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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.

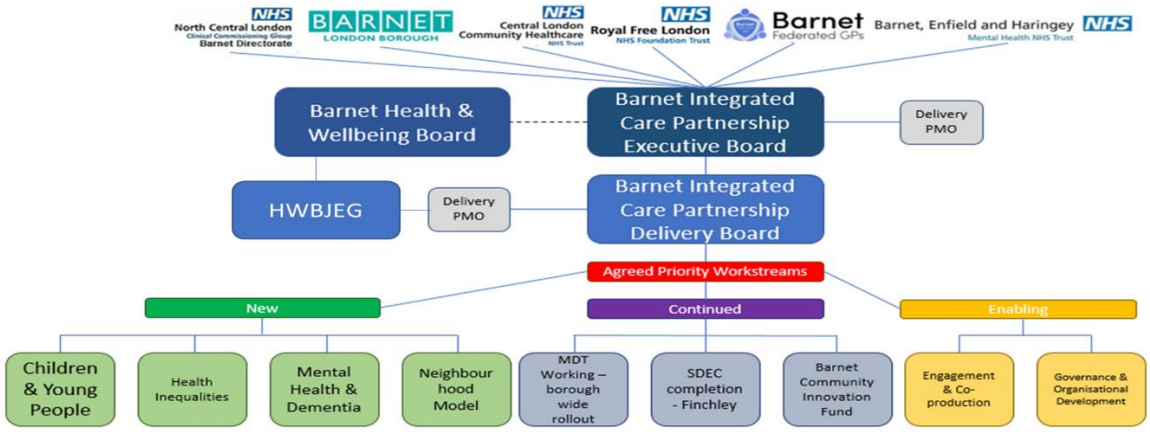
HWBJEG provides a forum for monitoring performance against the BCF section 75 agreement and how it is contributing to the commissioning strategies of the CCG and the Council. Standing agenda items in relation to the Better Care Fund include:

- 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.

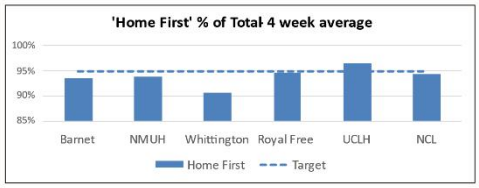
NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

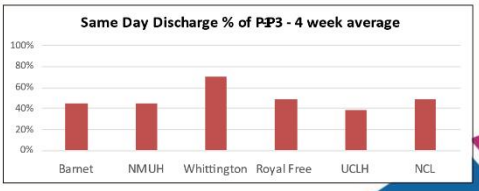
NHS

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 3 rd May, and Fri-Thurs from w/c 14 th May 2021.

OFFICIAL- SENSITIVE

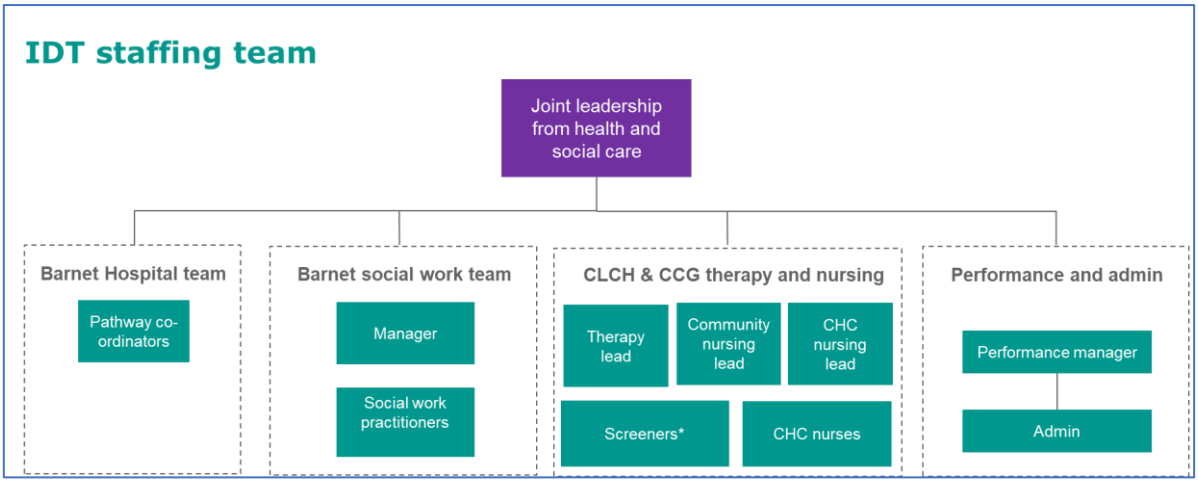
23

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

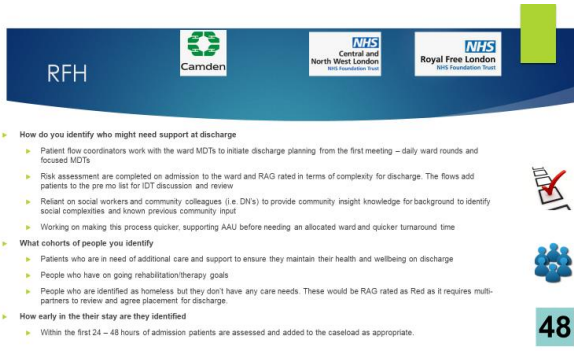
1. Managing winter pressures for 2021/22:
    a. Including system and staffing capacity
    b. Domiciliary and care home staff capacity to maintain hospital flow
    c. Interdependency of primary care, community, acute, social care partners and LAS with mitigation as early warning triggers and process 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:

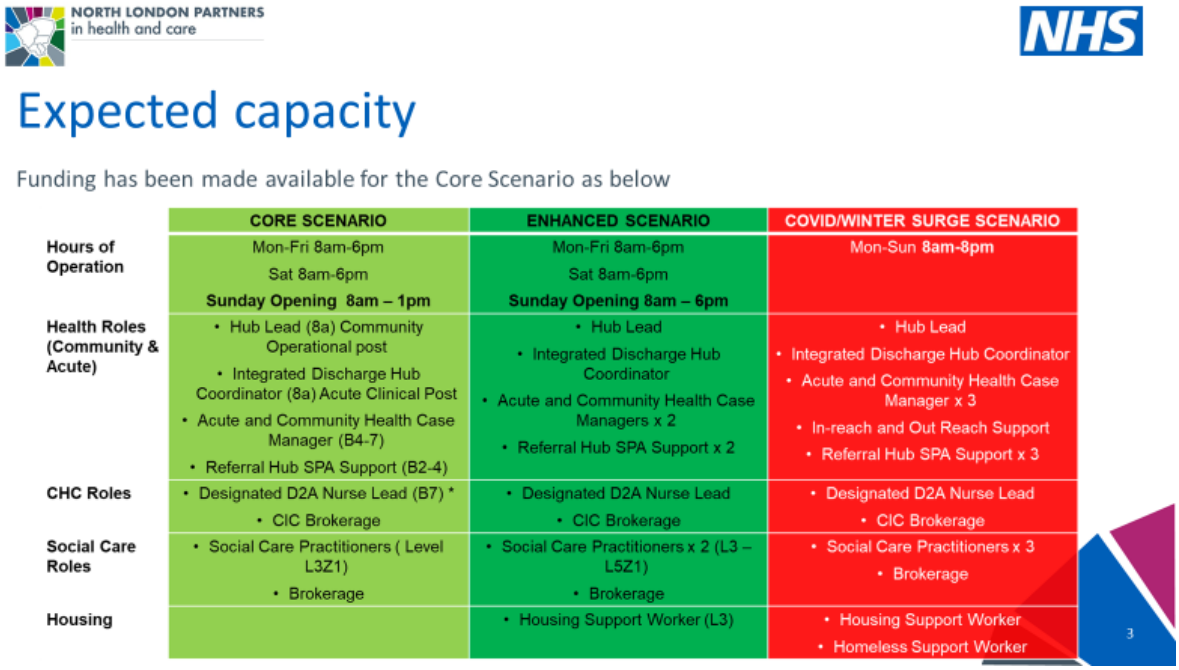
- A comprehensive flow monitoring system is in place led by acute trust and reviewed daily.
- Multi-agency discharge improvement working groups meetings
- Trusted Assessors
- A choice policy

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.



	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

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**.**

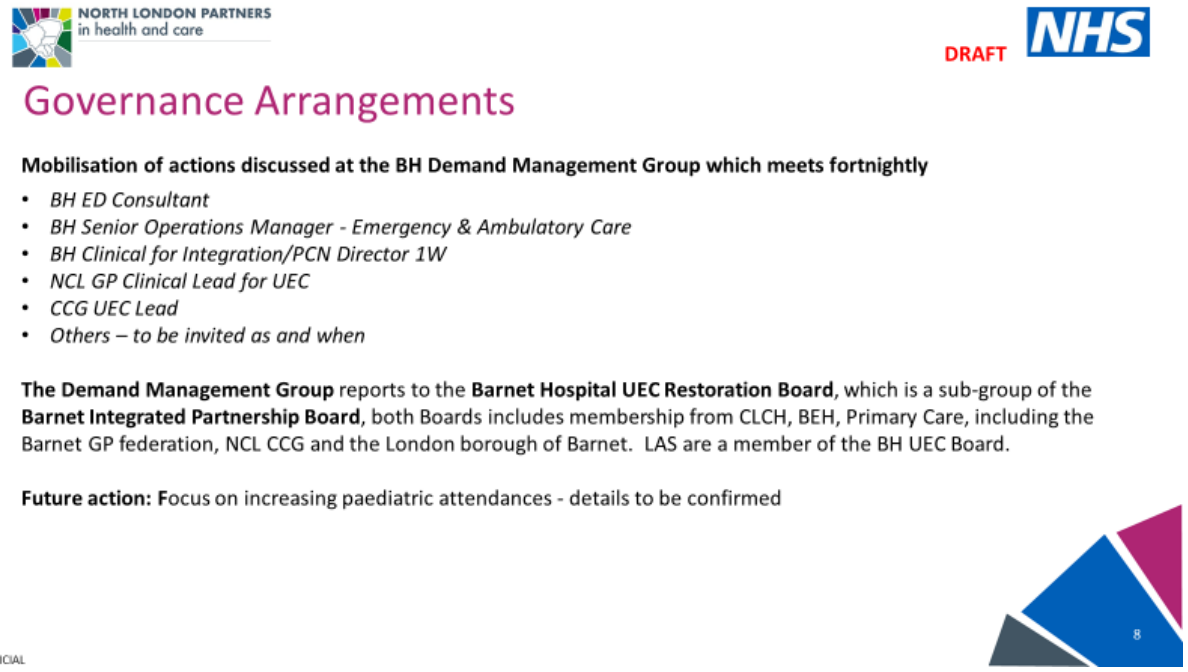
Metrics

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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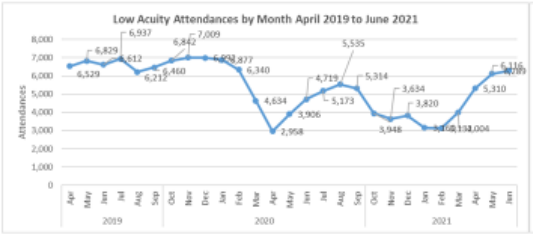
Purpose and objectives

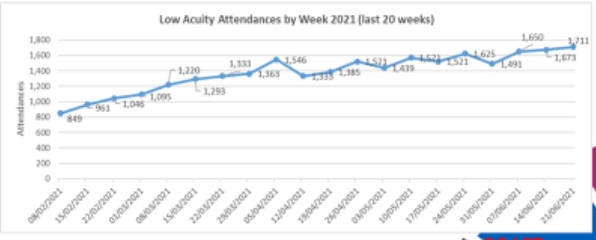
A key action from the NCL UEC Summit was to develop an analysis of low acuity ED demand across NCL sites.

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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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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DRAFT NHS

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

DRAFT NHS

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

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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

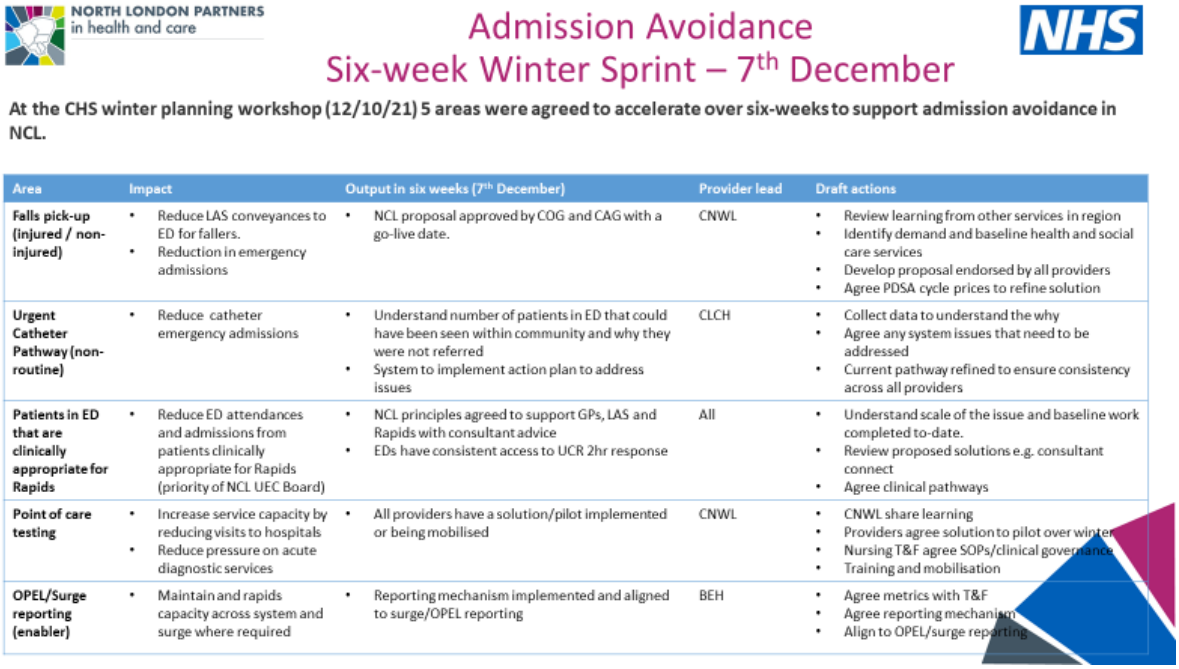
		19-20 Plan	19-20 Actual	21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	63.8%	87.0%	75.4%
	Numerator	324	80	**132**
	Denominator	508	92	**175**

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