BCF narrative plan 2022-23

Health and Wellbeing Board

BARNET

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

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

Stakeholder involvement

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

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

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1. Executive summary

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

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

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

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

Key changes in 2021/22

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

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

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

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

Priorities for 2022-23

The national BCF objectives for 2022-23 are to:

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

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

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

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

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

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

2. BCF Governance

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

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

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

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

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

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

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

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

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

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

3. BCF plan 2022-23

3.1. Barnet approach to integration

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

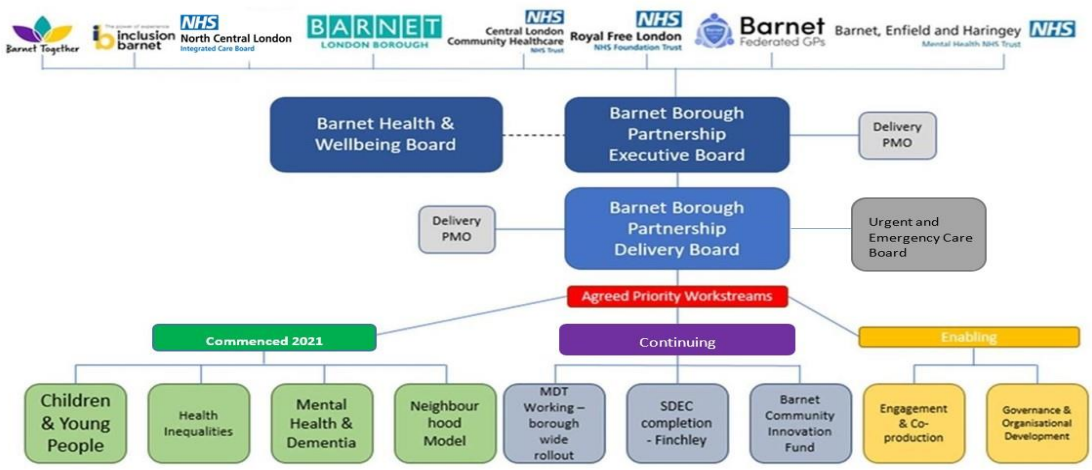
The Barnet Joint Health & Wellbeing strategy sets out our whole system place-based vision until 2025 for improving the health and wellbeing for those who live, study and work in Barnet around three key areas of focus. These key areas are:

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

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

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

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



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

3.2. Achievements in 2021-22

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

Reablement

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

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

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

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

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

Prevention/Early Intervention

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

It provides four key service elements:

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

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

3.3. Joint priorities for 2022-23

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

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

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

Key milestones for the ASC reforms work include:

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

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

4. Implementing BCF Policy Objectives (national condition four)

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

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

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

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

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

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

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

Integrated Service Delivery

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

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

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

Community based support

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

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

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

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

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

Steps to personalise care and deliver asset-based approaches

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

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

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

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

Integrated Frailty MDT Service-building foundations of neighbourhood model working

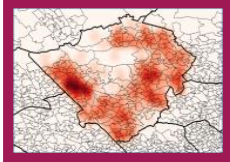
NCL ICB are in the final planning stages of implementing a generalised Long-Term Conditions Locally Commissioned Service (LCS) which aims to radically change the local approach of PCNs to population health management, focussing on secondary prevention of respiratory and metabolic long-term conditions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

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

Grahame Park Neighbourhood Model

2022-23

Case Study: Substance Misuse Outreach Services



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

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

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

Next Steps for the Neighbourhood Model

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

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

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

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

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

Prevention & early intervention

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

Intermediate Care

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

Supported Accommodation

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

Residential Care

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

Nursing care

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

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

Extra care schemes

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

Live in Care

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

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

Community support

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

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

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

Home care

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

Reablement

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

Admissions avoidance

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

Homeless/No Fixed Abode

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

High Impact Change Model

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

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

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

5. Support for unpaid Carers.

The current Barnet Carers strategy focuses on three priority areas:

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

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

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

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

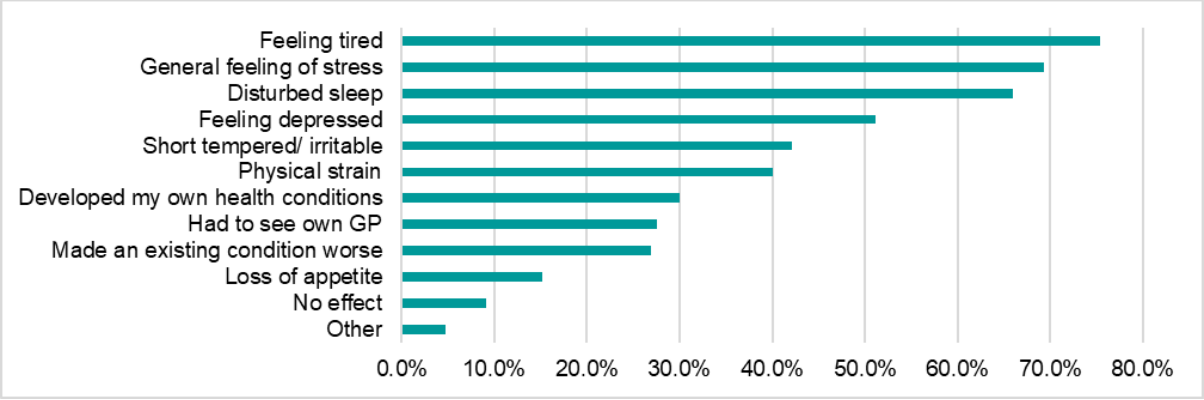
45.9% of carers felt that their caring responsibilities caused them no financial difficulties. ▲ from 40.1% in Barnet (48.1% in London and 53.4% in England 2018-19).

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

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

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

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



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

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

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

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

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

Achievements in 2021-22

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

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

Those who have attended the Dementia support service have reported –

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

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

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

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

Priorities for 2022-23

The key priorities for Barnet this year are to:

a) Continue to develop our dementia support offer through:

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

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

b) Strategic review of Carers' respite provision

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

6. Disabled Facilities Grant (DFG)

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

Achievements in 2021-22

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

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

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

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

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

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

- Funding adaptions in council housing stock

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

Challenges

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

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

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

7. Health inequalities

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

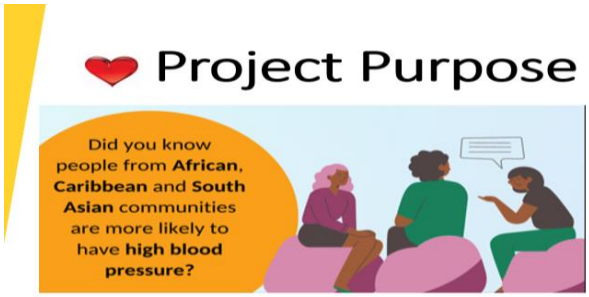
Life expectancy at birth in females (86.0 years) is higher than males (82.9 years). However, there are inequalities in life expectancy in Barnet by gender, locality/ward, and the area level of deprivation. For example, a man living in Burnt Oak on average lives 8 years less than a man in Hampstead Garden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

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

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

Achievements in 2021-22

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



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

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

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

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

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

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

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

Priorities for 2022-23

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

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

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

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

Cardiovascular disease Prevention Programme

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

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

This CVD programme aligns with the NHS Core20plus5 by incorporating

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

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

Frailty MDT

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

Long Term Conditions

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

Digital Inclusion

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

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

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

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

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

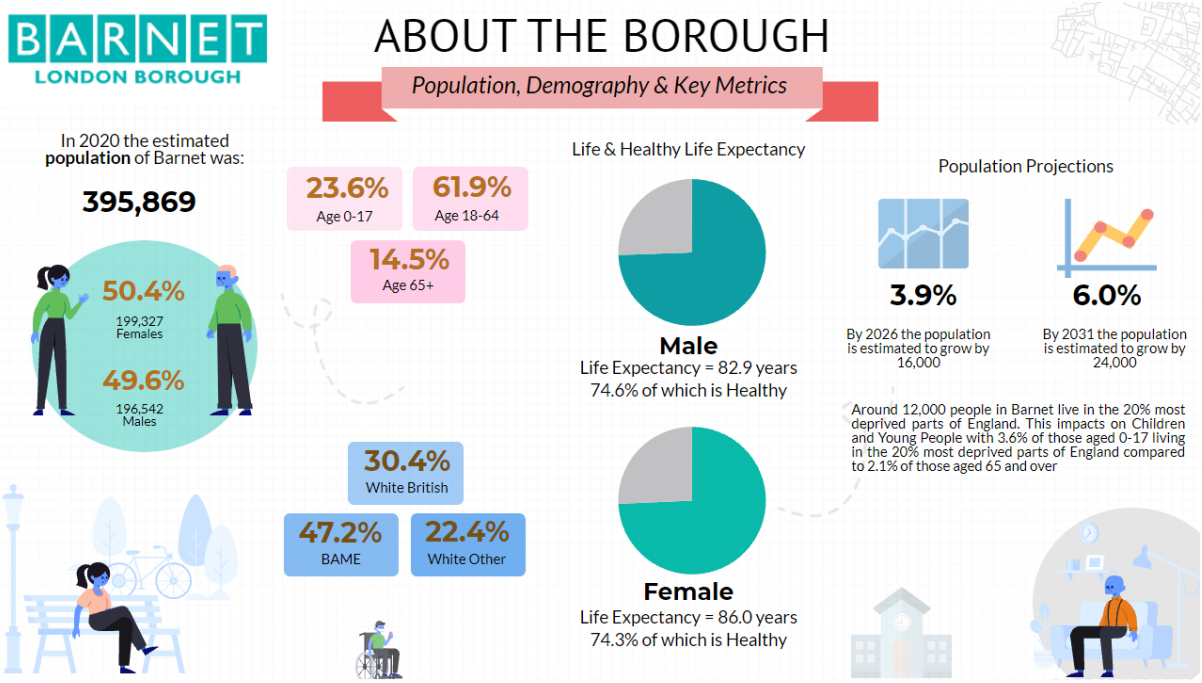
Tackling the Gaps

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

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

Falls Prevention

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


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