Key Area 3 – Deep Dive

Health and Wellbeing Board

14 July 2022

BARNET
LONDON BOROUGH

Our Commitments

Support digital transformation of services

We will work together to provide digital care and support for all who can benefit from it, as well as using the power of linked electronic health and care records to improve population health.

Enable carers health and wellbeing

We will support care staff and informal carers to look after their health and wellbeing.

Deliver population health integrated care

We will work together to ensure the Barnet Integrated Care Partnership is centred around residents' need, aims to reduce health inequalities, promotes good physical and mental health and enables seamless access to health and care services across the life course, delivered in collaboration with local communities at neighbourhood level.

Contents

Support Digital Transformation of Services

- Digital Inclusion Work with Age UK (Barry May and Fay Morris, London Borough of Barnet)
- HealtheIntent and the Shared Care Record (Sarah Dougan, NCL)

Enable Carers Health and Wellbeing

- Identifying and supporting Barnet's informal young and adult carers (Mike Rich, Barnet Carer's Centre)

Deliver Population Health Integration Care

- Impact of Frailty Multi Disciplinary Teams (Helen Newman/Jenny Jean-Charles, Age UK)
- Integrated Paediatric Clinics (Dr Claudia Tailor, PCN1W Clinical Lead Integrated Paediatric Hub)
- All Ages Autism Plan (Kim Miller, Barnet Education and Learning Service and Nazia Scott, CCG/LBB Joint Commissioner)
- Long Covid Experience (Nitish Lakhman, Healthwatch Barnet)
- Grahame Park Neighbourhood (Rachel Wells, Barnet Public Health)

Support digital transformation of services

We will work together to provide digital care and support for all who can benefit from it, as well as using the power of linked electronic health and care records to improve population health.

Digital Inclusion Update

Fay Morris - Digital Inclusion Coordinator

Barry May – Head of Customer & Digital Services

Who is Digitally Excluded?

In the UK - 9 million can't use the internet and their device independently*

7 million have no internet access in their home

1.2m more people online - are they all digitally included?

Regional variation 49% 35% London 18% 53% North East

4 x more likely from low income households

8 x more likely to be over-65 (42% of over-75s in England are digitally excluded)

56% of adult 'non-internet' users were disabled

*sources – Good things foundation * ONS * Llyod's Digital consumer index 2021 Extensive Internet users Limited or non-users *Used internet in last 3 months

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Who is digitally excluded?

Not for me

- This is the largest segment of non-internet users and are mostly older residents.
- They feel that they do not need to learn any digital skills in the future and see no benefits to accessing the internet

Unconfident

- Many do not know where to start or are worried about making mistakes
- Almost a third said that getting some more support from someone would encourage them to use the internet more in the future

Low income and confidence

- This group are more likely to face multiple barriers to digital inclusion
- They may lack the right equipment as well as confidence
- More than half explained that the high cost of devices was barrier

Reliant on others

- Many have impairments that make it hard to use the internet
- They are reliant on someone else to use the internet on their behalf

Financially constrained

- For this group, the high cost of devices is a key barrier
- Almost half said that free or low-cost internet access would encourage them more.

Benefits of being online

- 49% say digital helps manage and improve their physical and mental health
- 85% connect better with friends and family
- Manual workers with high or very high digital engagement earn £421 more per month
- The most digitally engaged users pay £228 less on their bills than the least engaged
- 67% say it helps save money and get better deals
- 92% of businesses want a basic level of digital skills from employees

Source: Digital Nation UK 2021

Digital Inclusion Plan

1 Improving digital skills and confidence

Key projects: Face to Face Customer Services Team, BOOST Programme

Progress and next steps:
BOOST Make It Click sessions taking place

Updated face to face customer services team will launch to provide digital support in partnership with libraries

2 Ensuring council services are accessible to all

Key project: Digital Inclusion Portal, web design to improve accessibility

Progress and next steps:
Accessibility improvements to the website, alongside internal campaign.

Single portal on the website will launch containing resources and support.

3 Improving digital connectivity

Key project: Gigabit Broadband Roll-Out

Progress and next steps:
Provided gigabit broadband to over 1,500 council properties. By 2023, will cover all council properties.

4 Providing devices to support residents

Key project: Laptop Upcycling

Progress and next steps:
400+ laptops given to residents.

Further roll out of laptops and devices to residents and community centres is planned.

5 Providing jobs and employment support

Key project: Gigabit Broadband Roll-Out, BOOST Programme

Progress and next steps:
BOOST offering digital employment support to jobseekers.

Community Fibre will recruit Barnet residents in roll-out.

6 Identifying digitally excluded residents

Key Projects: LOTI Pan-London Mapping

Progress and next steps: Pan-London map and personas of digital inclusion built
Utilise detailed census data and digital triage project to map local need better

7 Develop communications narrative

Progress and next steps: Develop corporate communications plan to increase awareness

Barnet Get Online Week – Mon 22nd – Fri 26th August

Call to Action: To raise awareness of Digital Inclusion in Barnet

- Promote the **Barnet Get Online Network**
- **Recruit** digital champions – new volunteering opportunities.
- Showcase existing **digital provision**
- Promote **CF FOC Broadband offer**.
- Launch Barnet Libraries **laptop donation points**.
- **#BarnetGetOnline**

barnet.gov.uk/digital-barnet

HealtheIntent

Sarah Dougan, Director of Population Health Intelligence, NCL

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North Central London's sustainability and transformation partnership

NHS

Direct care: HealtheIntent in North London

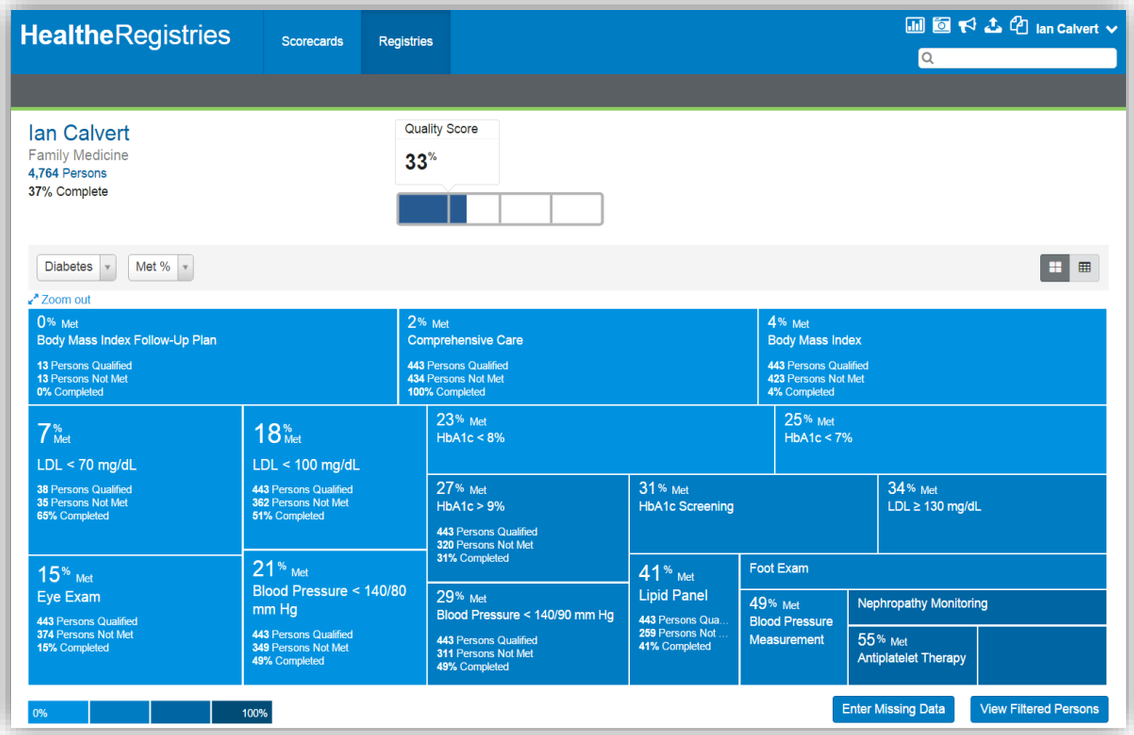
HealtheIntent is Cerner's population health management platform that is being deployed across North London to create an integrated health and care record to support direct care.

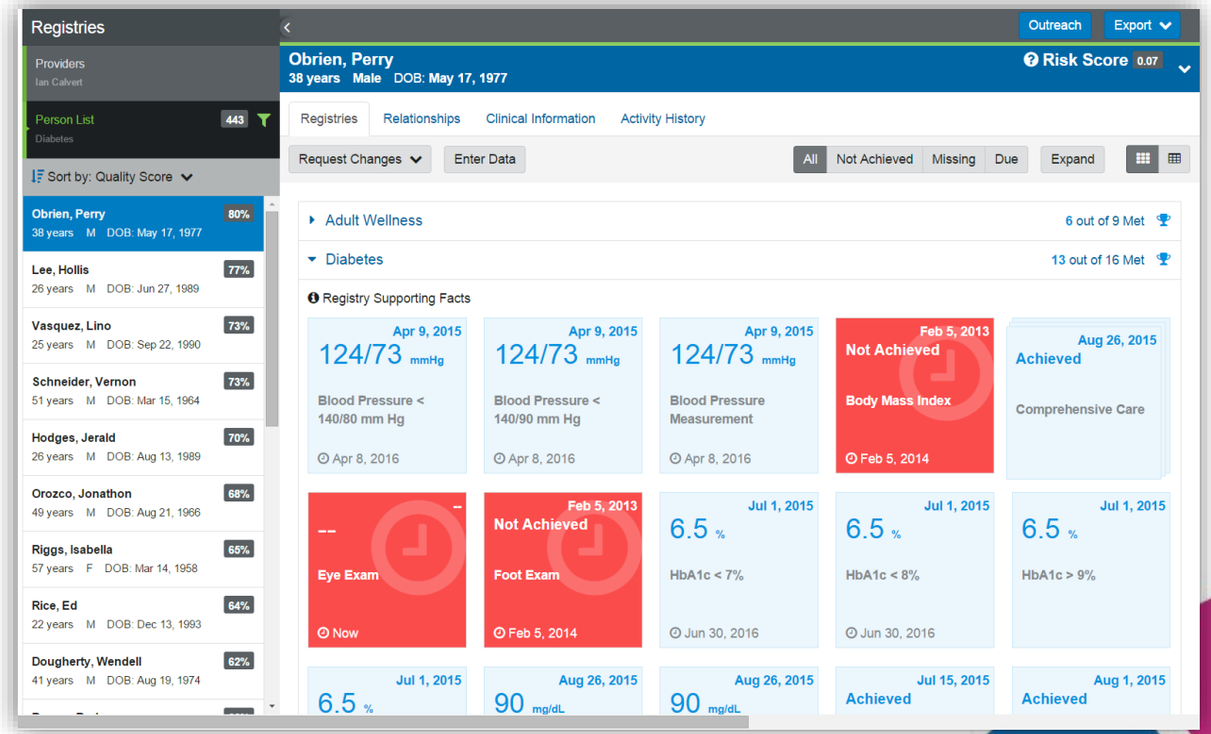
The aims of HealtheIntent and the Population Health Management programme are to enable:

- a system-wide population health approach, including prevention and early intervention
- a reduction in inequities in care and health inequalities
- fostering a learning system using data to frame problems and develop responses, particularly across different care teams
- improvements in the quality of care, with a focus on reducing unwarranted variation and delivering what matters to individuals

Registries - to close gaps in care

- Childhood asthma
- Diabetes
- Atrial Fibrillation
- COPD
- Physical health checks in people with SMI
- Living well after cancer*
- Physical health checks in people with learning disabilities*
- Hypertension & lipids*
- CKD*





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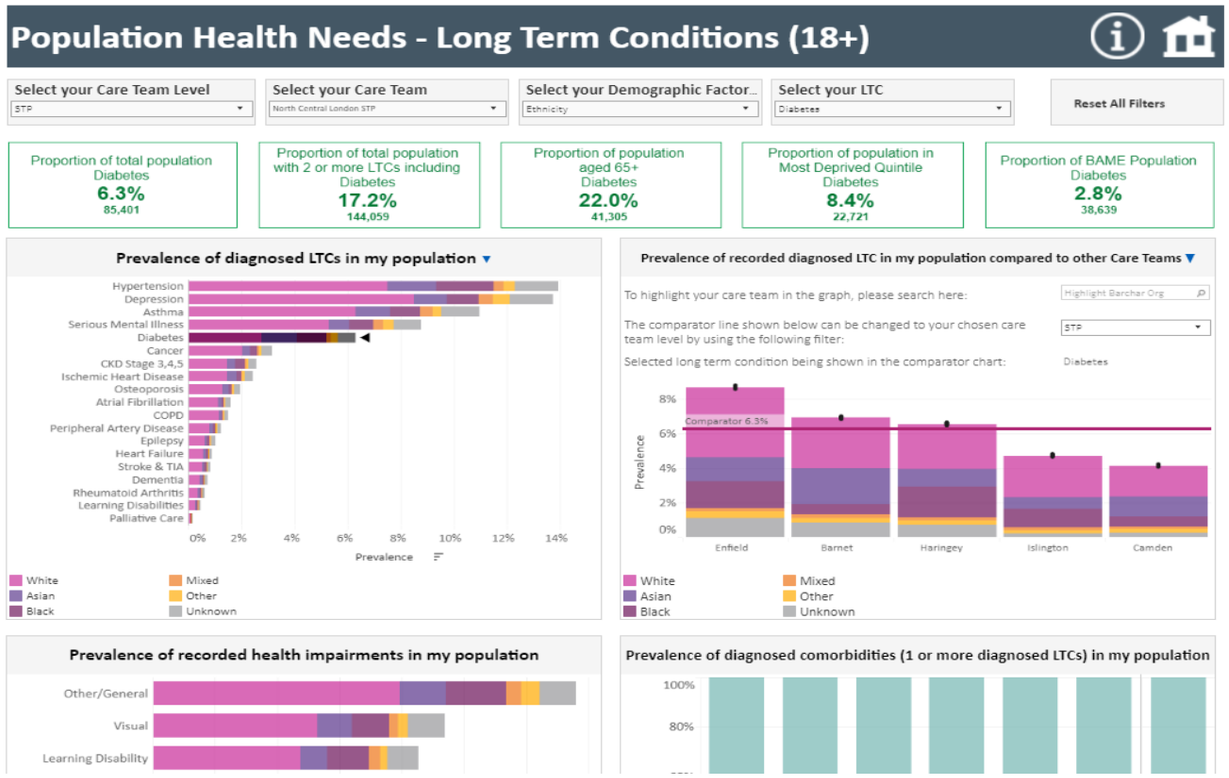
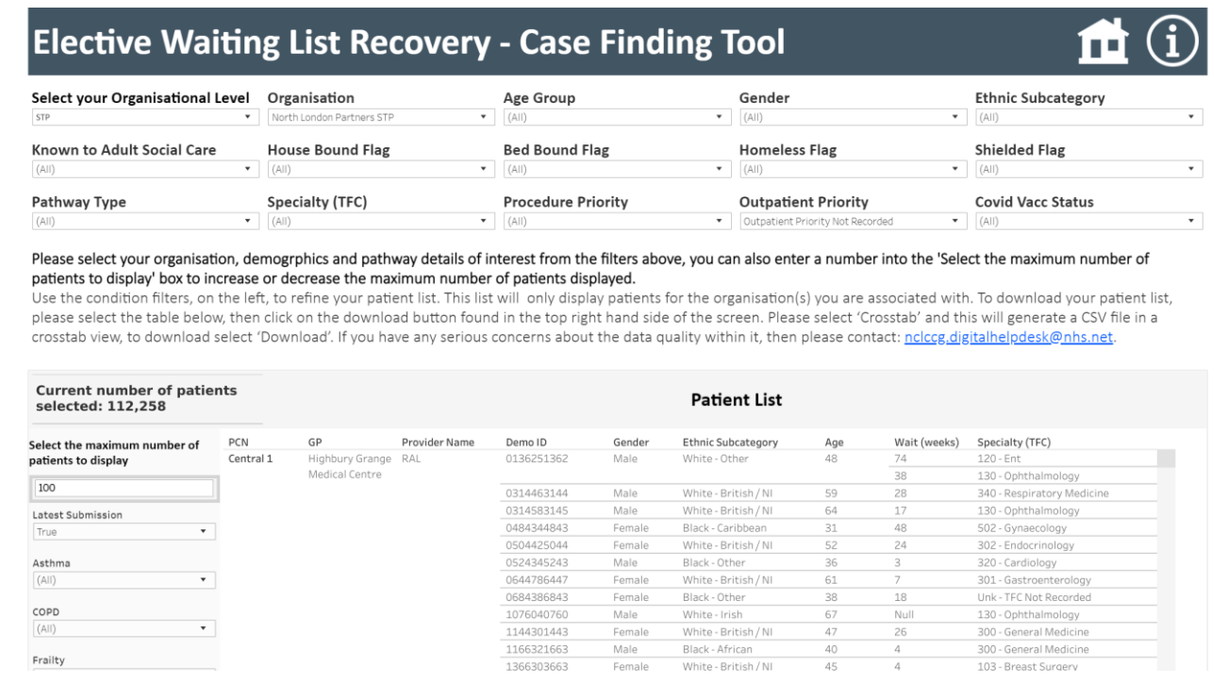
Analytics - detect unwarranted variation and support casefinding





- Population health needs and inequalities
- Flu and Covid vaccinations
- Covid discharge and management
- Frailty
- Childhood immunisations
- Quality improvement: childhood asthma, diabetes, atrial fibrillation, COPD and SMI
- Elective recovery (one system PTL)
- Sodium valproate
- Critical care
- Population segmentation*
- Patient interactions*
- *Long term conditions***
- *Hospital discharge – social care focus***
- *Homelessness***

*in development; ***in scoping*

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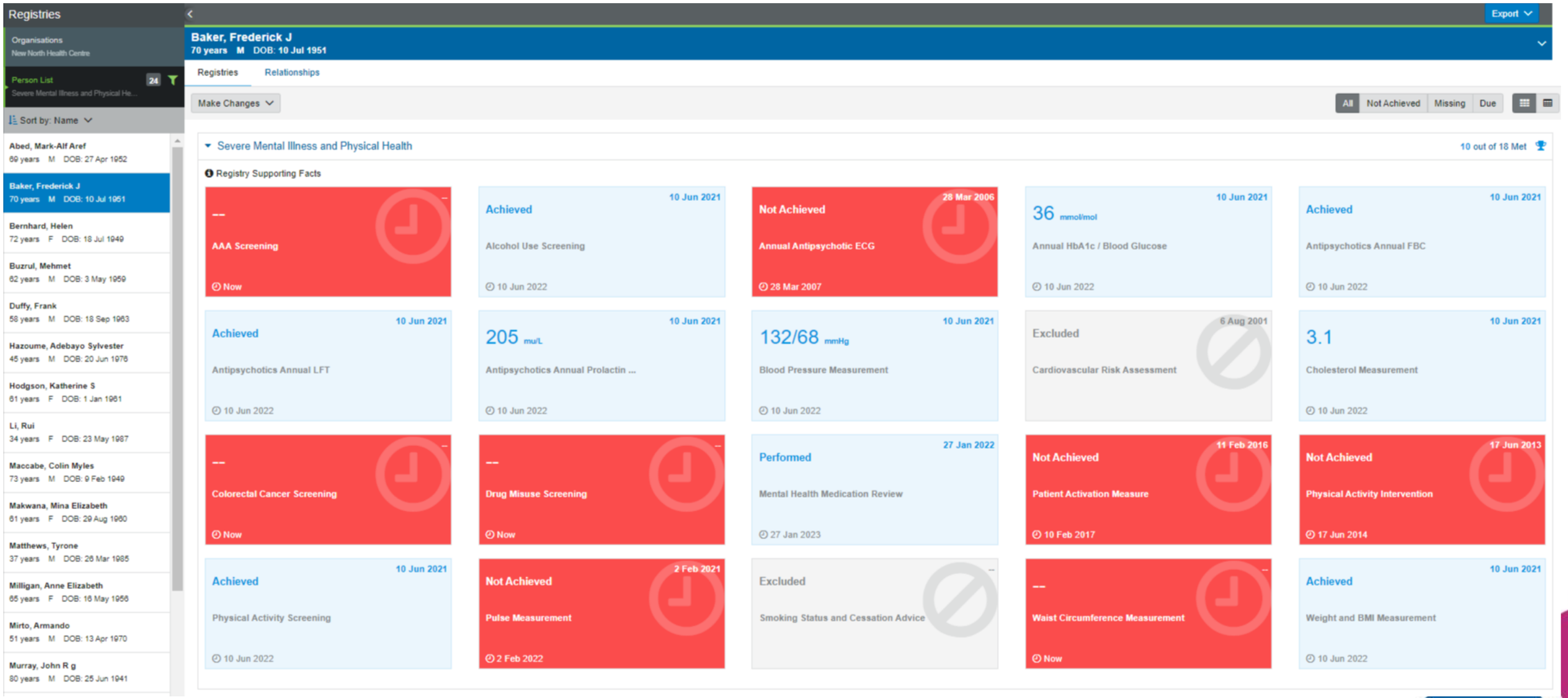
NHS

SMI physical health checks registry – individual patient view

Physical health checks in people with serious mental illness is part of the '5' in NHS Inequality Plan Core20Plus5



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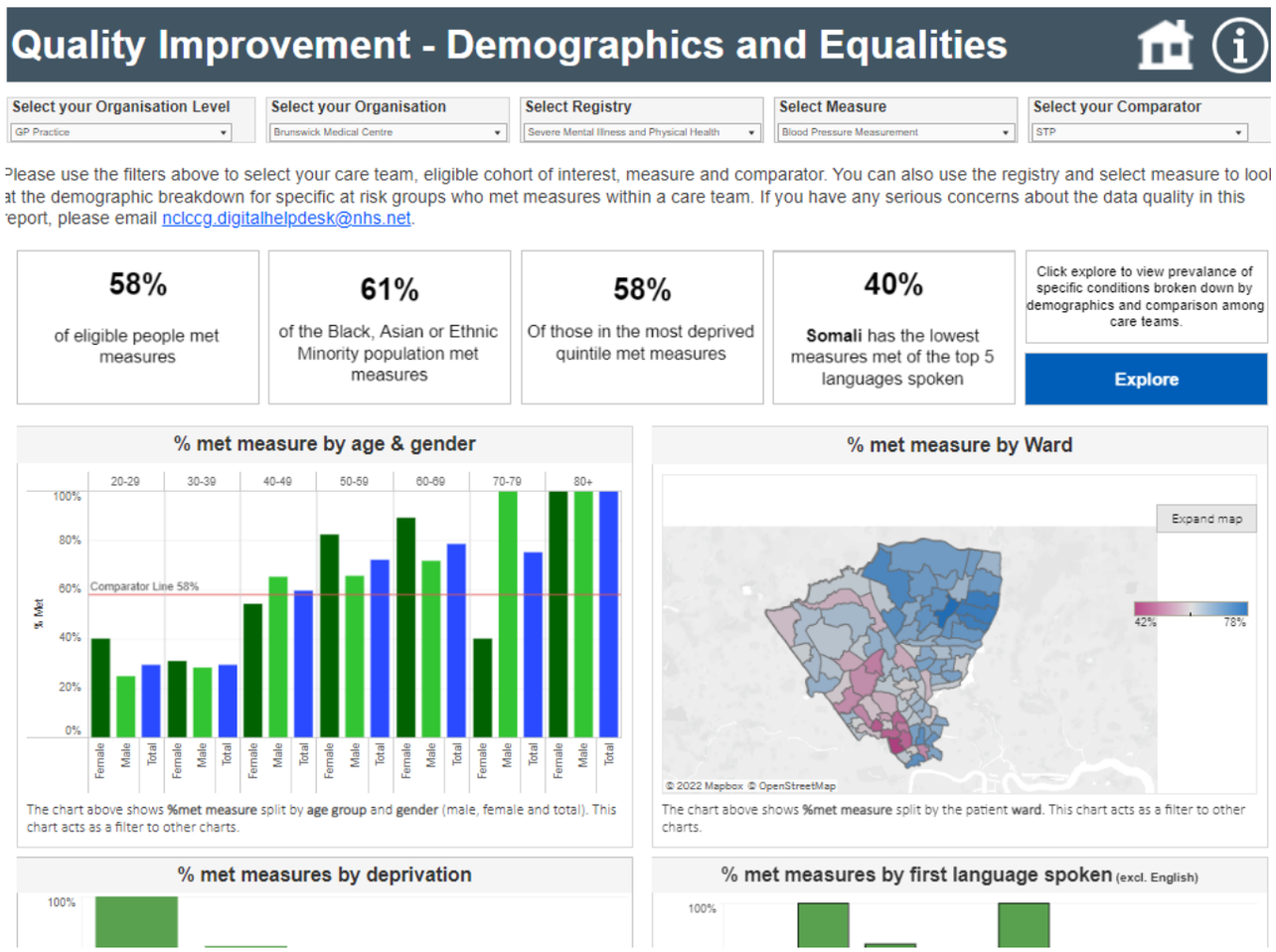
North Central London's sustainability and transformation partnership

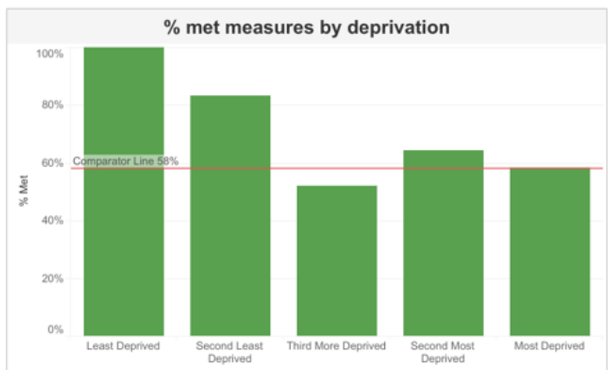
NHS

SMI registry quality improvement dashboard – demographics and equalities

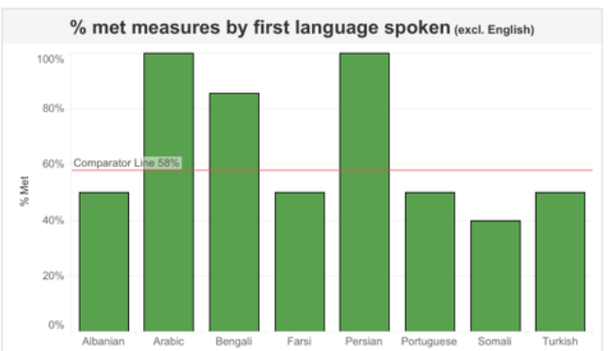
Physical health checks in people with serious mental illness is part of the '5' in NHS Inequality Plan - Core20Plus5



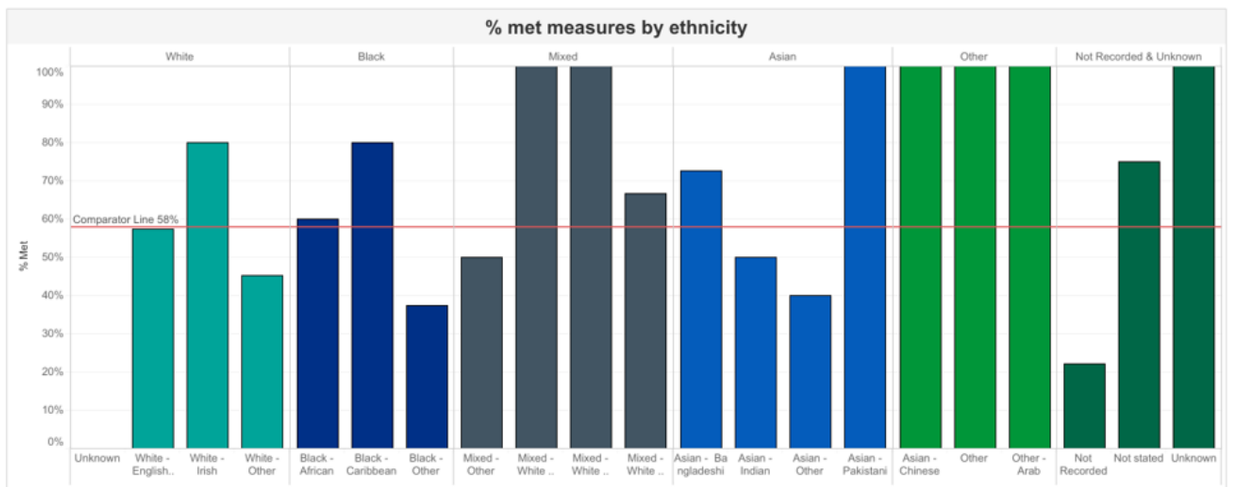
Bottom half of the dashboard:



The chart above shows **%met measure** split by **deprivation**. This chart acts as a filter to other charts.



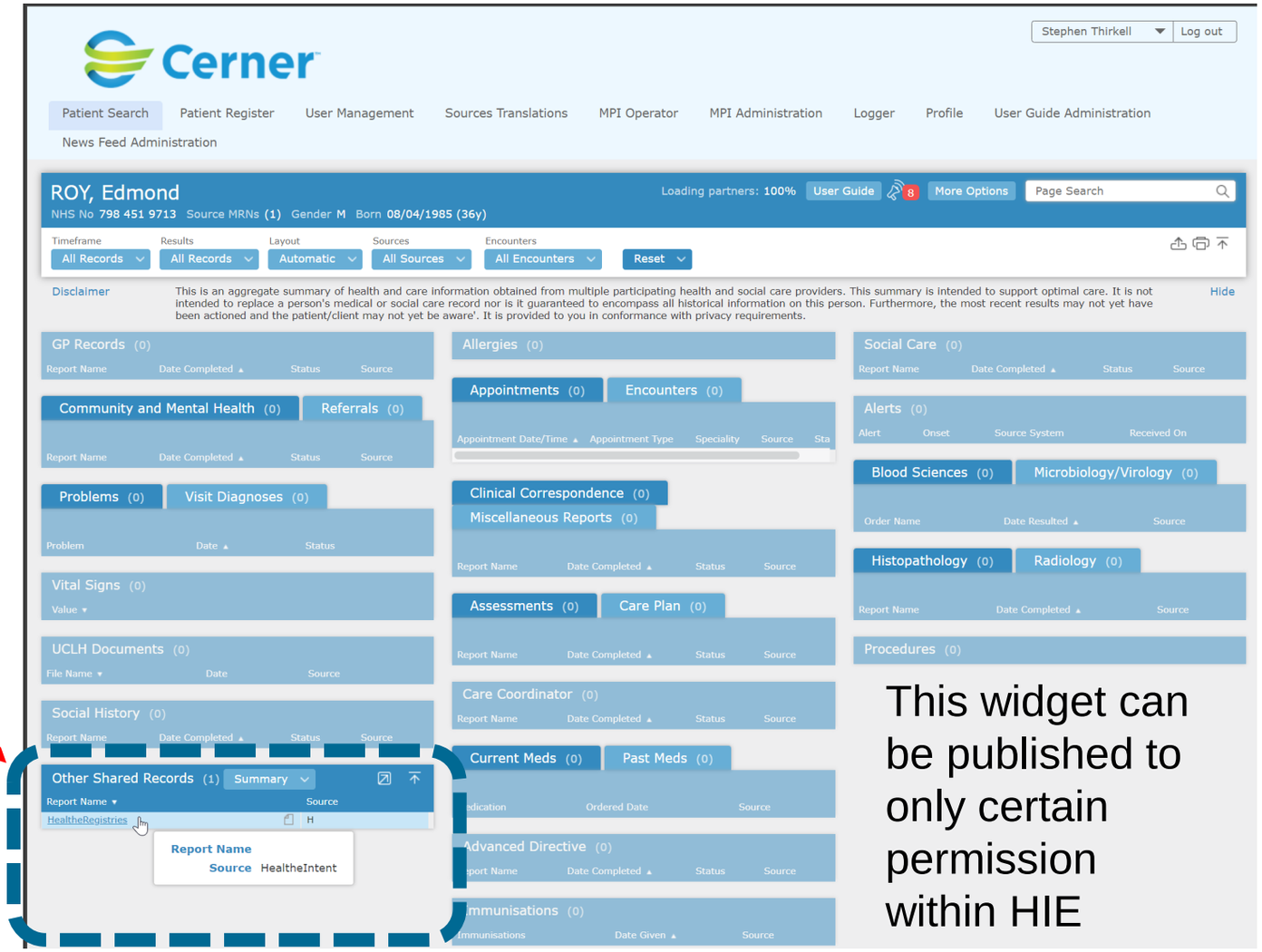
The chart above shows **%met measure** for the **top 5 first language spoken by eligible persons**. English has been excluded. This chart acts as a filter to other charts.



The chart above shows **%met measure** split by **ethnicity**. This chart acts as a filter to other charts.

Integration of Registries into HIE – will allow clinicians across the system to close gaps in care – shift towards mutual accountability

When a patient's record is viewed in HIE (which is available to clinicians and social workers through their own clinical system), the software will search HealtheIntent and display this button if the person is on one or more Registries. The user can click to launch them.



This widget can be published to only certain permission within HIE

Enable carers health and wellbeing

We will support care staff and informal carers to look after their health and wellbeing.

Encouraging the uptake of COVID vaccination amongst carers

20,000+ emails sent to carers to encourage them to take up vaccination opportunities and to provide information about process.

Dedicated secure website pages for carers to register their interest in a vaccination

Social media activity to promote local vaccination programme

Process to inform GP surgeries of carers seeking vaccination

barnet carers

A significant rise in carers seeking support throughout the pandemic

410 carers directly supported to have quicker access to COVID vaccination in collaboration with the local authority, health services and local GPs. Many more encouraged to take up vaccine.

Newly registered carers provided with access to information, support and grants.

Carers provided with ID to enable them to access supermarket and pharmacy priority shopping times.

Ongoing support available to all carers as we exit the pandemic including mental health support such as counselling and wellbeing activity.

barnet carers
enabling carers to thrive

Identifying carers and young carers

Active promotional and communication campaign to identify new carers.

Partnership activity with local VCS, schools and others to ensure carers are identified and referred.

Two-way referral processes with partners to ensure that carers do not fall between cracks and are appropriately supported

Outreach programme to reach carers across the borough – for example working with Colindale Community Trust

Small grant support to help identify carers in small communities

barnet carers
enabling carers to thrive

Deliver population health integrated care

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North Central London
Integrated Care Board

Barnet Frailty Multi-disciplinary Team Service

The journey

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- **Review of MDT models** across the borough, including successful PCN2 Frailty MDT pilot and 'One Care Home Team' model, including what works well, learning points, outcomes and areas that could be streamlined. PCN2 Frailty Model Evaluation

Adobe Acrobat Document

- **Engagement with system partners on designing and resourcing the frailty MDT** model via frailty working group and collaborative 1-1 discussions with clinical and operational leads across the system to co-design **a new Pan Barnet Frailty MDT model** discussed within following slides.

- Data collated via *EMIS* coding and *HeatheIntent* **to help to establish baseline frailty numbers known within healthcare system** and early discussions commenced on proactive identification, consideration of health inequalities, coding, record sharing and outcomes monitoring.

- Review of patient feedback from pilots and **plans to involve wider community and VCS sector**

Frailty Model Vision

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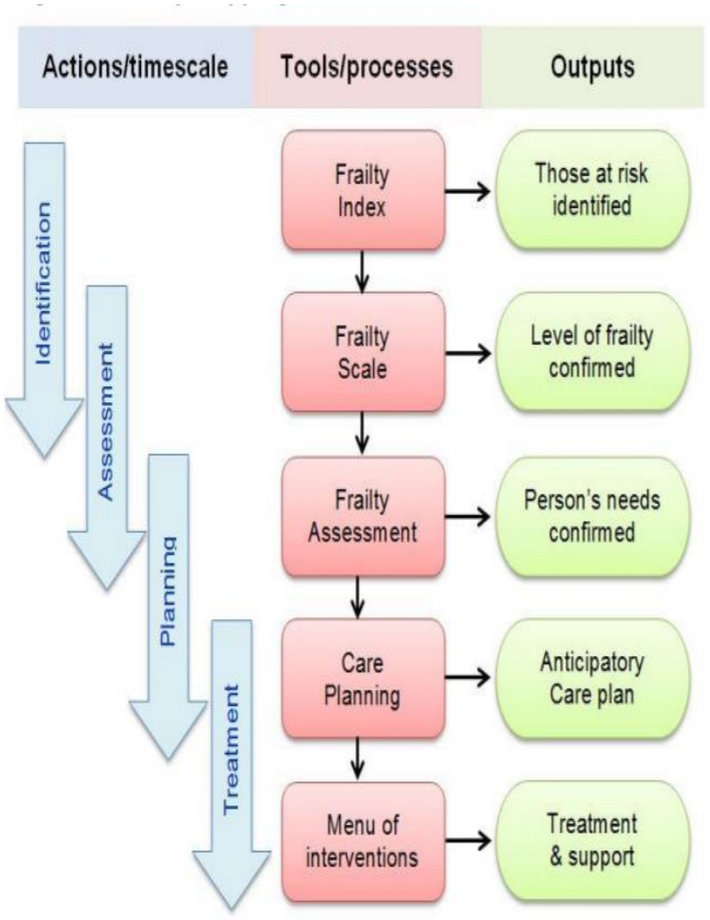
Integrated Care Board



- Shift away from a reactive, disease-focused, fragmented model of care towards one that is more proactive, holistic and preventive, in which people with long-term conditions are encouraged to play a central role in managing their own care.
- Personalised, joint-up care through multi-disciplinary, multi-agency collaborative working
- Pan Barnet equitable offer. Tiered offer but clinically indicated and fluid through pan Barnet offer
- Dedicated frailty multi-disciplinary team, rehabilitation and treatment and Consultant input into MDT including access to treat and escalation of care
- Centralised, MDT admin workforce extended to local MDT support

Goal/ Outcome of new model: More people will be supported to stay well and live well at home for as long as possible.

Royal Free London NHS Foundation Trust

Barnet ageUK

Barnet, Enfield and Haringey NHS Mental Health NHS Trust

A University Teaching Trust

DementiaUK

NHS North Central London Integrated Care Board

NHS Central London Community Healthcare NHS Trust

Primary Care and prevention

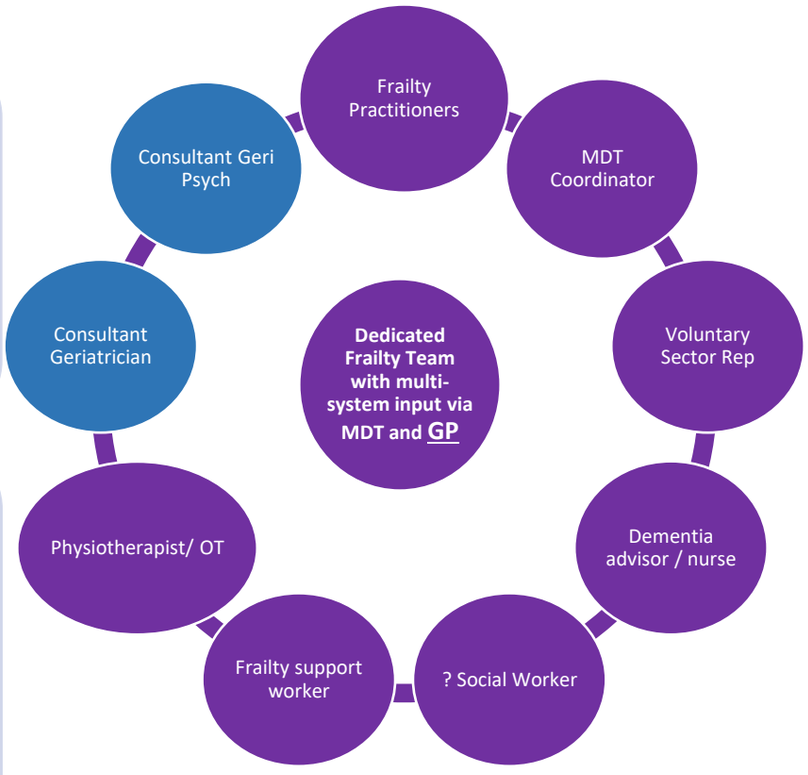
- **GP input** and central to identifying patients. Primary care interdependencies-DES, QOF, use of EMIS and coding.
- **Proactive identification, self management and preventative/ 'keep well'** element to be worked up with wider community sector input

Frailty offer

- **Dedicated Frailty Team** to assess and treat/ rehab/ case management frailty cohort and highlight patients for escalation/bring to MDT/ onward referrals via SPOA
- **SPOA**
- **Multi-disciplinary team meetings-**acute, community and primary care and VCS coming together to discuss cases-direct access to treat and educational benefits for team.

Secondary Care and palliative care Interface

- **Consultant attendance** and input from RF/BEH/North London Hospice into **MDT** and **direct access to treat/ escalation of care**
- Expert advice and access for patients and training element for all
- Acute link to service and **relationship building**/ open communication channel



How the Service Works

Age UK Barnet
MDT Coordinator - attends MDT meetings. Offers advice on the spot and takes away referrals!

- Wider Barnet VCs
- Other AUKB projects such as Scams Awareness, Walk and Talk, Pigeon Post, Active and Connected, Dementia Befriending, Household Support
- Statutory services

AUKB MDT team member receives referrals at the meetings

Guided conversation

What does the patient want/need?
What does the carer need?

Actions

Client invited to activities at AUKB -Client applies for benefits with volunteer support – client provided with solicitor information – client provided with CMC leaflet – carer referred to Barnet Carers – dementia support if appropriate

Outcomes

Client attends musical afternoon at AUKB -Client is awarded Higher Rate Attendance Allowance and Council Tax reduction– client has will/PoA in place – carer is given respite. Follow up in six weeks by adviser for monitoring/evaluation – client and carer have increased wellbeing (WHO measures), feel supported, have increased independence

What does the patient think?

‘I have a clearer picture’ ‘I feel confident about the future’

Strengths – why it worked well

Social aspects of wellbeing addressed

Case discussions – VCS and statutory

Continuing care

Seamless support

Strong communication

Only told story once

Patient felt listened to

Increased partnership working

Identifying gaps in provision

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Integrated Paediatric Service
Paediatric Multi-Disciplinary Team (MDT) Meetings

Dr Claudia Tailor

(PCN1W Integrated Paediatric Service Clinical Lead)

Integrated Paediatric Service Background

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Integrated Care Board

- The Integrated Paediatric Service Programme is identified as one of the **NCL ICB CYP priorities** and supports **NHS Long Term Plan** priority areas.
- The project has therefore aligned to and been identified as one of the **Children and Young People priorities within the Barnet Borough Partnership**, with support from the CYP SRO and mobilisation support via the Borough Partnership team.
- The project has fantastic **engagement and support** with local Paediatric Consultant Paediatricians, namely Dr Alexandra Pledge, Dr Priscilla Julies and Dr Krishna Jada.
- Paediatric MDT team meetings are successfully running in PCN1W and PCN5 with excellent feedback and clinical leadership from local GP's.
- Extensive engagement and plans to scale pan Barnet and launch peadiatric MDT's in PCN2, PCN1D and PCN4 in next quarter
- Secured **local CAMHS Consultant attendance** at the MDT to enhance scope and learning further
- Development opportunities include: **wider services** joining MDT including for example, early years services, social prescribing link workers, CAMHS. Consider adding **joint clinics** and MDT sessions as part of regular timetabled clinic. Integration and MDT working **potential foundations for neighborhood model working**

North Central London Integrated Care System

NHS
North Central London
Integrated Care Board

North Central London ICS Model

Integrated Paediatric Service

Running in Barnet and current area of focus to scale across the borough.

Consultant-led Triage

Triage of all general paediatric outpatient referrals

Joint Primary Care Clinics

Children will be seen jointly by a Consultant Paediatrician and local GP

Multi-Disciplinary Meetings

Specialist Advice & Guidance and Learning between Consultant Paediatrician and Team of Multi-Disciplinary professionals

Feedback received to date - Barnet

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Barnet Borough-example of feedback to date

In your view has the MDT contributed to improving patient care?	How much have you felt this MDT meeting has improved patient care? (1 = little; 3- somewhat; 5 = significantly)	Do you feel this has helped expedite secondary care involvement for your patient?	
Response	Open-Ended Response	Response	Other (please specify)
Yes	5	Yes	
Yes	4	Yes	CAMHS and paeds involvement really beneficial
Yes	5	Yes	
Yes	5	Yes	Very helpful session - thank you so much for all the advice and tips!
Yes	5	Yes	
Yes	5	Yes	
Yes	4	Yes	
Yes	5	Yes	
Yes	4	Yes	
Yes	5	Yes	
Maybe	4	Yes	

"A real success story for Barnet"

"A great idea"

"Really useful but would benefit from allocate a specific time in general practice/surgery rather than an add on to normal surgery"

Planned Benefits

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Benefits for patients:

- Enhanced early advice and management within primary care, potential to reduce time waiting for secondary care opinion etc. and reduced anxiety for residents and their families.
- Improved patient experience -more personalised care closer to home
- Appropriate referrals and investigations of patients prior to attendance at hospital appointment where necessary, resulting in fewer hospital follow up appointments and more efficient care.
- Holistic, multi-disciplinary care enhancing care

Benefits for System:

- Support long term plan commitment to reduce unnecessary outpatient activity through enhanced management, upskilling and integration with primary care
- Enhanced relationship building and integration between primary and secondary care
- Enhanced primary care expertise and provision and integration of services provision reduce A&E attendances
- Building blocks for integration, potential to build multi-disciplinary teams, offer for children and their families and consider neighbourhood model working with wider services.

Benefits for RFL:

- Support more appropriate referrals from general practice
- Potential to reduce waiting times
- Enhanced working relationship and integration with local primary care and wider teams

Benefits for General Practice:

- Increased confidence managing paediatrics
- Improved accessibility of secondary care consultant opinion
- Improved relationships with secondary care
- Resource shifted to primary care
- Reduced repeat attendances in primary care for key pathways (e.g. allergy)

Barnet Autism Plan

6 themes of the All Age National Autism strategy and related work by the Barnet ASAP

All Age Autism National Strategy and the Barnet Autism Strategy Action Plan

1. Improving understanding and acceptance of autism within society

- Cultural Change –Position statement – how we approach working with Autistic people.
- In-depth training offer: School police, Social care and Early help, Home -Start, Transport, Independent schools, Barnet and Southgate college, Adult Social Care Providers/Workforce, post 16
- Borough wide 6 sessions Autistic training – offered across health, Education, Social Care.
- BELS AAT to write NCL 7+ ATLAS Post Diagnostic Parent Support.
- Oliver McGowan mandatory training – CAMHS.
- Raising awareness of Autism in employment sector, and through **new** accommodation & support services.

2. Improving autistic children and young people's access to education and supporting positive transitions into adulthood

- Lot 2 Neighbourhood Networks – Peer to peer support.
- BEAM UP Programme – 5-7yrs and joint working Early Help.
- Post diagnostic steering group – Flexi schooling.
- Interest groups and The Autistic Discovery Journey - 6 session training.
- Neurodiversity Event - Double Empathy Problem -Dr Damien Milton.
- The Secondary project is underway it is being supported by Autistic consultants together creating opportunities and resources for schools.
- Post 16 and NEET - supported Internships – T levels.
- Pre-diagnosis support – social communication.
- Accommodation & Support – new transitions providers

3. Supporting more autistic people into employment

- Mentoring Bid- to possibly include mentoring into employment (currently being explored).
- Post 16 working on the Employment & Skills Strategy Autism Employment Action Plan created.
- ASC Employment Action Plan working alongside Family Services, BOOST, HR , Prevention team and others to deliver a number of workstreams to support Autistic people into employment. Priority is co-production with autistic people.

4. Tackling health and care inequalities for autistic people

- Pathway document has been produced – to be finalised.
- Diagnostic wait times are reported to have reduced 7+.
- NCL wide all ages assessment recovery pathway due September.
- TCAPS, Keyworker Project to prevent Tier 4 Hospitalisation.
- Health Inequalities CETR and LeDer review findings/workstreams ongoing to support development of projects to address health and care inequalities for Autistic people.

5. Building the right support in the community and supporting people in inpatient care

- TCAPS, Keyworker project, Barnet DSR (standardised across NCL).
- Lot 6 Supported Living for people with complex disabilities and Health needs.
- BELS and Specialist Social Care 0-25 – Bid for Autistic mentoring funding.
- BELS AAT – Translated Post Diagnostic Parenting Programme.
- ASC delivering of Accommodation & Support Services ; Lot 2 Neighbourhood Networks and Lot 6 Supported Living for people with complex disabilities and Health needs.
- NCL LD & Autism programme - implementing NHSE Autism Strategy - Development of NCL wide Neuro Developmental Disorder (NDD) Service and recommissioned Autism Advisor Service through Barnet Mencap

6. Improving support within the criminal and youth justice systems

- Schools police training.

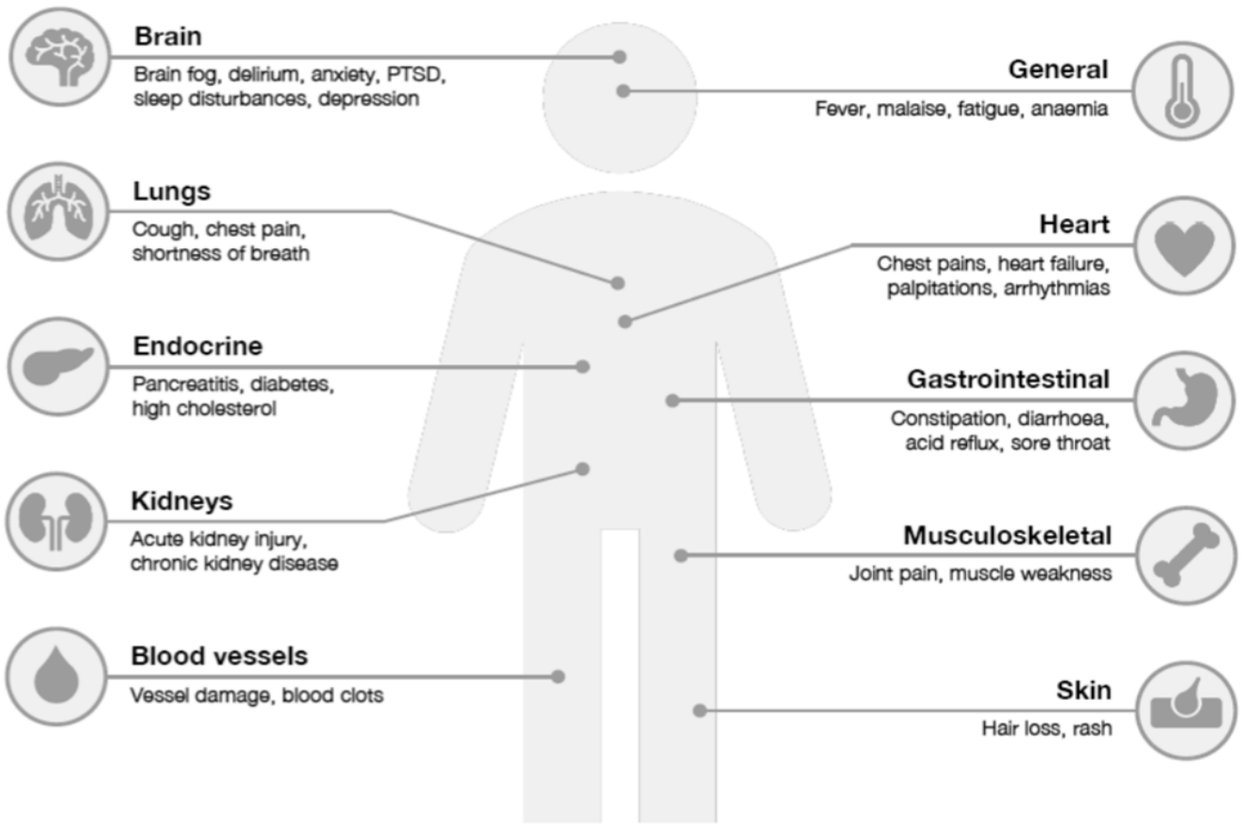
Working with Mencap, Adult Social Care and the Community Safety Team to inform the new Domestic Abuse Strategy.

- Identify funding and resources to review and consider commissioning
- VCS to produce tools for professionals to use in CJS for SU with ASD
- Use the Involvement Board to co-produce tools, work with the Carers Centre.

Long COVID: Services & Experience

Nitish Lakhman, Healthwatch Barnet

Symptoms



- Patients who experience Long COVID have reported **> 200 symptoms** which come and go over time.
- The most commonly reported post covid symptoms are fatigue, dyspnoea, cough, sleep disturbances, anxiety and depression, cognitive impairment, and difficulty concentrating.
- Taquet et al. 2021 estimated the incidence of 14 neurological and psychiatric outcomes 6 months after a confirmed diagnosis of COVID-19 to be nearly 34% of which 13% was a first diagnosis.
- NICE COVID-19 rapid evidence review

healthwatch
Barnet Camden Enfield Haringey Islington

Summary of findings

Experiences with the Health Care System

Accessing the Long COVID Pathway

Healthcare Support & Referrals

Useful Interventions

Diagnosis

GP Knowledge

Impact on Health

Physical Health

Mental Health & Wellbeing

Impact on Life

Employment & Job Security

Home Life

Moving Forward

Improve GP's Knowledge

Recognise Patients' Symptoms and their Impact

Improve Awareness of the Support Already Available

Improve Access to Primary Care

Improve Access to Specialist Care Where Needed

Enable Continuity of Care

Share Self-management Techniques Early

Peer Support Groups

NCL Patient Pathway

Identification

Acute

Patients who have been admitted to hospital for acute Covid and followed-up by the acute provider may be identified as having ongoing symptoms. These patients will be assessed by the acute provider and they will make any needed referrals.

Primary care

Patients may present to general practice with ongoing symptoms post acute Covid infection. **Active casefinding** in primary care may identify patients, e.g. follow-up to patients who have been on **Covid Oximetry @home**.

Post-Covid assessment should begin at 4 weeks post-acute diagnosis, and other diagnoses may need to be ruled out at this stage.

Referral for specialist advice should not be delayed for red flag symptoms or if a worsening trend.

Primary care assessment

1.Patients should be invited to complete a **post-Covid syndrome pre-assessment questionnaire** in advance of their appointment

2.Clinical assessment of the patient's symptoms guided by the **NCL Post-Covid syndrome EMIS template** to develop a care plan.

3. Completion of investigations outlined in the **NCL Primary Care Guidance document.** Offer self management advice.

4. If required, completion of a **Post-Covid Service Referral Form**

If red flag symptom(s), refer directly to **UCLH clinic on eRS** or for acute medical input

Other referrals to borough **Post-Covid single point of access**

Single point of access

Referral & safety netting

The borough **SPA** will review the referral and make recommendations about the patient's onward care.

Referral to the UCLH specialist post-Covid syndrome clinic

Referred to community therapy for rehabilitation

Safe to manage in primary care with supported self-management.

You may be invited to join a borough **virtual Post-Covid MDT meeting** for further discussion and care planning

Note: Please advise patients that if their symptoms improve before their appointment date at UCLH they should cancel it to allow other urgent referrals to be seen quicker.

Neighbourhood Model

Rachel Wells, Public Health Consultant, Barnet Council

Grahame Park Neighbourhood Model

Grahame Park Neighbourhood Model

Context: Grahame Park

The *Grahame Park Health Needs Assessment* was completed in 2021. This looked at the health and wellbeing, and their determinants, of people living in Grahame Park. It is an area of deprivation and poor health outcomes.

Cardiovascular disease are the leading cause of excess deaths.

Mental health disorders are a significant cause of disability.

1/3 of children live in relative low-income families.

Residents raised safety as a key concern in the *Neighbourhood Change Residents Survey 2019*.

There is a strong network of VCSFEs operating in the area.

What is the Neighbourhood Model?

The Neighbourhood Model is led by Public Health (Rachel Wells) and Strategy & Engagement (Will Cooper)

- **Place-based**: Strong emphasis on using local insight and local perspectives to design solutions which meet the unique needs of people living in Grahame Park.
- **Coproduction**: Working closely with residents and stakeholders to design these solutions, as opposed to one-off consultations.
- **Asset-based**: Building on the strengths of the community, in particular the VCSFEs, to improve the health of the population.
- **Partnership-working**: Working with stakeholders from the Council, the NHS, Integrated Care Partnership, VCSFEs, etc.
- **Evidence-based**: The Neighbourhood Model is built on evidence. We plan to measure success on an ongoing basis and monitor our progress using a robust evaluation framework.

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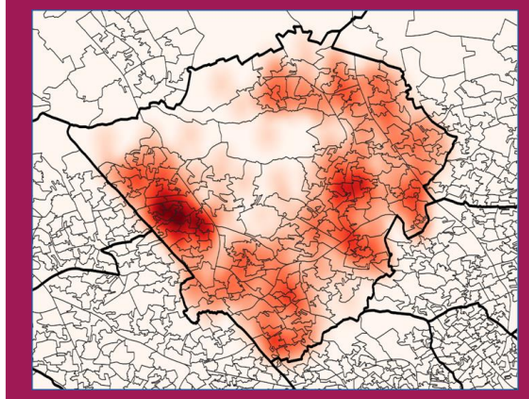
Case Study: Substance Misuse Outreach Services



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

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

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

Next Steps for the Neighbourhood Model

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

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