NORTH LONDON PARTNERS
in health and care
North Central London's sustainability and transformation partnership

Overview of the NCL Community Services and Mental Health Strategic Review
Presentation to Enfield Health and Wellbeing Board

June 2021

Background to the Community and Mental Health Services Strategic Reviews

- North Central London (NCL) CCG spends more than **£270m/Year** across a range of NHS, Local Authority and Private Providers delivering a wide range of community Services that supports our 1.7m population across the 5 Boroughs (Barnet, Enfield, Camden, Haringey and Islington). The CCG spends a further **£325m** on mental health services for this population.

- Before the formation of the NCL CCG services were commissioned by each of the **5 legacy CCGs in isolation leading to variation in service delivery models and services provided.** This range of services has lead to variations in outcomes, inequalities in access to provision. It has also created opportunities to identify improvements.

- For community services an **initial review was undertaken in 2020 and identified differing service specifications, differing thresholds for treatment**, differences in reporting and not unsurprisingly differing outcomes for the population we serve.

- Local Delivery of the LTP and mental health Investment standard etc. has already **started to deliver improvements in mental health**. These now need to be sustainably and consistently implemented and able to cope with the rising demand for care and treatment post Covid.

- With the formation of the NCL CCG and as we move toward an Integrated Care System (ICS) along with the development of Borough Based Integrated Care Partnerships (ICPs) we are in a position to address both the issues highlighted in the initial review as well as **accelerate the development of neighbourhood/PCN** local Care services in line with the Long Term Plan.

- This work will also enable us to create **sustainable community and mental health services that improve outcomes, addresses health inequalities and inequities and also drives better value from our current spend.**

Community and Mental Health Services Strategic Review Aim & Objectives

Aim:

Our aim is to have a **consistent and equitable core offer** for our population that is delivered at a **neighborhood/PCN level based** on identified local needs and that is **fully integrated into the wider health and care system** ensuring outcomes are optimised as well as ensuring our services are **sustainable in line with our financial strategy and workforce plans.**

Objectives:

- Provision of a **core & consistent** offer that is delivered locally based on identified needs and that addresses inequalities and inequities of access and health outcomes.
- Provision of community and mental health services that **optimises the delivery of care across NHS Primary, Secondary, Tertiary services and the wider system with Local Authority and Voluntary & Charitable Sector (VCS) partners and services.**
- Moves us closer to the **national aspirations around the delivery of care Out of Hospital** where clinically appropriate and ensuring it is as maximally accessible as possible.
- Improved data recording and **consistent Key Performance Indicators** to allow us to better track performance and delivery of **improved population outcomes**.
- Ensuring we have a **financially sustainable system** both now and into the future based on the growing and changing needs of our population.
- Ensure we deliver on **national planning guidance** for community and mental health services.

Scope of the Community and Mental Health Services Strategic Review

The scope of the Community and Mental Health Strategic Review is summarised below:

In Scope	Out of Scope
All NHS funded Community Services (meaning Adult and Children and Young People services delivered outside of a hospital setting and not part of an Acute Spell) delivered by both NHS Community and Acute Providers. All NHS funded mental health services (including Perinatal, Children and Young People, Adults and Older Adults and People with a Learning Disability).	Continuing Health Care
All NHS funded Community Services delivered by Private and other Providers (Voluntary and Charitable Sector etc). This includes Community Services delivered by Primary Care partners that are not part of a Primary Care Core Contract, Locally Commissioned Service/Directed Enhanced Service or similar arrangement.	Care Providers / Care Homes (except non Continuing Healthcare NHS Services delivered in a Care Setting)
The scope also includes services such as Discharge (Integrated Discharge Teams) etc, End of Life Care , services for people with Long Term Conditions etc where these are funded by the NHS and delivered outside an acute episode of care.	NHS Acute Services
	Primary Care contracts including core GP contracts and additional NHS service contracts
	Statutory Homelessness Services
	Local Authority Commissioned Services with the NHS (except where jointly funded)
	0-19 Services Delivered by Local Authorities
	Specialist Mental Health Services for Adults and Children/Young People
	Learning Disability Services (Transforming Care cohort of people)

Interdependencies will need to be considered and this review is being undertaken in conjunction with a strategic review of mental health services to take into account population co-morbidities and the need for integrated services for some people.

Structure of the Mental Health Services Strategic Review

Data Gathering & Baselining
1-2-1 Interviews (May)
Group Interviews (May)
Health & Care Survey (May)
User/Resident Engagement (May-September)
Activity Data (May-June)
Workforce Data (May-June)
On-Going Engagement (May-October)
Partner Meeting Attendance (May-October)

Design & Iteration
Structured questionnaires
Baselining Workshop (May)
3 x Design Workshops (June/July)
Deep Dive Workshops (June/July)
Ongoing engagement
Testing and Challenging Emerging Proposals (July-August)

Refinement
Options Appraisal (August)
Impact Assessment (August)
Financial Impact Analysis (August)
Initial Proposal (September)
Transition Plan Development (September)

Engagement with Partners, Service Users and residents and the System

Key findings from community baseline analysis

- **Need to address health inequalities**; includes a recognition there are unwarranted variations and that both within and between Boroughs people do not receive the same service offer. This can lead to different population and patient outcomes
- **Discrepancy between need/prevalence and provision;** resources (finance and workforce) are not distributed equitably across NCL. Challenge seen as how to support those with greatest level of need and support NCL commitment to reduce health inequalities
- **Relationships and Integrated Working;** Reflection that historically relationships between providers have not always been good, reflecting competition and access to resources. However Covid has improved how Community Providers work together. The challenge is now how to embed collaborative working
- **Organisational Form**; Concern that the review should focus on best models of care to meet different population outcomes and should not focus on Provider Form. This could be considered once core service offer had been designed

Emerging themes from mental health baseline analysis

Initial workshop held on 24th May on which there was consensus about:

- **Variation** and growth in population need
- **Overall gaps** in access and variation across NCL
- **Models of care** not fit for purpose e.g. focus on crisis, not prevention and early access
- **Lack of integration** (within Mental health and with primary care etc.)
- **Inequity of Funding** ; based on historic spends
- **Outcomes**; Poor data especially on clinical outcomes

And agreement about further work required in relation to the following in the next iteration:

- Understanding the voluntary sector contribution commissioned both by CCG and Local Authority
- Benchmarking with Getting it Right First Time (GIRFT)
- Explore co-morbidity further
- Triangulate quality, spend and outcomes

DRAFT; following slides are from baseline review findings

Commissioners report that patients in Enfield, Haringey and Barnet with LTCs have access to less comprehensive community health services than elsewhere

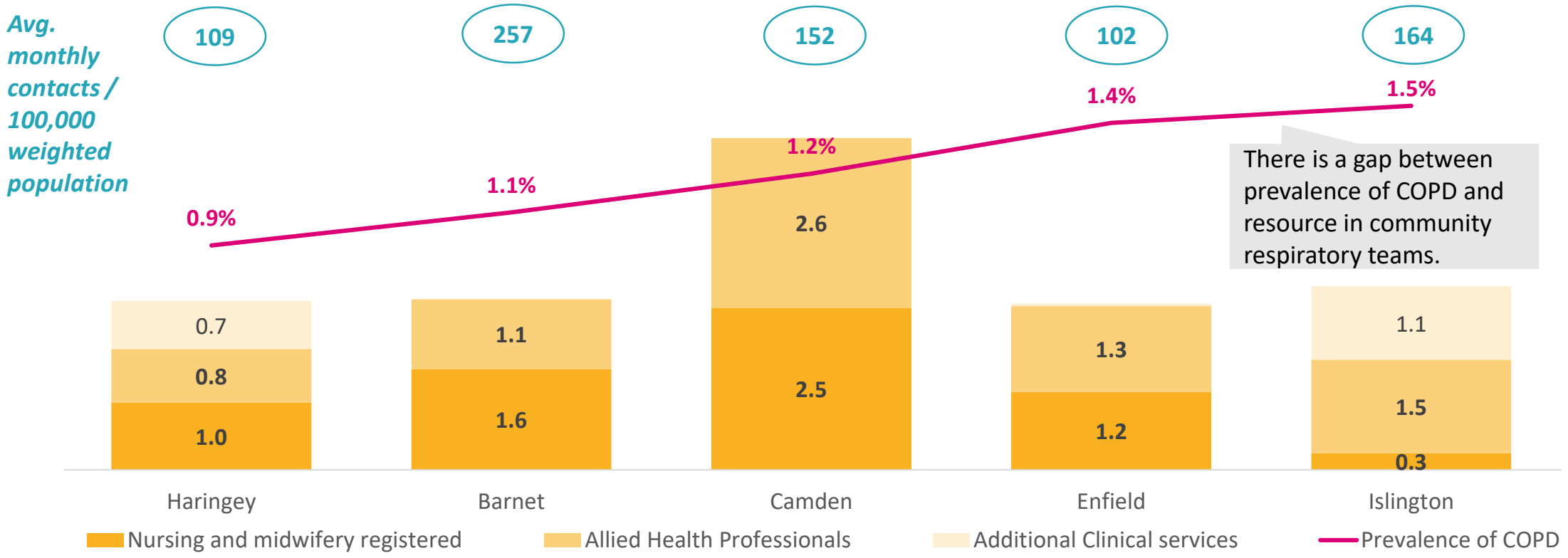
District nursing	All boroughs have district nursing provision, but there is variation in terms of scope and resource.	District nursing provision in **Enfield** is scaled back in comparison to other boroughs, in terms of staff numbers and skill mix.	Variation in how criteria for 'housebound' patients are implemented between boroughs.	Variation in levels of integration with GP practices, as well as variation in overnight nursing and cross-border provision.
Rapid response	The enhanced virtual ward offer in **Islington** and **Haringey** is unique in NCL. It bridges the gap between ambulatory care and rapid response.	The services operate consistently 7 days per week at least 8am-8pm, but there is variation in when last referrals are accepted ranging from last referrals received at 8pm to referrals accepted 24/7.	There is a need to ensure that pathways are consistent and enable staff to operate at the top of their license to maximise support for people at home.	
Long Term Conditions	**Enfield** has gaps in Long term condition teams and provision for structured education in heart failure, diabetes and respiratory.	There is a gap for community pain management services in **Haringey**.	There is limited structured education for patients in **Enfield** and **Barnet**. The Whittington's expert patient programme is not replicated elsewhere.	
Neuro-rehab and Stroke rehab	Pressure for neuro-rehab beds across NCL.	Neuro-Rehab Centre and St. Pancras beds now an NCL-wide offer.	Different non bedded offers. Camden, Haringey and Islington: integrated stroke and neuro community teams. Barnet: CLCH stroke services and RFH community neuro-rehab, Enfield: Community Stroke and general physio teams, some private neuro-rehab	**Islington** and **Barnet** do not have community MS nurses.
Tissue viability	There is a gap for leg ulcer care for ambulatory patients in **Haringey**. Additionally, tissue viability **Home visits** are not offered in Haringey.	The tissue viability service in **Barnet** is more specialist than the service in other boroughs. There is a gap for patients in Barnet who require less specialist care.	In **Enfield** district nurses doing more routine wound care. The specialist service is fragile. In **Islington and Haringey,** leg ulcer clinics are delivered by district nursing.	

Source: Service mapping developed based on review of service specifications and review of service mapping with borough commissioning leads, NCL CCG Neuo-rehab pathway demand and capacity April 2021

DRAFT; From Baseline Review Findings

Resource is not aligned with need in community respiratory services

Community respiratory service budgeted FTE per 100,000 community weighted population by borough, 2019/20
% prevalence of COPD, per GP registered population by borough, 2019/20, and **average monthly contacts with community respiratory teams,** per 100,000 community weighted population by borough, 2019/20



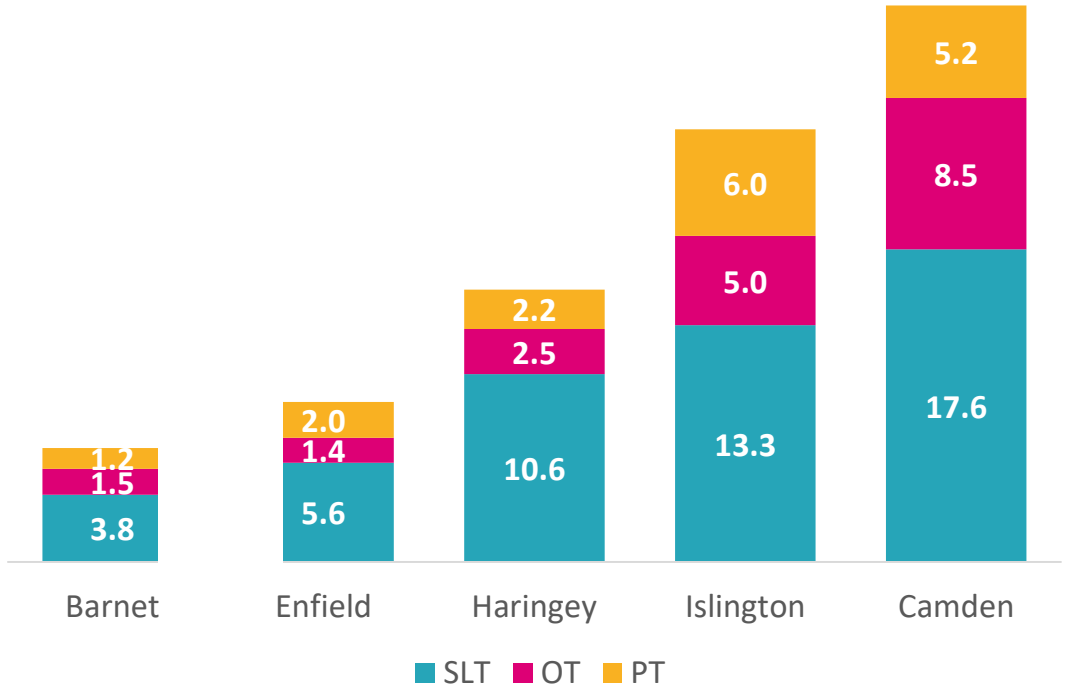
Note: Barnet (CLCH) service includes spirometry. Community spirometry provided by WH in Haringey, but not in Islington. Prevalence of COPD based on GP practice registers used as a proxy measure for demand, as there will be some patients who are not yet formally diagnosed.

Sources: C3.1 WH Monthly Community Report 1920 M09, CNWL Camden CCG Performance Report M11, ECS Commissioning report 2019-20 Q1, 4a. BIPA-BAU-003_Barnet SLA 19 20 M10 CLCH Final, CCG and GP community services weighted populations, Quality and Outcomes Framework 2019 data by GP practice, Provider workforce returns 2021, Community recovery dashboard 2021.

DRAFT; From Baseline Review findings

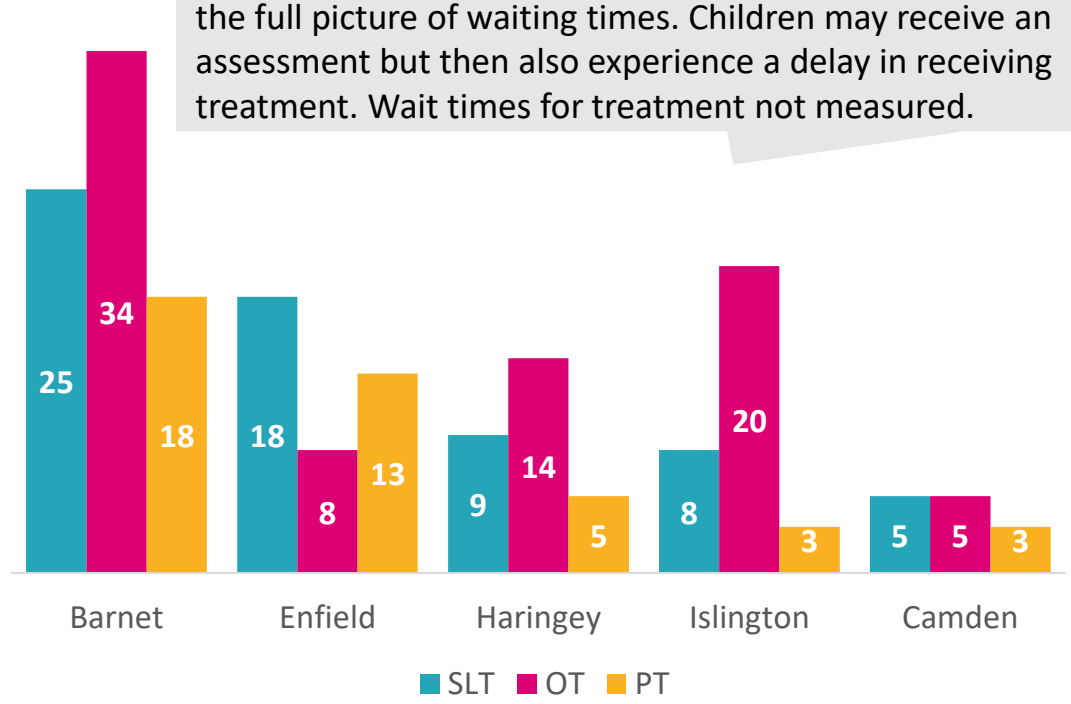
There is significant variation in children's therapy resource across NCL; Barnet has the lowest levels of resource and the longest waiting times for initial assessments

FTE for children's therapies services, FTE per 10,000 school age pupils, 2020/21 against **caseload,** 2020/21



Average wait for initial assessment, weeks, as of end of March 2021

Average waiting time to initial assessment is not necessarily the full picture of waiting times. Children may receive an assessment but then also experience a delay in receiving treatment. Wait times for treatment not measured.



Note: detailed work is in progress by NCL CCG on the variation in service offer and provision of children's therapies services across boroughs.

Source: NCL CCG Therapy services for CYP Current position

DRAFT; From Baseline Review Findings

There is variation in resource for children's community nursing (CCN) services; service offer and hours of operation are inconsistent, with Islington having an increased offer

Children's Community Nursing, FTE per 10,000 population aged 0-18, 2020

Note: detailed work is currently in progress by NCL CCG on the variation in service offer and provision of children's community nursing services

Source: NCL CCG, NHSD GP practice populations

Borough	Offer	CCN Hours
Barnet	• Barnet CCN provides generic nursing service • Hospital-based Epilepsy and Diabetes CNS and enuresis nurse • CCN works with GOSH and RFH to deliver palliative care • CLCH provide special school nursing and Integrated Specialist Children's Nursing Service for CYP with complex health needs	Mon-Fri 8am-6pm Sat-Sun 9am-5pm
Camden	• RFH CCN Team provides generic nursing service, palliative care (Life Force) and special school nursing • Continuing care is provided by the Islington CCN team • Community CNS's for Atopy and Epilepsy • Hospital based Diabetes CNS who does community work	Mon-Fri 8am-6pm Sat 9am-4pm
Enfield	• Enfield CCN provides generic nursing service • Asthma, Epilepsy and Enuresis CNS's • Enfield CCN provides palliative care	Mon-Fri 8am-6pm Sat-Sun 9am-5pm
Haringey	• NMUH CCN Team • Hospital CNS's for Atopy, Diabetes, HIV, Sickle Cell and Epilepsy • CCN provide palliative care (Life Force)	Mon-Sun 9am-5pm
Islington	• Islington CCN provides generic nursing service and sees children with long-term conditions; continuing care for children with complex needs and palliative care (Life Force) • Community CNS's for Atopy, Epilepsy • Hospital CNS's for Atopy, Diabetes, Haemoglobinopathy • Hospital @ home service treats higher acuity patients • Paediatric primary care nurse clinics for asthma, viral induced wheeze, constipation and eczema	Mon-Sun 8am-6pm Hospital @ Home 7 days 8am-10pm

DRAFT; from Baseline Review Findings

Lack of clarity of offer, insufficient capacity and unclear referral pathways are seen as key barriers to effective community health support across NCL

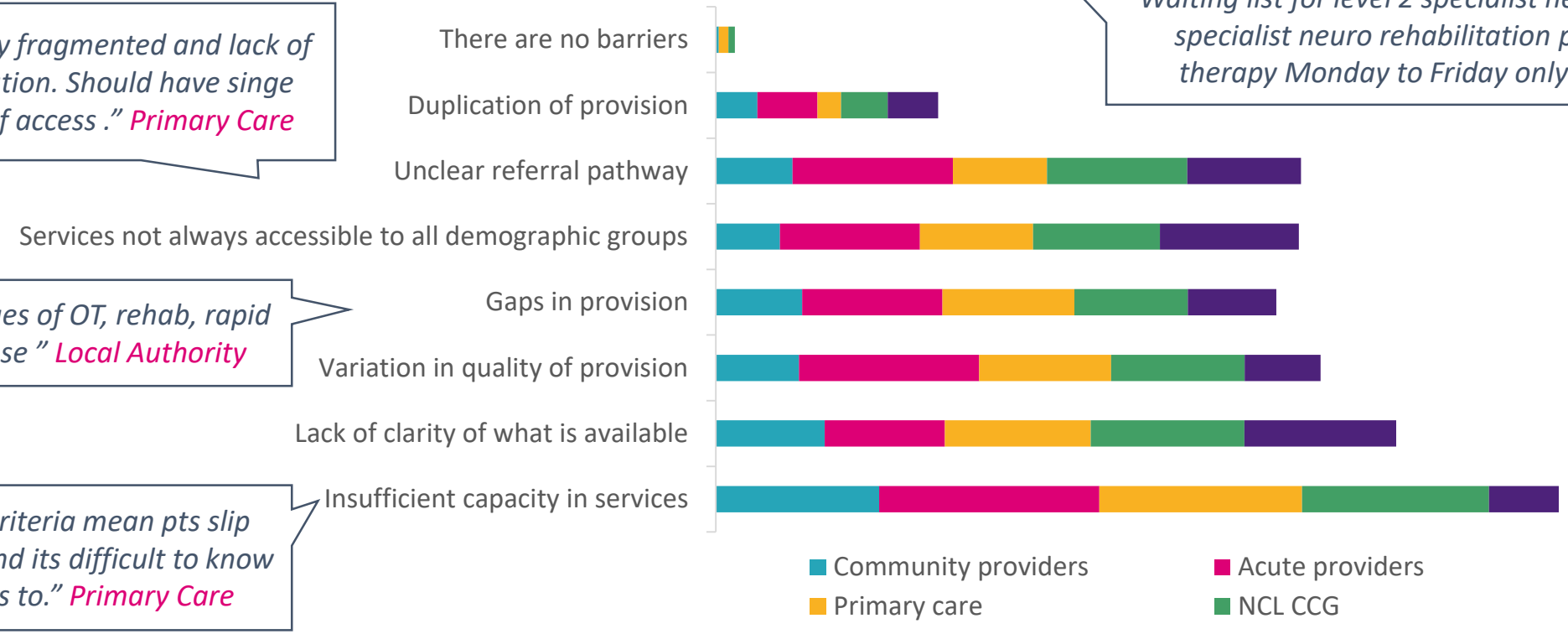
Barriers preventing service users and carers from accessing and receiving effective community health care. View of answers by organisation, based on organisation respondents primarily work in. Respondents could select multiple answers

"it is very fragmented and lack of integration. Should have singe point of access ." Primary Care

"Shortages of OT, rehab, rapid response " Local Authority

"Often referral criteria mean pts slip through the net and its difficult to know who to refer pts to." Primary Care

"Waiting list for level 2 specialist neuro rehab , specialist neuro rehabilitation provides therapy Monday to Friday only" Acute



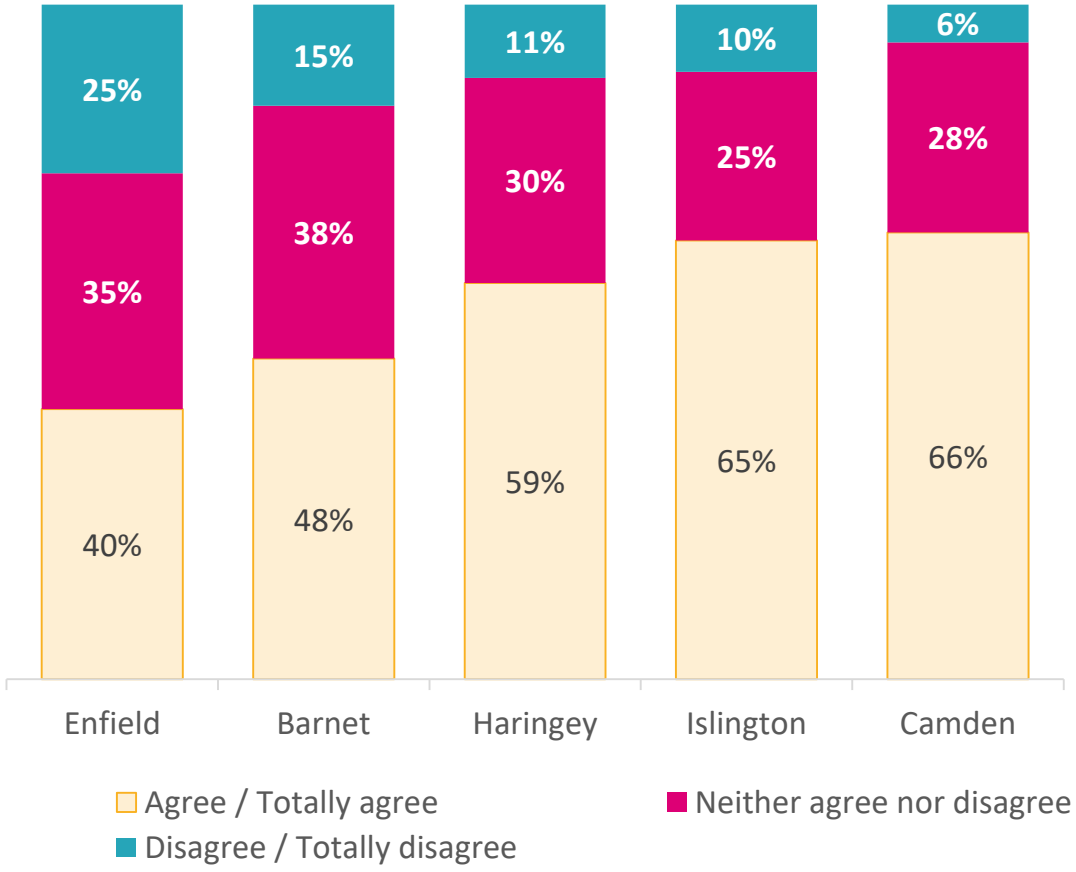
Note: Size of bar corresponds to % of respondents from borough who mentioned this barrier. Respondents were able to select multiple answers.

Source: NCL Community services review survey, 2021

DRAFT; from Baseline Review Findings

In boroughs with lower levels of community spend, survey respondents felt that patients were less likely to be effectively supported with their long term conditions

Do you agree with the statement 'Community services effectively support service users with long term conditions to avoid going into an acute hospital when their health needs escalate'? View of survey answers by borough, based on geography respondents primarily work in



Source: NCL Community services review survey, 2021

"There is variation between boroughs, maybe generally we are less good at upstream prevention" NCL wide

"Lack of step-down, prevention and admission avoidance." NCL wide

" Services for long term conditions are very under resourced and staffed" Enfield

"There is a deficit in specialist nurses for the area I work in to support patients at home and avoid hospital admissions." Camden