



NORTH LONDON PARTNERS
in health and care

North Central London's sustainability
and transformation partnership



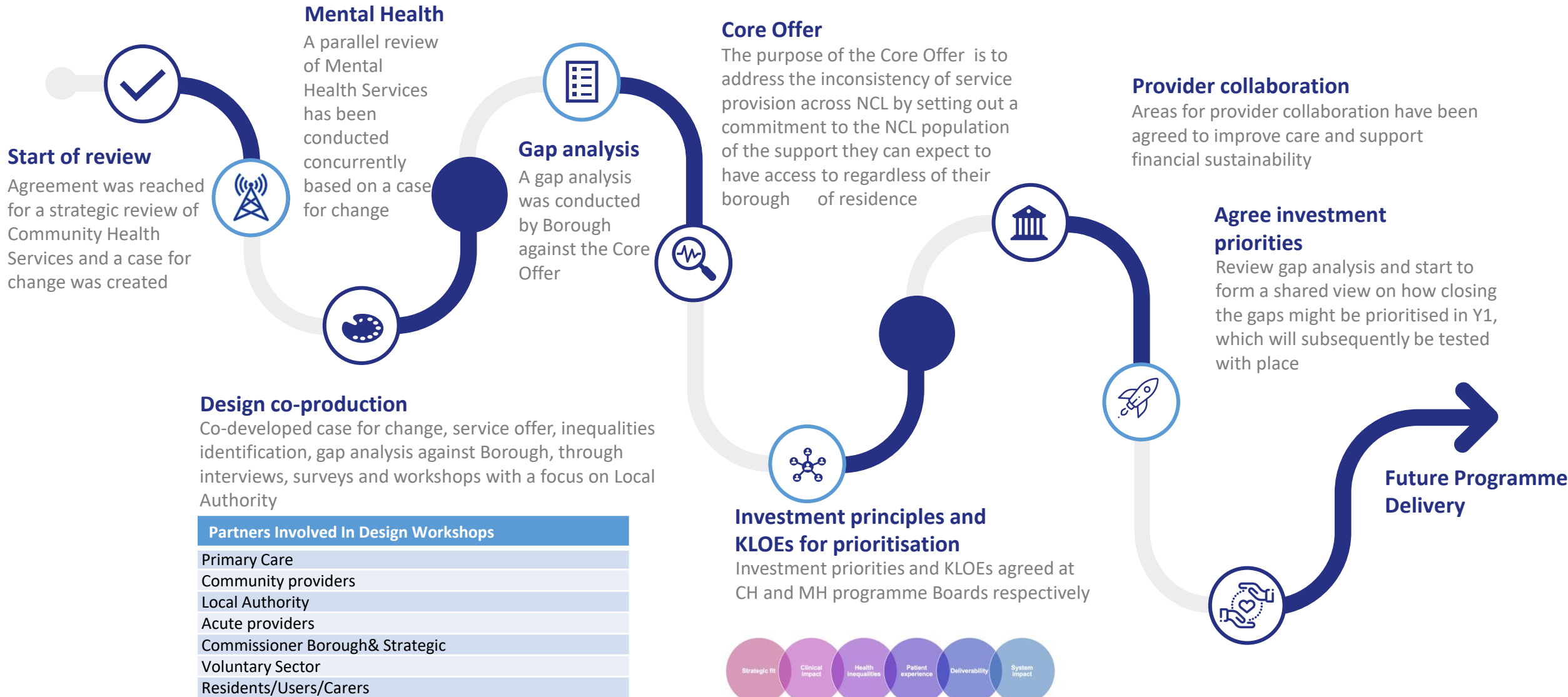
Enfield Health and Wellbeing Board

Update on Progress of Community and Mental Health Service Reviews and Development of Core Service Offer

7th July 2022

Recap: The journey so far...

Since the initial analysis was completed, extensive stakeholder engagement was conducted through the design phase of the core offer, including patient groups, providers, local authorities, and commissioners. This is set to continue as the programme moves forwards.



Mental Health Services Review Programme Board Membership

- **CCG** including Accountable Officer, Clinical Responsible Officer, Governing Body GP and Lay member
- **Mental Health Trust** Chief Executives; BEH/C&I, Tavistock and Portland and Whittington Health
- **Local Authority:** Chief Executive, Directors of Adults, Children and Public Health
- Two **Experts By Experience**
- **Voluntary Sector** Representative

Community Services Review Programme Board Membership

- **CCG** including Accountable Officer, Clinical Responsible Officer, Governing Body GP and Lay member
- **Community Trust** Chief Executives; Whittington Health, CNWL, CLCH
- Acute Trust CE Representative
- **Local Authority:** Chief Executive, Directors of Adults, Children and Public Health
- **Voluntary Sector** Representative

Engagement

- Residents Reference Group
- Residents Survey
- Borough Meetings e.g. with Healthwatch In Islington, Bridge Renewal Trust in Haringey
- Specific focused meetings e.g. Mencap in Barnet, Camden Parents of Children with Special Needs

Co-production and co-design

- Core Service Offer developed with Experts By Experience and some Voluntary Sector Reps
- All community providers
- All mental health providers
- Resident Reference Panel input into core service design
- Workstreams for Mental Health Core Service Offer (and Long Term Plan Delivery): service user co design

There is a powerful case for changing mental health and community health services in NCL



Inequalities

There are stark inequalities in health needs and outcomes across NCL



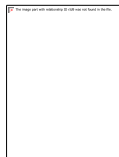
Provision

There is significant variation and gaps in service provision depending on where you live and this is not aligned to need



Access

The way you access services and how long you wait is also dependent on where you live



Spend

Different amounts are spent per head in different boroughs and this does not correlate with need



Service user / resident feedback

Services are difficult to navigate and require service users to repeat their stories

Enfield has over **twice the prevalence** of diabetes as Camden; but **half the diabetes resource**

NCL is the CCG in England with **the most number of people with a severe and enduring mental illness**

Camden's in-reach to care homes is **25% higher** than Barnet's, despite Barnet having an older population and the most care home beds in NCL

Dementia services in North and South of NCL are very different and services in the North provide less ongoing support

Community: In Haringey **£98 per head** is spent on community health services **vs. £192 per head** in Islington

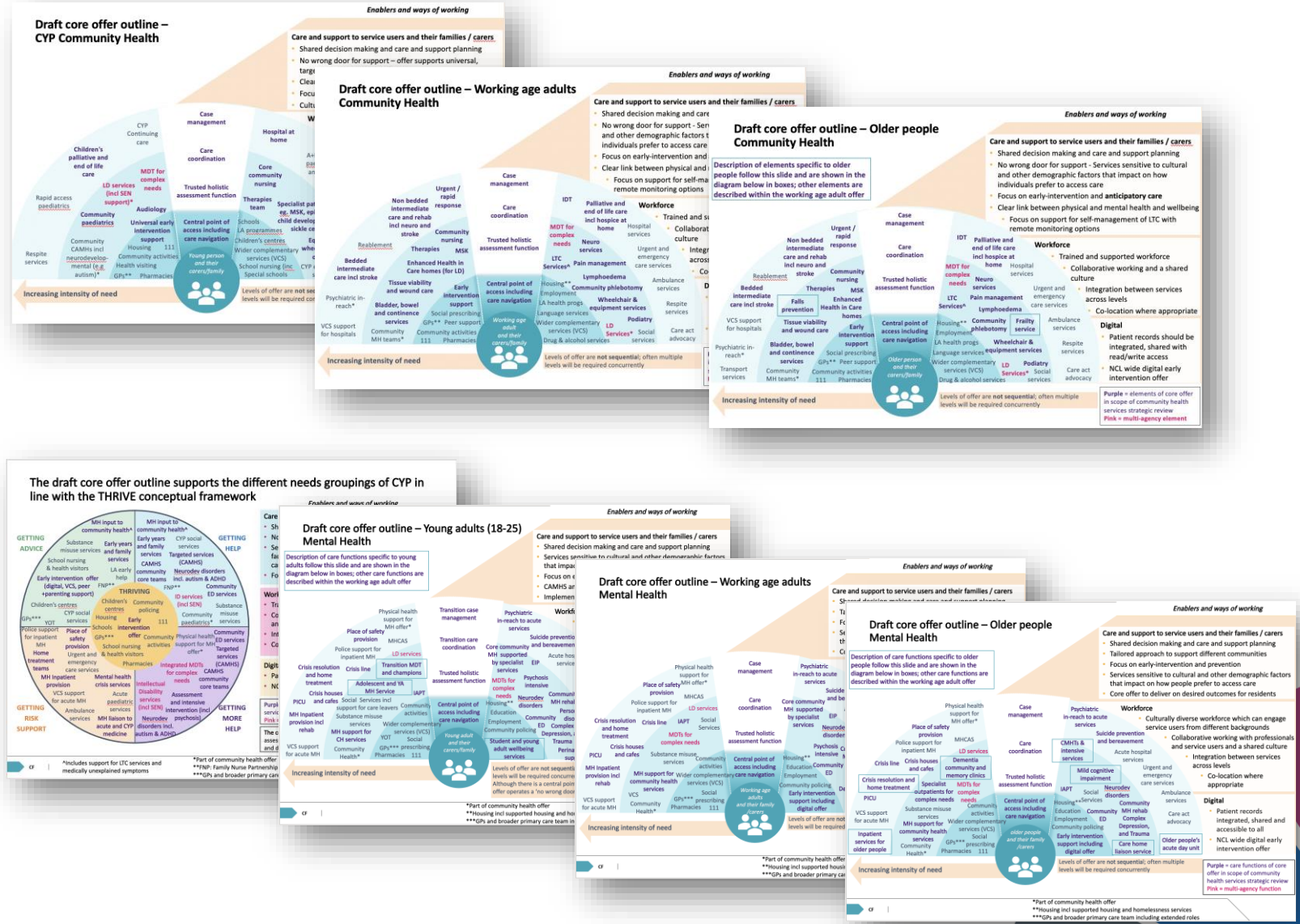
Mental Health: **Barnet £157 per head vs. £247 per head in Camden**

Children in Barnet wait **20 more weeks** than children in Camden for initial SLT assessments

Islington has the **highest number of CYP waiting over 18 weeks** from 1st referral to 2nd contact

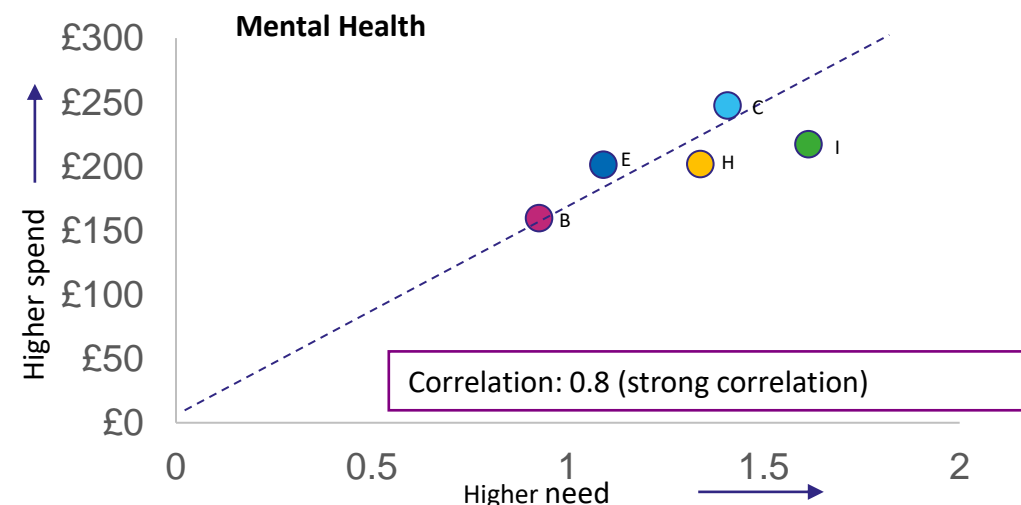
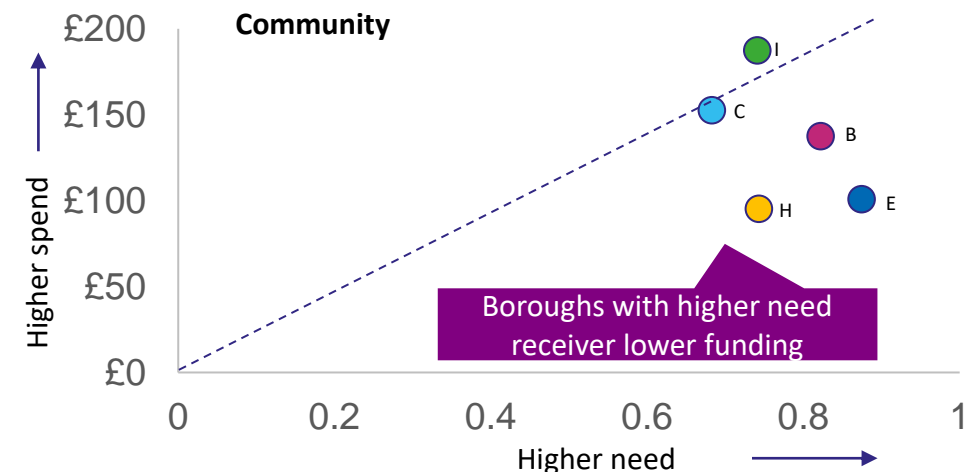
Community and Mental Health Services Core Offer

- The Offer represents the desired minimum standard to be delivered for all residents across NCL
- The Community services Core Offer is described in line with the NHS Long Term Plan categories of Start Well, Live Well and Ageing Well
- Additionally, the Mental Health services core offer includes the transition 18-25 service
- The offers are centred around the shared services functions; including, Case Management and Single Point of Access
- The Children and Young Peoples offer is structured differently to align to the THRIVE conceptual framework currently only rolled out in Camden



Comparing the spend vs level of need in each borough, mental health is well correlated and community is not correlated

Correlation between NHSE needs index for Community health services (x axis) and spend per head on community health services (y axis)



This table shows how well spend correlates to need based on the NHS England needs allocation formula.

As noted for community services there is no correlation whereas for mental health the correlation is stronger

In terms of understanding spending based on 2020/21 unweighted per head of population for community services spend is £101 per head in Enfield against a range of £101-£187 per head of population

For Mental Health in Enfield spend is £201 per head unweighted population against a range of £157-247 per head of population

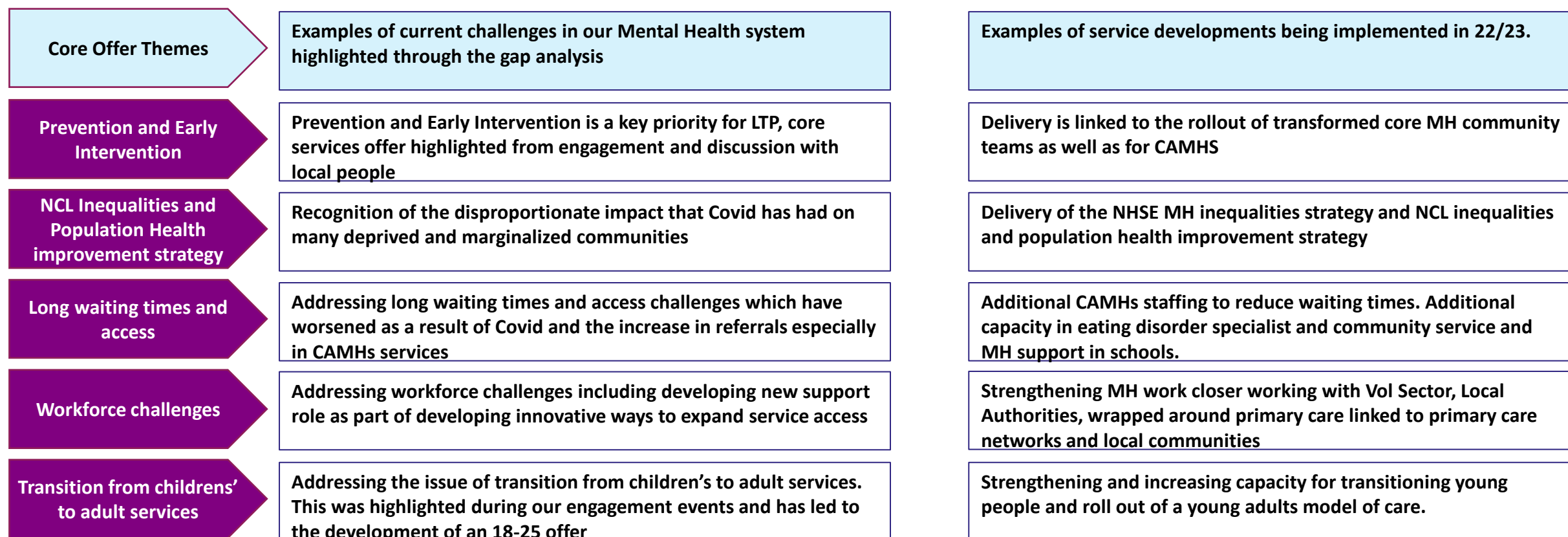
In order to sustainably fund the core offer delivery beyond FY22/23, cost savings will be required across the system, both in and out of hospital

C&MH provider savings	Efficiency	Providers improve productivity and redesign ways of working to meet system 'best in class' to release funds e.g. reshaping care models, use of technology
	Opportunities of Scale	We seek to deliver some services via Lead Provider models or similar to release efficiencies This will also help address workforce issues in smaller or more fragile services.
	Service workforce re-design	Providers change the footprint over which they deliver services and/or share resources to effectively increase investment in areas that are under-invested.
Acute savings	System Savings ¹	We will reinvest savings from elsewhere in the system that our work accrues. For example, via reducing acute demand, this would support the flow of funds from Acute to Community.
ICS funding	Growth Monies	Growth monies to be allocated asymmetrically with more growth going to areas that have had historic inequities in investment

Mental Health Service Update

Moving Mental Health Programmes; From Development to the Start of Implementation

Having agreed a set of NCL ICS core service offers in August 2021, a funding plan has been developed to support Mental Health services. Mental Health colleagues continue to focus on delivering the priorities of the Long Term Plan (LTP), and the White Paper on Health & Social Care Integration with its focus on integration and innovation. Priorities include;

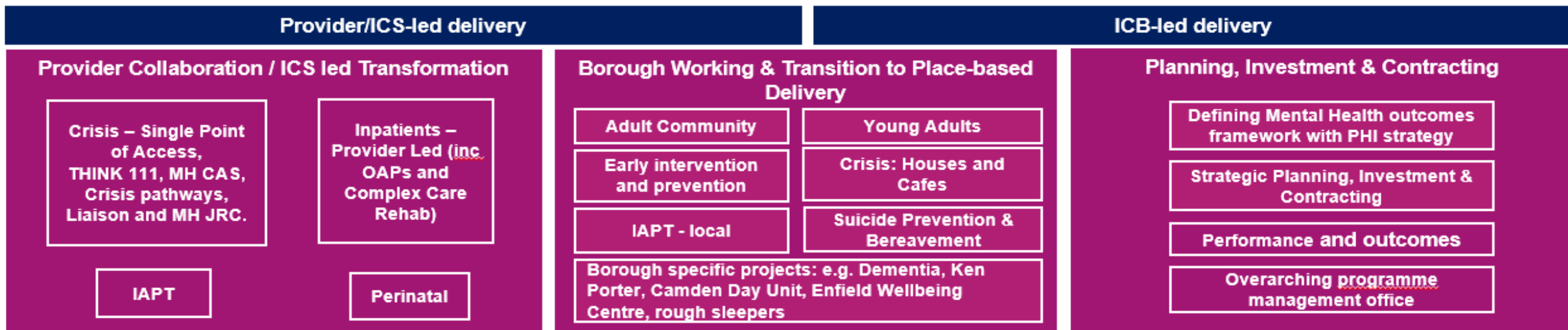


Mental Health transformation is a priority for NCL. Additional investment has been received in 22/23 in the following areas to develop and / or increase capacity in 22/23 in line with the LTP and NCL MH Core Offer.

(Borough)	Service	Description	Core Offer "Gap"	Summary system benefits
ALL	Adult Community	Services receiving investment delivered in the community inc. Community Transformation	Wide variation in support to Primary Care. Significant secondary care waiting lists, capacity gap in IAPT services	Reduces waiting times, addresses inequalities, pt experience, clinical impact, reduces acute activity Increase average IAPT access by ~40%. ~20k patients receiving transformed community models of care. Opportunity to reduce inpatient length of stay to national av. of 32 days and opportunity to improve position of Out of Area Placements (current position approx. ~1,000 OBDs per day (12 OAP/day).
ALL	Adult Crisis	Services receiving investment within the Crisis pathway inc. Crisis Houses / Cafes, MHLS	Limited capacity in admission avoidance and discharge beds. Limited Crisis Alternatives. Variation in MH Liaison Services	Reduction in Adult A&E attendances due to depression of between 274-365 (10-13%) and a reduction in Adult A&E attendances due to psychotic symptoms of 402-535 (15-20%). Improves pt experience and addresses inequalities.
ALL	Young Adults	Additional workforce and new roles supporting transition	Long waiting times, inequities in support moving to AMHS	Reduces waiting times, addresses inequalities, pt experience, clinical impact
ALL	CAMHS Community	Waiting Times recovery and transformation. New Home Treatment Teams	Long waiting times, variation between boroughs	Reduces waiting times, addresses inequalities, pt experience, clinical impact
ALL	CAMHS Crisis	Acute Trust MH nurse educators.	Services capacity / not in place	Average reduction in CAMH crisis admission of between:11-15 (31-41%). Reduction in CYP A&E attendances due to depression of between 101-135 cases (30-40%). Improves Pt experience.
ALL (C & H in 22/23)	CAMHs MHST	Embed new MHSTs in 2 boroughs in 22/23 as part of NCL expansion programme	Variation in MH support in schools	Increases access, prevention, improves pt experience
ALL	Eating Disorders	Embed Community team and increase specialist Eating Disorder Service capacity	Not enough CYP accessing support in LTP timescales	Reduces waiting times, addresses inequalities, pt experience, clinical impact



With the design principles in mind, the MH programme has been translated into three delivery workstreams, through which the work will be delivered and the planned benefits realised. These delivery workstreams will be aligned with enabling and ongoing workstreams / programmes



Lead(s): ICS Programme SROs **Support:** Provider programme support

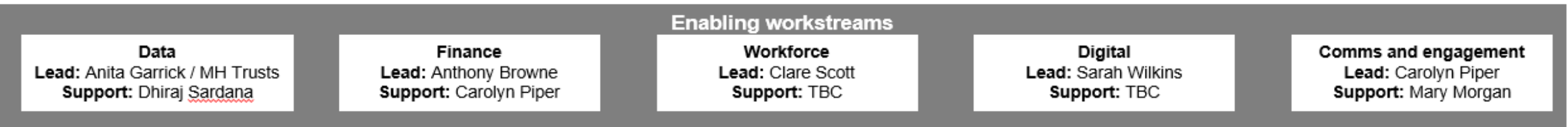
To unlock savings and financial benefits by improving productivity and increasing standardisation of service across the five boroughs for the benefit of NCL patients.

Lead(s): DoI's **Support:** MH Commissioners

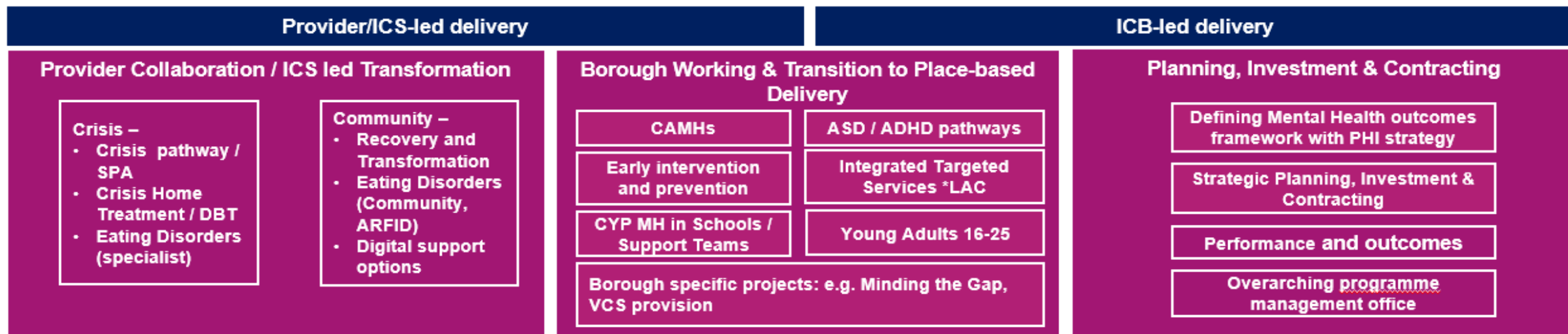
To identify and define delivery of the MH core offer, delivered at place, including alignment with borough based partners including primary care networks, LA, VCS and community services. Enabling resident co-production and engagement.

Leads: Sarah/Dan/Anthony **Support:** Carolyn/Mary

To oversee the governance of the MH Programme. To determine investment location and priorities, according to likely benefit; invest the additional money available for MH services in NCL and manage any required contracting work.



With the design principles in mind, the MH programme has been translated into three delivery workstreams, through which the work will be delivered and the planned benefits realised. These delivery workstreams will be aligned with enabling and ongoing workstreams



Lead(s): ICS Programme SROs **Support:** Provider programme support

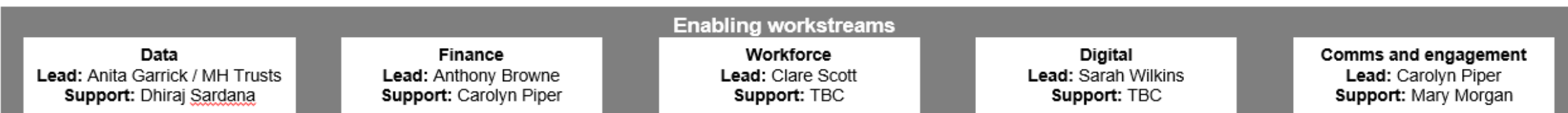
To unlock savings and financial benefits by improving productivity and increasing standardisation of service across the five boroughs for the benefit of NCL patients.

Lead(s): Dol's **Support:** MH Commissioners

To identify and define delivery of the MH core offer, delivered at place, including alignment with borough based partners including primary care networks, LA, VCS and community services. Enabling resident co-production and engagement.

Leads: Sarah/Dan/Anthony **Support:** Carolyn/Mary

To oversee the governance of the MH Programme. To determine investment location and priorities, according to likely benefit; invest the additional money available for MH services in NCL and manage any required contracting work.



Proposed services to be provided at Borough and NCL level for adult and CAMH services

MH Programmes	CYP	IAPT	Community	Crisis	Inpatients
Borough					
<ul style="list-style-type: none"> Borough specific projects (e.g. Barnet Ken Porter Ward) Rough sleeping Suicide Bereavement care Dementia Co-production* Quality* Health inequalities* Early intervention and prevention* 	<ul style="list-style-type: none"> Gap analysis delivery of THRIVE model LAC borough gaps WSOA (Haringey) H@H (exc. Islington) 	<ul style="list-style-type: none"> GP referrals LTC development pathways / Covid recovery* VCS offer Specific Health Inequalities outreach programme 	<ul style="list-style-type: none"> SMI Health Checks Individual Placement Support Borough co-production and implementation of Community Transformation Prog 	<ul style="list-style-type: none"> Crisis cafes Crisis houses 	<ul style="list-style-type: none"> Integrated discharge teams and flow into LA placements
<ul style="list-style-type: none"> Workforce Digital Perinatal NDD 	<ul style="list-style-type: none"> Provider led review Therapies accelerator Autism hub 	<ul style="list-style-type: none"> NCL digital HLP system maturity tool Group sessions / publicity Staff health and well-being hub 	<ul style="list-style-type: none"> NCL SMI Physical Health Clinical Network Overarching Framework for Community Transformation <ol style="list-style-type: none"> Personality Disorder Rehab Community Eating Disorders EIP Older / Young adults* 	<ul style="list-style-type: none"> Crisis lines / Think 111 / SPA MH Joint Response Car MH Liaison Services 	<ul style="list-style-type: none"> OAP Length of stay Quality Winter schemes
NCL ICB					

Community Health Service Update



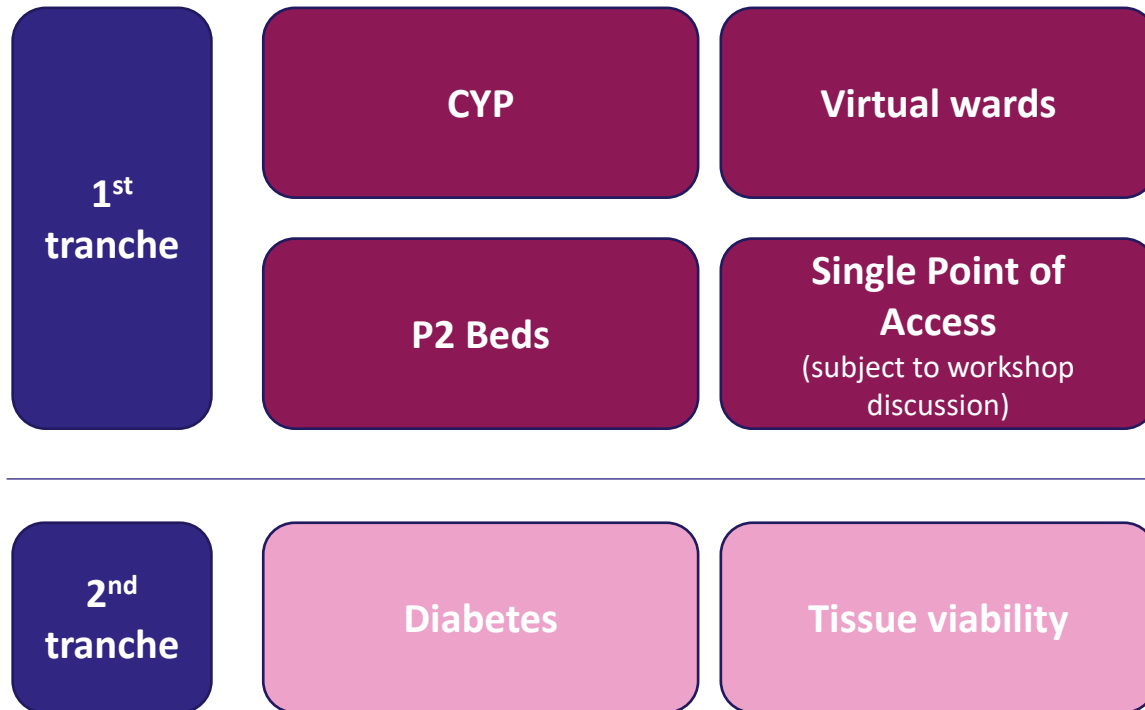
Update on Community Services; Plans to Transform Adult and Childrens Community Services



- Community Providers including BEH and North Middx have agreed a programme of collaborative and transformational work to support working at scale, and the clinical and workforce opportunities this will bring.
- This includes collaborative work on areas such as community beds, the development of virtual wards, diabetes and tissue viability. These were areas identified by Community Providers as areas they wished to work on collaboratively to deliver NCL wide transformation.
- BEH will act as the lead community provider in NCL's development of a system Diabetes strategy with primary care. This will be through NCL's Diabetes and Weight management clinical network. Other Providers are leading different work streams e.g. Central London North West London (CNWL) are leading work on community beds.
- North Middx are supporting work on the rollout of virtual wards and the CEO of North Middx is now the ICS' Community Senior Responsible Officer leading the provider response to the delivery of the community services review and chairing the implementation steering group.
- Work has continued with colleagues from community services including Barnet Enfield and Haringey MHT to deliver the Ageing Well Programme which as resulted in an Enfield investment of £1,672k recurrently for urgent community response and further community health support for anticipatory care.
- Funding is being identified for children and young peoples services and will initially focus on rolling out a children's hospital at home service and reducing waiting times for therapies and autism assessments.
- In terms of next steps we are starting to look a opportunities to reshape some services via a lead provider role. This would allow a focus on workforce which along with funding is the biggest challenge for the health and care system. However point of delivery will remain local i.e. either in a patient's home or locally in a clinic.
- We will also need to agree a series of new projects to provide a pipeline for transformation across NCL to ensure we can generate funding to recycle into community services along with system investment.

The provider collaboration workstream is a significant enabler for creating equitable and accessible community services for the people of NCL.

Areas for provider collaboration have been agreed to improve care and support financial sustainability



Project documentation is being completed for each of these areas

1. Project details

Project name: _____

Transformation lead (organisation): _____

Clinical lead (organisation): _____

Project lead (organisation): _____

Finance lead (organisation): _____

Date of completion: _____

Contents

1. Project details	3
2. Executive summary	4 - 5
3. Background and case for change	6
4. Benefits (aligned to KLOEs)	7
5. Population impact	8
6. Productivity Saving Impact / System Saving Impact	9 - 12
7. Delivery	13
8. Project roles and requirements	14
9. Engagement	15
10. Risks and mitigations	16
11. Dependencies	17
12. Key assumptions	18
Appendix:	
• 1: Key lines of enquiry framework	19
• 2: Risk scoring framework	

History

The Virtual Ward was launched on 20/12/21, in operation for 6 months.

The service is provided to residents of Enfield (by BEH) and Haringey (by WH)

Inclusion/exclusion criteria

- Residents of Enfield and Haringey
- Suitable home environment in which to provide care / treatment.
- Interventions within the scope of practice of the team.

Referral pathways

- Strictly from all wards / departments at NMUH only
- Daily case-finding / outreach by VW staff
- Daily site / Ops meeting
- Collaboration with IDT team

Clinical leadership

- The referring consultant retains responsibility
- SDEC consultant provides support to MDT and team
- Daily MDT
- VW GP 4 working days

Capacity

- Currently 20 beds (expanding from 8)
- Service hours are 08:00 – 20:00

Care activities

- Clinical assessment
- Phlebotomy / venepuncture
- Medication administration / review (including IV antibiotics)
- Therapy input

Workforce

- SDEC consultant
- GP
- 4 Nursing staff- band 7 and 6
- 1 admin
- Social care input , limited therapy input

Key interdependent services

- Social Service
- ERAS (RR and D2A)

Patient diagnostic cohorts

- Range of conditions within the inclusion criteria.
- Elderly / Frailty
- Post surgical
- Sepsis

Digital

- Currently none – but see future planning.

Future planning

- Increase to 28 beds 2022/23
- Explore virtual monitoring with digital technology
- Expand the referral criteria / higher acuity cases
- Regular slot on new docs induction program

Evaluation

- The service uses Careflow EPR
- Data collected manually working to pull data electronically.
- Awaiting Service evaluation by UCLP.



Update on Community Services: Funding Approach to Enfield



- In terms of funding, the NCL system (System Management Board and ICB Board) have been asked to agree some additional funding to invest in community services, with a particular focus on helping reduce pressures in acute services such as by reducing emergency admissions and better supporting people in their homes. Colleagues will be aware of the pressures being experienced by services and especially at the North Middx where there have been challenges with discharging patients and creating capacity.
- Part of this funding will be allocated asymmetrically to fund core services in the Boroughs with the largest gaps against the core service offer (Enfield, Haringey and Barnet). Included in this report is the draft proposal for investment in adult community services in Enfield. These are subject to a wider NCL system signoff and ICB governance. Recruitment remains a key risk for providers and providers will need to collaborate around innovative recruitment and retention work.
- We have set out the proposed shape of investment in Enfield. This proposal builds on the gap analysis we completed as part of developing the core services offer and is based on a set of system principles agreed with partners. This proposed investment e.g. into community nursing and therapy services has been discussed with some key colleagues in Enfield with whom it resonated and they recognised how it fits with identified gaps against the core services offer.
- A small amount of the funding being identified will be used to develop coordination functions such as a Single Point of Access which enables holistic assessments and case management. We are planning a workshop on June 22nd at which local colleagues will think through the benefits, opportunities and challenges that a Single Point of access might achieve
- Once Provider colleagues have completed their project documentation, which will include the measurable benefits we expect to see for local residents as well as an equalities impact assessment, we will shortly need to discuss with colleagues a further set of projects to ensure we have an agreed pipeline of areas for transformation for future years of the programme.

Progress to date

- Multidisciplinary audit of LAC health services gaps and recommendations developed
- Development of CYP community Services data dashboard to track progress and benchmark across NCL
- Investment in CAMHs services to reduce backlog of referrals
- Investment in Autism Hubs to clear backlog of referrals
- Therapies accelerator to clear back log of assessments
- Increased access to autism diagnosis and assessment
- **Prioritisation of 4 key areas for children's community transformation (ASC/ADHD, Community Nursing, Community Paediatrics and Therapies)**

Plans being developed For Implementation ;

- Roll out Children's Hospital at Home service in Enfield
- Rollout of asthma nursing model (in Haringey & Barnet)
- Looked After Children; building teams to have greater resilience and sustainability
- Reviewing community paediatrics to agree ways to make services more resilient and sustainable
- Review children's community nursing provision and the offer to special schools nursing



Subject to ICB Governance, the following 'gaps' within the 'core offer' in Enfield will be the focus during year 1.



"Gap"	Rational and benefits
1 Community nursing: skill mix and capacity gaps	Investment would boost skills and capacity gaps within community nursing to contribute to filling core offer "gaps" associated with case management capacity, IV/PEG/Catheter and TV to keep people well at home, inc. overnight response.
2 Community rehabilitation service	Investment would help establish a seven day community rehab service in line with the core offer, potentially filling gaps in neuro therapy capacity, and enabling more people to recover at home
3 Community Diabetic Services	Investment would boost skills and capacity gaps in the community diabetes service, to enable it to start to move towards meeting this "core offer" gap in terms of responsiveness.
4 Silver Line (NCL Wide)	Expanding our silver triage geriatrician advice line to LAS staff to 8-8pm, 7 dpw, following a successful pilot. This service allows an LAS staff member to gain consultant level advice at the point of potential conveyance from a care home. Our pilot avoided conveyances in over 80% of occasions that the silver triage phone was utilised.





Population Health Outcomes Framework

Proposed NCL Population Health outcomes framework




The proposed public health outcome framework has been agreed by the Programme Boards and will be used to demonstrate how the impact from Community and Mental Health Services Transformation will be measured. A more detailed set of service indicators is being developed in discussion with colleagues e.g. from public health and from discussions as part of public engagement e.g. on transition from children to adults services as that was a key area of feedback from parents and young people

Start well


Every child has the best start in life and no child left behind

-  Improved maternal health and reduced inequalities in perinatal outcomes
-  Reduced inequalities in infant mortality
-  Increased immunisation and new born screening coverage
-  All children are supported to have good speech language and communication skills

All children and young people are supported to have good mental and physical health



-  Early identification and proactive support for mental health conditions
-  Reduction in the number of children and young people who are overweight or obese
-  Improved outcomes for children with long term conditions

Young people and their families are supported in their transition to adult services



-  All young people and their families have a good experience of their transition to adult services

Live well




Reduction in early death from cancer, cardiovascular disease and respiratory disease

-  Reducing prevalence of key risk factors: smoking, alcohol, obesity
-  Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease

Reduced unemployment and increase in people working in good jobs




-  Support people to stay in jobs, including mental health and musculoskeletal services
-  Anchor institutions to employ local people including those with mental health illness, physical disability, and learning disabilities, and to buy locally including by using social value-based commissioning and contracting

Parity of esteem between mental and physical health



-  Reducing racial and social inequalities in mental health outcomes
-  Improved physical health in people with serious mental health conditions
-  Reducing deaths by suicide

Age well

Older people live healthy and independent lives as long as possible

-  Ensure that people get timely, appropriate and integrated care when they need it and where they need it
-  Prevent development of frailty with active aging
-  Improved outcomes for older people with long-term conditions, including dementia

Older people are connected and thriving in their local communities

-  Older people have fulfilling and meaningful social life
-  Older people are informed well and can easily access support for managing financial hardship



Next Steps; Delivery at Borough of Community & Mental Health Core Services Offer



- Whilst the Core Services Offer is designed to provide residents with a consistent experience and increase access to services, it is recognized that boroughs will lead delivery and that this will need to reflect local needs, priorities and wider relationships with partners including the Local Authority, and local voluntary sector colleagues as well as with local people.
- In delivering the core service offer via local delivery plans, further work will be needed to ensure ongoing engagement and communications to ensure local residents continue to be involved in shaping how the core services offer is delivered in their community
- Discussions are commencing with borough partners about the delivery of the core services offer, to think about where in local governance implementation needs to report to and how some of the work that is being undertaken at scale e.g. the community service providers work on community beds or tissue viability is interpreted and aligned with existing work and with work of other colleagues e.g. in primary care to deliver wrap around support for community mental health teams
- Although one of the outcomes from the reviews is to ensure we can better support people with both a mental and physical health need, further work is needed between both community & mental health providers and with primary care to think through how this aspiration will work in practice at a local place level, as the core service offer is delivered
- As part of delivering a community & mental health set of outcomes aligned to the population health outcome framework, local partners may wish to agree some Borough based community & mental health outcomes which can help inform local partners of on progress against the overall population goals.