Integration and Better Care Fund

Better Care Fund 2025-26 HWB submission

Narrative plan template

	HWB area 1	HWB area 2
HWB	Camden	
ICB	North Central London	
ICB		
ICB		

Section 1: Overview of BCF Plan

The intention is that the 2025-26 Camden BCF Plan will build on the momentum of the 2023-25 plan, which was aligned with our shared commitment to prevention, further developing strengths-based integrated health and care. There will be minor changes to investment and schemes.

The BCF continues to be an enabler to support Camden's Integrated Care Partnership, which has a strong shared purpose to make the borough the best place to start well, live well and age well and has five identified priority workstreams:

- Urgent Community Response
- Neighbourhood Working
- Community Connectedness
- Mental Health, Learning Disabilities and Autism
- Children and Young People

These ICP priorities are supported by continuing investment in a diverse range of BCF funded schemes in 2025-26 which include:

- **Improving urgent community response** - significant and increased investment in rapid response (scheme ID: 7). There also continues to be significant investment in reablement (schemes 28, 57, 58, 59 and 64) and rehabilitation services (scheme 61), along with integrated discharge teams (schemes 38 and 40) to support timely and effective discharge.
- **Neighbourhood Working** - funding for a range of personalised, strengths-based, packages of care at home to improve our neighbourhood working (schemes 14 and 35),
- **Increasing community connectedness** - investment in carers services (schemes 9, 10, 21, 36 and 72) advocacy (scheme 1) and care navigation (scheme 8),
- **Mental Health, Learning Disabilities and Autism** – investment in the mental health Crisis House (scheme 16), additional support for people with a learning disability (scheme 11, 12 and 13), and our local user-led Autism Hub (scheme 3).
- **Children and Young People** – funding for the innovative 'Minding the Gap' project to holistically address the mental health and wider support needs of young people (scheme 51).

A number of strategies and key areas of work act as enablers for delivery of BCF schemes:

The **Camden Health and Wellbeing Strategy 2022-2030** takes a population health approach with the aim of using the collective resources and organisational know-how across the borough to embed prevention of ill health to enable everyone to live and age well. The approach is summarised in the commitment of all partners to learn from each other and consider their influence over the four key drivers of health and wellbeing. The strategy unifies the partnership behind a set of guiding principles that were developed in response to

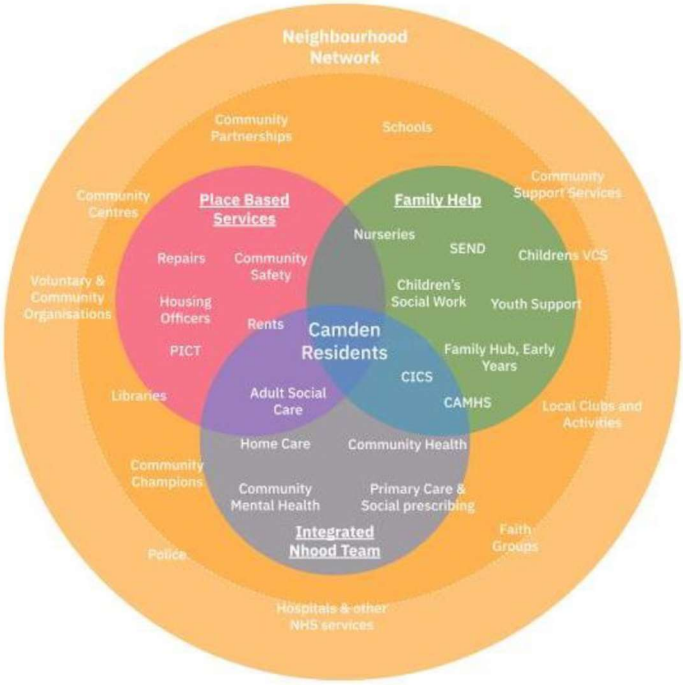
what residents outlined through the Citizens' Assembly project in 2020. Taking a population health approach seeks to take into account all the factors that contribute to improving health outcomes, and therefore the need for collaboration and involvement of partners who sit outside traditional health and care services to holistically address health challenges and reduce inequalities.

Building on this, the **NCL Population Health & Integrated Care (PH & IC) Strategy** was endorsed by system partners in April 2023 following a significant programme of engagement and co-production. It outlines an ambition to tackle health inequalities by a shared emphasis on early intervention, prevention and proactive care. A key aim of this next phase of delivery is aligning plans and strategies across partners to deliver population health outcomes in Camden. This will include bringing together borough plans, such as those reflected in the local Health and Wellbeing Strategy, system-wide transformation programmes, and individual organisational plans to ensure we are working together effectively to assure delivery of our joint population health aims and ambitions.

A significant strand of the Health and Wellbeing Strategy is **'Neighbourhoods and Empowered Communities'**. Across Camden, teams are working to embed the neighbourhoods' approach, working closely with communities to build a shared vision and understanding of what a 'neighbourhoods' approach' means in practice in Camden. In In 2021 a piece of work was commissioned jointly by Supporting People (Adult and Children's social care and Public Health) and Supporting Communities (including Housing, Community Safety and Development) directorates to produce an overarching strategic narrative to unite the full range of activity, which was taken place within Camden's neighbourhoods. It led to the production of the strategy document, The Way We Work in Neighbourhoods. The work is now pivoting to engage the whole Council and local partners to turn vision into reality.

Neighbourhoods refer to the geographical areas within which a wider range of services and support collaborate to improve the health and wellbeing of the local population. Camden neighbourhoods were devised as a 'system-facing' tool in that they help staff to identify colleagues and better operate across service and organisational silos, to ensure people get the support they need and when they need it. The goal is to establish 5 geographical neighbourhoods within the borough, with shared physical locations in **which integrated**

neighbourhood teams (INTs) will be based. The first INT pilot was funded by BCF and began in September 2024 in the East Neighbourhood, within Kentish Town and consists of multi-agency and multi-disciplinary partners from health and social care. There are signs that the new INT arrangements are having a positive impact on staff, as well as the residents they support, creating an environment for sustainable population health management interventions to take root, but evaluation will take place over the longer term. The lessons from the initial test pilot will inform the roll-out of neighbourhood working within the four other neighbourhoods.

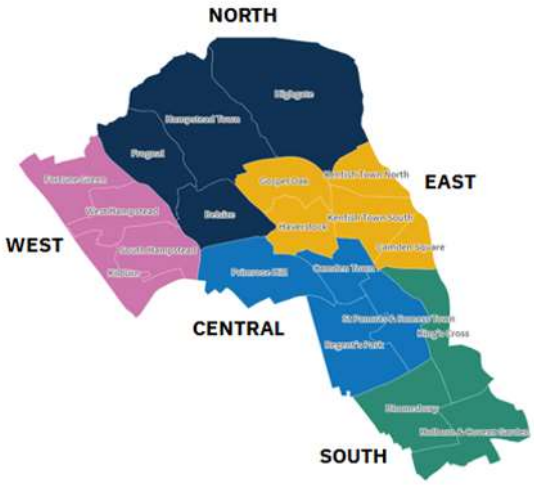


'Neighbourhood Network'

Adult Social Care has taken steps to align its services with the neighbourhood model. Following staff consultation in November 2023, proposals to transform Support and Safeguarding into **'Adult Social Care Neighbourhoods'** were implemented from June 2024. Adult Social Care Neighbourhoods is the largest service in the Adult Social Care directorate and serves adults with ongoing care and support needs, ensuring and maintaining their safety and independence. The new service is designed to facilitate closer working with health and community sector partners and align ASC service delivery footprints with the borough partnership understanding depicted in the map below. Following all social care practitioners, support staff and management will identify with one of five neighbourhoods. There will be careful management of the change to ensure little minimal impact to service delivery, and in future this will open more opportunities for collaboration with other services who support the same neighbourhoods. The infographic below shows some examples where Council and health services are aligning with this model.

Geography and service delivery

Camden's borough partnership has a shared understanding of neighbourhoods



Camden Council and local NHS organisations have worked together to develop a consistent understanding of neighbourhood (locality) footprints*.

- **LBC Adult Social Care** realigned Support & Safeguarding, becoming Adult Social Care Neighbourhoods in 2024.
- **CNWL Camden Integrated Community Health** realigned to the five neighbourhoods in 2024.
- **LBC Housing** is currently realigning onto the five neighbourhoods.
- **LBC Repairs** is going to realign onto the five neighbourhoods
- **NLFT Mental Health** teams are realigning their three locality areas that overlay the five neighbourhoods.
- **GPs** have demonstrated flexibility and willingness to work across PCNs, building strong ties with the council and other services.

The changes are providing the platform for integrated teams to come together and sustain in neighbourhoods.

*Not all council and NHS services, including GPs, will align their teams to the five neighbourhood footprints. Smaller teams will continue to work borough-wide or at system level but connect better with neighbourhood teams.

At borough level, partnership meetings provide a forum to ensure that BCF plans are being discussed and shaped with the relevant stakeholders present to contribute. Progress updates are shared by BCF leads at the NCL community of practice fortnightly to ensure plans for each borough are progressing and issues raised for resolution.

Plans are shared with partnership boards and AEDB's given the links to UEC flow whist the ICS population heath delivery plan will track the metric for admission avoidance for NCL. Regular progress updates on the BCF will be circulated to the NCL Executive Management Team and NCL DASS group to ensure schemes and metrics remain on track.

The balance of borough-based oversight and coordination on an ICS footprint via the community of practice ensures that the oversight is achieved at all levels. Learnings from the BCF Support Programme will be pivotal in providing a programme-based approach which will be embedded for future years whilst the role of the overview and check in group will support on-going development of plans.

Camden's Health and Wellbeing Board provides ongoing partnership leadership in delivering Camden's Health and Wellbeing Strategy 2022-2030, as well as strategic leadership for Camden's Better Care Fund Plans and Camden's Integrated Care Partnership (ICP). The Board brings together locally elected representatives (including from the VCSE and education), service user representatives, commissioners and providers of health and care services for adults and children to jointly assess local needs. The Board's purpose is to:

- Support people to live longer in good health and enhance people's quality of life and experience of care;
- Put residents at the heart of what we do and offer;

- Mobilise the skills and knowledge of local people and the connections and resources within communities and organisations to improve health and well-being.

The Camden BCF is supported by the diverse membership of the Local Care Partnership Board, which includes senior representatives from the ICB, Council, Primary Care Networks, NHS Trusts (Royal Free, UCLH, CNWL, Camden and Islington MH Trust) and the VCSE. The group offers a forum to review and discuss the annual BCF Plan and to review metric performance. This partnership is also key in ensuring that opportunities for the VCSE to enact a strategic partnership role in the ICS are realised at a borough and neighbourhood level.

The North Central London Community Partnership Forum was established in 2022, to provide a key arena for the further development of BCF strategy and schemes. The forum will ensure effective community and local people's participation in the work of the wider ICS. Membership includes the ICS Chair, VCSE partners and Alliance, local councils, Healthwatch, public members, people with lived experience and other partners from across ICS. It has an active expert reference group on community engagement, as well as a forum for discussion and debate on emerging proposals and strategies.

The BCF schemes are pivotal in supporting the UEC system and seen as a key enabler for contributing to delivery of successful strategic programmes across NCL as follows:

Emergency Bed Productivity Programme

Across NCL, demand for non-elective beds is projected to increase by 7% through to 2028/29, driven in part by demographic growth. In a "do nothing" scenario by 2028/29 the system would require an additional 325 non-elective beds.

The "do nothing" scenario is not an option as there isn't the workforce, estate or funding to continue to operate in the present way. Moreover, population health outcomes are likely to be worse for patients as our ICS strategy is to shift to a more proactive, community-based model of care, and as our analysis shows there are both opportunities to reduce avoidable admissions and reduce length of stay. In addition, the implementation of elective backlog reductions would be compromised.

Efficiency opportunity analysis has been undertaken at hospital site level looking at both opportunities to reduce demand and length of stay with each acute trust required to work with system partners and develop plans to deliver on the opportunities during 2025/26.

Across the different opportunities, reducing the medical optimised patients, reducing long length of stay (21+ days) and increasing virtual ward capacity would have the greatest impact in terms of bed savings.

The BCF schemes will continue to support the mitigation of increased beds.

Admission avoidance and virtual wards

Inclusion of BCF schemes in multi-agency services such as Urgent Community Response; Virtual Ward; Proactive (Anticipatory) Care Planning and Enhanced Health in Care Homes teams has meant more people are supported without requiring admission. The number of potentially avoidable admissions has fallen steadily in recent years as per the BCF performance.

Heart disease and heart failure, COPD and asthma are the top 3 clinical reasons for avoidable admissions and together make up more than 50% of total avoidable admissions. Analysis shows that our most deprived communities experience increased admission levels of 20-30% than the general population meaning there is potential to make further gains in admission avoidance through further upstream support with communities that experience poorer health outcomes.

The ICS has agreed a range of principles regarding admission avoidance which aims to prioritise the approach and ways of working. The purpose is to develop system and borough partnership plans which will be a key component of the joint transformation programme.

The NCL ICS virtual ward programme delivered by acute and community providers with support with care provision by adult social care increased virtual ward capacity from 130 to 185 beds by the end of March 2025. Partners continue to increase capacity and utilisation by implementing step-up pathways to general medical/frailty virtual wards in each borough. Three population health objectives have been developed for the virtual ward programme: equity of access (ensuring that services are equally accessible to all NCL residents based on clinical need); improving holistic health & well-being and reducing inequalities through service delivery; and allocating Virtual Ward funding to have the greatest benefit, i.e. in line with areas of greatest need.

Development of the P2 model and reablement models of intermediate care are two key priorities in Camden:

P2 model

Across the 256 community-based P2 beds across NCL, creating consistency has been key. Partnership working has achieved the following:

- Implement the P2 core offer of discharge service pathways
- Monitoring that all P2 units are working according to the six standards
- Standardising indicators used to understand patient outcomes

There are six standards which P2 units to work towards, across the three pillars of the P2 model:

1. Referral management and screening: processes are explicit, easy, efficient and equitable
2. Person centred rehabilitation and care co-ordination is primary process of the P2 MDT with interdisciplinary working essential
3. There is leadership and training from the specialist rehabilitation team
4. Services are integrated with the rest of the system

5. There is early effective integrated discharge planning using recognised NCL guidance

There is an agreed patient data set used for core and core plus.

Reablement

Camden's CQC Local Authority Assessment report (published February 2025) found that feedback from people on reablement provision was positive and that:

- the Better Care Fund was used well to fund home care and reablement services to support discharge
- There were no recorded waits for these services and people could get a service as soon as they needed it
- There was a clear commitment to a 'Home First' approach across the system which was evident from staff and partners. This was supported by SALT data (2023-2024) which showed more people aged 65 and over (4.74%) received reablement or rehabilitation services following discharge from hospital, than average (2.91%), and more people aged 65 and over (87.18%) were still at home 91 days after discharge from hospital into reablement or rehabilitation, than average (83.70%).

Adult Social Care is focused on development of its reablement model with health and social care colleagues and reablement providers. Central to this is development of our longer-term reablement commissioning strategy and model. Feeding into this are three test and learn initiatives, which will be delivered by each of our commissioned providers as part of new 18-month contracts from April 2025. These include piloting of an integrated model with Adult Social Care and Health as part of the East Integrated Neighbourhood Team, which includes the testing of a therapy-led reablement approach. This will see occupational therapists carry out the initial reablement assessment and goal setting with the provider and the person, and the colocation of the reablement provider at the East Integrated Neighbourhood Team in Kentish Town.

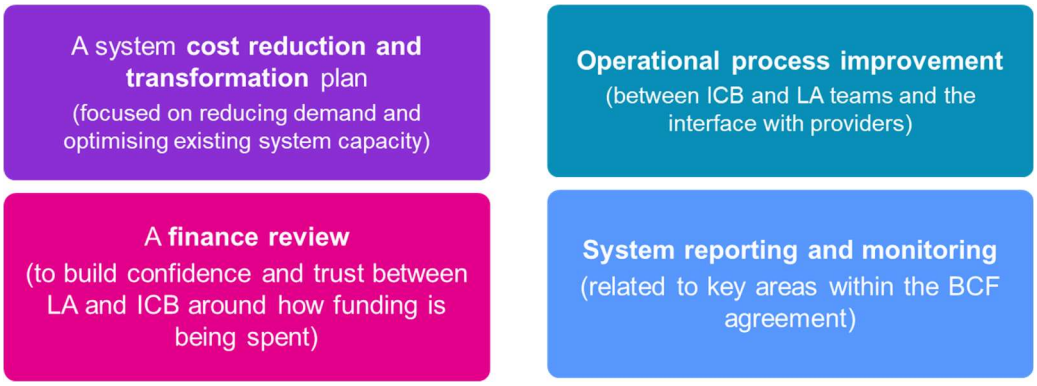
Currently we are working to enhance our reablement provision. All our enablers employed by our commissioned providers are being upskilled to ensure that they have the skills and confidence to support people to live as independently as possible. Enablers are taking part in a diverse training programme which includes sessions in safeguarding, occupational therapy and equipment and hydration and nutrition and developed with ASC and Public Health colleagues (this training is BCF funded). We are also exploring how technology can support reablement and care and support at home more broadly, and from April 2025 are piloting Lilli assistive technology (a tool which employs sensors to monitor everyday behaviours and activities within the home) to assess whether it could be used to support residents to live safely in their own homes for longer.

Section 2: National Condition 2: Implementing the objectives of the BCF

A joint system approach for meeting BCF objectives

The NCL system will continue to focus on a joint system approach with all boroughs aligned through the requirements of the BCF transformation programme. The BCF support programme will continue until the end of March and leave the system with an optimum programme management approach for delivery and an oversight and check-in group with a clear mandate to take accountability for the programme delivering the outcomes.

The programme will be delivered collaboratively and will focus on the four work areas illustrated below:



There are clear resident and system benefits to the programme, with key benefits to each partner articulated. As projects are scoped, there will be focused work to identify metrics and benefits.

Learning from the s75 exercise on value for money will be taken forward to ensure the necessary rigour is applied to ensure value for money is maintained within BCF schemes.

Oversight of the schemes at Place on behalf of the Camden Borough Partnership is through the ICB-led Aligned Commissioning Interface Meeting. Formally known as the Integrated Commissioning Group, this has been reconfigured this year to ensure a focus on both ICB and Local Authority schemes and to ensure that the requirements of the agreements are met. Furthermore, this is a space for operational escalation and de-escalation for operational matters. Neighbourhoods, for example, at a strategic level is led by the borough partnership's Camden Integrated Care Executive and has oversight from the Neighbourhood Delivery Board.

Adult Social Care schemes have benefited from the steer of the Supporting People Connecting Communities Programme Board. The Board is responsible for delivery of the vision and ambitions set out in Supporting People Connecting Communities – our cross Council strategic plan for living and ageing well in Camden, which was refreshed in November 2020 in the light of the Covid pandemic. The SPCC Board brings together key senior stakeholders from within ASC and across the Council including housing, public health and corporate support functions such as finance, HR and ICT. It is the key strategic stakeholder group to steer the strategic direction of the programme including key strategies and action plans, and transformation and change projects. It has a strong focus on use of

financial resources to support the delivery of strategic objectives, including early intervention and prevention, and receives a range of key reports information including on the use of the BCF.

Supporting People Connecting Communities strategic priorities

The new Care Quality Commission (CQC) inspection regime for local authorities has been an effective mechanism for self-assessment and identifying areas for development in adult social care. The inspection was in two stages, with an information return (including self-assessment) requested from Camden in July 2024 and inspection taking place in November 2024, and inspections are focused around four themes (working with people; providing support; ensuring safety; and leadership). The CQC assessment report was published in February 2025 and awarded Camden an 'outstanding' overall rating, with 'outstanding' ratings for five of the nine quality statements, and the rest rated as 'good'. In line with Camden's self-assessment, the report highlighted some areas for development, including comprehensive support for unpaid carers, support for people with autism, better co-production and comprehensive support for unpaid carers, but acknowledged that work was underway to address this. Other work in train includes the new model of mental health social work which was under a Section 75 arrangement with plans to move social workers back to the Council by early summer, and work to strengthen the offer for people experiencing multiple disadvantage.

Headline metrics

The borough will continue to set ambitious targets for metrics where we have established metrics with historic baselines such as long-term care needs for older people in residential and nursing homes. For the other metrics we will take a pragmatic approach linking our assumptions to the NHS planning guidance.

1. Emergency admissions to hospital for people aged 65+ per 100,000 population

An overall decrease from 2024/25 is being projected, from 5,653 in 2024/25 to 5,484 in 2025/26. Projections have been reached using current trends, seasonality and population growth for 65+ population using GLA mid-year projection. The impact of admission reduction has been incorporated in the projections, as well as the supporting indicators (unplanned hospital admissions for chronic ambulatory care sensitive conditions and emergency hospital admissions due to falls in people aged 65+). This was calculated using

NCL Bed productivity programme bed day savings for the Ambulatory Care Sensitive Conditions scheme. It is forecast that through preventing admissions of ASCS conditions, NCL could save an equivalent of 80 beds (97% occupancy) over five years, and an 11 bed reduction in 2025/26.

A number of BCF schemes will also support delivery against this metric. Other BCF schemes supporting delivery of this metric include Rapid Response, District Nursing, community equipment, Careline and support for carers. In addition, Urgent Community Response continues to surpass the 2 hour national target of 70% (performing at c.80%) and UCR priorities for the next 12 months include improving the productivity and utilisation of existing services, optimising clinical pathway improvements such as for falls and catheter care and the development of enhanced admission avoidance plans, which could become central to neighbourhood working.

2. **Average length of discharge delay for all acute adult patients**

Given this is a new metric, the baseline has been calculated using local SUS data based on Operating Plan guidance definition.

In light of local NCL work to support discharge and multiple BCF schemes, a stretch target has been developed by calculating the average of the 'best' three months of data in 2024/25. Given this is a new metric, performance will be assessed over the coming months.

BCF schemes which support delivery of this metric include continued investment in the D2A pathway, hospital social work teams, community equipment and reablement provision, including the reablement flats at Henderson Court sheltered housing scheme. An LB Camden and CNWL Action Plan for reduction in day delays (including initiatives such as virtual ward) aims to reduce mean day delays from 2.40 days to 1.48 across P1-P3 by September 2025.

3. **Long term support needs of older people (age 65+) met by admission to residential and nursing care homes**

Numbers of people in scope are low, so it has not been possible to determine a trend. Actuals have increased in recent quarters, and have been higher than planned. A 'stretch target' of 122 for the year has been modelled using an eight-quarter average and taking into account growth in the 65+ population. This is a more challenging target than that set in 2024/25, which we are not on target to achieve.

A number of BCF schemes will support delivery against this metric. Plans to embed a strengths-based model of care in care homes are progressing, with staff reablement training sessions being held, ahead of the recruitment of an Occupational Therapist to introduce this way of working. This will enable some residents to regain independence and potentially return to the community. There is also ongoing investment in reablement and homecare, to support people to live as independently as possible and remain at home.

BCF Plan objectives and related schemes, 2025/26

Camden's 2025/26 BCF plan will build on the momentum of the 2023-25 plan, which was aligned with our shared commitment to prevention, further developing strengths-based integrated health and care. These commitments also support the delivery of the two objectives for 2025/26: supporting the shift from sickness to prevention; and, supporting people living independently, and the shift from hospital to home.

1. **Supporting the shift from sickness to prevention (supports metric 1 & 3)**

Camden's population health approach and focus on early intervention and prevention supports the delivery of schemes relating to this objective. While many schemes support the delivery of both objectives (e.g. reablement, Disabled Facilities Grant), schemes which support this objective include:

- Targeted support for people with specific needs:
    - Support for people with learning disabilities, including relating to their physical health (schemes 11, 12, 13, 43, 52)
    - Support for people with mental health needs: Crisis House mental health accommodation provided as an alternative to hospital admission (scheme 16), funding for Approved Mental Health Professionals (scheme 46), and Minding the Gap, a preventative review service which support young people's transition from young people's services to adults services.
    - Complex Care Case Management - Coordination of joint health and social care for patients at risk of unplanned admissions to proactively identify interventions to prevent crises and enable people to remain at home (scheme 15).
    - Family Group Conferencing – preventing non-elective admission by building support networks (scheme 31).
- Admission avoidance schemes, including Camden Rapid Response Service, a home based intermediate care supporting people to avoid admission (scheme 7) and Complex Care Case Management, which provides joint health and social care for people at risk of unplanned admissions to remain at home (scheme 15).
- Wish+ - a referral hub for assessments regarding warmth, income, safety and health – will ensure residents have access to a range of preventative services in one place (scheme 70).
- Assistive Technology (Careline) – funding for emergency response team and range of preventative assistive technologies and telecare equipment (scheme 2).

2. **Supporting people living independently and the shift from hospital to home (supports metric 2 and 3)**

As noted previously, there are many schemes that support the delivery of both objectives but schemes which support this objective include but are not limited to:

- A range of schemes which support and enable discharge - investment in the D2A pathways (scheme 18), funding for hospital social work and integrated care teams (schemes 37 and 38), Transfer of Care Hubs (scheme 77).
- Home based rehabilitation (Care Link – scheme 61).
- Home based reablement (scheme 59).
- Reablement flats at Henderson Court, available for people when it is not possible to provide reablement to them in their own home (scheme 58).
- Long term homecare (scheme 35).
- Support to ensure people's homes are safe and easy to navigate – Disabled Facilities Grant (scheme 23), community equipment (scheme 39), Home Improvement Service (scheme 34), implementation of new therapeutic model of support for people with hoarding behaviour to support effective discharge (scheme 75).
- Support for people with specific needs – e.g. Advocacy services to support discharge under the Mental Health Act (scheme 1), Homelessness NCL Out of Hospital Care Model (scheme 76), Autism Hub which provides autism specific counselling, peer support, case work and information webinars for residents with autism (scheme 3).
- Support for unpaid carers, including services to support carers and the people they support to enable effective discharge from hospital (scheme 56).

A "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care

Camden's strength-based model of social care, 'What Matters', demonstrates a commitment to person centred self-directed support and empowerment for people. Combined with the shift to integrated neighbourhood working, which will ensure people get the support they need when they need it, Camden has firm foundations for the continued implementation of its 'Home First' approach.

The CQC Local Authority Assessment (published February 2025) feedback around integration in hospital discharge, reablement and admission avoidance was positive. The number of permanent admissions to care homes has reduced over the past three years. Reablement was effective at 86% in 2023-2024, up from their 2021 to 2022 performance of 75%. Section 1 covers some of the ways in which we are continuing to develop our reablement provision.

While the Better Care Fund will continue to fund activity to support hospital discharge, reablement and ways to avoid admission to residential or nursing care (where possible), it will also continue to fund other 'enabler' schemes.

Ensuring homes are fit for purpose continues to be a focus for the BCF. The recent CQC inspection report spoke about examples from staff about supporting people in housing settings with hoarding behaviours. Staff reported an understanding of their levels of hoarding in the local authority area and lessons had been learned from a safeguarding adult review (SAR) case. The local authority will be providing BCF-funded commissioned support for deep cleaning, alongside supportive therapeutic and psychology services, to support

individuals in the community. The services will include staff training around hoarding in order to avoid self-neglect. There is also a hoarding panel which had an overview of cases and outcomes.

The Home Improvement Service and Disabled Facilities Grant-funded works to private and housing association properties remain critical schemes to ensuring people's homes are fit for purpose, with DFG funding spend expected to be the highest to date in 2024/25.
There has been increased spend on community equipment in the past year. Work has also been taking place to improve the performance of the local authority's equipment contract. A joint performance and improvement plan had been implemented, which has seen a reduction in the median waiting time for equipment from 49 days to 3.74 days in November 2024.

For people who are unable to leave hospital and return home due to an issue with their property (e.g. due to pending deep cleans or home adaptations) the BCF continues to fund 13 reablement flats at Henderson Court, a supported living scheme.

To support people to maintain their strengths and independence as much as possible who may already be living in extra care or residential settings, a recuperative model of care is being developed and rolled out. Led by an Occupational Therapist, a reablement approach will be embedded with staff in care settings.

Consolidation of the Discharge Fund

All NCL boroughs are expected to keep to the 2024/25 levels of expenditure for discharge in 2025/26. Whilst the discharge fund has been consolidated, planning assumptions are to keep to the commitments made in the mediation agreement last year. In addition to the BCF schemes which support admission avoidance and discharge, a number of NCL initiatives are underway as described above in relation to the metrics.

There is a shared approach across NCL to Capacity and Demand. Despite not being in a position to utilise actual capacity and demand activity for Q4 due to the submission timelines, commissioners will be reviewing the figures to work with providers on the 2025/26 contracting levels. The ability to increase capacity will be wrapped up into the planning and contracting discussion with NHS providers.

Some of the shortfalls such as in Urgent Community Response will be mitigated through productivity improvements whilst pathway optimisation though 'shift left' will be key in managing demand on P1, P2 and P3. NCL is currently developing place based transformation plans with boroughs to support admission avoidance and discharge, with 'shift left' a key aim regarding discharge and, so using 2024/25 actuals, greater 'shift left' ambition and amending of the pathway proportions has been built into the Step Down modelling from Q2 onwards and has been agreed with LA discharge leads.

Virtual wards will be maturing which will need to be incorporated in additional capacity for the system or step up and step-down care.

Capacity will be reviewed alongside the delivery of providers in ensuring a minimum core offer has been met as part of the community services core offer. There is sufficient capacity in the three commissioned reablement contracts (P1), and spot providers are able to meet any increased demands in the system or to meet particular requirements (e.g. providers who specialise in supporting people from particular cultures). There have not been any issues to date regarding capacity of the 13 reablement flats at Henderson Court sheltered housing scheme.

Section 3: Local priorities and duties

Camden is an inner London borough with a population of 210,100 on Census Day 2021. The population has decreased by 4.6% since 2011, with those aged over 65 increasing by 3.4% and those aged 18-64 decreasing by 4.7%. We are one of the country's most unequal boroughs, with highly affluent areas set against significant areas of deprivation. The gap in healthy life expectancy between the poorest and richest parts of the borough is wide – poorer citizens are expected to die almost 20 years earlier than those who are better off.

The population of Camden is more ethnically diverse than England with 40% of our residents from a Black, Asian or other ethnic group compared to 19% in England – this is up from 34% in 2011. There are more than 85 different languages spoken here and we are home to more LGBTQ+ people than the national average, with 17% people identifying as LGBTQ+ in comparison with the national average of 14%. There are fewer disabled people as a share the population than the national average, 15.2% in Camden and 17.3% nationally.

Camden has the seventh highest proportion of people with depression in London and the prevalence of serious mental illness is amongst the highest in the country. Most of our older population live alone, and young people here are disproportionately affected by loneliness. We also face challenges with access to jobs, the availability of affordable high-quality homes and keeping citizens safe. In an Adult Social Care context, 56% of people drawing on our support are 65 or older. This analysis has helped shape our delivery plans for the BCF and other health, wellbeing and adult social care strategies.

Pre-pandemic there was a social gradient of 20 years in healthy life expectancy between the least and most deprived (and often most ethnically diverse) areas. Residents from the 20% most deprived neighbourhoods are 1.3x as likely (from birth to 75 years) to be hospitalised as their affluent peers, with notably higher admission rates amongst people from Black Caribbean/African and eastern European ethnic backgrounds. Our local intelligence and national reporting suggested people in under-served communities are at greater risk of being moderate/severe frailty than their age peers in better-served communities. There is good evidence our community services have responded well to rising demand, and this helped people manage their conditions. As part of learning from community responses to the COVID-19 pandemic, Camden Council has funded organisations to exist as community assets, to ensure their operations continued, without specific commissioning or contractual reporting requirements. This was in keeping with Camden's power-sharing partnership culture and its equity-focused approach to community wellbeing. The CQC Local Authority Assessment report (February 2025) reported that VCSE partners said the diverse needs of the different communities in the local authority was understood and partly addressed by commissioning many, varied VCSE services. By taking an asset-based approach to commissioning the VCSE sector, Camden has been able to reach into different communities and respond to their different needs, for example there are some specialist drug and alcohol services which include small VCSE services and other examples such as walking groups.

In summer 2024 our CQC self-assessment identified the need to strengthen our offer for people experiencing multiple disadvantage as a key area of focus. We are also seeing a growing number of people experiencing multiple disadvantage in the borough. Camden has the second highest number of people sleeping rough in London and in England (the majority of whom come from outside Camden) and figures for 2024 so far are significantly higher than

those for previous years. Those experiencing multiple disadvantage face significant health inequalities and are often under-supported by our existing health and care system, despite efforts to make our services more accessible and appropriate. We continue to see a high prevalence of serious mental illness, drug and alcohol issues and people with co-occurring needs. To tackle this challenge head on, the Council is leading a combined effort with partners to deliver enhanced support for those who experience the greatest disadvantage. We have co-produced new and specialist capacity within services, including Adult Social Care and are strengthening integrated approaches with Substance Misuse services, Housing, and our supported accommodation pathways

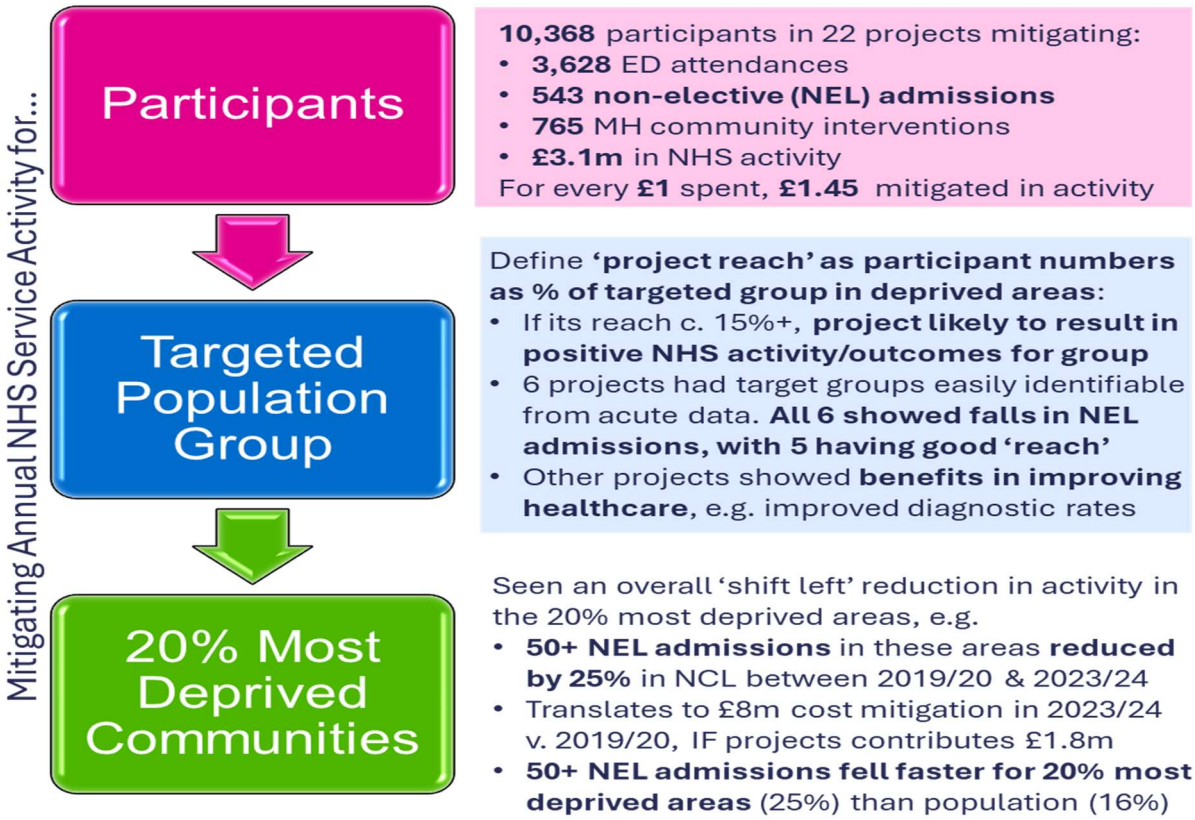
Our Health and Wellbeing Board provides partnership leadership in delivering Camden's Health and Wellbeing Strategy 2022-2030 and the Better Care Fund. The strategy was built on the learnings from our Health and Care Citizens' Assembly and outlines our population health approach, highlighting the social determinants of health alongside places and communities, healthy lifestyles, and health and care services. It is informed by our understanding of population health need and sets out three short-term priorities for partnership action: healthy and ready for school; good work and employment and community connection and friendships. The strategy is complemented by the Integration and Population Health Strategy led by North Central London Integrated Care System.

NCL ICS reaffirmed its commitment to improve equity of access and outcomes to under-served communities, particularly those living in deprived neighbourhoods in 2025/26 as part of its approach to addressing Core20Plus5. For example, the ICB committed non-BCF £5m Inequalities Fund (IF) Programme to fund solutions to address these issues and improve the health and life chances of people in the 20% most deprived neighbourhoods.
Partner working across the ICS are working towards incorporating exploration of, and tackling inequalities, within the roll out of the ICS's key Programme priorities set out in its Delivery Plan. For example, the ICB and individual Trusts produced dashboards associated with Community Health services to explore whether the results of key service and commissioning metrics – such as the 2-hour weight for Rapid Response – are equitable by deprivation and age.

A recent evaluation of the IF Programme in NCL suggested it had successfully supported BCF objectives, including improving preventative and planned care to support people to live as healthily as possible in the 20% most deprived (and often most diverse) community and avoid hospitalisation. The evaluation found that across NCL:

- Projects in the Programme worked with 26,000+ people annually, equating to c. 10% of the NCL population living in the 20% most deprived areas in England.
- 75+% of project objectives were achieved.
- The evaluation found those projects which had stronger partnerships between the statutory and voluntary sector and had good engagement with communities tended to be the more successful projects. Several projects related directly to, or incorporated aspects into its wider project planning, patient engagement on delivering projects in under-served communities as part of the Programme's overall 'Community Empowerment' workstream.
- Another Programme workstream relates to projects to encourage people to adopt healthy lifestyles or health screening, e.g. physical activation etc. – such projects are

more likely to have longer-term outcomes for individuals and 'compress need' amongst the population as part of the Darzi report's 'shift left' towards prevention.



- In Camden, the borough partnership continues to tackle entrenched inequalities through a wide range of NCL-funded partnership schemes. The Health Inequalities fund continued to deliver for our key priority areas and key populations. This included dementia awareness training and support with mental health resilience within Bengali, Somali and South East Asian populations, targeted outreach for diabetes prevention, enhanced health checks and outreach for those with SMI and LD, as well as physical health interventions and nutrition education for residents in one of the most deprived wards of Camden.
- In 25/26, Camden will capture and articulate further borough specific detail with regards to the impact and cost interventions in line with BCF reporting.
- Two IF workstreams relate to projects to help people better manage physical or mental health long-term conditions and projects supporting vulnerable people (e.g. those at risk of homelessness), respectively. Projects in these workstreams are more likely to have a measurable in-year 'compression of demand' on statutory services, including mitigating hospitalisation. Figure 1 shows the impact on NHS utilisation alone of 22 projects in these workstreams supporting over 10,000 participants chiefly from these two categories.
- Figure 1 suggests the IF Programme mitigated 'in year' healthcare activity, including hospitalisation, for participants – and for targeted populations and the 20% most deprived communities. Many projects had sufficient 'reach' into the targeted populations they wanted to engage with (e.g. those with heart failure living in the 20% deprived areas) and, due to their success, the targeted population groups from which participants were drawn. In turn, this contributed to a substantial impact on

hospitalisation of the 20% most deprived areas against demographic-based demand between 2019/20 and 2023/24 – the period the evaluation covered.

The IF evaluation noted the Programme has contributed to mitigated hospitalisation amongst these under-served communities but is one component of a network of support across the Borough as a whole and into these deprived and diverse communities. This network of support includes a range of services to promote prevention and planned care in the community funded through the BCF as described in other sections.

We continue to roll out our approach to determine the extent to which BCF and ICB-and Council-funded services are equitable for patients and residents they serve including:

- Ensuring we incorporate the views of particularly under-served communities and groups in the delivery or involve people in co-design of solutions (e.g. the Council's mental health day service was codesigned with people who drew on the service).

We will continue to build our community engagement, social capital and community infrastructure building within the BCF and non-BCF plans and services as a partnership in the Borough in 2025/26. For example, we intend to work with partners to:

- Refresh our EQIA associated with BCF or related topics within the Borough Partnership

- Ensure our future developments in this Narrative proactively consider equity as part of their codesign and implementation, including engaging with under-served residents and patients (e.g. in locality development). We will continue to measure equity and report on social gradients, and resident/patient feedback to monitor the success and impact of these services/projects, including those relating to BCF and its metrics.

- Part of this approach is to ensure 18-month ICS Delivery Plan priorities of the NCL ICS Population Health & Integrated Care Strategy to improve health and well-being across the population adequately considers equity of access and outcomes across its programme planning and monitoring. This includes exploring providing a deeper dive on inequalities and how to improve specific 'core metrics' – including one for avoidable admissions – through a deeper dive of the underlying drivers of the metrics and inequalities associated with these measures across the population.

- We will engage with communities and work across voluntary and statutory sector partnerships to realise partly BCF-funded Integrated Neighbourhood Health Teams to improve preventative and proactive care; and ensure there is monitoring of equity of access and outcomes for individuals' need to this service across the Borough. Neighbourhoods are a strategic priority for Camden's borough partnership and is a wide-ranging agenda jointly led by the London Borough of Camden, NHS providers and the North Central London Integrated Care Board. In Camden, there are five established health and care neighbourhoods with aligned provider footprints, with the development of an East Integrated Neighbourhood Team prototype to support co-location and aligned neighbourhood teams to support joined up care for residents and enhanced working experience for staff.

- Continue with our IF Programme projects, including its engagement with under-served communities but ensure projects are more closely aligned with emerging initiatives such as Neighbourhood Teams in these deprived communities in 2025/26.

The NCL Age Well Delivery Plan recognises the crucial role of unpaid carers and aims to enhance support through a mix of healthcare integration, social care collaboration, and financial/resource-based support.

Key Priorities for Carers are:

1. Enhancing Recognition & Support for Carers
   - Acknowledges the contributions of unpaid carers and integrates them into care planning and decision-making.
   - Ensures that carers' needs are assessed alongside the individuals they support.
2. Strengthening Health & Social Care Integration for Carers
   - Borough Partnerships will work with local councils, NHS providers, and voluntary sector organizations (VCS) to coordinate support for carers.
   - Community-based support initiatives aim to reduce the burden on carers by improving access to healthcare and social care services.
3. Respite & Wellbeing Support
   - Exploring respite care options to give carers time to rest while ensuring continuity of care for those they support.
   - Mental health and emotional support initiatives, including carer support groups and counselling services.
4. Training & Resources for Carers
   - Providing training for carers to help them manage the long-term conditions of their loved ones (e.g., managing medications, wound care, and mobility support).
   - Improving access to financial and practical support, including information on carers' benefits and entitlements.
5. Monitoring & Data-Driven Improvements
   - Core Metrics & Outcomes Tracking to assess how well carers are being supported, with reports to the Population Health & Health Inequalities (PH&HI) Committee.
   - Identifying gaps in service provision and targeting investment in underfunded areas to support carers more effectively.