes for people accessing day opportunities, with a focus on skills progression and achieving their personal ambitions.

Winter resilience funding (*BCF scheme 18)* provides the additional capacity in the system to mobilise additional support within the community to enable the person to be supported appropriately in the most suitable environment for them individually through person centred delivery of either short-term support through reablement, or long-term support through home care or residential care.

Home care

BCF schemes 11 and 19 aim to ensure that homecare services which currently support many residents to remain more independent for as long as possible, and support people as part of the hospital discharge to assess(D2A) pathways are also able to provide the right level of support to adults with dementia and more complex needs.

Reablement

The BCF plan currently contributes to the delivery of a reablement service (*BCF scheme 20*) in Barnet. As part of this service development, Therapy-led (OT) reablement across the hospital discharge pathways is being introduced in September 2022. The project will begin with occupational therapists based in the AEIT team supporting our contracted reablement providers, 'Your Choice Enablement' and 'Bliss Care', to achieve high standards of enablement practice and improved recovery outcomes for service users.

Admissions avoidance

Funding from the BCF is used to provide additional capacity in the local schemes supporting patient flow and admissions avoidance (*BCF scheme 29*). A pilot scheme has been introduced in 2022/23 as a collaboration between GPs, Urgent Community Response team and adult social care. The *Access to Care* service as a new joint initiative between CLCH Trust and the ASC admissions avoidance team, will work to provide a holistic response to reduce unnecessary transfers to A & E, and enable the person to receive the care and support required to remain in their own home.

Homeless/No Fixed Abode

Barnet as part of the NCL ICB is currently one of 17 national pilot sites in the UK, developing new discharge pathways for patients who are homeless or of no fixed abode as part of the Out of Hospital Care model. There is a designated move-on co-ordinator linked to each acute hospital for each borough, who through developing closer partnerships with housing officers to improve discharge outcomes and prevent readmission, provides holistic planning support to the person. Analysis will be conducted in 2022-23 to consider how BCF investment could support this function once the pilot ends.

High Impact Change Model

Barnet has carried out a refresh of our self-assessment of the implementation of the High Impact Change Model for managing transfers of care with our strategic delivery partners and have jointly agreed the following actions for improving future performance.

High Impact Change	Self - assessment 2022-23	Achievements	Future actions
1.Early Discharge planning	Mature	Discharge planning and the red bag system is business as usual across the system	Work on integrating housing planning for No Fixed Abode patients as part of early discharge planning.
2. Monitoring system demand and capacity	Established	A & E delivery board provides a co-ordinated system oversight of demand and capacity. NCL UCR delivery group monitors operational activity weekly to divert patients from LAS	Proposal for allocation of winter funding to improve diversion of patients from LAS to UCR services by early screening of referrals.
3. Multi-disciplinary working	Mature	MDT working operates in numerous parts of the system to provide an effective holistic response to discharge planning/admissions avoidance	Further development of in-reach services by MDTs to hospitals/LAS.
4. Home First D2A	Mature	Decisions about long-term care are not made in hospital settings.	Further work required with LAS and acute settings to facilitate home being fully seen as a safe alternative to bedded care.
5. Flexible working	Established	Increase in seven-day MDT provision to improve system flow	Further work required to achieve optimum response from res care, transport, and pharmacy providers to support smooth discharge at the point patient is ready to return home
6. Trusted assessment	Mature	There are dedicated posts within the main acute hospital, and we have introduced additional capacity in 2022-23 with the clinical inreach team delivered by the NHS community service provider.	Across NCL there is work planned to establish a sector wide service model to share resources and provide equity of response.
7. Engagement and choice	Established	Advice and information in place and choice protocol implemented. Red Cross commissioned to support home from hospital approach.	Work required to empower people and their families to manage their own discharge planning.
8. Improved discharge to care homes	Established	Clinical inreach to care homes to support safe discharge for people with increased acuity across seven days a week and manage new admission assessments.	Improvement seen in unnecessary admissions from care homes, particularly on evenings and at weekends.
9. Housing related services	Plans in place	NCL is part of a national pilot scheme during 2022-23, which places a Housing discharge support officer as part of the local hospital discharge planning team, working alongside the move on co-ordinator.	Consideration of a business case development for BCF funding to consolidate new service provision once pilot ends where evidence of impact is demonstrated.

The BCF Intermediate care demand and capacity analysis and the outcome of the 100-day challenge, will be used by the HWBJEG and A & E Delivery Board to consider how collaborative working can further support the maturity of the HICM in Barnet.

5. Support for unpaid Carers.

The current Barnet Carers strategy focuses on three priority areas:

1. Proactive identification of carers
2. Individualised support so that carers can maintain their own health and wellbeing
3. Recognising carers as key partners in care and support and recognising the important role they play in helping to support and manage the demand on statutory services.

From the Personal Social Services survey of Adult Carers in 2021-22 (SACE) the following findings were reported for Barnet

36.0% of those who had received services in the past 12 months were extremely or very satisfied with those services. ▲ from 34.1% in Barnet compared to 35.2% in London and compared to 38.6% in England in 2018-19.

10.7% were extremely or very dissatisfied. ▲ from 7.3% in Barnet, (8.1% in London and 7.2% in England in 2018-19).

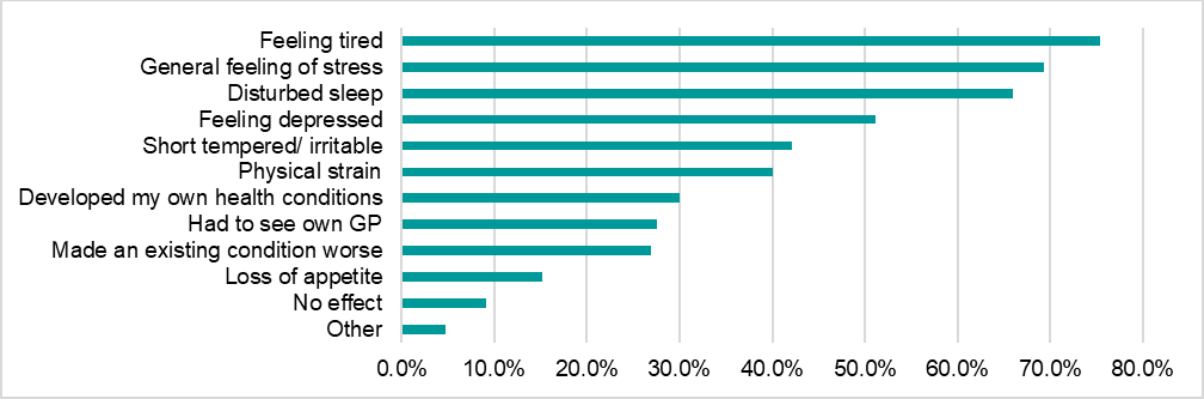
45.9% of carers felt that their caring responsibilities caused them no financial difficulties. ▲ from 40.1% in Barnet (48.1% in London and 53.4% in England 2018-19).

9.9% of carers said that caring caused them a lot of financial difficulties. ▼ from

75.4% of carers reported that caring caused them to feel tired, ▼ from 79.7% in 2018-19.

Other commonly reported effects of caring were feelings of general stress (67.3% ▲ from 62.3%) and disturbed sleep (64.1% ▼ from 76.1%)

Chart 1: Over two thirds of carers reported that caring caused them general feelings of stress



BCF supports services for carers in Barnet which act as a key component in the local early intervention and prevention offer, by enabling carers to have access to information, advice and support that promotes and maximises their health, wellbeing, and independence; and

providing access to respite provision that enables the carer to take care of their own health & wellbeing.

Most of the carers in Barnet provide care for a person with a physical disability (50.7%), followed by those caring for someone with dementia (37.6%), and then those residents with a long-term illness (37.6%). These figures total over 100% which reflects that some carers are caring for people with multiple health conditions.

BCF delivers the main contract for the provision of carers and young carers support services with Barnet Carers Centre (*BCF scheme 25)*, which is currently for a term of five years commencing on 1st April 2022. This provides the Carers assessment duties under the Care Act 2014 and delivers the Adult Carers emergency card scheme which provides peace of mind through the immediate provision of support for the first 48 hours following a carer emergency, pending longer term support being arranged.

A particular focus for BCF in 2022-23 continues to be developing support for unpaid carers of people living with dementia through the specialist dementia support service *(BCF scheme 24*). Barnet's offer includes a range of dementia community support, and the development of a dementia friendly alliance with the aim to embed dementia friendly communities throughout Barnet.

Achievements in 2021-22

The covid pandemic resulted in Barnet looking at how we deliver support and work with partners to ensure that people with dementia and their carers could be actively supported and continue to receive the care and support that they need throughout the lockdown period. Changes introduced at that time have resulted in changing the longer-term delivery models for dementia support in Barnet to ensure that the offer is more inclusive and can become more diverse.

In addition to strengthening the current dementia pathway and services, Barnet is embedding a more proactive model of care and support for people affected by dementia and their Carers, aiming to prevent avoidable crises and promote and maximise carer's own health, wellbeing, and independence.

Those who have attended the Dementia support service have reported –

"Very good and helpful, discussing our problems without being judged."

"Gradually I felt I was not alone, we had similar problems and issues that we can manage to come to terms with and accept the situation. The group support helped enormously".

"It was the first time I asked for help, I was promptly given advice and help I desperately needed, the sessions were wonderful for me with my husband"

Those staff working in the dementia service report that, seeing how intervention by the team can change the lives of people from a place of not coping to feeling able to cope gives great job satisfaction.

Priorities for 2022-23

The key priorities for Barnet this year are to:

a) Continue to develop our dementia support offer through:

- further integration with VCS and partners
- improving consistency of information and advice provision across the services in the Borough
- embedding dementia friendly communities
- improving early access to timely diagnosis
- delivering individualised and tailored support that is person centred to maximises people's independence, health, and wellbeing.

The initiatives introduced are still in the early stages of implementation, and more time is required to evaluate the wholescale impact of the changes being introduced, although the initial feedback from staff and residents involved has been extremely positive. The changes introduced have resulted in excellent collaboration with partners and our communities and we are building on the initial practices to continue to develop and build dementia support in Barnet and embed a new service model which is truly proactive, preventative and person centred.

b) Strategic review of Carers' respite provision

The BCF also delivers the respite provision for carers in the borough (*BCF scheme 26)*, which provides actual practical support to sustain them in their caring role.
There is work planned for 2022-23 to review and gain a better understanding of demand and capacity of the current respite provision, and to determine the required options going forward that increase choice and reflect the changes in demand.

6. Disabled Facilities Grant (DFG)

In preparation for Adult Social Care reform and in response to the new guidance on DFGs, Barnet's Housing integration plan covers both the assessment and monitoring of property adaptation needs. Specific work includes a deep dive into health equalities which will provide a better insight into impacts on life outcomes for groups with protected characteristics.

Achievements in 2021-22

The breakdown of support provided during 2021-22 from use of the DFG (*BCF scheme 23)* is shown in the table below. Where the description indicates a combination of items, this indicates a single contractor provided several adaptations to the same customer, but again most of this multiple work included the provision of level access showers.

Number	Description
6	Door Entry System
69	Level Access Shower
4	Extension
1	Scooter Store
7	Closomat toilets
3	Ramps
12	Stairlift
28	Combination of Items
2	Through Floor Lift
6	Ceiling Hoist
2	Safety Features
1	Shower Toilet Cubicle
1	Drop Kerb
2	Over Bath Shower
2	Kitchen adaptations

In response to market pressures, we have uplifted the approved DFG schedule of rates for 2022-23 and have continued to invest in assistive technology and equipment. We are actively jointly reviewing our housing strategies and policies and working closely with partners to join up key areas of activity so that residents with care and support needs, have an adequate choice of alternative housing and support options.

The DFG lead has initiated a review of the local housing assistance policies recognising that a refreshed policy with new investment will contribute to the health and well-being of residents by enabling people to live with greater independence in secure, safe, well-maintained, warm, and suitable housing. This includes close working with partners to

- tackle hoarding and insanitary housing
- enable affordable warmth through link to trialling of low carbon heating,
- identify and remedy defects impacting on the health, safety and wellbeing including risks of slips, trips, falls or accident.

Other activity that the DFG team are currently engaged in as part of the integrated approach with strategic partners includes:

- Funding adaptions in council housing stock

- Considering design options and guidance for new build housing delivery model
- Review of housing allocations policy and process to facilitate move-on and additional prioritisation of disabled residents
- Mobilisation of housing with support service contract, to provide greater quality assurance through the verification of approved providers
- Joint review of Barnet Housing strategy and Adults Right Home Strategy
- Continued expansion of Extra care housing programme

Challenges

In 2021-22 the total number of referrals from OTs was 249, which resulted in DFG funded works being completed for a total of 146 clients.

Barnet recognise that a barrier to the use of DFG can be where additional repair and improvement works are identified by our occupational therapists and the private sector housing team, which would need to be funded by the resident. This may limit the effectiveness and practicability of DFG for some clients.

During 2022-23 we will consider possible interventions and how processes can be strengthened and streamlined to enable greater take up of the DFG funding by residents.

7. Health inequalities

Although the health of residents and life expectancy for both men/women in Barnet is generally better than the England average, around 14% (9,700) of children live-in low-income families, and on average people spend the latter 22 years of their life in ill-health.

Life expectancy at birth in females (86.0 years) is higher than males (82.9 years). However, there are inequalities in life expectancy in Barnet by gender, locality/ward, and the area level of deprivation. For example, a man living in Burnt Oak on average lives 8 years less than a man in Hampstead Garden Suburb.

Smoking, poor diet, alcohol, lack of physical activity and high blood pressure are the most common causes of major illnesses leading to premature mortality and hospital admissions.

70% of Barnet residents are from an ethnic background other than White British. The COVID-19 pandemic highlighted the variations and gaps in our local health and wellbeing area that result in health inequalities. Our plan for addressing this is based on collaborative working via NCL sector-wide partnerships and our local place-based Borough partnership that aim to deliver high impact solutions.

Achievements in 2021-22

The focus on health inequalities in 2021/22 was delivering on two core priorities: childhood immunisations and cardiovascular disease prevention. Initial action on the latter was to establish a *Healthy Heart Peer Support* project, supporting and enabling people from South Asian, Black African, and Black Caribbean communities to better manage their own CVD conditions, starting with a focus on monitoring raised blood pressure.

The Healthy Heart Peer Support Project
Our peer support programme will offer community members the chance to meet other people from their community who share the same risks.

We know that by connecting people that share similar experiences, that this will assist them to learn together and can enable them to make changes to improve their heart health and maintain it.

What the project will deliver:
- Helping communities to understand the risks of high blood pressure,
- Guidance on how to monitor their blood pressure
- Access to the support needed to manage their blood pressure

Over the past year, Barnet also trialled BCF schemes for frailty and dementia MDTs (*BCF scheme 34)* in two local PCNs. Taking the learning from these pilots, the framework for a combined frailty / dementia MDT model is now being implemented across the Borough. Our wider seven-day social care support (*BCF scheme 1*) and seven-day community health provision (*BCF scheme 2*) and seven-day acute discharge team (*BCF scheme 3)* have supported the system to ensure that residents receive care and support at the right time and in the right place.

Through our Prevention and Early Intervention pathways (including *BCF scheme 30*) we have continued to roll out our social prescribing programme which supported 5689 patients in 2021-22. Of these 31% (1764) were people aged 65+, and of these, 27% were referred to carers support, 10% for social care assessment and 16% supported to address social isolation and loneliness. We also investigated ways to extend social prescribing to patients seen by

geriatricians at Barnet Hospital, which resulted in clarified referral pathways to help reduce or prevent hospital admissions.

At a whole population level, the Fit and Active Barnet (FAB) framework provides a key mechanism for tackling stark health inequalities with regards poor diets and low physical activity levels. The refreshed FAB Framework builds on successes of the last five-year period (2016–2021) such as the delivery of inclusive interventions such as wheelchair rugby, dementia swimming and multi-sports sessions for residents who have been previously excluded from mainstream sports activities.

Priorities for 2022-23

The approach that NCL ICB adopted for tacking health inequalities is to build on local place-based initiatives within the Borough partnership arrangements to complement, rather than duplicate, the existing Council & Public Health-led statutory and voluntary sector initiatives within Boroughs. To support this approach, the ICB is developing VCSE and Community Empowerment Strategies and action plans (with its VCSE Alliance partners) that emphasise a 'nested' and complementary approach to planning across a multi-geographical footprint, including developing community investment and infrastructure opportunities.

The ICB has committed £5m to fund preventative and proactive initiatives to improve equity of access, outcomes & experience to health & social solutions with NCL's under-served (particularly residents in its 20% most deprived & often most diverse neighbourhoods) communities and groups in 2022/23. This *Inequalities Fund (IF) Programme* is administered centrally but the projects are decided upon between partners in the Borough Partnerships, with several cross-Borough projects, and funding proportionate to need for individual Boroughs. This is part of a refreshed approach to placing residents at the centre of design & delivery of solutions to improve their health, well-being & life chances as part of our overall approach to population health and Core20Plus5 and ensure a more equitable access to preventative and proactive care.

There is a pilot programme underway at The Royal Free Hospital Trust to pilot a Healthy Living Hub partly funded by the IF Programme. The plan is to pilot a seamless system-wide prevention service for the population of three London boroughs (Barnet, Camden, and Enfield) overseen by multi-stakeholder steering group including community and primary care counterparts and an acute trust, co-designing, and co-developing an integrated lifestyle hub offer as proof of concept for NCL.

The NCL ICB is committed to ensuring prevention is a key element of all plans going forward and will be a central part of our *Population Health Improvement Strategy*. This is currently being socialised and will go through ICB and Borough Partnership governance during Autumn 2022. ICB have recently recruited a Public Health Consultant to the Population Health team, to ensure all strategic plans are evidenced based, and that our prevention focus aligns with the wider development of an NCL Outcomes Framework.

Cardiovascular disease Prevention Programme

As part of the Barnet Borough Partnership health inequalities workstream, we have recently launched our Cardiovascular Disease (CVD) prevention programme to reduce risks of CVD from behavioural and clinical risk factors while supporting those with long term conditions to manage their own health.

We have decided to focus on CVD because the differences in outcomes from CVD, are one of the biggest indicators of inequalities for Barnet residents. Therefore, the CVD prevention programme provides a specific and tangible focus on health inequalities, with key actions to identify support and guidance for Black African, Black Caribbean and South Asian communities, as well as people with learning disabilities and a serious mental illness diagnosis.

This CVD programme aligns with the NHS Core20plus5 by incorporating

- hypertension case finding,
- reducing smoking in pregnancy
- increasing annual health checks for people with SMI and
- a local focus on areas of deprivation.

The outcome from this work is expected to reduce admissions for ambulatory care sensitive conditions, which also feature as a target for development in our Health and Wellbeing Strategy.

Frailty MDT

In July 2022, Barnet launched the roll out of multi-disciplinary team meetings (MDTs) for residents with frailty to reduce and prevent unplanned admissions, funded through BCF. The model was first piloted in an area of high deprivation but is now extending to the rest of the Barnet. Age UK form part of the MDT team, providing support on addressing issues that benefit from a social prescribing approach.

Long Term Conditions

NCL ICB are in the final planning stages of commissioning GPs to provide a generalised Long-Term Conditions Service which will radically change the local approach by PCNs to population health management focussing on secondary prevention of respiratory and metabolic long-term conditions. This work which is planned to commence during 2022/23 will aim to prevent hospital admissions in those with multiple morbidities and reduce the number of ambulatory care sensitive condition admissions.

Digital Inclusion

Through our NCL Digital Board and in response to an Equality Impact Assessment which suggested key areas for improvement, we have agreed an ICS-wide digital inclusion framework based on developing a 'digital hierarchy of need' to tackle the underlying causes & reasons for individuals' digital exclusion and have begun to utilise the digital exclusion population mapping and personas developed through London Office of Technology & Innovation to inform our digital projects. We are in the planning phase in which we anticipate having complementary and 'nested' Council/NHS organisational, Borough Partnership & NCL ICS priorities & action plans during 2022/23. We intend to augment this planning through working with our patients and residents to understand their priorities and preferred solutions.

In the interim, 'quick win' projects in individual Boroughs have been progressed working with VCSE sector to improve individuals' digital capabilities & opportunities. In Barnet, the BCF programme (*BCF scheme 32)* mobilised a digital support offer with Age UK aimed at reducing social isolation and loneliness within the targeted 65+ population, as well as supporting the reduction of falls. This has involved supporting residents to develop digital skills through a

laptop loan scheme and digital inclusion volunteers, and access online sessions as part of the *Get active and Get Connected* Scheme.

In Barnet we identified that barriers to digital access are caused by a range of factors, and there is no 'one size fits' approach to addressing these challenges, therefore we aim to remove these barriers by:

- Investing in tools that make our current digital services more accessible to all residents.
- Providing digital literacy, skills workshops and services that support residents to build confidence in using digital tools.
- Supplying hardware and software for residents who are digitally excluded due to financial barriers.
- Working with micro and small businesses to help them get online, become a part of the digital economy, and benefit from a wider network of customers, services, and suppliers.
- Focussing on the individual needs of the resident by developing a network of digital champions and ambassadors who can identify barriers to access, support and upskill residents.
- Ensuring information and support services can be accessed through a range of different formats, so no resident is left behind.

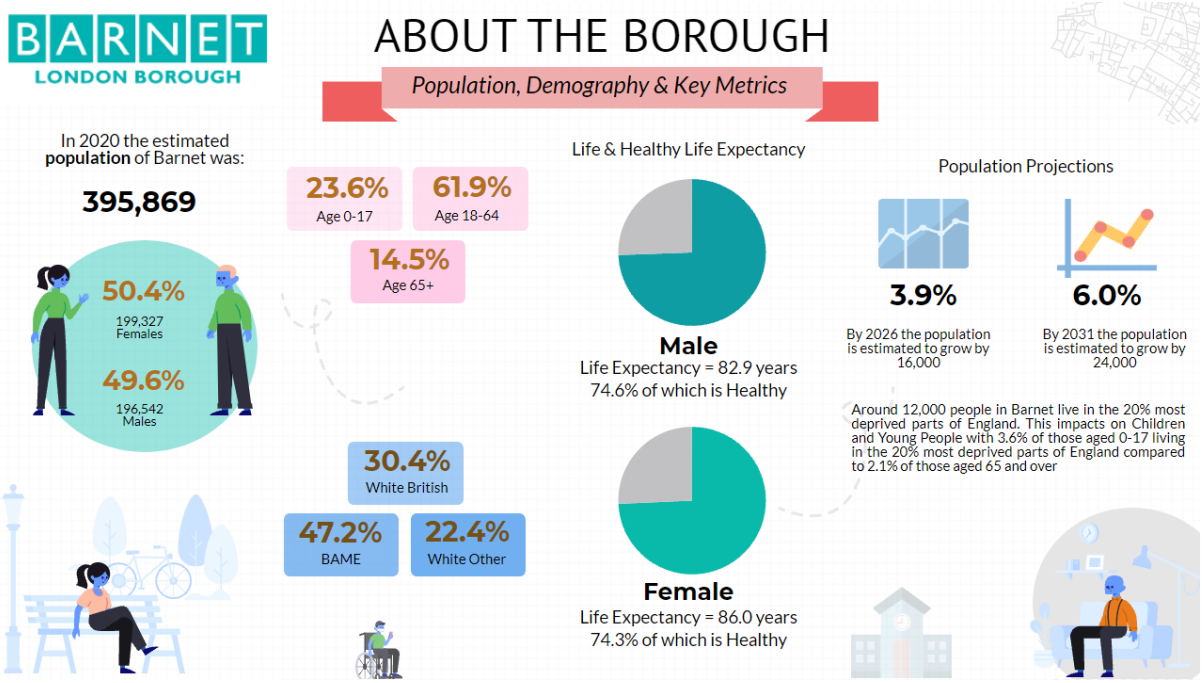
Tackling the Gaps

The *Tackling the Gaps* strategic approach has been developed to address inequalities in the borough by taking on an outward-facing, resident and partnership focused equality, diversity, and inclusion agenda. The aim is to ensure that we are both aware of and understand issues of disproportionality in the borough, and that we tackle these where applicable in policies, strategies, service delivery, procurement etc.

Council departments are expected to develop or integrate into plans specific activities which tackle the gaps in their service areas, improving long-term outcomes for residents. As a result of this work, we would expect to see a positive change in our disproportionality data sets and in relevant resident perception survey results. The work is being embedded into a range of development activity, with a particular focus on our understanding and developing how residents access support services.

Falls Prevention

The intention is to develop plans to review Barnet's local approach to falls prevention that encompasses identifying inequality in access to advice and support, through the development of an integrated health and social care strategy during 2022-23. The findings from the review will be utilised to inform the investment plan for BCF from 2023.


BARNET
LONDON BOROUGH
ABOUT THE BOROUGH
Population, Demography & Key Metrics
In 2020 the estimated population of Barnet was:
395,869
50.4%
199,327
Females
49.6%
196,542
Males
23.6%
Age 0-17
61.9%
Age 18-64
14.5%
Age 65+
30.4%
White British
47.2%
BAME
22.4%
White Other
Life & Healthy Life Expectancy
Male
Life Expectancy = 82.9 years
74.6% of which is Healthy
Female
Life Expectancy = 86.0 years
74.3% of which is Healthy
Population Projections
3.9%
By 2026 the population is estimated to grow by 16,000
6.0%
By 2031 the population is estimated to grow by 24,000
Around 12,000 people in Barnet live in the 20% most deprived parts of England. This impacts on Children and Young People with 3.6% of those aged 0-17 living in the 20% most deprived parts of England compared to 2.1% of those aged 65 and over

BCF Planning Template 2022-23

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution.

4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.

6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Conditions 2 and 3 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend under National Condition 3. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2022-23:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2022-23. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2022-23.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2020)
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value:
https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2021-22, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2022-23 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

3. Residential Admissions (RES) planning:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

4. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2022-23 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2022-23 Template

2. Cover

Version 1.0.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

Health and Wellbeing Board:	Barnet
Completed by:	Shirley Regan
E-mail:	Shirley.regan@barnet.gov.uk
Contact number:	07716 092411
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	
If using a delegated authority, please state who is signing off the BCF plan:	Chair of HWB Joint Executive Group and Chair of HWB

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Executive Director - Adults and Health
Name:	Dawn Wakeling

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Alison	Moore	cllr.a.moore@barnet.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Executive Director-	Dawn	Wakeling	dawn.wakeling@barnet.gov.uk
	Additional ICB(s) contacts if relevant	Director of Integration	Colette	Wood	colette.wood1@nhs.net
	Local Authority Chief Executive	Chief Executive	John	Hooten	john.hooton@barnet.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Director- Adults Social	James	Mass	james.mass@barnet.gov.uk
	Better Care Fund Lead Official	Health & Social Care	Shirley	Regan	shirley.regan@barnet.gov.uk
	LA Section 151 Officer	Executive Director-	Anisa	Darr	anisa.darr@barnet.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Barnet

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,884,527	£2,884,527	£0
Minimum NHS Contribution	£29,344,200	£29,344,200	£0
iBCF	£9,621,518	£9,621,518	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£41,850,245**	**£41,850,245**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£8,338,789
Planned spend	£19,079,990

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£8,767,921
Planned spend	£8,767,923

Scheme Types

Assistive Technologies and Equipment	£2,340,935	(5.6%)
Care Act Implementation Related Duties	£1,889,779	(4.5%)
Carers Services	£1,000,975	(2.4%)
Community Based Schemes	£4,180,644	(10.0%)
DFG Related Schemes	£2,884,527	(6.9%)
Enablers for Integration	£946,331	(2.3%)
High Impact Change Model for Managing Transfer of	£5,991,076	(14.3%)
Home Care or Domiciliary Care	£3,688,146	(8.8%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£426,901	(1.0%)
Bed based intermediate Care Services	£11,953,685	(28.6%)
Reablement in a persons own home	£791,873	(1.9%)
Personalised Budgeting and Commissioning	£474,854	(1.1%)
Personalised Care at Home	£1,499,494	(3.6%)
Prevention / Early Intervention	£733,420	(1.8%)
Residential Placements	£3,047,605	(7.3%)
Other	£0	(0.0%)
Total	**£41,850,245**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	0.0	0.0	0.0	0.0

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.4%	92.4%	92.4%	92.4%

Residential Admissions

		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	502	441

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	77.4%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementing the BCF policy objectives	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board: Barnet

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Barnet	£2,884,527
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,884,527**

iBCF Contribution	Contribution
Barnet	£9,621,518
Total iBCF Contribution	**£9,621,518**

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

NHS Minimum Contribution	Contribution
NHS North Central London ICB	£29,344,200
Total NHS Minimum Contribution	**£29,344,200**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	No

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£29,344,200**	

	2021-22
Total BCF Pooled Budget	**£41,850,245**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: Barnet

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,884,527	£2,884,527	£0
Minimum NHS Contribution	£29,344,200	£29,344,200	£0
iBCF	£9,621,518	£9,621,518	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£0	£0	£0
Total	**£41,850,245**	**£41,850,245**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£8,338,789	£19,079,990	£0
Adult Social Care services spend from the minimum ICB allocations	£8,767,921	£8,767,923	£0

>> Link to further guidance

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Seven day social care support	Support for 7 day a week discharge by ASC teams	High Impact Change Model for Managing Transfer	Flexible working patterns (including 7 day working)		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,113,987	Existing
2	Seven day community health provision	Support for 7 day a week discharge by NHS provider teams	High Impact Change Model for Managing Transfer	Flexible working patterns (including 7 day working)		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£2,671,466	Existing
3	Seven day support-acute	Support for 7 day a week discharge by NHS integrated discharge	High Impact Change Model for Managing Transfer	Early Discharge Planning		Acute		CCG			Local Authority	Minimum NHS Contribution	£150,299	Existing
4	Care Home Quality assurance	Quality assurance of community care home providers to enable safe	High Impact Change Model for Managing Transfer	Improved discharge to Care Homes		Social Care		LA			Local Authority	Minimum NHS Contribution	£286,880	Existing
5	GP support to Care homes	Primary care locally commissioned services(LCS) to deliver	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Primary Care		CCG			Private Sector	Minimum NHS Contribution	£603,998	Existing
6	Monitoring Patient flow	Support for D2A pathways	High Impact Change Model for Managing Transfer	Early Discharge Planning		Social Care		LA			Local Authority	iBCF	£956,633	Existing
7	Enhanced Health in Care homes	Staff supporting the delivery of the Enhanced Health in Care Homes	High Impact Change Model for Managing Transfer	Improved discharge to Care Homes		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£207,813	Existing

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
8	Ageing Well programme	The programme aims develop community capacity to support older	Prevention / Early Intervention	Choice Policy		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£658,209	Existing
9	Self-directed support	Direct payments to support the care of people in the community	Personalised Budgeting and Commissioning			Social Care		LA			Local Authority	Minimum NHS Contribution	£474,854	Existing
10	Memory Clinic	Support for early detection of dementia to prevent hospital	Community Based Schemes	Multidisciplinary teams that are supporting		Mental Health		CCG			NHS Mental Health Provider	Minimum NHS Contribution	£240,890	Existing
11	Care Packages - support at home	Building system resilience to support homefirst approach	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	Minimum NHS Contribution	£2,806,703	Existing
12	Day opportunities	Support for access to volunteering opportunities to improve	Community Based Schemes	Multidisciplinary teams that are supporting		Social Care		LA			Local Authority	iBCF	£53,575	Existing
13	Community Health services	Support to regain and retain independent living skills	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			CCG	Minimum NHS Contribution	£970,418	Existing
14	Fracture liaison service	Systematic approach to secondary prevention of osteoporotic fragility	Community Based Schemes	Multidisciplinary teams that are supporting		Acute		CCG			NHS Acute Provider	Minimum NHS Contribution	£109,058	Existing
15	Care Home provision	24 hour accommodation and support for those residents unable to live	Residential Placements	Care home		Social Care		LA			Local Authority	iBCF	£2,366,142	Existing
16	Supported Living	Accommodation with personalised support based on personalised	Residential Placements	Supported accommodation		Social Care		LA			Local Authority	iBCF	£681,463	Existing
17	Intermediate care /step-down	Services to support safe discharge from hospital	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£10,462,427	Existing
18	Winter resilience	Additional system capacity to support D2A pathways during peak	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Local Authority	iBCF	£1,491,258	Existing
19	Home Care packages of support	Personalised support at home	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	iBCF	£3,688,146	Existing
20	Reablement capacity	Additional system capacity to support D2A pathways during peak	Reablement in a persons own home	Preventing admissions to acute setting		Social Care		LA			Local Authority	iBCF	£206,060	Existing
21	Intermediate care /reablement	Support to regain and retain independent living skills	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	Minimum NHS Contribution	£294,930	Existing
22	Dignity for end of life	Palliative care at home or in hospice	Personalised Care at Home	Physical health/wellbeing		Continuing Care		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£1,499,494	Existing
23	Disabled Facilities Grant	Home adaptations & equipment	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Private Sector	DFG	£2,884,527	Existing
24	Care Act Implementation	Assessment of need and safeguarding	Care Act Implementation Related Duties	Safeguarding		Other	Care Act duties	CCG			Local Authority	Minimum NHS Contribution	£995,608	Existing
25	Carers Support - Asessment & Advice	Barnet Carers centre support for unpaid carers	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Local Authority	Minimum NHS Contribution	£372,571	Existing

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
26	Carers Support - Respite services	Support to unpaid carers in their caring role through provision of	Carers Services	Respite services		Social Care		CCG			Local Authority	Minimum NHS Contribution	£1,000,975	Existing
27	Care Act duties- MH advocacy	Independent advocacy services for clients with mental ill-health	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Local Authority	Minimum NHS Contribution	£521,600	Existing
28	Single point of access	Integrated approach to referral management	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£350,049	Existing
29	Admissions avoidance	Support at home to prevent health deterioration	Reablement in a persons own home	Preventing admissions to acute setting		Social Care		LA			Local Authority	Minimum NHS Contribution	£290,883	Existing
30	Social Prescribing	Signposting to community resources to promote self-resilience	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	iBCF	£75,211	Existing
31	Integrated Community Equipment	Provision of small equipment in the home to retain independent	Assistive Technologies and Equipment	Community based equipment		Community Health		LA			Local Authority	Minimum NHS Contribution	£2,237,905	Existing
32	Digital inclusion	Technical support at home for self-management to prevent	Assistive Technologies and Equipment	Digital participation services		Community Health		CCG			CCG	iBCF	£103,030	Existing
33	Joint Commissioning	Funding for staff in the joint commissioning and transformation team,	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	Minimum NHS Contribution	£946,331	Existing
34	Frailty MDT	Primary care funding: staff support for frailty MDT	Integrated Care Planning and Navigation	Support for implementation of anticipatory care		Community Health		CCG			Local Authority	Minimum NHS Contribution	£76,852	Existing

Further guidance for completing Expenditure sheet

National Conditions 2 & 3

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:

- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:

- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2022-23 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Safeguarding 4. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

Number	Scheme type/ services	Sub type	Description
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Number	Scheme type/ services	Sub type	Description
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.

Number	Scheme type/ services	Sub type	Description
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Barnet

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population	Indicator value	140.4	106.1	127.0	106.1	The ambition is based on the quarterly average and trends for 2021-22 reflected against the Q1 2022-23 actual outturn, to provide indicative targets for the remainder of this year.These projections will be further analysed by the HWB JFG in	The Access to Care pilot as a new joint initiative between CLCH Trust and the ASC admissions avoidance team, will work to provide a holistic response to reduce uneccessary attendances at A & E, and enable the person to receive the care
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(See Guidance)	Indicator value	99	81	88	79		
	Denominator	409,398	409,399	409,400	409,401		

>> link to NHS Digital webpage (for more detailed guidance)

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	92.9%	92.6%	92.5%	92.2%	The London average as of June 2022 was 92.5%.The Barnet 2021-22 actual outturn figures, indicate there is minimal in-year fluctuation of the overall % rates, and without the granular detail of whether this is achieved with/without input from social care support.For 22-23 we are therefore projecting a continuum of Q1 rates as the minimum stretch ambition in the face of	The reablement pathway has been revised with enhanced capacity for this year .There is additional investment from BCF funds to provide an extra 200 hours of reablement service capacity , and the establishment of an OT led reablement approach starting from September 2022.CLCH have also deployed nursing staff to care homes to provide clinical support for supported
	Numerator	6,750	6,736	6,720	6,389		
	Denominator	7,264	7,276	7,268	6,929		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(SUS data - available on the Better Care Exchange)	Quarter (%)	92.4%	92.4%	92.4%	92.4%		
	Numerator	6,595	6,595	6,595	6,595		
	Denominator	7,140	7,140	7,140	7,140		

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	502.0	485.7	500.8	440.9	Projected target is based on 10% reduction in admissions to residential care year on year, as alternative provision in the community continues to be developed.	Development of new extra care schemes and live in care services in Barnet this year, will enable people to receive higher levels of support within their own home as an alternative to residential admission.
	Numerator	292	290	299	269		
	Denominator	58,170	59,707	59,707	61,008		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	75.4%	75.4%	77.4%	77.4%	As a minimum the aim is to maintain 2021-22 outturn, although our assumption would be that based on last years delivery this years outturn will again exceed this plan. There will be close monitoring of the impact of new investment over the 2022	The expansion of rapid response (UCR)services to divert cases from LAS,and the introduction of therapy led reablement from september 2022, will both provide increased capacity over winter from an enhanced reablement approach following
	Numerator	132	132	340	340		
	Denominator	175	175	439	439		

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Barnet

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes			
	PR2	**A clear narrative for the integration of health and social care**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.	Narrative plan	Yes			
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Implementing the BCF policy objectives	**PR6**	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes			

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes			

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	Health and Wellbeing Board **29th September 2022**
Title	**Combating Drugs Partnership Overview**
Report of	Dr Tamara Djuretic, Joint Director of Public Health and Prevention, Directorate of Public Health
Wards	All
Status	Public
Urgent	No
Key	{Yes / No} *Note: The definition of a key decision is one which:* - *will result in the council incurring expenditure or savings of £500,000 or more; or* - *is significant in terms of its effects on communities living or working in an area comprising two or more Wards*
Enclosures	Appendix A – Barnet Combating Drugs Partnership Terms of Reference - Draft
Officer Contact Details	Louisa Songer – Public Health Strategist louisa.songer@barnet.gov.uk 020 8359 7587

Summary

This report introduces Barnet's "Combating Drugs Partnership" (BCDP) and presents the proposed terms of reference for the partnership. The report also presents the proposed governance and reporting for the BCDP.

The Combating Drugs Partnership is being formed in response to the national "From Harm to Hope" a 10-year drugs plan to cut crime and save lives (2021). The plan requires that national and local partners work collaboratively focusing on three strategic priorities, which include the plan to cut crime and save lives by reducing the of drugs, delivering a high-quality treatment and recovery system and achieving a generational shift in demand for drugs.

It is proposed that the BCDP will be chaired by Chair of the Health and Wellbeing Board, Cllr Alison Moore.

The BCDP will report directly to Barnet Council's Health and Wellbeing board, with a line into Barnet Council's Safer Communities Partnership Board. It is proposed that the first

Barnet Combating Drugs Partnership Board will be held on the 2nd November 2022 and every three months subsequently. Work programme and timelines for delivery are detailed in the Terms of Reference, appendix 1.

Glossary of terms:
BCDP – Barnet Combating Drugs Partnership
ToR – Terms of reference
SRO – Senior Responsible Officer
OHID – Office for Health Improvement and Disparities

Officers Recommendations
1. **To agree the establishment and terms of reference (as proposed in appendix one) of the proposed Barnet Combating Drugs Partnership (BCDP).**
2. **To agree and implement governance structure relating to the Barnet Combating Drugs Partnership (BCDP) as detailed in the report and the terms of reference.**

1. Why this report is needed

1.1 This report introduces Barnet's "Combating Drugs Partnership" (BCDP) and presents the proposed terms of reference for the meeting. The report also presents the proposed governance and reporting structure for the BCDP.

1.2 The Combating Drugs Partnership is being formed in response to the national "From Harm to Hope" a 10-year drugs plan to cut crime and save lives 2021. The plan requires that national and local partners work collaboratively focusing on three strategic priorities, which include the plan to cut crime and save lives by reducing the of drugs, delivering a high-quality treatment and recovery system and achieving a generational shift in demand for drugs.

The plan recognises that a whole-system approach is needed, with demand reduction a key component. It also acknowledges that to achieve and sustain recovery people need, alongside treatment, somewhere safe to live and something meaningful to do (a job, education, or training). These problems can only be solved through coordinated action by multiple departments and additional investment. Greater co-ordination and accountability at the national level will also flow through to the local level, where responsibility sits for the delivery of drug treatment and wider recovery outcomes.

Therefore, it is expected that national and local departments will have vital designated roles in achieving the outcomes of the plan:

- Outcome 1 - Break drug supply chains: Home Office and Ministry of Justice,
- Outcome 2 - Deliver a world-class treatment and recovery system: Department of Health and Social Care, Ministry of Justice, Department for Levelling Up, Housing and Communities, and Department for Work and Pensions.
- Outcome 3 - Achieve a generational shift in demand for drugs: Home Office, Department for Education, Department of Health and Social Care, Ministry of Justice,

Departmental for Culture, Media and Sport, Department for Levelling Up Housing and Communities.

1.3 The aim of the Partnership is to bring key partners together to ensure clear strategic direction and delivery of the aims and objectives set out in the national combating drugs plan through delivery of a local strategy and action plan.

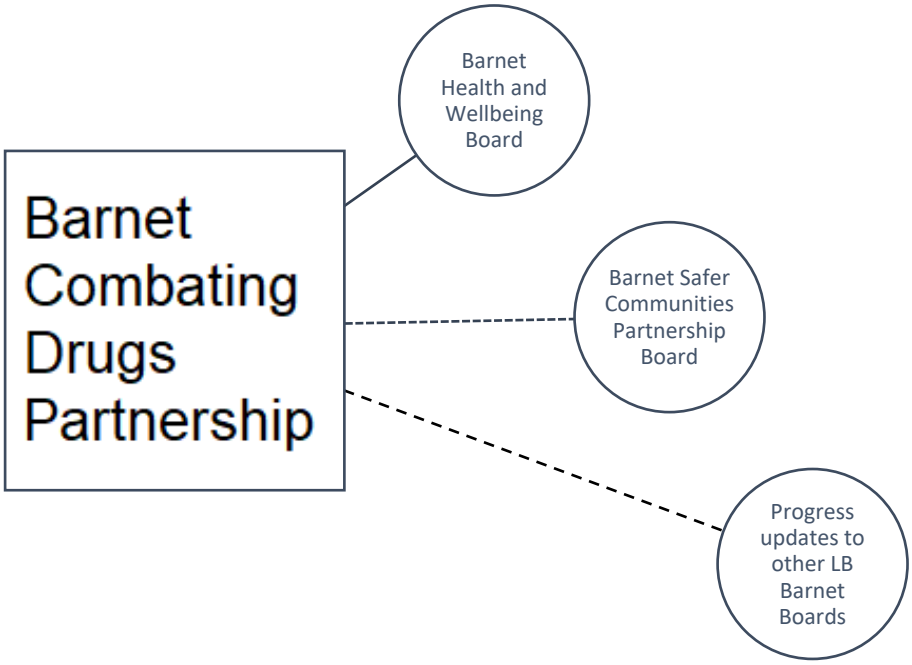
The partnership group will be responsible for:

- Establishing and implementing performance management to ensure the effective functioning of the group
- Overseeing delivery of the local combating drugs plan and other related substance misuse plans
- Discuss performance against agreed action plans
- A partnership level response to key issues and strategic challenges
- Providing visibility and accountability
- Productive engagement
- The ability to identify priorities and thematic activities
- Effective clear and timely communication of themes and emerging issues; and cross-partnership working
- Support the functioning of a local drug related death panel including conducting deep dives were required and monitoring related actions

1.4 Governance: It is proposed that the BCDP will be chaired by Chair of the Health and Wellbeing Board, Cllr Alison Moore.

The BCDP will report directly to Barnet Council's Health and Wellbeing board, with a line into Barnet Council's Safer Communities Partnership Board. As such the main CDPB Plan and strategy will be agreed by the Health and Wellbeing board and delivered via co-ordination of those with delegated powers at the CDPB.

The meeting is not a public meeting and will be administrated by members of the LB Barnet Public Health team.



2. Reasons for recommendations

2.1 Dame Carol Black was commissioned by the Home Office and the Department of Health and Social Care to undertake a 2-part independent review of drugs, to inform the government's thinking on what more can be done to tackle the harm that drugs cause.

Following the review, the new drug (and alcohol) strategy, From Harm to Hope, was published by the government in December 2021. In Spring 2022, funding and guidance was released to local areas to support the implementation of the new strategy, and in July 2022 a directive to local areas to establish local "Combatting Drugs Partnerships".

The approach detailed in this report is developed from guidance outlining the structures and processes through which local partners in England should work together to reduce drug-related harm.

3. Alternative options considered and not recommended

3.1 Larger geographic footprints for the Combating Drugs Partnership Board were considered however due to differences in Policing and Health footprint areas it was decided that a borough specific board was more suitable.

4. Post decision implementation

4.1 It is proposed that the first Barnet Combating Drugs Partnership Board will be held on the 2nd of November 2022 and every three months subsequently. Work programme and timelines for delivery are detailed in the Terms of Reference, appendix 1.

5. Implications of decision

5.1 **Corporate Priorities and Performance**

5.1.1 The Combating Drugs Partnerships has prevention at its core and its three outcomes align directly with Barnet's corporate plan.

- Outcome 1 - Break drug supply chains: Clean, safe and well run.
- Outcome 2 - Deliver a world-class treatment and recovery system: Healthy.
- Outcome 3 - Achieve a generational shift in demand for drugs: Healthy & Thriving.

5.1.2 As detailed above, the three outcomes of the CDP align with the objectives of Barnet's Joint Health and Wellbeing Strategy.

- Outcome 1 - Break drug supply chains: Creating a healthier place and resilient communities.
- Outcome 2 – Starting, living and ageing well & Ensuring delivery of coordinated and holistic care, when we need it.
- Outcome 3 - Achieve a generational shift in demand for drugs: Creating a healthier place and resilient communities/Starting, living & aging well

5.1.3 A key outcome of the CDPB is to conduct a joint needs assessment, reviewing local data and evidence. This forms a key part of the JSNA.

5.2 **Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**

5.2.1 In order to deliver the outcomes of the CDPB, Barnet received additional funding of £381,264 from the Office for Health Improvement and Disparities (OHID) to improve services in line with the ambitions of the 2021 drug strategy. An additional £41,476 is allocated by OHID for inpatient detoxification and rehabilitation. LB Barnet Public Health was asked to provide detailed plans to improve their treatment and recovery systems prior to funding being approved by OHID. The allocated funding is committed to the agreed plans submitted and approved by OHID.

A key role for the CDPB will be to support the mobilisation and delivery of these plans.

5.3 **Legal and Constitutional References**

5.3.1 The Combating Drugs Partnership Board's terms of reference include:

- To provide collective leadership and enable shared decision-making, ownership, and accountability
- To promote partnership and, as appropriate, integration, across all necessary areas, including joined-up commissioning plans and joined-up approach to

securing external funding across the NHS, social care, voluntary and community sector and public health.

- To explore partnership work across North Central London where appropriate

The board will have specific responsibilities for:

- Overseeing public health and promoting prevention agenda across the partnership
- Developing further health and social care integration.

5.3.2 No legal references – there are no procurement activities relating to this decision and there are no changes to existing commissioned services.

5.3.3 Barnet Combating Drugs Partnership Group is not a formal subcommittee of the Council and is an informal partnership board, and as such is not required to comply with the statutory requirements regarding publication of papers.

5.4 **Insight**

5.4.1 As detailed above, a substance misuse needs assessment is currently in progress and will be used to direct future planning and work programme for the CDPB. Initial plans have been made using existing data available including JSNA data and service level data.

5.4.2 Substance misuse treatment and trend data is closely monitored by the Public Health Intelligence team with strong performance monitoring in place.

5.5 **Social Value**

5.5.1 Not applicable – decision does not relate to commissioning

5.6 **Risk Management**

5.6.1 As part of the process for setting up Barnet Combating Drugs Partnership, a business implementation and risk plan to be developed and be agreed by Board members.

5.6.2 Timeframe for setting up the partnership Board to be agreed, details of activities and relevant staff/membership responsibilities as defined in terms of reference.

5.6.3 Alongside the implementation of a Business and Risk Plan, a performance framework will be agreed. The performance framework will include performance and outcome measures.

5.7 **Equalities and Diversity**

5.7.1 The core provisions of the Equality Act 2010 (the Act) came into force on 1st October 2010 and the Public Sector Equality Duty (Section 149 of the Act) came into force on 5th April 2011. Under Section 149, the Council must have due regard to the need to eliminate discrimination, harassment and victimisation prohibited under the Act and to advance equality for opportunity and foster good relations between those with protected characteristics and those without.

5.7.2 Prior to commissioning core substance misuse services, and Equality Impact

Assessment was carried out on the protected characteristics i.e., age, disability; race, gender reassignment, pregnancy and maternity, religion or belief, sex and sexual orientation. They also covered marriage and civil partnership regarding eliminating discrimination.

5.7.3 Combating Drugs Partnership under the guidance and stewardship of Barnet Council, will ensure that delivery of substance misuse service/reducing harm complies with the Public-Sector Equality Duty. This duty will continue to be monitored under the Contract.

5.8 **Corporate Parenting**

5.8.1 The Combating Drugs Partnership board will relate to children, adults and families. Care leavers and looked after children can be impacted by substance misuse on a multitude of levels and therefore will be included in the substance misuse needs assessment and their needs considered throughout the strategy development, planning and delivery.

5.9 **Consultation and Engagement**

5.9.1 Members of the CDPB have been approached and their view on the board sought. The board will include membership from service users and carers and there will be in depth consultation and engagement throughout the needs assessment process and strategy development.

5.10 **Environmental Impact**

5.10.1 There are no direct environmental implications from noting the recommendations. Implementing the recommendations in the report will lead to a positive impact on the Council's carbon and ecology impact, or at least it is neutral.

6. Background papers

6.1 None

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Barnet Combating Drugs Partnership Group

Terms of Reference (ToR)

1. Introduction

These Terms of Reference (ToR) are developed in support of the functionality and operation of the Barnet Combating Drugs Partnership Group (BCDPG).

The ToR sets out the key principles for the group including membership, the chairperson, roles and responsibilities, the objectives of the group and meeting frequency. Also identified in the ToR are the agreed reporting and governance arrangements.

2. Purpose of Strategic Group

The Combating Drugs Partnership has been formed in response to the national "From harm to hope: a 10-year drugs plan to cut crime and save lives 2021 [1]. The plan requires that national and local partners work collaboratively focusing on three strategic priorities which include the plan to cut crime and save lives by reducing the supply and demand for drugs and delivering a high-quality treatment and recovery system.

The plan recognises that a whole-system approach is needed, with demand reduction a key component. It also acknowledges that to achieve and sustain recovery people need, alongside treatment, somewhere safe to live and something meaningful to do (a job, education or training). These problems can only be solved through coordinated action by multiple departments and additional investment. Greater co-ordination and accountability at the national level will also flow through to the local level, where responsibility sits for the delivery of drug treatment and wider recovery outcomes.

Therefore it is expected that national and local departments will have vital designated roles to achieve the following outcomes of the plan:

- **Break drug supply chains:** Home Office and Ministry of Justice,
- **Deliver a world-class treatment and recovery system:** Department of Health and Social Care, Ministry of Justice, Department for Levelling Up, Housing and Communities, and Department for Work and Pensions.
- **Achieve a generational shift in demand for drugs:** Home Office, Department for Education, Department of Health and Social Care, Ministry of Justice, Departmental for Culture, Media and Sport, Department for Levelling Up Housing and Communities.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1079147/From_harm_to_hope_PDF.pdf

National Combating Drugs Outcomes Framework Our ambition: a safer, healthier and more productive society by combating illicit drugs	
What we will deliver for citizens (strategic outcomes)	**Measured by:**
Reducing drug use	• the proportion of the population reporting drug use in the last year (reported by age) • prevalence of opiate and/or crack cocaine use
Reducing drug-related crime	• the number of drug-related homicides • the number of neighbourhood crimes
Reducing drug-related deaths and harm	• deaths related to drug misuse • hospital admissions for drug poisoning and drug-related mental health and behavioural disorders (primary diagnosis of selected drugs)
What will help us deliver this (intermediate outcomes)	**Measured by:**
Reducing drug supply	• the number of county lines closed • the number of moderate and major disruptions against organised criminals
Increasing engagement in drug treatment	• the numbers in treatment (both adults and young people, reported by opiate and crack users, other drugs, and alcohol) • continuity of care – engagement with treatment within three weeks of leaving prison
Improving drug recovery outcomes	• the proportion who are in stable accommodation and who have completed treatment, are drug-free in treatment, or have sustained reduction in drug use **Key additional components integral to recovery include housing, mental health, and employment**

3. Membership

The CDP is comprised of representatives from the following Responsible Authorities (RAs), with the specific officers highlighted in the combating drugs plan 2021 [2]:

- Elected members
- Police and Crime Commissioner
- Police
- National probation service
- Secure Estate (prisons, young offender institutions etc)
- Barnet Councils officers
- NHS strategic lead
- People affected by drug related harm
- Substance misuse treatment providers
- Job centre Plus
- Higher Education
- Including relevant partners (representatives from organisations with a vested interest in combating substance misuse challenges for individuals and the community within Barnet who can share information and contribute to planning and partnership working)

2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1079147/From_harm_to_hope_PDF.pdf

Barnet's proposed CDP Membership:

Name	Job Title	Role on Programme	Email
Cllr Alison Moore	Chair of the Health and Wellbeing Board	Lead member for public health and CDP Chair	
Tamara Djuretic	Director of Public Health and Prevention	Senior responsible Officer	
TBC	Service User Representative	Service User Representative	
TBC	Carer Representative	Carer Representative	
Luke Kwamya	Head of Commissioning Public Health	Head of Public Health Commissioning	
Louisa Songer	Senior Public Health Strategist	Strategic lead for Substance Misuse	
Vacant	Public Health Commissioner	Commissioning Lead	
Maggie Higton-Brown	Head of Community Safety, Enforcement, CCTV and Intelligence	Community Safety Lead	
Lisa Sturrock	Adult Substance Misuse Service Manager, CGL	Substance Misuse Service Manager	
Tanya Lisak	Young People's Substance Misuse Service Manager, CGL	Team Leader for Substance Misuse Services, CGL	
Tina McElligott	Family Services	Director – Early Help & Children's Social Care Services	
Koreen Logie	Probation	Head of Service, Harrow and Barnet PDU	
Sean Lynch	Met Police	Chief Inspector – Neighbourhoods and Partnership	
Ellie Chesterman	Head of Mental Health Commissioning		
To be confirmed	NCL Integrated Care System		
To be confirmed	Licensing		
To be confirmed	YOT		
To be confirmed	Job Centre Plus		
To be confirmed	Barnet Homes		

Member's responsibilities:

- To enable the CDP to function efficiently and successfully it is important that members attend meetings consistently;
- Members must be prepared and well informed to contribute to discussions and provide updates on their areas of expertise as required;
- Members to represent their organisations and co-ordinate actions and feedback with their colleagues
- Members to communicate with each other fully and fairly, sharing ideas, information, insight, and objectives;
- Members have a responsibility to report back to their organisation, including both seniors and deputies;
- Seek authorisation or agreement, for decisions/actions, where required, by senior members/boards;
- The group will keep a tracker of individual attendances to the meetings, and a consistent lack of attendance will be escalated to the appropriate organisational leads.

4. Aims and Objectives

Aim: To bring key partners together to ensure clear strategic direction and delivery of the aims and objectives set out in the government's 2021 drug plan, "From harm to hope: a 10-year drugs plan to cut crime and save lives" through delivery of a local strategy and action plan.

Objectives: This group will be responsible for:

- Establishing and implementing performance management to ensure the effective functioning of the group
- Overseeing delivery of the local combating drugs plan and other related substance misuse plans
- Discuss performance against agreed action plans
- A partnership level response to key issues and strategic challenges
- Providing visibility and accountability
- Productive engagement
- The ability to identify priorities and thematic activities
- Effective, clear and timely communication of themes and emerging issues; and cross-partnership working
- Support the functioning of a local drug related death panel including conducting deep dives were required and monitoring related actions

5. Strategic Responsibilities of the Group / Duties

The responsibilities of the partnership are to:

- Nominate a local Senior Responsible Officer (SRO) for the project (Tamara Djuretic, Director of Public Health and Prevention)

- Agree Combating Drugs Partnership membership and footprint (Footprint agreed to be at the borough-level in North Central London)
- Agree Terms of Reference and governance structures
- Conduct a joint needs assessment, reviewing local drug data and evidence
- Agree local drugs strategy delivery plan
- Partners agree local performance framework to facilitate monitoring and impact of plans
- First progress report due
- Regular review progress reflecting on local delivery of strategy, current issues, and priorities

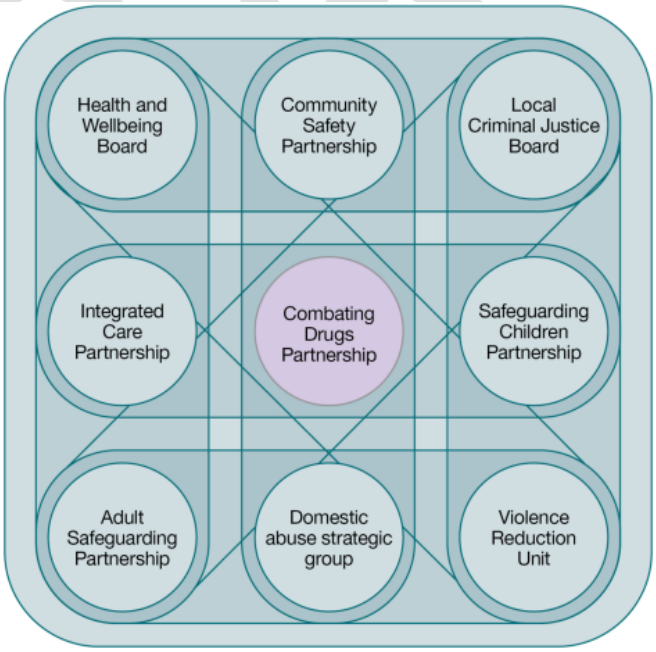
Please see **appendix 1** in appendices for the project`s key timelines

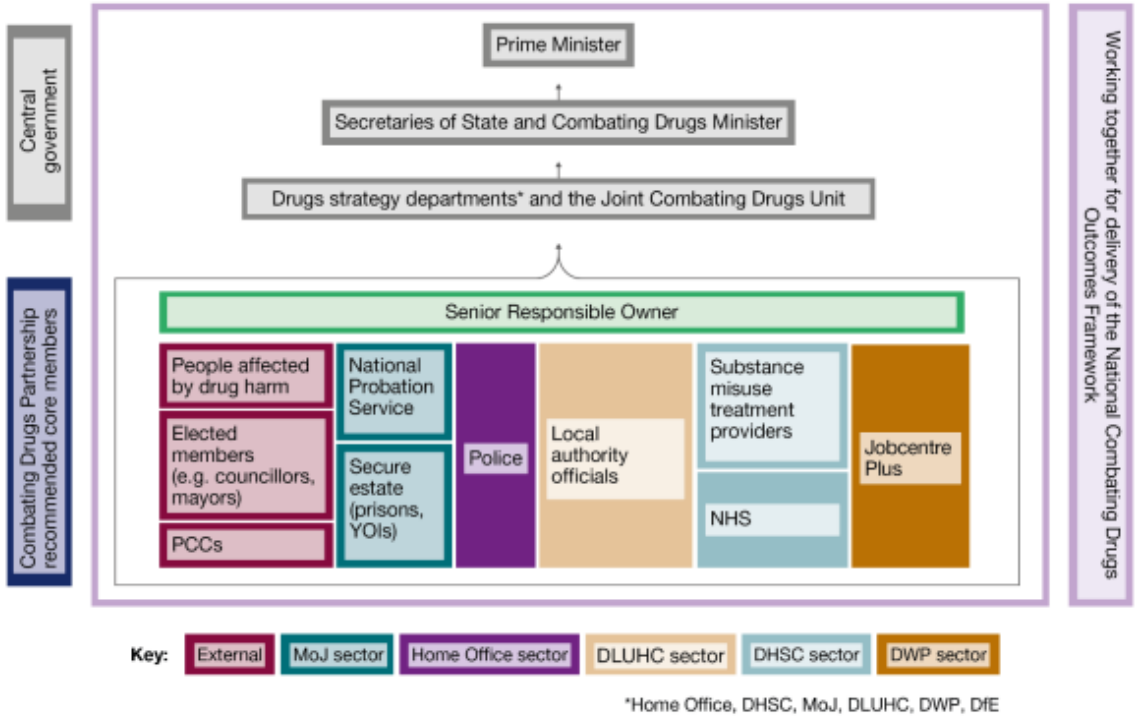
6. Governance and administration

The CDP meetings will be chaired by the Chair of the Health and Wellbeing Board.

Meetings will be held quarterly and require the attendance of half the representatives to have a quorum. The meeting is not a public meeting and will be administrated by members of the LB Barnet Public Health team.

The CDP will report directly to Barnet Council's Health and Wellbeing Board, with a line into Barnet Council's Safer Communities Partnership Board. As such the main CDPB Plan and strategy will be agreed by the Health and Wellbeing board and delivered via co-ordination of those with delegated powers at the CDPB.





(NB Senior responsible owner should say senior responsible officer, typo in main Guidance for local delivery partners (publishing.service.gov.uk)

The CDP needs to ensure that effective processes are in place for listening and capturing input from all members, including interfacing with relevant bodies. This will require understanding the composition and needs of the communities it serves.

7. Frequency of meetings

On a quarterly basis and a proposed schedule of dates for 2022/23 is listed in Appendix 2.

The board will be a hybrid meeting, initial meetings will be face to face with the option of joining remotely if necessary.

8. APPENDIX 1 Strategic Responsibilities and Timelines

Action	Time frame
✓ Nominate your local senior responsible owner (SRO)*	By 1 August 2022
✓ Agree the terms of reference for your local partnership and your governance structure	By end September 2022
✓ Conduct a joint needs assessment, reviewing local drug data and evidence	By end September 2022
✓ Agree a local drugs strategy delivery plan, including developing data recording and sharing	By end December 2022
✓ Regularly review progress, reflecting on local delivery of the strategy and current issues and priorities	First progress report by end of April 2023 and every 12 months thereafter

9. APPENDIX 2 Schedule of Dates for the Combating Drugs Partnership Group

Date	Time	Venue
2nd November 2022	2pm – 3:30pm	Barnet Council Offices, Colindale, Room TBC

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