MEETING

HEALTH & WELLBEING BOARD

DATE AND TIME

THURSDAY 9TH DECEMBER, 2021

AT 9.30 AM

VENUE

HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4BQ

TO: MEMBERS OF HEALTH & WELLBEING BOARD (Quorum 3)

Chairman: Councillor Caroline Stock (Chairman),
Vice Chairman: Dr Charlotte Benjamin (Vice-Chairman)

Sarah McDonnell-Davies	Fiona Bateman	Dr Clare Stephens
Dr Tamara Djuretic	Councillor Sachin Rajput	Dawn Wakeling
Dr Nikesh Dattani	Councillor Richard Cornelius	Nitish Lakhman
Chris Munday	Caroline Collier	

Substitute Members

Dr Barry Subel	Councillor Rohit Grover	Dr Murtaza Khanbhai
Dr Julie George	Councillor David Longstaff	Ben Thomas

In line with Article 3 of the Council's Constitution, Residents and Public Participation, public questions or comments must be submitted by 10AM on the third working day before the date of the committee meeting. Therefore, the deadline for this meeting is 10AM on Monday 6 December. Requests must be submitted to Salar Rida at salar.rida@barnet.gov.uk

You are requested to attend the above meeting for which an agenda is attached.
Andrew Charlwood – Head of Governance

Governance Services contact: Salar Rida 020 8359 7113, salar.rida@barnet.gov.uk
Media Relations Contact: Gareth Greene 020 8359 7039

ASSURANCE GROUP

ORDER OF BUSINESS

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Decisions of the Health & Wellbeing Board

30 September 2021

AGENDA ITEM 1

Board Members:-
* Councillor Caroline Stock (Chairman)
* Dr Charlotte Benjamin (Vice-Chairman)

* Dr Tamara Djuretic	Caroline Collier	* Nitish Lakhman
* Cllr Richard Cornelius	* Dr Clare Stephens	Cllr Sachin Rajput
Dr Nikesh Dattani	* Chris Munday	* Colette Wood
* Dawn Wakeling	* Fiona Bateman	

*Members present

1. MINUTES OF THE PREVIOUS MEETING (Agenda Item 1):

The Chairman of the Health and Wellbeing Board, Councillor Caroline Stock welcomed all attendees to the meeting being held at Hendon Town Hall and noted the Covid-secure measures in place throughout the meeting.

It was RESOLVED that the minutes of the previous meeting of the Health and Wellbeing Board held on 15 July 2021 be agreed as a correct record.

2. ABSENCE OF MEMBERS (Agenda Item 2):

Apologies were received from Caroline Collier, Dr Nick Dattani and Councillor Sachin Rajput.

3. DECLARATION OF MEMBERS' INTERESTS (Agenda Item 3):

Dr Charlotte Benjamin, Vice-Chair of the HWBB declared an interest on behalf of herself and Dr Clare Stephens, in relation to the relevant agenda items as primary care providers via their respective GP Practices and GP Federation in the interest of transparency.

4. PUBLIC QUESTIONS AND COMMENTS (IF ANY) (Agenda Item 4):

None.

5. REPORT OF THE MONITORING OFFICER (IF ANY) (Agenda Item 5):

None.

6. LIST OF HEALTH AND WELLBEING BOARD (HWBB) ABBREVIATIONS (Agenda Item 6):

RESOLVED – that the Board noted the standing item on the agenda which lists the frequently used acronyms in HWBB reports.

7. FORWARD WORK PROGRAMME (Agenda Item 7):

The Board noted the items due to be reported to future HWBB meetings.

RESOLVED that the Board noted the Forward Work Programme.

8. COVID-19 PANDEMIC UPDATE AND BARNET HOSPITAL UPDATE (VERBAL) (Agenda Item 8):

Dr Tamara Djuretic, Director of Public Health and Prevention provided an update on this item and noted that infection rates as well as average number of COVID-19 cases have been decreasing. She also reiterated the advice around keeping people safe and protected. The Board heard about the ongoing work to circulate the message to the communities including through the community and voluntary sector.

Dr Charlotte Benjamin, NCL CCG and Vice-Chair of the Board spoke about the work being carried out to support the system and noted that pressures on primary care was likely to carry on into the winter period.

The Board noted the update and the Chairman thanked the Board Members for the update and the discussion.

RESOLVED – that the Board noted the verbal update.

9. ICS DEVELOPMENT UPDATE (VERBAL) (Agenda Item 9):

The Chairman welcomed Frances O'Callaghan, NCL CCG Accountable Officer and Jo Sauvage Chair of the NCL CCG to provide an update on the developments of Integrated Care System to highlight the recent national guidance and how the plans are evolving regarding the move to the new organisation from 1st April 2022.

Ms O'Callaghan spoke about the challenges around the supply of vaccines and encouraged uptake of the vaccination. She also noted the development of the ICS which will be informed through close working with residents and communities and increase community representation through the set-up of the Integrated Care Community Form.

DrJo Sauvage, Chair of the North Central London CCG updated the Board about the feedback from resident participation group and the importance of addressing how the new system will differ for service users. She also spoke about the accelerated way in which collaborative working will involve residents, businesses, community voluntary sector representation, Local Authority and NHS.

Following a query about the role of the Board, Ms O'Callaghan noted the importance of the role of local health and social care and LA representation from the Board and to continue to build on the work of the HWBB.

In response to a query from the Board about outcomes for children and young people, it was noted that work will be taking place to enable feedback and dialogue to take place in order to continue to contribute towards improving outcomes for children and young people.

It was noted that future funding will be an area that will present challenges and which will require effective scrutiny.

Ms O'Callaghan and Dr Sauvage welcomed the feedback from the Board and spoke about the importance of continued local input and input from the HWBB to help inform the new system. The Chairman thanked the speakers and the Board for the discussion.

RESOLVED – that the Board noted the verbal update.

10. COVID-19 AND FLU VACCINATION UPDATE (Agenda Item 10):

Dr Charlotte Benjamin presented the update report on COVID-19 and Ms O'Callaghan reported a progress on flu vaccination. The Board noted the delivery of the extensive Covid vaccination programme, including through pharmacies, Primary Care Network hubs, StoneX mass vaccination site pop-up clinics.

Following a query from the Board about vaccination uptake of care homes staff, Dr Benjamin spoke about the vaccination model which includes encouraging access to mass sites across NCL or pharmacy sites, 1-2-1 engagement sessions with clinicians to discuss vaccination hesitancy factors and fertility discussion drop in sessions – she further noted that this has helped to increase uptake to 85.7%. It was noted that from 11 November, staff not vaccinated would not be able to work in care homes.

The Chairman thanked Dr Benjamin and Ms O'Callaghan and the Board for the update and the discussion on this item.

It was RESOLVED that the Health and Wellbeing Board noted the update report.

11. HEALTHWATCH PRESENTATION - ACCESSING YOUR GP REMOTELY (Agenda Item 11):

The Chairman invited a resident patient who spoke about her experience and difficulty in trying to book a face to face meeting with the GP. The Board thanked the resident for sharing their experience which will be taken into account together with the feedback to improve the overall user experience.

Nitish Lakhman, Barnet Healthwatch Manager summarised the report and noted the feedback and patient experience which included benefits for users as well as concerns around digital access.

Dr Jo Sauvage welcomed the feedback which will be taken into consideration to continue to improve various aspects of the system and improve patient experience.

It was RESOLVED that the Board noted the presentation.

12. FINAL JOINT HEALTH AND WELLBEING STRATEGY KEY PERFORMANCE INDICATORS 2021-2025 (Agenda Item 12):

Dr Tamara Djuretic presented the report which provides an update on the development of the Joint Health and Wellbeing Strategy (JHWS) 2021-25 Implementation and Action Plans.

The Board welcomed the report. In response to a query from the Board about digital exclusion, Dr Djuretic noted that data is being collated at the London level around digital access and barriers for digital exclusion to help inform relevant and new performance indicators. The Board will receive an update on the matter within the next update report on JHWS performance update report.

It was RESOLVED:

1. That the Health and Wellbeing Board approved the final version of the Key Performance Indicators (KPIs) for the Joint Health and Wellbeing Strategy 2021- 25 for implementation.
2. That the Health and Wellbeing Board noted the proposed approach to outcome monitoring and engagement reports.

13. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) 2021 (Agenda Item 13):

The Chairman welcomed Jeremy Hooper, Insight and Intelligence Lead for Public Health, to present the Joint Strategic Needs Assessment report. Mr Hooper summarised the report and noted that the full JSNA is available at https://open.barnet.gov.uk/insight-and-intelligence/jsna/

The Board welcomed the item and the practicalities of being able to use the data to help inform future key workstreams.

It was RESOLVED that the Board approved the Joint Strategic Needs Assessment (JSNA) for publication.

14. BARNET MULTI-AGENCY SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2020-21 (Agenda Item 14):

The Chairman invited Fiona Bateman, Independent chair of the Safeguarding Adults Board to present and summarise the annual report for 2020-21.

Ms Bateman spoke about the rise in domestic abuse cases from MASH as well as the increase in complexity of issues experiences including self-neglect and impact of financial issues on individuals. She noted the continued enhancements at operational level in multi-agency responses and the coordination of partnership working.

It was RESOLVED:
1. That the Health and Wellbeing Board noted the Safeguarding Adults Board Annual Report 2020-21.
2. That the Board noted that following initial reporting to the Adults and Safeguarding Committee meeting, the Annual Report will be published on the Council website and BSAB webpages.

15. ANY ITEMS THE CHAIRMAN DECIDES ARE URGENT (Agenda Item 15):

None. The Chairman thanked the speakers and the Board for the discussion.

The meeting finished at 11.45 am

Health and Wellbeing Board abbreviations	
AOT	Adolescent Outreach Team
ACT	Adolescent Crisis Team
ACE	Adverse Childhood Events
ASC-FR	Adults Social Care Finance Return
ADHD	Attention Deficit Hyperactivity Disorder
ASC	Autism Spectrum Condition
BAME	Black, Asian and Minority Ethnic Groups
BAS	Barnet Adolescent Service
BASB	Barnet Adults Safeguarding Board
BCF	Better Care Fund (NHS and local government programme which joins up health and care services so people can manage heath, live independently and longer)
BEH MHT	Barnet, Enfield and Haringey Mental Health Trust
BOOST	Burnt Oak Opportunity Support Team (multiagency team with staff from Jobcentre Plus, Barnet Homes, Councils Benefit Service, Education and Skills Team)
BOP	Barnet On Point
BSPP	Barnet Suicide Prevention Partnership
CAFCASS	Children and Family Court Advisory and Support Service
CAW	Case Assistant Worker
CBT	Cognitive Behaviour Therapy
CC2H	Barnet Care Closer to Home
CCG	Clinical Commissioning Group
CCS	Concepts care solutions
CDOP	Child Death Overview Panels
CEAM	Child exploitation and missing tool
CEPN	Barnet Community Education Provider Networks
CHIN	Care and Health Integrated Networks
CETR	Care, Education and Treatment Reviews
CLCH	Central London Community Healthcare
CNWL	Central and North West London NHS Foundation Trust
CRAT	Carer Recruitment and Assessment Team
CWP	Children's Wellbeing Practitioners
CYP	Children and Young People
DBT	Dialectical Behaviour Therapy
DCT	Disabled Children's Team
DPR	Delegated Powers Report
DPP	Diabetes Prevention Programme
DBT	Dialectical Behaviour Therapy
DPH	Director of Public Health
CWP	Children and Young People Wellbeing Practitioners
DSH	Deliberate Self Harm

DIT	Dynamic Interpersonal Therapy
DOT	Direction of Travel status
DRP	Disability and Resource Panel
DToC	Delayed Transfer of Care
EIA	Equality Impact Assessment
EHC	Emergency Hormonal Contraception
EET	Education, employment and training
EP	Educational Psychologist
EPS	Electronic Prescription Service
FAB	Fit and Active Barnet
GLA	Greater London Authority
HCA	Health Care Assistants
HCC	Healthier Catering Commitment
HEE	Health Education England
HEP	Health Education Programme
HLP	Healthy London Partnership
HSL	Healthy Schools London Programme
IAPT	Improving Access to Psychological Therapy
iBCF	Improved Better Care Fund (Additional money given directly to local government)
ICS	Integrated Care System
ICP	Integrated Care Partnership
IPC	Infection Prevention and Control
IPS	Individual Placement Support
IPT	Intensive Psychotherapy Treatment
IRIS	Identification and Referral to Improve Safety
IRO	Independent Reviewing Officer
JCEG	Joint Commissioning Executive Group
JHWS	Joint Health and Wellbeing Strategy
JOY	Joining Old and Young
JSNA	Joint Strategic Needs Assessment
Kooth	Online Counselling and Emotional Wellbeing
KPI	Key Performance Indicators
LACS	Local Authority Children's Services
LCRC	London Coronavirus Response Cell
LGA	Local Government Association
LGD	Local government declaration of sugar reduction and healthier eating
LOMP	Local Outbreak Management Plan
LOS	Length of Stay
LOCP	COVID-19 Local Outbreak Control Plan
LCS	Locally Commissioned Service
LTP	Local Transformation Plan
MDT	Community Multi-Disciplinary Team model
MTFS	Medium Term Financial Strategy
MASH	Multiagency Safeguarding Hub

MIT	Market Information Tool
MHST	Mental Health Support Team
MOMO	Mind of my own app
NCL (CCG)	North Central London Clinical Commissioning Group: Barnet, Camden, Enfield, Haringey and Islington
NCMP	National Child Measurement Programme
NEL	North East London
NP	Non-Pharmaceutical Interventions
OCHT	One Care Home in-reach Team
OT	Occupational Therapist
OHS	Occupational Health Service
PBS	Positive behaviour support
PEP	Personal education plans
PPE	Personal Protective Equipment
PSED	Public Sector Equalities Duty
PSR	Priorities and Spending Review
PCN	Primary Care Network
PMHW	Primary Mental Health Worker
PQA	Performance and Quality Assurance
RAG	Red Amber Green rating
REACH	Resident, Engaged, Achieving Children Hub
RMN	Registered Mental Health Nurse
RFL	Royal Free London
SEAM	Sexual Exploitation and Missing
SENCO	Special Educational Needs Coordinator
STP	Sustainability and Transformation Partnerships
STPP	Short Term Psychoanalytic Psychotherapy
SPA	Sport and Physical Activity
QAM	Quality Assurance Monitoring Panel
QIPP	Quality, Innovation, Productivity and Prevention Plan
QIST	Quality Improvement Support Team
QWELL	Online support for professionals and parent/carers/staff
S7	Significant Seven Training to support staff in early identification of deterioration of patients
SAB	Safeguarding Adults Board
SAC	Safeguarding Adult's Collection
SALT	Short and Long Term support
SARG	Safeguarding Adolescents at Risk Group
SCAN	Service for children and adolescents with neurodevelopmental difficulties
SEND	Special Educational Needs and Therapy

SENDIASS	Special Education Needs and Disabilities Information, Advice and Support Services
STP	Sustainability and Transformation Plan
STPP	Short Term Psychoanalytic Psychotherapy
TOR	Terms of Reference
TTT	Test, Track and Trace
UASC	Unaccompanied Asylum-Seeking Children and Young People
VARP	Vulnerable Adolescents at Risk Panel
VAWG	Violence Against Women and Girls
VCS	Voluntary and Community Sector
VCSE	Voluntary, Community and Social Enterprise
VOC	Variants of Concern
VCSE	Voluntary Community and Social Enterprise
YCB	Your Choice Barnet
YOT	Youth Offending Team
WDP	Westminster Drug Project
WHO	World Health Organisation

Health and Wellbeing Board Work Programme

2021-2022

Contact: Salar Rida (Governance) salar.rida@barnet.gov.uk

AGENDA ITEM 7

Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision
9 December 2021				
List of abbreviations	The Board to note the list	Chair of the HWB Board	Governance Officer	Non-key
Forward Work Programme	The Board to note the Programme	Chair and Vice Chair of the HWB	Governance Officer	Non-key
COVID-19 Pandemic Update (verbal)	The Board to note the update	Director of Public Health and Prevention Vice Chair of the HWB	Director of Public Health and Prevention Vice Chair of the HWB	Non-key
Deep Dive – JHWBs Key Area 1: Creating a Healthier Place and Resilient Communities				
Creating a Healthier Place	The Board to note progress and next steps	Director of Public Health and Prevention	Public Health consultant	Non-key
COVID-19 Champions – One Year On	To note the update	Director of Public Health and Prevention	Public Health consultant	Non-key
Social Prescribing – Two Years on and next steps	To note the progress	Director of Public Health and Prevention	Public Health consultant	Non-key
Business items				
Future of Health and Wellbeing Board update (verbal)	To discuss the proposal	Executive Director of Adults and Health and Director of Public Health and Prevention	Director of Public Health and Prevention	Non-key
Suicide Prevention Plan Update: Children and Young People	To approve additional actions	Director of Public Health and Prevention and Executive Director of Children and family Services	Public Health consultant	Key
OFSTED Report on Children in Care	To note recommendations	Executive Director of Children and Family Services	Strategic Lead – Children and Young People	Non-key

***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*

NCL CAMHS Transformation Proposal	To note plan for 22/23	Interim Director Aligned Commissioning NCL CCG	Interim Director Aligned Commissioning NCL CCG	Non-key
Better Care Fund Plan	To endorse approved plan	Executive Director of Adults and Health	Head of Joint Commissioning - Older Adults & Integrated Care	Key
24 March 2022				
List of abbreviations	The Board to note the list	Chair of the HWB Board	Governance Officer	Non-key
Forward Work Programme	The Board to note the Programme	Chair and Vice Chair of the HWB	Governance Officer	Non-key
Pharmaceutical Needs Assessment (PNA)	The Board to agree the recommendations	Director of Public Health and Prevention	Project Development Manager	TBC
COVID-19 Pandemic Update (verbal)	The Board to note the update	Director of Public Health and Prevention Vice Chair of the HWB	Director of Public Health and Prevention Vice Chair of the HWB	TBC

***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*

Suggested future and standing agenda items	
Suggested future items	**Standing agenda items**
Cardiovascular Disease Prevention – Deep dive	Forward Work Programme
Enhanced care in Care Homes	ICP Updates
Air Quality	BCF update plan
SEND Strategy	

***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*

AGENDA ITEM 9

	Health and Wellbeing Board **9th December 2021**
Title	**Joint Health and Wellbeing Strategy Key Area One deep dive**
Report of	Director of Public Health and Prevention
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix I: Overview of Key Area One presentation Appendix II: Progress report on Key Area One: Creating a Healthier Place and Resilient Communities
Officer Contact Details	Janet Djomba, Consultant in Public Health – janet.djomba@barnet.gov.uk

Summary

Key Area One of the Barnet Joint Health and Wellbeing Strategy (JHWS) 2021 to 2025 is about creating a healthier place and resilient communities. Within this key area are three outcomes which are Barnet is a healthy place to live, work and study, air we breath in Barnet is cleaner and Barnet communities are resilient and safe.

This report provides an update to the Board on projects underway to deliver the outcomes of Key Area One and the work across the council to improve health and wellbeing by creating a healthier place and resilient communities.

Appendix I is a presentation containing an overview of Key Area One projects.

Appendix II is the progress report on key area one and includes progress updates on workstreams, next steps to be delivered and a log of key risk and issues. The report also includes related updates on Making Every Contact Count (MECC) and the Health Champions programme.

Recommendations

1. **That the Board note the Key Area One overview presentation**

2. That the Board note the progress report on Key Area One

1. WHY THIS REPORT IS NEEDED

1.1 This report gives the Board an update on the activity of projects to implement key area one of the Barnet JHWS. In addition to an overview of performance indicators for this area the report provides a deep dive into healthy environment related projects currently underway in Barnet, including projects relating to the environment, air quality, town centres and healthy weight. The full deep dive to key area one is included as appendix I of this report.

1.2 The first outcome of this area is that Barnet is a healthy place to live, work and study. We have successfully recruited a Public Health Business Engagement Officer who will lead on the implementation of the Healthier High Streets programme. As part of this programme web content has been published and are working with relevant stakeholders to ensure information on the programme is linked across the website. To further support the aims of this outcome, a CYP Healthy Weight Action plan is currently in development which will link to current strategies and address gaps such as adolescent healthy weight management. The next steps for projects under this outcome is to engage with council officers on increasing the number of water fountains and to update the intervention pathways for child weight management ensuring those most in need are supported.

1.3 The second outcome is that the air we breath in Barnet is cleaner. This outcome is addressed through projects on air quality in general, tree planting and active travel. In terms on nitrogen dioxide levels, Barnet has the best air quality levels since 1992. Ongoing work to improve air quality includes addressing non-road machinery at construction sites, delivering electric vehicle chargers and planting trees near busy roads to absorb pollutants. Upcoming work will be to improve air quality awareness for vulnerable residents. Promoting active travel opportunities remains a key piece of work including the programmes such as Health Warks and Healthy Heritage Walks. Infrastructure works for active travel are also have a role in increasing opportunities with recent projects such as improved cycling route linking Silkstream and Montrose Parks. Future pieces of work n the active travel area include a refresh of the Fit & Active Barnet Framework and a study developing proposals to deliver a cycle route parallel to the A5.

1.4 Barnet communities are resilient and safe is the final outcome of key area one. This outcome includes social prescribing and prevention & wellbeing services with referrals to both services continuing and increasing. All practices in Barnet are now making referrals to social prescribing link workers and referrals for this year have increased by more that 50% compared to the last financial year. Next steps for this workstream include further recruitment in order to have cross-borough coverage and the reestablishment of community-based support following the pandemic. The Domestic Abuse and Violence against Women and Girls (VAWG) Strategy 2021-24 is currently in development with the public consultation on the draft strategy now taking place. Further to the strategy

development, VAWG services are currently being recommissioned alongside the ongoing delivery of the advocacy service, MARAC, perpetrator programmes and IRIS.

2. REASONS FOR RECOMMENDATIONS

2.1 The contents of this deep dive showcase the progress to date of the projects to implement the JHWS that was approved in July. This report showcases the partnership working that will improve health and wellbeing for all who live work and study in Barnet. This update also provides the opportunity for the Board to engage with these workstreams and ensure its continued active role in implementing the JHWS.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable

4. POST DECISION IMPLEMENTATION

4.1 For the duration of this strategy, regular updates will be provided to the Board by the Director of Public Health and Prevention. These updates will give the Board oversight of the key performance indicators (KPIs) and implementation plan for the strategy. Following this report, separate deep dives for the two remaining strategy key areas will be presented to the board in due course.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 This report provides updates on key projects and outputs for key area one of the Joint Health and Wellbeing Strategy. This deep dive provides narrative updates on workstreams linked to the priorities and aims of the JHWS. This includes projects which further the shared priorities of the JHWS and aligns with the Barnet Corporate Plan.

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

5.2.1 Implementation of the JHWS will need to be affordable and funded within the existing budget and staffing from the (non-Covid-19) PH Grant and wider system.

5.3 Social Value

5.3.1 Not applicable for this report.

5.4 Legal and Constitutional References

5.4.1 Developing a JHWS is a statutory responsibility of the Health and Wellbeing Board, as set out in the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care Act 2012). This report is an update on the progress of activities within the JHWS.

5.4.2 Article 7 Committees, Forums, Working Groups and Partnerships of the Council's Constitution sets out the terms of reference of the Health and Wellbeing Board which includes the following responsibilities:

• To jointly assess the health and social care needs of the population with NHS commissioners, and apply the findings of a Barnet joint strategic needs

assessment (JSNA) to all relevant strategies and policies.
• To promote partnership and, as appropriate, integration, across all necessary areas, including the use of joined-up commissioning plans across the NHS, social care and public health. To explore partnership work across North Central London where appropriate
• 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 wellbeing.
• Specific responsibilities for overseeing public health and developing further health and social care integration

5.5 **Risk Management**

5.5.1 As part of the risk management for the JHWS implementation plan, there is a risk register which is regularly reviewed to ensure that risks are effectively managed and escalated as appropriate. Risks associated with the delivery of projects related to this key area are identified in the appendix with mitigations where required.

5.6 **Equalities and Diversity**

5.6.1 A whole systems approach to prevention has been taken along with health and care integration with a focus on health inequalities which persist amongst groups with protected characteristics.

5.7 **Corporate Parenting**

5.7.1 Whilst there is no direct impact on the council's corporate parenting role as a result of the Health and Wellbeing Strategy development, the actions set out in the plan do provide opportunities to support the council's role as corporate parent through the health and wellbeing improvement interventions for children and young people residing in the borough including children in care

5.8 **Consultation and Engagement**

5.8.1 Not applicable for this report.

5.9 **Insight**

5.9.1 The KPIs and actions for the JHWS have been chosen with evidence and data at the forefront of decisions. Different sources of data have been used and identified to best demonstrate how we are performing against the goals of the strategy. These have been sourced from across the health sector and include the Joint Strategic Needs Assessment, Fingertips and the Public Health Outcomes Framework.

5.9.2 Looking forwards, to the implementation of the strategy, data will continue to inform the actions that are performed across Public Health. Any issues identified within the data currently available to the council, will be monitored and actioned as appropriate, striving for equality in health regardless of background, race, religion, gender. The KPIs will be informed by data and monitored accordingly.

6. BACKGROUND PAPERS

6.1 Final Joint Health and Wellbeing Strategy Key Performance Indicators 2021-2025. Available at: https://barnet.moderngov.co.uk/documents/s66682/Board%20Paper%20HWBS%2022.09.pdf

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KEY AREA 1: Creating a healthier place and resilient communities

Key Area 1 Deep Dive

Health and Wellbeing Board

9 December, 2021

DRAFT

BARNET
LONDON BOROUGH

Our commitments

Integrate healthier places in all policies

We will ensure that all of our policies and strategies across the system include specific actions on improving health and health equity through creating good housing, employment opportunities, active travel links and other economic and commercial conditions in Barnet

Create a healthier environment

We will create healthier choices locally with a focus on improving access to clean air, water, healthy food and physical exercise

Strengthen community capacity and secure investment to deliver healthier places

We will facilitate networking and capacity building between local communities and promote safety and cohesion while preventing violence and crime. We will make domestic abuse and violence against women and girls everyone's business.

DRAFT

Contents

There is so much excellent work underway to make Barnet a healthier place! Today will be highlighting just *some* of these areas. Partners will be presenting brief updates on the following workstreams:

Integrate Healthier Places into All Policies

- Healthier High Streets
- Town Centres

Create a Healthier Environment

- Sustainability
- Air Quality

Strengthen Community Capacity

- Domestic Violence Against Women and Girls (DVAWG) Strategy
- Health Champions
- Make Every Contact Count (MECC)
- Social Prescribers

DRAFT

Integrate healthier places in all policies

We will ensure that all of our policies and strategies across the system include specific actions on improving health and health equity through creating good housing, employment opportunities, active travel links and other economic and commercial conditions in Barnet

DRAFT

Healthier High Streets

Challenge

- Residents see accessibility of healthier food as a barrier to making Barnet a healthier place
- Building stronger communities was identified as a resident priority; ensuring high streets are accessible and welcoming for all will make our communities more resilient

Inputs

- Multidisciplinary team to identify workstream priorities
- Programme Action Plan developed
- Public Health Business Engagement Officer to support implementation

Actions

- Improve communication with businesses (online and in-person)
- Work with businesses to develop and improve operational resources for workstream(s) implementation
- Conduct a programme evaluation to understand barriers to workstream(s) uptake

Short/Mid Term Outcomes

- Collective understanding of the role local business can play on health
- Businesses feel empowered to take action
- Structure in place to launch additional healthier high street workstreams (e.g., alcohol smart serve & healthier convenience shops)

DRAFT

DELIVERING FOR BARNET

Barnet's Growth Strategy

- A Growing Borough
- A Connected Borough
- An Entrepreneurial Borough
- A Borough of Thriving Town Centres
- A Great Borough to Live In and Visit

A Borough of Thriving Town Centres

More town centres in Barnet than any other London borough…

Where we're going - Growth Strategy goals and next steps…

- Strengthened identity and diversification of town centres
- Joined-up service delivery for high streets
- New, high-quality workspace
- Thriving evening economy

What we've done…

- Support for businesses, 'Shop Safely, Shop Local'
- Secured extra £23.5M for priority town centre investment
- Finchley Square starting on site 2022: over 3,000 sqm of new public realm, seating, lighting, trees; active travel, Healthy Streets Principles
- West Hendon Broadway, Burnt Oak and Golders Green next in line
- Major town centre revitalisation programmes for Edgware and North Finchley

Create a healthier environment

We will create healthier choices locally with a focus on improving access to clean air, water, healthy food and physical exercise

DRAFT

Sustainability and Air Quality

Tree Planting, Air Quality Audits, Air Quality Communications & Awareness

"I have been working at Barnet Hospital for 10 years, but it was only at the beginning of the pandemic that I started cycling to work. I did my first journey with a colleague who already cycled; I hadn't realised how easy the journey could be. 90% of my route is on a cycle path and I feel really good by the time I get to work. I want people to realise you don't have to be this hard core cyclist, wearing all the gear etc. and you don't have to cycle every day. But when the weather is nice, it can be really pleasant." -Daniel Epstein, Consultant at Barnet Hospital

DRAFT

Sustainability

- A Sustainability Strategy Framework has been produced and will be discussed this evening at Policy & Resources Committee (9th December 2021). The report and appendix can be found online: https://barnet.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=692

- New webpages have been produced and a communications plan developed which links to the wider national picture, and specifically the agreements reached at COP26 and within the government's recently launched Net Zero Strategy. They include:
  - Actions the Council is already taking to ensure the borough is more sustainable
  - detail on the forthcoming Sustainability Strategy
  - Advice for residents and businesses on how they can become more sustainable
  - A statement from the Leader of Barnet Council

More info can be found here: https://www.barnet.gov.uk/sustainability

DRAFT

Sustainability

The framework includes the following:

- Baseline – an overview of the baseline and the key findings
- Strategy Framework – inc. info on actions already taken in each of the below areas, as well as the actions we are proposing
- Barnet as a place:
  - Housing and buildings (inc. new and existing private housing and our own housing stock)
  - Transport (inc. EV charging)
  - Renewable energy and waste
  - Business, skills and partner organisations
  - Natural environment and biodiversity
  - Communication activity
- Barnet as an organisation:
  - Supply chain (inc. sustainable procurement and working with existing suppliers)
  - Council operations (inc. corporate estate, energy procurement and fleet)

- Net Zero Ambition – Building on the commitments outlined in the Leader's Statement, the Sustainability Strategy framework includes detail on the net zero ambition of the council as an organisation and as Barnet as a place.

DRAFT

Sustainability: Next Steps

Following approval of the recommendations from P&R Committee on 9th December, work will continue on the development of the Sustainability Strategy. This includes:

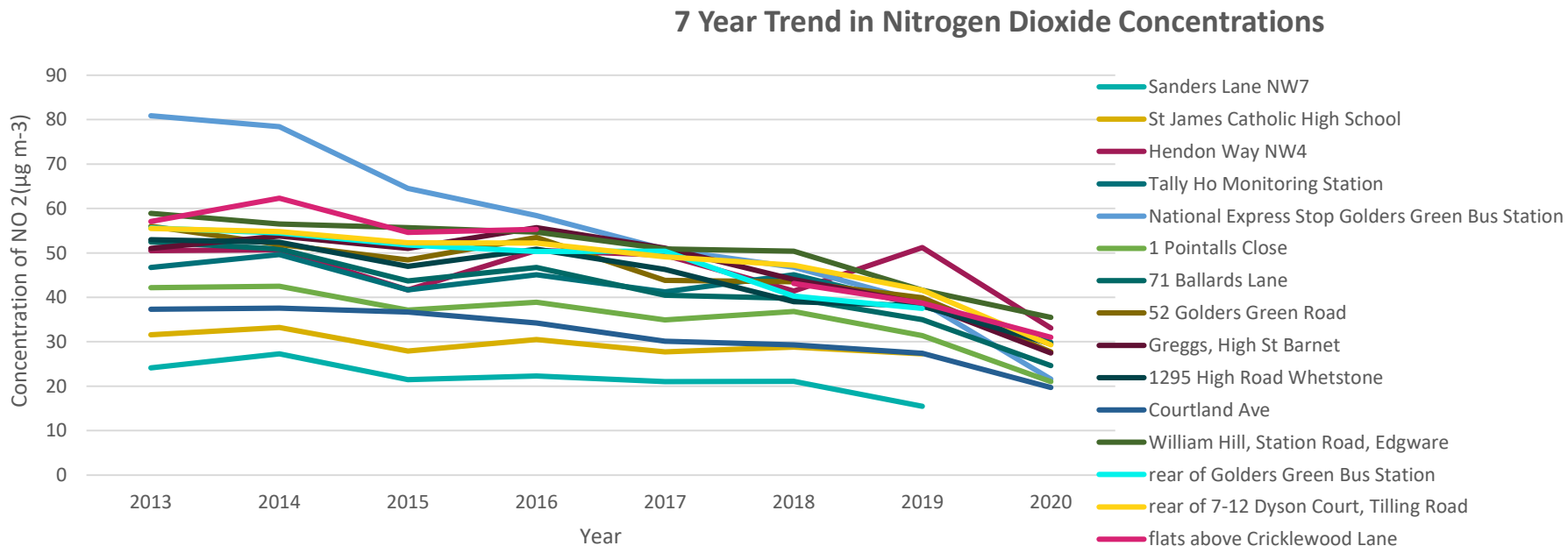
- **Engagement with residents and businesses and a full public consultation**
- **Development of the Sustainability Strategy for adoption**
- **Development of the commitments outlined in framework and further work to develop feasibility studies and implementation plan**
- **We will continue applying for funding and grants as and when it emerges**
- **Continue to communicate with residents and businesses about the actions we are taking, how the strategy is developing and how they can become more sustainable**

DRAFT

Air Quality

Air quality improvement Update:

- **Best air quality in Barnet since 1992 NO2 survey began**
- **Only 2 sites above objectives in 2019 – 0 in Lockdown 2020 (24% less pollution) 13/17sites exceeded objective in 2013 pre DRS.**



DRAFT

Air Quality

Improvement in Air quality - Lower Nitrogen Dioxide and Particulates 1992-2021 AQ Action Plan

- Cleaner engines for vehicles, London Low Emission Zone for HGV's, Ultra Low Emission Zone
- New Boilers Low NO2- new developments sustainable energy: air source heat pumps, solar and sustainable transport options for cycling, walking, electric vehicle hire, less parking
- Cleaner Non road machinery on construction sites(12% pollution) reducing smoke from JCB's & generators
- Improved public realm- Barnet High street North Finchley: more room for pedestrians, less parked cars and congestion on A roads
- A1000 experimental Cycle lane 8-24% less pollution on 3 monitoring sites
- Now measuring PM2.5 smaller particles that enter lungs at Martin school- 3 school audits- mosts Gold sustainable school travel STARS for any London Borough
- Over 150 Electric vehicle charge points to date,51 Km of 20mph roads, tree planting near busy roads absorbing pollutants- less pollution from 90+ permitted LAPPC processes

Air Quality

Next Steps

- Feedback from residents has shown that congestion is the third most important issue.
- Reducing parking on busy A roads will help to not just reduce congestion, but also air pollution and will also help aid sustainable transport.
- We will conduct air quality audits at selected schools
- Planting trees along busy roads will continue
- The forthcoming Sustainability Strategy will work to improve air quality
- We will increase awareness on air pollution, especially among vulnerable residents (https://www.barnet.gov.uk/.../air-quality/air-quality-monitoring)

DRAFT

Strengthen community capacity and secure investment to deliver healthier places

We will facilitate networking and capacity building between local communities and promote safety and cohesion while preventing violence and crime. We will make domestic abuse and violence against women and girls everyone's business.

DRAFT

Domestic Violence Against Women & Girls

Domestic Abuse and Violence against Women and Girls Strategy 2021-2024

February 2021 – October 2021	**Soft consultation**
29th October – 20th December 2021	**Full public consultation**
21st January 2022	**Final Strategy presented to Safer Communities Partnership Board for approval**
8th March 2022	**International Women's Day - Official launch of the new strategy**

DRAFT

Domestic Violence Against Women & Girls

Soft Engagement Outcomes

Our strategy to be renamed 'DA & VAWG Strategy' 2021-24

2017-20 Priority objectives	2021-24 Priority objectives
1. Preventing Violence against Women and Girls	1. Early intervention and prevention of Domestic Abuse and VAWG
2. Improving outcomes for victims and their children	2. Support all victims and survivors to report, access help and recover
3. Holding perpetrators to account	3. Pursue perpetrators and improve their engagement with behaviour change interventions to eliminate harm to victims and their families
4. Enhancing joint working practices between agencies	

DRAFT

Domestic Violence Against Women & Girls

Update

- Domestic Abuse Act training being delivered to the multiagency partnership
- Recommissioning of VAWG services
- New Culturally Integrated Family Approach (CIFA) to Domestic Abuse Perpetrator Programme successfully funded by Home Office and being delivered in Barnet, Brent & Enfield
- Ongoing delivery of Advocacy service, MARAC, perpetrator programmes and IRIS

Next Steps

- The public consultation for the draft DA and VAWG Strategy 2021-2024 is now live on Engage Barnet. You can find the draft documents and information about how to have your say here https://engage.barnet.gov.uk/da-vawg-strategy
- Roll out of Independent Domestic Violence Advocate (IDVA) and Young Peoples IDVA (YIDVA) Training to statutory and VCS providers working in front line roles on VAWG
- White Ribbon accreditation in progress

DRAFT

Health Champions

HEALTH CHAMPIONS RECRUITMENT FLYER

BECOME A COVID-19 HEALTH CHAMPION

COVID-19 HEALTH CHAMPIONS

Do you want to help your family and friends?
Anyone living, working or studying in Barnet can get involved.

Get live updates on COVID-19
Receive the latest information and government guidelines on how to stay safe and healthy.

Become a COVID-19 Health Champion
Join our network of local people to help during the COVID-19 pandemic.

Spread the word
Share this COVID-19 information with your family, friends, work colleagues and the wider community.

You can help to stop the virus
Keeping our communities well informed will help minimise the risk of the virus spreading.

Register to become a Champion
Visit: www.engage.barnet.gov.uk/health-champions
Email: barnethealthchampions@groundwork.org.uk

Together, we can make sure everyone in Barnet has the information they need to stay safe and healthy.

BARNET LONDON BOROUGH · KEEP BARNET SAFE · Barnet Together · GROUNDWORK CHANGING PLACES CHANGING LIVES

DRAFT

كن بطلاً صحيًا في أزمة كوفيد-19

COVID-19 HEALTH CHAMPIONS

هل تريد مساعدة عائلتك وأصدقائك؟
يمكن لأي شخص يعيش أو يعمل أو يدرس في بارنيت (Barnet) المشاركة.

احصل على تحديثات مباشرة عن كوفيد-19
احصل على أحدث المعلومات والإرشادات الحكومية حول كيفية الحفاظ على سلامتك وصحتك.

كن بطلاً صحيًا في أزمة كوفيد-19
انضم إلى شبكتنا من السكان المحليين للمساعدة خلال جائحة كوفيد-19.

ساعد في نشر الكلمة
شارك معلومات كوفيد-19 هذه مع عائلتك وأصدقائك وزملائك في العمل والمجتمع الأوسع.

يمكنك المساعدة في وقف انتشار الفيروس
سيساعد إبقاء مجتمعاتنا على اطلاع جيد في تقليل مخاطر انتشار الفيروس.

سجل لتصبح بطلاً
قم بزيارة: www.engage.barnet.gov.uk/health-champions
البريد الالكتروني: barnethealthchampions@groundwork.org.uk

مهما، يمكننا التأكد من حصول كل شخص في بارنيت
على المعلومات التي يحتاجها للبقاء آمنًا ومتمتعًا بالصحة.(Barnet)

BARNET LONDON BOROUGH · KEEP BARNET SAFE · Barnet Together

DEVENIŢI UN CAMPION AL SĂNĂTĂŢII ÎN CONTEXTUL COVID-19

COVID-19 HEALTH CHAMPIONS

Doriți să vă ajutați prietenii și familia?
Orice persoană care locuiește, lucrează sau studiază în Barnet se poate implica.

Primiți actualizări în timp real cu privire la COVID-19
Primiți ultimele informații și instrucțiuni guvernamentale cu privire la modalitățile de păstrare a siguranței și a sănătății.

Deveniți un campion al sănătății în contextul COVID-19?
Puteți să vă alăturați rețelei noastre locale pentru sprijin pe durata pandemiei COVID-19.

Răspândiți vestea
Răspândiți aceste informații referitoare la COVID-19 în rândul familiei, prietenilor, colegilor de muncă și comunității mai largi.

Puteți să ajutați la stoparea virusului
Informarea corectă a comunităților va ajuta la minimizarea riscului de răspândire a virusului.

Cum să vă înregistrați pentru a deveni un campion
Vizitați: www.engage.barnet.gov.uk/health-champions
Email: barnethealthchampion@groundwork.org.uk

Împreună ne putem asigura că toate persoanele din Barnet dețin aceste informații de care au nevoie pentru siguranța și sănătatea lor.

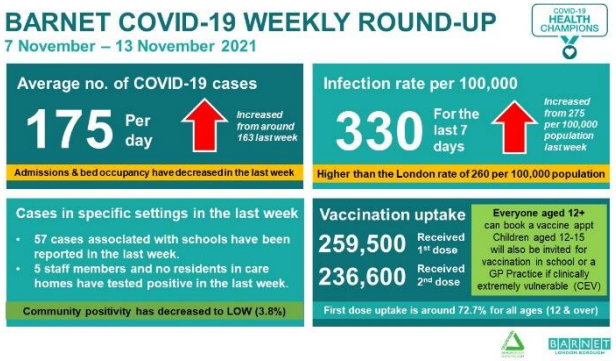
BARNET LONDON BOROUGH · KEEP BARNET SAFE · Barnet Together

268
HEALTH CHAMPIONS REGISTERED

21
Barnet Wards covered

COVID-19 HEALTH CHAMPIONS

Underhill, Woodhouse & Totteridge
with the largest number of Champions



80
current infographics

197
on WhatsApp Broadcast

111
on WhatsApp Group

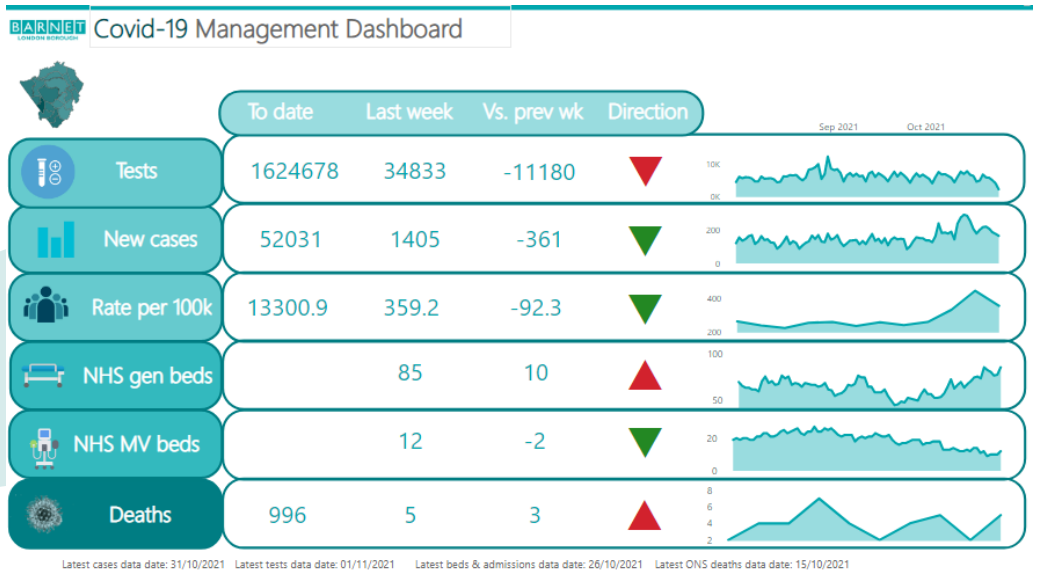
71
Zoom Sessions

48 Info
18 Welcome
5 Focus Groups

48
Friday Facts e-newsletters

Information sessions

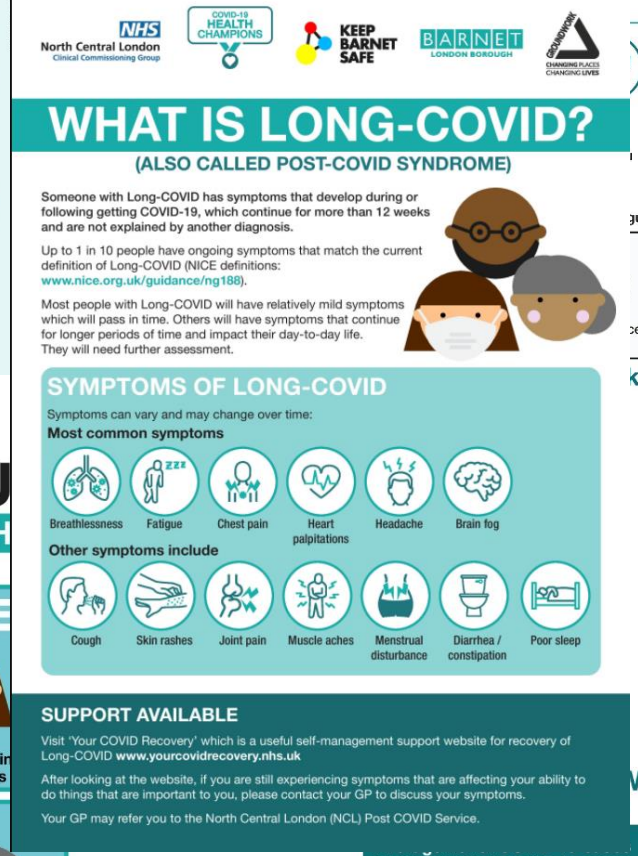
48 information sessions covering a whole range of topics

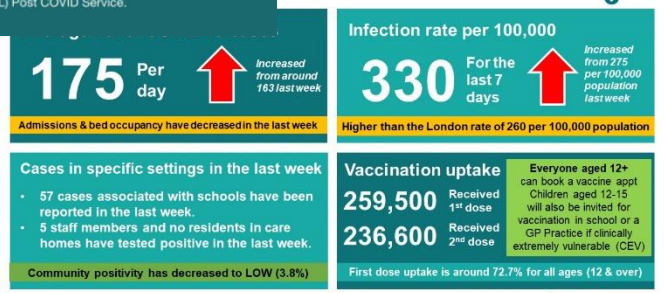


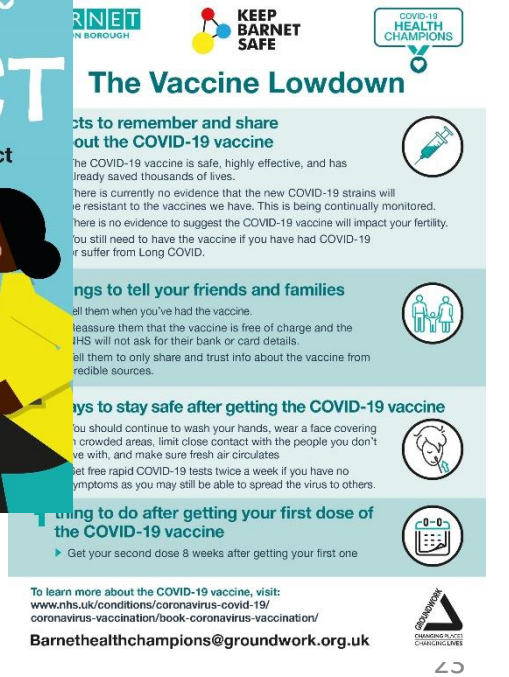
44

22

Infographics







Health Champions in campaigns

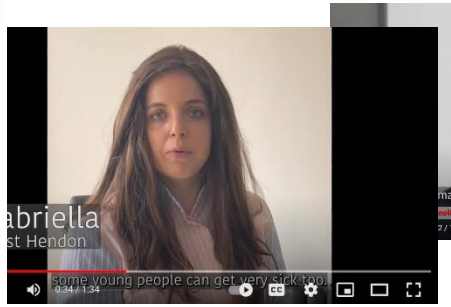
"I feel privileged that I can help people get accurate information" **– Health Champion**

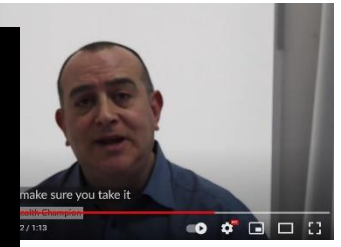
"I most enjoy the sense of having made a contribution towards the fight against the pandemic" **– Health Champion**

Rory, Barnet Health Champion, said:

"It's a mutual relationship between the Champions and the council. We're encouraged to feedback what's happening locally to help ensure we are supporting the needs of Barnet community.

"It's amazing to make a difference and join fellow Champions who come from a variety of backgrounds, faiths, and ethnicities. We learn so much from each other."





Next Steps

Autumn/Winter Plan

COVID-19 prevention

Booster jab, Evergreen offer, young person vaccinations, mask wearing

Vaccine confidence, Plan A/B

Winter wellness

Flu jab, A&E only if necessary, Staying home if unwell

Mental and physical wellbeing

Mental health

Future Opportunities

Wider topics

CVD/Diabetes Prevention

Bereavement Support

Suicide Prevention

Useful PH Resource

Consultations

Testing messages / comms

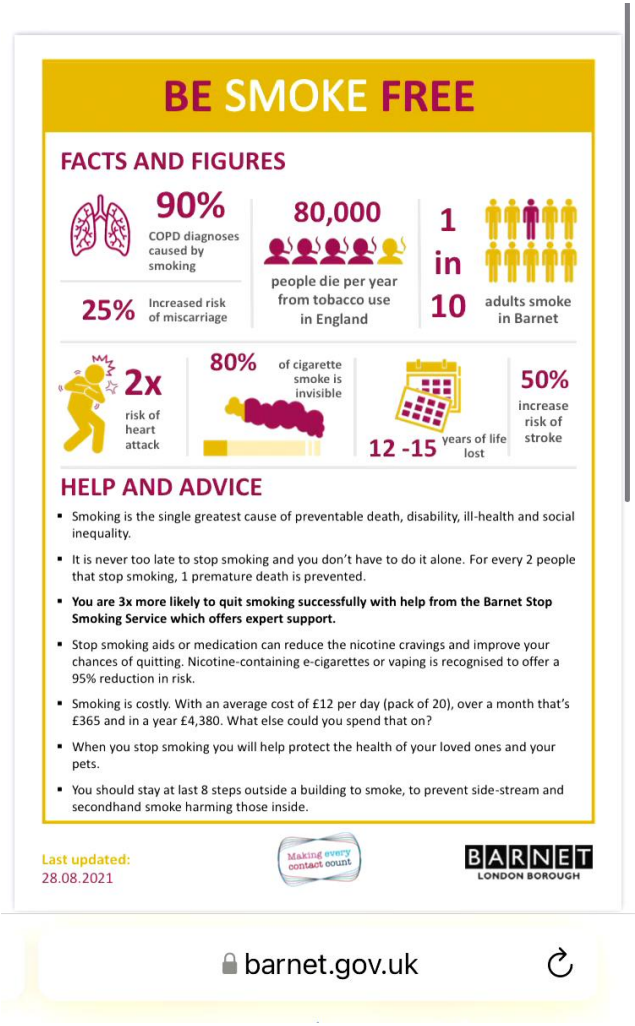
Wider reach into our communities

DRAFT

Make Every Contact Count (MECC)

- Launched interactive eLearning module jointly with LB Enfield in September 2021
- Published 19 newly designed factsheets covering an array of topics. 10 more in progress
- Started to socialise the MECC module within the LBB workforce – CMT approved
- Beginning to explore wider partner mobilisation across the ICP (including COVID-19 Health Champions)

To access the training and factsheets, visit: www.barnet.gov.uk/MECC



DRAFT

Make Every Contact Count (MECC)

Next steps

- **Increase workforce awareness across ICP of MECC and encourage uptake of the available eLearning module, where appropriate for their roles**
- **Highlight additional factsheet topics for development – can be wider than health & wellbeing**
- **Identify priority teams and organisations to undertake a more in-depth face-to-face training offer**

In the longer term, we seek to co-design a tiered approach to a MECC programme in Barnet, with the potential to build a network of MECC Champions

DRAFT

Social Prescribing; What is Social Prescribing?

- Key component of the NHS long term plan is to build a universal personalised care approach within the health and care system
- Enables health and care professionals to connect people community-based services, groups and activities to meet their non-medical needs
- Offers 1-1, short term support to help patients to identify what matters to them and how they can improve their situation or wellbeing

DRAFT

Social Prescribing in Barnet

- The service started in December 2019
- A total of 18 Social Prescribing Link Workers
- Age UK Barnet has managed the service since June 2020
- All Primary Care Networks have signed-up

Social Prescribing in Barnet: Summary 2020/21

12,424 total number of appointments made

2/3 referrals were female

50% increase in referrals this year

87% patients said their wellbeing improved

3224 total number of referrals

highest rate of referrals in those aged 85 and over

no GP appointments were booked during a social prescribing intervention

Most common referral reasons in people 75+

1. Social support (loneliness and isolation)
2. Carers support
3. Mental health support

Most common referral reason in young people aged 18-35

1. Mental health (depression and anxiety)
2. Housing, welfare, benefits and employment

DRAFT

Social Prescribing in Barnet: Next Steps

Social Prescribing Advisory Group set up to improve engagement with the wider voluntary and community sector

Elemental software/case management system allows community groups to create logins to update service information and see performance on prescribing

Preliminary conversations held with the RFG to set-up referral pathways

Evaluation – analysis of the impact on GP attendance and secondary care usage

DRAFT

Key Area 1: Summary

- Collaboration across the council and partners to achieve Key Area One outcomes
- This deep dive has highlighted just some of the amazing work that has been done and what is planned for the future
- Next Steps:
  - Bringing updates and/or highlight reports to the Health & Wellbeing Board on a regular basis
  - Keep tracking progress against targets
  - Increasing collaboration across stakeholders
  - Health and Wellbeing Strategy to go to other Boards across the council to raise awareness and help increase collaboration
- Does the Health & Wellbeing Board like this format for the deep dives of the HWBS areas?
- Feedback and suggestions are much appreciated and will help future deep dives and updates

Appendix II - Progress report on Key Area One: Creating a Healthier Place and Resilient Communities

Barnet is a healthy place to live, work and study.

1. Healthier High Streets & Drinking Water Stations
2. Child Weight Management

Healthier High Streets & Drinking Water Stations		
Overall Rating: Green		
Key Performance Indicator	**Baseline**	**Target**
Number of businesses involved in the Healthier High Streets programme.	New metric.	200 eligible businesses involved.
Number of free drinking water stations installed in the Borough.	Refill participating businesses (2021) – 76. Fountains – 0.	Two free drinking water facilities per town centre and at least one water fountain in Barnet.

Progress update:

- Successfully recruited to the post of Public Health Business Engagement Officer who will lead on the implementation of the Healthier High Streets programme which is due to formally launch in early 2022.
- Website content to support the programme has been published and we are working with stakeholders to ensure information is linked to all relevant webpages.

Next steps:

- To finalise a programme plan for the launch of the Healthier Highstreets programme.
- To engage with relevant Council officers on increasing water fountains throughout the Borough.

Key Issues & Risks:

Summary	**Mitigating Actions**	**Rating**
A cross-Council team to provide strategy on water fountains is not currently in place.	Health in All Policies team to approach relevant officers and plan introduction meeting of water fountains working group.	Green

Support requested from Health & Wellbeing Board

None requested at this time

Child Weight Management		
Overall Rating: Green		
Key Performance Indicator	**Baseline**	**Target**
The proportion of overweight or obese children at Year 6 (ages 10-11).	34.4% (2019/20).	No increase.

Progress Update

- To continue development of CYP Healthy Weight Action Plan and contribute to linked corporate strategies – the Healthy Weight Strategy and Physical Activity Strategy. Address gaps such as adolescent healthy weight management.
- To re-start implementation of NCMP following pause during COVID-19 and to use data and intelligence to effectively target support and intervention to those children and young people most in need.

Next Steps

- Work with partners to continue implementation and targeting of collaborative programmes.
- Updating the intervention pathways to ensure those most in need are supported.
- Continue development and implementation of programmes that address the wider obesogenic environment.
- Continue programmes that empower children and young people with knowledge, skills and confidence to make healthy choices such as Sugar Smart, Sugar Trans Fat programme, Healthy Schools London, Mayors Golden Kilometre.

Key Issues & Risks

Summary	Mitigating Actions	Rating
Complexity of influences on healthy weight across many sectors/services.	Acknowledge complexity and take whole systems approach to healthy weight management. Continue to work collaboratively.	Green
Range of partners and collaborators across different services.	Work collaboratively, acknowledging the contribution of all and avoiding duplication. Build on partnership development.	Green

Support Requested from Health & Wellbeing Board

Advocate whole systems approach to healthy weight management and to make the links across services, encouraging partnership and collaboration

The air we breathe in Barnet is cleaner.

1. Air Quality
2. Tree Planting
3. Active Travel

Air Quality		
Overall Rating: Green		
Key Performance Indicator	**Baseline**	**Target**
Number of deaths attributable to air pollution.	201 deaths in Barnet (8.4 per 10,000).	No increase.

Progress Update

- Best air quality in Barnet since 1992 where nitrogen dioxide levels are concerned.
- Only two sites above objectives in 2019 and no sites above objectives during COVID-19 “lockdown”.
- Cleaner engines for vehicles, London Low Emission Zone for HGV’s, Ultra Low Emission Zone.
- Cleaner non-road machinery on construction sites, reducing smoke from JCB’s and generators.
- Barnet High Street North Finchley: More room for pedestrians, less parked cars and less congestion.
- A1000 experimental cycle lane -24% less pollution on three monitoring sites.
- Now measuring PM2.5 smaller particles that enter lungs at Martin School.
- Barnet has the most Gold sustainable school travel stars of any London Borough.
- We have installed 72 Electric vehicle chargers, 51 Km of 20mph roads and continued tree planting near busy roads to absorb pollutants.

Next Steps

- Improve air quality awareness for vulnerable residents.

Key Issues & Risks

- *No key issues or risks to raise at this time.*

Support Requested from Health & Wellbeing Board

- *None requested at this time.*

Tree Planting		
Overall Rating: Green		
Key Performance Indicator	**Baseline**	**Target**
Number of trees planted a year along Barnet's road network.	211 (2021/22)	100 trees per year on the highway.

Progress Update

- Planting of new Memorial Woodland began in late November and will open to the public in Spring 2022.

Next Steps

- A five-year after-care plan has been agreed to maintain the Woodland.
- 60 trees to be planted in and around housing estates. Phase 1 began this year and Phase 2 begins next year.

Key Issues & Risks

No key issues or risks to raise at this time.

Support Requested from Health & Wellbeing Board

None requested at this time.

Active Travel		
Overall Rating: Green		
Key Performance Indicator	**Baseline**	**Target**
Proportion of residents who walk or cycle for travel (at least once a week).	Cycling – 5.5% (2018/19). Walking – 49.1% (2018/19).	Cycling – 7%. Walking – 60%.

Progress Update

Active Travel Promotion

- London Borough of Barnet continues to coordinate and promote the Health Walks and Healthy Heritage Walks programmes. Interventions are also delivered via partner agencies that contribute to the active travel agenda, e.g. Age UK Barnet Health Walks, GLL Health Walks and development of an app that encourages walking/movement through behaviour change, Re. Bikeability, cycle parking, and STARS.
- The pandemic resulted in the loss of Local Implementation Plans funding (TfL) which has seen a reduction in delivery of cycling interventions delivered by Re. LBB Greenspaces and Leisure also had funding withdrawn that was committed to deliver active travel interventions (prior to the pandemic a request for quote was developed with input from internal and external partners to support procurement of a digital active travel intervention, but due to withdrawal of funding this has been paused.)
- The Safe and Sustainable Travel Team in Re continue to work with schools to develop and implement School Travel Plans and obtain STARS accreditation for these. Currently Barnet has 81 schools with Gold accreditation, 3 with Silver and 22 with Bronze.

Active Travel Infrastructure

- An improved cycling route was provided through half a mile of Silkstream and Montrose Parks in Colindale in 2020 together with a road treatment and crossing linking the two parks.
- Two footbridges on walking/cycling routes in the Dollis Valley are being replaced and widened to improve conditions, particularly for cyclists - one completed in 2020, the other in progress.
- A1000 Cycle Lane: A predominantly segregated cycle route of around 3.2km was introduced in late 2020, between Tally Ho Corner and the boundary with LB Haringey. This was funded utilising Government emergency funding. The A1000 is highlighted in the Borough's Long-term Transport Strategy. The opportunity offered by government funding to achieve early installation of a section of the route provides a clear commitment to the aspirations of the LTTS. This funding provided for the installation of temporary alternative transport measures to mitigate the impact of Coronavirus on public transport. However, the Government is keen to avoid removal of all such schemes without reason. We are currently monitoring the scheme in terms of traffic volumes, journey times and air quality. We will be taking the scheme back to Environment Committee in January 2021 to report on the result of these surveys.

Next Steps

- Interventions will continue to be delivered and funding/investment opportunities explored.
- The Fit & Active Barnet (FAB) Framework is being refreshed with strategic input from partners, stakeholders and residents. Active Travel has been a common and reoccurring theme amongst feedback and will be a focus within the new Framework – demonstrating clear alignment with other policy documents such as the Long-term Travel Strategy, Growth and Development Strategy and Joint Health and Wellbeing Strategy.
- A study developing proposals to deliver a cycle route parallel to the A5 is underway. This will build on the parks routes already delivered to provide a continuous route from Edgware to West Hendon.
- The Long-term Transport Strategy identifies the aspiration to deliver a Barnet Loop cycling and walking route within the borough, of which the A5 parallel route will form a part.
- Subject to funding, construction of the A5 parallel route and development and construction of other parts of the Barnet Loop will continue.

Key Issues & Risks

Summary	**Mitigating Actions**	**Rating**
Withdrawal of TfL (LIP) funding has reduced delivery of programmes/interventions.	LBB and partner agencies continue to deliver interventions and promote active travel within resources and scope available and by maximising partnership working opportunities. Funding will continue to be sought and dialogue remains open with TfL.	Amber

Ability to expand and evolve active travel interventions, e.g. cycling is contingent on supporting infrastructure. Cycle parking provision is minimal due to funding limitations.	As above, in addition to dialogue remaining open with colleagues in Growth & Development and Environment to advocate the importance of active travel on health and wellbeing outcomes. Recommendation: Establish an active travel steering group with service area leads represented to drive this agenda forward via a collaborative approach.	Amber
Cycle Training: Only 625 people were trained in 2020/21 – about one eighth of the normal level – owing to the pandemic and limited cycle training funding from TfL. Lower levels of training are also expected in 2021/22 owing to reduced funding.	Issue raised is an update on cycle training programme during the pandemic with no mitigating actions.	

Support Requested from Health & Wellbeing Board

- Continue to advocate the importance of active travel on health and wellbeing outcomes to influence policy/decision-making.
- Promote collaborative working through alignment, e.g. connecting service areas and partners.
- Identification of funding/investment opportunities.

Barnet communities are resilient and safe.

1. Social Prescribing / Prevention & Wellbeing
2. Domestic Abuse and Violence Against Women and Girls (VAWG)

Social Prescribing / Prevention & Wellbeing		
Overall Rating: Green		
Key Performance Indicator	**Baseline**	**Target**
Number of people in contact with Social Prescribers/Prevention and Wellbeing Co-ordinators.	3,224 (2020/21).	Interim target.

Progress Update

Prevention & Wellbeing:

- 86 referrals since April 2021.
- 100 meaningful contacts with Barnet residents.
- 186 possible Adult Social Care referrals supported via the team.
- 168 Wellbeing Principles improved.

Social Prescribing:

- 2771 referrals made to Social Prescribing Link Working (SPLW) team at the end of Q2.
- The referrals have increased by more than 50% compared to the same period in the previous financial year.
- Now have 18 employed SPLW's to meet this increased demand.
- As of this financial year, all Practices in Barnet are now making referrals to SPLWs

Next Steps

- Recruitment to the team in order to have cross-Borough coverage and support local "neighbourhood model".
- Re-establishing community-based support post-COVID-19.
  Initial engagement steps towards possible joint new staff induction with partner organisations.

Key Issues & Risks

Summary	**Mitigating Actions**	**Rating**
Organisations and services unclear - several services in the borough with differing remits.	Joint forums, multi-disciplinary meetings, continual staff training.	Green

Support Requested from Health & Wellbeing Board

None requested at this time.

Domestic Abuse and VAWG		
Overall Rating: Green		
Key Performance Indicator	**Baseline**	**Target**
Rate of domestic abuse incidents.	Barnet's rate of domestic abuse incidents is 8.2 per 1000 of population (12 months up to the end of September 2021).	Barnet to become lowest rate of all 32 London Boroughs (currently second lowest).
Number of GP surgeries trained under IRIS (Proposed KPI)	TBD	Train all 50 GP surgeries under IRIS.

Progress Update

- The Domestic Abuse and VAWG Strategy 2021-2024 development and consultation.
- Domestic Abuse Act training being delivered to the multiagency partnership.
- Recommissioning of VAWG services.
- New Culturally Integrated Family Approach (CIFA) to Domestic Abuse Perpetrator Programme successfully funded by Home Office and being delivered in Barnet, Brent & Enfield.
- Ongoing delivery of Advocacy service, MARAC, perpetrator programmes and IRIS.

Next Steps

- The public consultation for the draft DA and VAWG Strategy 2021-2024 is now live on Engage Barnet. You can find the draft documents and information about how to have your say here: https://engage.barnet.gov.uk/da-vawg-strategy
- Roll out of Independent Domestic Violence Advocate (IDVA) and Young Peoples IDVA (YIDVA) Training to statutory and VCS providers working in front line roles on VAWG.
- White Ribbon accreditation in progress.
- Further details can be found within the Action Plan of the draft Strategy; however, this will not be finalised until consultation closes and the Strategy is reviewed by Safer Communities Partnership Board.

Key Issues & Risks

Summary	Mitigating Actions	Rating
Lack of strong internal and external partnership engagement in the delivery of the DA and VAWG Strategy 2021-24.	VAWG Delivery Board will need to hold the partners to account and report at each quarterly meeting.	Amber

Support Requested from Health & Wellbeing Board

Promote the consultation of the Strategy and its Action Plan to Barnet residents and partners.

Promote the engagement with Barnet residents to help delivery of the DA/VAWG Action Plan.

Related Updates

Make Every Contact Count (MECC)

- Progress Update
    - MECC eLearning module published with accompanying factsheets on Council website in September 2021.
    - Action plan to be in two parts: 1) LBB mobilisation, 2) wider partner and stakeholder mobilisation.
    - Initiated LBB mobilisation in October 2021. LBB CMT agreed to support mobilisation of MECC training across appropriate council teams, partners and future programme development.
- Next Steps
    - Stage 1 of MECC Action Plan development in collaboration with prospective Council teams.
    - Identification of relevant partner organisations to engage with MECC programme – starting with (COVID-19) Health Champions.
    - To review MECC KPI to find a more appropriate measure of progress.
- Risk of inadequate capacity for programme development and delivery at pace and scale across the ICP. Initial capacity has been secured from LBB Public Health.

Health Champions

- 268 Health Champions registered in 21 of Barnet's wards.
- 48 information sessions delivered to Health Champions, covering a wide range of subjects, including restrictions surrounding COVID-19, information about vaccines and boosters, Long-COVID, wellbeing advice, etc.
- Health Champions have been involved in campaigns, featuring in the "What are YOU waiting for?" campaign for vaccinations.
    - "I feel privileged that I can help people get accurate information." – Health Champion.

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AGENDA ITEM 11

	Health and Wellbeing Board **9th Dec 2021**
Title	**London Borough of Barnet Suicide Prevention Strategy 2021-2025: Children and Young People Action Plan Updates**
Report of	Director of Public Health and Prevention
Wards	All
Status	Public
Urgent	No
Key	Yes
Enclosures	London Borough of Barnet Suicide Prevention Strategy 2021-2025.
Officer Contact Details	Rachel Wells (rachel.wells@barnet.gov.uk), Maeve Gill (maeve.gill@barnet.gov.uk), Jayne Abbott (Jayne.abbott@barnet.gov.uk)

Summary

This paper presents amendments to the Suicide Prevention Action Plan 2021-2023 presented to the Board on 15th July 2021. The amendments incorporate additional actions on the planned activities for children and young people and are informed by a recently published National Child Mortality Database review on suicide prevention in children and young people. In addition, the Suicide Prevention Action Plan 2021-23 also includes more specific timescales for the delivery of actions targeting adults, as far as they have been agreed thus far. This further level of granularity on delivery timescales will be developed for all other action outcome measures in early 2022.

The Barnet Suicide Prevention Strategy 2021-2025 provides an update to the Barnet Suicide Prevention Action Plan 2019-2020. The overall strategic intention is that every year, the number of Barnet residents lost to suicide falls.

The strategy was co-produced with the multi-agency Barnet Suicide Prevention Partnership to be appropriate to the national and our local context, to be insight-led, to be informed by evidence of what works, and importantly to be practical, achievable, and effective.

The strategy organises our whole-system suicide and self-harm prevention response under three themes: our foundation for action, prevention, and postvention activities. Under these themes, we have identified eight areas within which we can act to improve our prevention efforts:

- Insights from data, research, and people with lived experience
- Leadership and collaboration
- Awareness

- Interventions
- Services & Support
- Wider determinants of mental health and wellbeing
- Bereavement support
- Community response

Within each area, this strategy defines one aim and several objectives that we will strive to achieve over the four-year duration of the strategy.

The strategy includes the first biennial action plan (2021-2023) outlining the priority suicide prevention activities agreed by partners of the Barnet Suicide Prevention Partnership. To ensure that over the lifetime of the strategy our actions remain focussed yet responsive to emerging insights, we intend to collectively review our priorities and form a second biennial action plan in 2023.

When the action plan was first presented to the Board, it was agreed that further engagement on preventative actions focused on children and young people would be appropriate to strengthen the plan.

Recommendations

1. **That the Board discuss and notes the amendments to the action plan.**

1. WHY THIS REPORT IS NEEDED

1.1 Children and young people are significantly affected by suicide from an individual, family and community perspective. The action plan has been amended to ensure that the areas of action under each of the Barnet Suicide Prevention Framework themes (foundations for action, prevention of suicide and self-harm and postvention) have been further developed with a lens on the specific needs of children and young people.

2. REASONS FOR RECOMMENDATIONS

2.1 To ensure that the resources available to the multi-agency Barnet Suicide Prevention Partnership have the greatest impact by taking a longer-term strategic approach to suicide prevention activities, that the specific needs of children and young people are recognised and that activities are appropriately tailored to address them.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 None.

4. POST DECISION IMPLEMENTATION

4.1 Public Health and the Barnet Suicide Prevention Partnership partners will meet on 14th December to endorse and continue implementing all the actions described in the action plan. The Partnership will meet formally twice-yearly to discuss progress against actions and course corrections. The Partnership will further develop the specific delivery timescales for all action outcome measures.

4.2 Regular reports on the Suicide Prevention Strategy's progress will be shared with the Health and Wellbeing Board; the Health Oversight Scrutiny Committee will also be briefed, as requested. The Children, Education and Safeguarding Committee will also be briefed on specific actions relating to children and young people, with the Children & Family Services Mental Health and Wellbeing Board also providing input into the delivery of these actions.

4.3 The Barnet Suicide Prevention Partnership will develop and agree a second biennial action plan for 2023-2025 by 2023.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The Barnet Corporate Plan 2021-2025 includes the aim to be the healthiest borough in London by focussing on mental health and wellbeing. This includes a commitment to support the mental health of children and young people and adults, including prevention, early identification of mental health issues, increasing mental health awareness and appropriate access to mental health support across the spectrum from mild need through to crisis.

5.1.2 The Health and Wellbeing Strategy includes focus on improving mental health and wellbeing for all and makes specific reference to this Suicide Prevention strategy.

5.1.3 The Joint Strategic Needs Assessment identifies the suicide rate and rate of hospital admissions for self-harm in Barnet and compares these with the national and London rates.

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

5.2.1 Suicide prevention is delivered within existing staffing and financial resources in Public Health and partner agencies such as NHS, Local Authority, Police, Voluntary and Community sector organisations who are funded from diverse sources and for a wide range of purposes.

5.2.2 North Central London Suicide Prevention activities are funded from awarded NHS England Suicide Prevention Wave 3 funding.

5.3 Social Value

Not applicable

5.4 Legal and Constitutional References

5.4.1 Barnet Council Constitution, Article 7 – Committees, Forums, Working Groups and Partnerships, Health and Wellbeing Board responsibilities:

"(2) To agree a Health and Wellbeing Strategy (HWBS) for Barnet taking into account the findings of the JSNA and strategically oversee its implementation to ensure that improved population outcomes are being delivered."

(3) To work together to ensure the best fit between available resources to meet the health and social care needs of the whole population of Barnet, 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 wellbeing"

(5) Specific responsibilities for overseeing public health and promoting prevention agenda across the partnership"

5.5 **Risk Management**

5.5.1 The Barnet Suicide Prevention Strategy 2021-2025 requires collective effort across the multi-agency Barnet Suicide Prevention Partnership (BSPP) to reduce the number of lives lost to suicide in Barnet. If the council or partners do not engage with the strategy and progress their actions, it may lead to poor overall delivery of the 2021-23 Action Plan. Poor engagement may also lead to failure to agree a 2023-2025 Action Plan. This could have a detrimental impact on local suicide and self-harm prevention.

5.5.2 The following controls and mitigations are in place:

5.5.2.1 The multi-agency Barnet Suicide Prevention Partnership was consulted throughout initial strategy development and co-owns the strategy and action plans.

5.5.2.2 The Barnet Suicide Prevention Partnership meets twice-yearly to re-engage partners, align activities, and implement changes based on new insights. They are next meeting on 14th December.

5.5.2.3 The strategy includes by design a requirement for all partners to re-engage in 2023 to assess progress, re-prioritise and agree the Action Plan for 2023-2025.

5.5.2.4 The Barnet Suicide Prevention Strategy is being presented to the Health and Wellbeing Board and included in Barnet's Health and Wellbeing Strategy. Partners' progress against the action plan is reported annually to the Health and Wellbeing Board and Health Overview Scrutiny Committee as requested.

5.5.2.5 Barnet Council's Suicide Prevention activities are supported by the North Central London Suicide Prevention Strategy Group and its activities.

5.6 **Equalities and Diversity**

5.6.1 Nationally, there are variations in suicide rates by age, gender, disability, maternity status, and sexual orientation. This strategy is cognisant of the disparity in the risk of suicide across different groups with protected characteristics and aims to address this disproportionate risk through targeted actions for high-risk groups.

5.7 **Corporate Parenting**

5.7.1 It is intended that the suicide prevention actions in this strategy improve the mental wellbeing and reduce the risk of self-harm and suicide for children and young people including children in care, care leavers and Unaccompanied Asylum-Seeking Children and Young People (UASC). The amendments to the 2021-23 Action Plan include activities to strengthen the existing tailored support arrangements that are in place. For example, this involves incorporating the learning from the Camden Serious Case Review of UASC into relevant clinical protocols within the Barnet Integrated Clinical Service and into the Public Health Needs Assessment on Refugees and Asylum Seekers.

5.8 **Consultation and Engagement**

5.8.1 The original strategy was co-produced with the Barnet Suicide Prevention Partnership through a series of workshops and written consultation.

5.8.2 The group comprises a broad range of local partners including representatives from the Barnet Clinical Commissioning Group, Police, NHS Health Trusts, Barnet Enfield and Haringey Mental Health Trust (BEHMHT), Children's and Adult Social Care, Voluntary and Community Sector, and people with lived experience of suicide.

5.8.3 The amendments to the action plan were developed in consultation with partners from Children and Family Services (Early Help & Children's Social Care Services, Barnet Education and Learning Service, and Barnet Integrated Clinical Services), Barnet Enfield and Haringey Mental Health Trust and North Central London Clinical Commissioning Group. The amendments have also been shared with Designated Safeguarding Leads from Barnet primary and secondary schools, with their feedback being incorporated on an ongoing basis as delivery plans are further developed.

5.9 **Insight**

5.9.1 Our strategy, prevention framework, aims, objectives and actions are built upon the national evidence of the risk factors for suicide and self-harm, 'what works' for prevention, and insights from local and national data such as suicide rates, rates of emergency admissions for self-harm, and indicators of the wider determinants of mental health and wellbeing. The insights, evidence, and policy context which informed this strategy are described in the report Appendix.

5.9.2 Our amendments to the action plan are also informed by the National Child Mortality Database Programme Thematic Review, published in October 2021 based on data from April 2019 to March 2020.

6. BACKGROUND PAPERS

6.1 Suicide Prevention Plan Update, Health Oversight Scrutiny Committee, 5th October 2020.
https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=179&MID=10208

6.2 Original London Borough of Barnet Suicide Prevention Strategy 2021-25, presented to the Health and Wellbeing Board on 15th July 2021.
https://barnet.moderngov.co.uk/documents/s65855/Barnet%20Suicide%20Prevention%20Strategy%202021%20-%202025%20_cleared.pdf

6.3 National Child Mortality Database Programme Thematic Review, published in October 2021.
https://nspa.org.uk/wp-content/uploads/2021/10/NCMD-Suicide-in-Children-and-Young-People-Report.pdf

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London Borough of Barnet Suicide Prevention Strategy 2021-2025

Contents

Introduction

The death of someone by suicide is a tragedy that has devastating effects across families, friends, schools, workplaces, and communities. In the last four years for which we have data (2016-2019), Barnet lost eighty-nine people to suicide: on average one person every sixteen days[1]. In the UK, suicide is the leading cause of death in people aged 15-24, and the biggest killer of men under 49.

The time to act is now - self-harm and suicide rates could rise further without action.

Nationally, suicide rates are rising. After several years of decline during 2014 to 2017, the suicide rate in 2019 for England and Wales is the highest in men since 2000, the highest in women since 2004, and the highest recorded in 10 to 24-year-old women since 1981[2]. In Barnet the suicide rate rose through 2014 to 2017 and has since fallen, with rates in 2018 and 2019 consistent with those seen during 2002 to 2013[1].

Self-harm is the most important risk factor for subsequent death by suicide; over half of people who die by suicide have a history of self-harm, many with an episode close to their death[3]. Most people who self-harm do not die by suicide, but the strength of the association between self-harm and suicide means this is a signal that cannot be ignored. The rate of emergency hospital admissions for intentional self-harm in Barnet is currently similar to the London average, but has remained stable over the past four years. We want to see admissions for self-harm decrease, so we must do more to prevent and support people who self-harm.

We are currently gripped by a health and economic crisis caused by COVID-19, of which the long-term effects on physical health, mental health and prosperity are unknown. This strategy recognises the potential for COVID-19 to increase suicidal behaviour due to the negative impact of the pandemic and restrictions on mental wellbeing, and the already evident increase in multiple risk factors for suicide and self-harm such as bereavement, social isolation and loneliness[4], domestic violence, and unemployment[5]. Alarmingly, following previous recessions where there has been high unemployment, rates of suicide have increased[6]. Mitigating the negative impact of the pandemic on the lives of people in Barnet is an urgent necessity.

We can make a difference - suicide is preventable.

Significant reductions in suicide rates have been achieved in US healthcare systems following the introduction of a systematic approach to suicide prevention and quality improvement [7]. The first to apply these methods, the Henry Ford Health System in Detroit, achieved a 75% reduction in suicides in patients known to the service in the first four years, with no patient suicides in 2009[8]. By understanding the risk factors for suicide and mitigating these through targeted interventions, we *can* prevent deaths by suicide.

[1] Office for National Statistics (2020), 'Suicides in England and Wales by local authority',
[2] Office for National Statistics (2020), 'Suicides in England and Wales: 2019 registrations',
[3] The National Confidential Inquiry into Suicide and Safety in Mental Health (2021), Annual Report: England, Northern Ireland, Scotland and Wales 2021, University of Manchester
[4] Office for National Statistics (2020), 'Coronavirus and loneliness, Great Britain: 3 April to 3 May 2020'
[5] Office for National Statistics (2021), 'Employment in the UK: May 2021',
[6] Barr B, Taylor-Robinson D, Scott-Samuel S et al. (2012), 'Suicides associated with the 2008-10 economic recession in England: time trend analysis', BMJ, Volume 345, e5142
[7] Labouliere C, Vasan P, Kramer A, et al (2019), 'Zero Suicide - A model for reducing suicide in United States behavioral healthcare', Suicidolog, Volume 23, Issue 1, pages 22 to 30
[8] Covington D, Hogan M (2019), 'Zero Suicide: The Dogged Pursuit of Perfection in Health Care', Psychiatric Times, Volume 36, Issue 1

We need to act together - suicide prevention is everyone's business.

Suicide is a complex behaviour with no single explanation or cause. Risk factors for suicide can occur at the individual, community, and societal level[9]. Most people who lose their lives to suicide in England have no prior contact with health services – only 27% of suicides in the UK in 2008 to 2018 were in people under mental health care, and the rate of suicide in this group has been falling since 2011[3]. Excellent mental health care is important, but to reach that majority with no service contact, suicide and self-harm prevention must be embedded across our community. The myriad risk factors mean that in order to successfully prevent deaths from suicide, it is critical that we work in wide-ranging partnerships, across all our communities, to systematically improve the lives and wellbeing of everyone that lives, works, and studies in Barnet.

Our ambition is to create a practical, achievable, and effective suicide prevention strategy, that uses the resources available to the multi-agency Barnet Suicide Prevention Partnership (BSPP) to have the greatest impact. We believe that through the collective actions of the Partners we can achieve the objectives set in this strategy. We will move Barnet closer to each aim, and each year the number of Barnet residents lost to suicide will fall.

[9] Samaritans (2017), 'Socioeconomic disadvantage and suicidal behaviour', March 2017

Our Intention

Every year, the number of Barnet residents lost to suicide falls.

Our Principles

This strategy was developed with the multi-agency Barnet Suicide Prevention Partnership (BSPP) on the following principles:

- A local strategy that takes a whole-system approach and builds on regional and national programmes and policy.
- Multi-agency design, with co-produced solutions that are insight-led and evidence-informed.
- Shared implementation of a strategy that is responsive and adaptive year on year.

The evidence underpinning the development of this strategy is summarised in the Appendix.

Our Commitment to Improvement

Our Action Plan 2021-2023 was collectively agreed by the multi-agency Barnet Suicide Prevention Partnership (BSPP) in June 2021. We believe it is practical, achievable, and effective. To ensure that over the lifetime of this strategy our actions remain focussed yet responsive to emerging insights, we intend to collectively review our priorities, cross-cutting concerns of notable focus, and actions after the first two years, in order to develop a new biennial action plan for 2023-2025. Some objectives have also built in responsiveness to emerging insight so we can make course corrections in-year.

Our Structure – Barnet's Suicide Prevention Framework

The Barnet Suicide Prevention Framework was devised specifically for this strategy as a structure to design and evaluate Barnet's longer-term suicide prevention work. This approach was agreed by the BSPP in November 2020. Our framework draws on the wide range of national and regional guidance on suicide prevention; notably the National Suicide Prevention Strategy seven key areas, NICE Suicide Prevention Quality Standard [QS189] and Guideline [NG105] and the London Suicide Prevention Framework 9 pillars (Appendix – policy context).

Figure 1: Barnet Suicide Prevention Framework

Theme	Foundation for action		Prevention of suicide and self-harm				Postvention	
Area for action	Insights from data, research, and people with lived experience	Leadership and collaboration	Awareness	Interventions*	Services & Support	Wider determinants of mental health and wellbeing	Bereavement support	Community Response
Cross-cutting concerns	1. Each area should address high-risk groups 2. Each area should consider the need for tailored approaches for specific groups 3. Each area should mitigate the impact of high-risk distressing life events							

**In this strategy, interventions are actions which delay or disrupt suicidal thoughts or actions; for example, reducing access to means, increasing the opportunity or capacity for human intervention, and providing opportunities for help seeking.*

The Barnet Suicide Prevention Framework (figure 1) organises our whole-system suicide and self-harm prevention response under three themes: our foundation for action, prevention, and postvention activities. Under these themes we have identified eight areas within which we can act to improve our prevention efforts. Within each area, this strategy defines one aim and several objectives that we will strive to achieve over the four-year duration of the strategy. Our framework is action-oriented, making a clear distinction between the area within which we are striving for improvements (e.g. awareness), and the actions (e.g. campaigns, education, training) we will take to achieve our objectives.

Our Cross-Cutting Concerns

Our cross-cutting concerns reflect the priorities identified in the national suicide prevention strategy and from local insights. These concerns require action within all eight strategic areas to adequately reduce the risk posed to these groups or by these life events.

The national strategy identified a large number of groups at heightened risk. The BSPP agreed to align our collective effort on achieving improvements for a more focussed number for our first two-year action plan. These are shown in the table below in bold italics as cross-cutting concerns of notable focus. Our concerns of notable focus will be reviewed for the second two-year action plan to ensure our activities remain responsive to emerging insights and the changing suicide and self-harm prevention landscape.

Cross-Cutting Concerns [CC] for Barnet Suicide Prevention Strategy 2021-2025 ***Cross-Cutting Concerns of Notable Focus for Action Plan 2021-2023***		
CC1: Each area should address these high-risk groups:	CC2: Each area should consider the need for a tailored approach in these specific groups:	CC3: Each area should mitigate the impact of high-risk distressing life events**
• **Young and middle-aged men.** • **People with a history of self-harm.** • **People identified locally as potentially at increased risk, e.g. Eastern European migrants.** • ***People who misuse drugs or alcohol.*** • People in the care of mental health services. • People in contact with the criminal justice system. • People with long term health problems. • Older adults.	• ***Children and young people.*** • ***People with a family history of suicide.*** • ***People with autism and learning difficulties.*** • ***Black and other ethnic groups.*** • ***People who identify as LGBTQIA+.*** • Veterans; • Asylum seekers. • Victims and survivors of trauma, abuse or violence (including learning from ongoing Camden Homicide review).	• ***Economic wellbeing e.g. redundancy, debt, unemployment, unsecure accommodation / homelessness.*** • Social wellbeing e.g. ***people who are living alone, socially isolated***, or excluded, and young people impacted by social media. • Emotional wellbeing e.g. family conflict or breakdown, relationship breakdown or divorce. • Psychological wellbeing e.g. ***bereavement (particularly by suicide), bullying,*** family mental health problems, perinatal mental health.

***High-risk distressing life events are those where there is evidence for an increased risk of suicidal thoughts or behaviour in people following that life event.*

Our Suicide Prevention Strategy 2021-2025 and Action Plan 2021-2023

Key to Amendments

X *Amendments to the Action Plan 2021-2023 to include further detail on suicide prevention actions for Children and Young People*

Key to Lead Teams Referred to Throughout the Action Plan

PH Adults	Barnet Public Health Adults & Healthcare	Comms	Barnet Strategy & Communications
PH CYP	Barnet Public Health Children & Young People	FS	Barnet Family Services
BEHMHT	Barnet, Enfield, Haringey Mental Health Trust	NCL CCG	NCL Clinical Commissioning Group
BEH CAMHS	Barnet, Enfield, Haringey Mental Health Trust Child and Adolescent Mental Health Services	NCL SP	North Central London Suicide Prevention Strategy Group
BELS	Barnet Education and Learning Service	NCL D&I	NCL Suicide Prevention Data & Insights Subgroup
BICS	Barnet Integrated Clinical Service	NCL SaS	NCL Suicide Prevention Support After Suicide Subgroup

Theme: Foundation for action

Area for action

Insights from data, research, and people with lived experience

Aim: Enhanced insights on every suicide that occurs in the borough to inform future prevention work, using both qualitative and quantitative information.

Our current position

BARNET
The Barnet Suicide Prevention Partnership (BSPP) has produced annual Suicide Prevention Action Plans since 2014, informed by local and national insights. Data on deaths by suicide confirmed following a coroner's inquest are provided by the Office for National Statistics, however, these can include a time lag of months to years. Partners of the BSPP also contribute to local insights – for example, Middlesex University is currently undertaking a review of safeguarding cases involving suicidal ideation and intent. People with lived experience are represented in the Barnet Suicide Prevention Partnership and provide qualitative insights for our prevention work– but we can and should do more to ensure that our actions are informed by the experiences of people who have encountered suicide.

NORTH CENTRAL LONDON
The North Central London (NCL) Suicide Prevention Strategy Group was formed in 2021. A data and insights sub-group was also formed in 2021, with the aim of improving the completeness and local response to data in the Thrive London Suicide Prevention Information Sharing Hub.

LONDON
The Thrive London Suicide Prevention Information Sharing Hub is a Real Time Surveillance System (RTS) launched in 2020. The RTS Hub provides data on local suspected suicides uploaded by the Metropolitan Police Service and NHS Mental Health Trusts and shared with key partner institutions. The Thrive London Hub presents new opportunities to quickly identify and respond to emerging trends, as well as implement regional learnings on a local level.

What we want to achieve

Strategic Objectives 2021-2025 How we will move towards our aim	Biennial Action Plan Strategic Actions 2021-2023 How we will progress our objectives	Action Outcome Measures How we will measure our efforts	Lead Team	Review
1. Improve the processes for identifying local emerging trends and incorporating sector learnings into the Barnet Suicide Prevention Partnership's activities.	a) Barnet will take a lead role in the North Central London (NCL) Suicide Prevention Strategy Group Data & Insights Subgroup to improve local use of RTS data.	○ A standardised process for monitoring and acting upon Real Time Surveillance (RTS) has been agreed by the NCL Data and Insights subgroup and implemented locally.	NCL D&I	February 2022
		○ A standardised process for assessing whether emerging trends may indicate a potential suicide cluster has been agreed by the NCL Data and Insights subgroup and implemented locally.	NCL D&I	2022
		○ A process for incorporating NCL Data & Insights Subgroup learnings into Barnet suicide prevention activities has been established.	PH Adults & CYP	February 2022
		○ A protocol to improve real-time data sharing across agencies during the investigation of potential suicide clusters has been developed and implemented to strengthen information sharing arrangements between Child and Adolescent Mental Health Services (CAMHS) and the Barnet Multi-Agency Safeguarding Hub (MASH) where children are a known risk of suicide.	BEH CAMHS /NCL/PH/FS	2022

			b) Review and improve how recommendations from Child Death Overview Panels (CDOP), learning and thematic review meetings and the child death review meetings are shared with the BSPP and incorporated into our actions.	○ An agreed process for learning to be shared has been established.	PH CYP	2021
			c) Incorporate relevant learnings from Drug Related Death Panels into our suicide prevention activities.	○ Learnings from Drug Related Death Panels are shared with the BSPP regularly and recommendations for action are incorporated into Action Plan 2023-25.	PH Adults	September 2022
		2. Investigate signals indicating local groups that may be at higher risk. [CC1, CC3].	d) Review if there is an increased risk of death by suicide across NCL in Eastern European communities and communities disproportionately affected by COVID-19.	○ NCL RTS insights report is shared with the data and insights group.	NCL D&I	2021
			e) Use local health service data to track rates of self-harm.	○ The annual BSPP progress report incorporates data on local rates of self-harm.	NCL CCG	September 2022
			f) Work as part of the North Central London Suicide Prevention Group to understand how across the sector we can work to best to prevent suicides in the context of the criminal justice system.	○ Recommendations for local action from the NCL Suicide Prevention Group are incorporated into our Action Plan 2023-25.	NCL SP	2023
			g) Review the findings from the Camden Serious Case Review report of Unaccompanied Asylum-Seeking Children and Young People (UASC) to consider the learnings for Barnet.	○ Recommendations from the review incorporated into the Public Health Needs Assessment on Refugees and Asylum Seekers and to inform the UASC clinical protocol being developed within family services.	NCL/PH/BICS	2022

Theme: Foundation for action

Area for action	Leadership and collaboration **Aim: Co-ownership of strategic success**				
Our current position	BARNET Suicide prevention work within Barnet is coordinated through the multi-agency Barnet Suicide Prevention Partnership (BSPP), who have produced and reviewed our annual suicide prevention action plans since 2014. The group brings together a range of local partners including representatives from the Clinical Commissioning Group, Police, NHS, Barnet, Enfield and Haringey Mental Health Trust (BEHMHT), Children's and Adult Social Care, Education and Family services, schools and universities, and organisations in the Voluntary and Community Sector. Partners are committed to suicide prevention. In Barnet Council, suicide prevention is a key objective in the Barnet Joint Health and Wellbeing Strategy 2021-2025 and this strategy is reviewed by Barnet's Health and Wellbeing Board and Health Oversight Scrutiny Committee. Collaboration is happening across Barnet Council to deliver the committed actions for 2021-23. In addition to the Barnet Suicide Prevention Partnership (BSPP) annual report to the Health and Wellbeing Board to review delivery, specific actions relating to children and young people will also be considered as a report of the Children, Education and Safeguarding Board. The Children & Family Services Mental Health and Wellbeing Board will also provide input into the delivery of these actions. Other Partners, such as Middlesex University and CommUNITY Barnet, are championing suicide prevention with commitment from the senior leadership team and provision of wellbeing services. NORTH CENTRAL LONDON North Central London (NCL) Sustainability and Transformation Partnership (STP) has successfully bid for NHS England Suicide Prevention Programme Wave 3 funding. Barnet is hosting the Programme Manager for this work; details on the programme are included in the Appendix (policy context). LONDON Barnet is a member of the Thrive LONDON Suicide Prevention Partnership, which aims to improve the mental health of Londoners and has a zero-suicide ambition for London. NICE Suicide Prevention Quality Standard [QS189] Statement 1: "Multi-agency suicide prevention partnerships have a strategic suicide prevention group and clear governance and accountability structures."				
What we want to achieve	**Strategic Objectives 2021-2025** How we will move towards our aim	**Biennial Action Plan** **Strategic Actions 2021-2023** How we will progress our objectives	**Action Outcome Measures** How we will measure our efforts	**Lead Team**	**Review**
	3. Partners of the Barnet Suicide Prevention Partnership (BSPP), will co-produce, co-own, and co-lead the delivery of this strategy.	h) Partners will collaborate to deliver their committed actions for 2021-23, and we agree new priorities and actions in 2023.	○ Updated Terms of Reference for the BSPP have been agreed.	All partners	December 2021
			○ BSPP partners will report annually on successful completion of actions and make recommendations for adjustments.		June 2022
			○ Ensure appropriate services for children and young people are included in the partnership.		2022
			○ A biennial Action Plan is agreed for 2023-25.		2023
		i) People with lived experience are equal partners in the BSPP and represented in all meetings and workstreams, including hearing the voices of children and young people with lived experience through appropriate channels.	○ Meet our aim for more than 90% of BSPP meetings and workstreams to have people with lived experience represented.	PH Adults	March 2023
			○ Meet our aim for more than 90% of BSPP meetings and workstreams to have representation from the Barnet Integrated Clinical Service (BICS) Youth Engagement Officer to ensure that the voice of children and young people with lived experience is represented.	BICS	2022
			○ Explore how to involve children and young people with lived experience of child and adolescent mental health services (CAMHS) and recommend actions to include their voices.	BEH CAMHS/ NCL/ PH CYP	2022
			○ Via the Child Participation and Family Involvement (My Say Matters) consultation, ensure young people's voices are sought and heard.	FS	2023
		j) Partners will advocate for suicide and self-harm prevention within their organisations	○ Partners have a named suicide and self-harm prevention champion.	All partners	June 2023

				○ Barnet council has an exemplar corporate approach with enhanced policies, procedures and practices for addressing risk of suicide and self-harm and supporting those affected by suicide.	Barnet Council	December 2022
		4. BSPP strategic actions will contribute to and enhance wider suicide and self-harm prevention activities.	k) Ensure the actions within this strategy are aligned with suicide prevention activities across the borough, across North Central London (NCL) and London-wide.	○ Barnet Public Health will actively participate in the North Central London (NCL) Suicide Prevention Group and Thrive London Suicide Prevention Group.	Selected partners	December 2021

Theme: Prevention of Suicide and Self-Harm

Area for action	**Awareness** **Aim: Everyone that lives, studies, or works in Barnet knows where to find help if they are thinking about suicide or are concerned about someone else.**
Our current position	BARNET Barnet Council has mapped the available suicide prevention training and uptake in the Borough, including face to face Making Every Contact Count (MECC) training. Barnet Public Health raised awareness of suicide and self-harm prevention at events and workshops throughout 2020, including for World Mental Health Day and World Suicide Prevention Day. During COVID-19, there was a shift to raising awareness and promoting online resources such as Zero Suicide Alliance's (ZSA) online suicide prevention training. There are also ongoing communication campaigns to increase awareness of the current offer of support for school-age children inside and outside of school (e.g. out-of-school hours or during holidays). This work includes targeted poster campaigns with details of child and adolescent mental health crisis support services, social media posts highlighting Hopeline UK and the distribution of factsheet resources detailing the support available to children, schools, parents and carers. Signposting to services is also happening via the Barnet First magazine distributed to all residents. NORTH CENTRAL LONDON North Central London Clinical Commission Group has been leading on the expansion of community-based education in suicide awareness across the sector. During the pandemic, in-person training was suspended, and the focus has shifted to raising awareness of online digital mental health support services such as Kooth, Good Thinking and Able Futures. LONDON Papyrus have been awarded funding to deliver suicide awareness education across London to faith-based charities, schools, colleges and universities.

	Strategic Objectives 2021-2025 How we will move towards our aim	**Biennial Action Plan**			
		Strategic Actions 2021-2023 How we will progress our objectives	**Action Outcome Measures** How we will measure our efforts	**Lead Team**	**Review**
What we want to achieve	5. Raise general awareness and reduce stigma around suicide and self-harm so that everyone feels able to start conversations about mental wellbeing, self-harm, and suicide.	a) All partners of the BSPP will internally promote the Zero Suicide Alliance (ZSA) online training.	○ Partners have established baseline engagement with ZSA online training in their organisation and agreed a trajectory for an increase in uptake over the remainder of this strategy.	All Partners	December 2022
		b) Promote suicide prevention training for all primary care staff.	○ ZSA or other suicide prevention training has been promoted or offered to all primary care staff.	NCL CCG	2023
		c) Raise awareness of suicide and self-harm in all schools and mechanisms for signposting to relevant services.	○ Report the proportion of Barnet schools taking part in the Resilient Schools programme, with an aim to increase the level from 50% to 75% by the end of academic year 2021/22.	PH CYP	2022
			○ All Barnet schools have a Youth Mental Health First Aider.	PH CYP	2022
			○ A localised self-harm prevention toolkit based on the Essex self-harm prevention toolkit has been produced and shared with all schools.	PH CYP	2022
			○ Emotional health support by school nurses is promoted via PSHE and assemblies in all schools.	PH CYP	2022
			○ Facilitate information and experience sharing between schools; raise awareness of issues; share best practice at relevant meetings e.g., Head Teachers, Deputy Head Teachers/Assistant Head Teachers, Special Educational Needs Co-ordinators, Pastoral Leads and Designated Safeguarding Leads.	BELS	2022
			○ Ensure the curriculum in each school includes the promotion of effective mental health/well-being strategies for students; follow up with any schools where this is identified as a concern to offer further support.	BELS	2022
			○ Explore raising awareness of wider impacts of exclusion from school; develop guidance to schools; ensure offer of multi-agency engagement prior to exclusion including the use of outreach mentors from Pavilion Pupil Referral Unit.	BELS	2022
			○ Ensure that all schools are aware of the stepped care pathway of mental health support and understand how to refer to appropriate services.	BELS/BICS/ PH CYP/ BEH CAMHS	2022
			○ All schools to be offered suicide prevention training through Papyrus and Zero Suicide Alliance.	PH CYP	2022
			○ All further education settings have a self-harm and suicide prevention document within their safeguarding policy.	PH CYP	2022

			d) Raise awareness of suicide and self-harm in further education and higher education settings and mechanisms for signposting to relevant services.	○ All further education settings have a suicide prevention champion.	NCL SP	2022
				○ Facilitate information and experience sharing between further education settings; raising awareness of issues; sharing best practice (e.g. Young People's Thrive Service).	BELS	2022
				○ Ensure that all further education settings are aware of the stepped care pathway of mental health support and know how to refer to appropriate services.	BELS/BICS/ PH CYP/ BEH CAMHS	2022
		6. Increase community knowledge of the first place to turn to access suicide and self-harm services in Barnet and make this information easier to find.	e) Maintain an up-to-date, brief resource that clearly signposts the first place to turn to in Barnet for self-harm and suicide prevention services.	○ Maintain an online 'one-page' resource for adults signposting to local self-harm, suicide prevention, and crisis support.	NCL CCG / PH Adults	December 2021
				○ Refresh the Making Every Contact Count (MECC) CYP mental health action card and share with partners. ○ MECC card is reviewed and updated every six months along with all public health cards.	PH CYP	2021
			f) Develop an engagement campaign that aims to reduce stigma around self-harm and suicide and raise awareness in Barnet of the first place to turn to seek help.	○ Awareness of Barnet's brief resources for local suicide prevention support (action 'e', above). ○ Report on the reach and engagement of the campaign with Barnet Residents.	NCL CCG / PH Adults	February 2022
				○ Pilot an expansion of the Resilient Schools programme to include awareness-raising with parents, including promotion of the ZSA online training.	PH CYP	2023
			g) Engage with children and young people, and their parents and carers, to understand how well awareness-raising is performed and how it can be improved across school years.	○ Use Resilient Schools snapshot survey and Barnet Integrated Clinical Service focus groups to understand pupil, parent/carer awareness and use insights to further develop future communication campaigns.	PH CYP/BICS	2023
				○ Maintain ongoing pre-school holiday digital awareness and poster campaigns and ensure they are run effectively by working with schools to strengthen awareness around the current mental health support offer for school-age children.	Comms/BELS	2022
				○ Develop a communications plan for children and young people, as part of wider family service participation work, tailored to their needs and preferred channels.	FS/Comms	2022
			h) Engage with local LGBTQIA+ groups to understand how we can better meet the needs of local LGBTQIA+ communities.	○ Recommendations produced through engagement are included in Action Plan 2023-25.	PH Adults	June 2023
			i) Produce culturally competent communications specifically for high-risk groups to highlight local self-harm and suicide prevention service.	○ Development of tailored communications materials for each group in CC1 and CC2.	All Partners	2023

Theme: Prevention of Suicide and Self-Harm

Area for action	Interventions* **Aim: Provide timely and accessible information at potential trigger events.**				
Our current position	*In this strategy, interventions are any actions which delay or disrupt self-harm or suicidal thoughts or actions. BARNET A recent review of local data has not identified any local frequently used locations. NORTH CENTRAL LONDON Barnet, Enfield, Haringey Mental Health Trust (BEHMHT) have unmanaged risk forums in all boroughs to review and support clinicians working with cases where suicide risk remains high. BEHMHT work with the British Transport Police to create suicide prevention plans, identify and work with those at high risk of suicide. A trial of pop-up reminders on GP computer systems that alerts doctors if a patient has previously self-harmed or attempted suicide began in 2019. LONDON Thrive London's 'reducing access to medications as a means' project aims to help community clinicians and primary care staff reduce medication as a means of suicide for those people identified as at risk. Suicide prevention policies are currently being developed by the Metropolitan Police and British Transport Police. Nationally, there is ongoing work with technology and media companies on responsible reporting and social media, including interventions around online posts that encourage self-harm or suicide.				
What we want to achieve	**Strategic Objectives 2021-2025** How we will move towards our aim	**Biennial Action Plan** **Strategic Actions 2021-2023** How we will progress our objectives	**Action Outcome Measures** How we will measure our efforts	**Lead Team**	**Review**
	7. Support regional and sector-led programmes aiming to: ○ reduce access to means, ○ identify high frequency locations, ○ prevent and responds to clusters.	j) Collaborate with Thrive London and NCL Suicide Prevention Groups to monitor data on geography and means, identify emerging areas of risk, and initiate a co-ordinated response.	○ Participation in NCL Suicide Prevention Strategy Group and Thrive London Suicide prevention group.	PH Adults	January 2023
			○ Production of a NCL Cluster Response Plan.	NCL D&I	2023
		k) Collaborate as part of North Central London Suicide Prevention group to create a media plan for monitoring and supporting local media to report responsibly on self-harm and suicide.	○ Review of current media monitoring across the NCL boroughs and the production of a joint media plan for a systematic, standardised approach.	NCL SP	2023
	8. Increase individual capacity and confidence for bystander intervention in Barnet's communities by teaching suicide intervention skills.	l) Prioritise suicide intervention training for community members that support people who have an increased risk of suicide or self-harm, or that provide support to people around distressing life events.	○ Map of organisations in Barnet that support high risk groups or support people around high-risk distressing life events, for example Citizens Advice Bureau, Job Centre Plus, Department for Work and Pensions, Homeless Action Barnet, faith groups, community organisations.	PH Adults	June 2022
			○ The organisations identified above have been engaged and encouraged to provide regular self-harm and suicide prevention training for employees and community leaders.	PH Adults	January 2023
			○ Audit of the number of schools that have added the suicide prevention document template co-produced with schools to their safeguarding policy.	PH CYP	2022
			○ All staff that have contact with young people in schools, colleges, and universities receive an annual update on the services and support available for their students, including promotion of the Zero Suicide Alliance online training.	PH CYP	2022
			○ All schools and community organisations and groups that work with children and young people to be offered yearly suicide prevention training through commissioning Papyrus and Zero Suicide Alliance online offer.	FS/PH CYP	2022
			○ All schools to have a Mental Health First Aider.	FS/PH CYP	2022
			○ Perinatal Health coaches attend suicide prevention training and raise awareness as appropriate with clients.	PH CYP	2022
		m) Co-design 'guidelines for accessible training', to ensure that all locally promoted training takes account of approaches needed for specific groups, such as people with autism.	○ Co-produced 'guidelines for training' have been shared with the BSPP.	NCL SP	2023
			○ Signposting is included on council materials such as financial abuse materials, penalty notices, and council tax bills.	Barnet Council	2023

		9. Increase the likelihood of early help seeking by decreasing the time from people experiencing high-risk events to receiving signposting information to local self-harm and suicide services.	n) Include mental health, self-harm and suicide prevention information with written notifications that may negatively impact on mental wellbeing.	○ Signposting information is included in Homeless Action Barnet assessments next to mental health and suicide questions.	Homeless Action Barnet	March 2022
				○ Signposting is sent to all residents who become unemployed, and after six months unemployment.	BOOST	2022
				○ Signposting information is sent to all people living in Barnet in a building that meets RICS criteria for an EWS1 assessment.	Barnet Homes / Council	2022
			o) Explore the role that detecting searches of online material in relation to mental health, self-harm and suicide can have in signposting to supportive information and encouraging early help seeking.	○ Review the potential of the R;pple Suicide Prevention Tool (a free tool that can be downloaded on to devices which detects when someone searches harmful content about self-harm or suicide online, intercepts and provides support information and messages of hope) and explore the implementation requirements for schools and parents.	PH CYP/BELS/ BEH CAMHS	2022

Theme: Prevention of Suicide and Self-Harm

Area for action	Services and Support **Aim: Ensure that services are available, integrated, accessible and appropriate for all members of the Barnet community.**
Our current position	BARNET Local service mapping has been undertaken of the support available for further education, crisis pathways, and emergency department pathways. There are many mental health support services available to Barnet residents, from wellbeing support through The Barnet Wellbeing Hub, to crisis support such as the Barnet Crisis Café, Crisis Teams, and 24/7 CAMHS crisis line. Barnet, Enfield and Haringey Mental Health NHS Trust provides Tier 3 and 4 commissioned services. Several services exist for Barnet residents with thoughts of suicide or self-harm, such as Maytree which provides residential respite care for people who are feeling suicidal, and a drop-in service provided by North London Samaritans. The Barnet Community Mental Health Service transformation programme is underway, focussing on improving access, patient experience, patient outcomes and tackling inequalities in mental health. Work includes mental health needs assessments, service mapping, and a series of engagement events with the aim of co-producing an equalities action plan. In 2018 Barnet undertook a thematic review of death by suicide in children and young people (CYP). The review took an overview of strategy, services, and user experiences to identify and analyse areas of good practice and areas for improvement. The recommendations from this review have been integrated with this strategy. The Barnet Multi-Agency Safeguarding Hub (MASH) for Children and Vulnerable Adults are multi-agency partnerships that share key information about children, families, and vulnerable adults in order to make safe and timely decisions about the help children and vulnerable adults need. Barnet has the CYP continuum of help and support, a guidance document to support professionals working with children and young people to consider their needs and any risks to welfare in the context of the range of support available. Key support services include the Barnet Integrated Clinical Service (BICS), which is a universal, community mental health service for mild to moderate mental health problems. It offers a range of evidence-based interventions (such as individual work, consultations around the child, family therapy, group workshops, dedicated phone support lines for young people, families, and professionals). These are delivered in a range of modes: in person, online or over the phone, and a mobile app is also in development. This accessible and flexible service is for children in the community, including in schools, but also for those with a dedicated social worker, those known to Youth Offending Services (YOS) and UASC. In addition, further tailored support is also available for specific groups. For example, long-term counselling support for care-leavers is available through Terapia and specialist counselling and play therapy for children and young people experiencing violence and domestic abuse is available through Rephael House, which is an independent charity offering one to one professional therapy. The Resilient Schools Programme is an early intervention and preventative approach based on the THRIVE concept – looking at the two first quadrants of 'coping' and 'getting some help'. The programme is being developed as a whole school approach to mental health and resilience by providing training to staff, parents and pupils, to raise awareness and provide coping strategies, to commission providers, and to use 'schools champions' to build a bank of knowledge, resources and shared learning to support vulnerable members of the school and wider community. Barnet CYP team is undertaking a series of focus groups with children and young people to understand how the universal CYP offer could be improved. NORTH CENTRAL LONDON North Central London Clinical Commissioning Group (CCG) are leading on projects to improve responses to self-harm, such as the expansion of the Brandon Centre to Barnet & Enfield, and a pilot of peer-support for young people who self-harm who are at the threshold for statutory mental health services. BARNET ENFIELD HARINGEY MENTAL HEALTH TRUST, CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (BEH CAMHS) For children and young people requiring more support for their mental health, BEH CAMHS provides a range of specialist services which include: a 24 hour mental health crisis service for young people and their families, and; a dedicated adolescent mental health service, as well as offering adolescent inpatient care at The Beacon Centre. LONDON Online digital mental health support is available to Barnet residents through several platforms such as Kooth, Good Thinking and Able Futures.

	Strategic Objectives 2021-2025 How we will move towards our aim	**Biennial Action Plan** **Strategic Actions 2021-2023** How we will progress our objectives	**Action Outcome Measures** How we will measure our efforts	**Lead Team**	**Review**
What we want to achieve	10. The Barnet Suicide Prevention Partnership has a complete understanding of all local services and support for self-harm and suicide, and uses this knowledge to quickly identify gaps in services in response to local insights.	p) Collaborate with BSPP partners, VCFS organisations, and the Barnet Integrated Care Partnership to understand service provision and identify gaps.	○ Care pathway map and gap analysis of the support for individuals and their families following a suicide attempt.	NCL SP	2023
			○ Care pathway map and gap analysis of the support for individuals and their families following self-harm.	NCL SP	2023
			○ Work with schools and school nurses to build preventative support for CYP at transition from mainstream schools – such as transition from tier 4 CAMHS, home schooling, or post-exclusion.	PH CYP	2023
			○ Establish ongoing mechanism for public health and child and adolescent mental health services to work together to address inequalities in access and service use.	BEH CAMHS/PH/ NCL	2022
			○ Work with child and adolescent mental health services and other partners to share learnings and best practice on the use of co-produced safety plans at points of transition, including the development of the safety app being developed for North Central London CCG.	BEH CAMHS/PH/ NCL	2022

			q) Understand the local resilience support available to professionals whose work involves people with suicidal thoughts or behaviours.	○ Map of the resilience support for first responders in Barnet, including police, fire, healthcare staff, and park rangers.	PH Adults	July 2023
		11. Use a quality improvement approach to improve local services and pathways, involving service users and people with lived experience as equal partners in improvement.	r) Understand whether the uptake of early help services reflects the groups known to be at an increased risk of suicide.	○ Monitor the use of the online counselling and wellbeing services commissioned for CYP (Kooth) and report the proportion of users by gender to guide awareness-raising activity in schools.	PH CYP	2022
				○ Monitor the use and waiting time to access Terapia to ensure service is appropriately resourced to meet demand from care-leavers.	FS	2022
			s) Engage with children and young people to co-produce ideas for service improvement.	○ Share learning from CYP focus groups for service improvement for the universal CYP offer with the BSPP.	PH CYP BICS	2021
				○ Consult young men (especially black young men), all young people who are not in education, their parents and carers, and other community groups who are not currently accessing emotional wellbeing and psychological support services to understand barriers and facilitators to access. Use this consultation to inform the development of appropriate services.	FS	2022
				○ Share findings of the National Child Mortality Database Thematic Review with the BICS Youth Engagement Officer. Explore whether the understanding of young people around the bounds of the current offer of support (in terms of confidentiality and the statutory duty to safeguard) is a barrier to accessing support and explore improvements that can be made.	BICS	2022
			t) All partners engage with CC1 and CC2 groups that they support to identify and mitigate barriers to access and to improve service provision.	○ Partners have worked during the first year to improve accessibility for people with high functioning autism and people with learning disabilities.	All partners	2023
				○ The results of the joint commissioning unit mental health inequalities survey have been shared with Partners.	NCL CCG	2021
			u) Provide community pathways to access self-harm and suicide support e.g. self-referral, voluntary, community, and faith organisations.	○ Community referral pathways to self-harm and suicide prevention support services for young men have been developed for NCL boroughs.	NCL SP	2023
				○ Monitor the use of Rephael House, which can be accessed via community referral pathways such as Primary Care and report the needs and demands of the service.	FS	2022
				○ Community referral pathways to suicide prevention services for people who are homeless have been developed.	PH Adults / NCL SP	January 2023
			v) Review how primary care is informed of vulnerable persons and how support is activated e.g. notification by the Public Protection Unit/Liaison Team	○ Review has been shared with BSPP and recommendations are incorporated into the Action Plan 2023-25.	NCL CCG	2023
			w) Review how people seen by the crisis team subsequently engage with other services.	○ Review has been shared with BSPP and recommendations are incorporated into the Action Plan 2023-25.	NCL CCG	2023
			x) Informed by National Child Mortality Database Programme Thematic Review, explore opportunities to strengthen information sharing processes with different agencies and consider information sharing with private counselling services.	○ Explore the role of Professional Portal and strengthening relationships with external agencies such as private counselling services.	BICS/FS /BEH CAMHS	2023

Theme: Prevention of Suicide and Self-Harm

Area for action	Mental health and wellbeing **Aim: Support and improve the mental wellbeing of Barnet residents**				
Our current position	Improving our offer for general wellbeing support, and preventative mental health services should help to prevent people reaching crisis point. BARNET The Barnet Wellbeing Service provides mental health and wellbeing support to residents, connecting them with community organisations to improve their wellbeing and prevent them from escalating to the point of crisis. Middlesex University is working to promote mental wellbeing in students by promoting healthy lifestyles, providing financial support, societies and engagement, and wellbeing activities, in addition to clinical services and therapeutic support. Ways to improve the mental wellbeing support for overseas students is currently being explored. The Barnet Integrated Care Partnership (ICP) brings together all NHS organisations working in the borough, the council, HealthWatch and Voluntary, Community and Faith Sector (VCFS) representatives to provide better health care to Barnet residents. Barnet's ICP has a focus on expanding housing and employment opportunities for people with learning disabilities and autism and is developing a new community model for care and support for adults with Severe Mental Illness (SMI). The new community-based offer will improve holistic care for residents with SMI including physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use. The new offer will have prevention embedded throughout, apply a population health management approach, and proactively focus on reducing health inequalities. As part of this, Core Community Mental Health Teams will be redesigned and expanded to move towards new multidisciplinary services across health and social care aligned with primary care networks to support people who have the most complex needs. NORTH CENTRAL LONDON Work is underway to address inequalities in mental health, engaging with racialised communities to improve mental health services and co-produce a mental health inequalities action plan. For example, this workstream includes addressing the physical health needs of those at risk from COVID such as people on SMI registers from BAME communities, improving psychological support for racialised communities with culturally appropriate therapies, ensuring crisis prevention is accessible, developing the mental health community model, and increasing capacity for community support to residents with social prescribers, suicide prevention and mental health first aiders. North Central London will focus on improving access, people's experience of care, and treatment outcomes. LONDON Thrive London is an initiative by the Greater London Authority aiming to improve Londoners' mental health and wellbeing. Thrive London and partners work to reduce mental health stigma, support community actions, raise awareness of mental health, support children and young people, improve services, foster a healthy, happy workforce, and have a zero-suicide ambition. Projects supported include training mental health first aiders, supporting the Healthy Schools London programme, problem solving booths, and the London Healthy Workplace Charter. The GLA is currently consulting on the COVID-19 recovery plan for mental health and wellbeing with the mission is that 'By 2025, London will have a quarter of a million wellbeing ambassadors, supporting Londoners where they live, work and play.'				
What we want to achieve	**Strategic Objectives 2021-2025** How we will move towards our aim	**Biennial Action Plan** **Strategic Actions 2021-2023** How we will progress our objectives	**Action Outcome Measures** How we will measure our efforts	**Lead Team**	**Review**
	12. Partners in the Barnet Suicide Prevention Partnership will lead by example and provide comprehensive mental wellbeing support for their employees and/or volunteers.	y) Partners will review their existing mental wellbeing provision and address any gaps in their in-house provision.	○ All partners have a mental wellbeing offer for their staff or volunteers.	All partners	December 2022
		z) Partners will train and promote mental health first aiders within their organisations.	○ All partners have mental health first aiders within their organisation proportionate to the size of the organisation.	All partners	December 2022
	13. The community mental health transformation programme should address risk factors for self-harm and suicide.	aa) Improve digital resilience in children and young people.	○ Co-produce and promote a film on digital resilience with and for Barnet's young people.	PH CYP	2023
	14. Gain new insights on local priorities by bringing together data on self-harm and suicide and data on wider determinants of mental wellbeing and use these to shape future actions.	bb) Collect and analyse local data on wider determinants of mental wellbeing such as employment security, student demographics, social isolation, and housing quality with self-harm and suicide data.	○ A report outlining the trajectory of local risk factors is shared with the BSPP and insights are incorporated into the prioritisation and action plan setting for 2023-2025.	PH Adults / Insights	September 2022

Theme: Postvention	Area for action	**Bereavement Support** **Aim: Provide support to everyone that wants it after bereavement by suicide**				
	Our current position	NORTH CENTRAL LONDON Rethink Mental Illness, commissioned by NCL, launched a Support after Suicide service in October 2020. The Thrive LONDON Information Sharing Hub is used, with consent, to proactively reach out and connect those recently bereaved by suicide into the service. The service offers engagement with those bereaved by suicide, one-to-one emotional and practical support and advice, group-based support, and peer support where possible, both face-to-face and online. NICE Suicide Prevention Quality Standard [QS189] Statement 5: "People bereaved or affected by a suspected suicide are given information and offered tailored support".				
	What we want to achieve	**Strategic Objectives 2021-2025** How we will move towards our aim	**Biennial Action Plan** **Strategic Actions 2021-2023** How we will progress our objectives	**Action Outcome Measures** How we will measure our efforts	**Lead Team**	**Review**
		15. Increase the number of people supported by the NCL Support after Suicide Service.	a) Use the Thrive London Real Time Surveillance Hub to proactively identify and offer help from the NCL Support after Suicide service.	○ Meet the target for all contacts identified on the Thrive London Hub to be offered support.	NCL SaS	2022
			b) Raise awareness of the NCL Support after Suicide service in Barnet by ensuring service details are included in Barnet resources.	○ The percentage of online and in-print council owned mental health resources that include details of the NCL Support after Suicide service.	NCL CCG / PH Adults	December 2021
				○ Liaise with the educational psychology service and BICS who support schools after suicide and update them on the current offer of services available in Barnet, including the NCL Support after Suicide service.	BELS/BICS	2022

Theme: Postvention	Area for action	**Community Response** **Aim: Ensure a co-ordinated local response of partners with every death by suicide.**				
	Our current position	BARNET When a person dies by suicide and they are connected to a school - for example, a child, parent or member of staff - Barnet Integrated Clinical Service (BICS), in conjunction with the educational psychological service, provide support to the school. This includes drop-in sessions for children and young people alongside other formal interventions. Child and Adolescent Mental Health Services (CAMHS) also provide a significant school support response and update the care plans of all children under their care who are likely to have been impacted by this death. The death of a child by suicide also triggers a Serious Incident Review, with provision of support and resources, for example assembly and class materials to the school. 'Working with children in Barnet: the education escalation policy' is a document that informs schools of the procedure to follow should a critical incident take place, and the support that the local authority will provide. Jami, a mental health service for the Jewish community, co-ordinates and leads the Emergency Response Initiative Consortium (ERIC). Partners have written a guide for Barnet schools to help them respond to sudden traumatic death and suicide and put in place actions to prevent suicide such as training and staff awareness and safeguarding in relation to suicide. ERIC trained First Responders can be mobilised by Jami to go into schools to support grieving students and staff. LONDON Thrive London are reviewing and improving the current mechanisms for identifying and responding to potential clusters across London.				
	What we want to achieve	**Strategic Objectives 2021-2025** How we will move towards our aim	**Biennial Action Plan** **Strategic Actions 2021-2023** How we will progress our objectives	**Action Outcome Measures** How we will measure our efforts	**Lead Team**	**Review**
		16. Support local organisations to respond sensitively following a death by suicide and support individuals following a suicide.	c) Ensure that all secondary and further education settings in Barnet have a postvention plan.	○ Engage with the educational psychology service and BICS to better understand how they work with schools after a suicide and agree a process for sharing school-level plans with relevant partners to ensure sensitivity, particularly around the time of anniversaries and memorials.	BICS/BELS/ PH CYP/ BEH CAMHS/	2022
				○ Develop a Suicide Response Protocol which includes a co-ordinated offer for schools including a menu of interventions available; and preparation of Headteachers for Joint Action Review (JAR) and Child Death Overview Panel (CDOP) responsibilities.	BICS/BELS/ PH CYP/ BEH CAMHS	2022
			d) Set-up a Postvention Response to support public and private sector workplaces with postvention advice and resources.	○ Scope options for a postvention response at a local and/or sector level e.g. resource pack, or postvention response team e.g Emergency Response Initiative Consortium (ERIC) model, led by Jami, and share with BSPP.	PH Adults	September 2022
			e) Develop a Suicide Cluster Response Protocol to enable nimble and co-ordinated response across Barnet.	○ Develop Suicide Cluster Response Protocol with appropriate focus on specific population groups including one for Children and Young People linked to CDOP and one for Adults.	PH / BICS / BELS	2022

APPENDIX

Strategy Development

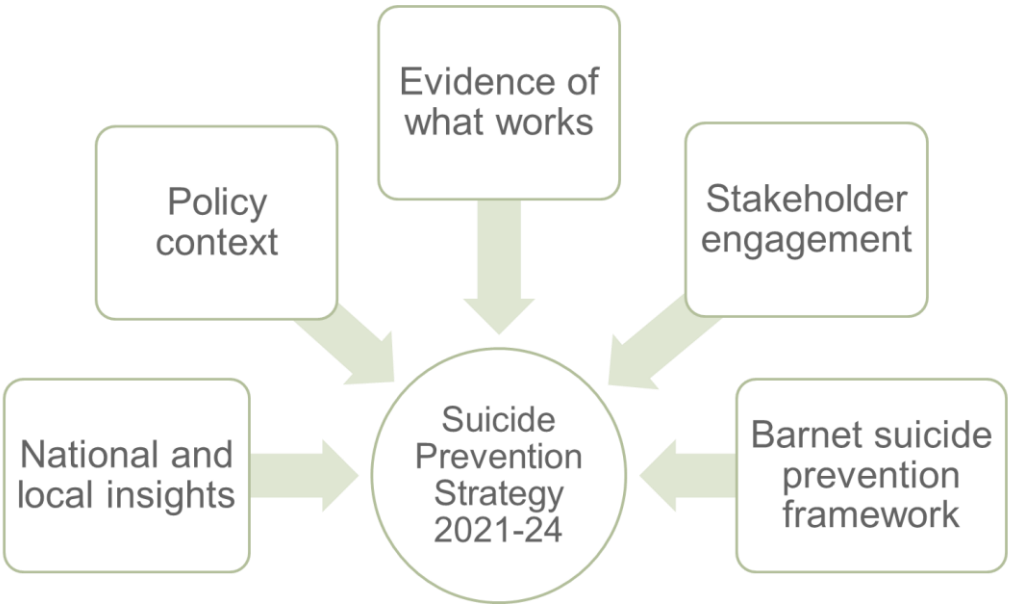
This strategy was co-produced with the multi-agency Barnet Suicide Prevention Partnership (BSPP) to be appropriate to the national and our local context, to be insight-led, informed by evidence of what works, and importantly to be practical, achievable, and effective.

The BSPP has worked together to prevent people dying by suicide since 2014, producing annual action plans and reporting to the Barnet Health Oversight Scrutiny Committee. The group comprises a broad range of local partners including representatives from the Barnet Clinical Commissioning Group, Police, NHS Health Trusts, Barnet Enfield and Haringey Mental Health Trust (BEHMHT), Children's and Adult Social Care, and the Voluntary and Community Sector. The Barnet Suicide Prevention Strategy 2021-2025 provides an update to the BSPP Action Plan 2019-2020.

Development of this strategy followed four stages:

- Development of our Barnet Suicide Prevention Framework.
- Co-production of our aims and initial objective scoping through a workshop and consultation with the Barnet Suicide Prevention Partnership.
- Consolidation of objectives using national and local insights and evidence of what works.
- Joint priority setting and commitment to Action Plan 2021-23 through workshops and written consultation with the BSPP and wider stakeholders.

Figure 2 – Inputs to the Barnet Suicide Prevention Strategy



Policy Context

This strategy exists amongst an extensive backdrop of national and regional guidance, strategies, and action plans for preventing self-harm and suicide in the UK. Our strategy aligns with these national priorities, integrates with local strategies supporting mental health and wellbeing, and supports sector-level programmes aiming to prevent self-harm and suicide.

The National Institute for Health and Care Excellence (NICE) produces guidance and pathways to inform evidence-based practice. NICE Guideline 105 and NICE Quality Standard 189 include recommendations for local authorities relating to suicide prevention partnerships, strategies, and action plans which have been incorporated into this strategy.

Barnet's objective to reduce deaths by suicide in each year of the four years of this strategy is consistent with the national ambition set in the Five Year Forward View for Mental Health (2016) to reduce deaths by suicide nationally by 10% over five years from 2016/17 levels. The Five Year Forward View Implementation Plan includes a recommendation for all local authorities to develop multi-agency suicide prevention plans that address the areas for action outlined by the Suicide Prevention Strategy for England (2012), and accompanying progress reports (2013, 2015, 2017, 2019). The national strategy set two objectives:

- ☐ A reduction in the suicide rate in the general population in England.
- ☐ Better support for those bereaved or affected by suicide.

To achieve these objectives, there are seven key areas of action:

1. Reduce the risk of suicide in key high-risk groups.
2. Tailor approaches to improve mental health in specific population groups.
3. Reduce access to the means of suicide.
4. Provide better information and support to those bereaved or affected by suicide.
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour.
6. Support research, data collection and monitoring.
7. Reduce rates of self-harm as a key indicator of suicide risk (added 2017).

The London Mayor Health Inequalities Strategy (2018) includes the objective (2.5) that 'Action is taken across London to prevent suicide, and all Londoners know where they can get help when they need it'. The Strategy includes a pledge to support a long-term vision for London as a 'zero-suicide city', with funding for Thrive London – an initiative to improve the mental health and wellbeing of all Londoners, and to prevent suicide. The London-wide Suicide Prevention Framework, 2018, recommends the following as priority areas for London boroughs; reducing the risk in men, engaging BAME (black, Asian and minority ethnic) communities, bereavement support, preventing and responding to self-harm, mental health of children and young people, acute mental health care, supporting primary care, tackling high frequency locations, reducing isolation and loneliness, and media engagement. The London-wide Suicide Prevention Framework sets out Nine Pillars for prevention plans:

1. Background Framework
2. Leadership / Governance
3. Areas of high frequency, individuals at high risk, reducing access to means and promoting support
4. Training
5. Intervention and support
6. Suicide bereavement, postvention and the prevention of 'suicide clusters'
7. Evaluation measures
8. Sustainability and capacity building
9. Suicide Prevention, Mental Health and Wellness Promotion & Awareness

In March 2021, the Department of Health and Social Care announced the COVID-19 Mental Health and Wellbeing Recovery Action Plan for 2021 to 2022, to mitigate and respond to the impact of the COVID-19 pandemic on mental health, and prevent or support people at risk of self-harm or suicide. The recovery plan bolsters our local actions on wider determinants with national support to reduce inequalities and mitigate risk factors for self-harm and suicide.

Reducing deaths by suicide is a priority for the NHS. The NHS Long Term Plan committed to implementing a new Mental Health Safety Improvement Programme as well as rolling out suicide bereavement services across the country. The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together to make sure that people get the help they need when they are having a mental health crisis, focussing on increasing access to support before crisis, access to crisis care, improving care when in crisis, and supporting recovery after crisis. In 2018, the Secretary of State for Health and Social Care launched a zero-suicide ambition for mental health inpatients. The **Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) Zero Suicide Ambition Suicide Prevention, Learning and Support Strategy 2020** aims to achieve a 20% reduction in suspected suicides amongst patients under their care by the end of 2021, with a zero-suicide goal for all in-patients.

The North Central London Sustainability and Transformation Partnership (NCL) successfully bid for wave one and wave three funding from the Suicide Prevention National Transformation Programme. The Barnet Suicide Prevention Strategy 2021-25 works synergistically with the planned activities of the **North Central London Suicide Prevention Programme**. North Central London utilised wave one funding to introduce a Support after Suicide Service in October 2020. The NCL programme plan for wave three includes several elements:

a. Programme management (hosted by Barnet) and establishment of an NCL Suicide Prevention Strategy Group.
b. Gap analysis and quality improvement of responses to self-harm.
c. Development of specific service improvements to address identified gaps including support for young adults (18-25), other non-statutory services with a focus on middle-aged men, and a specific trial of psychologically informed peer support following self-harm.
d. Expansion of community-based training in suicide awareness.

Prevention of suicide and self-harm and the improvement of mental health and wellbeing is a priority in Barnet. The implementation of this strategy is an objective of **The Barnet Joint Health and Wellbeing Strategy 2021-2014**. The Barnet Corporate Plan 2021-2025 priority of 'Healthy' has improving mental health and wellbeing as a key outcome, work which is supported by the North Central London Integrated Care System (ICS) community mental health transformation programme.

Insights

Local and Regional

This section provides a summary of local and national trends on deaths by suicide. It is important to note that in May 2019, the standard of proof for a suicide conclusion at inquest changed from the criminal standard (so that you are sure) to the civil standard (more likely than not). The significance of this in comparing data before and after 2019 has not yet been elucidated.

The four-year average annual number of suicides for Barnet residents was 22 in 2019 (for 4-year period 2016-19). In 2019, the median registration delay for suicides in Barnet was 149 days, down from 162 days in 2018. The most recent Office of National Statistics (ONS) data available (2017-19) for deaths by suicide registered in Barnet shows a count of 66 deaths and an age standardised rate of 6.7 deaths per 100,000 persons. This rate is:

- Significantly lower than England (10.1 per 100,000).
- The 6th lowest rate in London.
- Not significantly different to North Central London boroughs (except Camden) with whom the borough shares mental health services.

Suicide rates in North Central London Boroughs, London and England, 2017-2019

Area	All		Men		Women	
	Rate*	Count**	Rate*	Count**	Rate*	Count**
Enfield	5.9 (4.3-7.8)	50	7.9 (5.3-11.3)	32	4.1 (2.4-6.5)	18
Barnet	6.7 (5.2-8.6)	66	9.7 (7.1-13.0)	48	3.8 (2.2-6.0)	18
Haringey	9.6 (7.2-12.4)	65	14.0 (9.7-19.3)	46	5.6 (3.3-8.8)	19
Islington	10.4 (7.6-13.9)	54	15.0 (10.0-21.5)	37	6.1 (3.3-10.2)	17
Camden	11.3 (8.7-14.5)	69	17.4 (12.6-23.3)	48	6.0 (3.6-9.2)	21
London	8.2 (7.8-8.6)	1,845	12.4 (11.7-13.1)	1,359	4.3 (3.9-4.6)	486
England	10.1 (9.9-10.3)	14,788	15.5 (15.2-15.8)	11,145	4.9 (4.7-5.1)	3,643

*three year age-standardised death rate and **total deaths

Office for National Statistics - Suicides in England and Wales: 2019 registrations

In Barnet, the emergency hospital admissions for intentional self-harm was 98.8 per 100,000 (95% CI 89.2-109.2) in 2019 to 2020 this rate:

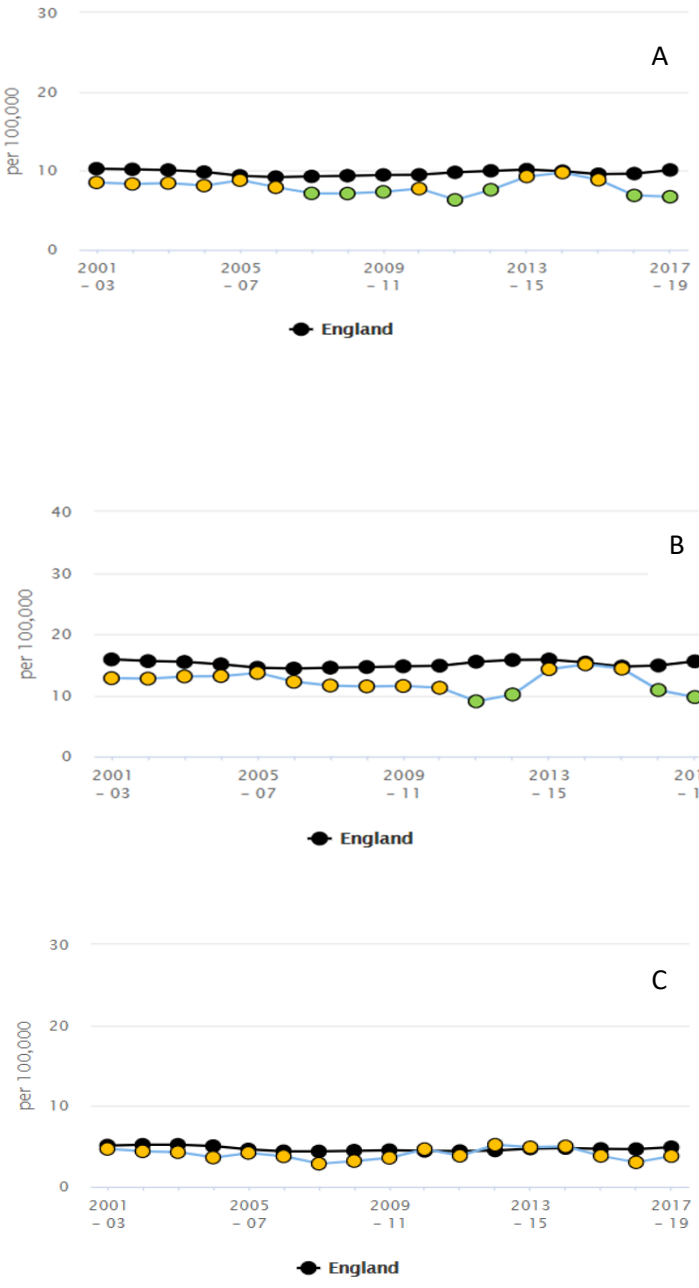
- Is significantly lower than the rate in England (193.4 per 100,000)
- Is similar to the average rate in London at 88.4 per 100,000 versus 81.6. per 100,000.

The rate of emergency admissions for intentional self-harm has not significantly changed over the previous decade.

RECENT TRENDS

Since 2001, the Barnet rate of suicide in men has been higher than women, in keeping with the national picture. The rate for men has decreased significantly from 14.3 (2015-17) to 9.7 per 100,000 (2017-2019), while the suicide rate for women has remained static at 3.8 per 100,000.

Figure 3. Trends in Suicide Rate in Barnet in comparison to England. A = Persons. B = Men. C = Women. Office for National Statistics – Suicides in England and Wales: 2019 registrations.

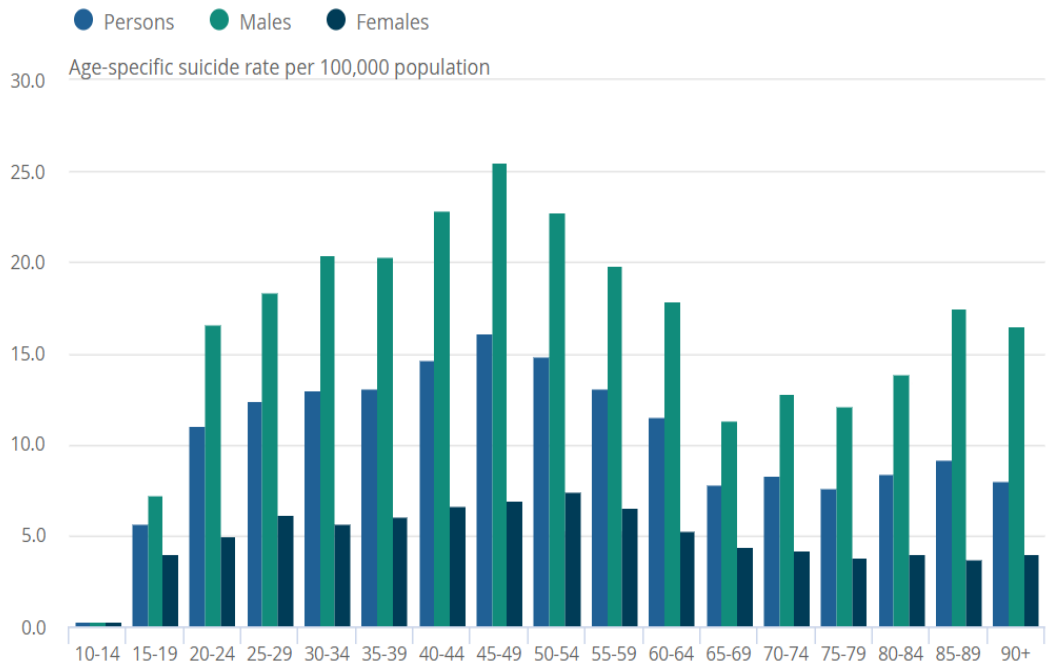


National (England and Wales)

National data shows us that suicide affects some groups more than others. These insights have been used to guide our cross-cutting concerns. For example, men are three times more likely to die by suicide compared with women. People in the lowest socio-economic group, living in the most deprived areas are ten times more at risk than those in the highest socio-economic group, living in the least deprived areas.

In 2019, there were 5,691 suicides in England and Wales, an age standardised rate of 11.0 deaths per 1000,000 population. Three quarters of the deaths registered were among men[2]. When analysed by five-year age group, there is a double peak in suicide rates; ages 45 to 49 and ages 85 to 89. Men aged 45 to 49 years have the highest age-specific suicide rate overall -25.5 deaths per 100,000 men. For women, the age group with the highest rate was 50 to 54 years, at 7.4 deaths per 100,000.

Figure 4: Age-specific suicide rates by sex and five-year age groups, England and Wales, registered in 2019. Office for National Statistics – Suicides in England and Wales: 2019 registrations.



As seen in previous years, the most common method of suicide in the UK was hanging, accounting for 61.7% of all suicides among men and 46.7% of all suicides among women.

RECENT TRENDS

Despite having a low number of deaths overall, rates among the under 25s have generally increased in recent years, particularly 10 to 24-year-old women where the rate has increased significantly since 2012 to its highest level with 3.1 deaths per 100,000 women in 2019.

Evidence that informed our strategy

Our strategy, prevention framework, aims, and our objectives are built upon the national evidence of the risk factors for suicide and self-harm and 'what works' for prevention. Wide ranging evidence authoritatively and comprehensively summarised in reports elsewhere has been used to inform this strategy. To maintain the usability of this strategy, this section briefly covers some of the key evidence that informed our thinking when deciding our local priorities and choosing our strategic actions for the first two years.

This strategy aligns with the evidence and recommendations in recent national reports and guidelines including:

- NICE Quality Standard 189 (Suicide Prevention), NICE Guideline 105 (Preventing suicide in community and custodial settings), Clinical Guideline 16 (Self-harm in over 8s: short-term management and prevention of recurrence), Clinical Guideline 133 (Self-harm in over 8s: long-term management)'. This strategy is cognisant that NICE guidelines on self-harm are due for review.
- Public Health England's Suicide Prevention Resources including The National Suicide Prevention Strategy for England (2012), accompanying progress reports (2013, 2015, 2017, 2019), and the Local Suicide Prevention Planning Practice Resource.
- National Confidential Inquiry into Suicide and Safety in Mental Health Annual Reports (latest 2021) and guidance (e.g. Safer Services Toolkit)
- Reports and guidance such as From Grief to Hope [University of Manchester], Dying from Inequality [Samaritans], All Party Parliamentary Group Inquiry into the support available for young people who self-harm.

This strategy addresses, and through our action plan meets the recommendations in the NICE Quality Standard and Guidelines for suicide prevention.

NICE Quality Standard 189: Suicide prevention
Statement 1: Multi-agency suicide prevention partnerships have a strategic suicide prevention group and clear governance and accountability structures
Statement 2: Multi-agency suicide prevention partnerships reduce access to methods of suicide based on local information.
Statement 3: Multi-agency suicide prevention partnerships have a local media plan that identifies how they will encourage journalists and editors to follow best practice when reporting on suicide and suicidal behaviour.
Statement 4: Adults presenting with suicidal thoughts or plans discuss whether they would like their family, carers or friends to be involved in their care and are made aware of the limits of confidentiality.
Statement 5: People bereaved or affected by a suspected suicide are given information and offered tailored support.

NICE Guideline 105: Preventing suicide in community and custodial settings
1.1 Suicide prevention partnerships
1.2 Suicide prevention strategies
1.3 Suicide prevention action plans
1.4 Gathering and analysing suicide-related information
1.5 Awareness raising by suicide prevention partnerships
1.6 Reducing access to methods of suicide
1.7 Training by suicide prevention partnerships
1.8 Supporting people bereaved or affected by a suspected suicide
1.9 Preventing and responding to suicide clusters
1.10 Reducing the potential harmful effects of media reporting of a suspected suicide

Evidence that informed our strategic priorities for 2021-2023

Suicide is a complex behaviour with no single explanation or cause. There are numerous risk factors for suicide, present at the individual, community, and societal level, as shown in Figure 5. The wide range of risk factors for suicide shows how critical it is that we work across the whole system in wide-ranging partnerships.

In order to make a difference in Barnet, it is crucial that we understand and focus our prevention efforts on reducing the impact of the risk factors that are most significant for our local residents. This section provides an overview of some of the key insights that have informed our choice of strategic priorities, such as the cross-cutting concerns of notable focus, for the Action Plan 2021-2023.

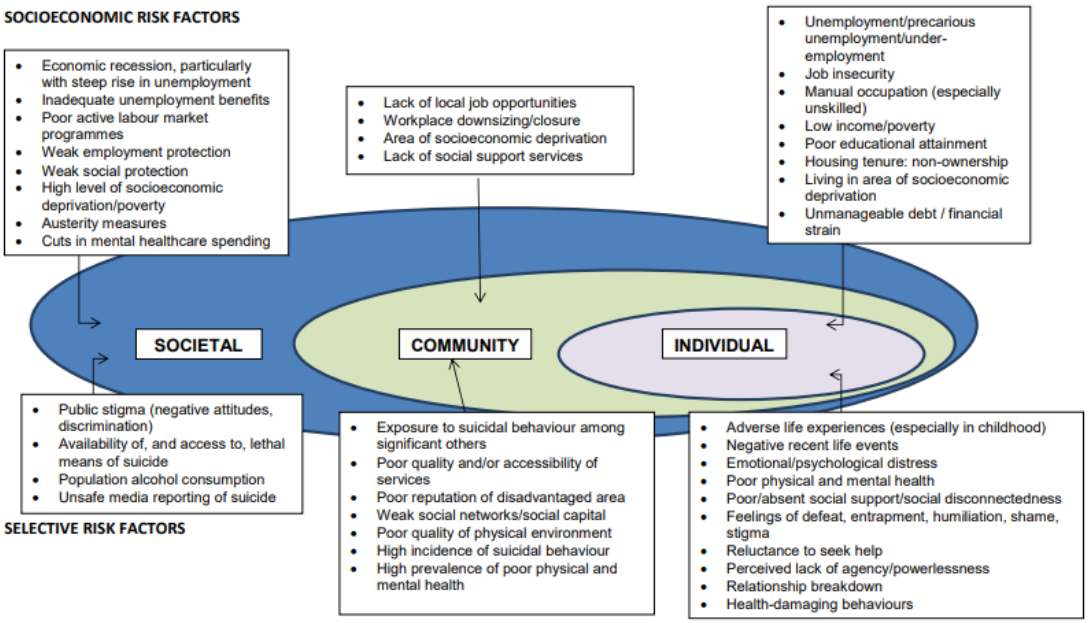


Figure 5: Model of suicidal behaviour, highlighting socioeconomic risk factors. Reproduced from: Samaritans (2017), 'Socioeconomic disadvantage and suicidal behaviour', March 2017

Cross-Cutting Concerns of Notable Focus for Action Plan 2021-2023 were chosen by the Barnet Suicide Prevention Partnership as locally important areas that demanded immediate collective effort to achieve improvements.

- Young and middle-aged men

In the UK and in Barnet, men are three times more likely to die by suicide than women. Men aged 45 to 49 have the highest suicide rate in the UK. In 2017, of the 1,516 men aged 40-54 who died by suicide, 30% were unemployed at the time of death, 27% were in the most deprived areas in England, and 45% reported living alone. Physical health conditions were present in over half (52%), while bereavement and substance misuse occurred in over one third (34% and 49% respectively) of cases. Strikingly, 91% had been in contact with at least one front-line service or agency – 67% within 3 months of deaths[10]. This is an opportunity for intervention. There is emerging evidence of a preference for informal, de-medicalised provision such as peer-led support, community and work-based based initiatives, and non-clinical spaces and respite.

[10] The National Confidential Inquiry into Suicide and Safety in Mental Health (2021), Suicide by middle-aged men 2021, University of Manchester

- People with a history of self-harm

Self-harm is the most important risk factor for subsequent death by suicide; half of people who die by suicide have a history of self-harm, many with an episode close to their death, and some presenting to hospital within the year before their death[8]. NICE guidance CG16 and CG133 provides comprehensive recommendations for the short and long term management of people over 8 years old who self-harm. Particularly in patients known to mental health services, recent self-harm is an important antecedent of suicide, with 29% of people who died by suicide between 2006-16 recently self-harming[17].

Findings from many community-based studies show that around 10% of adolescents report having self-harmed, of whom some will report some extent of suicidal intent underpinning their self-harm. Presentation to hospital occurs in only about one in eight adolescents who self-harm in the community, being more common in those who take overdoses[11]. While many people will not present to health services, they may confide in family and, particularly for young people, in friends[12]. This is an opportunity to provide help. We can support residents by working to raise awareness of self-harm, build community skills in having conversations about suicide, and make it easier to find locally available services and support.

- People who misuse alcohol and drugs

Misuse of alcohol or drugs is an aggravating factor that further increases risk in particular sub-groups including men, people who self-harm, and people with a mental health diagnosis. In patients who died by suicide in England (2008 to 2018), 45% had a history of alcohol misuse and 34% had a history of drug misuse[3]. The 'Better care for people with co-occurring mental health and alcohol/drug use conditions (2017) report'[13] emphasises the importance of specialist service provision, joint working, 24/7 crisis response, and accessible care pathways to meet the complex needs of this groups.

- Children and young people (CYP)

Suicide is the leading cause of death for young people. Since 2017, there has been a significant increase in the suicide rate for men aged 10 to 24, rising to 8.2 per 100,000 in 2019. For women aged 10 to 24, the 2019 suicide rate for England and Wales is the highest recorded since 1981 at 3.1 per 100,000, almost doubling from 1.6 per 100,000 in 2012, when the rate began to rise[2]. The Early Intervention Foundation Social and Emotional learning briefing recommends PSHE, a whole-school approach to emotional skills-based interventions, and delivering targeted evidence-based support for CYP with emerging mental health needs. There is evidence for the success of school strategies, mental health first aiders, peer support, staff training for awareness and signposting, and clear referral routes into specialist services[14]. Young people have expressed a desire for trusted sources of information and not wanting to negotiate complex systems to access services[15]. In 2018, the Department of Education published guidance for schools supporting CYP with their mental health. The guidance advocates that each school creates a whole school culture for mental wellbeing, identifies, assesses and creates a plan to support children at risk of mental health problems, which could include working with external agencies and services.

[11] Hawton K, Saunders KEA, O'Connor RC (2012). Self-harm and suicide in adolescents. Lancet; 379:2373–82. doi:10.1016/S0140-6736(12)60322-5
[12] Royal College of Psychiatrists London (2010), Self-harm, suicide and risk: helping people who self harm, College Report CR158.
[13] Public Health England (2017), 'Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers', June 2017.
[14] Public Health England (2019), 'Universal approaches to improving children and young people's mental health and wellbeing', Report of the findings of a Special Interest Group, October 2019.
[15] Public Health England (2014) Improving young people's health and wellbeing: A framework for public health, January 2015.

• People who experience distressing life events

High-risk distressing life events are those which negatively impact on an individuals' mental wellbeing and increase their risk for suicidal thoughts and behaviours. High risk events may influence metal health by impacting upon:

- Economic wellbeing e.g. redundancy, debt, gambling addiction.
- Social wellbeing e.g. people who are living alone, socially isolated, or excluded, and young people impacted by social media.
- Emotional wellbeing e.g. family conflict or breakdown, relationship breakdown or divorce.
- Psychological wellbeing e.g. bereavement (particularly bereavement by suicide), family mental health problems, recently relapse of substance misuse, recent self-harm, bullying.

It is likely that for many, COVID-19 will have caused or exacerbated these events, which already disproportionately affect those in high risk groups for suicide. Of all mental health patients who died by suicide in England in 2008-2018, 48% were living alone and 46% unemployed[3]. There is a higher rate of key risk factors and distressing life events in men who die by suicide when compared to the incidence in the general population. Most (57%) had experienced economic problems (unemployment, finance, or unstable accommodation) at the time of death, while some experienced distressing events in the 3 months prior to their death such as problems with; family relationships (36%), alcohol misuse (36%), bereavement (34%), substance misuse (31%), finance (30%), housing (24%), problems at the workplace (24%), or divorce/separation (21%). The number of men living in the most deprived areas (27%) losing their life to suicide is almost twice that of those in the least deprived areas (14%)[10]. Unemployment is a key risk factor for suicidal behaviour in men, and this higher risk is exacerbated during a downturn or period of economic growth[9]. Following the 2008 Global financial crisis, there was an increase in the rate of suicide in England.

There is opportunity for intervention following distressing life events. 53% of men who died by suicide in 2008-2018 expressed ideation or intent at some time, 20% in the week prior to their death. 91% had been in contact with at least one frontline service or agency, (most often primary care – 82%). Services can provide support following for example unemployment, for debt, social isolation, family breakdown, homelessness, and bereavement. A focus within these services should be on recognising risk, responding to unmet need, and better joint working across support services, primary and secondary care, social care, and local authority. Upskilling frontline staff and providing gatekeeper training is critical in building system capacity to recognise risk and intervene.

Theme 1 – Foundation for Action

Insights from data, research, and people with lived experience

Robust data and relevant insights underpin the development of effective suicide prevention activities. Making progress towards our first strategic aim for 'enhanced insights on every suicide that occurs in the borough to inform future prevention work' will enable us to improve our local evidence base where there are known current gaps, such as in ethnicity and sexual orientation , as well as better inform our prevention activities. Co-produced solutions form the core of our second principle in the development of this strategy. Involving people affected by suicide brings a crucial perspective that can help to identify gaps between policy and practice, and ground prevention work in the real-life impact of self-harm and suicide.

Public Health England's Local Suicide Prevention Planning recommends local authorities to focus on the collection and analysis of local information that could provide additional insights alongside close consideration of the national data[16]. A limitation of our local data is the relatively small annual numbers makes it difficult to detect significant differences between nationally and locally important risk factors, and longer timescales are needed to evaluate the impact of our suicide prevention activities. Local data can be improved and used to produce more responsive prevention activities by reducing the time from suicide events to data analysis[4]. Current data from the Office for National Statistics is published annually, but registrations of suicide deaths following a coroner's inquest can be delayed by days or months – currently in Barnet the median registration delay for suicides is 149 days (2019)[1]. Real-time surveillance systems can help to close this gap.

Leadership and collaboration

The All-Party Parliamentary Group on Suicide and Self-Harm Report advises the establishment of a multi-agency suicide prevention group as one of the main elements to successful suicide prevention work. This is also recommended by The National Suicide Prevention Strategy and NICE QS 189 based on evidence that "By combining expertise and resources, partnerships can cover a much wider area more effectively and implement a range of activities" and that "when partnerships share knowledge and experience, this is of greater benefit than working individually." For a successful whole-system approach that tackles the wider determinants of health and wellbeing, we need to collaborate across public, private and health services. Involvement of our Health and Wellbeing board should provide further opportunities for multi-agency working.

Theme 2 – Prevention of Suicide and Self-Harm

Awareness

In this strategy, 'awareness' is the first action area within the theme 'prevention of self-harm and suicide'. This action includes building general awareness of mental wellbeing, self-harm, and suicide, as well as raising awareness of the services and support available locally.

Collecting research evidence demonstrating the effectiveness of raising awareness would be challenging. Our expert view is that building general awareness is the first step of prevention as it aims to increase general understanding of mental wellbeing, improve skills that build positive mental wellbeing, and reduce barriers to help seeking such as stigma and discrimination.

There is evidence that bystander interventions as well as timely signposting can be effective in preventing suicides[17]. We believe that raising the awareness of the local services and support available to those in need amongst everyone in Barnet is the crucial second step that will enable timely help-seeking or effective bystander intervention.

Increasing awareness of suicide and self-harm support across the population in Barnet will help us reach our aim that 'everyone in Barnet knows where to find help if they are thinking about suicide or are concerned about someone else'.

[16] Public Health England (2020), 'Local suicide prevention planning: A practice resource', September 2020.

Interventions

Timely interventions that interrupt the suicidal process can be lifesaving: they buy the time needed to give people the chance to reconsider, and they increase the likelihood that help reaches out to that person in time[17]. Interventions that delay or disrupt a suicidal act could include:

- Reducing access to means

This includes restricting access to high frequency locations, package size for medications and mediation reviews, removing ligature points in inpatient settings, and reducing access to weapons. Reducing access to means is known to be one of the most effective methods of preventing suicide. There has been a significant reduction in deaths by paracetamol overdose since the pack sizes of paracetamol reduced, and there is evidence demonstrating an 86% overall reduction in deaths when structural interventions are carried out at high risk locations for suicide by jumping, with little evidence of substitution to other potential jumping sites[17]. Currently, the most common method of suicide is hanging. Removal of ligature points in criminal justice and inpatient settings has shown to reduce deaths but designing interventions for hanging in the home remains difficult.

- Increasing the opportunity for intervention

Evidence shows that passer-by interventions are most likely to come from strangers. This is why raising general public awareness of suicide prevention and interventions is so important. The opportunity for human intervention can also be increased by specifically training frontline staff to recognise the risk factors for suicide - education of primary care doctors targeting depression recognition and treatment has been identified as one of the most effective interventions in lowering suicide rates[15].

- Increasing opportunities for help-seeking

Timely signposting of services and support around high risk events increases the chance that a person with suicidal thoughts can reach out for help. For example, signs that encourage help seeking at high frequency locations, inclusion of signposting information with written notices that may be distressing, and timely provision of signposting to individuals known to be at higher risk, such as following a bereavement.

Services & Support

Early access to effective support can save lives. The latest data and recommendations for suicide prevention of those in the care of mental health services can be found in the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) annual report. Evidence shows that patients with the highest risk are inpatients, those who refuse treatment, and those recently discharged, greatest within the first few days to first week.

It is important we provide high quality services that are accessible. NCISH have published a 'Safer Services Toolkit'[18] with ten ways to improve patient safety, which are incorporated in Barnet, Enfield and Haringey Mental Health Trust's Suicide Prevention Strategy. Recommendations include personalised risk management, follow-up within three days of discharge from in-patient care, 24-hour crisis care, following NICE guidance for depression and self-harm, and local services for dual diagnosis that work jointly with mental health services. Improving care across the system is also important, with clear pathways between emergency, primary, secondary, community, and specialist services.

[17] Public Health England (2015), 'Preventing suicide in public places: A practice resource', November 2015.
[18] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2017), 'Safer service: A toolkit for specialist mental health services and primary care. 10 key elements to improve safety', updated March 2021.

Theme 3 – Postvention

People who are bereaved by suicide have an increased risk of suicide and suicidal ideation compared to people bereaved through other causes[19], and bereavement can result in depression and poor social or occupational functioning. Bereavement by suicide affects not only immediate family, but entire communities; school friends, work colleagues, neighbours, and those whose work brings them into contact with suicide such as frontline emergency services staff, teachers, and faith leaders. Timely and effective support to those bereaved or affected by suicide may reduce the risk of these consequences.

A joined-up community response is essential in providing support to those impacted after a suicide and preventing further suicides. One suicide can trigger a cluster of suicides within the family or community, particularly among young people[20]. This can be exacerbated by news reports, which have been associated with imitative suicidal behaviours[21]. Evidence shows the risk of clusters can also be reduced with community-level post-suicide interventions at schools, workplaces, and healthcare settings, and that implementing guidelines on responsible reporting has been associated with sustained reductions in numbers of suicides. Significant work to promote responsible reporting is conducted at a national level with the Samaritans, and includes collaboration with news media and internet companies on responsible reporting and removal of content which encourages suicide or self-harm.

[19] Pitman A, Osborn D, Rantell K, et al. (2016), 'Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults'. BMJ Open, 2016 Volume 6, e009948, doi: 10.1136/bmjopen-2015-009948.
[20] Department of Health (2012), 'Preventing suicide in England. A cross-government outcomes strategy to save lives', September 2012.
[21] Sisask M, Värnik A, (2012), 'Media roles in suicide prevention: a systematic review'. Int J Environ Res, Public Health. Volume 9, Issue 1, pages 123 to 138.

Barnet Suicide Prevention Partnership Members

The Barnet Suicide Prevention Partnership has representation from the following organisations:

- London Borough of Barnet Council teams; Public Health, Mental Health, Safeguarding, Human Resources, Commissioning, Community Safety, Adult Social Care, Early Intervention, Enablement, BELS (Barnet Education and Learning Service).
- People with lived experience
- Central London Community Healthcare NHS Trust
- Barnet, Enfield, Haringey Mental Health Trust
- North Central London Clinical Commissioning Group
- Metropolitan Police
- British Transport Police
- BOOST
- Barnet Homes
- Middlesex University
- Mind in Barnet
- Trinity London
- Colindale Communities Trust
- Young Barnet Foundation
- Barnet Mencap
- Inclusion Barnet
- Change, Grow, Live
- AgeUK Barnet
- Young Barnet Foundation
- Meridian Wellbeing
- Jami UK
- Barnet Carers Centre
- CommUNITY Barnet
- Samaritans
- New Citizens Gateway
- Unitas Youth Zone
- Your Choice Barnet
- Home Start Barnet

Acronyms

APPG	All Party Parliamentary Group.
BAME	Black, Asian, minority ethnic, and racialised communities.
BEHMHT	Barnet, Enfield, and Haringey Mental Health Trust.
BELS	Barnet Education and Learning Service.
BICS	Barnet Integrated Clinical Service.
BOOST	Partnership with Barnet Homes, JobCentre Plus, Barnet & Southgate College a number of local community organisations.
BSPP	Barnet Suicide Prevention Partnership.
CAMHS	Child and Adolescent Mental Health Services.
CC1	Cross Cutting Concern 1 (each area should address identified high-risk groups).
CC2	Cross Cutting Concern 2 (each area should consider the need for a tailored approach in identified specific groups).
CC3	Cross Cutting Concern 3 (each area should mitigate the impact of high-risk distressing life events).
CCG	Clinical Commissioning Group.
CDOP	Child Death Overview Panel.
Comms	Strategy and Communications.
CYP	Children and Young People.
FS	Family Services.
ICP	Integrated Care Pathway.
ICS	Integrated Care System.
JAR	Joint Action Review.
LBB	London Borough of Barnet.
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and people with non-normative gender identities or sexual orientations.
MASH	Multi-Agency Safeguarding Hub.
MECC	Making Every Contact Count.
NCISH	National Confidential Inquiry into Suicide and Homicide.
NCL	North Central London.
NCL D&I	NCL Suicide Prevention Data & Insights Subgroup.
NCL SaS	NCL Suicide Prevention Support After Suicide Subgroup.
NCL SP	North Central London Suicide Prevention Strategy Group.
NICE	National Institute of Health and Care Excellence.
PH	Public Health.
PSHE	Personal, social, health and economic education.
RTS	Real Time Surveillance system.
SMI	Severe Mental Illness.
VCFS	Voluntary, Community, and Faith Sector.

ZSA	Zero Suicide Alliance

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AGENDA ITEM 12

	Health and Wellbeing Board **9 December 2021**
Title	**OFSTED Report on Children in Care**
Report of	Executive Director of Children and Family Services
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix 1 – Focused visit to the London Borough of Barnet local authority children's services
Officer Contact Details	Brigitte Jordaan, Director of Children Social care 0208 359 3012 Brigitte.jordaan@barnet.gov.uk

Summary

Local authorities judged to be good or outstanding at their most recent inspection will usually receive a short inspection about every three years after the previous inspection. In between inspections, the local authority will receive one focused visit or a Joint Targeted Area inspection of Children Services (JTAI).

Ofsted inspectors conducted a focused visit to Barnet children's services on 23 and 24 June. The visit was carried out in line with the Inspection of Local Authority Children's Services (ILACS) framework and looked at the local authority's arrangements for children in care.

Their findings were published on 2 August 2021 and are included in this report.

Recommendations

1. **That the Health and Wellbeing Board note the letter and recommendations made by Ofsted.**

1. WHY THIS REPORT IS NEEDED

1.1 Her Majesty's Chief Inspector of Education, Children's Services and Skills is leading Ofsted's work into how England's social care system has delivered child-centred practice and care within the context of the restrictions placed on society during the COVID-19 (coronavirus) pandemic. The findings of a focused visit to Barnet local authority children's services on 23 and 24 June 2021 are summarized in the Ofsted letter attached.

1.2 Inspectors found that, despite the challenges of the Covid pandemic, services for children in care have continued to improve since the last inspection in May 2019. They stated that "Senior leaders and partner agencies in Barnet have worked together to deliver a well-coordinated and effective response to the COVID-19 pandemic. This has included surge testing and support to asylum-seekers placed without notice by the Home Office in dispersal centres within the borough."

1.3 According to the findings most children in care benefit from living in placements that meet their individual needs. Ofsted spoke to partners including Children and Family Court Advisory and Support Service (CAFCASS), and the judiciary, who reported positive partnership working and this has contributed to our "well coordinated and effective response to the Covid-19 pandemic" and they stated that "Leaders understand what further improvements can be made and have plans in place to deliver this."

1.4 They found that disabled children in care benefit from the social work interventions in the 0-25 team – "Workers know their children and families well and demonstrate a strong awareness of their complex needs and increased risks due to additional vulnerabilities."

1.5 In relation to the health response to children in care they found that "throughout the pandemic, there has been close collaboration with the looked after children's health service to help to improve the health outcomes of children in care." They saw evidence that health assessments of children in care have continued to be prioritised and children benefit from the integrated clinical service that is fully embedded into family services.

1.6 Inspectors highlighted two areas of social work practice that need to improve:

- Case recording, including the recording of supervision, visits and direct work with children, and the rationale for decision-making on placements
- The completion and quality of 'All about me' plans.

1.7 We accept these recommendations and will be detailing our plans to make improvements to these areas of practice in our annual self-assessment, which we will meet with Ofsted about in November and will be presented to the Children, Education and Safeguarding committee (CES) thereafter.

2. REASONS FOR RECOMMENDATIONS

2.1 Members are asked to note the work of Children and Young People's Services, and to fulfil the council's statutory obligations in this regard.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable

4. POST DECISION IMPLEMENTATION

4.1 Not applicable

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 Family Friendly is a key part of the Barnet Plan for 2021-2025 with the vision of "Creating a Family Friendly Barnet, enabling opportunities for our children and young people to achieve their best".

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

Not applicable

5.3 Social Value

5.3.1 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. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.4 Legal and Constitutional References

5.4.1 Local authorities have specific duties in respect of children under various legislation including the Children Act 1989 and Children Act 2004. They have a general duty to safeguard and promote the welfare of children in need in their area and, if this is consistent with the child's safety and welfare, to promote the upbringing of such children by their families by providing services appropriate to the child's needs. They also have a duty to promote the upbringing of such children by their families, by providing services appropriate to the child's needs, provided this is consistent with the child's safety and welfare. They should do this in partnership with parents, in a way that is sensitive to the child's race, religion, culture and language and that, where practicable, takes account of the child's wishes and feelings. Under the Children and Families Act 2014, local authorities must consider how the child or young person can be supported to facilitate their development and to help them achieve the "best possible educational and other outcomes".

5.4.2 Under Article 7 of the Council's Constitution, the terms of reference of the Health and Wellbeing Board includes the following responsibilities

- To jointly assess the health and social care needs of the population with NHS commissioners, and apply the findings of a Barnet joint strategic needs assessment (JSNA) to all relevant strategies and policies.
- To promote partnership and, as appropriate, integration, across all necessary areas, including the use of joined-up commissioning plans across the NHS, social care and public health. To explore partnership work across North Central London where appropriate
- 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 wellbeing.
- Specific responsibilities for overseeing public health and developing further health and social care integration

5.5 Risk Management

5.5.1 Specific risk management is being carried out for Children and Young People's Plan. Any Family Services risks are recorded on the Family Services Risk Register and monitored each quarter by the Senior Leadership Team with escalations to CMY if necessary.

5.6 Equalities and Diversity

5.6.1 The 2010 Equality Act outlines the provisions of the Public Sector Equalities Duty which requires Public Bodies **to have due regard** to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people from different groups
- foster good relations between people from different groups

5.6.2 The broad purpose of this duty is to integrate considerations of equality into day business and keep them under review in decision making, the design of policies and the delivery of services

5.6.3 In addition all templates should advise the inclusion of:

- Up to date information about the Equalities impact of the proposal and details of how this has been assessed
- Sources of data
- Assessment of equalities risks and what has been done to mitigate them

Advice on completing Equality Impact Assessments (EIAs) can be found here.

5.7 Corporate Parenting

5.7.1 In July 2016, the Government published their Care Leavers' strategy Keep on

Caring which outlined that the ‘‘… [the government] will introduce a set of corporate parenting principles that will require all departments within a local authority to recognise their role as corporate parents, encouraging them to look at the services and support that they provide through the lens of what a reasonable parent would do
to support their own children.’

5.7.2 The corporate parenting principles set out seven principles that local authorities must have regard to when exercising their functions in relation to looked after children and young people, as follows:

- to act in the best interests, and promote the physical and mental health and well-being, of those children and young people;
- to encourage those children and young people to express their views, wishes and feelings;
- to take into account the views, wishes and feelings of those children and young people;
- to help those children and young people gain access to, and make the best use of, services provided by the local authority and its relevant partners;
- to promote high aspirations, and seek to secure the best outcomes, for those children and young people;
- for those children and young people to be safe, and for stability in their home lives, relationships and education or work; and;
- to prepare those children and young people for adulthood and independent living.

5.8 Consultation and Engagement

Not applicable

5.9 Insight

5.9.1 Insight data will continue to be regularly collected and used in monitoring the progress and impact of the Children and Young People’s Plan and to shape ongoing improvement activity.

6 Environmental impact

6.1 There are no direct environmental implications from noting the recommendations.

7 BACKGROUND PAPERS

7.1 None

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raising standards
improving lives

2 August 2021

Mr Chris Munday
Executive Director, Children's and Family Services
London Borough of Barnet
2 Bristol Avenue, Colindale
NW9 4EW

Dear Chris

Focused visit to the London Borough of Barnet local authority children's services

Her Majesty's Chief Inspector of Education, Children's Services and Skills is leading Ofsted's work into how England's social care system has delivered child-centred practice and care within the context of the restrictions placed on society during the COVID-19 (coronavirus) pandemic.

This letter summarises the findings of a focused visit to Barnet local authority children's services on 23 and 24 June 2021. Her Majesty's Inspectors for this visit were Tara Geere and Christine Kennet.

Inspectors looked at the local authority's arrangements for children in care.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework. However, the delivery model was adapted to reflect the COVID-19 context. The lead inspector and the director of children's services agreed arrangements to deliver this visit effectively while working within national and local guidelines for responding to COVID-19. This visit was carried out fully by remote means. Inspectors used telephone and video calls for discussions with local authority staff, managers, leaders and partner agencies, including the Children and Family Court Advisory and Support Service (Cafcass) and the judiciary.

Headline findings

Despite the significant challenges presented by the COVID-19 pandemic, the committed and stable senior leadership team has continued to improve services to children in care in Barnet. Leaders have an accurate understanding of the strengths and weaknesses of their services. They have identified areas for improvement and have appropriate plans in place to address these issues. Leaders recognise that some changes in response to the key areas highlighted at the last inspection in 2019 still require further strengthening. The vast majority of children in care benefit from living in placements that meet their individual needs and impact positively on their experiences and progress.

What needs to improve in this area of social work practice

- Case recording, including the recording of supervision, visits and direct work with children, and the rationale for decision-making on placements.
- The completion and quality of 'All about me' plans.

Main findings

Senior leaders and partner agencies in Barnet have worked together to deliver a well-coordinated and effective response to the COVID-19 pandemic. This has included surge testing and support to asylum-seekers placed without notice by the Home Office in dispersal centres within the borough. Despite the ongoing pressures, leaders have continued to prioritise children's services, underpinned by strong corporate and political support. At the beginning of the pandemic, all children's cases were risk assessed to establish visiting schedules to children in accordance with their vulnerability. Social workers have continued to keep these arrangements under regular review.

When children cannot live safely with their families, decisive action is taken so that children come into care in a timely manner to protect and safeguard their welfare. Practice leaders have built strong relationships with Cafcass and the Family Court.

The vast majority of children in care benefit from living in placement arrangements which meet their individual needs. Children told inspectors that they valued their carers and felt well supported. The rationale for placement matching and for decisions to move older children into unregulated provision is understood by staff. However, managers' decisions are not consistently recorded on case files.

A small number of children have had to move home too many times. As a result, placement stability is being closely monitored by senior leaders. Any concerns identified are responded to with a range of additional support, including increased frequency of visits by workers, strengthened management oversight and placement stability meetings, so that children remain in their homes if appropriate.

The director of children's services is leading the Barnet placement transformation programme to develop more local placements for children and young people. He is also leading pan-London work on placement sufficiency. Throughout the pandemic, managers have continued to recruit new foster carers and hosts for supported living arrangements.

Leaders have strengthened the systems and processes to monitor placements and to track arrangements to secure permanence for children and young people. An increasing number of children are benefiting from being placed in matched long-term arrangements, although these are not consistently celebrated formally. Life-story work is not routinely evidenced on files for children in long-term foster care,

although consultation on how to undertake this specialist work is available from the special guardianship team.

Out-of-borough placements are not routinely informed by consultations with host authorities. This means that children may not receive services promptly to meet their needs, such as education. Notification letters do not provide sufficient information about how the proposed arrangements are expected to meet the child's needs.

Disabled children in care benefit from the work of the staff in the 0-25 team. Workers know their children and families well and demonstrate a strong awareness of their complex needs and increased risks due to additional vulnerabilities.

Barnet has seen a significant rise in the number of unaccompanied asylum-seeking children within the borough. These children benefit from effective, timely work to ensure that their needs are assessed and responded to. Their educational, emotional and physical health needs are well considered, and translators are used to support children's engagement if necessary.

Since the last inspection, senior leaders have focused on improvements to planning for children in care. However, completion of the 'All about me' plan is not consistent, especially when children's cases are in the court arena. Stronger examples of these plans demonstrate clear co-production with children, although the language used in plans is not always child friendly.

Case recording does not always do justice to the child-centred and creative work that is being undertaken by social workers, particularly in relation to the recording of visits and the direct work undertaken with children.

Senior leaders, managers and social workers demonstrate a clear focus on hearing the voices of children and young people to develop and further improve services. The Barnet children in care council, 'Barnet on Point' (BOP), has continued to support children and young people in having their views heard throughout the pandemic. Children have been engaged through a range of activities, including virtual cook-alongs, consultations, celebration events and the recently commissioned Bright Spots survey.

The corporate parenting panel has continued to provide scrutiny to the service throughout the pandemic, obtaining children's feedback to focus improvements for children and young people in Barnet.

When children in care go missing, they receive a timely offer of a return home interview, although not all children take up the offer. This limits the understanding of the push and pull factors for children. To mitigate this, social workers undertake a robust analysis of risk using a child exploitation and missing (CEAM) tool. This is assisting in ensuring that missing children are routinely discussed at CEAM strategy meetings, to inform analysis and to develop plans to reduce risks.

Throughout the pandemic, there has been close collaboration with the looked after children's health service to help to improve the health outcomes of children in care. Despite the challenges that the pandemic has caused for health services, health assessments of children in care have continued to be prioritised and, before dental surgeries reopened, emergency dental treatment was available if required. Children benefit from the integrated clinical service that is fully embedded into family services.

The virtual school acted swiftly at the start of the first national lockdown to work with school leaders to identify and support vulnerable pupils. School attendance for children in care has been closely monitored and has significantly improved over the lockdown periods. Social workers have maintained close liaison with carers and the virtual school to ensure planned returns to school for pupils following lockdowns. Children's educational experiences have been further supported through the use of additional tuition, distribution of laptops and development of online learning resources to support foster carers. COVID-19-specific personal education plans (PEPs) have been developed to focus on supporting children during this period.

Since the last inspection, leaders have strengthened the offer of independent visitors and of advocacy. Advocacy is offered as routine. Children benefit from this support to help them to share their views and opinions in a range of meetings.

Independent reviewing officers (IROs) provide effective oversight of children's planning at timely reviews. Minutes from reviews have been significantly improved by writing them to the children. However, leaders are aware that these could be further strengthened by ensuring that actions are focused on children's lived experiences.

Social workers are supported by a well-established learning and development programme that has continued with online training. The proportion of permanent social workers has increased in the last year. Staff talk positively about their manageable caseloads. They report feeling supported by visible and approachable managers and senior leaders through the challenges of the pandemic and the home-working arrangements. Staff have had regular team meetings and good access to IT equipment, while also having access to office bases if necessary. Staff value regular supervision, however, recording does not always do justice to the quality of the reflection reported by social workers.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

Yours sincerely

Tara Geere
Her Majesty's Inspector

AGENDA ITEM 13

	Health and Wellbeing Board **9th December 2021**
Title	**North Central London Children and Young People's Mental Health Transformation Plan**
Report of	Dan Morgan, Interim Director Aligned Commissioning NCL CCG
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix 1 - Powerpoint pack 'North Central London Children and Young People's Mental Health Transformation Plan'
Officer Contact Details	Julia Mills (please add title) - Julia.mills3@nhs.net/ D. Usherwood (please add title) - d.usherwood@nhs.net

Summary

Since 2015, NHS England has required Clinical Commissioning Groups (CCGs) to work with commissioners and providers across health, social care, education and youth justice and the voluntary sectors, to develop local transformation plans for Children and Young People's Mental Health (CYP MH), published so that residents can access them. The plans set out how local services will invest resources to improve children and young people's mental health across the "whole system".

Due to the pandemic the last refreshed plans were published in 2019/20. At that time, each borough published its own local plan. From this year, with the move towards becoming an Integrated Care System (ICS), the Transformation Plan has been developed at ICS level but seeks to maintain a balance between delivering a plan across the ICS footprint and highlighting each borough's progress and plans.

The plan is structured around the 'Thrive Framework for System Change'. This has five domains ranging across a spectrum of need. Against each 'Thrive framework' domain, we have highlighted key examples of progress in Barnet (and the other four North Central London (NCL) boroughs) and priorities going forwards, alongside a summary of progress on NCL-wide initiatives and future priorities.

Some highlights included in the plan of achievements and plans for Barnet include:

1. *Thriving (health promotion and prevention work)*:

- **Achievements**: Barnet teams developed a wide range of additional resources, programmes and support for staff to help promote whole school working around children's emotional and mental health and wellbeing; created more information for CYP and families to access online via the Local Offer and other sites; and strengthened early help and Voluntary and Community Sector (VCS) support (*see slide 26 for full details*).
- **Plans**: Further training and support for schools including around suicide prevention and around supporting autistic CYP; further developing peer champion and peer support programmes in schools and for autistic CYP and their families; further co-production work planned with CYP and with parent/carer forums (*see slide 28 for full details*).

2. *Getting advice (supporting those who need advice and signposting*):

- **Achievements**: Restructured CAMHS pathways together with CYP to improve access, including self-referral; over 70 schools now participating in the Resilient Schools programme; Mental Health in Schools Teams are in place in all mainstream schools; a BICS phone support line established for families and professionals; and strengthened the early intervention offer for children with autism and their families (*see slide 32 for full details)*.
- **Plans**: Continue the ongoing roll out and delivery of schools and community based programmes of support; undertake more co-production with families to strengthen services further; deliver a range of actions to support CYP with autism including opening a new Autism Support Hub in 2022 with respite provision, and developing an 'autism' social care team *(see slide 34 for full details*).

3. *Getting help (those who need focussed goals based input)*:

- **Achievements**: Barnet have exceeded NHS England's access targets; implemented an all age model for Special Educational Needs and Disability (SEND) support; enhanced support for families including those on the edge of care and for families with CYP with autism/learning disabilities/ADHD; improved support for Unaccompanied Asylum Seeking CYP (UASC) and children in care; and rolled out an online counselling offer (*see slide 39 for full details*).
- **Plans**: Develop the online offer further; develop further targeted work with care leavers; strengthen training and development for the workforce around trauma, eating issues and neurodevelopment/learning disabilities; further strengthen autism pathways (*see slide 41*).

4. *Getting more help and risk support (those who need more extensive and specialist support*):

- **Achievements**: developed an improved access and triage model to standardise and streamline care across the borough; enhanced input into acute hospitals; inpatient protocol agreed across LA and NHS CAMHS; new therapeutic children's home opened; multi-agency work between schools, police and Autism Advisory Team to develop and understand good practice engaging with autistic/neurodiverse CYP (*see slide 53*).
- **Plans**: Continue developing transition services between CYP and adult mental healthcare and continuing care/continuing healthcare; reviewing thresholds across the system to ensure children access the right support as quickly as possible; implement a multi-agency hospital discharge protocol; and implement keyworker support for CYP with learning difficulties and/or autism at risk of hospital admission (*see slide 55*)

Some highlights of achievements and plans across NCL, across all domains, include:

- **Achievements**: NCL continues to be above NHSE's performance targets for the % of CYP accessing MH services; online counselling has been rolled out in all boroughs; we have established a 24/7 crisis phone line and improved 111 provision; crisis hubs and an Out of Hours service were set up; and hospital admissions have reduced by 34%.
- **Plans**: Improve the digital/online offer available to all CYP across NCL; roll out Mental Health in Schools Teams across all boroughs; continue investing in interventions to reduce waiting times, such as single front door triage across pathways and/or agencies, growth in overall staffing and use of online counselling where appropriate; improve support for and achieve greater consistency across all boroughs for targeted groups of CYP where MH risks are higher such as children in care, LGBTQ+ CYP, young black men/boys and UASC; reduce waiting times for autism diagnostics and increase support for children with LD and/or autism; roll out a new Community Eating Disorders service, a Home Treatment offer and dialectical behaviour therapy (DBT) pathway across NCL; all boroughs to review/implement suicide prevention recommendations; enhance support for CYP with MH presentations on general hospital wards; and continue reducing inpatient admissions.

The plan is a 'living document' and ICS areas are asked to refresh, and CCGs to republish them, on CCG websites every year. We also ask each Local Authority to publish the plan.

Recommendations

1. **That the Board approve Barnet's priorities for inclusion in this plan and approve publication of the Transformation Plan on Barnet's website alongside NCL CCG's.**

1. WHY THIS REPORT IS NEEDED

1.1 Since 2015, NHS England has required Clinical Commissioning Groups (CCGs) to work with commissioners and providers across health, social care, education and youth justice and the voluntary sectors, to develop local 'Transformation Plans' for Children and Young People's Mental Health (CYPMH). From this year, with the move towards becoming an Integrated Care System (ICS), NHSE has recommended that Transformation Plans should be developed and assured at ICS level. This plan sets out NCL and borough progress and plans around children and young people's emotional and mental health and wellbeing.

1.2 The plan sets out our ambitions to:

- Offer all children and young people growing up in NCL high quality information, advice and guidance to support their emotional and mental health and wellbeing – and to better understand and target and tailor support to groups of children and young people where evidence tells us the risk of emerging mental health needs is higher
- Ensure CYP with emerging or lower level mental health and wellbeing needs can access advice and support in a range of ways including online and

through their schools and wider communities and that there is greater equity across NCL in the support available

- Ensure CYP get access to the right mental healthcare support more quickly and there is less variation in waiting times across NCL.
- Make sure that CYP experiencing serious mental illness are supported quickly, at home and/or out of hospital wherever possible. We want to see further reductions to the number of inpatient mental health admissions.
- Offer CYP with disordered eating concerns access to a wider range of specialist support in the community.
- Ensure CYP with suspected autism access and complete diagnostic assessments more quickly.
- Deliver a sustained and more equitable offer across NCL of pre and post diagnostic support for children and young people with learning disabilities and/or autism including those with behaviour that challenges. Continue to support more young people with the most complex needs closer to home and outside of inpatient settings.
- Achieve more consistency across NCL in the emotional health and wellbeing support offered to families of children under five
- Introduce more support for young adults moving between CAMHS and adult mental health services

2. REASONS FOR RECOMMENDATIONS

2.1 NHS England require all areas to publish CYP Mental Health plans. They provide a means to communicate achievements and plans around children and young people's emotional and mental health and wellbeing to interested families and professionals across different sectors.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 N/a

4. POST DECISION IMPLEMENTATION

4.1 The plan will be published on LA and CCG websites and refreshed annually. As a 'live' document, it can also be updated at any point throughout the year, if necessary. Monitoring and oversight of the plan takes place through NCL CYP MH Programme Delivery Board and at borough level through Barnet's Children and Families' Services Mental Health and Wellbeing Board.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The plan contributes to delivering against Barnet's 'Family Friendly' priority by supporting emotional and mental health and wellbeing – key to enabling all five of the 'Family Friendly' priorities set out in the Corporate Plan

5.1.2 The plan also supports the 'starting, living and ageing well' priority in the Health and Wellbeing Strategy.

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

5.2.1 The priorities within the plan are based on existing NHS and LA budgets and focus on ensuring existing resources are delivering best value for money.

5.3 **Social Value**

5.3.1 In any procurement associated with these plans we will ensure Social Value considerations are taken into account.

5.3.2 The plans set out a range of commitments to improving care for local people. Wherever possible, where these plans involve growth of workforce, we will endeavour to promote opportunities through local networks to maximise opportunities for local, suitably skilled professionals to help us deliver these plans.

5.3.3 Co-production and peer support/engagement are priorities both in Barnet and across NCL. These schemes provide young people with the opportunity to develop useful skills for their personal and career development.

5.4 **Legal and Constitutional References**

5.4.1 Terms of Reference for the Health and Wellbeing Board include:
To work together to ensure the best fit between available resources to meet the health and social care needs of the whole population of Barnet, by both improving services for health and social care and helping people move as close as possible to a state of complete physical, mental and social wellbeing. 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.

5.5 **Risk Management**

5.5.1 Partnership: The ICS governance is not fully mature and many plans set out within this overarching document are delivered at 'Place' level. The plan sets out borough partnership arrangements for CYP Mental Health and notes a commitment to reviewing current governance structures across NCL as the ICS arrangements develop.

5.5.2 Finance: At the time of writing, future years' funding allocations for the CYP MH system are not available. However, the NHS nationally and locally has a strong commitment to prioritising CYP MH. Plans are based on the existing financial envelope; should there be any future growth, decisions on allocations will be made in consultation with local authorities and NHS teams.

5.6 **Equalities and Diversity**

5.6.1 No disadvantages to any protected characteristics and an active commitment to ensuring equality and inclusion in our services

5.7 **Corporate Parenting**

10.7.1 The plan sets out a range of actions to improve emotional and mental health and wellbeing support for Looked After Children growing up in Barnet and

other NCL boroughs.

5.8 **Consultation and Engagement**

5.8.1 A wide range of stakeholders NHS, VCS, LA and CCG have contributed to this plan.

5.8.2 The plan reflects feedback from consultation and engagement exercises undertaken in each borough related to CYP MH.

5.8.3 We will continue to work closely with CYP and their families both in Barnet and across NCL to implement our priorities and develop services further.

6. I**nsight**

N/a

7. Environmental impact

7.1 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*. (officers may revise this statement if they are aware of any environmental implications as a result of their recommendations).*

8. BACKGROUND PAPERS

8.1 None

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NHS

North Central London Children and Young People's Mental Health and Wellbeing Transformation Plan

November 2021

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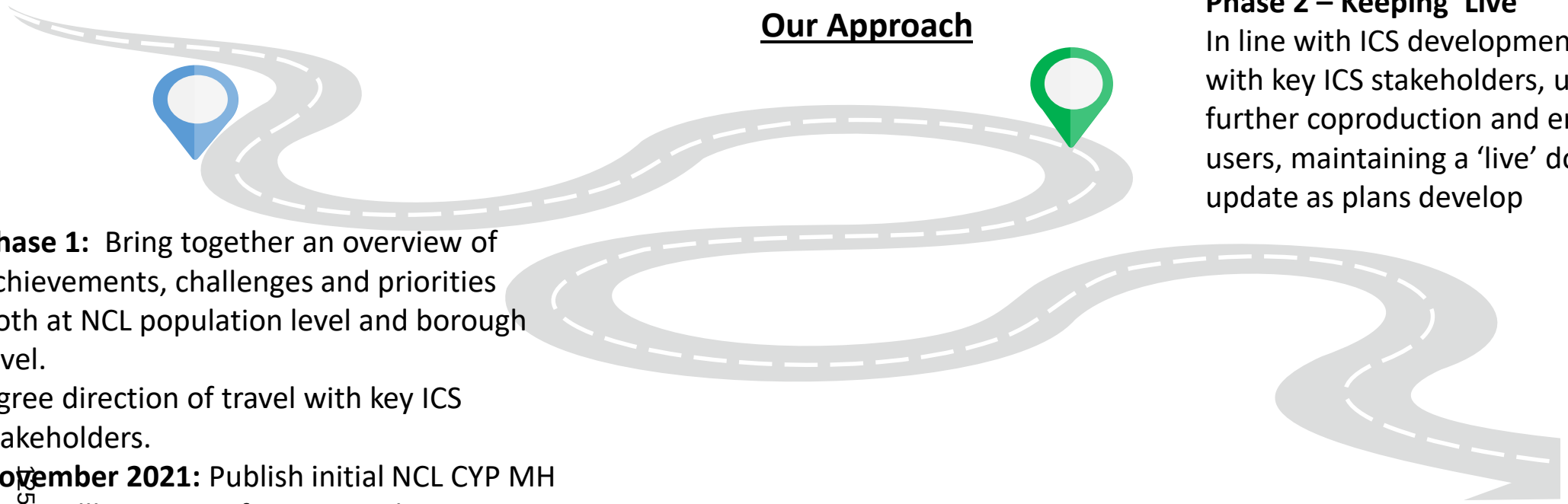
Contents

Developing our North Central London Plan

- Improving support for children and young people with emotional wellbeing and/or mental health concerns is a key priority for North Central London's NHS and Local Authorities. This document sets out what we've done so far and our plans to improve care and support further.
- Across the NHS, every Integrated Care System publishes an annual CYP MH Transformation plan. In the past, we published a plan for each borough, and in our last plans each borough included a NCL section setting out shared priorities.
- This year, we take another step towards operating as an Integrated Care System with a single plan setting out collaborative priorities across boroughs, alongside priorities in each borough, as we increasingly work together to meet our population's needs.

Our Approach



Phase 1: Bring together an overview of achievements, challenges and priorities both at NCL population level and borough level.
Agree direction of travel with key ICS stakeholders.
November 2021: Publish initial NCL CYP MH and Wellbeing transformation plan

Phase 2 – Keeping 'Live'
In line with ICS development, work on joint plans with key ICS stakeholders, undertake prioritisation, further coproduction and engagement with service users, maintaining a 'live' document which we will update as plans develop

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Developing our ICS – Key Partner Quotes

Our Children and Young People's mental health and wellbeing partners have a good foundation of working in partnership to meet the needs of CYP and families in the borough. Below are some thoughts from Key Partners across our developing ICS.

"Children's mental health and emotional wellbeing services are experiencing considerable pressure and this is likely to continue. However, over the last few years NCL providers and commissioners been working in close collaboration and have developed a strong system partnership – and we'll build on this to continue improving outcomes for CYP through this plan ."

Sally Hodges, Tavistock and Portman Clinical Chief Operating Officer and Tina Read, BEH Trust Wide Service Lead, Joint Chairs of NCL CAMHS Board

"Children and young people need to be able to access mental health provision in the spaces they occupy. Services need to be dynamic and flexible and informed by the changing demographics and needs of our child population. We have a good foundation from which to step forward for change"

NCL Directors of Children's Services

"Improving mental health outcomes for children and young people and addressing inequalities in access to care are key priorities for NCL's emerging Integrated Care System. We've made good progress but know there is more to do. We look forward to delivering on the ambitions set out within this plan"

Jinjer Kandola & Sarah Mansuralli MH SROs and CCG representatives on behalf of ICS

"Providers and professionals across North [Central] London worked together well to try and meet the needs of children and young people with mental health needs. Necessary changes were made quickly. Professionals from across the system shared examples of good joint working."

Draft Provider Collaboration Review findings CQC 2021

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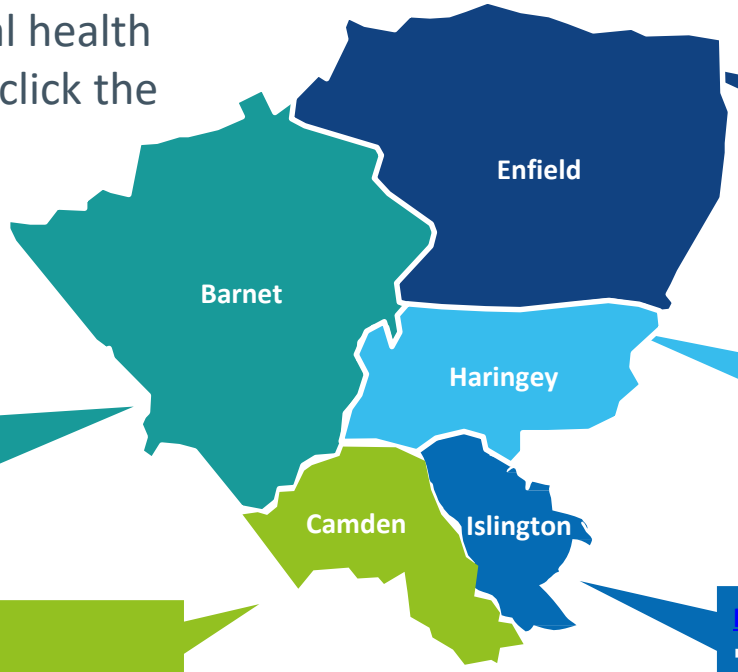
North Central London – Our Area

North Central London has a population of approximately 1.7 million residents, of which 323,000 are under 18. If you are a resident and want more info on how to access mental health and wellbeing services in your borough click the relevant borough name below.



Enfield
- 354,822 total registered population
- 83,683 under 18s

Barnet
- 437,371 total registered population
- 94,898 under 18s

Haringey
- 331,754 total registered population
- 62,540 under 18s

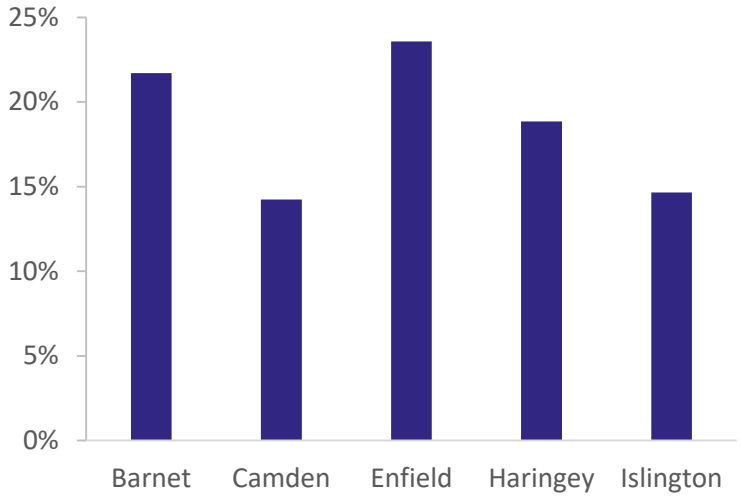
Camden
- 284,807 total registered population
- 40,549 under 18s

Islington
- 280,828 total registered population
- 41,126 under 18s

Across our area we have one NHS Clinical Commissioning Group (CCG) and five Local Authorities, who work with NHS Trusts, LA staff, the voluntary and community sector (VCS) and residents to plan and fund services. We work together through an Integrated Care System (ICS) – with a Children's Mental Health Board overseeing CAMHS and are developing pathways from our borough based boards.

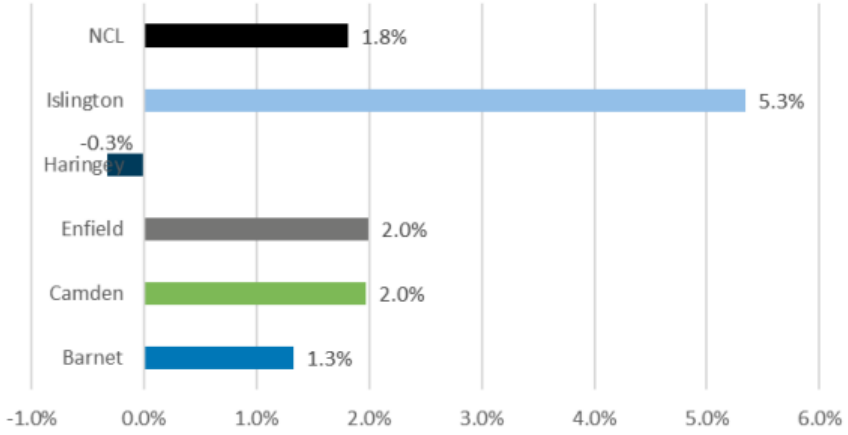
Child Population and Growth

North Central London Boroughs | 2021
Proportion of Population Under 18



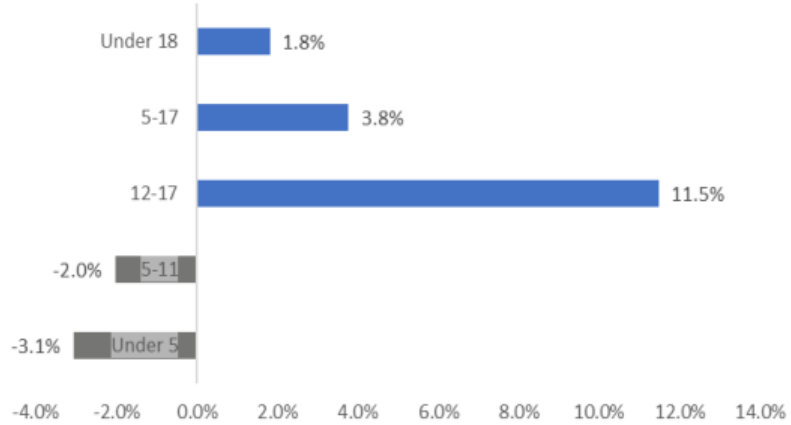
Source: NHS Digital

Population % change by Borough



Source: ONS Population Data; analysis by Attain

NCL Population % change (>2020) by Age group



Source: ONS Population Data; analysis by Attain

- As of September 2021, there were **322,796** children registered in North Central London, 19.1% of the total population.
- Barnet and Enfield have both the highest numbers of children and the highest proportions of their population who are under 18.
- The population of under 18s across NCL is expected to **increase by 1.8% (over 6000 CYP)** between 2020 and 2030, with the largest increase expected in Islington.
- The largest increase by age group is expected among the **12-17 age group** (+11.5%).

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NCL Demographics and Characteristics

Ethnicity

- 69% of children in North Central London have an ethnicity other than White British
- The largest ethnic groups across NCL are White British (31%), Other White Groups (18%) and Black African Groups (10%)
- There are differences in the ethnic composition of each borough as the graphic to the right shows
- Children in NCL speak a wide range of languages, with approximately 130 languages spoken by Haringey school children alone
- 46% of NCL school children do not speak English as a first language
- An increasing number of unaccompanied children come to live in NCL each year. A number of children from Afghanistan have also recently arrived in NCL and are being supported by system partners.

10% of children in Camden are Bangladeshi

Barnet has the largest number of Indian children in NCL

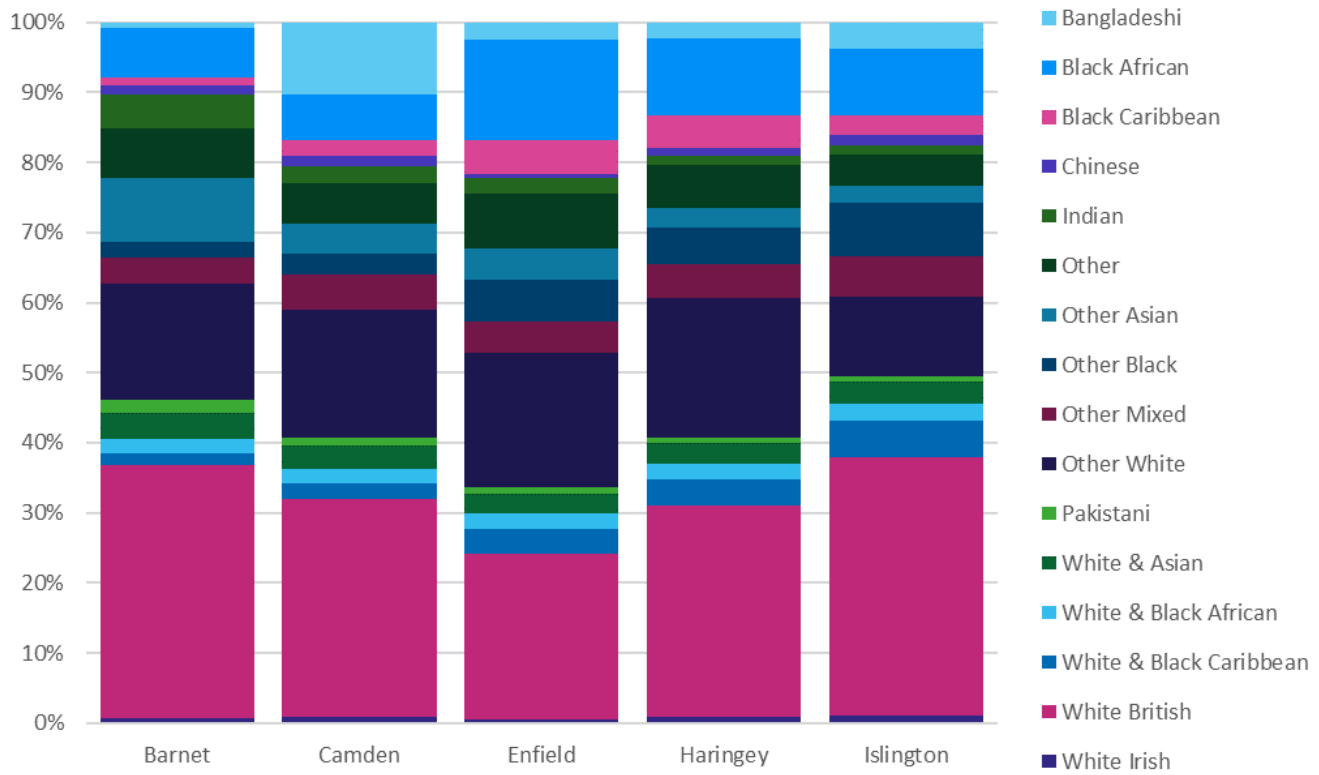
Around 20% of children in Enfield and Haringey are from Other White backgrounds, with significant numbers of Turkish, Greek and East European residents

14% of children in Enfield are from Black African backgrounds

Islington has the highest proportion of White British children and also has the highest proportion of children from mixed backgrounds

16% of Barnet's population is Jewish

Proportion of children in each borough by ethnic background



Sources:
GLA (2017): Local authority population projections – trend-based ethnic group projections, central migration scenario
Haringey Council: Our Changing Borough
Dfe (2021): Schools, pupils and their characteristics

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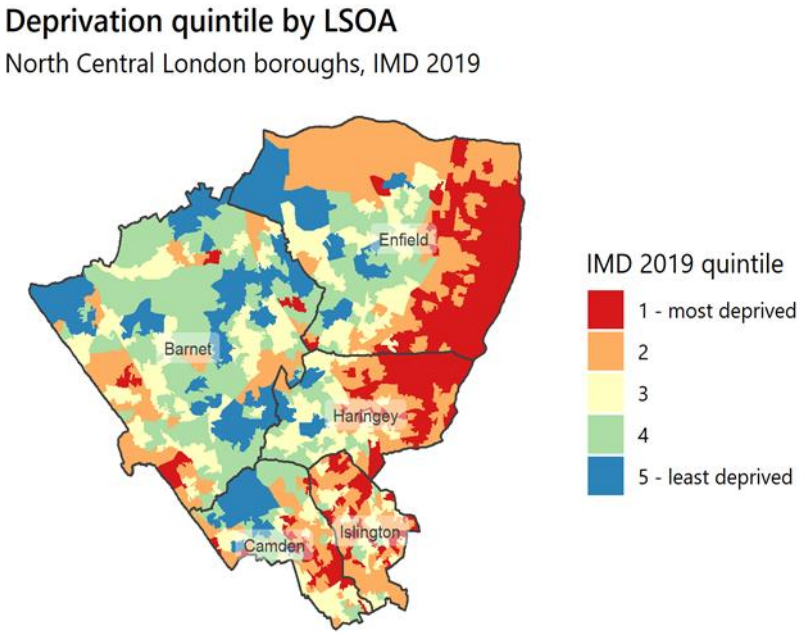
NCL Demographics and Characteristics

Deprivation



[1] Index of Multiple Deprivation, 2019

- NCL is characterised by wide differences in deprivation between areas. The areas of highest deprivation are along the eastern corridor of Enfield and Haringey, but there are also pockets of deprivation in Camden, Islington and, to a lesser extent, in Barnet.
- 29% of small neighbourhood areas in Islington are within the 10% most deprived areas nationally, based on IDACI 2019. 26% of Haringey children live in poverty with 36% living in social housing.
- Approximately 50,000 children in NCL live in relative low income families. We know that living in poverty increases the likelihood of poor mental health.
- While not explaining all differences, the intersectionality between ethnicity and deprivation is very important. Black, Asian and minority ethnic communities that are living in the most deprived areas include Black, White Irish, Turkish, and Eastern European communities in Enfield, Haringey and Islington, the Bangladeshi community in Camden, and Gypsy, Roma and Irish Traveller communities in Barnet, Enfield and Haringey.
- Further information about each borough's children can be found within their JSNA profiles which are available via the links below:

  Barnet
  Camden
  Enfield
  Haringey
  Islington

Children's deprivation indicators

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Better than London
Similar to London
Worse than London

Indicator	Period	England	London	NCL	Barnet	Camden	Enfield	Haringey	Islington
Percentage of children in relative low income families (under 16s)	2019/20	19.1%	18.3%	18.7%	13.9%	14.7%	18.1%	19.1%	18.3%
Free school meal: % uptake among all pupils	2018	13.5%	15.6%	17.1%	11.3%	25.0%	15.2%	17.1%	27.9%
School readiness: % of children achieving a good level of development at the end of reception	2018/19	71.8%	74.1%	72.5%	74.3%	72.8%	69.7%	74.6%	71.0%
Percentage of 16-17 year olds not in education, employment or training (NEET)	2019	5.5%	4.2%	4.7%	1.5%	4.2%	4.1%	10.9%	4.1%
First time entrants to the youth justice system, per 100,000	2019	208	260.2	263.2	161.7	266.6	275.3	330.3	367.1
Children in Care, per 10,000	2020	67	49	50	35	36	44	67	86

Source: PHE Fingertips

- Within NCL, there is significant variation between and within boroughs relating to some of the key children's indicators, some of these, mainly linked to deprivation are shown at borough level in the table above. It's important to note that these indicators only tell part of the story and each borough, regardless of the indicators has its own challenges.
- 18.7% (50,000) of under 16s in NCL live in relative low income families, which is above the London average and this figure is highest in Haringey, Islington and Enfield. More than 25% of pupils in Camden and Islington have free school meals.
- Young children in NCL are less likely to reach a good level of development by the end of reception compared to the rest of London, with particularly low rates in Enfield and Islington.
- Haringey has a significant proportion of 16-17 year olds not in education, employment or training, while both Haringey and Islington have some of the highest rates in the country of first time entrants to the youth justice system. There are also higher rates of children in care in these boroughs. Rates of looked after children (LAC) also vary significantly by ethnicity, with higher rates seen among black and mixed children.

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Emotional and Mental Health Needs in NCL

Prevalence of mental health, behavioural, and emotional disorders in NCL is **higher** than the national average for most conditions.
The table below shows the estimated prevalence of mental health conditions across NCL, together with additional relevant indicators relating to school children, children in care and hospital admissions for self-harm.
Our approach to meeting these needs is varied and must be undertaken in close partnership with the wide range of partners across the system, such as our work in schools to address social emotional and mental health needs amongst our school age population or developing capacity in community services to support CYP with disordered eating.

Indicator	Time Period	England	London	NCL	Barnet	Camden	Enfield	Haringey	Islington
Estimated number of children and young people with mental disorders – aged 5 to 17	2017/18	-	-	**27,725**	7,827	4,234	7,206	5,072	3,385
Estimated prevalence of conduct disorders: % population aged 5-16	2015	**5.6%**	**5.7%**	**5.7%**	5.0%	5.5%	6.1%	6.1%	6.2%
Estimated prevalence of emotional disorders: % population aged 5-16	2015	**3.6%**	**3.6%**	**3.7%**	3.2%	3.6%	3.8%	3.9%	4.0%
Estimated prevalence of hyperkinetic disorders: % population aged 5-16	2015	**1.5%**	**1.5%**	**1.5%**	1.4%	1.5%	1.7%	1.6%	1.7%
Estimated prevalence of potential eating disorders, aged 16-24	2013	-	-	**22,069**	5,146	4,327	4,850	3,819	3,927
% of school pupils with social, emotional and mental health needs	2020	**2.7%**	**2.5%**	**2.9%**	2.6%	3.4%	2.7%	2.8%	3.4%
Percentage of looked after children whose emotional wellbeing is a cause for concern	2019/20	**37.4%**	**32.1%**	**35.1%**	33.3%	40.7%	28.1%	40.0%	34.4%
Hospital admissions as a result of self-harm (10-24 years) – Per 100,000	2019/20	**439**	**192**	**202**	253	201	176	205	223

Source: PHE Fingertips

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COVID-19 and Our Response

- NHS, LA and VCS services remained open, delivering through a mix of face to face, virtual and telephone appointments
- Schools, LAs and some Trusts offered laptops and/or confidential spaces for counselling sessions
- The Out of Hours Service was quickly expanded and a 24/7 Crisis Line fast tracked.
- Trusts worked together and flexed the workforce to where most needed
- Crisis Hubs were established to divert children from acute hospitals
- Enhanced our Eating Disorders capacity
- Consolidated MH Liaison support into acutes to support A&E diversions

Barnet

- Partnerships delivered new programmes and models to support CYP with MH and SEND needs returning to schools
- BICS and other teams introduced support hotlines for young people, parents and professionals plus extra MH support and toolkits from LBB teams, Terapia, Resources for Autism and other partners.
- Open spaces project created safe enclosed play spaces & swimming fo CYP & families experiencing autism or challenging behaviours and 'Gardens for All' scheme supporting emotional wellbeing with access to safe outdoor spaces
- LA led information campaign including a poster campaign with Kooth and a wellbeing brochure delivered to every household

Enfield

- Virtual panel events held with Healthwatch and Our Voice to provide CYPMH advice to public during lockdown.
- Early Years Speech and Language Therapy and CAMHS Clinical Psychology conducted a successful pilot on autism assessments via video call, for children under 6

Haringey

- Consultations led by CAMHS/MHSTs and Educational Psychology with parents/carers on how to manage the return to school
- 80 schools survey on what support was needed
- As a result ran webinars on sleep, bereavement and behaviour and ran additional training in Mental Health First Aid and bereavement and Educational Psychology services. Open Door provided support to young people and their families while on the waiting list.

Camden

- Multi channel approach to share information for CYP and parents on MH services & support via routes such as Camden Rise Website, Camden New Journal newspaper, Faith Leaders forums & Peer Education
- Extended our equine therapy offer & expanded content of sessions to focus on reducing anxiety, resilience to transition and behaviour management
- Introduced 'Level Up': A psychological transition support for 6 primary schools linking to the secondary school accordingly and the wider VCS offer to support those who were transitioning after lockdown.

Islington

- A&E diversion hubs for the South of NCL.A
- Therapeutic support, where risk assessed, delivered digitally le to maintain services Increased communications re central point of access and ability for parents and young people to self-refer to make as accessible as possible
- Virtual parenting sessions held across a number of priority delivery programmes

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Impact of the Pandemic

The Covid 19 pandemic caused disruption and uncertainty for all. Children and young people were particularly affected from the changes to education, socialising and access to services. We know there will be longer term impacts for our children, young people ad families which will require a system wide approach to address:

- **Modelling** predicts increases in new cases **of moderate-severe anxiety depression** in adults with an almost 20% rise in depression in the **under-25s**[4];
- NHSE Benchmarking shows an increase in MH conditions in under 18's increasing from 1 in 9 to 1 in 6 young people over the past year
- **Young people are worried** about their education, finances and future. **Young children were** responding to the **uncertainty** around them and **worry** about their family members. **Parents** were concerned about **children's mental health and wellbeing**[3] and **feel overwhelmed** by financial insecurity, childcare and home schooling**.**
- Mental health had deteriorated somewhat or a lot for **70%** of **LGBT+ residents**[2].
- For **people with learning disabilities**, there was a gap in services around emotional wellbeing, and accessing suitable information around Covid-19 and support has been a particular difficulty[3].
- **Some people have suffered more from Covid-19's effects on mental health and wellbeing**. The wider determinants of health, including but not limited to ethnicity, gender, family and employment status, have an influence. Levels of **depression and anxiety** are **still highest**[1] among, for example: **women**, **young adults**, **people who live alone or with children or in urban areas**, or are from **Black, Asian and Minority Ethnic (BAME) backgrounds**.

1 UCL Covid-19 Social Study Results Release 25. Nov 2020
2 Camden & Islington Stakeholder meetings, Nov-Dec 2020, and stakeholder survey
3 Covid-19 resident engagement. Camden and Islington Public Health team, Oct 2020
4 Centre for Mental Health Forecast Modelling Toolkit, Nov 2020 – full results available on request

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Our Strengths as a System

Our CYP MH and Wellbeing Transformation Plan has been informed by:

- Engagement undertaken with CYP and families across the boroughs
- The NHS Long Term Plan and its commitments to CYP mental health
- Covid recovery planning
- An external audit – ATTAIN NCL System Mapping and Borough Modelling with THRIVE framework for system change (Wolpert et al., 2019) principles based recommendations
- An NCL wide review of Mental Health offers for children and adults
- Local needs analyses undertaken in boroughs
- CQC visit to NCL regarding provider collaboration for CYP MH during the pandemic period.

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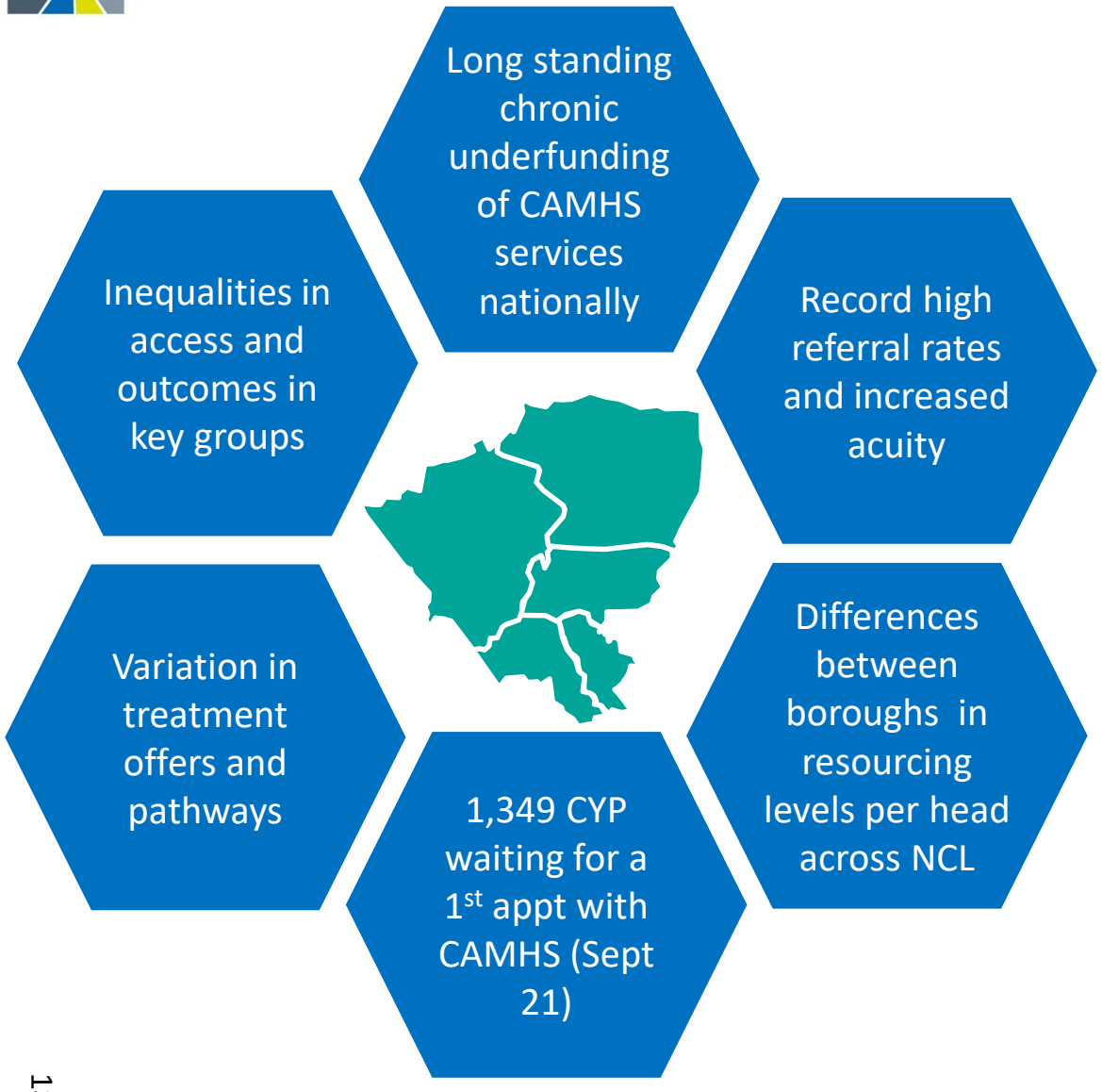
Our System Challenges



Our pressures:

- Rising demand has meant that 670 Children and young people were waiting more than 4 weeks for a first appointment with community CAMHS in August 21
- Particular pressures in Enfield and Haringey
- 155% increase in referrals to our Eating Disorder Intensive Service between 2020/21 and 21/22
- Out of Hours referrals to crisis services grew from 21 in April 2020 to 108 in March 2021
- Too many children waiting longer than 12 weeks for Autism assessment
- Demand for CYP MH services has been forecast to grow by 20-30% following the impact of Covid-19
- Some specialist MH placement providers have had issues with maintaining a highly skilled, trained workforce during the pandemic, resulting in significant quality concerns raised about several care providers. A new Quality Assurance Framework for children and adults developed together with ICS partners will work to address this

What we want to achieve through this plan

Our vision:

"Children and young people living in North Central London grow up knowing how to protect and develop their emotional and mental health and wellbeing and they and their families get the right help from the right place quickly to support their mental health if they need it"

We want CYP in NCL to be able to:

- Have access to high quality information, advice and guidance to support and protect their physical, emotional and mental health and wellbeing – ensuring we better understand and target and tailor support to groups of children and young people where evidence tells us the risk of emerging mental health needs is higher
- Access advice and support in a range of ways including online and through their schools and wider communities, when CYP have emerging or lower level mental health and wellbeing needs. Ensuring greater equity across NCL in the support available.
- Get support from professionals who think about both their mental health and physical health needs holistically, thinking about all the factors that impact on a child and young person's wellbeing.
- Access the right mental healthcare support more quickly and experience less variation in waiting times across NCL.

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What we want to achieve through this plan

- Be supported quickly if they experience serious mental illness, at home and/or out of hospital wherever possible. We want to see further reductions to the number of inpatient mental health admissions.
- Be kept safe, by ensuring self harm and suicide risk factors are identified early and managed safely through strong multi-agency networks.
- Be able to access a wider range of specialist support for CYP with disordered eating concerns, in the community wherever possible.
- Access and complete autism diagnostic assessments more quickly, where autism is suspected.
- Experience a sustained and more equitable offer across NCL of pre and post diagnostic support for children and young people with learning disabilities and/or autism including those with behaviour that challenges. We will continue to support more young people with the most complex needs closer to home and outside of inpatient settings.
- See more consistency across NCL in the emotional health and wellbeing support offered to families of children under five
- Have access to greater support for those young adults moving between CAMHS and adult mental health services

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NCL Guiding Principles for CYP MH and Emotional Wellbeing Delivery

✓ **MHIS invested into CYP MH services at a faster rate than adult MH services**

1. Commitment to addressing inequality– ensuring services are accessible and sensitive to the diverse communities that make up NCL, in addition to addressing structural inequalities, so investment goes where it is most needed
2. Service user input from CYP and their families must be central to service transformation
3. Shift prioritisation towards community and school-based settings for earlier intervention, proactive care management and step up/down services
4. Partnerships are key to delivering integrated services (particularly working together across the LA, Education, VCS and mental and physical health)
5. Ensure CYP in NCL experience no wrong door, minimal hand-offs and joined up, consistent care offers wherever they present.
6. Workforce wellbeing and sustainability at the heart of ensuring quality services
7. Continue to grow our analytics capabilities so we can make evidenced based decisions on robust, timely data
8. Shared service standards across NCL CYP MH and wellbeing services or ensure CYP receive timely, quality care and support, regardless of where they present or live.
9. To focus on holistic services which improve outcomes for CYP and their families, implementing THRIVE - the Thrive Framework for System Change (Wolpert et al. 2019)

Coproduction Informing This Plan

Engagement and coproduction are key strategic priorities for our CYP mental health and wellbeing service developments.

- In every borough, local teams have involved children, young people and families in developing services. Our residents have been involved in workshops and working groups, shared their views and experiences through a range of consultation exercises and shaped services by sitting on interview and procurement panels.
- In NCL CCG our Mental Health strategic review was informed by feedback from CYP and parent groups
- Our provider collaborative engaged with parents and service users to develop their strategic health needs analysis
- We have developed a co-production workstream to share good practice and drive improvements.

The next slide highlights just a few examples of co-production and engagement since our last Transformation Plans were published.

Spotlight on NCL co-design project

- A group of parents and young people with lived experience have been supported to undertake projects related to system-wide codesign.
- The group co-designed a NCL Home Treatment Team model, reviewed a Great Ormond Street Hospital research proposal and developed a mental health wish list that has been utilised by numerous A&E depts across London.
- A report outlining the approach, learning, outcomes and learning points has been created and the group continues to meet to take part in service design and review.

Spotlight on borough: Barnet

- A Peer Champions Pilot ran in two secondary schools delivering a Champion Mental Health First Aid course to selected 6th form students. A follow up co-production workshop was held with students to explore how they use the training to fit within their school ethos.

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Borough Examples of Co-production & Engagement

Barnet
The Barnet Integrated Clinical Services (BICS) Youth Engagement officer carried out a post lockdown September 2021 service user engagement survey and forum on what affects their mental health; how they access support; how they would like to contribute to content and delivery; what they would like in return for their participation.

Camden
2020 CAMHS virtual Takeover Challenge week took place in schools on the theme of Lockdown including a challenge related to lockdown and mental health resulting in recommendations to Education, Health Council staff and elected members on their views for future service development

Haringey
Worked with social enterprise 'Ideas Alliance' to reimagine mental health support for CYP in Haringey in preparation for a 100 day kick start challenge. Scoping with local stakeholders showed support for co-creation with CYP/families and a collaborative system accessed through one front door

Enfield
How Are You? – launched in Mental Health Awareness Week 2021. This was developed by the Young Mayor with young people from Kratos and Our Voice (with support from LBE Educational Psychology Service, LBE Strategy Team, LBE Libraries and LBE Youth Development Services)

Islington
Participation project led by an organisation called Peer Power, engaged with over 100 young people some of whom on edge of criminal justice pathways or already known to YOS, to understand how they want to access health services.

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Major Achievements Across NCL Since Plans Last Published

Embedding a strong foundation of collaboration and delivering value

- Strong partnership working across boroughs, NCL, VCS, LA's and schools – which helped deliver a robust COVID response
- North Central and East London (NCEL) Provider Collaborative: Devolved referral management and commissioning of inpatient beds to our area from NHS England. Reduced admissions and length of stay, releasing funds for a new Hospital at Home Eating Disorders service from 2022
- ICS wide commitment to alignment with the THRIVE Framework for System Change and principles

Significant Delivery Achievements

- The 12 month CYP rolling access rate indicator continues to be well above the annual target - 39.5% (target 35%).
- NCL wide 24/7 crisis line established
- Crisis hubs and Out of Hours service set up
- Mobilised 11 MHSTs in schools across the 5 boroughs
- NCEL Provider Collaborative have reduced inpatient admissions by 34%, Out of Area placements by 73%, Length of stay by 43% and admissions for CYP with ASC down 50%.

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Spotlights on good practice

Barnet

Improving MH in schools:

- Successful rollout of mild-to-moderate CYP MH service to *all* mainstream schools in the borough,
- 58% Primary Schools, 43% Secondary schools and 62% Special Schools part of the established Resilient Schools Programme
- New self-harm and suicide protocol in Barnet schools safeguarding policy
- Over 115 MH First Aiders in schools

Camden

Camden CAMHS has a specialist service for Looked after children (LAC) and refugee CYP/families. These services are integrated within the Camden local authority to optimise collaborative multiagency working. The team have co-produced videos with both LAC and unaccompanied asylum seeking children (UASC) on what to expect from CAMHS and strategies to support emotional well-being

Islington

Islington work on engaging Young black men

The new Elevate Young Black Men and Mental health initiative is a innovative community based, multifaceted and youth led mental Health wellbeing programme designed to support young black men aged 11-25 through a suite of culturally competent therapeutic and mentoring interventions to support young black men to thrive and access the best life opportunities.

Enfield

Mentalisation Based Therapy Training /Anna Freud Centre Collaboration - Following a tri-borough CAMHS collaboration with the Anna Freud Centre, a number of CAMHS clinicians have been trained in the child protocol for MBT, with supervision groups running from April-October to embed the learning.

Haringey

Expanded trailblazer programme through the NCL Inequalities funding delivering sports and arts with therapeutic support, provided by Open Door.

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Clinical Services Performance Summary

NHS Long Term Plan indicator	RAG	Note
12 month CYP rolling access rate indicator of 35%		Currently at 39.5%
24/7 Single point of access		In place, NHS 111 link under development
Crisis assessment within the emergency department and in community		In place and expansion to OOH support to diversion hubs in 21/22
Intensive Home Treatment service aimed at CYP who might otherwise require inpatient care		Pilot planned for 21/22 and bid to be submitted via accelerator for short term bed base increase
Continue to invest in workforce and training		Investment in 21/22 and plans re workforce development
Advance mental health equalities in children and young people's mental health services		Lived experience group in place. Data recorded but not flowing to MHSDS
Eating disorders: deliver the waiting and access standard. 95% of CYP with a suspected eating disorder should receive (NICE)-concordant treatment within a max. of 4 weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases		Urgent – 91%/ 95% target and routine – 74%/ 95% target
Eating disorders: deliver effective evidence based services, to include support for children and young people presenting with avoidant restrictive food intake disorder		ARFID planned as part of 21/22 investment
Local indicator	**RAG**	**Note**
Ensure CYP waiting times standards are met across NCL		Planned improvement in 21/22 based on trajectories

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Our Progress and Priorities

- **THRIVE framework;** Children and Young People's Mental health and wellbeing services in NCL are working towards being organised and delivered within the THRIVE framework. This consists of support falling into one of 5 domains, recognising CYP and families may move between domains
- **Priorities**; Across the THRIVE domains, this plan sets out our progress since our last Transformation Plans were published and our priorities going forwards. We have priorities reaching across all our boroughs as well as borough specific priorities
- **Meeting needs holistically**; Boroughs have worked to gather and incorporate feedback from their residents and are instrumental in developing a seamless interface with the social care and education offers to holistically meet CYP and their families' needs
- **Mental Health Strategic Review**; In 2021/22 NCL CCG has undertaken an NCL wide strategic review of all our community and mental health services segmented by age group. Through a series of workshops a 'Core Offer' for health services has been developed setting out our aspirations to delivering an equitable and high quality offer across NCL, aligning access criteria, hours of operation, referral pathways etc. As such, this work will inform our workplan and priorities as we move towards becoming an Integrated Care System. The Core Offer and our analysis of work to do to address gaps in achieving this offer has shaped the plans that follow.

The next section of this plan sets out progress towards and future priorities in achieving these ambitions across NCL and in each borough across the THRIVE Framework for System Change.

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THRIVE* Approach

This diagram sets out the THRIVE domains around which this plan is organised *[*THRIVE Framework for system change]*

Universal services focused on early identification and prevention. Available from within schools, GPs health visitors and other universal services

System wide partnership working with shared responsibility and accountability to build capacity to support CYP presenting with a range of complex need and risk. Eg. breakdown of family/ educational placement, engagement with youth justice and frequent MH crises

E.g. - Targeted services/provision: low intensity interventions that can be delivered through universal settings or within VCS services, with provision aimed at identified groups with specific identified needs and/or considered to be vulnerable. Also available online.

E.g. - Specialist community CAMHS provided by various NHS organisations including

- Tavistock & Portman NHS FT
- Whittington NHS FT
- Barnet, Enfield and Haringey FT
- Royal Free NHS FT
- Inpatient CAMHS (facilitated through the NCEL Provider Collaborative)

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THRIVING

In NCL, we support promotion of mental health and wellbeing by:

- Developing and sharing prevention and health promotion information that keeps our children, young people and their families informed about how to maintain mental wellbeing and spot the signs that extra help or support may be needed.
- Working closely with a range of partners who are in contact with CYP and families every day in settings such as school or children's centres as well as through harnessing digital and other means to share the message to all parts of the population.
- Valuing children and their families as key delivery partners - peer education can be a powerful means to share messages about mental health and wellbeing.

Since the last plan, across all our boroughs we've seen:

- Recovery support to schools returning from lockdown, through the Education for Wellbeing project and other local initiatives
- CYP and Parent Participation groups continued through lockdown, often virtually
- Partnerships growing in strength, brought together by the pandemic

Across NCL, our future 'Thriving' priorities are:

Digital innovation	Partnership working	CYP voice
Improve the digital offer and digital innovation in sharing mental health and wellbeing advice	Continue working with key delivery partners such as Public Health teams across NCL to analyse needs, target health promotion campaigns and root our work in an understanding of the wider determinants of health. Including strengthening engagement with groups of CYP where MH needs can be higher, e.g. young black men, LGBTQ+ YP, Looked After Children and care leavers	• Improve our approach to involving YP in key decisions about care, prevention and health promotion • Review peer to peer engagement and education models across NCL, moving to address inequalities where necessary

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Borough progress in the 'Thriving' domain

Haringey

- Increased the capacity of Anchor Project to support all Haringey schools trauma informed-practice. This is a systemic model to improve relationships within schools.
- Increased mental health training across the CYP workforce and Haringey Academy.
- Public Health and CCG implemented Haringey Schools and Colleges in Mind, planned for Senior Leadership within Schools/Colleges

Enfield

- New networks set up – for example: 'Babies in Lockdown', 'Enfield Thrives Together' and ' Mental Health Lead networks'
- 16 Schools were awarded the Sandwell Wellbeing Charter Mark. The *Enfield Thrives Together* Bulletin provided further information to schools on service offers.
- '*How are you*' film produced: https://www.youtube.com/watch?v=C4GSeQvPFww
- Enfield Trauma Informed Practice in schools (E-TIPS) partnership initiative began in July 2020, training 180 professionals.
- Emotional Literacy Support Training underway – 48 ELS Assistants working in schools

Barnet

- Development of whole school training to raise awareness of MH signs and symptoms in 2019/20
- Development of RS website to provide MH and Resilience resources, support and signposting for schools https://wwc.barnet.gov.uk/wwc/working-children-barnet/information-schools/resilient-schools-programme and Resilience in Schools Forum offering training and guidance in whole school resilience
- Updates to Barnet Local Offer and Barnet Integrated Clinical Services websites to keep families informed and provide links to online resources (eg podcasts)
- Early years and Early help groups, workshops interventions in children and community centres.
- Space2Grow – LA funding for 5 VCS project as part of early intervention offer
- Support for pastoral staff through a new forum
- Commissioning of Brook to support RSE in secondary schools and youth sector and building sexual health and emotional resilience, including direct counselling support through the 'my life programme'
- HSL programme supporting whole school approaches to health and wellbeing with some schools focusing on mental and emotional resilience.

Borough progress in the 'Thriving' domain cont'd

Islington

- Developed a framework to support a whole school approach to mental health and resilience in schools: iMHARS (Islington Mental Health and Resilience in Schools www.islingtoncs.org/imhars).
- Trauma informed training is being rolled across Secondary/ Primary schools to embed trauma informed principles and ways of working to support whole school approaches in responding to children affected by trauma and effects of intergenerational trauma
- In 2019, launched a central point of access for CYP to access all social, emotional and mental health services (SEMH), integrating CAMHS into Islington's Children's Service Contact Team (CSCT) front door. Operating from the principle of 'no wrong referral' the model extends beyond traditional CAMHS settings to improve access into a wide range of health, social and digital community-based services for local CYP.

Camden

- Recommissioned mental health-focussed peer support. Young people in the peer support programme have fed back that the sessions and training have helped with, identifying their own MH needs, sharing experiences, supporting others and developing their own resilience tools. Evaluation results show that 72% of participants improved in their overall mental health and emotional wellbeing, 78% said they feel more optimistic about the future, and 77% felt able to deal with problems well.
- TIPiC (Trauma-Informed Practice in Camden) training and support to schools to implement trauma informed approach to provide an effective response to children and young people who have experienced trauma

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Borough plans in the 'Thriving' domain

Barnet

- Collaboration with Youth Realities and Barnet young people to co-produce a campaign style film, addressing the impact of the digital world on mental health and increase awareness of how to stay **mentally and physically** healthy
- Suicide Prevention Training and at least one Mental health first aider for all schools
- Commissioning of Peer Champion Training for Secondary Schools to increase self-esteem and confidence, and reduce the stigma of poor mental health
- To support the wellbeing of Autistic CYP peer support groups and programmes are being rolled out & develop training packages and links to the parent carer forum
- School Training on Mental Health for Autistic students in collaboration with CAMHS
- Develop resources for Autism training packages and strengthen links with Barnet Parent Carer Forum

Haringey

Address gaps in universal emotional health and wellbeing work using Thrive framework.

- Develop an approach to supporting mental health support in early years settings, working across Early years, public health, VCS and NHS partners to maximise impact and value for money.
- Work with Early Help and Early Years Services to improve CYP workforce understanding of intersection of mental health and neuro diversity.
- Undertake a review and refresh of our communications and information resources to support people to navigate mental health and wellbeing services.

Enfield

- Mental Health Leads Network Meeting will be open to Mental Health Leads across all schools
- Engage with schools to plan new support to enhance the health and wellbeing needs as a school community; and establish a whole school approach to physical and mental wellbeing steering group
- The Anna Freud 'Link' Programme will be working with Enfield partnership from January 2022.
- Continue to roll out the Trauma Informed Practice initiative as a whole system approach.
- A Public Health approach to Youth Violence Reduction is in development

Borough plans in the 'Thriving' domain cont'd

Islington

- Continue to roll out Trauma Informed Practice across secondary and primary schools
- Develop a joint commissioning approach to deliver a transformation programme/ provision to support children aged 0-7 with autism, including whole workforce practice and training on Autism, to strengthen understanding of autism and approaches
- Working with schools (alongside health and wellbeing team) to develop guidance for schools on the new senior mental health lead role
- Roll out of families learning bout self harm across schools.

Camden

- Recommission mental health-focussed peer education and peer support service, involving CYP in all elements of the process
- Evaluate our universal information offer to highlight areas of focus
- Further explore how young people access information (particularly digital formats) and tailor communications projects to provide better reach
- Undertake work to define, further develop and embed a public health (asset building) approach to mental health and wellbeing

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Getting Advice

In NCL, we want to ensure those who need advice and signposting can access this at the earliest opportunity by:

- All professionals working with CYP and their families being able to identify and support these CYP to access early mental health support
- 24/7 access to an online offer of information and support
- Ensuring a wide range of VCS and LA provided community based mental health and wellbeing programmes across all boroughs
- An universal offer of training and support to Health, education and care staff in all settings
- Whole school approaches delivered through Mental Health in Schools (Support) Teams (MHSTs)
- CAMHS liaison and in-reach into every school
- Tailored approaches to address inequalities in access to mental health and wellbeing services

Since the last Transformation plans were published, across all our boroughs we have:

- Rolled out Kooth, an online counselling service, in all our boroughs
- Established a 24/7 crisis line established and improvements to 111
- Expanded and embedded Mental Health in Schools Teams in most boroughs

Across NCL, our emerging Getting Advice priorities are….

Provide a range of ways to access advice and support	Expand Mental Health in Schools Teams	Enhance CAMHS in Schools
• Recommission digital counselling e.g. Kooth across NCL • Enhance blend of digital and face to face offers	Roll out new MHSTs in Enfield, (2021/22), Haringey and Camden (2022/23) and Enfield and Islington (2023/24)	Review the CAMHS in schools offer in all boroughs to identify key gaps

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Borough progress in the 'Getting Advice' domain

Islington

- Developing our Trailblazer Programme of MHSTS, building on the existing service offer within schools to deliver increased early intervention programmes. So far the trailblazer programme has: In 2021 in last quarter, Supported 265 young people/families through groups or 1:1 interventions.
- Delivered 28 groups or workshops in 19 schools. Supported other SEMH partner services with high levels of need Consulted on the model for scaling up to work with all mainstream schools. Set up meetings at additional 30 primary schools this term – to be fully operational in all mainstream schools in September
- Developed small multi-disciplinary teams of support and expertise across schools, including CAMHS clinicians, SENCOs, Education Mental Health Practitioners (EMHPs) and Educational Psychologists.
- Good range of personalized bespoke services for parents, KOOTH counselling and supportive forums for Children and Young People.
- Significant additional local funding into the VCS has increased capacity by providing access for a minimum of 500 children and young people into community-based counselling and therapeutic services.
- Piloting Families Learning About Self Harm (FLASH) group this term and Sibs pilot group (supporting siblings of CYP with additional needs)

Camden

- Delivered a new Wellbeing Champions programme-primary and secondary pupils trained to raise awareness about mental health in their school and educate peers about wellbeing strategies
- Adapted all training and support following Covid and provided an enhanced and increased virtual offer to staff and mental health leads and 18 virtual parent workshops involving 163 parents from 9 primary schools
- Developed and coordinated a new peer support for staff wellbeing programme-a collaboration between Camden Learning, Tavistock, Brandon Centre (VCS provider) and Camden Educational Psychology Service to provide regular small group sessions for staff on mental health topics, staff wellbeing and consultations about difficult cases, open to all staff in schools, delivered by a mental health professional
- MHSTs have delivered a range of workshops on topics worrying CYP and parents post lockdown, and facilitated parent webinars and groups on healthy transitions including one in Bengali
- Production of videos with both Looked after Children and Unaccompanied Asylum Seeking Children on what to expect from CAMHS and strategies to support emotional well-being

Borough progress in the 'Getting Advice' domain

Barnet

- Through co-production with parents/ carers and CYP, BEH have restructured their clinical pathways using usage data to create a clear offer to families accessing the service. Enhanced communication and clarity of offer are key components of the offer.
- Barnet Public Health has a roll out Resilience School Programme since 2017 and over 70 schools are now participants.
- Barnet has over 100 trained Mental Health First Aiders that can be also accessed through dedicated support lines
- BICS has rolled out MHSTs and CWPs to all 130+ mainstream schools in the borough as well as low-intensity offer across GP surgeries
- Universal workshops co-produced with young people and offered by BICS virtually or face-to-face in schools, EH hubs, libraries etc.
- BICS Support Line established for YP, parents/carers, education staff and professionals for easy access to guidance, support and signposting (Monday-Friday, 9am-5pm, response time within the day)
- Piloted a BEH programme for self-re-referral into the service (2020)
- Development of a responsive short breaks offer for children with a disability
- Development of an early intervention/prevention offer for families experiencing autism – with VCS - Resources for Autism

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Borough progress in the 'Getting Advice' domain

Enfield

- Mental Health in Schools teams launched in 2019 and MHST future funding was secured, meaning 50% coverage of the borough's schools,. The MHST future funding wave 5 has been secured meaning 95% coverage. Network meetings were established with schools to enhance timely advice and signposting
- Virtual panel events held with Healthwatch and Our Voice ran to provide CYPMH advice to public during lockdown.
- Children's Wellbeing Practitioners complemented the MHST offer by working with non-MHST schools, through libraries and with Early Help – developing pre-recorded webinars on key areas.
- Enfield Thrives Together Bulletin provided further information to schools on service offers.
- Children's portal and SEMH Local Offer is in place.
- EPS Telephone Support were established, providing parents/carers easy access to advice and guidance throughout the pandemic. Calls responded within 3 days.
- Kooth offer integrated into the Enfield Thrives Together Network meetings presenting to partners and schools through various forums and meetings.

Haringey

- Implemented the Trailblazer Pilot and expanded it through the NCL Inequalities funding through sports and arts with therapeutic support provided by Open Door and others.
- Implemented a digital offer Kooth, NHS GO and Good Thinking, and ran parent/carers and CYP webinars in Pandemic
- Strengthened the role of VCS organisations such as Open Door, Hope in Tottenham, Deep:black and Mind in Haringey
- Healthy Schools programme has agreed to coordinate social emotion and mental health information and mental health training programme in its newsletter and website.
- Haringey CHOICES open access self-referral team offer one to three therapeutic sessions for support and advice for Haringey CYP and families to enable better navigate access to social, emotional and mental health support offers in the borough.

Borough plans in the 'Getting Advice' domain

Islington

- Establish 2 further MHSTs over 2 localities
- Annual progress and evaluation review of impact and outcomes achieved by the MHST schools trailblazer programme

Haringey

- Implement in 22/23 more coverage of Mental Health Support Teams in schools and integrating that with Healthy Schools programme, Early Help Strategy and other school approaches to meeting need, improving outcomes and reducing exclusions. Extend the offer further through use of Inequalities funding
- Refresh advice and information under Preparing for Adulthood
- Learn from work in Camden and Islington about integrating front door access for mental health support
- Embed CAMHS practitioners within key Council Services

Barnet

- Working with Barnet Parent Carer Forum to develop a You Said We Did as part of CAMHS service development.
- Continued partnership working LA and VCSE to commission local initiatives relevant to population
- Continued low intensity delivery within School and community
- BICS to run train the trainer: eating issuers, neuro/learning disabilities and gender diversity training
- Opening of new Autism Support Hub in Barnet in 2022 incorporating respite provision.
- Development of social care Autism Team
- Embedding effective autism pathways across partnerships
- Establish and embed post-diagnostic support and parent support groups

Borough plans in the ‘Getting Advice’ domain

Camden

- Continue and further develop the Peer Support for Staff Wellbeing programme in collaboration with EPS, Tavistock and Brandon Centre
- Pilot a new project to engage young males from Black Asian and other ethnicity backgrounds to share lived experiences and support local mental health services to become more culturally competent
- Continue provision of advice, information and training to schools that supports the return to school and addresses the on-going impact of COVID-19 on staff, parents and pupils

Enfield

- The Enfield Council website is being transformed, which will improve access to advice and signposting.
- Mental Health Leads Network Meeting for all schools launching in October. Key strand will be signposting information.
- Social Prescribing continues to be built on.
- Pilot initiated for peer support workers will be evaluated and reviewed.

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Getting Help

In NCL, we want to ensure those who need focussed support from a service to meet their mental health needs:

- Have a holistic assessment and timely access to support services with coproduction of a care plan at the heart of the intervention.
- Get support from services offered flexibly, delivering interventions at times and locations that fit in with family life.
- Access care integrated across health, education and social care, ensuring that the most appropriate service is identified mental health support is in line with other plans or needs identified by the team around the child/family.

Since the last Transformation plans were published, across all our boroughs we have:

- Rolled out and developed approaches to reducing waiting times through 4 week wait pilot funding in Haringey and Camden
- Undertaken an external audit through the ATTAIN programme and used findings to inform how services develop
- Increased joint working between Trusts to share practice and support mutual aid where needed
- Introduced virtual appointments alongside face to face care, learning from pandemic experience

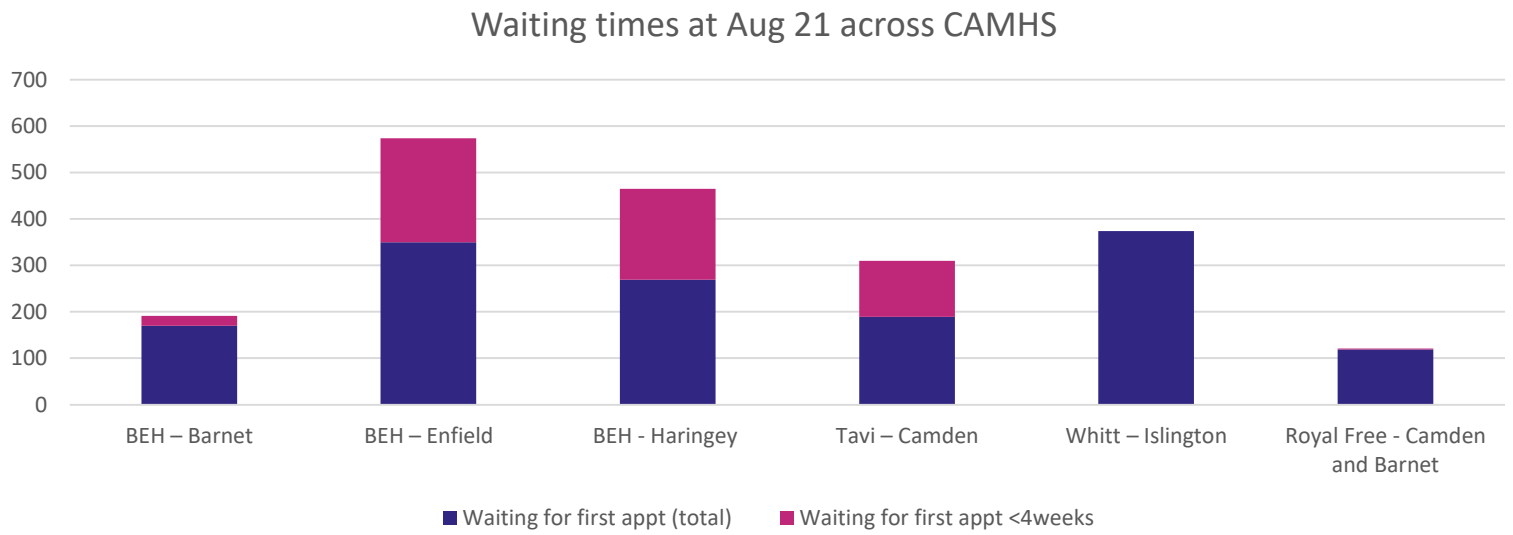
The next slide shows our waiting times for NHS CAMHS services as at August 2021. We have seen significant growth in referrals this year and going forwards, our priority is to work together to manage the level and acuity of need our children and young people are experiencing,

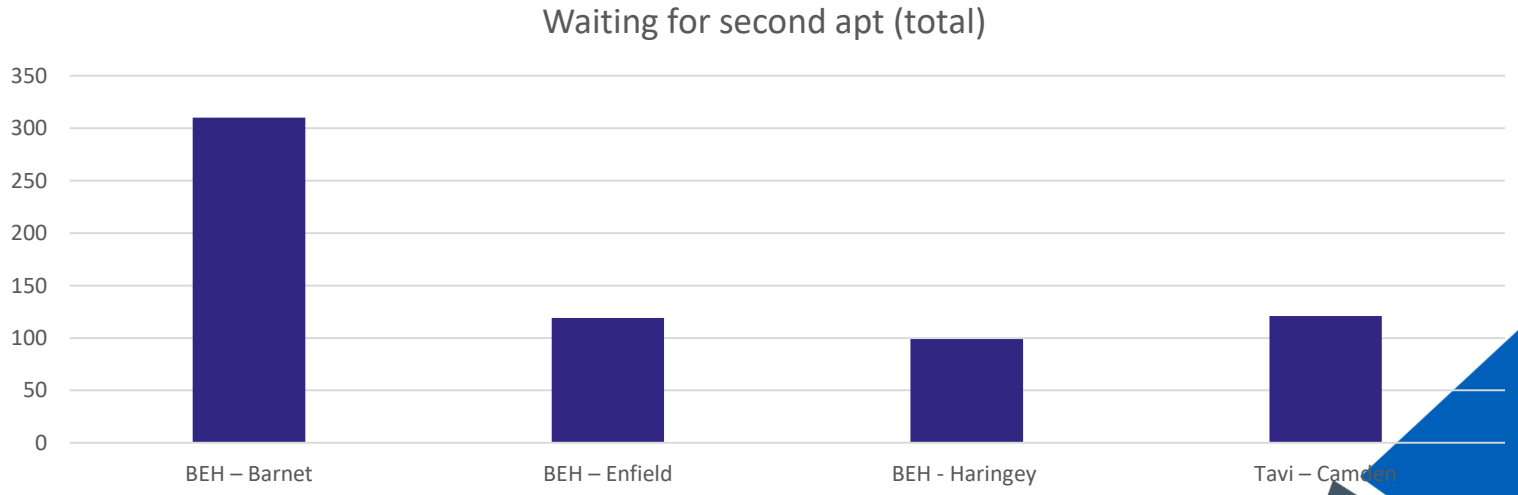
Waiting times and access across CAMHS services

- Like all CCGs, we measure the percentage of CYP estimated to have a diagnosable mental health condition who are in contact with a mental health service. Not all CYP with a diagnosable condition will need services. **We are above the national target of 35% with nearly 40% of our CYP accessing a service**

However rising referrals mean that:

- **1,471** CYP across **NCL** are currently (Aug. 2021) waiting for a 1st appointment with NHS CAMHS
- **679** CYP (42%) are waiting over 4 weeks
- **649** CYP are currently waiting for a 2nd appointment





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Getting Help

Some of our challenges are:

- Different levels of coordination between Education, Social Care, Early Help, Youth Services, voluntary sector and all MH services in different boroughs
- Not all boroughs have 14+ supported accommodation for CYP with MH needs and transition support generally varies
- Variation in CAMHS services and pathways for under 5ys
- Variation in provision of targeted support for groups including unaccompanied minors, those in pupil referral units and looked after children (LAC) and care leavers

Our emerging plans and priorities across NCL are:

Target and tailor support to address inequalities

- Share good practice and strengthen offer for LGBTQ+ CYP
- Improve consistency of targeted support offer for key groups such as unaccompanied minors, those in pupil referral units and LAC and care leavers
- Work with the Lighthouse Child Sexual Abuse centre to mitigate the impact of a MOPAC/NHS England pilot ending and funding reducing.

Integrating access to social and mental health support

- Build on Islington's Central Point of Access model to Implement single points of access to social care and mental health services ('Integrated Front Doors'), starting in Camden
- Ensure our support for LAC and care leavers is in line with new NICE guidelines (Oct 21), including building expertise about trauma across the children's workforce and ensuring access to CYP MH services where needed.

Reduce Waiting Times

Invest in interventions to reduce the number of children waiting and waiting times in all boroughs, drawing on NHS, VCS and LA workforce, skills and experience

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Borough progress in the 'Getting Help' domain

Enfield

- The CYP access rate for Q1 2021/2022 was 41.9%, above the ICS target of 39%.
- Parenting offer has continued to be offered by a range of local partners
- Further development of Nexus, a community project run by the Behaviour Support Service, partnering with external services/organisations e.g. the Butterfly Project (build self-esteem, confidence and resilience of girls and young women through coaching and mentoring) https://www.nexusenfield.com/nexus-projects/butterfly
- The Youth Offer in Enfield includes the Council's dedicated youth service provision, grant funded targeted youth support provision in partnership with third sector providers and community groups and wider youth offer delivered independently by third sector and community groups. Including targeted youth support https://new.enfield.gov.uk/youth/
- New Health and Wellbeing Youth Worker developed by Public Health and located with the Youth Development Service – delivering social prescribing
- Kooth was built into pathways of specific services, e.g. CAMHS Access and Early Help.

Haringey

- Integrated front door pathway between BEHMHT CAMHS and Open Door, funded to deliver 4 week wait targets, has reduced waiting times and made it easier for young people to reach the right treatment
- Used the learning from 4WW and the NHSE Improvement Team to improve systems within Open Door and Haringey CAMHS & aligned funded opportunities such as Youth Endowment Fund, etc with Trailblazer work to maximise impact.
- Increased jointly funded posts between Council and CAMHS in YOS and the Disability Team
- Rolled out PBS training

Barnet

- Access targets met and exceeded
- Implemented a targeted model for all-age SEND provision across LA, NHS, VCS and Parent Forums with a focus on key transition ages [primary to secondary, 16+, 18-25years]
- BICS UASC-designated clinician based in social care appointed to lead on UASC and refugee offer to Barnet community
- BICS established PHMT and low intensity (MHST and CWP) clinical services
- Family Therapy Clinic
- Kooth online counselling commissioned and expanded
- Early years parenting HUB for families at the edge of care proceedings opened & Parenting Programmes for CYP with ASD/LD/ADHD
- Enhanced offer of therapeutic support for children in care transitioning to adulthood through VCS counselling service,
- Corporate parenting strategy revision prioritises emotional health and wellbeing

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Borough progress in the 'Getting Help' domain

Camden

- Improved access rates exceeding target
- Introduced a clinic based programme called Parent Child Psychological support, building on the healthy child programme led by health visitors providing additional universal checks for CYP aged 3-18months
- Whole Family team outreach project promoted engagement and addressed difficulties with attending appointments through discussion with multi-agency network and meeting the YP and family where they are at (home visits, school, park etc)
- Project on Young peoples' reasoning for carrying a weapon to support clinicians' understanding help with discussions around future educational placements
- Reorganisation of multi-disciplinary resources within our MOSAIC child development services to direct resource support autism assessment and diagnosis
- Established 'The Crib' a new project at the Haverstock school which assesses and stabilises children excluded from school using creative therapies
- The Hive (adolescent service) developed a number of new groups in response to suggestions from service users and youth board incl. young black men's and women's group. Introduced new therapies such as CBT and systemic therapy

Islington

- Islington Parent and Baby Psychology Service delivered a specialist assessment and treatment service to over 100 children aged 2 and under in 18/19
- Focus on increasing access to services for vulnerable adolescents and CYP with Learning Disabilities and Autism, as well as young people known to or on the edge of criminal justice pathways (including mandatory speech and language screening for YP entering YOS)
- Developed an All Age action plan to address STOMP / STAMP to support professionals to think about behavioural interventions before prescribing psychotropic medication
- Strategy and plan in place to reduce waiting times for Autism assessment, including streamlined assessment process, single keyworker and improved clinic system.
- Implementation of the new LD and Autism Key worker service.
- The service will be delivered across NCL, working in partnership with health, SEND, social care and education partners as required, to deliver the specified outcomes.
- The Keyworker service will support young people in Tier 4 and those at highest risk of admission, with the aim of reducing inpatient numbers, progressing towards the NCL 2021/22 target of 9 inpatients across NCL. Priority for the service will be given to children and young people who are inpatients, followed by those at risk of admission

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Borough plans in the 'Getting Help' domain

Camden

- Launch Integrated Front Door service to manage referrals – integrated between CAMHS and social care/early help
- Provide training to Personal Advisors about talking to young people about self-harm and when they express emotional difficulties
- Roll out mindfulness groups for Looked After young people and Foster carers
- Expansion of the CWP team as the Emotional Wellbeing Service to increase the capacity for mild to moderate mental health difficulties
- Continued partnership providing consultation to Camden YOS ENGAGE team to ensure earliest possible engagement and intervention with CYP in custody
- Work with occupational therapists to grow work on tackling sleep, diet and exercise in relation to exposure to adverse childhood experiences. Target programme at Unaccompanied Asylum Seeking Children (UASC), residential staff and foster carers through training and ongoing consultation

Barnet

- All young people between 11-26 to be able to continue to access Kooth (on line counselling) with plans for targeted promotion to young males and looked-after children and hard to reach groups.
- Develop further targeted work with care experienced young men and young people aged 16+. Based on evidence of local need and feedback from young people. Terapia supports care leavers that have experienced trauma, isolation and abuse.
- BICS: 'getting trauma-informed training and supervision (all children's workforce involved in direct work /practice supervisors)
- BICS: train the trainer incorporating eating issues, neuro/learning disabilities and gender diversity training
- LA and BEH Memorandum Of Understanding for psychiatry input for children in care across the Local authority to be in place and operational
- Early years parenting HUB for families at the edge of care proceedings established
- Joined up Autism pathways including diagnosis agreed and operational

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Borough plans in the 'Getting Help' domain

Islington

- Reduce waiting times for Autism spectrum assessments for children 5-18 years. Jointly commission an autism-specific Joint Strategic Needs Assessment (JSNA) topic / chapter
- Identify further data sources across the partnership, collate and analyse in order to build up a better picture of service provision
- Develop our Transforming Care Work embedding system wide work for CYP with LD / Autism including prevention of admission into Tier 4 services and residential provision.
- Address pathways into adulthood by developing a Joint Strategy across Council and CCG to support and set out our ambitions and activity to support 'Progression to Adulthood'
- The LD and autism Keyworker service will support young people in Tier 4 and those at highest risk of admission, with the aim of reducing inpatient numbers, progressing towards the NCL 2021/22 target inpatients across NCL.

Haringey

- Mobilise expansion of core CAMHS services to meet growing demand. Successfully embed all new workers within the borough CAMHS and Council teams
- Continue to improve CAMHS and Council services working relationships and governance
- Reduce waiting lists for speech and language therapies and autism assessments, including better support children and their parents waiting for assessment or having recently had a diagnosis
- Continue to address ongoing inequalities in access to CAMHS amongst some of our most deprived wards.
- Reintroduce access to borough CAMHS services for Looked after Children living in Borough, and address issues in transition (including for those returning to the borough).
- Successfully embed eating disorder liaison workers in borough teams to improve access and outcomes, supported by other teams including the Autism Team
- Improve ADHD care pathways, e.g. with a nurse prescriber.

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Borough plans in the 'Getting Help' domain

Enfield

- Expansion of Enfield's Advisory Service for Autism (0-25) – a multi-agency offer to schools, parents/carers and CYP
- Development of the Speech and Language Communication Hub – a multi-agency to increase access to support in this area.
- Expansion of CAMHS digital offer
- Continue to review Child Development Service waiting times for autism diagnosis and adapt pathway to ensure early access to services such as CAMHS at key stages
- Roll out Disrupting Exploitation package for the secondary schools to support CYP with speech and language needs at risk of exploitation.

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Getting More Help and Risk Support

Some of our children and young people will need intensive and specialised support from across the system to meet their needs. Since the pandemic, we have seen the number of children experiencing a mental health crisis grow. We have also seen a sharp rise in the number of children and young people with eating disorders. Conversely however, fewer young people are entering inpatient CAMHS – and our ambition is to reduce this even further, ensuring children and young people have timely access to practitioners and services skilled to meet their individual needs, including;

- 24/7 support for children experiencing a mental health crisis
- Risk Support available for CYP with high needs who are not currently in a space to actively utilise treatment to ensure they stay connected and the integrated networks of professionals and family/carers are clear on the plans to mitigate risk and pathways to escalate
- Access to Positive Behaviour Support/Non violent resistance training for professionals within health and social care
- Good paediatric liaison to coordinate between hospital, social care and CAMHS
- Support for children and young people with particular needs such as disordered eating concerns or conditions

Since the last Transformation plans were published, across all our boroughs we have:

- Rolled out Crisis Hubs during the pandemic so families can get support outside of hospital and an Out of Hours Service
- Implemented a 24/7 Crisis telephone line
- Increased paediatric liaison capacity
- Increased capacity in our Eating Disorders Intensive Service (EDIS)
- North Central and East London Provider Collaborative have reduced the number of inpatient admissions by 34%, Out of Area placements by 73%, length of stay by 43% and admissions for CYP with Autistic Spectrum conditions down 50%.
- Introduced Transforming Care Prevention and Support services (TCaPS), providing support for families and young people with Learning Disabilities, autism and/or challenging behaviour

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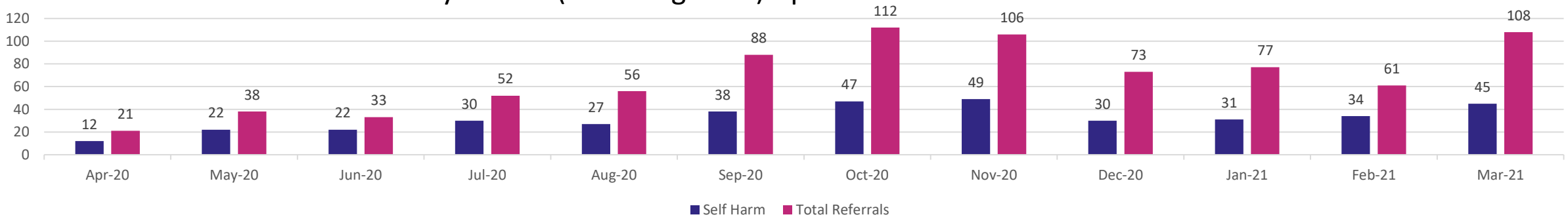
Performance - CYP in Crisis Data

More children and young people are being referred for mental health crises.
Referrals have increased from 21 in April 2020 to 108 in March 2021.

NCL CYP MH Crisis Service Summary Apr20 – Mar21

Total Referrals 20/21 (excluding hubs)	No. of Local CAMHS	No. of Hospital Locations	No. of Females	No. of Males	No. of Intermediate	Community	Known to CAMHS
825	7	7	628	169	28	587	136

CYP Crisis Out of Hours Referrals by Month (excluding hubs) Apr20 – Mar21



NCL CYP MH Crisis Helpline Summary Jan21 – May21

Total Calls	Further Action Required	Calls (Mon-Fri)	Calls (Sat-Sun)	Call Duration (<15 mins)	Call Duration (15-29 mins)	Call Duration (30-59 mins)
291	196	199	92	51	100	50

NCL CYP MH Crisis Hubs Summary Apr20 – May21

Total Combined Referrals (OOH with Hubs) 2020/21	Total Combined Referrals (OOH with Hubs) - 2021/22	Total Hub Referrals (April 20 - May 21)	Total North Hub Referrals (April 20 - May 21)	Total South Hub Referrals (April 20 - May 21)
3048	669	2564	1401	1163

Performance – CYP Eating disorders

- There were significantly more referrals (N=130) in Q1 21/22, compared to Q1 of 2020/21 (N=51), **an increase of 155%.**
- There were significantly more referrals triaged as urgent (N=30) compared to last year (urgent n=15).
- This is undoubtedly a result of Covid and the lockdown, which has led to a nationwide increase in people presenting with ED. This is in line with research evidence demonstrating the negative impact of lockdown on individuals with ED (Castellini et al. 2020). We have seen a steep and consistently rising rate of referrals and caseloads since October 2020.

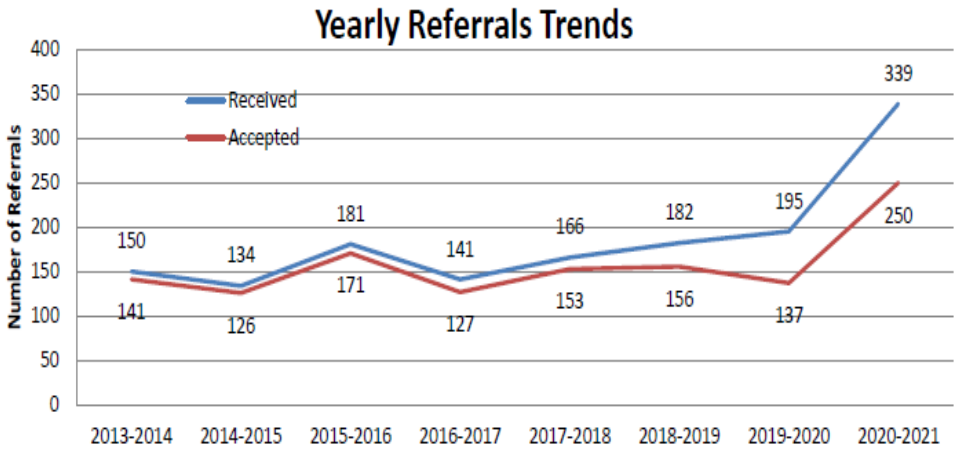
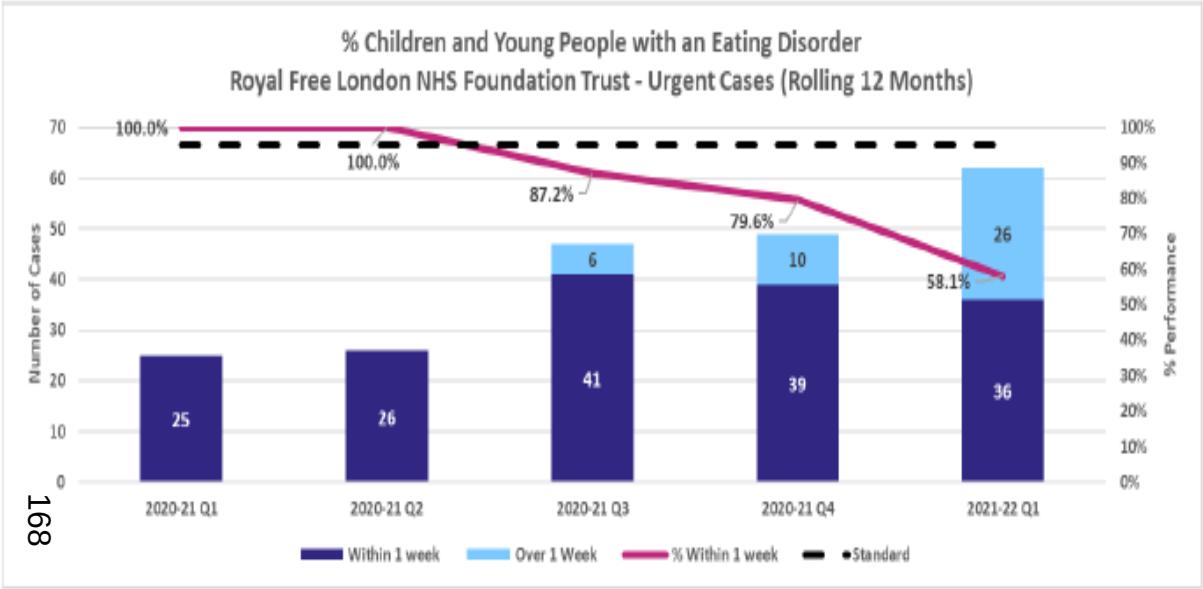
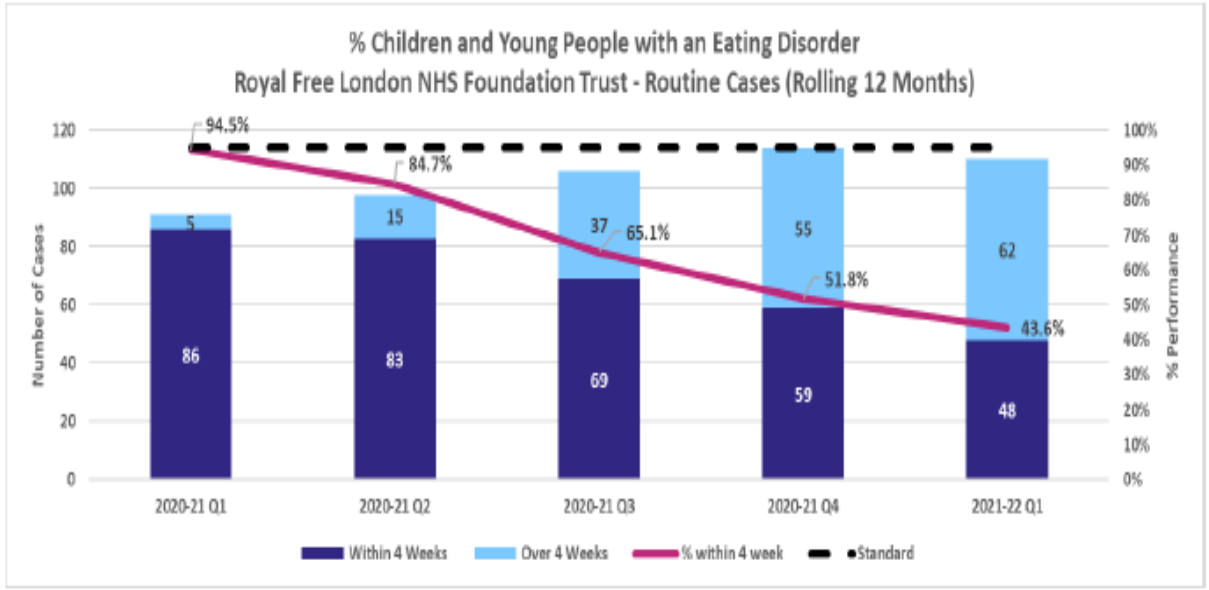


Table 1&2. Children and Young People Eating Disorder Performance – Urgent and Routine Quarterly





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Getting More Help and Risk Support

Some of our challenges across all boroughs are:

- Addressing the sharply rising levels in demand and acuity we are witnessing post pandemic, particularly around Eating Disorders. We are also seeing lots of children with multiple needs, e.g. disordered eating and autism
- Ensuring the children's education, health and care workforce recognise risk factors for suicide (see National Child Mortality Database (NCMD) 'Suicide in CYP' report, Oct 21) and continue to work in partnership across our systems to identify and support young people at risk of significant self harm and suicide
- Many boroughs have some home support but not home treatment teams
- Crisis, Out of Hours, Assertive Outreach Teams and Hospital Liaison capacity and staffing models vary between our Trusts
- Gaps in pathways for binge eating and Avoidant Restrictive Food Intake Disorder (ARFID)
- Not all boroughs hold an effective Admission Avoidance Register to prevent young people with autism/LD from reaching crisis and there is no NCL wide register
- We do not have any S136 'Place of Safety' suites in our area

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Getting More Help and Risk Support

Our emerging plans and priorities across NCL are:

Community Eating Disorders

- Embed a new NCL Community Eating Disorders service
- To work in partnership with local CAMHS with support from Eating Disorders Intensive Service (EDIS)

Eating Disorder Intensive Service and Hospital at Home for ED

- Increase resource to recover and maintain performance against our targets
- Using reinvestment from NCEL Provider Collaborative, roll out an Eating Disorders Hospital at Home service in 22/23

Avoidant Restrictive Food Intake Disorder

- New community ED provision to offer ARFID support with training and support from Royal Free

Acute Paediatric Mental Health Liaison

- Embed additional resources
- New consultant and practitioner response at North Middlesex and Barnet Hospitals

Community Intensive Home Treatment

Implement a HTT pilot, demonstrating an invest to save impact in NCL.

Dialectical Behavioural Therapy (DBT)

- Employ DBT service lead(s)
- Agree the model and timeline for an NCL pilot

Building capacity with the system wide children's workforce

- Expanding our training offer across all system wide stakeholders including Education, Social Care, VCS, Police and Ambulance Service

Crisis service out of hours

- Ensure adequate capacity during winter pressures period

Suicide prevention

- All boroughs and CCG to review and implement recommendations outlined in NCMD Oct 21 report

Access to National and Specialist CAMHS

- Monitoring outcomes and out of borough investment to review whether we can invest in local service development to deliver care closer to home for CYP needing to access specialist community support.

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Crisis, Liaison and Home Treatment

Purple = Transitioning service in 2022/23

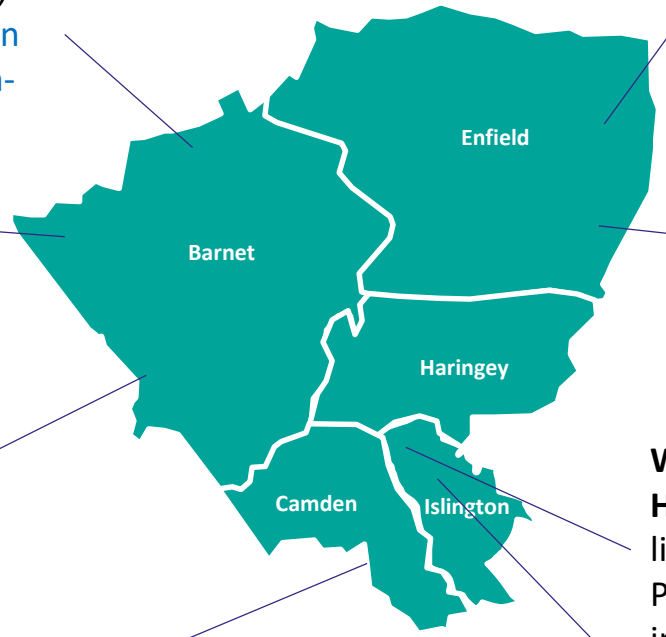
Green = new service for 2023/24

BGH - Paediatric liaison on wards, Psychiatric liaison in paediatrics (in-hours)

NMUH – Paediatric liaison on wards, Psychiatric liaison in paediatrics (in-hours)

Home Treatment Team pilot - Barnet (Hospital @ Home) – Intensive home treatment to avoid T4 admission and improve outcomes

Home Treatment Team pilot - Enfield (Hospital @ Home) – Intensive home treatment to avoid T4 admission and improve outcomes



Enhanced NCL 24/7 Crisis Line – Crisis line for all CYP in NCL. Additional CYP specialist clinician to upskill team on CYP advice and support (Increase 9-12am, 7 days per week)

Safe haven– Diversion from A&E for crisis assessment and bedded site for 72 hour admission

Edgware Community Hospital (North Hub) – Diversion from A&E for crisis assessment and treatment – transforming into home treatment teams

Whittington Health - Paediatric liaison on wards, Psychiatric liaison in A&E (in-hours)

NCL Out of Hours team – Crisis response out of hours in NCL. Increase to support 2 x diversion hub sites

UCLH - Paediatric liaison on wards, Psychiatric liaison in A&E (in-hours)

Northern HC (South Hub) – Diversion from A&E for crisis assessment and treatment – Transforming into home treatment teams

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Health and Justice

NCL CCG is committed to working with partner organisations to ensure YP who are engaged with youth offending teams are given a care plan and support. There is a commitment to:

- Ensure Plans are developed jointly with key stakeholders in the Justice system including YOT/S, Liaison and Diversion Services, YOIs, Police, Courts, Probation, FCAMHS
- Co-produce pathways with YP their families and carers
- Develop a dashboard to measure outcomes for this group of young people in relation to their care plans
- Understand the inequalities impact on youth offending and develop and implement an NCL wide strategy to reduce inequalities

Our draft action plan for the interface between CAMHS and youth offending services has the following key priorities

- Development of a health in justice task and finish group to review our collective offer and approach to tackling inequalities and develop a multi-agency prevention and intervention strategy
- Inclusion of progress (RAG rated) within the CAMHS transformation dashboard
- Improved links to existing governance structures to ensure visibility, collaboration and cohesion across the NCL footprint
- Evidence of CYP and communities working with agencies to coproduce more effective and efficient services

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Spotlight on Good Practice: Violence affecting Young People

- NCL will receive ~£1m (per annum for 3 years) to pump prime existing projects and work in specific areas of high rates of violence against young people and deprivation
- The priority is to target service provision in areas of high need, greatest prevalence of local risk factors associated with SYV such as unemployment, crime, deprivation and low service uptake.
- Plan is to mobilise more provision in Enfield, Haringey and Islington Boroughs which have the highest level of violence in London, as well as deprivation indices, spread the learning across NCL and encourage access across all NCL boroughs.
- The priority focus is to enhance existing schemes;
  - Islington: Finsbury Park, Holloway and Caledonian will be prioritised; building on initiatives expanding Young Black Men and Mental Health Programme and Youth Transitions project.
  - Haringey: Project Future in Tottenham
  - Enfield: Developing a Project Future in Lower Edmonton and Edmonton Green wards
  - Camden and Barnet: Preventative work with families of children at risk and expanding training, consultation and supervision around trauma informed approaches to working with young people at risk of engaging in or being affected by serious youth violence.

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Getting More Help and Risk Support – Borough Progress

Islington

- CETR's (Care Education Treatment Reviews) in place to prevent admission to hospital for C/YP and to prevent readmission to hospital
- Good progress of the AAOT team in supporting highly complex children and young people. Good partnership working with Health, Social Care and Education.
- Strong relationship with JAP funding panels and engagement with Tier 4 panels and good representation in CETR's and CETR reviews.
- Tier 4 panels monthly working well to reduce admissions and readmissions to inpatient hospitals, engaging a broad range of professionals. Includes children with learning disability, autism and/or challenging behaviour.
- Further implementation of AAT/ Dynamic risk register meetings to avoid hospital readmission
- Embedded a CAMHS Liaison and Diversion nurse, CAMHS Psychologist and Speech and Language service into YOS and TYS, with mandatory speech and language screening for all young people entering YOS, resulting in better outcomes for some young people undergoing court proceedings
- Islington has strong and robust joint commissioning partnership arrangements through the delivery of JAP panels comprising of representation from across Health, Social Care and education. Strong collaborative decision making is in place to ensure we are putting in place the right packages at right time for children and young people. This is underpinned by Pre jap panels arrangements which exhaust all community options for children and young people.

Enfield

- A MDT Professional Dynamic Risk register in place to prevent admission to residential settings and ensure that CYP with LD, Autism and Challenging Behaviour are supported (led by Disability Services).
- PBS training has been provided to special schools and partners. Staff are trained to coach level in Autism Special Schools and in key specialist services. Physical Intervention training has been reviewed and a BILD Act accredited training provider has trained trainers across all special schools and CYP/Adults disability services.
- Monthly multi-agency decision making panel to support children with mental health needs to access to education (Admissions led)
- Emotional Based School Avoidance (EBSA) Partnership Group established in January 2021, with the proposed development of a multi-agency specialist intervention linked to a special school.
- There continues to be urgent prioritisation of crisis pathway enhancements to ensure the most vulnerable CYP can access specialist support
- Introduced greater flexibility around self-referral to CAMHS during lockdown

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Getting More Help and Risk Support – Borough Progress

Haringey

- Promoted to schools, Social Care and Early Help - FCAMHS, Lighthouse, 24/7 Crisis Line, OOH Nursing Support
- Reduced 15 CYP in mental health beds through improved working between partners
- 75% of acute hospital admissions reduced due to the out of hours support.
- Introduced a Brandon Centre suicide prevention programme for care leavers

Barnet

- Standardisation of care pathways and service across the borough & earlier access through developed access and triage model
- Enhanced response into Acute hospitals including assessments in A&E
- Inpatient protocol for Barnet CYP agreed by LA, Barnet CAMHS and Barnet inpatient provision
- Opening of Therapeutic Children's Home with clinical intervention on site and refreshed foster carer and residential staff training to include trauma informed care and mentalisation
- Multi agency work between school police and Autism Advisory Team to develop understand and good practice when engaging with Autistic/ Neurodiverse CYP.
- NCL LD/ASD keyworker project to avoid admission and aid discharge

Camden

- Implemented the Brandon Centre suicide prevention pilot undertaking clinical work with a focused group of care leavers, with good engagement to date.
- Raised awareness of CETR process to engage wider professionals
- Transitions for Tier 4 Task and Finish groups to develop multiagency pathway for young people in Tier 4 settings to ensure planning for discharge at earliest opportunity, home visits wherever possible, earlier support from Adult Mental Health services and flexibility on end dates from CAMHS for children being discharged at transition age.
- Closer to Camden strategy to reduce out of borough placements for children and young people with complex needs wherever possible.
- Complex needs panel includes governance for dynamic risk register and a 'watchlist' developed to support those below threshold for dynamic risk register
- CAISS team offering flexible and responsive service, including outreach work, and in-reach to inpatient units and hospitals

Getting More Help and Risk Support – Borough Plans

Islington

- Strengthen interface and working with Royal Free Hospital to support and ensure step down and discharge pathways from EDIS are robust. This will part of the strategic work and plans we are developing regarding preventing tier 4 admission and developing community reintegration pathways to avoid repeated hospital readmission.
- Further strategic diagnostic work is being undertaken to prevent Tier 4 admissions and improve step down from Tier 4 admission into the local community.
- Implement new key working service to specifically provide intensive engagement support to launch (Nov 2021) supporting C&YP in tier 4 settings in preventing admission to tier 4 and supporting safe landings back into the community.
- Implementation of the new Keyworker service will support young people in Tier 4 and those at highest risk of admission, with the aim of reducing inpatient numbers, progressing towards the NCL 2021/22 target of 9 inpatients across NCL. Priority for the service will be given to children and young people who are inpatients, followed by those at risk of admission

Enfield

- Emotional Based School Avoidance will be further developed for CYP and their families where difficulties are more entrenched (this will be complemented by a preventative approach providing borough guidance, training and consultation to promote early identification and support).
- Identify funding to roll out PBS training to special and mainstream school staff.
- Enfield's commitment to restraint reduction will be overseen by a partnership group, linked to trauma informed practice - accountable to Enfield's Transforming Care and Enhanced Family Support Board.
- Enhanced service provided by the Integrated Learning Disability service for crisis response in terms of challenging behaviour.

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Getting More Help and Risk Support – Borough Plans

Haringey

- Reinstate an Admission Avoidance Register to improve coordination between Health, Schools, Social Care and Education in supporting young people with autism/LD who may go into crisis;
- Continue the promotion of NCL/NHSE initiatives so that Haringey's use is proportionate to its CYP population
- Successfully introduce the Home Treatment Teams into Haringey's pathways, ensuring Council and Education partners are able to rapidly respond to hospital admission avoidance plans and hospital discharge plans for young people.
- Level up paediatric mental health liaison offer so that there is an on-site presence in hours at BGH and NMUH and embed that in borough pathways and post-attendance follow up

Camden

- Take forward closer to Camden strategy multiagency priorities for CYP with complex needs including improving outcomes for CYP based out of borough, investment in positive behavioural support, personal budgets and support this group of CYP and their families to remain within or closer to home
- Develop an offer of DBT and group work sessions for adolescents through Minding the Gap
- Multidisciplinary communications and AMBIT training for professionals supporting those due to be discharged from inpatient settings

Barnet

- Continue to develop improved services for CYP at key transition points including 18+ into adult mental health services, working across NCL in line with our Long Term Plan ambitions
- Review of thresholds across services within getting help and getting more help to improve pathways across the system
- Barnet Inpatient agreed protocol with an established a discharge protocol for CYP leaving inpatient treatment to prioritises a wrap around multiagency plan
- Improve transition planning for children receiving Continuing Care on basis of complex behaviours to ensure timely assessment for Continuing Health Care
- NCL LD/ASD key worker project involving Tier 4 and crises support to avoid admission and enable discharge.

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A Population Based Approach

Although the THRIVE framework encompasses an all age approach, there are two age periods highlighted in national policy and identified as workstreams in their own right:

- 0-5s Mental Health and Emotional Wellbeing support for families of young children
- 0-25s – Mental Health and Emotional Wellbeing support for Young Adults

We also have a workstream around supporting children and young people with Learning Disabilities and/or Autism including those with behaviour that challenges, reflecting the additional complexities this group sometimes have of accessing the care and support that benefits them.

This section sets out our ambitions, progress and plans for these children and young people

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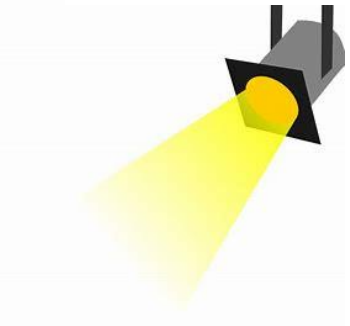
Our ambitions for Early Years mental wellbeing



Our 0-5s core offer aspirations

- An offer of training for families and early years professionals around children's emotional and behavioural development and family relationship issues
- Advice, liaison, and training for assessment, triage and provision for family drop ins.
- Consistent involvement of CAMHS in Multi Disciplinary Team (MDT) planning with key stakeholders across the system

Identified challenges

- No CAMHS in Haringey early years settings
- In Enfield there is no established U5's pathway

Spotlight on good practice

Enfield Parent Infant Partnership (EPIP) is a small therapeutic team within CAMHS made up of two parent infant psychotherapists and a therapeutic specialist health visitor. The team works with families when there are concerns about the parent infant relationship. Parents may be struggling with factors such as mental illness, postnatal depression, post-natal anxiety, adjustment to parenthood, previous loss of a baby, traumatic birth or adverse childhood experiences

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0-5s: NCL Specialist Mental Health Perinatal Service

The NCL Specialist Mental Health Perinatal Service offers care and support for women who are planning a pregnancy, pregnant or who gave birth within the last 24 months and have been diagnosed at any time with a severe mental illness.
The service works together with the mother, her partner, her family and other professionals involved in her care to help her stay as well as possible during pregnancy and post birth.
The teams consist of various WTE: consultant psychiatrist, nurses, social worker, occupational therapist, clinical psychological, family therapist, pharmacist, nursery nurses and peer workers.

As well as psychiatry and psychology, care planning and crisis planning, the service provides the following intervention for children under 5.

- Support parents to breast feed
- Teaches parents first aid
- Runs baby massage and yoga to support bonding
- Facilitates Play & Stay sessions that provide socialising opportunities to children and parents, and provides peer support opportunities for parents
- Delivers Video Interactive Guidance (VIDS) – providing feedback on parents playing with their child
- Provides New Brazelton Observation – new born behaviour observation to support positive parent interactions

Performance: The NCL service achieved 4.6% in 2020/21 whilst the London region access rate was 5.0%, which increased to 5.5% in Q1 of 2021/22. Average waiting times for initial assessment is 28 days and 86% of referrals to psychological treatment started within 6 weeks.

Partnerships: Perinatal services work in Partnership with; public health, health visitors, other CYP health and community services, CAMHs services in cases where the mother is under 18, adult and children safeguarding leads.

Co-located service: Runs clinics from local children's centres, introducing the centres and their range of offers to parents

Training: Designs and delivers training to a range of services, including the development of joint training packages e.g. with social services.

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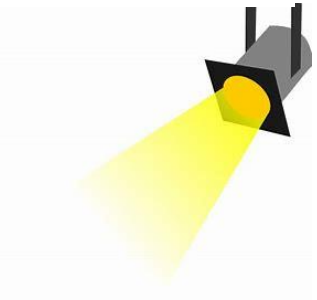
Our ambitions for young adults mental health and emotional wellbeing provision



Our 16-25 Young Adults aspirations

- Extend current service models to create a comprehensive 0-25 offer
- Support transitions from CAMHS to AMHS
- Consistent support and counselling offer for young adults and students available in the community and online
- Online counselling, self help and peer support options
- Locality based wellbeing hubs for young adults with emerging emotional wellbeing and mental health needs

Identified challenges

- Programmes such as Minding the Gap not present in all NCL boroughs

Spotlight on good practice

Camden's Complex Adolescent Intensive Support Service (CAISS) is a nurse led service for CYP in emotional/psychological crisis which has contributed to a consistent reduction to admissions to Tier 4 since 2019. In addition to temporarily stepping into CAMHS teams to provide intensive support they also support local acute providers i.e. hospitals, paediatric liaison teams with a rapid response to any admissions to their acute wards.
Their approach of using flexible interventions (outreach, CBT, DBT informed work, etc) and ways of working alongside families and other services to provide support without waiting lists or strict criteria for intervention type or length has supported management of risk outside of hospital.

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Young Adults

Our challenges to date: Young adults moving between CAMHS and Adult Mental Health Services have:

- Historically faced a 'cliff-edge' in support
- Found the AMHS offer not appropriate, appealing or easy to engage with
- Been especially impacted by Covid-19 with a rising prevalence of mental ill health.

Progress made:

- Pockets of excellent practice eg Camden's Minding the Gap holistic support service and Adolescent Intensive Support Service

Further improvements planned: We are investing £1.1m in 21/22 to implement new Young Adults-focussed roles:

Young adults clinical specialists in MH networks

Implement Young Adults Clinical Specialists and EBEs in 10 early implementer Primary Care Networks, where they will :

- Proactively reach out into community settings and partner providers incl. Local Authority Services (YOS and LAC) and the VCS , bridging young people into services as required. There will be a particular focus on vulnerable groups specifically BAME, care leavers (incl. people seeking asylum) and young offenders.
- Offer developmentally appropriate pan-diagnostic assessment, formulation intervention and support colleagues to do the same
- Develop and roll out training for Adult MH staff in specialist services on adolescence and transitioning, including trauma impact on developmental delay.

Clinical Transition Champions

Develop new clinical transition 'champion' roles and key worker roles to support YA transitions from CAMHS including Tier 4, Care Leavers and patients with emerging EUPD into AMHS:

- Transition champions will identify CAMHS users requiring continued adult mental health support. They will deliver highly specialist psychological and systemic assessment, formulation and care planning as appropriate for young adults and their families and bridge YA into the most appropriate AMHS service. They offer leadership, consultation, training, supervision around YA within the adult teams. Transition workers (primarily Expert by Experience) will help YA access signposted services and support care planning activities.

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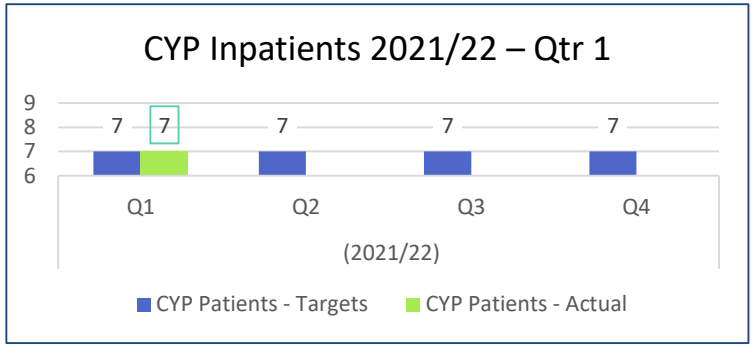
Learning Disability and Autism

Our challenges to date:

- Rising number of referrals of CYP with suspected autism (nearly 1000 CYP waiting to start autism assessment in Aug 21 of whom 600 waiting longer than NICE guidance of 12 weeks) and some children wait 2 yrs+ to achieve diagnosis. Exacerbated by delays to assessments during lockdowns
- Pre and post diagnostic support offer varies across boroughs
- Complexity of need – supporting children with LD, autism and/or challenging behaviour to remain at or close to home

Progress since the last Transformation plans:

- Only 7 CYP with LD/autism/challenging behaviour in inpatient settings at Q1 21/22
- New Care Co-ordinator and Keyworking roles in places/being recruited to
- Positive Behaviour Support approaches introduced or enhanced in most boroughs
- Autism diagnostic pathway review undertaken
- STOMP/STAMP plans to reduce inappropriate use of medicine developed



Emerging priorities include:

Expand Keyworking	Reduce Autism waiting times	Improve post-diagnostic Autism support for families	Quality provision and care closer to home
Continue recruiting to Keyworker posts and explore sustainability for TCaPS provision	Progress recommendations of CYP ASD diagnostic pathway review 2020/21, including options to sustainably address waiting lists, pilot of online assessment model, manage future capacity and deliver wider quality improvements to CYP LD/ASD pathway.	Implement ATLAS post-diagnostic support programme and review pre-diagnostic support offers	Develop a quality assurance framework for specialist residential provision and explore new ways to reduce the number of CYP with complex LD/autism/SEMH needs in residential schools/colleges and inpatient settings far from home

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System Enablers

All of the ambitions in this Plan are underpinned by some key enablers:

- **Placing a focus on equalities at the heart of our work:** We can only support the best outcomes for our children and young people if we ensure our services are tailored to their needs. We will ensure our workforce, systems and policies are actively anti-racist and anti-discriminatory and our services reflect the needs of our communities.

- **Workforce**: Our plans are only possible through the recruitment and retention of a skilled, diverse workforce. Our workforce in NCL is highly skilled and committed to our young people. NCL had 779 WTE staff working in children and young people mental health services in 20/21. By the end of 21/22 we will have 908 WTE staff – a 17% increase. But we know that there are key recruitment and retention challenges faced by Trusts and the VCS providers

- **Digital**: The pandemic highlighted the importance of making best use of digital technology to deliver and support care – whilst ensuring everyone can access care in the way that is right for them

- **System Governance and data**: Achieving and monitoring progress is supported by strong, multi-agency governance that acts on children and their families' views and uses rigorous population and performance data to track delivery

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Driving equality and addressing inequalities in outcomes for CYP

- **Improving data quality and reporting:** We want to improve our monitoring of and use of population and service data on ethnicity, gender, age, sexual orientation, disability and other characteristics (where necessary) to ensure our services continue to meet our populations' needs effectively
- **Targeted initiatives**: We know that mental health and emotional wellbeing outcomes are more at risk in some population groups than others and will continue to develop targeted initiatives where appropriate and adapt services where needed
- **Co-production:** We will ensure we involve CYP and their families from our borough's diverse population groups in shaping services
- **Organisational development:** We will engage with our communities to ensure our services are culturally competent, disability and LGBTQ+ aware and share learning between Trusts
- **Training:** Trusts and the CCG will continue to ensure staff receive anti-racism training and undertake ongoing work to ensure the workforce is culturally competent, along with continuing to provide access to training tackling other forms of discrimination.

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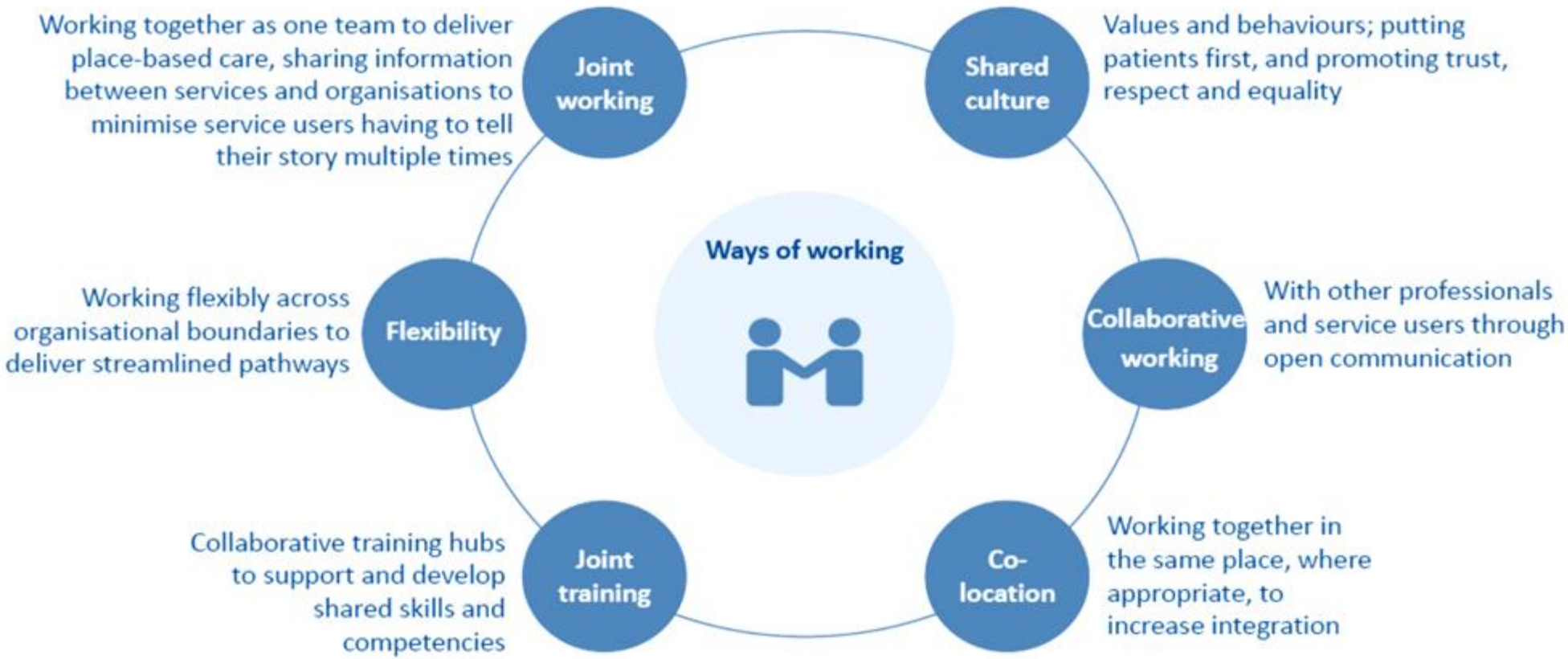
Workforce Ways of Working Summary

CYP	Working as an Integrated Care System for children and young people, families and their carers across North Central London



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Workforce Risks and Mitigations

There are significant challenges facing the workforce, particularly the clinical workforce, whilst this presents a level of risk, mitigating actions have also been developed

- ***Recruitment*** - Risk is based on the ability to attract enough applicants with the right competencies and skills to address the high level of current vacancies and future resource requirements to deliver the ICS CAMHS strategy. Future strategies will include additional sessions for existing staff and wider flexibility for staff across NCL to work across clinical divisions. Locum and agency will provide back-fill wherever possible. Training opportunities and increasing the skill matrix - Apprenticeship levy and peer support workers, nurse associates, graduate mental health workers training, leading to RMN pathways.

- ***Retention*** - Risk is based on the capacity and capability of the ICS partners to compete with staff opportunities in the private sector and agencies offering higher pay rates and better work life balance. Future plans include CAMHs engagement in HLP Pan London Staff retention wellbeing project. Current mitigation includes hybrid working at home and in clinic, flexible hours, weekend sessions available for staff and patients, greater mobility between divisions and roles to enable staff to step away from high stress areas of work but remain within CAMHS, increased supervision and group supervision as a preventative against burn out. Longer term strategies include review of roles and bands to identify career progression options for lower banded staff through the CAMHS system. Mentoring – Trusts mentoring junior nurses into more senior roles. Innovation staffing rotations – MH Trusts looking into rotations of staffing esp. into specialist placements.

- ***Cultural Competence*** - Risk is the timeline required to safely change the workforce composition to better reflect and relate to the NCL demographic. Short term mitigation is a challenge due to the current and future availability of candidates that reflect the diverse communities in which we work. More work is required in this area and will be a focus of the Workforce workstream in the CAMHS transformation. This will also link into the workforce sustainability work - creating new roles in CAMHS with new core competencies, increasing workforce skillsets.

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Digital, Governance and Data

Digital

As well as commissioning online services to offer direct support to CYP (e.g. Kooth), we will:

- Explore roll out of high quality platforms that facilitate digital assessment and support health promotion, such as the 'NCL virtual waiting room' with regular reviews built into the process, including reach and furthering digital inclusion.
- Engage with and make use of digital programmes such as HealtheIntent, Health Information Exchange and Digital First Primary Care to inform our practice and knowledge of our population's needs

Governance and Data

- We want to further align how we collect, align and use performance data across our Trusts to inform clinical and strategic developments. In 21/22, we plan to develop common datasets and reporting principles across all Trusts.
- Progress on our plans is monitored through a robust multi-agency governance structure as set out on the next slides
- In addition, commissioners and the Trusts lead meet weekly, as do Trust Leaders – providing routes to escalate and address challenges systematically.

The Tavistock MH NHS trust has developed the an **NCL virtual waiting room** to support families from the moment their referral is accepted by CAMHS, during their wait to be seen, throughout their episode of care and potentially beyond the point of discharge.

The platform provides CYP and their families with information and resources related the Service they were referred to and their borough of residence, it allows them to share goals, track mood and progress and get involved.

The NCL waiting room is being piloted within the Tavistock MH trust in services spanning all NCL boroughs and has the potential to roll out to other trusts.

It has also been optimised to enable use from devices located at services, to reach CYP and families without access to their own digital devices.

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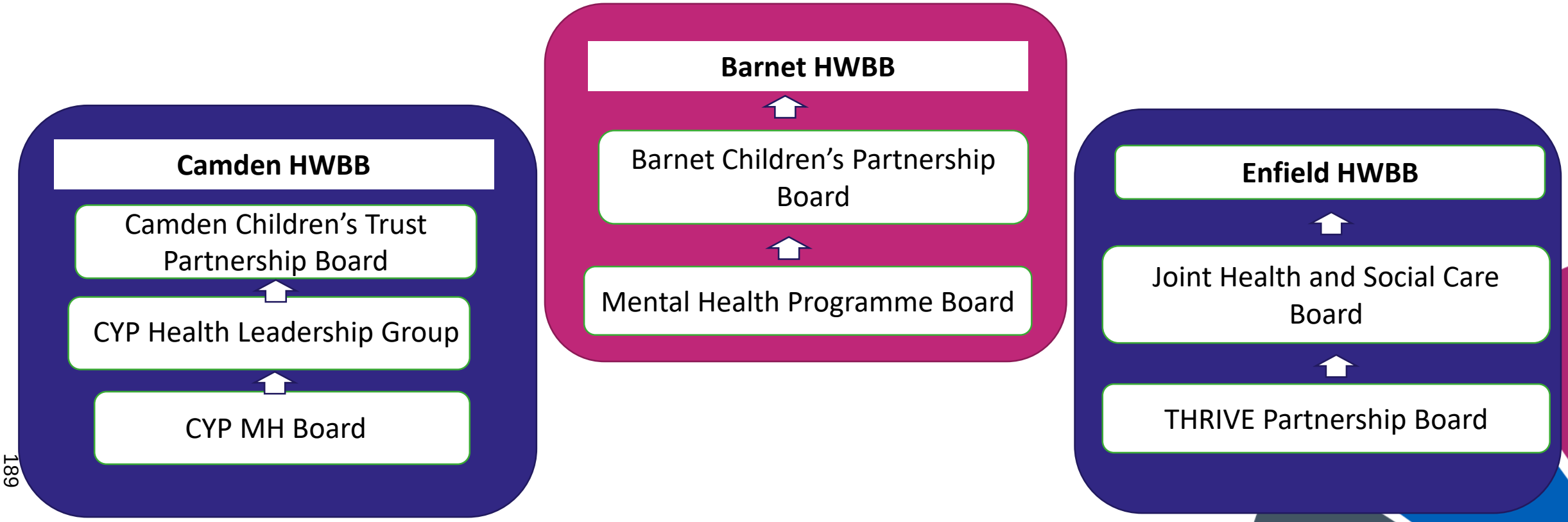
Our Governance

Each borough has a local CYP Mental Health Partnership Board bringing together local NHS, Local Authority, VCS and in some cases parent/carer and/or CYP representatives. These boards have oversight and accountability for NHS borough-based and LA funding, strategic direction and partnership working for CYP Mental Health in each borough. They both inform and are informed by NCL CYP MH Programme priorities. Local Health and Wellbeing Boards are key partners in the development of our ICS plan and the local action plans that sit beneath. Co-ordination across NCL is provided by an NCL CYP MH Delivery Board underpinned by key working groups. This reports up into the NCL ICS Mental Health Board. At present (Autumn 2021) we are reviewing governance to make sure that NCL and local governance interfaces work effectively.



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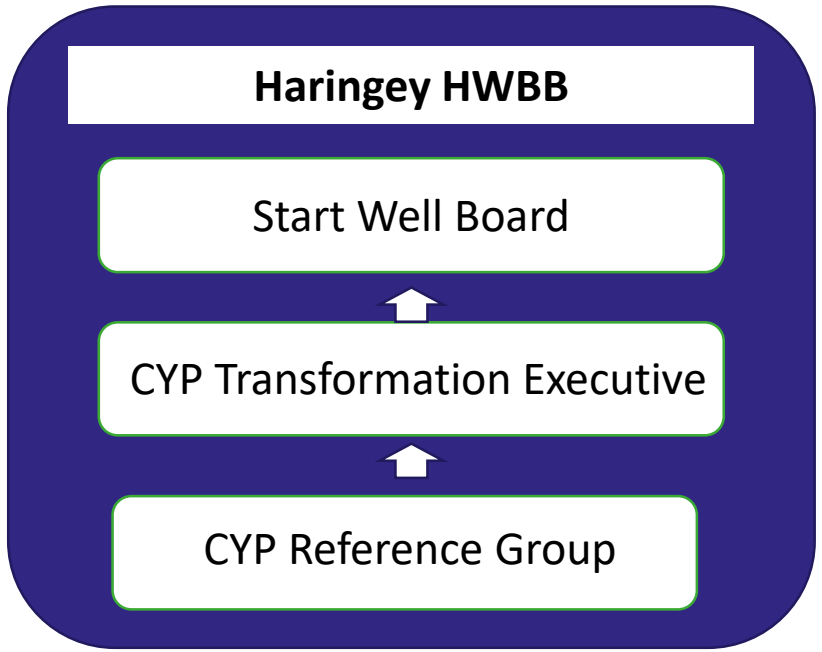
Our borough-based governance cont'd



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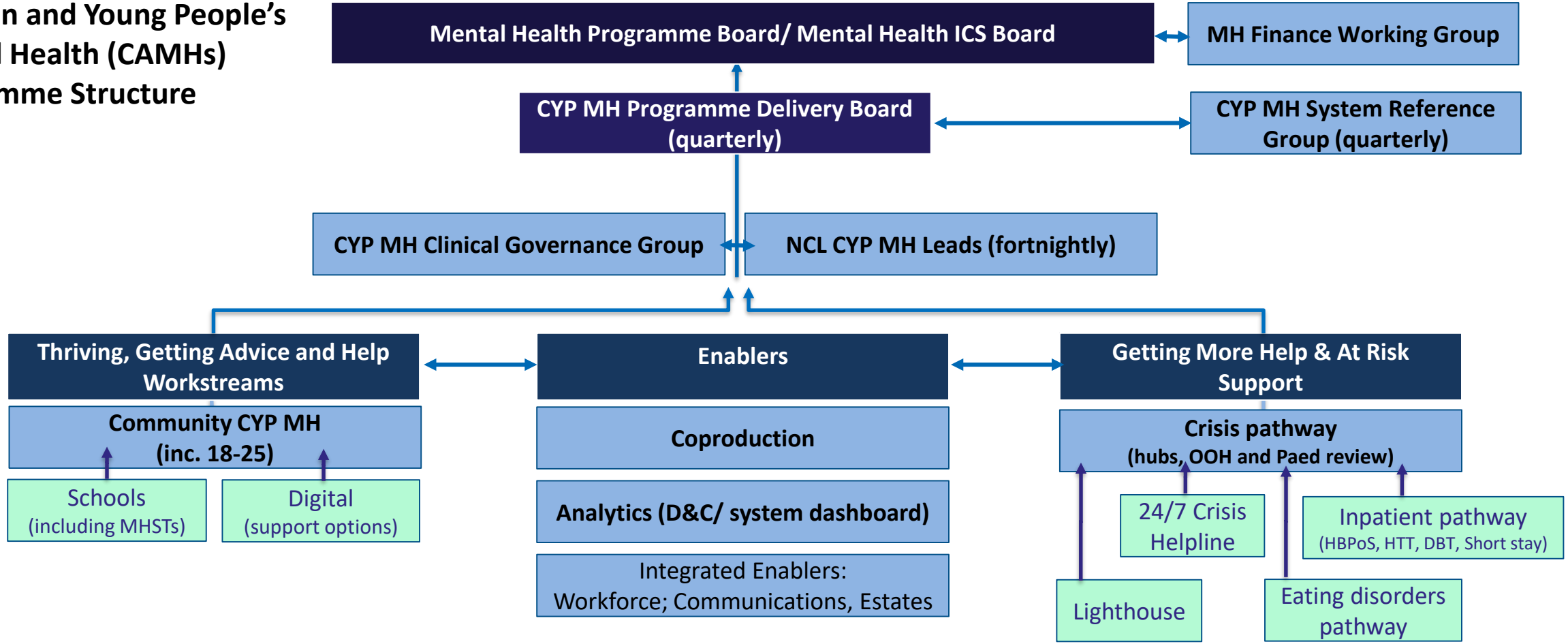
North Central London's Governance for CYP Mental Health (under review)

Children and Young People's Mental Health (CAMHs) Programme Structure



NCL CYP and MH partners continue to work collaboratively across the breadth of primary care, community CAMHS, borough partnerships and NCL-wide pathways to ensure CYP receive safe, equitable care, regardless of where in the system they present. We also continue to work across NCL CYP and Paediatrics governance structures to ensure integrated models of care and CYP are receiving support for their MH needs wherever they present.

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21/22 NHS Funding Summary for NCL

Mental Health Investment Standard	Source of funding	MH Trust	Other NHS	Non NHS	Total £
Children & Young People's Mental Health (excluding LD)	MHIS	23,022	11,618	5,392	£40,032,000
Children & Young People's Eating Disorders	MHIS	0	2,394	0	£2,394,000
				Total	**£42,426,000**

Funding available - CYP Mental Health and Young Adults via System Development Fund and Spending Review		
	Source of funding	2021/22 allocation
Children and Young People's Community and Crisis	Central / Transformation Funding (SDF)	£2,297,000
	Spending review settlement	£1,543,000
Children and Young People's Eating Disorders	Spending review settlement	£411,000
Young Adults (18-25)* Young Adults is within the NCL Adult Community Transformation Workstream	Central / Transformation Funding (SDF)	£686,000
	Spending review settlement	£446,000
	Total Central / Transformation Funding (SDF)	**£2,983,000**
	Total spending review settlement (SRS)	**£2,400,000**
	Total SDF + SRS	**£5,383,000**

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MHST and 4WW SDF funding TBC (£4,960,000 in 2020/21).
This does not include any Local Authority Children's and Young People's funding.

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NCL Partners
Providing CYP MH and Wellbeing Services

Borough	NHS Service Providers
Barnet	Specialist CAMHS services are provided by Barnet Enfield and Haringey Mental Health NHS Trust and Royal Free London NHS Foundation Trust. The services commissioned are Eating disorders and Tier 4 specialist inpatient service.
Camden	Specialist CAMHS services are provided by the Tavistock and Portman NHS Foundation Trust and Royal Free London NHS Foundation Trust (ADHD CAMHS)
Enfield	Barnet Enfield and Haringey Mental Health NHS Trust. Enfield has a spot contract arrangement with South London and Maudsley NHS Foundation Trust, and the Tavistock and Portman NHS Foundation Trust.
Haringey	Barnet Enfield Haringey Mental Health NHS Trust, Tavistock and Portman NHS Foundation Trust, Whittington Health NHS Trust for the Parent Infant Psychological Service.
Islington	Specialist CAMHS services are provided by Whittington Health NHS Trust Tavistock and Portman – Child and family and adolescent clinic
NCL wide	Royal Free London NHS Foundation Trust - Out of hours Nursing Service. Royal Free London NHS Foundation Trust - Intensive Eating Disorder Service NSPCC, UCLH & Tavistock and Portman – Lighthouse

Borough	Non NHS Service Providers
Barnet	Mental Health Support Teams Health & Justice liaison and diversion CAMHS in schools Children and Young People's Wellbeing Practitioner (CWP) services Xenzone – online counselling Barnet Integrated Clinical Services (BICS)
Camden	Brandon centre – counselling and psychotherapy and parenting (jointly funded with London Borough of Camden) Strength and Learning through Horses (LB Camden) Coram Creative therapies (LB Camden) Fitzrovia Youth in Action – peer support Manor gardens – parental peer support (LB Camden funded) Depaul Camden Kaleidoscope (supported housing) Catch 22 (Adolescent Mental Health)
Enfield	Brandon Centre
Haringey	Brandon Centre Open Door Haringey Mind Haringey Shed Deep Black
Islington	Mental Health Support Teams – School Wellbeing Service (provided by Whittington Health and London Borough of Islington) Tavistock and Portman – Child and family and adolescent clinic Xenzone – online counselling * Barnardos – Third sector counselling and therapeutic service * Isledon – Emotional Wellbeing workers * Brandon Centre – young people counselling and psychotherapy * Islington Council - TYS counselling *
NCL wide	Kooth – online counselling

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AGENDA ITEM 14

	Health and Wellbeing Board **9th December 2021**
Title	**North Central London Clinical Commissioning Group Strategic Review of Community and Mental Health Services**
Report of	NCL CCG - Strategic Review of Community and Mental Health Services
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix 1 - NCL Community and Mental Health Services Strategic Review (slides)
Officer Contact Details	Jo Murfitt Programme Director for NC London CCG Strategic Reviews of Community and Mental Health Services joanne.murfitt1@nhs.net

Summary

This brief update is intended to provide members with the latest update on the community and mental health services review.

Recommendations

The Health and Wellbeing Board is asked to note the progress of the NCL CCG reviews of community and mental health services.

1. WHY THIS REPORT IS NEEDED

1.1 This report is needed to provide the latest update on the community and mental health services review.

1.2 At a previous meeting North Central London Clinical Commissioning Group (NCL CCG) presented an update on their work to review community & mental health services

across the five Boroughs of North Central London. The previous report noted that as a result of historical variations in the level of spending residents across NCL experienced differential impacts on the level of services they receive e.g. in terms of access criteria, opening times etc. The CCG as one organisation is determined to address this variation in service accessibility as part of its wider approach to reducing health inequalities and to improving the health and health outcomes of all its residents.

1.3 The slides accompanying this report set out details of the findings of the initial stage of the reviews. This has resulted in two cases for change which are available on the CCG's website and which provide more details e.g. about levels of deprivation, the impact of Covid especially on mental health services as well as some of the challenges faced by services. For example in Barnet the report highlights issues such as waiting times for therapy services, the numbers of District nurses as well as for example the fragility of some very small services e.g. the bowel and bladder service where there are gaps in staffing and the service is struggling to recruit to vacant posts.

1.4 The slides then provide an update on the core service offer and the implications of its delivery in full. Over the summer a series of iterative workshops were held involving a wide range of CCG staff, clinical and commissioners, Local Authority colleagues, staff from Provider Trusts along with experts by experience and some residents and community & voluntary groups. These workshops led to the development of an agreed set of core service offers including a coordinating function to support service delivery. An example of the coordinating function is provided for community service but is equally applicable to mental health services. This sets out the importance of the coordinating functions i.e. a central point of access, a trusted assessment function and then case management. These proposals reflected feedback from both earlier work that organisations such as Healthwatch had lead and from discussions at meetings and presentations held by the CCG and with the CCG's Residents Reference Group as part of this work. The feedback unanimously was that local people wanted easier access to services and wanted to tell their story once and then have it shared (with patient consent) so they did not need to constantly repeat the information. A set of coordinating functions would help deliver this request.

1.5 Included in the slides is also an example of a core service offer for district nursing. This sets out the type of skills and competencies expected e.g. to be able to provide intravenous antibiotic drugs in a person's home, as well as setting out who can access the service, where its provided and how the service works or interfaces with other services e.g. for community nursing there will be close local working with GP practices, but also with the Extended Care Team that will support people living in Care homes etc. As part of the Core service offer there are approx. 50 service descriptions for community services and a similar number for mental health services. All these have been developed to reflect best clinical practice and where possible incorporate best local NCL practice e.g. plans to implement a Thrive model and Minding the Gap (a wraparound service for young people) across all NCL Boroughs.

1.6 The slides set out why implementing the full core service offer will bring system and patient improvements and these benefits are being further explored as part of the current phase of work, which is to understand the non-financial impact assessment of delivering the core service offer in full. Four domains are being used to undertake this analysis; access, quality, equality and equity and workforce. This should help the CCG and its partners understand more about the opportunities that should be possible as part of these reviews. E.g. for quality both reviews have as a focus the need for prevention and early intervention and to move away from the current focus on emergency and crisis care. In time this should bring opportunities to review the current bed base and to move away from the current focus on emergency and crisis care. But

until that is safe and out of hospital services are sufficiently developed the CCG and its partners must use the opportunity for investment in preventive services to help move away from current models of delivery. An example of this is the need to invest to reduce waiting times for speech and language therapy, as there is evidence that early intervention helps some children' development and can in turn have an impact on reducing the need for mental health services.

1.7 The work on understanding the non-financial impact assessment should be completed in the following weeks and will be combined with work that is taking place to understand the staffing costs including inner and outer London weighting, overhead costs and for example work to be able to compare service lines and understand efficiencies. Provider colleagues have been sharing data to allow these comparisons to take place, and again this work is due to be completed by mid-December. It will, alongside completing the non-financial impact assessment, help the CCG in developing a menu of approaches which will help it fund the consistent delivery of the core service offer. Although the work to fully understand the costs and opportunities is still being developed it is likely that approaches to funding will be based on a combination of transformation i.e. looking at opportunities for productivity and efficiency benefits and doing things differently, along with some at scale provision especially for services that are very fragile and difficult to attract a workforce and some investment differentially to reflect the needs of a particular Borough. NCL has already taken that approach e.g. with the use of the Mental Health Investment Standard and with the allocation of the Ageing Well funding and its use to fund the Extra Care Home team in Barnet.

1.8 Discussions are also in progress with Mental Health colleagues. Barnet, Enfield and Haringey MH Trust & Camden & Islington FT are working together on the first phase of a review. This has been focused on four themes; reducing health inequalities, eliminating unwarranted variation, improving outcomes for local patients and developing a sustainable workforce model. Part of the next steps of this and the CCG's review is to look together at opportunities for alignment and agree a transition delivery plan for mental health services. At the same time work continues with mental health colleagues to focus on how existing investment can help deliver the core service offer.

1.9 As part of working through next steps a series of discussions are being held with Borough partners and the ICS to consider a plan for prioritisation, funding and delivery. Work on this will continue during December and into January/February. Work is in progress to look at fragile services, noting this is about the options for delivering the management of the service rather than the interface with patients. The core service offer sets out where a service will be provided but this an opportunity to think differently about how services might be organised and how if there were larger services covering a wider footprint might these be more resilient, offer opportunities on skill mix etc. This is becoming more of a priority given the workforce challenges in terms of recruitment and retention for a number of smaller services e.g. Bowel and Bladder services in Barnet, our Community paediatrics, our children continuing care assessment team etch as well as for services such as tissue viability or possibly falls etc.

1.10 The CCG is anticipating that the current phase of work i.e. to better understand the opportunities that consistently delivering the core service offer would bring along with the costs of doing so, are being developed. It is clear already that the costs required will likely be considerable and will not be found overnight, so the CCG expects to develop a three year transition plan to move to full implementation of the core service offer. However to find the funding will require considerable service transformation and the support of the Acute Sector who are likely to have to contribute funding but agreeing less money for themselves. Hence the importance of having confidence in the system benefits of implementing the core service offers. The funding plans also

have to recognise the current workforce challenge and that Providers are currently struggling to find workforce to fill existing vacancies. The development of the Integrated Care System, working with Borough and Borough Partners will all help contribute to the delivery of the core service offer, but this will require deeper integration and different ways of working to fuller realise its benefits for local people.

1.11 Moving into the New Year the CGG will continue its round of discussions, currently with Local Authority partners, but then with Provider colleagues as it seeks to develop its plans and have more detailed discussions on next steps. Although the intention is to have developed more detailed plans during first months of 2022, implementation will only start after April 2022, as plan are worked through to provide the level of detail and confidence to start delivery and when we are assured that appropriate engagement and discussion has taken place.

2. REASONS FOR RECOMMENDATIONS

The Barnet Health & Well Being Board are asked to note the progress of the reviews to date and the next steps.

A further review will be brought with more details at the next meeting.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

Not applicable.

4. POST DECISION IMPLEMENTATION

A further report providing more details on delivery plans will be presented.

5. IMPLICATIONS OF DECISION

5.1. Corporate Priorities and Performance

One of the aims of the Barnet Joint Health and Wellbeing Strategy is to improve the health and wellbeing of the local community and reduce health disparities for all ages which is aligned to the Council's Corporate Plan.

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

Not applicable in the context of this report.

5.3. Legal and Constitutional References

The terms of reference of the Health and Wellbeing Board, which is set out in the Council's Constitution Article 7, includes the following responsibilities:

• To promote partnership and, as appropriate, integration, across all necessary areas, including the use of joined-up commissioning plans across the NHS, social care and public health. To explore partnership work across North Central London where appropriate
• 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 wellbeing.
• Specific responsibilities for overseeing public health and developing further health and social care integration

5.4. Insight

As set out above.

5.5. Social Value

Not applicable in the context of this report.

5.6. Risk Management

Identified risks and risk management actions are as follows:

Risk 1: The scope and complexity of reviews may put the timelines under pressure as well as creating potential issues with ensuring all partners have adequate capacity to contribute, particularly during a pandemic and then recovery phase. This will likely be exacerbated during the winter period given the continuing challenges of Covid, plus flu etc.

Mitigation; Management includes oversight by Programme Boards, joint community and mental health steering group including representation from other reviews, regular meetings with Review Design Partners Carnall Farrar and active communication and engagement strategy with Providers, Local Authority, partnership groups and residents on review, timescales etc. Review existing meetings for opportunities to discuss review rather than set up new meetings.

Risk 2: The review may suffer a lack of engagement by partners and especially residents and service users.

Mitigation: A Comms and Engagement Strategy has been produced and is being updated. The programme so far has used existing groups to talk to local residents, other partners such as the Local Authorities, Healthwatch etc. A Residents Reference Group has been set up, a resident's survey has been undertaken over a 3 month period, and there has been attendance at a range of borough based groups including attendance at events set up by partners in Barnet. Triangulation has shown that the programme has engaged with a comprehensive range of groups by borough, age, diversity etc. However once decisions are made on new steps in terms of delivery of further engagement and discussion will be required.

Risk 3: The review will need to agree how the potential costs of delivering a core service offer across all Boroughs might be funded within the context of the ICS financial strategy and current CCG financial position.

Mitigation: A Financial Sub-Group has been set up and as part of the Reviews we will be assessing the financial impact. A costing methodology has been agreed between

Carnall Farrar, the CCG and Providers Chief Financial Officers on approaches to costing. Further work is in progress to review financial data and look at opportunities for funding within the ICS financial strategy.

Risk 4; The scope of the review may expand to include a wider range of issues than originally set out in the aims and objectives for the review.

Mitigation; Review of Terms of Reference and restating of overarching aim to create sustainable and affordable service models for community and mental health services which seeks to address inequalities in service provision, spread good practice and improve outcomes for residents of NCL. Regular updates to stakeholders and users/residents etc. on aims and objectives. Steering group recording comments on wider issues e.g. primary care services that will be useful in sharing with other CCG reviews.

5.7. Equalities and Diversity

Decision makers should have due regard to the public sector equality duty in making their decisions. The equalities duties are continuing duties they are not duties to secure a particular outcome. The equalities impact will be revisited on each of the proposals as they are developed. Consideration of the duties should precede the decision. It is important that Cabinet has regard to the statutory grounds in the light of all available material such as consultation responses. The statutory grounds of the public sector equality duty are found at section 149 of the Equality Act 2010 and are as follows:

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.

Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

a) Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
b) Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
c) Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

a) Tackle prejudice, and
b) Promote understanding.

Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act. The relevant protected characteristics are:

a) Age
b) Disability
c) Gender reassignment
d) Pregnancy and maternity
e) Race
f) Religion or belief
g) Sex
h) Sexual orientation
i) Marriage and civil partnership

Advice on completing Equality Impact Assessments (EIAs) can be found here

The CCG has completed an initial Equalities Impact Assessment which is available and will undertake a further review once the plans start to be developed to support implementation.

5.8. Corporate Parenting

Decision makers to consider whether the decision may have a direct or indirect impact on looked after children and care leavers. If there are likely impacts, to consider and provide details and what steps have been taken to mitigate them.

Not applicable

5.9. Consultation and Engagement

The NCL CCG Comms Strategy includes newsletters, website and bulletins to various groups e.g. GPs, community staff, mental health staff.

The engagement plan includes, for example, a Resident's Reference Panel, involvement of service users and carers, plus voluntary sector in design workshops and user representation at Programme Boards. Actions also include attendance for discussion at key partnership and community groups, as well as internal work to link with CCG's communities' team to work with groups whose voice is seldom heard.

A revised plan will be developed to build on the engagement work already undertaken.

6. BACKGROUND PAPERS

Link to Baseline Reports on CCG website.

Strategic reviews of community and mental health services - North Central London CCG

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NHS

NCL Community and Mental Health Strategic Reviews

Barnet Health and Wellbeing Board: 9th December 2021

Recap on rationale, context and ambitions for strategic reviews

- Earlier work undertaken by NCL CCG identified a significant range of service variations in access, availability, quality and cost of current provision as well as substantial fragmentation, which was considered a barrier to providing more care in community settings and impacting on the delivery of care for key groups e.g. CAMHs.

- This was confirmed by both clinical feedback and patient feedback which highlighted the variation in access, criteria and availability per borough of specific services resulted in greater reliance on acute care for community services and more admissions under the Mental Health Act for those with a mental health illness. Patient feedback also highlighted the view that nobody should have to navigate the system in order to receive care.

- For example, one variation is criteria for step down or rehabilitation pathway beds across NCL. If you reside in Camden, you have access to high quality rehabilitation bedded care. If you reside in Haringey you have access to step down bedded capacity without the same rehabilitation focus. This complexity and variation has a huge impact on length of stay and quality of discharges.

- The development of a core consistent and equitable offer for community and mental health services would therefore achieve the following ambitions:

  - ❑ A core consistent equitable offer for community and mental health provision that could be easily accessed and navigated by other services and patients themselves
  - ❑ Contribute to addressing the need for health equity recognising the key role local community and mental health services play at place level
  - ❑ Reduced reliance on inpatient care and improve the quality and equality of community based pro-active and preventive services
  - ❑ Provide the foundation for integrated care and a population health improvement approach to service delivery at place level
  - ❑ Reduce unnecessary back office and overhead costs associated with fragmentation and duplication
  - ❑ Ensuring a sustainable and resilience workforce and at scale solutions for fragile services
  - ❑ Contribute to mitigating the impact of Covid in terms of increased demand and backlogs

Work to date and headline findings

- NCL CCG currently spends £250m on community services. Across the 5 Boroughs there are differing levels of NHS spending on Community services from £117 in Haringey to £232 in Islington. The Barnet spend is £158 (figures based on NHS community spend per capita unweighted 21/22). The current disposition and availability (opening hours, range of services etc.) is largely based on the historic funding available to the 5 legacy CCGs in NCL and not generally related to need of populations based on age, deprivation, ethnicity etc.

- The reviews have identified examples of where variation including staff competencies, thresholds for admission to services etc. have led to different service experiences for patients. These variations have wider implications as well and impact on other partners including the Acute sector, London Ambulance Service etc.

- For Mental Health, NCL currently spends £350m. The variation in spend per head is between £160 in Barnet to £264 in Camden (figures based on NHS Mental health spend per capita unweighted 21/22). Analysis of finance and activity shows that service provision and investment do not correspond with level of need. For example in Haringey Children & Young People (CYP) have a higher mental health need relative to other boroughs and have the highest number of CYP presenting at A&E with a mental health need, but spend per head in on CYP is lower than NCL average.

- There are a number of examples of specific workforces under pressure, especially small services e.g. Looked After Nurses in Enfield, Special school nursing in Enfield, Bowel & Bladder nursing in Barnet, as well as community paediatrics and CAMHs nursing across all 5 Boroughs. All of the 5 Boroughs have examples of these small services which generally have longstanding vacancies, limited clinical leadership and little skill mix.

- There are increasing workforce challenges with local Providers competing for staff with resulting costs as staff seek higher grades. This also limits opportunities for larger and more resilient teams able to benefit from skill mix etc.

- Current fragmented arrangements in NCL do not easily facilitate a collective approach to delivery and there is a danger of a lack of alignment with different IT systems, shared records and equipment which will reduce the opportunities for a more coherent offer.

- Equally, the fragmented disposition of services potentially increases costs, particularly where these are duplicated or overlapping.

Work to date and headline findings

- Analysis shows that not only are services fragmented, but service provision and investment do not correspond to the level of need: For example:
  - ❑ Waiting times for children's therapy assessments are between 5-7 times as long in Barnet as in Camden, which is linked to the size of the workforce, which is 5 times as large in Camden as in Barnet
  - ❑ For children's nursing Barnet has 0.4 FTE per 10,000 0-18s, whereas Islington has 2 FTEs per 10,000 population. In Barnet 22% of population are aged between 0-18, in Islington it is 15% aged between 0-18
  - ❑ For District Nursing Barnet had 19 registered FTEs undertaking 4435 average contacts per month; Islington had 30 Registered FTE undertaking 6602 average contacts a month. Barnet's over 65 population is 14% compared with Islington's over 65 Population at 9%
- Provision is fragmented; For Community; BEH providing Enfield, Whittington providing Haringey and Islington with CNWL providing Camden and CLCH providing Barnet.
- Gap analysis shows that Barnet has gaps in the existing core service offer e.g. early intervention, or for Children Hospital at Home as well as the proposed new services e.g. Central point of access and trusted assessor function. However, the gap analysis does not show a more detailed position on service gaps i.e. vacancies or where services, although provided, do not deliver the broader aspects of core service offer.
- NCL CCG is already investing in Barnet via the Ageing Well Programme, for example, by investing in an expanded permanent Extended Care Home Teams, intended to support care homes and reduce emergency admissions etc.

NORTH LONDON PARTNERS
in health and care

NHS

A core offer has been developed for different age segments of the population and consists of core offer outlines, coordinating functions and specifications for services

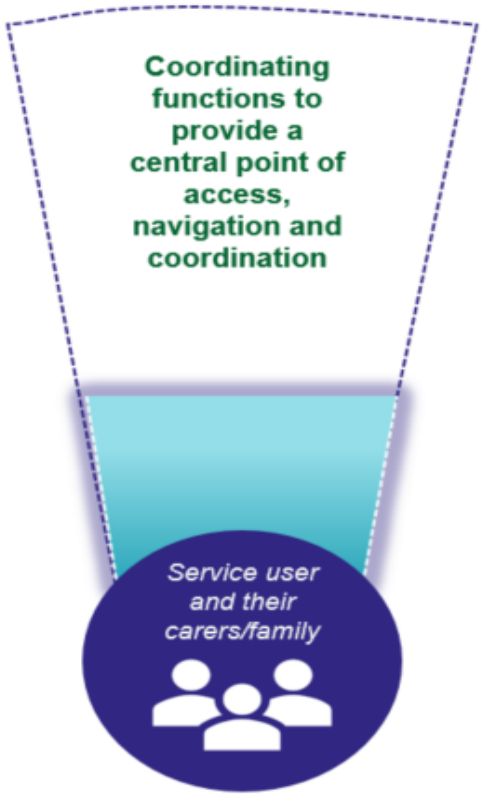
Core offer outlines provide a summary of elements and services that are part of the core offer for each age profile. The outlines also show elements not within scope of the review but that should be linked in with the core offer, as well as enablers.

Children and young people

Working age adults

Older people

Each outline also contains a set of **coordinating functions** encompassing a central point of access, care coordination and case management.

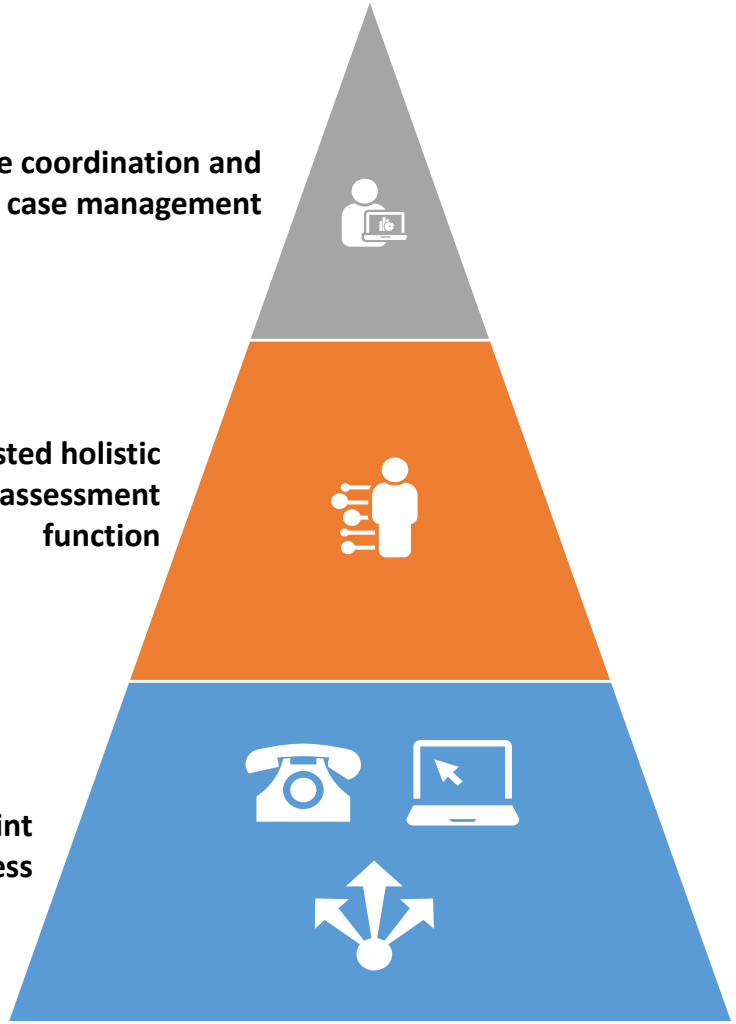


Following each core offer outline, in-scope elements are further detailed in a set of service descriptions. These provide a description of the element and lay out access criteria, hours of operation, capabilities required, where the element should be delivered, waiting times and how the element should link in with the wider health and care system.

The Core Offer – Coordinating Functions

A set of coordinating functions act to support, integrate and navigate care for service users across the layers of the core offer

Increasing complexity of need



- Service users with complex needs are allocated a clinical **case manager**. This individual leads the development of a **holistic care plan and its delivery**
- Care coordinators support this through **organising MDT meetings** and supporting service users and their families and carers to **navigate health and care appointments**

- Service users have **a single up front holistic assessment of their health needs, functioning, living environment & preferences**
- This is conducted by a senior professional with trusted assessor competencies who has the trust of the full MDT
- Service users and their families and carers **only have to tell their story once**

- Central point of contact at borough or NCL level for initial referrals and contacts with local community and MH health services
- Provides telephone and/or email hub which **directs referrals or queries to the right individual or service**
- Accessed by any health or care professionals, by service users and families / carers
- Administrators have access to directory of local services and assets and are able to **help service users and professionals navigate the wider available support**

Implementation of the coordinating functions will be key to delivering the full potential benefits of the core offer

The **coordinating functions** are **key to realising the potential benefits** from implementing the core offers for both community and mental health services. The coordinating functions act to support, **integrate and navigate care** for service users across the layers of the core offer.

The coordinating functions consist of:

- **A central point of access, including care navigation:**
  - The main purpose of the central point of access is to move people seamlessly through services by acting as a central point of contact. The care navigation function acts to give advice, information and signposting.

- **A trusted holistic assessment function**
  - Acts to ensure that service users with complex health and care needs can have a single up-front assessment to enable an initial holistic care plan to be co-developed

- **Care coordination and case management**
  - Care coordination links service providers, ensuring effective communication, monitoring service delivery, preventing duplication of services, identifying gaps in care, and assuring better health outcomes, particularly for service users with complex medical or behavioural health needs.
  - Case management helps to integrate services around the needs of individuals with long-term conditions and complex needs. It is a targeted, community-based and pro-active approach to care that involves case-finding, assessment, care planning, and care co-ordination.

Case studies have shown that implementing a set of coordinating functions like these can lead to benefits realised in several areas, including acute savings.

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Example; Draft specifications

Working age adult | Older person

Contains national requirement targets

Core offer care function:	District nursing

Overview

Description of the care function

Provide 24 hour care to housebound* patients including routine bladder and bowel care, wound care including post surgical wound care, pressure ulcers and leg ulcers, LTC management, IV and controlled drug administration. Provide support for families and carers alongside formal care workers to maintain independence and unnecessary prevent hospital admission.

To provide specialist clinics for leg ulcer care for ambulatory and non ambulatory patients (exact cohort to be defined).

Supported by specialist input from other community services (e.g. bowel and bladder services and tissue viability) as required

On the assumption that national funding is agreed ; to provide vaccinations to 'housebound patients and those living in a care homes

Capabilities required

Leg and Pressure Ulcer Care, Wound care, naso-gastric and PEG feeding management. Phlebotomy, Palliative care, syringe drivers, Catheterisation, give Intravenous antibiotics, administer controlled drugs, skill mix needs development with other community staff to provide accountability & continuity 24/7

Who the care function is for

Over 18 housebound patients and ambulatory patients with leg ulcers (cohort to be defined)

How the function is accessed

Primary care referrals, referrals from other community services, referrals from intermediate care via integrated discharge team.

Linked into central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Service user's home Including Care Homes and in hostels and other homeless accommodation. Leg Ulcer Clinics	24/7 Ambulatory Leg Ulcer Clinics 9-5 Mon - Fri	Within 48 hours prioritised on need	As by clinical assessment and care plan

Integration with wider health and care system

Aligned to geographical localities. Work alongside primary care and practice/PCN extended roles with expectation of named point of contact in team for each GP practice.

Close working relationship with specialist nursing, palliative care and other community health services, community beds, adult social care and community Mental Health Services as well as the voluntary sector.

Work closely with acute services in particular, elderly care wards.

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NHS

Benefits of Implementing the Core Offer

- The benefits associated with the core offer are multiple and the COVID pandemic has resulted in a context of significant increased demand on all parts of the health and care system.

- This has resulted in large numbers of patients waiting for both elective treatment and cancer diagnosis/treatment. Although part of the national accelerator programme, NCL still has a large backlog of people waiting over 52 weeks for Treatment as well as waits within community, primary care and mental health services which are addressing unmet demand.

- To be able to truly focus on elective recovery and restoration, Acute Trusts have to be confident that they have capacity both from a bed perspective, but also from a clinical and managerial perspective to focus on this important recovery task. However there are pressures on acute beds from more emergency admissions, as well as pressure on A&E.

- To support system recovery community services must keep more people at home, support people in the community (including care homes) better manage their long-term conditions, and when necessary support and enable the clinically safest and earliest discharge possible. This work is starting with investment in Care Home Teams, but further investment is needed to reduce activity before it reaches a hospital.

- There is evidence to suggest that there is a link between community investment and acute activity. For example Camden & Islington's higher spending on community services seems to be linked to smaller number of avoidable admissions, 9.6 based on 1000 weighted population 2019/20 Islington rates when compared with Haringey at 10.2.

NORTH LONDON PARTNERS in health and care

Early work on the impact assessment shows there are benefits to be taken from implementing the core offer . Example for Community Services

Access

- Standardised service provision aligned to clinical best practice
- Extended opening hours and access to OOH services – more convenient access to services
- Standardised waiting times (e.g., to first contact and follow up)
- Improved access through central points of access

Quality

- Following clinical best practice and national guidance
- Focus on prevention and early intervention
- Help service users stay well and avoid hospitalisation
- Support timely and safe discharge from hospital
- Enhanced service offer for older people

Equity and equality

- Consistent and standardised offer so all NCL residents have equitable support
- Interdependencies with other agencies so residents receive holistic, joined-up support that focuses on wider determinants of health
- Resource distribution aligned with need

Workforce

- Collaborative ways of working with other professionals across agencies and organisational boundaries
- New roles and skill mix, with staff working at the top of their license
- Improved staff satisfaction, supporting recruitment and retention

This work is also linked into our review of costs so we can get a fuller picture of both non financial and financial impact of fully implementing the core service offer

Next steps

- Moving into new phase focused on understanding financial implications of delivering core service offer consistently across all Boroughs.
- This will include benchmarking across a range of domains and testing for value for money, efficiency potential to support reinvestment into core offer delivery.
- Further discussion on deliverables and outcomes in relation to the core offer, exploring options for some at scale provision to achieve efficiencies and reduce overhead costs and a consistent outcomes framework across NCL which measures the impact of the core offer.
- Starting a round of discussions with Local Authority Officer leadership to explore the reviews and discuss local delivery.
- Further discussions with Local Authorities and integrated care partnerships to explore their role in the implementation of the core offer as the foundation for integrated care delivery between primary, community, mental health, social care at place.
- Planning a process to review priority areas e.g. fragile services because of clinical risk. Should changes drive a different delivery model and determining whether there needs to be prioritisation between service resilience and clinical quality in comparison to a more local service which lack these.
- Working with Mental Health Providers to look at opportunities to reduce inconsistency and service fragmentation e.g. CAMHS services across NCL have a range of different providers who are struggling to come to grips with challenges such as workforce and rising demand
- Determining pace of change and what are the risks that might need mitigation as part of this.
- Developing realistic financial plans underpinning implementation of the core offer that considers the context of national planning guidance requirements and the developing ICS.
- Next phase communications and engagement to ensure continued coproduction and collaboration with patients/carers and partners. This will include an updated comms and engagement plan to ensure appropriate engagement input and discussion

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AGENDA ITEM 15

	Health and Wellbeing Board **9 December 2021**
Title	**Better Care Fund Plan 2021-22**
Report of	Executive Director, Adults and Health
Wards	All
Status	Public
Urgent	No
Key	Yes
Enclosures	Appendix 1 "Final BCF 2021/22 Narrative" Appendix 2 "BCF planning template"
Officer Contact Details	Muyi Adekoya, Head of Joint Commissioning – Older Adults and Integrated Care Muyi.adekoya@nhs.net

Summary

The Better Care Fund (BCF), operating since 2014-15, is the current national policy approach for integrating health and adult social care. Spanning the NHS and local government the BXF seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible. The policy stipulates that local plans are overseen by each Health and Wellbeing Board (HWB) across England.

Our local BCF plan has a total pooled budget of £39,995,465 for the financial year 2021-22, covering schemes that support the core work programmes of for delivering placed based care, managing transfers of care, prevention and system flow.

Usually, national BCF guidance is issued each December for the following financial year's BCF plans. The Barnet HWB then approves the Barnet BCF plan in the subsequent spring, for submission to NHS England, and the plan is then enacted for the new financial year. Due to the impact of the pandemic, the Better Care Fund policy guidance and associated financial uplifts was only released on 30th September 2021.

Barnet's BCF plan therefore, reflects arrangements that are to a significant extent already in existence, since we are now 8 months into the financial year. Nevertheless, we will still aim to maximise the impact that we can have during the remainder of the year.

This report presents the 2021-22 BCF Plan for approval.

Recommendations

1. **That the Health and Wellbeing Board approve the Barnet Better Care Fund plan for 2021-22.**

1. WHY THIS REPORT IS NEEDED

1.1 The Better Care Fund (BCF), one of the biggest incentives for the integration of health and social care, requires Clinical Commissioning Groups (CCG) and Local Authorities (LA) to pool budgets and to agree an integrated spending plan for how they will use their allocation.

1.2 This report sets out how the local plan addresses the BCF planning requirements and the metrics conditions that must be satisfied in order to receive assurance from NHS England.

2. REASONS FOR RECOMMENDATIONS

2.1 The BCF has been in place since 2014-15 and is a mechanism for joint health and social care planning, service commissioning and delivery of activity to patients'/residents. The BCF schemes provide residents with integrated health and social care services, resulting in an improved experience and better quality of life.

2.2 This report sets out the trajectories for the 5 metrics that the CCG/ LA will be measured against, together with a summary of the plan that support these measures, as well as presenting the BCF budget for sign-off

2.3 PROGRESS TO DATE

2.3.1 Full details of the 2020-21 achievements are set out in the supporting narrative. A summary is provided below.

2.3.2 NHS and local authority joined up working has been key to supporting the pandemic response on a range of fronts and is now instrumental to the recovery. A journey that has highlighted and brought into focus the health inequalities that affect areas of our local footprint. Key areas where the BCF is having an impact are:

- Enabling more residents to stay at home for longer
- Reducing pressure on carers, who have been under increased pressure during the pandemic

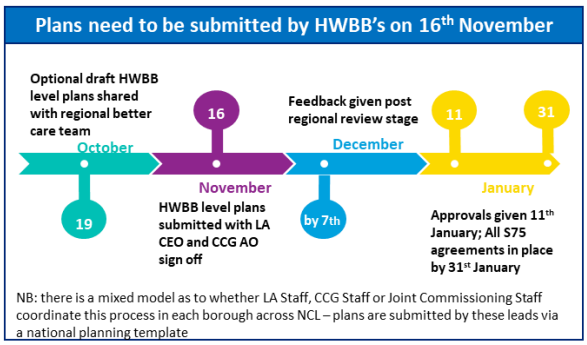
- Providing additional support to hospital social work and discharge teams, which in turn enables better hospital flow for patients presenting in A&E who need to be admitted
- Enabling the development of systems and processes as part of local ICPs, including the development and support of neighbourhood models
- Providing greater access to preventative care to help reduce unnecessary admissions.

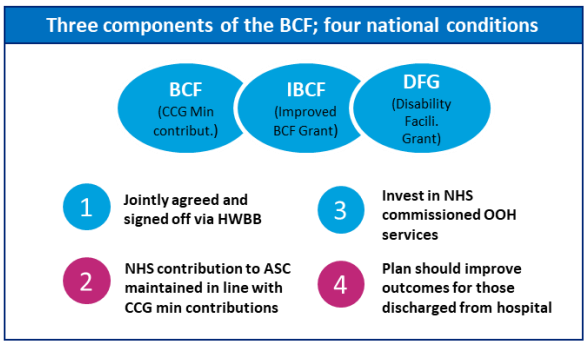
2.3.3 The 2021-22 plan reflects the local ambition to continue to support commissioned schemes that have adapted delivery models, in response to the pandemic, to ensure services and support to some of our most complex and vulnerable residents have been maintained (or even increased) during this time.

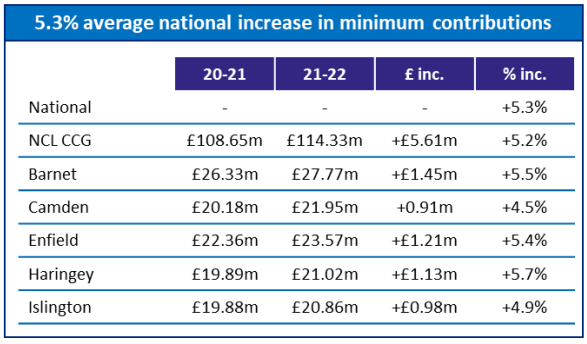
2.4 Better Care Fund Guidance 2021/22

2.4.1 The BCF guidance asks CCG and LAs to make submissions broadly consist of 3 components: (1) financial plans confirming levels of investment; (2) narrative plans confirming the borough approach to integration and commissioning collaborative discharge models; and (3) setting trajectories and ambitions for the BCF metrics that will be monitored for remainder of year.

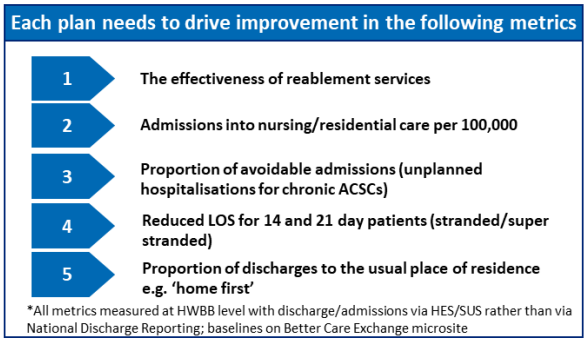
2.4.2 The diagram below summarises the key features of the BCF guidance, including the different funds, the timescales for submission, increase in minimum contributions required and the metrics on which we will be measured:







	20-21	21-22	£ inc.	% inc.
National	-	-	-	+5.3%
NCL CCG	£108.65m	£114.33m	+£5.61m	+5.2%
Barnet	£26.33m	£27.77m	+£1.45m	+5.5%
Camden	£20.18m	£21.95m	+0.91m	+4.5%
Enfield	£22.36m	£23.57m	+£1.21m	+5.4%
Haringey	£19.89m	£21.02m	+£1.13m	+5.7%
Islington	£19.88m	£20.86m	+£0.98m	+4.9%



2.5 Barnet's Better Care Fund 2021-22

2.5.1 The vision for this Better Care Fund period is to continue to invest in community-based services that will enable the local health and care system to deliver place-based services at the right time in the right place and support system flow.

2.5.2 As a continuation of the 2020-21 plan, the BCF Plan 2021-22 plan as shown in Appendix A is presented for review and support by the Health and Wellbeing Board.

2.5.3 CHANGES AND NEW DEVELOPMENT

2.5.3.1 **Financial**: The funding allocations for the 2021-22 BCF are summarised below:

Funding Sources	Income	Expenditure
DFG	£2,884,527	£2,884,527
Minimum CCG Contribution	£27,772,288	£27,772,288
iBCF	£9,338,650	£9,338,650
Total	**£39,995,465**	**£39,995,465**

2.5.3.2 Overall, there is a £5.7 million uplift to the CCG minimum contribution across North Central London, which is 5.2% of the total CCG contribution. Barnet received a 5.5% uplift.

2.5.3.3 **Delivery**: Our BCF narrative and financial template sets out our local approach for:

2.5.3.3.1 How collaborative commissioning of discharge services support managing transfers of care; taking into consideration the fact that Systems should have regard to the guidance on collaborative commissioning published by the Local Government Association (LGA)[1], in partnership with the BCF Programme

2.5.3.3.2 Providing details of planned spend on discharge-related activity.

2.5.3.3.3 How joint health and social care activity will contribute to the improvements agreed against BCF national metrics for discharge (reducing the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days).

2.5.3.4 **BCF Metrics:** We have worked with local stakeholders to develop a plan for the new BCF metrics.

[1] https://local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high

2.5.3.4.1 The targets have been triangulated with senior representatives at Central London Community Health Care Trust (CLCH and The Royal Free London (RFL), indicating that the targets set reflect the level of ambition agreed for local trusts. *This is particularly applicable to the unplanned hospitalisations and length of stay metrics.*

2.5.3.4.2 A summary of the metrics, together with 19/20 and 20/21 levels of performance is set out below (full details are available in the template). The regional lead for the BCF has provided CCGs with forecasting methods and in general the targets have been set on the basis of hitting or slightly exceeding the forecasted levels. The system has also taken into account the expected pressures that we are likely to experience over winter in the context of an upswing in non-COVID related A&E attendances and a potentially increase in the number of COVID-related admissions at the same time.

2.5.3.4.3

Metric	19-20 Actual	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	472.9	453.9	470.9

2.5.3.4.4

Metric		14+ days	21+ days
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for i) 14 days or more ii) 21 days or more, as a percentage of all inpatients	21-22 Q3	10.8%	4.3%
	21-22 Q4	8.7%	4.1%
	21-22 Q4	10.20%	5.40%

2.5.3.4.5

Metric	**Percentage of people, resident in the HWB who are discharged from hospital to their normal place of residence 21-22 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)*	92.2%

2.5.3.4.6

Metric	19-20 Plan	19-20 Actual	20-21 Actual	21-22 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)	327	503	502	486

2.5.3.4.7

Metric	19-20 Plan	19-20 Actual	21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into a reablement/ rehabilitation programme (% annual)	63.80%	87.00%	75.0%

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not Applicable

4. POST DECISION IMPLEMENTATION

4.1 Not applicable. All areas are required to submit a BCF Plan.

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 A breakdown of the proposed spend is set out in the main BCF plan for 2021-22, summary below.

Scheme name	Area Of Spend	Budget 21/22
		£
Seven Day Social Care Support	Local Authority	1,054,313
Seven Day Community Support	NHS Community Provider	2,568,717
Single Point of Access	NHS Community Provider	336,586
Social Care Demand Pressures	Local Authority	2,656,353

Scheme name	Area Of Spend	Budget 21/22
		£
Community Equipment	Local Authority	1,721,521
Enablers for integration LBB	Local Authority	895,638
Primary prevention & Early intervention and support closer to home	Private Sector	603,998
Community based integrated support	Local Authority	449,417
Intermediate Care in the Community - Step down	NHS Community Provider	10,060,026
Fracture Liaison Service	NHS Acute Provider	107,235
Intermediate Care in the Community - Reablement/rehabilitation	Local Authority	279,131
Quality in Care Home Team	Local Authority	271,512
Wellbeing Services	Charity / Voluntary Sector	622,950
End of Life care	Charity / Voluntary Sector	1,499,494
BCF Programme Governance to support system flows	Private Sector	76,852
Personalised Care- Safe guarding/mental health pressures	Local Authority	493,659
Memory Assessment	NHS Mental Health Provider	236,863
Care Act	Local Authority	942,275
Carers Support	Local Authority	352,613
Carers Support - CCG	Local Authority	947,354
Seven day social care support - Acute	Local Authority	142,248
Winter Resilience	Local Authority	1,447,489
Admissions Avoidance	Local Authority	275,301
Community support offer	CCG	970,418
Assistive technology	CCG	100,000
Day care Provision	Local Authority	52,000
Enablement	Local Authority	200,000

Scheme name	Area Of Spend	Budget 21/22
		£
Homecare	Local Authority	3,579,682
Prevention	Local Authority	73,000
Care Home provision	Local Authority	2,296,557
Supported Living	Local Authority	661,422
Staffing and support to monitor flows including development of toolkits	Local Authority	928,500
Care Home Support Programme	CCG	207,813
DFG	Private Sector	2,884,527
Total		**39,995,465**

5.3 Social Value

5.3.1 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. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.3.2 Social Value will be considered during any procurement and review of activity detailed in the BCF plan for 2021-22. Our plans clearly recognise the importance of addressing wider factors such as education, employment, income and welfare. These wider factors can both impact on and be impacted by the health and wellbeing of an individual or population, and need to be considered in order to make sustainable improvements to health and wellbeing

5.4 Legal and Constitutional References

5.4.1 The BCF is allocated to Local Areas and placed into pooled budgets under joint governance arrangements detailed in s75 Agreements for Integrated Care between CCGs and Councils (Section 75 of the NHS Act 2006, provides for CCGs and local authorities to pool budgets). In Barnet, s75 Agreements and spend are monitored by the HWBJEG which reports its minutes to the HWB.

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

(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; and Section 75 partnership agreements between the NHS and the Council.'

(9); Specific responsibility for:
Overseeing public health
Developing further health and social care integration

5.5 Risk Management

5.5.1 Risk management is an integral part of the BCF plan and there is an embedded risk management plan within the Section 75 pooled budget agreement.

5.5.2 As part of managing the resilience across the system, partners have considered the overall pressures within the BCF spending plan, the level of investment needed to meet the BCF metrics and national conditions.

5.5.3 The HWBJEG is the executive for the BCF pooled budget and delivery of the BCF Plan, therefore the HWBJEG will receive progress updates, finance and risk reports and monitor the delivery of the Section 75. The HWBJEG reports, with its minutes, to the HWBB.

5.6 Equalities and Diversity

5.6.1 The 2010 Equality Act outlines the provisions of the Public Sector Equalities Duty which requires Public Bodies **to have due regard** to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people from different groups
- foster good relations between people from different groups

5.7 Corporate Parenting

5.7.1 In line with Children and Social Work Act 2017, the council has a duty to consider Corporate Parenting Principles in decision-making across the council.

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

5.8 Consultation and Engagement

5.8.1 The content of our BCF plan has been discussed with providers as an integral part of our strategic planning processes. The starting point for all discussions has been our jointly agreed Joint Strategic Needs Assessment (JSNA) and the

priorities and plans agreed by the HWB.

5.9 Insight

5.9.1 Our Better Care Fund (BCF) Plan for 2021-22 is informed by the:

- Barnet Joint Strategic Needs Assessment (JSNA)
- Contract management performance data and any service reviews/evaluations as appropriate
- The NHS Long Term Plan

6. Environmental impact

6.1 There are no direct environmental implications from noting the recommendations.

7. BACKGROUND PAPERS

7.1 2021-22 Better Care Fund: Policy Framework
2021 to 2022 Better Care Fund policy framework - GOV.UK (www.gov.uk)

7.2 Better Care Fund Planning Requirements for 2021-22
B0898-300921-Better-Care-Fund-Planning-Requirements.pdf (england.nhs.uk)

7.3 Better Care Fund Plan for 2019-20
https://barnet.moderngov.co.uk/documents/b33359/Better%20Care%20Fund%20Plan%202019-20%2003rd-Oct-2019%2009.00%20Health%20Wellbeing%20Board.pdf?T=9

Contents

Cover
Barnet Health and Wellbeing Board

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

Our local plan is based on the wider system programme of work taking place across North Central London (NCL) involving a strategic, place-based plan for transforming the health and care system. Joint working on this wider footprint is helping to address the complex challenges we face and improve health of the population through the delivery of a NCL Population Health Plan which will form a central driver for commissioning and provision of health and care services via the emerging Integrated Care System (ICS).

Plan approved by delegated powers: 16-11-2021

To be signed off by HWB: 09-12-21

Executive Summary

Barnet's vision for health and care is set out in the recently refreshed Joint Health and Wellbeing strategy (JHWS); the aim being to create a "borough of health" through working together with partners and residents.

The recent pandemic demonstrated the importance of having established relationships and joint working across the system. Circa 8% of local population tested positive for the virus (with the highest numbers in people over 80 years of age) and, of those, 748 people died (as of June 2021). It is estimated that a total number of truly positive cases is much higher than that; other areas impacted include waiting times for healthcare services, increased social isolation and loneliness.

Our local response to ensuring the delivery of both health/care services and support during the period along with the lessons learnt have helped shape our vision, guiding principles and the priority areas that we will being focusing on moving forward.

It is important to acknowledge that the pandemic has been a challenge for both service recipients and service providers in Barnet; it has changed the way that patients and service users liaise with health and social care. Hence, the schemes within our 2021-22 Better Care Fund (BCF) plan are intended to support the delivery of programmes of work that are based on the changing health and care landscape.

Key Changes Since Previous BCF Plan

The pandemic has been an unprecedented national and local challenge, this latest plan has been developed whilst the system is still recovering and stepping up services. As such, lessons learnt from delivering services and programmes of work during the pandemic have been a big consideration when reviewing the profile of the programme of work in the 2021-22 BCF plan.

A majority of the schemes within the plan played a pivotal role in supporting the local health and care system in delivering the capacity required to manage the demand for services during the pandemic; especially those services that are linked to supporting the system to manage the flow of patients being discharged back into community settings or the community-based services delivering care and support to residents in their own homes e.g.

Scheme/Service	Changes in 2021/22
Health inequalities and inequalities for people with protected characteristics:	Specific schemes in place to support Barnet residents to better manage existing long-term conditions and addressing inequalities in outcomes.
iBCF schemes: Provided valuable workforce, enabling the system to collectively manage discharges back to community settings	The pandemic highlighted a need to ensure that the workforce essential to deliver the care capacity required by the system is made available. Funding has been allocated to services to strengthen the support for continued maintenance of provision.

Support to Care Homes: The Enhanced care home offer scheme was the foundation for the initial support offer to care homes. It included the Significant 7 training to care and nursing home staff and the red bags for facilitating a better care experience for care home residents by improving communication between care homes and hospitals along with the Medicines management reviews and support to care and nursing home staff.	An integrated place based clinical in-reach team has been mobilised. The team provides proactive clinical support to care homes. Bi-weekly MDT meetings are in place; attendees include geriatricians, Consultant Old Age Psychiatrists, GPs and one care home team
Delivery of planned and unplanned care was at the heart of the previous plan	The community rapid response service linked with the wider unplanned and planned offer to ensure that the appropriate systems were in place to deliver key input to bed based settings where COVID outbreaks occurred. *With Barnet having the most care homes in London this was a crucial pathway change*
Prevention and selfcare: Locally we commissioned integrated services that support Barnet residents, especially those over 55 and with long term conditions, to maintain and improve their health and wellbeing through prevention, early intervention and rapid response at times of crisis	The pandemic highlighted the need to provide a cohesive pathway that included both a face-to-face and digital offer. The 2021-22 plan includes schemes that will deliver the ambitions identified. An example of service provision is the prevention service: Get Active and Get Connected, delivered by the voluntary sector offering both face to face and online classes for adults 55+. The main aims are to improve the mobility of older adults who are vulnerable to falls through the provision of exercise classes across the borough and to reduce social isolation and loneliness of this cohort by offering an array of online activities and sessions to improve their digital skills and confidence.

Priorities For 2021-22

Our local Health and Wellbeing Board (HWBB) has chosen three key areas to focus on, where local system partners and providers, including the voluntary sector, can come together to achieve accelerated changes with the aim of driving forward integrated improvements in health and wellbeing in the borough.

Key Areas	Priorities

Creating a healthier place and resilient communities	- Integrate healthier places in all policies - Create a healthier environment - Strengthen community capacity and secure investment to deliver healthier places
Starting, living and ageing well	- Improve children's life chances - Get everyone moving - Support a healthier workforce - Promote mental health and wellbeing - Prevent long term conditions
Ensuring delivery of coordinated holistic care, when we need it	- Support digital transformation of services - Enable carers health and wellbeing - Deliver population health integrated care

Whilst the JHWS provides the shared vision and strategic direction across North Central London (NCL) Clinical Commissioning Group (CCG), London Borough of Barnet (LBB) and our Barnet system partners, the 2021-22 BCF plan also incorporates the local deliverables related to the wider system including:

- North Central London (NCL) Integrated Care System
- Barnet Integrated Care Partnership (ICP)
- Barnet's Primary Care Networks (PCNs)

Our BCF plan will still focus on providing services that will:

- Support people to remain independent at home
- Reduce health inequalities and inequalities for people with protected characteristics
- Provide support for safe and timely discharges
- Continue delivering our local home first model
- Deliver person-centred outcomes; provide care that is tailored to individual needs.
- Promote choice and independence
- Provide better, more joined-up and place-based care for residents; especially in relation to prevention and self-care
- Help people to live healthier lives for longer
- Help people to stay out of hospital when they don't need to be there

Agreement to invest in NHS-commissioned out-of-hospital services – iBCF

As with other system areas, the last year has been challenging for providers in and out of hospital settings, especially those delivering care services. The detailed spending template demonstrates the breadth of our BCF plan in investing in NHS commissioned services out of hospital:

- The plan funds not only NHS community services and social care services but a range of prevention services that support the delivery of the Ageing Well programme and the Enhanced Health in Care Homes (EHCH).

Examples of services are, the maintenance of Dementia Hubs, the carers support services, and the palliative/end of live services.

- iBCF played a crucial part in enabling the system to mobilise services to support more people to be discharged from hospital when they were ready by ensuring that the social care provider market was supported.

Funding will continue for the identified schemes targeted at supporting people in a community setting and strengthening the care market. The use of digital and assistive technology played a significant role in our local response to the pandemic; we will continue to explore opportunities to use these technologies to avoid non elective admissions for older people, enabling residents with long term conditions, and to support those being discharged back to community settings.

Governance

The Health and Wellbeing Board (HWB) continues to oversee the Better Care Fund and sponsor the Barnet Joint Health and Wellbeing Strategy to tackle local population health challenges and drive forward work to reduce inequalities. In addition, our local HWB takes a leadership role in the Barnet Integrated Care Partnership (ICP) to promote the integration of services across health and care and improve outcomes for the borough's population

Although the HWB has overall responsibility for both operational and financial delivery of the Better Care Fund, and will maintain oversight of the outcomes, it has delegated the day to day delivery and oversight of the plan to the Health and Wellbeing Board Joint Executive Group (HWBJEG). The Health and Wellbeing Board has also approved a scheme of delegation for the Pooled Budget and Section 75 agreements.

The group is co-chaired by the Director of Adult Social Services and the Director of Integration, North Central London CCG, and has responsibility for the oversight of the BCF. This includes monitoring budget, decisions about funding, ensuring delivery of metrics and reporting requirements and other key governance decisions.

HWBJEG meets quarterly and has a well-established and effective programme governance structure, designed to ensure that there is transparency on decision making and momentum in the delivery of the agreed schemes. Depending on the schemes within the BCF, different groups will be involved in co-ordinating delivery either at a Locality, ICP or ICS level.

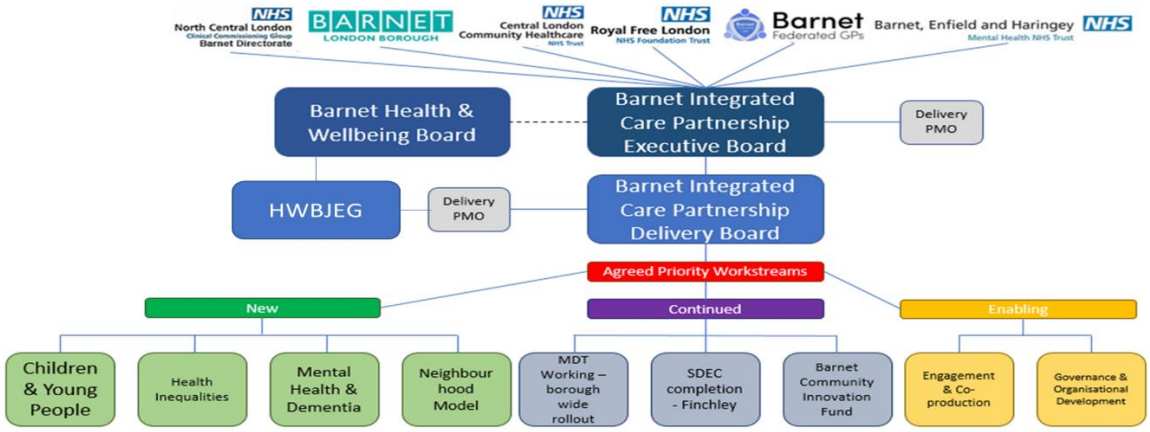
HWBJEG provides a forum for monitoring performance against the BCF section 75 agreement and how it is contributing to the commissioning strategies of the CCG and the Council. Standing agenda items in relation to the Better Care Fund include:

- A review of financial monitoring reports relating to the services, including expenditure compared with agreed budgets, forecasts and reasons for any actual or potential underspends or overspends and plans to address.
- Review of performance against the BCF metrics and oversight of the performance of individual BCF schemes.
- Maintaining a system overview and make recommendations to the CCG and the Council in relation to the aligned funds, including agreeing any changes or updates to the agreed list of contracts and associated contract specifications.

The HWBJEG is supported by a sub-group comprised of Council and CCG Officers. Attendees include budget and service leads for the schemes set out within the plan. Leads are responsible for linking in with wider system partners e.g. acute, community, primary care, voluntary and housing leads; monitoring and receiving highlight reports on progress either directly or via established meetings including the ICP, UEC and planned contract meetings. Commissioning leads have bi-monthly

meetings with the voluntary sector and monthly meetings with the extra care board, attended by housing leads.

The sub-group meets on a monthly basis to review finance and performance against the BCF Plan, alongside regular touch points with scheme leads to explore performance data, system pressures and best practice. The plan will be signed off by the Health and Wellbeing Board and shared with the LBB and NCL CCG.



Overall approach to integration

Scheme ID:3,6,9,13,14,17,19,20,24,28,33

Like all health and wellbeing areas, our plan is shaped to offer services that will support the wider system to deliver health and care and during a period where the long-term impact of the pandemic is not fully known. In 2021-22 schemes within the plan are focused on using the allocated capacity and funding to ensure the resilience of our local systems and partnerships to support the borough to recover.

Whilst this plan is in part a continuation of the programme of work commenced in 2020, it has been refreshed to ensure that schemes and service provision reflects the changes and gaps identified over the last 18 months when we responded to the COVID 19 pandemic. The plan also includes the delivery of key initiatives from the ICS and ICP as well as the ambitions of both the Ageing Well Programme and the Enhanced Health in Care Homes.

What we did

- **Mental Health:** Implemented a new model of community based multi-disciplinary dementia support for people with dementia and their carers. The service team includes a specialist dementia nurse, input from the council's specialist dementia support team, and the implementation of multi-disciplinary case management (MDT). This is currently in the pilot stage and work is underway to look at aligning the model with the PCN 2 Frailty MDT to create an efficient and patient focused model across Barnet.
- **Supporting people to remain at home:** Our One Care Home Team, along with the Locally commissioned Service, successfully supported care home providers and residents over the last year, especially during the peaks of the COVID pandemic.
    - The integrated offer alongside the input from general practice has ensured that care homes have access to proactive support enabling residents to remain within the care home.
    - The proactive offer enables care home providers to request a clinical review of new patients, ensuring that care plans are reflective of the needs of the residents.
    - The weekly ward rounds have proven to be valuable, enabling the team to quickly identify support for deteriorating residents.
    - Where required, the multi-disciplinary team provide an additional layer of support.
- **Primary care support to care homes - Locally commissioned service:** This service ensures that each CQC registered Nursing, Residential, Learning Disability and Mental Health care home is offered care by practices commissioned under the Nursing Homes LCS via dedicated weekly ward rounds. This includes;
    - timely access to clinical advice for care home staff and residents

    - proactive support for people living in care homes, including through personalised care and support planning as appropriate
    - care home residents with suspected or confirmed COVID-19 are supported through remote monitoring – and face-to-face assessment where clinically appropriate – by a multidisciplinary team (MDT) where practically possible (including those for whom monitoring is needed following discharge from either an acute or step-down bed) and
    - sensitive and collaborative decisions around hospital admissions for care home residents if they are likely to benefit
- **Joint Collaborative Commissioning:** We have continued to commission integrated services that support Barnet residents, especially those over 55 and with long term conditions, to maintain and improve their health and wellbeing through prevention, early intervention and rapid response at times of crisis. Our local offer includes:
    - Increased prevention and place-based support services; provided through the voluntary sector. E.g., our Neighbourhood services offer deliver by Age UK, Barnet Wellbeing hub, and our well-established dementia cafes delivered by Alzheimer's society. The new "Get Active and Get Connected" offer to reduce isolation and loneliness.
    - Provision of an Integrated mental health service which continues to deliver services to people closer to home, working with people in their own homes, supported living and residential placements.
    - Access to the Intensive Enablement team following discharge from a hospital setting.
    - Provision of multi-disciplinary care and support for people with learning disabilities from the Barnet Integrated Learning Disability Service (BILDS), based in the council and made up of social care, community health and mental health trust staff.

Joint priorities for 2021-22

The finances of the BCF are contained within a Section 75 agreement signed by NCL CCG and Council. Barnet has a joint commissioning unit responsible for leading on joint initiatives and procurements. Jointly commissioned services include:

- Integrated Community Equipment service: the newly launched service has been revised following feedback from service users. The service now offers one hour deliver timeslots enhancing convenience and supporting early discharge from hospital.
- ASC Enablement Network: delivers targeted preventative interventions to alleviate pressures on secondary mental health services and primary care. This provides Barnet with a rich and diverse enablement offer for mental health service users to prevent needs from escalating and promote recovery. The service focuses on three key areas:
    - Prevention of escalating mental ill health
    - Prevention of re-occurring mental ill health including relapse

    - Supporting step down from secondary mental health services
- Care Quality Team: provides reactive and proactive quality support to both bedded and non-bedded settings across the borough. During the pandemic the team were instrumental in supporting providers; actively making contact on either a daily or weekly basis and monitoring or providing education and training on infection control alongside the NCL IPC leads and Public Health leads. In addition, the team have increased their work and monitoring of mental health supported living providers, engaging with providers through a range of forums and events.
- Barnet Integrated learning disability team: is made up of the Learning Disabilities Nursing and health functions provided by CLCH and Mental Health specialist services through BEH. Team also includes specialist occupational therapy and social care.
- Consistent and enhanced offer of 7 day working supporting the development of the *Integrated Discharge Team* (IDT)
- Delivering joint assessments: there are a number of services with well-developed approaches to joint assessment and care planning enabling service providers to offer care and support that is patient centred. These include:
    - Continuing health care: Supporting residents with complex needs.
    - Planned care, case management approach inclusive of GPs: Community based support delivered by Central London Community Healthcare
    - Discharge to Assess pathways: Integrated working between community health, acute sector, social care and continuing care on admission avoidance, supporting early discharge and managing transfers of care.
    - Mental Health

Our commissioned offer includes schemes that enable working age adults and older people to have timely access to health and social care support that maintains independence and avoids hospital admission or admission to residential care

Achievements in 2020-21

- Same day access and discharge: Work between community and acute providers to develop pathways for the Finchley memorial hospital (FMH) front door model. Mobilisation is planned for quarter 3 2021 (winter resilience).
    - As part of implementing community placed based services, supporting a reduction in A&E activity, x-ray at FMH extended into weekends.
    - The IDT has had a significant impact in helping save bed days by reducing length of stay and massively avoiding what would have been delayed transfers of care (challenging to compare data given different circumstances and recording approaches but average

length of stay February to April 2019 was 21 days in Barnet Hospital, same period in 2020 was 8 days).

- ASC Enablement Network: As with many services, the COVID19 pandemic affected delivery of mental health services. However, the need to support vulnerable people during the pandemic meant partners had to rapidly mobilise support across the partnership. Highlights from the arrangements and adaptations made in Barnet this year include:
    - Translating the majority of support delivered via the ASC network to digital interface options to ensure continuity of delivery of the Barnet mental health enablement programme
    - Continuing to deliver weekly joint multi-disciplinary meetings with BEHMHT colleagues, the Barnet Wellbeing Service and the ASC Network to ensure robust case management and coordination and manage demand for support effectively
    - Delivery of a wide range of online preventative support and activities to service users to help them to maintain and maximise their health, wellbeing and independence and prevent escalation of need

Changes in 2021-22

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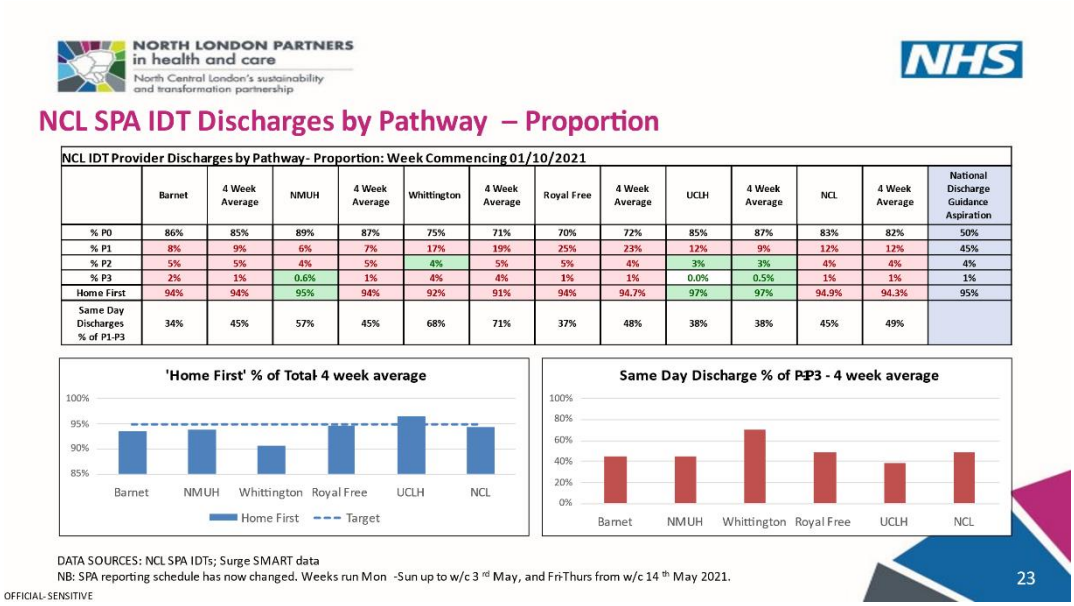
Scheme/Service	Changes
Anticipatory Care & Support	- Broader offer in place in community settings to better identify and support residents. - Expansion of the frailty and multi-morbidity service to cover all PCNs - Introduction of a care home specific MDT
Prevention	- Established a mental health crisis café. offering a new community based out of hours crisis alternative. A service that has proven to be a key pathway point in recent months
Mental Health	- The Barnet community mental health model continues to be developed supported by the Barnet ICP; the new model went live in PCN 3 delivering a new holistic model of support for people with severe mental illness and will be rolled out borough-wide

Supporting Discharge (national condition four)

The plans for discharge have been developed and agreed with both the hospital and community trusts.

The previous 18 months saw our local NHS A&E services come under considerable pressure. In recognition of the increased pressure on NHS services and the ongoing recovery from the COVID-19 pandemic system, partners have worked closely to ensure that residents are discharged from hospital safely and promptly.

As a system, partners have continued to enable high numbers of discharges from hospital (with increased activity compared to the last three years). For example, adult social care facilitated 657 discharges in Q1 of this year (approx. 220 cases per month, compared to 175 in previous years). The table below provides a snapshot of activity during a given period.



NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

NCL SPA IDT Discharges by Pathway – Proportion

NCL IDT Provider Discharges by Pathway- Proportion: Week Commencing 01/10/2021

	Barnet	4 Week Average	NMUH	4 Week Average	Whittington	4 Week Average	Royal Free	4 Week Average	UCLH	4 Week Average	NCL	4 Week Average	National Discharge Guidance Aspiration
% P0	86%	85%	89%	87%	75%	71%	70%	72%	85%	87%	83%	82%	50%
% P1	8%	9%	6%	7%	17%	19%	25%	23%	12%	9%	12%	12%	45%
% P2	5%	5%	4%	5%	4%	5%	5%	4%	3%	3%	4%	4%	4%
% P3	2%	1%	0.6%	1%	4%	4%	1%	1%	0.0%	0.5%	1%	1%	1%
Home First	94%	94%	95%	94%	92%	91%	94%	94.7%	97%	97%	94.9%	94.3%	95%
Same Day Discharges % of P1-P3	34%	45%	57%	45%	68%	71%	37%	48%	38%	38%	45%	49%	

DATA SOURCES: NCL SPA IDTs; Surge SMART data
NB: SPA reporting schedule has now changed. Weeks run Mon -Sun up to w/c 3rd May, and Fri-Thurs from w/c 14th May 2021.

OFFICIAL- SENSITIVE

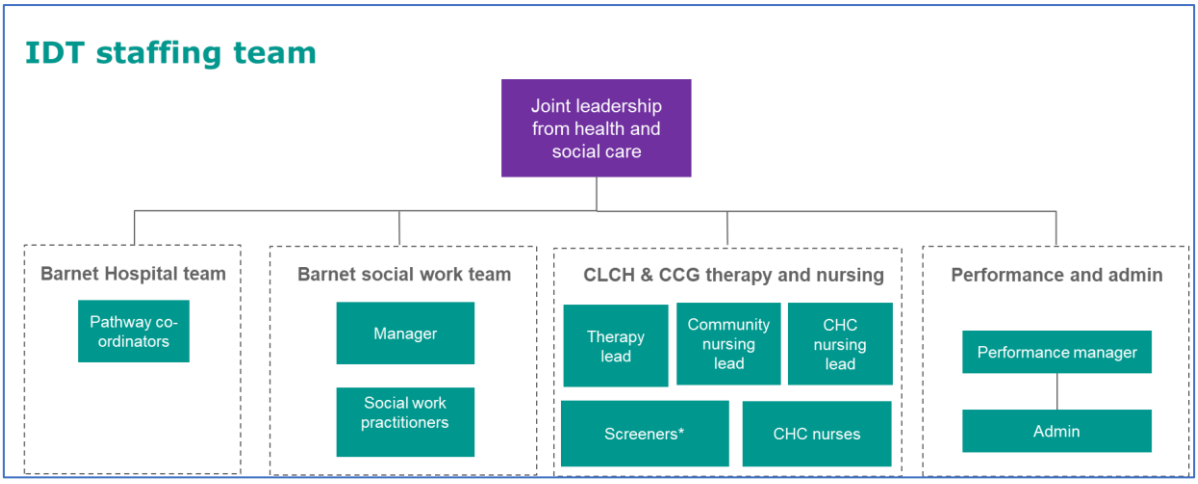
23

Supporting Safe and timely discharge

System partners have commissioned services to support discharge and home first.

Discharge services: The Royal Free Trust is fully involved with system partners in delivering the integrated discharge team (IDT) which was mobilised in rapid time in response to the pandemic, as required by the national discharge guidance issued in March 2020. Our local model is fully compliant, working 7 days a week, available from 8-8. The IDT discharges people as quickly as possible using the 'discharge to assess' 4 pathway model.

The diagram below provides a high-level overview of the governance and team structures in place.



Our BCF schemes and pathways linked to the IDT ensure that residents requiring acute care are supported to receive services:

- In the right place;
- At the right time;
- With the support they need;
- Whilst being enabled to be as independent as possible

Implementing home first model:

The following services and activities are in place to support the local home first model:

- Enablement Service: Barnet has an established service supporting patients within a community setting.
- As part of the agreed discharge pathway, commissioned initiatives will continue to maintain focus on reducing LOS, supporting home first, reducing delays in transfers of care and maintaining prevention of admission activity.
- Investment in accommodation pathway support workers is enabling a more efficient movement out of hospital for homeless patients and foreign nationals returning to home countries.
- Multidisciplinary team working is in place to improve flow and free capacity locally for our patients and avoid delays, by working with system partners via scheduled weekly discharge meetings.

The above is backed up by the community-based services below:

- Strengths based social care offer: Our Social Workers work with older and working age adults to support them to remain independent, focusing on their strengths, what they can do for themselves and what support can be drawn upon from family, friends and the local community.

- Community planned care service model: incorporating district nursing/intermediate care/falls support provision/speech and language

therapy. The team continues to deliver community services that enable patients to receive care closer to home which in turn eases the burden on acute services by improving patient flow from hospital and reducing unnecessary attendance. MDT working enables the effective care of patients with complex medical and social care needs.

- Intermediate Care Therapy: Provision of multi and uni-disciplinary rehabilitation to patients in their own homes for up to 6 weeks following acute/intermediate care admission or as early intervention to prevent the need for acute admission. The multi-disciplinary team work closely with the acute, intermediate and primary care services, social and voluntary agencies to deliver collaborative health and social care rehabilitation for patients. The team includes physiotherapists, occupational therapists, speech & language therapists and rehabilitation assistants.

Changes in 2021-22

Scheme/Service	Changes
There was limited discharge team staffing coverage at the weekend with no nursing or therapy led discharge in acute.	Integrated discharge team now mobilised with links to the care homes clinical in-reach team and the council reablement and brokerage teams.
Barnet has a comprehensive approach to supporting continuous quality improvement in care homes.	The BCF funds the care quality team, staff now work closely with the one care home team. Bi-weekly multi-disciplinary meetings take place. Model includes clinicians from the local mental health trust and geriatricians from RFL as well as input from the palliative care specialist from North London hospice.
Enablement Service	Service offer adapted to deliver a home first model of care. Discharged patients are assessed in their own home. Service provides 7 day coverage.

Achievements:

- In the first year of operation, the team enabled over four thousand residents to leave hospital to the right place for them.
- It has had a significant impact in helping save bed days by reducing length of stay and massively avoiding what would have been delayed transfers of care (challenging to compare data given different circumstances and recording approaches but average length of stay February to April 2019 was 21 days in Barnet Hospital, same period in 2020 was 8 days).
- There is staff capacity available at the right time to support timely discharge – from community health, CHC, brokerage and social care.
- **Improved linkages and communication between providers:**
    - It is much easier to find appropriate residential / nursing placements for individuals – communications in the whole process have been improved to

ensure needs are properly understood and there has been a change to focus on a quick initial move to further assess and understand ongoing needs.
    - Around 20% of those reviewed have been enabled to return home or to extra-care housing and there have been very few moves to other care homes as the brokerage process has worked hard to identify appropriate provision even whilst working at such pace.
- Flexible approach to use of community rehabilitation beds and greater focus on ensuring people move on in a timely way has helped with improving flow across the system.

Challenges

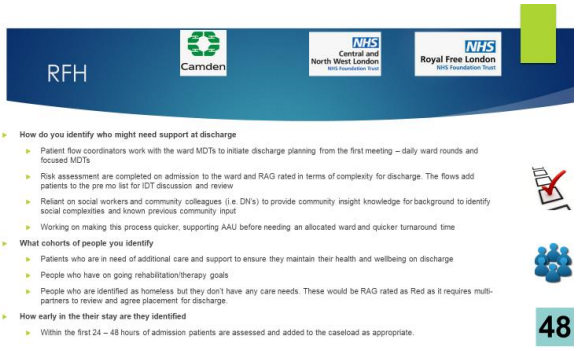
1. Managing winter pressures for 2021/22:
    a. Including system and staffing capacity
    b. Domiciliary and care home staff capacity to maintain hospital flow
    c. Interdependency of primary care, community, acute, social care partners and LAS with mitigation as early warning triggers and process to monitor agility of each system partner;
2. Issues with identifying and discharging patients back to community settings.

Mitigations

Work is underway across NCL to deliver a system approach. Actions include utilising the discharge funding in addition to existing service delivery to ensure system flow. Others are:

- Monitoring primary care: Reinstating a fortnightly all-practice SITREP survey which asks practices to rate current demand and capacity, identify specific pressures or emerging trends in increased patient presentations and identify long and short term support required to continue to deliver business as usual primary care.
- Communication and Engagement plan
- Optimisation of patients flow via the IDT
- Monitoring system capacity. Where applicable we have used discharge funding to source additional capacity.

The diagrams below provide a pictorial view of the mitigations in place to ensure system flow.



Next Steps

The detailed expenditure tab in the finance template demonstrates the breadth of the local plan in investing in NHS commissioned services out of hospital; clearly aimed at either prevention or supporting discharge pathways e.g., the prevention and enablement services targeted at helping resident in community settings. Where residents do require a stay in hospital Barnet has commissioned services to enable them to be discharged to the most appropriate setting to support in regaining independence.

The high impact change model has been embedded into operational processes; in addition to the seven days services described above we also have:

- A comprehensive flow monitoring system is in place led by acute trust and reviewed daily.
- Multi-agency discharge improvement working groups meetings
- Trusted Assessors
- A choice policy

In 2021-22 we will:

- Continue discharge training for all staff with a focus on choice policy. The aim being to support all staff understand choice policy, discharge procedures and related services available.
- Integrate the role of the trusted assessors into the clinical in reach service – Barnet one care home team
- Continue to focus on the patient journey and flow through the system, reducing transfers of care and improving the patient experience
- Under Ageing Well there has been some extra funding into rapid response in both NCL
  and Barnet; supporting the delivery of capacity to manage demand.

Approach to Winter Resilience

Below is a table setting out the local approach to ensuring winter resilience.

NORTH LONDON PARTNERS in health and care

NHS

Expected capacity

Funding has been made available for the Core Scenario as below

	CORE SCENARIO	ENHANCED SCENARIO	COVID/WINTER SURGE SCENARIO
Hours of Operation	Mon-Fri 8am-6pm Sat 8am-6pm **Sunday Opening 8am – 1pm**	Mon-Fri 8am-6pm Sat 8am-6pm **Sunday Opening 8am – 6pm**	Mon-Sun **8am-8pm**
Health Roles (Community & Acute)	• Hub Lead (8a) Community Operational post • Integrated Discharge Hub Coordinator (8a) Acute Clinical Post • Acute and Community Health Case Manager (B4-7) • Referral Hub SPA Support (B2-4)	• Hub Lead • Integrated Discharge Hub Coordinator • Acute and Community Health Case Managers x 2 • Referral Hub SPA Support x 2	• Hub Lead • Integrated Discharge Hub Coordinator • Acute and Community Health Case Manager x 3 • In-reach and Out Reach Support • Referral Hub SPA Support x 3
CHC Roles	• Designated D2A Nurse Lead (B7) * • CIC Brokerage	• Designated D2A Nurse Lead • CIC Brokerage	• Designated D2A Nurse Lead • CIC Brokerage
Social Care Roles	• Social Care Practitioners (Level L3Z1) • Brokerage	• Social Care Practitioners x 2 (L3 – L5Z1) • Brokerage	• Social Care Practitioners x 3 • Brokerage
Housing		• Housing Support Worker (L3)	• Housing Support Worker • Homeless Support Worker

3

Disabled Facilities Grant (DFG) and wider services

SCHEME ID:5,6,21,26

The DFG forms part of our overall approach to supporting the local agenda on prevention and early intervention especially following the COVID-19 pandemic. We work closely with colleagues in housing to develop the overall approach for supporting residents in Barnet. The use of the DFG has been agreed through the capital programme by Barnet Council - the housing authority.

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We anticipate that our integrated approach towards commissioning services both locally and as part of the NCL ICS will continue to ensure that people access to the support to enable them to remain at home and in their communities for as long as possible.

DFGs are administered by RE (Regional Enterprise) who provide technical skills and essential knowledge of the specialist contractor market to ensure quality and best outcomes for residents. This contract is between the council and a joint venture company jointly owned by Capita and the council.

As well as the DFG within the BCF, we also have a separate pooled budget which provides community equipment. This community equipment pooled budget ensures that Barnet has a joined up approach to enabling residents to stay at home.

Achievements:

- The Council invested £55 million capital funding to build an additional 200 extra care housing units, including for couples.
    - Ansell Court, a dementia friendly scheme with 53 flats (51 x 1 bedroom flats and 2 x 2 bedroom flats), was the first of the three new developments in Barnet. Building works were completed in February 2019 and residents moved in from April onwards.
    - The next scheme Stag House is currently under development and will open during the summer/autumn period of 2022.
- Commissioners work closely with Housing leads to develop and agree the programme.
- All referrals of adults for DFG are assessed by our social work team and occupational therapists who work together to apply our ‘strengths-based approach’; having ‘good conversations’ at the start of the application for DFG supported people along appropriate pathways.
- We have established processes for considering new accommodation and support e.g. A key step is to consider extra care as a high quality and sustainable option alongside additional telecare and equipment.
- We provide equipment, minor adaptations, telecare, housing options and support to move as well as the major adaptations funded by the DFG.

- We have recommissioned accommodation and support services to contract with new providers of housing and support for people with physical disabilities including profound and multiple learning disabilities.

Our aim in 2021-22 **is to continue to:**

- Support more people of all ages to live in suitable housing so they can stay independent for longer and join up action across environmental health, housing, health and social care to achieve this.
    - We will progress a physical and sensory impairment strategy working closely with voluntary sector and community partners.
    - Our strong bid for funding under the Changing Places programme (accessible toilets and facilities for people with disabilities) under the Governments new Disability strategy will be progressed, maximising joint funding from the council and partners including our leisure services provider and voluntary sector.

- Use DFGs, in conjunction with the Council's Accommodation Strategy, to secure early discharge from hospitals and reduce non-elective admissions.

- Ensure effective use of the DFG through an innovative approach to assistive technology. This approach can be evidenced through the achievement of the DTOC metrics over the last two years.
- Review how we further simplify processes through our single point of access. This aims to ensure a person-centred service that meets a disabled person's needs in a more preventative, holistic and timely way and effective communications with occupational therapy leads.

We have also ensured that people with learning disabilities and / or autism who require adaptations to either their existing or new home are accessing capital funding available through the NHSE Learning Disabilities and Autism programme () programme.

Next Steps

- Priorities for the Council and CCG for include a review of adaptations policy, to be considered and agreed by our Health & Wellbeing Board. To inform this we want to have a better analysis of local need to underpin our preventative strategies and help determine levels funding required – this work has started and will be supported with further analysis in 2021/22. This will include how we measure outcomes and align our systems to improve intelligence and reporting through shared care records.

- To build on our innovative use and application of telecare we will also consider whether smart home starter kits can be included in adaptation schemes.

Equality and health inequalities.

SCHEME ID: 1,2,3,7,8,13,18,19

The COVID-19 pandemic highlighted the variations and gaps in our local health and wellbeing area that result in health inequalities. As such, key elements of this year's plan are focused on targeting the most deprived communities in the borough, reaching out proactively to our resident black and minority ethnic populations. Our plan is based on collaborative working via Multi-Borough and NCL wide partnerships that will deliver high impact solutions.

Consideration has been given to schemes that support the systems ambitions to expand primary care capacity to:

- improve access,
- local health outcomes
- and address health inequalities

What we have done

Barnet has adopted a health improvement and prevention approach to address health inequalities in BAME communities, building on work initiated through the Covid 19 vaccination programme.

Furthermore, tackling inequalities, neighbourhood model working and engagement and co-production are all priority workstreams for Barnet Integrated Care Partnership with Senior Responsible Officers assigned from across the system for each.

Increasing uptake and equity of uptake of Childhood immunisations and Cardiovascular Disease prevention and management have both been identified as the two areas of short-term focus within the tackling inequalities workstream within Barnet ICP, with an emphasis on building trust in the community & reaching targeted high-risk populations to reduce the equality gaps.

The associated programmes of work aim to take a population health approach as recommended for ICPs by NHSE/I concentrating on a holistic approach to health and wellbeing and addressing the wider determinants of health through engaging communities in neighbourhoods. Both workstreams include wider community group and VCS representation as well as Public Health leadership to ensure aligned to the local population needs.

Engagement Activities**:** Over the last year we have hosted workshops and engagement sessions to identify and agree priority areas of work.

- Locally we identified as priorities for the inequalities programme:
    - Access
    - Diagnostics
    - Learning from vaccines and vaccine hesitancy for smears,
    - children's vaccinations and flu
    - CVD prevention programme (learning from
    - Building trust in deprived areas of borough

    - Education of patients about the system and how it functions
    - Outreach to high-risk populations borough wide
- Work is already underway to deliver initiatives within the programme, examples of the local approach include:

Stakeholder	Offer
Voluntary Sector	**CommUNITYBarnet:** Oversee the Barnet Wellbeing Service and has a membership of over 500 local charities and reach into diverse communities through networks and contacts
NCL CCG	**Communities Team** Are initiating programmes of work that develop and embed new ways of working with, and listening to communities to support "Building trust in deprived areas of borough" and improve understanding of barriers to "access" .
Community Services Provider	**CLCH** has a Promoting Equality & Tackling Inequality Strategy running 4 campaigns: 1.Access to Services 2.Workforce Equality 3.Understanding our Communities 4.Our role as an Anchor Organisation,

Next Steps:

It is recognised that there are existing inequalities in primary care capacity across NCL including in LCS', across NCL we have identified that there are stark NEL admission rates between most/least affluent and amongst people from different ethnic backgrounds from birth onwards. In Barnet's admissions are driven more by our older (often more affluent) population than any other Borough which means the 'differential' is dampened down, nevertheless there are identified pockets of inequalities that still need to be addressed.

Although the health of people in Barnet is generally better than the England average. c14% (9,700) of children live-in low-income families and life expectancy for both men/women is higher than the England average. In addition, it should be noted that there are:

- Inequalities in life expectancy in Barnet by gender, locality/ward and the level of deprivation.
- Life expectancy at birth in females (85.0 years) is higher than males (81.9 years) and overall life expectancy for both the male and female populations in Barnet is higher than the average for England (male = 79.4 years, female = 83.1 years).

Area	What we have in place or underway

Restore NHS services inclusively	Supporting those with complex needs: We have: • Use of health services by different segments of the population. • Integrated care in mental health, learning disabilities, urgent care/hospital discharge and primary care networks across Barnet • 0-19 hubs and integrated support for young people with complex needs in place • Long standing Prevention and Wellbeing model in Barnet, led by a team of local area co-ordinators and supported by a network of commissioned evidence-based prevention services
Mitigate against digital exclusion	Barnet is a national leader in the use of technology in care. Our local service is a high quality, mainstreamed, innovative offer that uses care technology, monitoring and support to empower and enable people to live as independently as possible within their settings. We are piloting a digital offer with Age UK, supporting residents to develop skills as part of the Get active and Get Connected Scheme. We also have a care home specific pilot underway within the care homes sector utilising the whzan Digital Health Monitoring 'Blue Box tool. The solution enabling clinicians to monitor patients, make recommendations and deliver support remotely.
Preventative programmes that proactively engage those at greatest risk of poor health outcomes -	Pathway workstream to improve CVD prevention (primary & secondary) and reduce inequalities ICP Frailty programme supporting the reduction in health inequalities for frail elderly residents. Pathways supporting the uptake of prevention programmes proportionate to the local ethnic group and their risk of LTCs

- Where commissioned services involve a change or transformation of service delivery, the project is subjected to an equalities impact assessment.
- Enhance our prevention programmes with the aim of supporting people to stay well and when people become unwell, to recover quickly.
- Ensure that mental health services continue to have equal priority to physical health services.
- Providing consistent standard of care available to everyone and reduce variation**.**

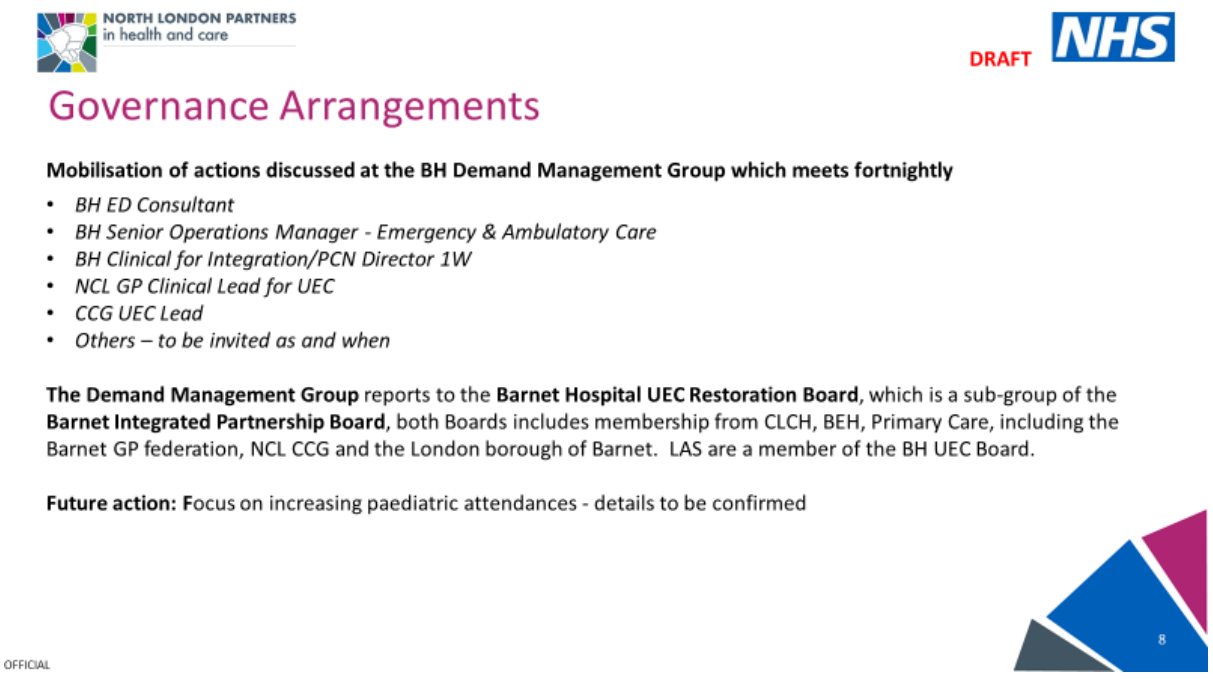
Metrics

1. Metrics have been discussed and agreed with The Royal Free London (RFL), Central London Community Healthcare Trust (CLCH).
2. Our hospital trusts and HWB area have developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more.
3. Our ambitions across hospital trusts and HWB area for reducing the proportion of inpatients that have been in hospital for 21 days are aligned.

Barnet's performance against the national metrics has previously been generally good, for example:

- Barnet Hospital significantly reduced the proportion of long stayers during the COVID pandemic and increased flow through the development of the integrated discharge teams.
- We take an integrated approach to system delivery as evidenced by the work with our local acute trust who have schemes that address the delivery of all the metric areas in the plan e.g.:
    - SDEC,
    - flow & length of stay reduction,
    - discharge as part of local & NCL programmes.

Below are the extracts for the local approach for managing lower acuity attendances and the supporting community-based pathways.



NORTH LONDON PARTNERS in health and care

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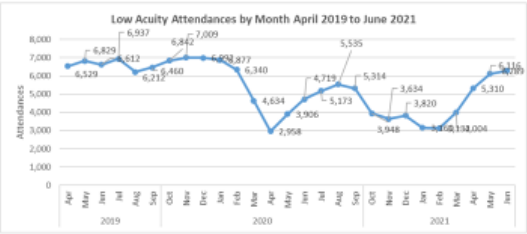
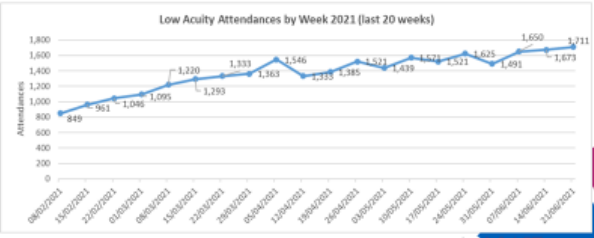
Purpose and objectives

A key action from the NCL UEC Summit was to develop an analysis of low acuity ED demand across NCL sites.
The intention is that each local system work together to review the output and **agree actions** that respond to the demand drivers specific to the local hospital site. **BH and the CCG have identified Five priority areas for initial focus.**

Summary of attendance data patterns (Up to August 2021):

- Total attendances are higher than pre-covid-19, with paediatrics (0-9 year olds) making the majority of attenders. This reduced in August but likely to increase again now schools re-opened.
- Low Acuity patients (VB06Z-VB11Z) remain high, making up the majority of attendances. This is an increase on the 77% in August 2019 (pre-covid-19)
- VB11Z attendances have been increasing since March 2021, accounting for 9% of attendances in August 2021. This is a slight increase on the 8% last August 2019 (pre-Covid-19)
- 0-9 year olds and 20-29 year olds make up the majority of VB11Z attenders
- The top 5 conditions of low acuity attenders: Chest and Abdo pain, Fever, Pain in hip/leg/knee/ankle/foot, unknown





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2

OFFICIAL *NCL activity only*

NORTH LONDON PARTNERS in health and care

DRAFT NHS

BH low acuity ED attendance action plan (1/5)

Purpose: *To by-pass ED and stream patients to the appropriate speciality within the hospital, or direct outside of the hospital (see slides 3,4 & 5)*

KEY FOCUS AREA 1	ACTIONS	Timeframe	Lead
1. **Mobilise BH Triage Hub 24/7 to enable the by-pass of ED and reduce crowding in the department.**	1.1 Agree time line for mobilisation of the Triage Hub	8 October	BH
	1.2 Review and agree space options to locate the Hub	30 September	BH
	1.3 Map out pathways for adults and paeds • Internal – surgical/Orthop/Medical/ED • External – Primary Care/CLCH • LAS pathway	8 October 30 November	BH/PCNs/ LAS
	1.4 Map impact on ED work force	30 November	BH
	1.5 Review Performance Impact on ED	30 November	BH
	1.6 Once Triage Hub is trialled and risk assessed, send out comms to relevant stakeholders	30 November	BH/CCG

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NORTH LONDON PARTNERS in health and care

DRAFT NHS

BH low acuity ED attendance action plan (2/5)

Purpose: *To support reduced attenders for minor ailments and injuries to Barnet Hospital UTC particularly from the west of the borough and support redirection from the UTC to this WIC.*

KEY FOCUS AREA 2	ACTIONS	Timeframe	Lead
2. **Re-Open ECH Walk-in Centre**	2.1 Update DoS to reflect WIC reopening on 1.10.21 with reduced opening hours 8am-6pm 24/7 until 31.12.21	26 September	CLCH
	2.2 Confirm X-Ray opening hours/days with RFL	26 September	CLCH/RFL
	2.3 Re-establish Direct Booking via NHS 111 into ECH WIC booking slots	26 September	CLCH/CCG /DOS
	2.4 Comms sent out to all relevant stakeholders, websites updated, including border boroughs, local community groups	26 September	CLCH/CCG
	2.5 Open up direct booking of NHSE 111 patients into ECH WIC for Harrow and Hertfordshire patients.	31 October	CLCH/CCG /DOS
	2.6 Mobilise AQP for LAS to convey patients to ECH WIC away from Barnet Hospital. Refresh old agreement with LAS representatives.	30 November	CLCH/CC/ LAS/DOS

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BH low acuity ED attendance action plan (3/5)

Purpose: Develop the pathway between Barnet UTC and Finchley WIC to support the redirection of patients. Strengthen relationships through collaborative learning and new opportunities for pathway development.

KEY FOCUS AREA 3	ACTIONS	Timeframe	Lead
3. Redirection from the Triage Hub to Finchley WIC	3.1 Agree pathway between BH and FMH, including IT link to support redirection and booking arrangements • CLCH to access BH AAU pathways ie DVT	30 September 31 December	ED/CLCH
	3.2 BH to appoint an ED consultant to work at FMH WIC to support new pathway development, leadership and training for 6 months: • Advertise • Appoint to post	31 December	ED/CLCH
	3.3 Agree the governance arrangements for the redirection of patients between BH and CLCH/FMH WIC. • Approval by BH and CLCH Governance Boards	30 November	ED/CLCH

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NORTH LONDON PARTNERS in health and care

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BH low acuity ED attendance action plan (4/5)

Purpose: Strengthen the relationship with Primary and Pharmacy services to support safe redirection for suitable patients.

KEY FOCUS AREA 4	ACTIONS	Timeframe	Lead
4. **Strengthen redirection to Primary Care and Pharmacy Services**	4.1 Barnet Federation to allocate 10 EAS appointments per day to BH for redirection until March 2022. • Set up same arrange with Hertfordshire – HUQ • Other NCL boroughs – if NCL H2 funding application successful • Identify a senior GP clinical lead to support the Triage Hub to redirect back to primary care	30 September 31 December 31 January 2022	BH/CCG/G P Fed
	4.2 Set up EMIS viewer so that Barnet Hospital has direct booking capability into the EAS appointment book.	31 October	ED/CCG
	4.3 Pilot CPCS Pharmacy Scheme at Barnet Hospital – NCL Pilot site to support redirection of patients to local pharmacies via a direct referral and appointment slot.	Tbc by national team	ED/CCG

OFFICIAL 6

The BCF is an embedded part of the local ICP, who have produced a plan to reduce ambulatory care sensitive admissions.

Our ICP has produced a plan to reduce ambulatory care sensitive admissions. Our local plan is in line with other NCL ICPs and shares the following common themes including:

- Care homes – an integrated case-based approach to care homes, mobilising clinical in-reach teams, with regular MDT meetings involving consultant, geriatricians, GPs and care home teams
- Using the Disabled Facilities Grant for home adaptations to allow people to remain safely at home, with an emphasis on BAME communities and people in unstable accommodation in the private rented sector
- Strengthening urgent community response services and refreshing our rapid response offer
- Updating training for care staff on how to manage patients who are deteriorating
- Anticipatory care – expansion of frailty and multi-morbidity models of care across Primary Care Networks
- Addressing health inequalities, with a focus on BAME communities and those areas with high income inequality, putting in place extra capacity to maintain preventative interventions such as childhood immunisations and more proactive treatment of long term conditions such as cardio-respiratory diseases and diabetes
- Putting in place a consistent and enhanced offer for integrated discharge teams (IDTs) delivering joint assessments including CHC, supporting residents with complex needs
- Enhancing prevention and self-care: helping the population to get active and maintain connectedness to others. Helping people to remain independent at home
- Investment of the iBCF uplift in workforce to strengthen and monitor social care provision and enable rapid discharge

In line with the requirements set out in the policy document the local plan is ambitious yet has achievable trajectories for improvement. Our plan has taken into consideration the risks associated with rolling out new schemes which in the longer term will support the delivery of the metrics but may, in the short term, have an impact on performance.

SCHEME ID:2,3,5,9,11,13,17,19,20,24,26

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	453.9	470.9

Avoidable Admissions Next Steps

The plan includes a small stretch which will deliver an improvement on the 19-20 position; the plan has factored in the challenges to the local system and the role out of a number of new initiatives e.g., the UEC workplan, the 6-week winter sprint and the wider NCL winter resilience plan.

As some of these initiatives are only just initiating, the plan has taken into consideration the risks and required mitigations that will need to be in place to reduce or manage the ripple effect on existing processes and performance while the new schemes are being mobilised and bedded in. Additional schemes include:

1. Barnet have piloted a Frailty MDT in PCN 2 the offer is being scaled up to roll out across all the localities and PCNs: The service offer includes Support to GPs, a Community frailty model for acute teams to integrate with and Support for community teams with complex patients. The pathway process includes:
    - Patient identification via frailty tool/well-known referral routes
    - Patients triaged and assessed with complex case MDT if needed
    - Holistic. personalised care & support planning coordinated & in place
    - MDT to support assessment, planning & review for complex patients
2. Other services areas supporting the delivery of this metric include the wider work across NCL and the ICS through increased provision of a 2 hour response to avoid admission (via the Rapid Response Team);
3. Expansion of remote monitoring within care homes and respiratory patients to identify early signs of deterioration, and through improved advanced care planning in care homes.
4. The work around the delivery of the anticipatory care model will also strengthen the local placed based care and further enhance our overall response.

SCHEME ID: 26,27,28,29,30,31,32,33

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	10.8%	8.7%
	Proportion of inpatients resident for 21 days or more	4.3%	4.1%

Length of Stay Next Steps

The targets are based on the 19-20 (pre-pandemic) performance and reflects the local position. Barnet is already forecast to deliver this metric, we have therefor put in a stretch.

The 2021-22 targets are considered to be a stretching ambition for this year in the context of continued Covid-19 related pressures on both acute and community-based care, in addition to challenges around the health and care workforce in the approach to winter. There is an anticipated peak in demand for services in Q3, which accounts for the aim to continue to stabilise and rebuild in Q3 and Q4 with a view to further improving performance in future years when the longer-term impact of the pandemic is clearer.

BCF funding for IDT and the placed-based services will continue to support safe, timely and effective discharge locally in line with the National Discharge Policy and Operating Model. Implementing these requirements alongside the already embedded HCIM processes will enable better patient flow and outcomes, as well as creating a cohesive system for support for people when they leave hospital.

Scheme ID 23, 2, 5, 6, 9, 11

8.3 Discharge to normal place of residence

	21-22 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)	92.2%

Discharge to normal place of residence next steps

Targets are based on 19/20 performance. It is noted that the 95% national target is being met across NCL at a hospital level, however the Barnet SUS data does not reflect this therefore performance targets have been tailored accordingly to the Barnet level SUS data. Homecare and reablement services continue to benefit from BCF funding and are experiencing sustained pressures on demand and workforce.

The discharge section of this plan sets out the wide range of schemes in place to support the coordination of timely discharges to the normal place of residence, this includes the IDT, reablement, homecare, integrated community equipment and telecare offer, along with specific care home services one care home team and trusted assessor.

In addition, workstreams relating to development of the integrated place based model will ensure that residents are supported to return to their communities with access to the health and care support, equipment and networks required to safely do so.

SCHEME ID: 26,27,28,29,30,32,33

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 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	327	503	502	486
	Numerator	188	288	292	290
	Denominator	57,441	57,304	58,170	59,707

Barnet Adult Social care delivers approximately 1400 placements a year. A figure that is between 25% to 30% of our care provision. Do note that there has been a very slight (3.5%) reduction in placements for financial year 2020-21.

Targets are based on 19/20 performance due to the uncertainty regarding resistance to care home admission which appeared during the pandemic. This has been reflected in increased pressures on homecare but early indications show a slow return to pre-pandemic trends with increased demand for residential placements. It is too early in the recovery phase to determine whether a more ambitious target can be put in place for 21/22 but performance will be monitored closely.

Next Steps – Residential Admissions

- Two additional extra care sites are in development, one is due to open in 2022 and the other is entering buildings stages.
- We will continue to monitor our engagement plan with key partners in community and tertiary health settings around joint working e.g. working with Intermediate Care Service; Occupational Therapists in A&E; supporting the IDT.
- We will continue to promote and work closely with other preventative resources e.g. Home from Hospital and Telecare, as ways of promoting safe hospital discharges where enablement is not appropriate.

Reablement

SCHEME ID: 5,6,8,14,16,18,19,20,26,27,30

		19-20 Plan	19-20 Actual	21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	63.8%	87.0%	75.4%
	Numerator	324	80	**132**
	Denominator	508	92	**175**

All clients discharged in a snapshot period of 1st of October to 31st of December are traced to see if they are within their own homes from 1st of January to 31st of March which is 91 days following their discharge and with current levels of increased discharges from Hospital in to social care specially for older people we expect this year we will have an approximate 175 clients receiving reablement support in this period while the success rate of them being in their own homes to be around 75% considering it is for Older people (aged 65 and over) impact of Covid and deaths and in particular deaths impact negatively as they are not considered within their own homes. NOTE: 19-20 plan has a higher target value than subsequent years; the value for 10/20 was the full year effect. This error has now been corrected

In recent years Barnet previously underperformed against the target as we struggled to contact clients following their reablement episodes on the 91st day. The impact of the pandemic is reflected in the outturn for 20-21. Bearing in mind the significant increase in demand for reablement services the plan for 20-22 is based on the historical performance the proposed target is a stretch and is still aspirational compared to last year's performance.

Appendix

1. Admission Avoidance – Actions

NORTH LONDON PARTNERS in health and care

Admission Avoidance
Six-week Winter Sprint – 7th December

NHS

At the CHS winter planning workshop (12/10/21) 5 areas were agreed to accelerate over six-weeks to support admission avoidance in NCL.

Area	Impact	Output in six weeks (7th December)	Provider lead	Draft actions
Falls pick-up (injured / non-injured)	• Reduce LAS conveyances to ED for fallers. • Reduction in emergency admissions	• NCL proposal approved by COG and CAG with a go-live date.	CNWL	• Review learning from other services in region • Identify demand and baseline health and social care services • Develop proposal endorsed by all providers • Agree PDSA cycle prices to refine solution
Urgent Catheter Pathway (non-routine)	• Reduce catheter emergency admissions	• Understand number of patients in ED that could have been seen within community and why they were not referred • System to implement action plan to address issues	CLCH	• Collect data to understand the why • Agree any system issues that need to be addressed • Current pathway refined to ensure consistency across all providers
Patients in ED that are clinically appropriate for Rapids	• Reduce ED attendances and admissions from patients clinically appropriate for Rapids (priority of NCL UEC Board)	• NCL principles agreed to support GPs, LAS and Rapids with consultant advice • EDs have consistent access to UCR 2hr response	All	• Understand scale of the issue and baseline work completed to-date. • Review proposed solutions e.g. consultant connect • Agree clinical pathways
Point of care testing	• Increase service capacity by reducing visits to hospitals • Reduce pressure on acute diagnostic services	• All providers have a solution/pilot implemented or being mobilised	CNWL	• CNWL share learning • Providers agree solution to pilot over winter • Nursing T&F agree SOPs/clinical governance • Training and mobilisation
OPEL/Surge reporting (enabler)	• Maintain and rapids capacity across system and surge where required	• Reporting mechanism implemented and aligned to surge/OPEL reporting	BEH	• Agree metrics with T&F • Agree reporting mechanism • Align to OPEL/surge reporting

2. **Email Confirmation from Trusts**

RE_ 21-22 Draft BCF Plan - Metrics signo

RE_ Better Care Fund - Metrics meet

Better Care Fund 2021-22 Template

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 respective 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 2021-22. It will be pre-populated with the minimum CCG 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 the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 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 CCG 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.

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 to our understanding of how BCF funding is being used and levels of investment against different priorities.
- 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 “CCG 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.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.

7. Provider:

- Please select the ‘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 CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- 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 2021-22 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 performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.

1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB 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 average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric

3. 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.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service 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.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- 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) for the Residential Admissions numerator measure.
- 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.

5. 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 planned 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.
- 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 & 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 2021-22 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 2021-22 Template

2. Cover

HM Government

NHS

Version 1.0

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 2021-22.

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

Health and Wellbeing Board:	Barnet
Completed by:	Muyi Adekoya
E-mail:	muyi.adekoya@nhs.net
Contact number:	7849629451

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

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Thu 09/12/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Caroline	Stock	Cllr.C.Stock@barnet.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Frances	O'Callaghan	Frances.O'Callaghan@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		Colette	Wood	Colette.Wood1@nhs.net
	Local Authority Chief Executive		John	Hooton	John.Hooton@barnet.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Dawn	Wakeling	Dawn.Wakeling@barnet.gov.uk
	Better Care Fund Lead Official		Muyi	Adekoya	muyi.adekoya@nhs.net

	LA Section 151 Officer		Anisa	Darr	Anis.Darr@barnet.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 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 CCG Contribution	£27,772,288	£27,772,288	£0
iBCF	£9,338,650	£9,338,650	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£39,995,465**	**£39,995,465**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£7,892,097
Planned spend	£18,450,398

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£8,298,241
Planned spend	£8,298,241

Scheme Types

Assistive Technologies and Equipment	£1,821,521	(4.6%)
Care Act Implementation Related Duties	£1,435,934	(3.6%)
Carers Services	£1,299,967	(3.3%)
Community Based Schemes	£2,634,609	(6.6%)
DFG Related Schemes	£2,884,527	(7.2%)
Enablers for Integration	£895,638	(2.2%)
High Impact Change Model for Managing Transfer of C	£6,303,370	(15.8%)
Home Care or Domiciliary Care	£279,131	(0.7%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£10,396,612	(26.0%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£200,000	(0.5%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£6,288,035	(15.7%)
Prevention / Early Intervention	£1,150,653	(2.9%)
Residential Placements	£4,405,468	(11.0%)
Other	£0	(0.0%)
Total	**£39,995,465**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	453.9	470.9

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SLIS data - available on the Better Care Exchange)	LOS 14+	10.8%	8.7%
	LOS 21+	4.3%	4.1%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SLIS data - available on the Better Care Exchange)	0.0%	92.2%

Residential Admissions

		20-21 Actual	21-22 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	486

Reablement

	21-22 Plan

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%

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: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Barnet

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

iBCF Contribution	Contribution
Barnet	£9,338,650
Total iBCF Contribution	**£9,338,650**

Are any additional LA Contributions being made in 2021-22? 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**	

CCG Minimum Contribution	Contribution
NHS Barnet CCG	£27,772,288
Total Minimum CCG Contribution	**£27,772,288**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£27,772,288**	

	2021-22
Total BCF Pooled Budget	**£39,995,465**

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

Better Care Fund 2021-22 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 CCG Contribution	£27,772,288	£27,772,288	£0
iBCF	£9,338,650	£9,338,650	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£39,995,465**	**£39,995,465**	**£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 CCG allocation	£7,892,097	£18,450,398	£0
Adult Social Care services spend from the minimum CCG allocations	£8,298,241	£8,298,241	£0

Checklist

Column complete:

Yes	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	social care support	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,054,313	Existing
2	Seven Day Community Support	community support	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Continuing Care		CCG			NHS Community Provider	Minimum CCG Contribution	£2,568,717	Existing
3	Single Point of Access	Integrated care planning constitutes a co-ordinated, person	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£336,586	Existing
4	Social Care Demand Pressures	Schemes specifically designed to ensure that a person can continue to	Personalised Care at Home	Physical health/wellbeing	personalised care at home	Social Care		LA			Local Authority	Minimum CCG Contribution	£2,656,353	Existing
5	Community Equipment	Using technology in care processes to supportive self-management,	Assistive Technologies and Equipment	Community based equipment		Community Health		LA			Local Authority	Minimum CCG Contribution	£1,721,521	Existing
6	Enablers for integration LBB	Schemes that build and develop the enabling foundations of health,	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	Minimum CCG Contribution	£895,638	Existing
7	Primary prevention & Early intervention and	changes or approaches identified as having a high impact on	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Primary Care		CCG			Private Sector	Minimum CCG Contribution	£603,998	Existing

8	Community based integrated support	changes or approaches identified as having a high impact on	High Impact Change Model for Managing Transfer	Flexible working patterns (including 7 day working)		Social Care		LA			Local Authority	Minimum CCG Contribution	£449,417	Existing
9	Intermediate Care in the Community - Step down	Integrated care planning constitutes a co-ordinated, person	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£10,060,026	Existing
10	Fracture Liaison Service	Services or schemes where the population or identified high-risk	Prevention / Early Intervention	Social Prescribing		Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£107,235	Existing
11	Intermediate Care in the Community - Reablement/rehab	services that aim to help people live in their own homes through the	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	Minimum CCG Contribution	£279,131	Existing
12	Quality in Care Home Team	changes or approaches identified as having a high impact on	High Impact Change Model for Managing Transfer	Trusted Assessment		Social Care		LA			Local Authority	Minimum CCG Contribution	£271,512	Existing
13	Wellbeing Services	Schemes that are based in the community and constitute a range of	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£622,950	Existing
14	End of Life care	Schemes that are based in the community and constitute a range of	Community Based Schemes	Multidisciplinary teams that are supporting	community based services	Continuing Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£1,499,494	Existing
15	BCF Programme Governance to support system	changes or approaches identified as having a high impact on	High Impact Change Model for Managing Transfer	Monitoring and responding to system demand		Primary Care		CCG			Private Sector	Minimum CCG Contribution	£76,852	Existing
16	Personalised Care-Safe guarding/mental	Funding planned towards the implementation of Care	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Local Authority	Minimum CCG Contribution	£493,659	Existing
17	Memory Assessment	Schemes that are based in the community and constitute a range of	Community Based Schemes	Integrated neighbourhood services		Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£236,863	Existing
18	Care Act	Funding planned towards the implementation of Care	Care Act Implementation Related Duties	Carer advice and support		Other	care act	CCG			Local Authority	Minimum CCG Contribution	£942,275	Existing
19	Carers Support	Supporting people to sustain their role as carers and reduce the	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum CCG Contribution	£352,613	Existing
20	Carers Support - CCG	Supporting people to sustain their role as carers and reduce the	Carers Services	Respite services	advice and support	Social Care		CCG			Local Authority	Minimum CCG Contribution	£947,354	Existing
21	DFG	The DFG is a means-tested capital grant to help meet the costs of	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Private Sector	DFG	£2,884,527	Existing
22	Seven day social care support - Acute	changes or approaches identified as having a high impact on	High Impact Change Model for Managing Transfer	Engagement and Choice		Acute		CCG			Local Authority	Minimum CCG Contribution	£142,248	Existing
23	Winter Resilience	Residential placements provide accommodation for people with learning	Residential Placements	Discharge from hospital (with reablement) to	provision of support to required care	Social Care		LA			Local Authority	iBCF	£1,447,489	Existing
24	Admissions Avoidance	Schemes that are based in the community and constitute a range of	Community Based Schemes	Low level support for simple hospital discharges	community based schemes	Social Care		LA			Local Authority	Minimum CCG Contribution	£275,301	Existing
25	Community support offer	Services or schemes where the population or identified high-risk	Prevention / Early Intervention	Risk Stratification	offer support for complex discharges e.g.	Continuing Care		CCG			CCG	Minimum CCG Contribution	£970,418	Existing

26	Assistive technology	Using technology in care processes to supportive self-management,	Assistive Technologies and Equipment	Wellness services		Continuing Care		CCG			CCG	iBCF	£100,000	Existing
27	Day care Provision	Schemes specifically designed to ensure that a person can continue to	Personalised Care at Home	Physical health/wellbeing	personalised care at home	Social Care		LA			Local Authority	iBCF	£52,000	Existing
28	Enablement	Provides support in your own home to improve your confidence and	Reablement in a persons own home	Reablement to support discharge - step down	reablement/rehabilitation	Social Care		LA			Local Authority	iBCF	£200,000	Existing
29	Homecare	Schemes specifically designed to ensure that a person can continue to	Personalised Care at Home	Physical health/wellbeing	personalised care at home	Social Care		LA			Local Authority	iBCF	£3,579,682	Existing
30	Prevention	Services or schemes where the population or identified high-risk	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	iBCF	£73,000	Existing
31	Care Home provision	Residential placements provide accommodation for people with learning	Residential Placements	Care home		Social Care		LA			Local Authority	iBCF	£2,296,557	Existing
32	Supported Living	Residential placements provide accommodation for people with learning	Residential Placements	Supported living		Social Care		LA			Local Authority	iBCF	£661,422	Existing
33	Staffing and support to monitor flows	changes or approaches identified as having a high impact on	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	iBCF	£928,500	Existing
34	Care Home Support Programme	changes or approaches identified as having a high impact on	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process	enhancing health in Care Homes	Other	care homes	CCG			CCG	Minimum CCG Contribution	£207,813	Existing

2021-22 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. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG 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 shoukld 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
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.
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.
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.
17	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 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Barnet

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	453.9	470.9	The plan includes a small stretch which will deliver an improvement on the 19-20 position; the plan has factored in the challenges to the local system and the role out of a number of new initiatives e.g., the UEC workplan, the 6-week winter sprint and the wider NCL winter resilience plan.

Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	10.8%	8.7%	The targets are based on a slight reduction from current projections and reflects the local position. The 2021-22 targets are considered to be a stretching ambition for this year in the context of continued Covid-19 related pressures on both acute and community-based care, in addition to challenges around the health and care workforce in the approach to winter. There is an anticipated peak in demand for services in Q3, which accounts for the aim to continue to stabilise and rebuild
	Proportion of inpatients resident for 21 days or more	4.3%	4.1%	

Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.3 Discharge to normal place of residence

	21-22 Plan	Comments
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)	92.2%	Targets are based on 19/20 performance. It is noted that the 95% national target is being met across NCL at a hospital level, however the Barnet SUS data does not reflect this therefore performance targets have been tailored accordingly to the Barnet level SUS data. Homecare and reablement services continue to benefit

Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
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	327	503	502	486	Targets are based on 19/20 performance due to the uncertainty regarding resistance to care home admission which appeared during the pandemic. This has been reflected in increased pressures on homecare but early indications show a slow return to pre-pandemic trends with increased demand for residential placements. It is
	Numerator	188	288	292	290	
	Denominator	57,441	57,304	58,170	59,707	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

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

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	63.8%	87.0%	75.4%	All clients discharged in a snapshot period of 1st of October to 31st of December are traced to see if they are within their own homes from 1st of January to 31st of March which is 91 days following their discharge and with current levels of increased discharges from Hospital in to social care specially for older people we expect this year
	Numerator	324	80	**132**	
	Denominator	508	92	**175**	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 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 CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? 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	Please see supplementary narrative. The governance arrangements are set out. Plan has been received input from all stakeholders		
	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 • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for 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 BCF plan will address these	Narrative plan assurance	Yes	Supporting narrative details the local approach. Barnet is part of the NCL ICS and has a borough ICP Board. BCF schemes are clearly linked to supporting people to remain independent at home A robust ICS/ICP plan is in place setting out the local approach for reducing inequalities		
	PR3	**A strategic, joined up plan for 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 Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	The plan sets out the achievements over the last year and the next steps for 21-22		
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG 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	The total spend matches the minimum required contribution		
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 CCG minimum BCF contribution?**	Does the total spend from the CCG 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	Narrative sets out the total spend on out of hospital services.		
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes	See supporting narrative		

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 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG 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 plans and confirmation sheet	Yes	Please see supplementary narrative. Details of next steps and supporting schemes set out		
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes	Details set out in metric tab and BCF narrative		