Barnet Health and Wellbeing Board

BCF Narrative Plan-2023-2025

A. Cover

Health and Wellbeing Board

Barnet

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

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

How have you gone about involving these stakeholders?

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- including Director of Operations, Barnet Hospital, The Royal Free and Director of Operations, CLCH- have given approval on on the plan content and provided additional information on current work in progress to support delivery of the BCF objectives.

In addition, we have also worked together to read-across with the BCF Plans of other boroughs across NCL to ensure consistency.

B. Governance

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

In addition, our local HWB takes a leadership role in the Barnet 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 are 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.

C. 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.

This is aligned to the Barnet Council Corporate Plan 2023-2026, which outlined the following vision for *Caring for People*

- work closely with organisations at a local level to fight poverty and tackle inequalities which affect everything from health to education and work opportunities; ensuring no one is held back, whatever their background
- create a more family friendly borough, giving our children and young people the best possible start in life, with excellent education and support to grow.
- enable all residents – particularly our older and disabled communities – to live well so they can lead fit, healthy and happy lives, feeling safe in their own homes and as part of a supportive community.

Barnet Overview

Barnet is the second largest borough by population in London, home to over 389,000 people, 26,000 businesses, and 1,000 charities.

It is an incredibly diverse borough and 44% of our residents were born in another country. The population of Barnet is slightly older than the London population with a greater proportion of the population aged 60 and over. One in 10 people in Barnet is older than 75 years old.

The schemes within our 2023-2025 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 and our system recovery over the past years. For example, our expenditure in the **Ageing Well Programme (Scheme 8)** and with the Memory Clinic aligns with our objectives to provide high quality adult social care and improve holistic support for people living with dementia and their loved ones.

Recent Context

In 2022/23 the Barnet Health and Wellbeing Board acknowledged and adapted to the following key contextual changes:

- It was recognised that within the Integrated Care System there would be an increased focus on Place as this new system is implemented across NCL.
- The NCL Population Health and Integrated Care Strategy was presented to the Board in March and will continue to inform aspects of our approach to joint working.

- This period also saw approval by the Board of the **Cardiovascular Disease Programme 2022-26 and the Cardiovascular Disease Action Plan 2022-24** as well as a new **Dementia Strategy 2023-28** and **Carer and Young Carers Strategy 2023-28.**

Other key areas of focus in 2022-2023 include:

- An increased **focus on Neighbourhood working** -. e.g., the Borough's innovative hyperlocal neighbourhood working model at Graham Park.
- **An Assessment of the Health needs of Migrants and the Boroughs move towards becoming a "Borough of Sanctuary**" including the need for health checks taking place both on arrival and over a period for these groups.
- **Focus on addressing Cost of Living issues** especially the risk that prescriptions for medication were not being used by some due to rising costs.

The national BCF objectives for 2023-2025 are:

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

Barnet's BCF allocation has been aligned with delivery against these objectives and the impact of each funded scheme will continue to be reviewed to ensure on-going relevance to achieving the required BCF objectives.

The BCF provides a foundation for continuing to identify and stretch service delivery in 2023/25 as part of the ongoing local planning and commissioning cycle.

Review of Existing Section 75 Agreements

In 2022-2023, The north central London Integrated Care Board (ICB) and the five north London councils of Barnet, Camden, Enfield, Haringey and Islington agreed to conduct a review of all existing Section 75 (S75) agreements and the Better Care Fund (BCF). The purpose of the review was to assess the extent to which the current schemes support the integrated care ambitions of each council, the ICB and the borough partnership; and offer value for money.

At the borough level, ICB and council officers also regularly conduct a review of current schemes. The feedback from this ongoing review will continue to be built into our BCF planning and assessments over the next two years.

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.
- 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.

Note on Discharge Funding:

- Plans across North Central London do not include schemes for the ICB Discharge Funding for 24/25. The process the ICB has agreed is summarised below – note that both schemes, commissioner and funding per borough for the ICB Discharge Funding for 24/25 is subject to change. In developing this approach, the ICB have engaged with our regional Better Care Manager and whilst it means we cannot identify our 24/25 spend at this stage, we are confident that our approach is fully aligned with meeting the BCF principles and outcomes.
- The process we are working to locally is: The councils and the ICB in NCL have struggled to reach an agreement on the use of the discharge funding for 23/24 and 24/25. To move this forward, an alternative approach will be taken in accord with the principle we agreed for open book transparency between partners. The ICB will agree to the allocation to social care of 50% of the ICB ADF allocation as a one off in 2023-24 (£3.4m).
- This is agreed on condition that we jointly appoint and fund an independent financial expert, to review both the ADF, BCF and all budgets within both social care and the ICB that the independent financial expert and CFOs feel necessary to resolve this issue, with open book financial reporting and activity counting on both sides.
- This independent expert's work will report jointly to a nominated council CFO and Phill Wells as ICB CFO; they will be able to make binding recommendations to inform how the 2024-25 BCF and ADF are spent in an equitable way.
- The terms of Reference, a specification and principles for the work including definitive timescales for completion will need to be jointly agreed between CFOs and the independent financial advisor before the final stages of BCF sign-off including the s75 sign offs are completed and the £3.4m one off for 23-24 is transferred to councils.

D. Overall BCF Plan and Approach to Integration

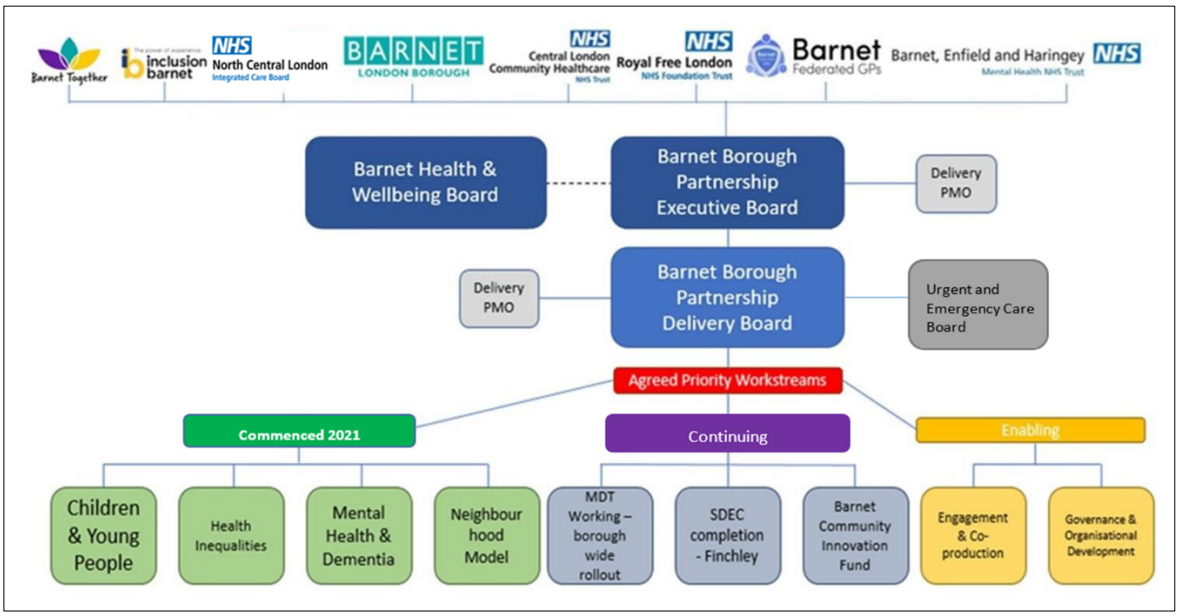
Approaches to Joint/Collaborative Commissioning

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 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. 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

North Central London Population Health and Integrated Care Strategy

The North Central London Population Health and Integrated Care Strategy sets out the ICB's approach to improving the health of our population across North Central London. An integrated care partnership is in a unique position to work together to tackle some of our biggest population health challenges – ones that no individual organisation or sector could achieve on its own.

A recent example of this approach within Barnet is Graham Park- joint working between Council, NHS, Integrated Care Partnership, VCSFEs to develop an evidence-based neighbourhood model. The team focused on identified needs (for example substance misuse outreach services) and co-produced solutions with impacted communities.

The ICB Population Health strategy outlines both principles for new ways of integrated working as well as 5 key priorities for the system to coproduce solutions towards together. These are:

- Start Well- Childhood Immunisation
- Live, Work and Age Well- Heart Health preventing heart disease and strokes
- Live, Work and Age Well- Cancer-prevention, early detection, and good quality of care
- Live, Work and Age Well- Lung health- e.g., asthma and COPD
- Whole Life Course- Mental Health and Wellbeing

E. National Condition 2: Enabling People to stay well, safe and independent at home for longer

Scheme ID	Scheme Name	Brief Description of Scheme
4	Care Home Quality assurance	Quality assurance of community care home providers to enable safe discharge from hospital
5	GP support to Care homes	Primary care locally commissioned services(LCS) to deliver the PCN/GP offer to care homes
7	Enhanced Health in Care homes	Staff supporting the delivery of the Enhanced Health in Care Homes Programme, liaising with individual homes to offer training and provision of the clinical in-reach team
8	Ageing Well programme	The programme aims to develop community capacity to support older people to self-manage, create peer networks, create voluntary capacity to support people in their homes; Dementia Services including dementia advisors service, day services, dementia hub and dementia cafes
9	Self-directed support	Direct payments to support the care of people in the community settings
10	Memory Clinic	Support for early detection of dementia to prevent hospital admission through the provision of community-based support.
13	Community Health services	Support to regain and retain independent living skills
14	Fracture liaison service	Systematic approach to secondary prevention of osteoporotic fragility fractures and referral to specialist falls clinics.
19	Home Care packages of support	Personalised support at home
23	Disabled Facilities Grant	Home adaptations & equipment
31	Integrated Community Equipment	Provision of small equipment in the home to retain independent living skills
32	Digital inclusion-Assistive Technologies	Technical support at home for self-management to prevent health deterioration
33	Joint Commissioning	Funding for associated projects to support delivery of transformation projects
34	Frailty MDT	Primary care funding: staff support for frailty MDT

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.

In support of our prevention agenda and maximising 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.

Steps to personalise care and deliver assets-based approach

Barnet is committed to a strength-based approach underpinning all the work that is done in adult social care and identifying ways to make people's lives significantly richer and more rewarding as a result. Every 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.

A particular focus of the Barnet HWBB is to use a community asset-based approach in an area of the borough with high levels of deprivation. This is a project targeting the reduction of hospital admissions for residents on the Grahame Park estate who substance misuse,

through increasing outreach services and co-producing the planning of interventions with the local residents.

The Adults and Safeguarding Committee has set Prevention and Wellbeing Team within the community to increase opportunities for people to stay independent. During Q4, 43 Drop-ins sessions were facilitated by the Prevention Team in 15 different wards across Barnet. The Drop-in sessions involve support for individuals through advice, signposting and community connections, as well as bringing different teams together to provide easy access to support for residents. As an example, in Friern Barnet, the Prevention Team runs a drop-in service sitting alongside the libraries. A Barnet resident attended the drop-in feeling overwhelmed and unsure how to navigate adult social care as they were hoping for support with their adult son who has a diagnosis of autism. With the support of the Prevention Team, the Barnet resident was signposted to the Carers Centre for support with their informal caring role, was supported in recognising what is a social care need and what a Care Act Assessment entails, as well as what community groups and activities may benefit both the informal carer and their son.

Implementation of joined-up care to promote population health management and proactive care

An example of our joined-up approach to proactive care is the Pan Barnet MDT to provide anticipatory care for frail 65yrs+ living in the Borough of Barnet. Core MDT Membership includes a Frailty Consultant, Mental health Consultant GP, Frailty nurse. The service includes a dedicated case management team to support the MDTs including Dementia nurses, Age UK Barnet support and therapists.

Achievements in the last year- The Frailty MDT Service (Scheme 34)

A Frailty MDT Barnet Borough Locally Commissioned Service (LCS) to support and remunerate GPs to attend the Frailty MDT model was co-created with primary care and launched in November 2022. This is to enhance the uptake and engagement of primary care with the Frailty MDT model. The new service has been promoted and uptake has been positive across the borough with 90% of GP practices currently signed up to this LCS.

Since the service commenced over 49 virtual MDTs have taken place with a total of 352 patients (164 new referrals and 151 reviews) collaboratively discussed. The team currently have 108 patients on the frailty caseload with an average waiting time of 2-3 weeks for an initial assessment.

Multi-disciplinary teams at place or neighbourhood level

A neighbours based **Paediatric MDT** is running in 4 PCN's, with discussions ongoing in a further 2 PCN's. There has been a successful bid for social prescribing link workers to further develop the mode and is due to launch imminently. At the NHSE launch of the Fuller review in London, the Barnet model was referenced as good and innovative practice.

Similarly, a fortnightly MDT Meeting including representatives from dementia services, Age UK, Admiral nurses and others works together to review dementia care pathways for our residents.

F. National Condition 2: Related Metrics

Metric 1: Avoidable Admissions

8.1 Avoidable admissions

*Q4 Actual not

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	131.2	106.4	133.4	79.0
	Number of Admissions	481	390	489	-
	Population	395,869	395,869	395,869	395,869
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
	Indicator value	130	105	132	122

Schemes supporting the delivery of the metrics:

Scheme ID	Scheme Name	Brief Description of Scheme
2	Seven day community health provision	Support for 7 day a week discharge by NHS provider teams
17	Intermediate care /step-down	Services to support safe discharge from hospital
21	Intermediate care /reablement	Support to regain and retain independent living skills
26	Carers Support	Support to unpaid carers in their caring role through provision of respite
28	Single point of access	Integrated approach to referral management
29	Admissions avoidance	Support at home to prevent health deterioration
31	Integrated Community Equipment	Provision of small equipment in the home to retain independent living skills
34	Frailty MDT	Primary care funding: staff support for frailty MDT

How the Schemes will support delivery:

The above schemes are expected to impact the metric:

1. The Access to Care pilot ***(*Scheme 2)*** -a new joint initiative between CLCH and the ASC admissions avoidance team, that aims to provide a holistic patient response to reduce unnecessary attendances at A&E and enable people to receive the care required to remain in their own homes.
2. Frailty MDT ***(Scheme 34)***
    - Patient identification via frailty tool/well-known referral routes
    - Patients triaged and assessed with complex case MDT if needed
    - Holistic. personalised care & support planning coordinated & in place
    - MDT to support assessment, planning & review for complex patients
3. Other services areas supporting the delivery of this metric include the wider work across NCL and the ICS through increased provision of a 2-hour response to avoid admission (via the Rapid Response Team);
4. Expansion of remote monitoring within care homes and respiratory patients to identify early signs of deterioration, and through improved advanced care planning in care homes.
5. The work around the delivery of the anticipatory care model will also strengthen the local placed based care and further enhance our overall response.

***Our ambition**: The ambition is based on the quarterly averages for 2022-2023, overlaid on annualised trends, with a 0.5% reduction assumed due to additional investment in ongoing schemes.*

Metric 2: Falls

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,217.9	2,350.3	2,200.0
	Count	1,340	1,329.1	1300
	Population	56,551	56,551.0	62522

Schemes supporting the delivery of the metrics:

Scheme ID	Scheme Name	Brief Description of Scheme
3	Seven day support- acute	Support for 7 day a week discharge by NHS integrated discharge teams outside of core hours
7	Enhanced Health in Care homes	Staff supporting the delivery of the Enhanced Health in Care Homes Programme, liaising with individual homes to offer training and provision of the clinical in-reach team
8	Ageing Well programme	The programme aims develop community capacity to support older people to self-manage, create peer networks, create voluntary capacity to support people in their homes; Dementia Services including dementia advisors service, day services, dementia hub and dementia cafes
14	Fracture liaison service	Systematic approach to secondary prevention of osteoporotic fragility fractures and referral to specialist falls clinics.
15	Care Home provision	24 hour accommodation and support for those residents unable to live independently
16	Supported Living	Accommodation with personalised support based on personalised level of support need
23	Disabled Facilities Grant	Home adaptations & equipment

How the Schemes will support delivery:

Across NCL ICB within a five-month period in 2021 there were over 320 falls by residents.

1. over **100 of them occurred across 10 Care Homes** and;
2. over **65% resulted in a conveyance to hospital**.

NCL UCR cars is a partnership project between NCL and LAS covering Barnet. The project aims to increase UCR response to 999 calls; ensure ongoing care at place; reduce conveyances to A&E through appropriate care at home.

Other schemes include:

- Our continued investment in multi-agency, multi-disciplinary proactive care, and Enhanced Health in Care Homes ***(Scheme 7)*** across all Boroughs in NCL focusses

on identifying, assessing, planning, and meeting the holistic health, social and environmental needs of people with moderate/severe frailty, including those who at risk of falls/repeat falls, in the community and in care homes. This multi-agency approach includes integrated primary care, adult social care, community health, acute care, mental health services and voluntary sector services across NCL.

- Due to the significant impact falls can have on residents' health, NCL is committed to reducing their occurrence and has put in a bid to run a Falls Prevention Pilot Project. The device for care homes monitors sounds throughout the night and provides an alert to care home staff via handheld devices if the sounds are abnormal and above threshold. The use of acoustic technology will initially focus on those homes that have the highest incidence of falls and will be rolled out in a phased manner to include additional homes over the course of the next 12 months.
- NCL are also looking at the option of piloting to use of raiser lifting chairs as part of the falls support offer.
- A key NCL strategic programme is the multi-year community services review which includes a core offer (minimum requirements) across a range of services including falls prevention, UCR which will be ensuring a coherent joined up service by creating the consistency and clarity is service provision. Borough teams will be reviewing gaps and identifying priority investment areas. Self-referral will be incorporated into the approach.
- The role of the local AEDB's and borough teams remains pivotal in joining up services including partners across Adult Social Care (ASC) and voluntary sector given the diverse offers of falls prevention services.
- NCL worked with an external agency on identifying opportunities to reduce utilisation of LAS in care homes. The report has flagged several areas which will be scoped as part of the 23/24 plan ensuring that there is focus on where we have above average utilisation by care home. The variation in rates or urgent care sensitive conditions and ambulatory care sensitive conditions will ensure that we are targeting the appropriate support to the care homes.

Our ambition: *This metric shows significant fluctuations over the last four years and a lot of our schemes are still at a nascent stage. Our ambition would be to maintain the count at similar levels to 2021-2022*

Metric 4: Long term support needs of older people (65 years and over)

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	543.2	440.9	354.1	345.5
	Numerator	316	269	216	216
	Denominator	58,170	61,008	61,008	62,522

Schemes supporting the delivery of the metric:

Scheme ID	Scheme Name	Brief Description of Scheme
4	Care Home Quality assurance	Quality assurance of community care home providers to enable safe discharge from hospital
5	GP support to Care homes	Primary care locally commissioned services(LCS) to deliver the PCN/GP offer to care homes
7	Enhanced Health in Care homes	Staff supporting the delivery of the Enhanced Health in Care Homes Programme, liaising with individual homes to offer training and provision of the clinical in-reach team
11	Care Packages - support at home	Building system resilience to support homefirst approach through the provision of care support packages to someone at home
15	Care Home provision	24 hour accommodation and support for those residents unable to live independently
35	Community equipment (P1)	Supporting the continuing high level of expenditure beyond BCF and base budgets on care to enable effective discharge from hospital including enabling discharges at weekends

How the Schemes will support delivery:

The development of new extra care schemes and live-in care services in Barnet is expected to enable people to receive higher levels of support within their own home as an alternative to residential admission.

Next Steps

- We will continue to monitor our engagement plan with key partners in community and tertiary health settings around joint working e.g., working with Intermediate Care Service; Occupational Therapists in A&E; supporting the IDT.
- We will continue to promote and work closely with other preventative resources e.g., Home from Hospital and Telecare, as ways of promoting safe hospital discharges where enablement is not appropriate.
- We will continue to support the provision of multi-agency, multi-disciplinary proactive care, and **Enhanced Health in Care Homes (Scheme 7).**

***Our Ambition**: As current indicators show a significant improvement in performance against 2021-2022 actuals and 2022-2023 plans, our ambition will be to attempt to maintain that performance and build resilience in our system provision. However, we will keep this figure under review as our care schemes continue to mature.*

Metric 5: Reablement

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	77.4%	77.4%	98.7%	98.7%
	Numerator	340	340	305	305
	Denominator	439	439	309	309

Schemes supporting the delivery of the metric:

Scheme ID	Scheme Name	Brief Description of Scheme
20	Reablement capacity	Additional system capacity to support D2A pathways during peak periods
21	Intermediate care /reablement	Support to regain and retain independent living skills
24	Care Act Implementation	Assessment of need and safeguarding
25	Carers Support - Assessment & Advice	Barnet Carers centre support for unpaid carers
26	Carers Support	Support to unpaid carers in their caring role through provision of respite
27	Care Act duties- MH advocacy	Independent advocacy services for clients with mental ill-health
30	Social Prescribing	Signposting to community resources to promote self-resilience
33	Enablers to Integration	Funding to support delivery of transformation projects

How the Schemes will support delivery:

Over the past years, the reablement service pathway (D2A Pathway 1) has continuously 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.

***Our ambition:** As current indicators show a significant improvement in performance against 2021-2022 actuals and 2022-2023 plans, our ambition will be to attempt maintain that performance.*

G. National Condition 3: Provide the Right Care in the Right Place at the Right Time

Scheme ID	Scheme Name	Brief Description of Scheme
1	Seven day social care support	Support for 7 day a week discharge by ASC teams
2	Seven day community health provision	Support for 7 day a week discharge by NHS provider teams
3	Seven day support- acute	Support for 7 day a week discharge by NHS integrated discharge teams outside of core hours
6	Monitoring Patient flow	Support for D2A pathways
11	Care Packages - support at home	Building system resilience to support home first approach through the provision of care support packages to someone at home
12	Day opportunities	Support for access to volunteering opportunities to improve wellbeing
15	Care Home provision	24 hour accommodation and support for those residents unable to live independently
16	Supported Living	Accommodation with personalised support based on personalised level of support need
17	Intermediate care /step-down	Services to support safe discharge from hospital
18	Winter resilience	Additional system capacity to support D2A pathways during peak periods
20	Reablement capacity	Additional system capacity to support D2A pathways during peak periods
21	Intermediate care /reablement	Support to regain and retain independent living skills
22	Dignity for end of life	Palliative care at home or in hospice
28	Single point of access	Integrated approach to referral management
29	Admissions avoidance	Support at home to prevent health deterioration
42	Neuro Rehabilitation	Support with rehabilitation

Ongoing arrangements to embed a home first approach

Housing and support

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.

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. A growing demand has been identified for care homes that can provide complex care for conditions such as dementia and nursing services.

Extra care

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 September 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.

Nursing care

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.

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.

Shared Lives Plus

Shared Lives is an alternative to supported living, domiciliary care and care homes for adults with care needs. Barnet has recently supported 2 individuals discharging from care settings with this offer; and continues to work towards identifying and developing more Shared Lives Carers in the community.

Therapy led reablement

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

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. We will continue to support investment in this and other admissions avoidance schemes **(Scheme 29).**

Investments in discharge funding to support discharge and free up beds

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.

Ruby Ward

Opening 17 beds at Ruby enabled discharges from acute beds, including at weekends. The aim /objective of the ward was to decompress the hospital with patients that no longer required acute clinical care but needed further support to be in place before discharge. This freed up beds for the hospital but also provided patients with a better experience compared to the acute environment. The capacity was shared across the 5 boroughs to ensure value for money and effective flow. 170 patients benefitted from this support across NCL.

Sustained Improvements in Outcomes for People and System Flows

Similar to other systems nationally, our three main challenges are set out below and we will work with our partners through the BCF and ASC Discharge fund for:

- Ensuring out-of-hospital systems are well prepared for winter activity in local Trusts to facilitate safe and timely hospital discharge and recovery. This includes addressing workforce recruitment challenges in key professions, including therapists, nurses and social care;
- Addressing underlying issues associated with equity of access, outcomes and experience in Barnet. We know people living in deprived (and often more diverse) neighbourhoods have 17 years shorter healthy life expectancies than their most affluent peers and there is evidence nationally social gradients in inequality have worsened as a result of the pandemic.

Urgent Community Response

During 2022/23 all the providers in NCL have worked on their internal pathways linking with their local borough partners and Accident and Emergency Delivery Boards (AEDB's) to ensure delivery of the 9 clinical conditions 7 days a week:

- All UCR providers have mobilised falls pick-up working with the borough-based Technology Enabled Care (TEC) provider some of which is delivered through Local Authorities
- Additional equipment purchased by all UCR providers is supporting delivery of the 9 clinical conditions (falls pick-up equipment, point of care testing, mobile Electrocardiogram (ECG) machines and bladder scanners)

NCL LAS Urgent Community Joint Response car - a three-month partnership project commenced in February 2023 with Central London Community Health (Barnet borough) and Enfield Community Services nursing and therapy staff joining LAS paramedics in a joint response car which will be dispatched from the LAS control centre as an alternative to conveyance and increase in referrals to UCR. The car will have access to the LAS stack allowing the team to pull patients from the queue if clinically suitable. Evaluation of this pilot will be essential in demonstrating future opportunity and ways of working. Activity is planned for 5-7 visits per car.

H. National Condition 3: Demand and Capacity Rationale

Our approach to demand and capacity modelling draws on three key sources:

- Hospital discharge data; both 2022-23 and the NCL ICB Operating Plan for 2023-24. We work across the ICS to develop the agreed operating plan; this means confirming expected hospital activity with all acute providers and breaking this down into P0/1/2/3. This is informed by the activity delivered in the previous year and our ICS wide planning approaches for the coming year.
- The service activity for 2022-23 and for the coming year.
- Finally, we review against our ambitions for 2023-24 and the impact of ongoing schemes. In terms of P2, we are also launching a single clinical model across NCL and refreshing our LOS and occupancy ambitions.

We then take our demand modelling and review against our capacity. For 2022-23 we have largely been able to deliver against expected demand, but have reached the following areas of learning:

- In general, the focus on Capacity and Demand as currently portrayed in the BCF is limited as it does not pay due attention to Pace. This is particularly relevant in our local system for P3, but is also important for P1 and P2 capacity. Our approach is to often spot purchase capacity in care homes due to our local market. This means that we will, eventually, find the right capacity and meet the demand, and so from a modelling approach capacity will often match demand. However, we know we want to be able to do this faster and have a Complex Care Homes group working at this across NCL.
- At a high level, our P0/1/2/3 demand numbers were accurate. We work across NCL to develop this model and have established effective, daily reporting mechanisms that we use to track our flow in these pathways.
- We have launched a substantial, NCL wide approach to housing and homeless needs that has become embedded into our transfer of care hubs.
- We have also increased our virtual ward capacity which continues to support patients to receive care at home.

Key Assumptions for Demand and Capacity Modelling

- **P0**- Barnet capacity estimate is based on previous years outturn of schemes that provide low level support.
- **P1**- The default pathway for those leaving hospital in Barnet is reablement. Barnet's capacity and demand are similar as the council will procure the majority of placements to demand but does have some block provision. Demand for 23/24 is expected to increase slightly and has been reflected in the figures. The combined capacity for P1 is larger than the demand as some discharges will require both health and care support; and both health and care capacity is reflected in our estimate.
- **P2** - Barnet has estimated a Length of Stay (LOS) of 21 days for most cases, and 42 days for more complex placements. The NCL ambition is for the average LOS to further reduce to 14 days and this will be reflected in future capacity calculations as this may not be achieved by 23/24. Beds are shared across NCL to ensure access to a wider pool of beds than is shown here. This estimate does not included beds commissioned outside of the ICB (such as NHSE beds). Finally, where necessary, Barnet spot purchase rehabilitation beds and this capacity is not shown here.
- **P2 bedded capacity** is considered at a NCL wide footprint and includes the capacity at the CLCH wards- Finchley Memorial (MW), and Jade; as well as the Neuro

Rehabilitation ward in RFL. The capacity at Adams ward has also been included in our P2 reablement provision as consideration is being given to utilise this, Barnet's step down capacity to further bolster the local P2 capacity. The mis-match between borough capacity and demand is explained by NCL sharing approaches - e.g. Enfield and Barnet have more capacity than demand as they take admissions from across NCL. Barnet have split P2 demand roughly as 50% between reablement and rehabilitation.

- **UCR**- demand is based on total number of referrals received for Rapid Response – including those which are subsequently not accepted and assumes one new referral = one client. It covers all referrals that each Rapid Response team received NOT just 2hr UCR. The activity is based on 22/23 actuals – averaged out over each quarter so that there is seasonality element incorporated. Capacity is considered the same as demand because our rejection rates are minimal.
- **P1** Rehabilitation bedded capacity for community discharges is estimated from the CLCH IAP.
- While Barnet does have capacity to take admissions from the community for bedded reablement and rehabilitation, the capacity flexes across both hospital and community pathways. Given that there are usually low volumes of activity from community admissions, we have recorded the capacity as being against acute for this. We are reviewing our clinical model for P2 in 2023-24 and will look at increasing 'step-up' or community access.

I. National Condition 3- Impact on Metrics: Discharge to Residence

Metric 3: Discharge to normal place of residence

8.3 Discharge to usual place of residence

*Q4 Actual not a

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	92.4%	92.1%	91.5%	92.4%
	Numerator	6,567	6,229	6,328	6,595
	Denominator	7,108	6,760	6,917	7,140
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
	Quarter (%)	92.4%	92.4%	92.4%	92.4%
	Numerator	6,567	6,567	6,567	6,567
	Denominator	7,108	7,108	7,108	7,108

Schemes supporting the delivery of the metric:

Scheme ID	Scheme Name	Brief Description of Scheme
2	Seven day community health provision	Support for 7 day a week discharge by NHS provider teams
17	Intermediate care /step-down	Services to support safe discharge from hospital
18	Winter resilience	Additional system capacity to support D2A pathways during peak periods
21	Intermediate care /reablement	Support to regain and retain independent living skills
31	Integrated Community Equipment	Provision of small equipment in the home to retain independent living skills
35	Community equipment (P1)	Supporting the continuing high level of expenditure beyond BCF and base budgets on care to enable effective discharge from hospital including enabling discharges at weekends
40	D2A 7 Day Working	Support for 7 day working
41	CHC Assessor	Support for Continuing Healthcare

How the schemes will support delivery:

- The reablement pathway has been revised with enhanced capacity for this year. There is additional investment from BCF funds to provide additional reablement service capacity, and the establishment of an OT-led reablement approach starting from September 2022.

- A recent scheme that supports is - CLCH deployed nursing staff to care homes to provide clinical input for supported discharge. The new care technology framework will also provide additional assistive community equipment to enable patients to return home safely with additional monitoring.
- The discharge section of this plan sets out the wide range of schemes in place to support the coordination of timely discharges to the normal place of residence, this includes the IDT, reablement, homecare, integrated community equipment and telecare offer, along with specific care home services, one care home team and trusted assessor.

Our Ambition: *Given the minimal in-year fluctuation of rates, and that the London rate for 2020-2021 was 92.6%, we are projecting a continuation of 2022-2023 Q1 rates for this metric as a plan.*

J. National Condition 3- High Impact Change Model

Over the last couple of years, 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 NFA 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. To identify and develop a robust centralised system for sharing information to minimise patient delays. NCL ICS will review options for partners to improve real-time sharing/tracking of information, assigning case management & progress on discharge preparation, including through the Optica platform in local Trusts. Forecast Modelling reporting now taking place at NCL and local level with regular submission and presentation to AEDB.
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 inreach 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. NCL-wide improvements relating to UCR/111 response, e.g. Frailty Car etc. to continue.
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 Part of NCL-wide review to include strengthening DTs/TOCHs on multi-agency 7-day basis
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. Learning and development including upskilling acute staff in local system on applying the NCL Choice Policy will continue into 2023/24 - seen as important element of changes to discharge processes
8. Improved discharge to care homes	Established	Clinical inreach to care homes to support safe discharge for people with increased acuity across seven	Improvement seen in unnecessary admissions from care homes, particularly on evenings and at weekends.

High Impact Change	Self - assessment 2022-23	Achievements	Future actions
		days a week and manage new admission assessments.	
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.

K. National Condition 3- iBCF and Discharge Fund to fulfil the duties of the Care Act

Our ASC discharge funded schemes as well as our iBCF funding continue to support the council in fulfilling its duties under the Care Act. Additional information about how these discharge schemes aid our population in providing the right care at the right time can be found in **Section G above**.

List of ASC Discharge Funded Schemes		
Scheme ID	**Scheme Name**	**Scheme Description**
35	Community equipment (P1)	Supporting the continuing high level of expenditure beyond BCF and base budgets on care to enable effective discharge from hospital including enabling discharges at weekends
36	Reablement capacity (P1)	Supporting the continuing high level of expenditure beyond BCF and base budgets on care to enable effective discharge from hospital including enabling discharges at weekends
37	Residential and nursing care (P3)	Supporting the continuing high level of expenditure beyond BCF and base budgets on care to enable effective discharge from hospital including enabling discharges at weekends
38	D2A Plan (P1)	Home Care or Domiciliary Care
39	D2A Plan (P3)	Residential Placements
43	Reablement Capacity (P1)	Supporting the continuing high level of expenditure beyond BCF and base budgets on care to enable effective discharge from hospital including enabling discharges at weekends
44	Residential and nursing care (P3)	Supporting the continuing high level of expenditure beyond BCF and base budgets on care to enable effective discharge from hospital including enabling discharges at weekends

Key achievements in 2022-2023

All of our discharge schemes supported management of system flows during a difficult period and provided valuable learnings about joint working and system coordination. Some of our key successes were:

- **Additional P2 Beds-** Opening 17 beds at Ruby enabled discharges from acute beds, including at weekends. The aim /objective of the ward was to decompress the hospital with patients that no longer required acute clinical care but needed further support to be in place before discharge. This freed up beds for the hospital but also provided patients with a better experience compared to the acute environment. The capacity was shared across the 5 boroughs to ensure value for money and effective flow. 170 patients benefitted from this support across NCL.
- **Bolstering CMHT and Community rehabilitation teams- BEH**- The additional funding supported the procuring of items to facilitate discharge, food, heating fund, white goods etc. Number of people supported is wrapped up with the overall 459 beneficiaries.
- **MH IDTs- LBB**- The Older People remit within IDT was extended along with the commissioned floating support to MH IDTs and an Housing post attached to MH IDTs.
- It was estimated that the additional discharge funding for improving MH discharge pathways benefitted nearly 300 beneficiaries in Q4 2022-2023

List of iBCF Funded Schemes		
Scheme ID	**Scheme Name**	**Scheme Description**
6	Monitoring Patient flow	Support for D2A pathways
12	Day opportunities	Support for access to volunteering opportunities to improve wellbeing
15	Care Home provision	24 hour accommodation and support for those residents unable to live independently
16	Supported Living	Accommodation with personalised support based on personalised level of support need
18	Winter resilience	Additional system capacity to support D2A pathways during peak periods
19	Home Care packages of support	Personalised support at home
20	Reablement capacity	Additional system capacity to support D2A pathways during peak periods
30	Social Prescribing	Signposting to community resources to promote self-resilience
32	Digital inclusion- Assistive Technology	Technical support at home for self-management to prevent health deterioration

Our iBCF schemes have helped with supporting system flows and increasing resilience in the system including by providing additional system capacity to support D2A pathways during peak periods and by supporting digital inclusion.

For example, In Barnet, the **Winter Resilience (Scheme 18)** has enabled flexing capacity during peak periods in a way that improved operational system flows across the borough.

L. Support for Unpaid Carers

Scheme ID	Scheme Name	Scheme Description
24	Care Act Implementation	Assessment of need and safeguarding
25	Carers Support - Assessment & Advice	Barnet Carers centre support for unpaid carers
26	Carers Support - Respite services	Support to unpaid carers in their caring role through provision of respite
27	Care Act duties- MH advocacy	Independent advocacy services for clients with mental ill-health

Context

The 2021 Census data shows that Barnet has 28,808 carers, which makes up 7.9% of total Barnet population. This number exceeds the number of carers known to the council and our commissioned services, thus reinforcing the importance of proactive identification and raising awareness of the valuable role carers play in our society.

Key Achievements in 2022-2023

- Barnet's new Carers and Young Carers Strategy was launched in 2023, after extensive engagement with over 300 carers, ensuring that the community was consulted with and their voice formed an integral part of our proposed priorities and approach.
- 44 carers participated in a 6-week Training Programme for Carers for people living with Dementia in 2022-2023
- The Barnet Carer Centre Contract had ~1600 instances of supporting carers in the year 2022-2023 and is expected to support as many over the next two years.

	Referrals	Assessed	Trained	Total
Adults	481	520	309	1310
Young Carers	160	133		293

Carers and Young Carers Strategy 2023-2028:

Barnet's new **Carers and Young Carers Strategy 2023-28** focuses on the importance of the identification of individualised support for, and meaningful collaboration with, carers, for their benefit and for the benefit of the person they care for. The priorities defined within this strategy and the outcomes the council and partners intend to achieve are a result of listening to the collective voice of carers (of all ages) and stakeholders.

The strategy sets out four coproduced priorities to guide our action planning:

- Proactive identification of carers and young carers
- Individualised support so that carers and young carers can get the support they need and are entitled to
- Involving carers to shape future services and support offer
- Raising the profile of carers and young carers

Existing support offer:

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.

BCF Scheme 25 delivers the main contract for the provision of carers and young carers support services with Barnet Carers Centre, 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. In the last year the Centre has completed 48 New Stars reviews and 34 carer reviews.

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. 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.

Support that is available to carers within the borough includes:

- Information and advice
- Respite vouchers (for use in residential or nursing homes)
- Training – including modules on practical support like safe Moving and Handling, supporting those living with dementia, or a mental health diagnosis. Carers Journey 10
- Service Provision to address the needs identified in the Assessment – delivered by a provider arranged by the local authority or funded via a Direct payment (these are cash payments, which can be used to purchase support, which you have been assessed as needing to support you in your caring role)
- Peer support and carer forums and Counselling for carers
- Mental Health support (through Barnet, Enfield & Haringey Mental Health Trust) Working with key partners to provide whole family support where needed (e.g., health and Family Services)

Support offered through the commissioned lead provider, Barnet Carers Centre, includes:

- Activities/Information and advice
- Engagement with, and support within, schools
- Leisure pass scheme
- Wellbeing support
- Counselling for carers
- Carer specific training
- Referrals to local agencies and services
- Mentoring and Educational support to young carers.

In addition to the above, other statutory and voluntary sector organisations working across the borough also offer support to carers both formally and informally.

Use of Schemes to fulfil the duties of the Care Act:

MH Advocacy- Part of our Mental Health Advocacy is commissioned by the **BCF scheme 27.** During 22/23 Barnet's joint commissioning team led on a comprehensive recommissioning process for a new contract start from 1st April 2024. The new contract has combined all advocacy types (IMHA, IMCA, Care Act advocacy and community advocacy) under one provider, creating a single point of advocacy and enabling people to have one advocate who can support them with a range of issues.

M. Disabled Facilities Grant

The Government's social care white paper 'People at the Heart of Care', published in December 2021 ('People at the Heart of Care'), set out an intention to balance demand for specialised supported housing with adapting mainstream housing to meet needs and enable people to continue to live in it. We are working closely with Barnet Homes to deliver social care plans and the Right Homes Strategy, ensuring that every decision about care is also a decision about housing, and embedding housing within the health and care system.

We are investing in preventative services wherever possible to enable people to remain in their own homes for longer, whether they are social housing tenants or residents of the council or private registered providers, private renters, or owner occupiers. We are also working together to make it easier for all homes to be adapted to enable independent and safe living, including ensuring we make the best use of funding available for delivering aids and adaptations to homes for people who need them.

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 is providing a better insight into impacts on life outcomes for groups with protected characteristics. In 23/24 we will co-produce a new Physical and Sensory impairment strategy to prioritise actions.

Achievements in 2022-23

The breakdown of support provided during 2022-2023 from use of the DFG 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.

Type of Adaptation	Number	Adult	<18 years
Combination of Items	40	34	6
Stair Lift - Curved	9	8	1
Ceiling Hoist	4	3	1
Safety Features	3	2	1
Extension	1	0	1
Through Floor Lift	1	1	0
Level Access Shower	90	88	2
Stair Lift - Straight	12	10	2
Scooter Store	2	2	0
Ramps - To/From Dwelling	8	8	0
Closomat	8	8	0
Central heating boiler replacement (+Con	1	1	0
Rise & Fall Bath	2	1	1
Step Lift	1	1	0
Door Entry System	3	3	0
Kitchen Facilities	1	1	0
Steps - To/From Garden	1	1	0
	187	172	15

In response to market pressures, we will review the approved DFG schedule of rates for 2023-25 and have continued to invest in assistive technology and equipment. We continue

to 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.

Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO)

We use the RRO to enable funding of DFG for discretionary services. Discretionary funding is assessed on an individual needs basis alongside an assessment of the overall grant available for mandatory grants.

Over the last three years, we have disbursed discretionary funding as follows;

Financial Year	Number of Grants to Landlords	Number of grants	Total discretionary spend
2020-1	2	1	£12,000
2021-2	2	5	£53,177.23
2022-3	1	3	£40,902.83
Committed (Previous years)	**Number of Grants to Landlords**	**Number 'top up' grants**	**Total discretionary commitment**
	1	3	£43,097.23

Our review of private sector housing assistance will include how greater use can be made of this flexibility.

Priorities for 2023-24

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.

Consultation on the housing strategy has recently completed including engagement with residents recruited through the councils engagement panel. The insight into experiences and barriers in the private rented sector will help inform work on housing assistance.

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
- Re-opening 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 – consultation has recently completed and included engagement with residents on the councils engagement panel
- Continued expansion of the 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 155 clients.

Preliminary data for 22/23 shows a reduction in referrals from 249 to 176 alongside a temporary reduction in capacity within the grant assessment team. This has been addressed through work to reduce waiting times for assessments and successful recruitment of interim staff.

In the meantime, our preliminary estimate for the next two years would be to address 150 referrals in each year.

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. We are considering whether reclaimed DFG can be made available for such ted housing assistance (repairs) grants.

During the next period of the BCF we will consider interventions through the broader housing strategy and how processes can be strengthened and streamlined to enable greater take up of the DFG funding by residents.

* *This is the most recent finalised data – DFG data returns are completed in the Autumn*

N. 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 2022-2023

The key objectives deliverables for the year 2022-2023 for Barnet were:

- Deliver Healthy Heart Peer Support project to raise awareness of hypertension/ CVD prevention in Black African, Caribbean and South Asian communities.
- Reduce inequalities in the uptake of childhood immunisations starting with MMR
- Barnet Young Brushers (BYB) Deliver supervised toothbrushing in 40 early years settings by March 2023

The key achievements for these priorities were as follows:

Cardiovascular disease:

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.

The Cardiovascular disease Prevention Programme and Action Plan was agreed at cross partner task and finish group and approved and at the Health and Wellbeing Board in Q3 2022-2023.

Healthy Hearts is a community-based programme aiming to support increased understanding and behavioural interventions to reduce cardio-vascular disease in target communities in Barnet. Delivered by Inclusion Barnet the programme has targeted Black African, Caribbean and South Asian communities in Burnt Oak, Colindale, Edgware, Hendon and Golders Green. This peer education intervention has developed increased understanding of the risks and

preventative factors for CVD and has seen increased uptake of blood pressure testing in this community leading to the diagnosis of hypertension in some community members who were unaware of their high blood pressure. This programme has explored how wider determinants affect engagement in health protection and health seeking behaviour as well as identifying structural issues such as access to health services as a barrier for engagement.

> *"Healthy Heart has saved lives. After my uncle got his blood pressure taken and was told to see his doctor as it was above 190/100. He saw his doctor and ended up in hospital. It turned that he had a very serious heart problem and got treatment. Without Healthy Heart, he may not have found out until it was too late".* ***Community Leader – Centre of Excellence.***

A programme of work to support hypertension case finding in community pharmacy settings has identified a diagnosis gap in primary care and is working to provide opportunities for the delivery of blood pressure monitoring for targeted individuals in community pharmacy settings.

The programme continues into year 2 (23/24) and is developing its evaluation process and plans for sustainability.

Childhood Immunisations:

- Survey results insight has shaped a future action plan that focuses on areas such as collaborative engagement and education events, PCN approaches to vaccination efforts, exploring broader vaccinating workforce and launching call/recall systems to support.
- Two polio vaccination clinics held at the London Jewish Family Centre in December, exploring scope of running at scale clinic in PCN1W
- Development of childhood immunisation leaflet that has been translated in top 5 languages

BYB:

The Barnet Young Brushers project aims to reduce dental complications and increase regular tooth brushing through the provision of targeted supervised tooth brushing interventions in early years settings. The programme provided education and training in 47 early years settings in Barnet.
Out of 117 children/parents from the 15 settings that responded to a survey questionnaire in March 2023, 73.50%(n=86) of parents agreed that toothbrushing at the setting has improved their brushing habits at home.

Our Approach

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.

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.

In the last two years, 'quick win' projects in individual Boroughs have been progressed working with VCSE sector to improve individuals' digital capabilities & opportunities.

In Barnet, the BCF programme (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.

CORE20PLUS5

NCL ICS reaffirmed its commitment to improve equity of access and outcomes to under-served communities, particularly those living in deprived neighbourhoods in 2023/24. The ICB committed non-BCF £5m Inequalities Fund Programme to fund solutions to address these issues and improve the health and life chances of people in the 20% most deprived neighbourhoods.

The Programme was focussed largely on addressing the 'Core20Plus5' issues within the 20% most deprived neighbourhoods: alongside other sources of funding, such as the MH Transformation Fund, the Programme includes investments in projects supporting people living with SMI, those with or at risk of LTCs, such as cancer, COPD, CVD/hypertension, and inclusion health. We have engaged with PCNs to support the 'Plus' component.

Within Barnet the Inequalities Fund has been used to invest in the - **Healthy Living Hub**- a structured pilot aims to deliver a prevention approach across three years, to deliver an integrated living hub offer as proof of concept for NCL. Specifically addressing smoking, alcohol and obesity, for Royal Free London patients and staff, It has mapped NCL system prevention offers, establishing a baseline, and set up or aligned networks for smoking, alcohol and weight management across NCL. It has established a smoking cessation offer for patients and continues to work with partners to take an asset-based community development approach.

Mental Health Inequalities- Art Against Knives

Art Against Knives delivers focused work with young black men targeting issues of poor mental health. This programme based at 'The Lab' in Finchley provides opportunities for young people to engage with creative arts, including music making as a conduit for the delivery of mental health and wider well-being interventions. This includes employing peer leaders to conduct research with other young people to understand how mental health provision could be shaped to better serve this group of young people.

As well as providing safe spaces for young black men to explore issues of mental health the programme increases social value by providing local young men the opportunity for employment, training and development through the peer mentor's programme.

From July 2022 to January 2023, 78 young people engaged with the LAB (AAK's hub in Finchley), with 63 of those receiving one-to-one/mentoring support.