Appendix B - Progress report on Key Area Three: Ensuring delivery of coordinated and holistic care, when we need it

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PRIORITY: Support digital transformation of services

Work is underway to agree specific KPIs around digital transformation with a focus on capturing digital exclusion. There are challenges around identifying public data sources that are routine and regularly updated. Current candidates include broadband availability by postcode, number of LSOAs in Barnet that count as Census Hard to Count, and number of residents supported through digital inclusion schemes.

Overall Rating: AMBER				
Key Performance Indicator	Baseline Date	Baseline Data	Current Data	Target Data
Indicators continue to be under development in this area with the wider partnership				

Progress Update:

Integration of data for direct patient care and population health improvement.

North Central London Partners in Health and Care procured two digital products from Cerner for roll-out across NCL:

- London Care Record (was Health Information Exchange but now being rolled out across London and beyond now)
- HealtheIntent – a population health management platform

The **London Care Record** enables health and social care staff to have one secure view of a person's relevant heath and care information at the point of care. Even if a person's details are held in other London, Hertfordshire, West Essex or Milton Keynes care organisations, information can still be accessed safely and securely by their clinician or social worker. For example, if someone from Barnet (North Central London) attends the emergency department at Chelsea and Westminster Hospital (North West London), staff directly involved in their care can access the information they need to treat and care for that person quickly and safely. This could include information on allergies, current medications, existing long-term conditions, or hospital admissions. Information is transferred securely, via a health information exchange system - this enables more effective care at the first point of contact.

The London Care Record had over 1 million views in May 2022, by over 49,000 unique users and the programme is working to increase this usage. The number of health and care settings using it, including care homes, is being expanded, as are the number of digital systems connected to it. The main local statutory health and care partners are party to the London Care Record, including local GP practices and the GP Federation, the Royal Free Group, London Borough of Barnet, Central London Community Healthcare Trust, and Barnet Enfield and Haringey Mental Health Trust, amongst others.

HealtheIntent is a digital platform that will allow health and care professionals in NCL to be more proactive in the care of clients, patients and communities. It is an essential tool to enable more integrated working between different care teams, to improve care and outcomes for clients, patients and communities, and to reduce health inequalities.

The digital platform links elements of health and care information from different sources (GPs, acute hospitals, mental health and community trusts, adult social care) and enables

health and care professionals to manage and plan care for individuals and groups of patients in relation to health or social care in 'near real' time – the data is refreshed every 24 hours. Health and care professionals directly involved in a patient or client's care can view the person's joined-up record, showing information collected by different care teams over time. The joined-up record helps to spot trends, concerns or gaps in care for both individuals and groups of patients, and inequalities in access and outcomes.

Teams across NCL have been using HealtheIntent to support with:

- **Flu and Covid-19 vaccinations** – particularly the identification of inequities in vaccination rates by different equalities group and by geographical location to inform community engagement and vaccine bus routes, for example.
- **Childhood immunisations** – GPs and practice nurses have been using the platform to identify children who still require vaccination.
- **Frailty and structured medications reviews** – community pharmacists have been using the platform to identify patients who have missed a review.
- **Elective recovery** – GPs have had the waiting lists for elective recovery for the first time and are working with hospitals and a wider integrated care team to proactively support those waiting for care.

In addition to the analytics and case lists that HealtheIntent provided, there are also registries which are for a specific cohort (e.g. people with diabetes). These registries identify where individuals have gaps in care for evidence-based interventions. For diabetes, gaps would include having a blood glucose that is above the recommended levels or being overdue on an annual foot examination. These gaps will shortly be available to all frontline health and care professionals who are using the London Care Record. NCL wants to make a cultural shift so that there is mutual accountability for closing these gaps and we can shift towards earlier intervention.

Registries that will be available include: diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation (risk for stroke), childhood asthma, physical health checks for people with severe mental health illness and learning disabilities, high blood pressure, care after cancer, multi-morbidity, prevention, and chronic kidney disease.

Digital Offer to Support Prevention and Timely Accessible Care

Although prior to the pandemic, people were already accessing services to support their health and wellbeing online, the pandemic has had a profound impact on the way people use digital technologies, with an unprecedented growth in delivery of services online. The overarching aim in this area is to ensure that we have tools in place to support those who require services to receive pro-active, well planned, personalised care helping them to lead the happiest and healthiest lives possible.

There are a number of digital projects underway currently. North Central London (NCL) Digital Care Home programme is working with care homes to increase their access to digital tools which can improve care, whilst also working alongside care home staff to provide training. This digital care programme includes, amongst other aspects, working with care homes to:

- Increase care home connectivity,
- Invest in and pilot digital tools such as
    - remote monitoring: Using the Whzan blue box
    - acoustic technology for falls prevention.
- Meet key data security standards

A second project has been to roll out digital consultations using the e-consult form for primary care services. Patients complete key information about their current health issue in the on-line form which allows GP practices to triage patients more efficiently. This has led to an increase in the number of patients that GPs are able to speak to within 48 hours but has presented some real challenges for access for some patients who struggle to use the form. Healthwatch England produced a report which highlighted the experience of accessing GP services digitally.

Some areas of health improvement use apps or websites to support individuals to improve their own physical or mental health without needing to access NHS services first. For example, Public Health commission DrinkCoach (www.drinkcoach.org.uk) which helps individuals assess the risk from their alcohol consumption and be supported to reduce their levels of drinking either on their own or with an online personalised support service. For people with more complex issues, they are referred into the substance misuse treatment pathway. Public Health have also promoted use of the Staying Alive app as part of the high-profile suicide prevention campaign this year. The app provides information on support services for those in crises but also helps individuals make a safety plan and store images that are important to them. Young families have access to Ask Teddi, an early years (0-5 years of age) robo-support app, provided as part of our Healthy Child Programme contract. The Teddi app provides advice and support to families, and is built on evidence-based data, resources from trusted sources, knowledge from key subject matter experts, insights from large teams of Health Visitors and School Nurses, parenting expertise, user feedback, and advances in AI. Users can have a general conversation with Teddi, ask Teddi questions, or talk about issues or concerns they may have. There are other services such as the C-Card scheme for young people to access condoms from participating outlets and Kooth which provides on-line mental health support which support or improve children and young people's health.

Address inequalities in digital access to health services

Digital exclusion is a multifactorial issue, with a number of areas requiring intervention. Barnet Council have developed a programme to address digital exclusion. The programme includes:

- **Identifying digitally excluded residents** to target interventions through digital triage to make every contact count and provide an accurate picture of need.
- **Improving digital skills and confidence** through digital champions within frontline services and community groups providing digital skills drop-in sessions and workshops close to home.
- **Ensuring council services are accessible to all** including ensuring residents have a clear view of support on offer, and that communications and information is accessible. But also providing business support to help high street and micro-businesses take advantage of digital tools.
- **Improving digital connectivity and affordability of connections** through free fibre connections for community centres, to create a network of localised digital inclusion hubs; alongside free fibre-for-a-year for unemployed and low-income households to help them get online at home.
- **Improving access to the equipment to get online** through free refurbished laptops for residents to help with access to study and work opportunities and to build their independence online.

- **Providing jobs and employment support** through investment in digital infrastructure, including jobs, apprenticeships, and work experience opportunities in the digital and telecoms sector.

The results of the Healthwatch report mentioned above, as well as local experiences of residents collected by LBB, will be part of the CCG's emerging sector-wide programme on digital exclusion, in which LBB are participating.

Next Steps:

1. Develop robust KPIs to monitor improvements in this area.
2. Further development of HealtheIntent with a focus on data quality and cultural change. See below for requests for support from the Board.
3. LBB Digital Exclusion Forum to continue to promote digital skills, capabilities, and inclusion to ensure no one is left behind and all thrive in a digital era, through:
   - co-design and provide services and technology around the needs of the people using them
   - ensure staff and the public feel confident using technology, investing in digital capabilities and skills, and providing access for all
   - ensure digital inclusion and support is at the heart of the digital strategy and we leverage our technology supply chains to support digitally excluded staff, residents, and businesses
   - develop work programme with NCL ICS colleagues around digital inclusion affecting access to health and care
4. Continue to deliver the NCL Digital Care Home Project in Barnet
5. Continue to adapt the e-consult tool to reduce access issues for those adversely affected by the tool.
6. Strengthen the systematic use of health improvement apps and websites through the redevelopment of the Public Health microsite.

Key Issues and Risks:

Summary	Mitigating Actions	Rating
If the data used in population health systems is poor, incomplete or contradictory, front-line staff will stop using the system and population health gain will be lost.	HealtheIntent team is working to secure collective commitment from local organisations as data controllers to prioritise making improvements to data quality systems, including funding resources required to do this. Support from the Board on this point is requested	AMBER
If the partnership does not focus on ensuring that all residents have the ability to electronically access to health services, then a switch to digital only methods will disenfranchise some people, and	- Partnership focusses on delivering programme of overcoming digital barriers for residents accessing services - Alternative non digital methods of accessing services remain in place	AMBER

Summary	Mitigating Actions	Rating
potentially have a negative impact on their health and wellbeing	for those who are unable to access them digitally	

Support Requested from Health and Wellbeing Board:

1. Realising the benefits of new population health management tools requires care teams to work differently together and to adopt the tools, as well as wider cultural change for mutual accountability and responsibility for closing gaps in care. While there is an increasing focus on the conditions for adoption of these tools across the system, support from the Board is requested to ensure further development in this area is aligned with the emergence of the ICB and place-based partnerships.

2. Realising the benefits of new population health management tools requires care teams to work differently together and to adopt the tools, as well as wider cultural change for mutual accountability and responsibility for closing gaps in care. While there is an increasing focus on the conditions for adoption of these tools across the system, there needs to be further development in this area aligned with the emergence of the ICB and place-based partnerships.

3. Individual organisations are asked to support the ICS digital exclusion work to ensure that inequalities are not increased through wider roll-out of digital services.

PRIORITY: Enable carers health and wellbeing

Overall Rating: GREEN				
Key Performance Indicator	Baseline Date	Baseline Data	Current Data	Target
Number of carers registered with their GP	2021	12,125	12,297 ↑ (June 2022)	12,500
Proportion of carers who feel socially isolated	2018/2019	26%	25% ↓ (2021/22 Survey)	20%

Progress Update:

Identifying informal carers unknown to health and social care

During the pandemic, a collaboration between the council, the Carers Centre and Adult Social Care, identified of a significant number of additional carers who were previously unknown to health and social care. This work not only ensured that they could access the COVID vaccination which was offered to carers before the general population but also means they are now aware of the support and further assessment offer (see below). A priority focus for Barnet Carers Centre under their new contract (from 1st April 2022) is to ensure that the service reaches the borough's diverse carer population from a range of ethnic backgrounds, social circumstances and age profiles.

Support for informal carers

The council commissions Barnet Carers Centre to deliver a holistic support offer to informal carers of all ages. The service offers a range of peer and group support to help sustain people in their caring role through access to information and advice, training opportunities, emotional support, social contact and informal respite. The service also delivers carers assessments on behalf of the council, which is an opportunity to discuss and plan how the carer can be supported to best manage their own health and wellbeing. Where there is an assessed need, a carer's budget will be offered. This could be used to fund health and wellbeing support, such as massage therapy or to purchase a laptop to facilitate access to online exercise classes and promote social inclusion.

In addition to the Carers Centre, there are a number of other voluntary community and faith sector partners across the borough who provide support to carers who are collaborating on strategy development.

Support for care staff

All care staff working in Barnet are encouraged to sign up to Proud to Care Rewards which offer members a range of savings and benefits. The Informal Carers Network for Council staff provides (online) peer support, information and advice to Barnet Council staff members who have an informal caring role.

Commissioned care providers are required to have robust support arrangements in place for their staff, for example opportunities to reflect and debrief following an incident.

New Carers Strategy for Barnet

Barnet's all-age carers strategy is being refreshed in 2022/23 in co-production with local residents. The strategy will ensure that the voice of carers is heard in the review and future

shaping of the support offer to informal carers in Barnet. Amongst other things, the strategy will reflect upon:

- Identification of informal carers, including young carers
- Equity of access for minoritized communities
- Support for carers to look after their own health and wellbeing
- Social connectedness amongst carers

The strategy is due to be presented to Adults and Safeguarding Committee, and the relevant bodies/partnerships for Children's in March 2023, with a draft due in late 2022.

Address the COVID risk to staff from Black, Asian, and other minority ethnic groups

Information about how to protect against Covid19 and its effects has been regularly communicated through forums targeting employees in public sector organisations. One of the main ways of protecting against the impact of Covid19 is to be vaccinated. Information has been produced in a variety of different languages and circulated to voluntary groups, as well as outreach events held in areas where there are higher proportion of BAME communities.

Next Steps:

1. A carers steering group has been established and is meeting regularly in order to drive forward the refresh of the carers strategy (it also acts as the carers workstream of Adult Social Care reform programme);
2. An engagement plan has been drawn up to drive the refresh process, including workshops with carers and young carers of all ages to develop strategy, and other methods of engagement in order to reach the widest possible audience.

Key Issues and Risks:

Summary	Mitigating Actions	Rating
Other system pressures occur, leading to the loss of momentum on identifying and connecting informal carers to services to support them, resulting in carers not being supported and their health and wellbeing suffering No Board level risks identified	- Continue and build on funded service with Barnet Carers Centre - Continued development work with carers groups to inform the partnership of the picture on the ground - Carers Strategy update to understand what is working currently, and what needs to be a priority in future	GREEN

Support Requested from Health and Wellbeing Board:

1. Board members asked to assist identifying informal carers amongst their staff so they can access the support available and to feed into strategy when asked for their input.

PRIORITY: Deliver population health integrated care

Further work is needed to agree KPIs which measure integration of services and the impact this integration has on residents' health and wellbeing. Early diagnosis of cancer is a good proxy measure for how well the system including preventative care are working together to deliver integrated care.

Overall Rating: GREEN				
Key Performance Indicator	Baseline Date	Baseline Data	Current Data	Target Data
Stage of diagnosis for Cancer/Percentage of cancer diagnosed at stages one and two	2018	57.9%	National reporting on indicator stopped during C19 pandemic	75% by 2028
Emergency admissions from ambulatory care sensitive conditions	March 2021	6,971	Awaiting confirmed data	6,500
Resident satisfaction on overall care and perceived integration/joined up care	New indicator	New indicator – no baseline available	New indicator	New indicator
Carer satisfaction - overall care and perceived integration/joined up care	New indicator	New indicator	New indicator	New indicator
Staff satisfaction – overall care and view of integrated working	New indicator	New indicator	New indicator	New indicator

Nick Goodwin, in a paper on Understanding Integrated Care identifies that integration can be described in the following ways:

- the *type* of integration (i.e. organisational, professional, cultural, technological);
- the *level* at which integration occurs (i.e. macro-, meso- and micro-);
- the *process* of integration (i.e. how integrated care delivery is organised and managed);
- the *breadth* of integration (i.e. to a whole population group or specific client group); and

- the *degree* or *intensity* of integration (i.e. across a continuum that spans between informal linkages to more managed care co-ordination and fully integrated teams or organisations).

Integration can also take a number of key forms:

- *Horizontal integration.* Integrated care between health services, social services and other care providers that is usually based on the development of multi-disciplinary teams and/or care networks that support a specific client group (e.g. for older people with complex needs)
- *Vertical integration.* Integrated care across primary, community, hospital and tertiary care services manifest in protocol-driven (best practice) care pathways for people with specific diseases (such as COPD and diabetes) and/or care transitions between hospitals to intermediate and community-based care providers
- *Sectoral integration.* Integrated care within one sector, for example combining horizontal and vertical programmes of integrated care within mental health services through multi-professional teams and networks of primary, community and secondary care providers;
- *People-centred integration:* Integrated care between providers and patients and other service users to engage and empower people through health education, shared decision-making, supported self-management, and community engagement; and
- *Whole-system integration:* Integrated care that embraces public health to support both a population-based and person-centred approach to care. This is integrated care at its most ambitious since it focuses on the multiple needs of whole populations, not just to care groups or diseases.

The Barnet partnership has examples of a range of different integrated provision which is already established, as well as further work ongoing to increase the extent and the depth of integration. Our ambition that we are working to is whole-system integration, so it can streamline the journey of all residents, and capitalise on opportunities to support them to prevent ill-health and improve their overall health and wellbeing.

In the section below, we describe both existing integration of services and current transformation underway.

Existing Work

Type of integration	**Examples in Barnet**
Shared priorities and outcomes across the population	• Barnet Borough Partnership • Joint Health and Wellbeing Strategy
Shared strategies, priorities and outcomes, focussed on particular group(s)	• Dementia Strategy • All-ages Autism Plan • Children and Young People's Plan • SEND Strategy • Carers and Young Carers Strategy
Virtual and In Person Multi Disciplinary Teams	• Adults and Children's Multi-Agency Safeguarding Hubs (MASH) – brings partners together to ensure collaboration and consistency when responding to safeguarding concerns. • Multi-Agency Adults risk panel – provides a forum for partners to come together and discuss joint approaches to high risk cases.

Type of integration	Examples in Barnet
	• 0-19 Early Help Hubs – co-location and co-delivery of Early Help to children and families, including Health Visitors, schools and appropriate VCS organisations • Dementia Multi-Disciplinary Team (MDT) • Care (Education) and Treatment Reviews (MDT) • Paediatric Multi-Disciplinary Team (MDT) sessions enable joint collaborative discussions which continues to scale and develop in PCNs within Barnet, in collaboration with local Consultant paediatricians from Royal Free NHS Foundation Trust. • Frailty Multi-Disciplinary Team (MDT) provides personalised, proactive and holistic care for patients over 65 years who are (or at risk of) moderately and severely frail. The team continue to work on the referral pathway and clinical model of the pan Barnet Frailty MDT model, which it intends to launch in the summer of 2022
Borough Wide Sectoral integration / aligned working	• Integrated discharge team – LBB, CLCH, NCL CCG/ICB – A collaborative approach to ensuring adults have the right care and support put in place quickly to allow them to leave hospital as quickly and safely as possible. • Integrated Adults learning disability team – LBB, CLCH and BEH MHT. A joint team that brings together health and social care practitioners to provide holistic services to adults with a learning disability. • Admission prevention service at the front door to emergency department at Barnet Hospital (BH) and other hospital sites – LBB/BH. A new team being trialled this year to more quickly intervene and avoid hospital admissions through social care interventions. • Integrated community equipment service– LBB and NCL CCG. The council and CCG have jointly commissioned a service that all health and social care professionals can effectively utilise. • Mental Health teams / services – LBB, BEH MHT, VCS. The health and social care teams across health and social care, alongside VCS colleagues, work closely to join up services for adults in Barnet. • 0 – 25 Tripartite Panel – LBB, BELS (Barnet Education and Learning Service) and NCL CCG/ICB
Borough/Cross borough Joint Appointments and Pooled Budgets	• Director of Integrated Commissioning – LBB and NCL CCG/ICB • Adults Joint commissioning team – LBB and NCL CCG/ICB • Better Care Fund - LBB and NCL CCG/ICB • NCL Public Health Team – NCL ICS / NCL DPHs

Transformational Work Currently Underway

Integrated Health Services for Children and Young People

Children's and Young People priorities will be driven by the Barnet Borough Partnership Integrated Care Strategy for Children and Young People (currently in development) and overseen by the Children & Young People's Partnership Board. Existing programmes are listed above. New areas currently being developed / rolled out are summarised below

Paediatric Multi-Disciplinary Team

These Multi-Disciplinary Team (MDT) sessions enable joint collaborative case-based discussions with secondary care Consultant Paediatricians, early years representatives and primary care GP's, to help facilitate early expert advice and care and provide education and support to primary care clinicians to enable enhanced care in the community. Sessions are taking place in two Primary Care Networks (PCNs) currently, with local Consultant paediatricians from Royal Free NHS Foundation Trust. The sessions have been favourably received and have received excellent engagement from secondary care colleagues. The Barnet Borough Partnership (BBP) team are reviewing the scope to expand further to CAMHS support and wider roles such as social prescribing link workers and supporting further rollout across the borough. The number of children seen by the team will be published in July 2022.

Long Term Condition Work – Asthma exemplar

CYP partners are progressing integrated approaches whereby services work together to mitigate the impacts of asthma on school attendance and other aspects of Children and Young People development. Part of this work is ensuring LBB strategies and services consider the impacts on Children and Young People with asthma, for example environmental strategies and approaches to improving the quality of housing provision.

Children and Young People Mental Health & Wellbeing Strategy

A Barnet-focused strategy is currently being drafted and a Mental Health & Wellbeing Partnership Board established with the aim of bringing together the whole system to develop an integrated coherent offer to children and young people which also addresses wait times.

SEND – Integrated Therapies

The LA, CCG and Lead Provider continue to work together to develop the service offer to Children and Young People and to early years settings, mainstream and special schools so that interventions are delivered in an integrated way within settings.

SEND - Autism and Child Development Centre

As part of the Autism All-Ages Plan, a cross-service project is developing integrated pathways and seeking to ensure that teams of different specialists are co-located. When all plans come to fruition, the Centre will enable families to access a range of services and support from the same location.

Integration of Clinical Pathways for Adults, including Primary and Secondary Prevention

Frailty Multi-Disciplinary Team (MDT)

The Frailty MDT approach provides personalised, proactive and holistic care for patients over 65 years who are (or at risk of) moderately and severely frail. PCN2 ran a pilot frailty MDT to develop processes and assess impact, while PCN 5 did similar with a dementia MDT approach. Both pilots included the Adult Social Care Prevention and Wellbeing team as part of the model. The Barnet Frailty Working Group have now reviewed this model and others from across the system and engaged with stakeholders to design a finalised model and identified workforce needed to take this work forward. Central London Community Healthcare are recruiting to new roles to enable a new, dedicated pan-Barnet Frailty MDT, including dementia nurses and advisors and frailty nurses/ case managers and therapists, to support MDT meetings, case management and proactive care in the community with continued engagement and support from secondary care and voluntary care sector to ensure a holistic, integrated model. This model will launch across all PCNs in the summer of 2022.

Cardiovascular Disease (CVD) Prevention Integration with new LTC Locally Commissioned Service

A new NCL Local Care Service focusing on Long Term Conditions (LTC) is being developed for North Central London, intended for introduction in 2022/2023. Primary care clinical representatives (commissioner and provider) across NCL and London-wide Medical Committee, supported by Public Health, are involved in the development of the new service, which will focus on metabolic and respiratory conditions and builds on the excellent examples of LTC care already in place in NCL. It aims to streamline monitoring and support for people with a Long-Term Condition, with a view to improving their health and reducing the impact of their condition.

The new Cardiovascular Disease Prevention (CVD) Programme provides a whole-system approach to supporting the CVD aspects of the LTC LCS, integrating primary and secondary prevention into these pathways. The programme includes workstreams to co-ordinate general population awareness of CVD, to address the behavioural risk factors for CVD, bringing in community pharmacy as well as general practice for clinical risk factor management, and supporting individuals to sustain their behaviour change through peer support and other programmes. A pan-Barnet Task and Finish Group is overseeing the development and implementation of the programme, with wide-ranging membership.

Key to the plan is addressing health inequalities, especially the greater risk and worse outcomes of CVD for local residents from Black African, Black Caribbean and South Asian communities. A joint partnership bid between Inclusion Barnet and Public Health, supported by the Barnet Borough Partnership, has been designed to develop an integrated peer-support approach to CVD prevention and management, called Healthy Heart Peer Support. The project focusses on providing support to these residents to educate themselves and others on CVD prevention and management starting initially with hypertension management. The Peer Support Team leader and Peer Support Workers have been recruited and are currently developing the work programme.

Barnet is also represented on the NCL CVD and Stroke Prevention workstream to ensure that local voices are heard in that forum and local place-based initiatives are in line with sector-level work.

Continued Development of Pathways for Long Covid

Work to develop appropriate clinical pathways for Long COVID have continued as the understanding of this condition, also known as Post-COVID Syndrome (PCS), has

developed. The pathway has been developed by the NCL Long COVID Steering Group, informed the NCL PCS Needs Assessment. The needs assessment was initially undertaken in August 2021 and most recently updated in June 2022. It has been informed by the extensive report published by Healthwatch in all five NCL local authorities, entitled People's experience of Long Covid in North Central London | Healthwatch.

A crude estimate of cases of Long COVID in Adults in Barnet are 3,027 men and 4,286 women, using the ONS prevalence of 1.54% of men and 2.15% in women combined with local population figures. Similar synthetic estimates have been produced for age groups, deprivation areas and ethnic groups in Barnet, using the ONS survey results. There are no Barnet figures available for primary-care-diagnosed cases since this data was not available to the NCL Commissioning Support Unit. Elsewhere in NCL there is a significant gap between primary care diagnosis and the estimated prevalence. It should be noted that Long COVID is more likely in unvaccinated individuals as well as those with a variety of other risk factors such as being female, being middle-aged, larger number of symptoms during acute COVID phase, higher BMI, and pre-existing long-term conditions, especially asthma.

The NCL PCS service for Adults (aged 18+), in line with NICE guidance on PCS, consists of:

1. **Identification** (in acute and primary care)
2. **Assessment** in primary care
3. **Onward referral** through a single point of access (SPA) to:
    - Specialist UCLH Clinic
        - Specialist secondary care
    - Community rehabilitation
        - Physiotherapy
        - Psychological therapy
        - Fatigue Management
    - Supported self-management and digital platforms

To date, the specialist service at UCLH has assessed 1585 NCL patients, 72% of whom were referred by primary care. The demographics of these patients were broadly in line with ONS estimates. 47% went on to be receive rehabilitation services, 17% support from social care or the voluntary sector and 14% referred for self-care. The remainder are still being assessed.

The Healthwatch report identified impacts of Long Covid on health, life and healthcare experiences. The Long COVID Steering Group has developed an action plan to address the issues raised in the Healthwatch reports which is currently being implemented, along with other improvements to streamline the pathway. Health Champions have also been active in promoting the care pathway as well as approaches to self-care using NHS resources.

Build on the neighbourhood model of service delivery

Barnet Borough Partnership has set up a programme board to lead the programme, and is currently working through the principles and developing a shared understanding of what neighbourhoods are and the future ways of working. Public Health and the LBB Strategy Team are co-leading developing an example of neighbourhood working on the Graham Park estate. Building on a joint needs assessment, work is underway to develop more localised programmes addressing the priorities identified by the needs assessment.

Reducing the impact of COVID and LTC on BAME communities in Barnet

The focus of the partnership over the past 12 months has primarily been about raising both awareness of Covid19, and the Covid19 vaccine. This has led to a range of programmes to improve understanding and countering misinformation about Covid19 and the Covid19 vaccine. Work has been delivered through the:

- Health Champions programme, which has involved people of different cultures and communities to share messages about COVID and increasingly about other health topics that support COVID resilience such as CVD and mental health.
- Infographics and videos prepared in different languages and shared via different channels
- Outreach virtual and in-person events held with communities who are lower take up of the vaccination, e.g. Romanian community

Significant funding (£485,000) from the Department of Levelling Up, Housing and Communities (DLUHC) was secured to further address inequalities in COVID vaccine take-up. The COVID Vaccine Champions programme is embedding Health Ambassadors within community organisations in communities with the lowest uptake to work with local residents to address COVID vaccine confidence but also help with other health issues.

Support those with complex needs (homeless, substance misuse and/or mental health) by ensuring rapid access to care in the most appropriate way

To appropriately address the needs of street homeless people in Barnet through the pandemic, a multi-agency partnership task and finish group was established. This group developed a needs assessment to understand the support needs and complexities of this group, and a partnership workplan was developed. This work has been reported to the HWBB previously.

The partnership group has worked collaboratively to embed the new rough sleeping substance misuse team and ensure pathways work effectively. The team are funded through a grant from the Office of Health Inequalities and Disparities and consists of a lead nurse, a substance misuse worker, and a floating support worker employed by Change Grow Live (the local substance misuse provider), a complex needs worker employed by BEH MH Trust, and a Romanian speaking worker employed by local VCS organisation Romanian Culture and Charity Together. Although the team are employed by three different organisations, they work to the same line manager and within a single service. This ensures the service is truly multi-disciplinary. The team co-locate with local homeless organisations such as Homeless Action in Barnet and work alongside Barnet Homes in a task orientated way. Service users benefit from a rapid, holistic approach which addresses their physical health, mental health, substance misuse and housing issues in a proactive manner.

In addition, NCL CCG are reviewing the locally commissioned homeless health services. A new service specification has been drafted that will transform the current specialist service to a more holistic and multidisciplinary offer. The specification supports improved pathways to broader health, mental health and wellbeing services. Furthermore, practices will be encouraged to sign up to a new specification which supports them to deliver the “safe surgery” model. Safe Surgeries recognise the barriers to healthcare access that exist, particularly for migrants and homeless people in vulnerable circumstances, and believe that small changes in practice can make a difference. They are willing to lead by example and work to ensure that nobody in their community is excluded.

Mental health access remains a significant challenge for people who are homeless. This was a theme echoed throughout the health needs assessment. Service users and staff working in

homelessness services report that the pathways are difficult to navigate and not responsive for the client group. The Barnet Safeguarding Adults board is currently conducting a review relating to the potentially avoidable death of an individual with a recent history of long-term homelessness and a second recent death of a homeless person will also be referred to the board. Learnings from these deaths will be noted in the Homeless Health Action Plan.

Next Steps:

1. Continue to work to develop relevant KPIs for this complex area of work.

2. Integrated Health Services for Children and Young People

- Integrated Therapies - Continue to work together to develop solutions to reduce wait times for assessment and treatment including early intervention, SEN support and delivery of specified provision in EHCPs.
- Integrated Paediatric Clinics – Expand the number of integrated primary and secondary paediatric clinics into two more PCNs in Summer 2022.
- Mental Health – Finalise the Children and Young People Mental Health & Wellbeing Strategy

3. Frailty MDT, Cardiovascular Prevention Programme, and the LTC LCS

- Expansion of both teams to more Primary Care Networks to take place in Summer 2022
- Continue development of the service specification, and transition to the new delivery model in 2022/23
- Implementation of the CVD Prevention Programme, once approved by the HWBB

4. Neighbourhood Model of Service Delivery

- Confirm objectives for neighbourhood working, and develop the model of service delivery
- Look at ways of expanding the Graham Park approach to larger geographical area.

5. Reducing the impact of COVID and LTC on local communities from different ethnic groups

6. Continue to roll out the Covid Vaccine Champions programme, adapting as lessons are learnt from early implementors.

7. Complex needs

- Continue to identify ways to improve the way in which the mental health needs of residents with complex needs are met.

Key Issues and Risks:

Summary	**Mitigating Actions**	**Rating**
Providing rapid access to suitable mental health support for homeless people has been a challenge. The existing pathway is not effective for homeless people and there is no community mental health specialist offering in-reach to homelessness services.	- A complex needs role has been funded to work in the substance misuse service which will be employed by BEH. The role has failed to recruit on two occasions. The budget has been uplifted and person specification being changed to accept applications from nurses, social workers and	AMBER

Summary	Mitigating Actions	Rating
	psychologists. - A meeting has been scheduled with LB Barnet Public Health, Head of Mental Health commissioning and HAB to explore pathways.	
Support to build a relationship with Youth Justice and Police services to help them understand how to work with young adults with autism	- Explore ways of engaging with youth justice and police in this work	AMBER
Review and create an offer Mental Health in Schools and Colleges for Autistic children with mild to moderate anxiety	- Explore ways of engaging with relevant services to develop the offer	AMBER

Support Requested from Health and Wellbeing Board:

1. NHS Board members are asked to strengthen leadership of Early Help Assessments by Health professionals, with more Health professionals leading plans where needed