VIRTUAL MEETING

BARNET CHILDREN'S PARTNERSHIP BOARD

DATE AND TIME

WEDNESDAY 3RD NOVEMBER, 2021

AT 4.30 PM

TO: MEMBERS OF BARNET CHILDREN'S PARTNERSHIP BOARD (Quorum 5)

You are requested to attend the above meeting for which an agenda is attached.

Andrew Charlwood – Head of Governance

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ASSURANCE GROUP

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ORDER OF BUSINESS

Item No	Title of Report	Pages
1.	Welcome	
2.	Absence of Members'	
3.	Minutes of Previous Meeting	5 - 10
4.	Update on North Central London CCG's Review of Community and Mental Health Services	11 - 190
5.	Young People's Item - TBC	
6.	Environment/ Sustainability Strategy - To Follow	
7.	Life Chances Action Plan: Summary Highlight Report	191 - 198
8.	Any Other Business	

Decisions of the Barnet Children's Partnership Board

15 July 2021

AGENDA ITEM 3

Members Present:

Chris Munday	Executive Director for Children's Services (Chair)
Councillor David Longstaff	Lead Member for Children, Education & Safeguarding and Deputy Leader of Barnet Council
Ian Harrison	Chief Executive and Director of Education and Learning
Neil Marlow	Director, School Improvement and Traded Services, BELS
Helen Phelan	Director, SEND & Inclusion
Lee Robinson	Children's Strategy & Policy Advisor
Sarah Sands	Head of Garden Suburb Infants, Chair of Nursery and Primary Headteachers' Forum
Ben Thomas	Assistant Director Education, Strategy and Partnerships, Family Services
Luke Ward	Assistant Director, Development & Economy
Jess Baines-Holmes	Deputy Director for Adults Joint Commissioning and CYP Health Commissioning
Rebecca Morris	Voice of the Child Participation Officer
Sharon Smith	Public Health Strategist, Children & young Peoples' Team
Emma Burton-Lee	Senior Communications and Campaigns Manager
Lisa Coffman	Barnet Parent Carers Forum
Tal Berman Howarth	Barnet Parent Carers Forum
Graig Bradley	Metropolitan Police Barnet

1. WELCOME

The Chairman, Chris Munday, welcomed everyone to the meeting.

2. MINUTES OF PREVIOUS MEETING - TO FOLLOW

The minutes of the meeting held on 23 February 2020 were agreed as an accurate record.

3. ABSENCE OF MEMBERS'

Apologies for absence was received from Elizabeth Longworth and Janet Matthewson.

4. EDUCATION RECOVERY

Following the return to school in March, school leaders focused on learning which was impacted by student absence as a result of Covid-19. The curriculum has been adapted accordingly and disadvantaged students have been receiving the support needed to fill in the gaps.

The Recovery, Reset and Renaissance (RRR) Project has been developed. £600,000 of funding was made available to fund projects with £321,000 used for successful bids by schools or partnerships of schools to deliver bespoke projects supporting recovery, reset and renaissance. Expected outcomes from RRR included diminishing gaps in learning, a range of provision for academia and Social, Emotional and Mental Health (SEMH) needs as well as increasing schools' resilience to meet the needs of children and young people.

Speech and Language was as an area of concern for which the Speech and Language Enrichment training had been offered and provided which was successful.

The Compass for Life programme provided action planning tools to help teachers and pupils through recovery, reset and renaissance.

From September, support for SEMH needs would be provided by the Educational Psychology and Inclusion Advisory teams. Free workshops on how to maximise attendance at school were being run by the Educational Welfare Team and Barnet Partnership for School Improvement (BPSI) offered training adapted to the school's recovery to ensure the curriculum was correct.

Other projects looked at reducing the number of Black exclusions in schools and engaging care leavers with employment, education and training. A working party found that the number of exclusions amongst Black Caribbean and Black African pupils were disproportionately higher than other ethnic groups. Therefore, a sub board had been set up to look specifically at exclusions and attendance. In addition, the Pupil Referral Unit (PRU) provided mentoring support to help identify barriers and how to overcome to enable Black pupils to remain in the system.

A contract with Growing Against Violence is being formed to expand services and support to schools. The recruitment of Black and Ethnic Minority Governors was also underway to ensure that governing boards were more representative of the community.

In support of inclusion and diversity, relevant training, sharing good practice and Early Years projects to support the needs and equalities of committees were being set up in schools.

Nearly half of the RRR bids (20 bids) were successful albeit some only part funded. 55 schools will benefit from this funding and over 13,000 pupils. The total amount allocated to schools was **£321,000**. Added to this 7 further schools benefitted from the Speech and Language Therapy funding of £50,000 meaning that 62 schools received some funding from this process.

5. SEND SELF-EVALUATION

The Local Area Special Educational Needs and Disabilities (SEND) inspection and Self-Evaluation (SEF) had to be completed to identify strengths and areas of improvement. It was linked to the SEND Strategy 2021-2024 and partnership work involving education, health and social care, parents and young people.

Strong partnership working and coproduction were areas of strength for Barnet in terms of the SEF and SEND workstreams. The SEF included the local context and needs in comparison to other areas as well as outcomes for children with Education, Health and Care Plans (EHCPS) and SEND.
A SEND assurance visit from Ofsted and CQC looked at the impact of the pandemic on children and young people with SEND and their families and the response to the impact on families. The views of families and children were obtained and positive outcomes were found. There were elements to be taken forward which have been incorporated into the action plans for SEND workstreams and the SEF.

It was a statutory requirement for the local area to have a Local Offer website to include information on the provision and resources available. The website also contained up to date information on personal budget, health and social care and personal budget.

Data showed an increase in the amount of SEND requests in Barnet with 3.5% for EHCPs and 2.5% for SEND support. It was also linked to accessing Speech and Language Therapy and Occupational therapy.

Strong working partnerships had been formed to increase engagement from parents and young people. There was parent representation on the SEND Development Group and SEND Partnership Board. Parents and Carers were also involved in complex needs panels and the auditing of EHCPs.

In terms of the young person's voice, the Barnet Inclusive Next Generation (BING) group had been consulted with regards to strategies. The views of children and young people in need of SEND support were also represented more widely in the area of work undertaken.

It was noted that excellent outcomes were achieved for children with SEND and those with an EHCP in terms of attainment and progress data.

Innovative practice in response to the pandemic have been demonstrated well in the Open Spaces Project, providing families with a safe space to go to.

The key areas of strength were noted as follows:
(a) Good quality of education provision for pupils with SEND
(b) A good Local Offer
(c) Development of a Mental Health Zone with links to CAMHS and other services
(d) Good Early Years Offer with well-coordinated arrangements focusing on early identification
(e) Clear outcomes for pupils with SEND and pupils with EHCPs
(f) Good transitional support for pupils between primary to secondary and secondary to Post-16
(g) Good range of support available across Health and Social Care.

Work in relation to the Therapy Recovery Programme linked to language enrichment would be extended next term for Early Years and PVIs.
Good pathways for Autism action plan and SEMH provision had been developed, ensuring clarity on what was available for parents, carers and schools.
The SEF would be updated in August before the next inspection anticipated between this September and March 2022.

It was noted that prioritising an additional resource provision would help support schools and Barnet children. More work on SEND transition support was needed for several schools and the substantial amount of work needed on therapies could be taken forward with the right provider in place for a comprehensive programme of continuous improvement to lead to the correct support for children and families.

6. SCHOOLS ENGAGEMENT - TO FOLLOW

A verbal update was provided. Policing had not been up to its maximum strength in the Borough due to recruiting problems. It was noted that only officers with specialised skills could take on the role of working with children and young people.
The lack of vehicles reduced the effectiveness of police presence for schools.

For patrols, partnership working continued with Safer Neighbourhoods, BTP and Safer Transport which generally occurred at the end of term. As there was a shortage of after school patrols a joined up approach was being developed to encourage school staff and parents to partake in patrols.

Sexual inappropriateness and sexual violence were highlighted as big issues faced by schools. Training was being offered to all secondary schools on areas such as personal safety, what constitutes sexual misconduct and what constitutes a sexual offence. Anti robbery and personal safety talks were being held in September on self-awareness.

A Safer Schools Board was being set up in Barnet in relation to safeguarding needs of the school.

It was noted that young people's views on policing needed to be captured during summer camps and to ensure that as many officers were available.

7. YOUNG PEOPLE - TO FOLLOW

None.

8. FAMILY FRIENDLY BARNET

An overview of the family friendly vision was provided. The growing population of children in Barnet and changing numbers made it difficult to predict future school places. The number of pupils with EHCPs and those in need of SEND support had increased by more than 20% in a single year.

There was an increase in the number of Unaccompanied Asylum Seeker Children (UASC) in Care due to Home Office restrictions during lock down.

The outcomes from children and young people plans and their measures in RAG ratings were presented. Significant changes were noted post pandemic particularly with revenue and benefits support and UNICEF badges.

Children and Young People's views on whether Barnet was family friendly were acquired through the youth perception survey. It was found that 84% of children and young people thought that Barnet was a family friendly borough.

Safe and secure outcomes were supported by a resilient social care service evidenced by audits and performance reporting, service user feedback as well as a good Ofsted rating in 2019.

Crime was the biggest concern amongst young people with knife crime being on the top of the list, showing that perception was quite different to reality. Barnet was one of the safest boroughs with crime rates being low. Youth reoffending rates also remained low in comparison to national figures.

The Education Strategy had continued to produce very positive outcomes. 500k in funding had been allocated to RRR in response to the impact caused to education by the pandemic.

Health and Wellbeing outcomes were generally good but there was an increase need for the provision of therapies. The pandemic has had a huge impact on mental health of young people and the demand for services. A lot of work was being done in response to that need. As part of the Council's Covid response, an additional £1.5m funding had been agreed for mental health support in all schools.

In terms of family and belonging, revenues and benefits was one area which was significantly impacted by the pandemic as well as the increase in unemployment and free school meals.

As part of the Covid Winter Grant Scheme, more than 33,000 vouchers were given out to support vulnerable families.

There has been an increase in demand for housing among Care Leavers as the numbers had risen in the last year for both permanent and transitional housing.

Young people also felt that they were being involved in decision making. Barnet was the first borough that signed up to the UNICEF Child Friendly Cities accreditation. Good progress was being made although there was not much flexibility on achieving the certification.

In Barnet, low figures for those Not in Education, Employment and Training (NEET) had been achieved and additional Covid funding was being invested to reduce unemployment figures especially among those from Black ethnic groups.

9. JOINT STRATEGIC NEEDS ANALYSIS - TO FOLLOW

None.

10. ANY OTHER BUSINESS

None.

The meeting finished at 6pm

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Barnet Children's Partnership Board Report

AGENDA ITEM 4

Title: Update on North Central London CCG's Review of Community and Mental Health Services

Meeting Date: 3 November 2021

Author: Jo Murfitt, Programme Director Community & Mental Health Service Reviews;

Service/ Dept.: North Central London CCG

Enclosures:
-PowerPoint Presentation: NCL Community and Mental Health Services Strategic Review: Barnet Children's Partnership Board
-Core Offer for Community Services
-Core Offer for Mental Health Services

Report to be Presented By: Daniel Morgan, Interim Director of Aligned Commissioning (MH, LD/ Autism and CYP)

1. Summary

The purpose of this item is to provide Barnet' s Children Partnership Board with an up to date position on the progress of two strategic service reviews, one for community services and one for mental health services, that the CCG is running. The purpose of the reviews is to ensure that over time the North Central London (NCL) Clinical Commissioning Group (CCG) commission sustainable and affordable community and mental health services for all of its residents. Historically the five legacy CCGs commissioned services for their own geographical populations. This has led to substantial variation in the ways services, including services for children and young people are commissioned and delivered across NCL. This variation is closely linked to different levels of historic funding within the former CCGs.

To compliment the baseline assessments for community and mental health services a similar assessment has been created for Children and Young People. This is currently being finished and will be available on the CCG's website once it is completed.

This report (slides) sets out the process the CGG is following in terms of the two reviews which are running in parallel. Both reviews started in March and have completed their initial phase at the end of September. This report describes the work between March and September and sets out the next phase of work. The slides also provide information on the scope of the reviews which are limited to services the CCG funds, and the governance of the review process.

The slides provide information on user and resident engagement which has sought to ensure conversations with a wide range of diverse groups across all five Boroughs. The report includes a summary of the feedback received and sets out some of the actions the CCG is taking to address these comments. It should be noted that there has been limited engagement with young people and parents as part of these reviews although the output from local engagement work including with young people etc has fed into this process. The slides set out work on the refinement of core service offers and a detailed gap analysis of the 'as is' picture versus the new core service offers. Work is now in progress to undertake an impact assessment on the gap analysis to help inform the CCG of the implications, including costs of the new core offers. This work will be shared with local partners and meetings are being arranged with Local Authority partners to discuss the emerging implications of these reviews.

It is currently anticipated that the CCG's Governing Body may be able to agree an implementation plan by early 2022, ready to start implementation from April 2022.

2. Updates since last BCPB

N/A.

3. Impact

- Equalities and Diversity

Included as part of the review.

- Corporate Parenting

These reviews include services provided to children in care.

The scope of the Community and Mental Health Services Review includes:

- 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).

4. Consultation and Engagement

Included within the presentation.

5. Conclusion and Recommendations

This is a work in progress and the presentation gives an opportunity to update on progress and next steps.

The presentation provides an opportunity to discuss the possible implications of the reviews for children's services in Barnet.

6. Background Papers

None.

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NCL Community and Mental Health Services Strategic Review
Barnet Children's Partnership Board

November 2021

Background to the Community and Mental Health Services Strategic Review

- North Central London (NCL) CCG **spends £595 million** annually across a range of NHS, Local Authority and Private Providers delivering a wide range of **Community Services and Mental health services** that supports our 1.7m population across the 5 Boroughs.

- Before the formation of the NCL CCG services were commissioned by each of the 5 legacy CCGs in isolation **leading to substantial variation in service delivery** models and **the range of services provided**, e.g. opening hours, provision of a community IV service, different models of dementia care etc. This has lead to **variations in outcomes and inequalities in access to provision**. It has also created opportunities to identify improvements.

- 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 PCN/neighbourhood based services in line with the Long Term Plan.**

- This work will also enable us to create **sustainable community and mental health services** that starts to improves health outcomes, and **address inequities in access and disproportionality** and also drives better value from our current spend.

- Following discussion with **Trust and Local Authority partners** we have agreed that we would **run the two reviews in parallel**. This will enable us to consider the **overlap and interdependencies** for people with complex co-morbidities and both physical and mental health needs.

- The CCG have **commissioned Carnall Farrar as design partners** to deliver the two strategic reviews. Both reviews have active **Programme Boards** which include Trusts and Local Authority senior leadership along with service users and clinical representatives.

- The **ambition of the reviews** is to agree with partners a **consistent and equitable service 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 optimized as well as ensuring our services are sustainable in line with our financial strategy and workforce plans.

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 .	Continuing Health Care
All NHS funded Community Services and Mental Health services delivered by Private and other Providers (Voluntary and Charitable Sector etc).	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

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.

Good User and Resident Engagement has been central to driving the programmes of work. Summary of service user and resident engagement

Resident Reference Group established

- 20+ volunteers recruited comprising service users, carers, residents, representatives from patient groups and who are broadly representative of each of the five boroughs and in terms of diversity and age. Reference Group feedback has been incorporated into the review process and also shared with commissioners and providers.

Residents survey

- Open for over 3 months; limited responses (just over 100) but comments very similar to those received from Residents Reference Panel and in a review of previous work/recommendation undertaken by Healthwatch, Citizens Assembly's etc prior to start of reviews.

Engagement Events

- Wide range of events across all five Borough including an event hosted by Healthwatch in Islington and one in Haringey organised by Bridge Renewal Trust. Attendance at ICP partnerships, Health & Well Being Boards as well as smaller focused sessions e.g. Barnet Mencap 'have your say meeting with adults with a learning disability with or without autism' etc.

User Engagement with Service Reviews

- Both Programme Boards have user and or voluntary sector representation. Experts By Experience and voluntary sector reps included Healthwatch attended design workshops and have contributed to shaping the core service offers.

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Next Slides Outline The Process we have followed From March-September

Initial Process was a Baselining Review to understand the current position

Baselining the current position
Interviews with key stakeholders from CCG, Provider and Local Authorities (May)
Health & Care Survey (May) to wide range of colleagues in primary care, providers, Local Authority
Data analysis (May-June) including finance, contracts, workforce and Public Health information on demographics, need and impact of Covid
Baselining workshop x 2 (April and May); attending by a wide range of colleagues from CCG, Providers, Local Authority, Experts By Experience and Voluntary Sector
Development of baseline report (May-July); widely shared and will be on CCG website soon
Completed; set out on next 2 slides are key highlights from Baseline Reports. These have then formed the basis of our case for change

Key messages from the baseline analysis of NCL mental health services

There is significant **variation in demographics** both across and within NCL boroughs which is associated with **different needs** for support from mental health services:

- 10.8% of the Enfield has a diagnosis of depression compared with 7.9% in Barnet and 8.2% London wide
- NCL STP has the highest prevalence of SMI of STPs in England, with particularly high levels of need in Camden, Haringey and Islington

Analysis of finance and activity show that **service provision and investment do not correspond to the level of need:**

- In Haringey CYP have higher mental health needs relative to other boroughs, with highest number of CYP presenting at A&E with mental health needs, but the spend per head is lower than NCL average
- Enfield and Islington have higher diagnosed rates of depression but spend less per head on IAPT services, potentially contributing to more presentations in A&E due to depression and self-harm

There are **significant health inequalities** including significant disparity by ethnicity:

- The black population are higher users of acute mental health services, with 27% of admitted patients being black, compared to representing 11% of the NCL population
- C. half of patients admitted are unknown to services; this is particularly high among black population groups

There appears to be **a large focus on crisis response** rather than early intervention and there is recognition that further investments are needed for more preventative offers

- Workforce is concentrated in Community Mental Health Teams and Crisis Response and Home Treatment Teams; there are over 3 times as many staff in NCL in Crisis Response teams compared to Early Intervention in Psychosis teams
- Rejected referrals to community mental health teams are most likely to be referred onwards to crisis teams

Key messages from the baseline analysis of NCL community services

There is significant **variation in demographics** both across and within NCL boroughs which is associated with **different needs** for support from community health services:

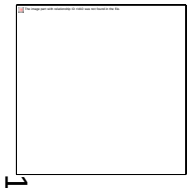
- 25% of Year 6 pupils in Islington have childhood obesity compared to 11% in the least deprived London borough
- Enfield and Haringey have over 30% of LSOAs in the 2 most deprived deciles; research has shown that people in the most deprived areas develop long-term conditions approximately at least 10 years earlier

Analysis of finance and activity show that **service provision and investment do not correspond to the level of need:**

- Waiting times for children's therapy assessments are between 5-7 times as long in Barnet as in Camden, which is linked to the size of the workforce which is 5 times as large in Camden as in Barnet
- Enfield has over twice the prevalence of diabetes as Camden yet has a community diabetes resource that is less than half the size

This disparity appears **related to levels of historic and current funding**

- Camden spends 1.2 times as much on community health services per weighted head of population compared to Enfield
- In boroughs with lower levels of community spend, survey respondents felt patients were less likely to be effectively supported



There are **significant health inequalities and inequities in outcomes** for patients across NCL

- Barnet has 3 times as many care home beds per 65+ population as Haringey. However, Barnet also has the lowest coverage of care home in-reach
- Enfield has the lowest % of diabetics receiving the 8 care processes or attending structured education. However Enfield, has lower rates of admissions for hypo- and hyper- glycaemia

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Development of the Community and Mental Health core offer during June and July

Initial design

- Aligned on population focused approach and pen portraits for initial design discussions
- Joint design workshop on principles and outcomes
- Collated national requirements
- Deep dive workshops as initial input on offer including existing best practice

Development of the outline core offer

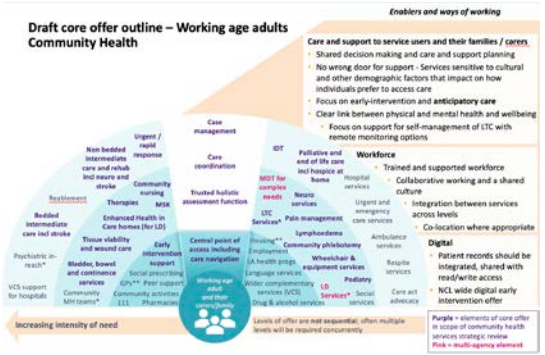
- Collated initial design inputs
- Developed initial draft, setting out the care functions of the core offer for different age cohorts
- Included critical links to wider services
- Design workshop 2 and 3 involving c.60 attendees from community providers, primary care, LA, CCG, mental health, acute providers

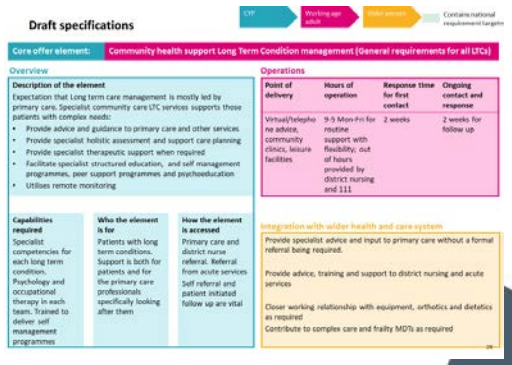
Iterated core offer and developed specifications

- Collated feedback from design workshops 2 and 3
- Iterated core offer based on feedback
- Further developed offer alongside commissioners and providers
- Complete draft of the core offer shared with programme team at the end of July for review and further iteration during August

Through this process, a core offer outline was developed for different age segments of the population and specifications were drafted for each care function of the core offer

Example core offer outline showing all services





Example specification for single service

What the “core offer” is and what it isn’t

The purpose of the core offer is to set out a commitment to the support the NCL population can expect to have access to, regardless of their borough of residence

Purpose of the core offer

The purpose of the core offer is to address the inconsistency of service provision across NCL by setting out a commitment to the NCL population of the support they can expect to have access to regardless of their borough of residence.

The core offer will provide clarity to the population, clinicians and professionals in the system on what support is available, when it is available and how to access it.

The core offer is:

- A description of elements and services that should be available across NCL for different age segments of the population and how these elements integrate with the wider health and care system
- In particular, the core offer provides a brief specification for each element that describes:
  - What the element is and what it aims to deliver
  - Operating hours and any out of hours provision
  - Response times for first contact with service user and ongoing contact (in line with national requirements)
  - Who the element is for and how the element is accessed
  - Links/ integration with other services and agencies
  - Workforce capabilities required
  - Point of delivery (e.g. in person, virtual)

The core offer is not:

- A detailed specification for how providers should deliver care
- A description of how providers should organise workforce, facilities etc. in order to deliver the core offer

The “core offer” is about the minimum requirements

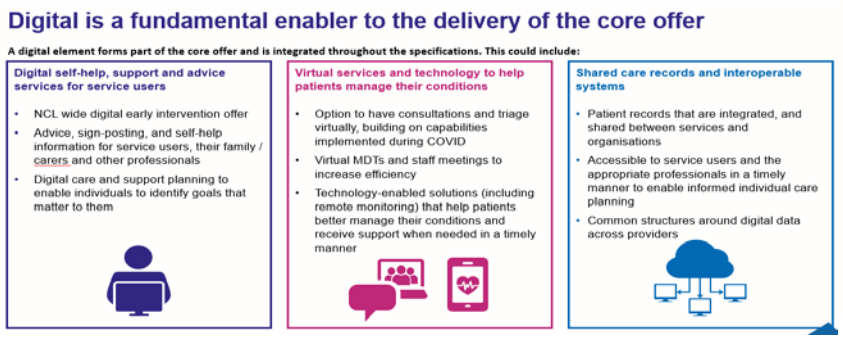
Process to review and refine the community and mental health core offer during August

Review

- During August, the Community and Mental Health core offers were extensively reviewed by a group of over 30 people including:
  - Joint borough commissioners
  - Provider colleagues
  - Clinical leads including GPs and nursing colleagues
  - Clinical SROs
  - Residents' reference group
  - Experts by experience
- The work on the Mental Health core service offer has been consistently triangulated with the work on the Long Term Plan for Mental Health to ensure a consistent and aligned approach

Feedback and comment

- Comments and feedback were provided on the core offer document including to:
  - Clarify, refine and add detail to aspects of the service specifications
  - Amend details of the service specifications, such as opening hours
  - Add or rename services
  - Add on a more local details on integration and partnership working
  - Add in involvement of other non qualified workforce e.g. peer workers, foot care assistants etc



Final revisions

- Versions of the core offer reports with comments and feedback log shared with CF on 13 September
- CF has incorporated the comments through the final version of the core offer report
- CF has also added to the upfront materials in the report around enablers (digital and ways of working) and patient initiated follow up based on feedback received

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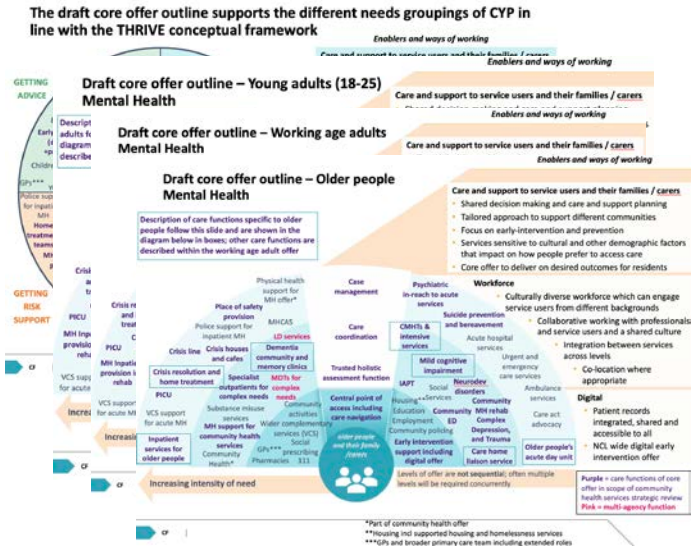
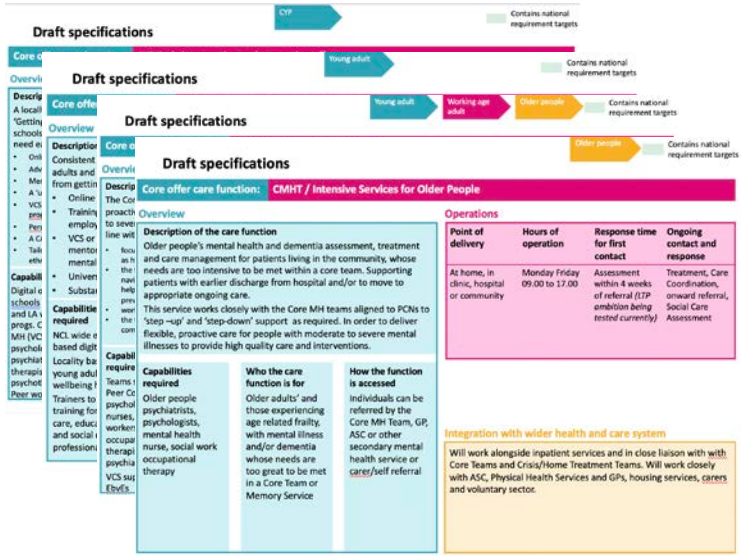
Move to next phase approved by Community and Mental Health Service Review Programme Boards

- CYP
- Young adults
- Working age adult
- Older people

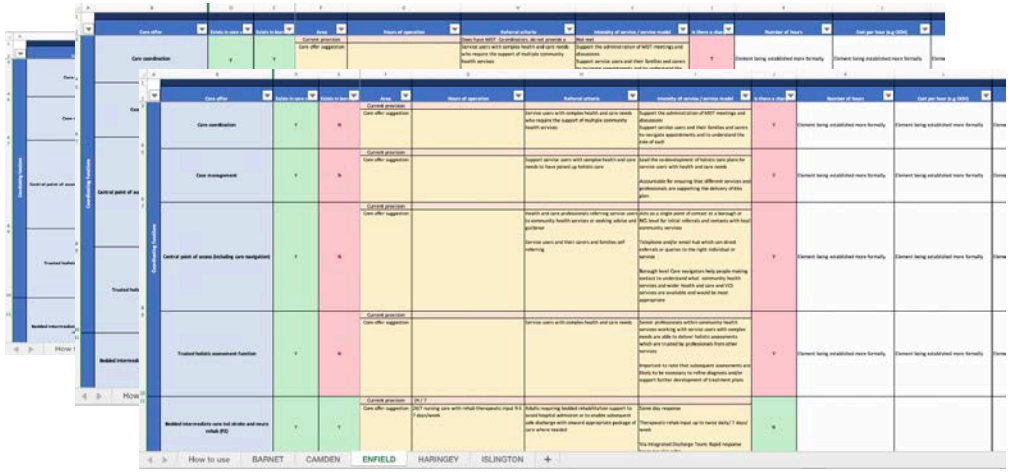




Core Service Offer presented to Community Services Review Programme Board on 24th September and Mental Health Services Review Programme Board on 30/9.

Some minor changes to be made to core service offer to reflect final comments.

Community and Mental Health Programme Boards have given approval of the service gap analysis process



Presented to Programme Boards in September

Acknowledge the context, but need to future proof as far as possible; increasing need in population, new populations moving into area, ongoing impact of Covid etc

Workforce and finance two of biggest challenges. Conversations with NCL workforce planning programme

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Next Steps; October/ November: Assessment of the impact of the core offer on access, inequalities, quality, workforce and finance

Through mapping existing services compared to core offer and leveraging best practice evidence, CF are assessing the core offer against 5 domains

Domain	Criteria
Access	• Comparison of current access hours vs core model access hours • Comparison of referral ease (including implications of consistency of services across NCL, central point of access, ability to self-refer in some cases)
Inequalities	• Comparison of current need (population segmentation) vs current offer (finance and demand)
Quality	• Impact of delivering national must-do's and consistently implementing best practice • Service user and family experience (strengths based approach, personalised care, joined up care e.g. people only need to tell their story once)
Workforce	• Current types of workforce compared to future types of workforce • Flexibility requirements – difference from current ways of working • Impact of integration (e.g. opportunities to work more closely with other organisations/professionals, training/rotation opportunities)
Finance	

Next Steps

- **Complete Impact Assessment** to understand overall impact of core service offers (**October)**
- Continue work within **ICS Financial Framework** as part of development of a financial plan and **time table for implementation (October-November)**
- Continue work with ICS to **think through commissioning implications** for the transition implementation plan (**October-December)**
- Continue to work with **ICS leadership to consider transition to new core offer (October-December)**
- **Conversations with Borough leadership** to discuss progress, pace and place (**October-November)**
- **Work with NCL workforce development team** to think through opportunities for local people to support workforce as part of implementation plan along with considering other opportunities for staff **(October-December but ongoing)**
- **Work with Boroughs and ICP leadership** and place based partnerships to help determine implementation locally to achieve a balance between an NCL wide core and consistent service offer v local population need **(October-January)**
- Further work on comms and engagement approach to be able to clearly articulate to local people the '**so what' of the service reviews and be able to set out how these will make a difference** to their care and experience and health outcomes locally (**November-January)**
- **Develop high level delivery options to inform further discussion (November-December)**

NCL Community Services Strategic Review: Core offer report

September 2021

Contents

Introduction and purpose of this report

Introduction

Before the formation of the NCL CCG, services were commissioned by each of the 5 legacy CCGs in isolation, leading to **substantial variation in the way services are commissioned and delivered across NCL**. This disparity is closely related to different levels of **historic funding** within the CCGs. The NCL Community Services Strategic Review seeks to create a **sustainable and affordable community model** across NCL that **addresses inequalities, spreads good practice** and **improves outcomes** for residents.

Community services would ideally be the **glue across our system** that help patients **stay well and support them to recover**. The review brings together **stakeholders from community services, primary care, acute care, social care and mental health services** to develop the interfaces and collaborative working across pathways. A **review of mental health services** is running in parallel, with integrated workstreams.

Purpose of this report

This report contains the **outputs from the development of the core offer for community health services.** The core offer was developed through an iterative engagement process through workshops, small working groups, one-to-one conversations and written feedback and input. The purpose of the report is to present the NCL-wide core offer for community health services across Children and Young People, Working-Age Adults and Older People. The core offer is intended to be **aspirational** and to reflect a **consistent** offer that **any resident of NCL can expect to access**, whichever borough they reside in. For each care function of the core offer, a specification is shown that aims to describe broad criteria for **delivery of a consistent and equitable offer across NCL.** Select pen portraits have been used to **highlight example pathways through the core offer.**

Aim, objectives and scope for the community and mental health services review

Aim

The aim of the reviews 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 accessible as possible
- Ensure we deliver on national Must Dos for community and mental health services

In 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).
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.
The scope also includes services such as Discharge (Integrated Discharge Teams), End of Life Care, **services for people with Long Term Conditions where these are funded by the NHS** and delivered outside an acute episode of care.

Approach to development of the core offer for community health services

Baselining work

A case for change for community health services across NCL was developed based on:

- Baseline analysis of data
- As-is service mapping
- Stakeholder interviews

Initial design

- Aligned on population focused approach and pen portraits for initial design discussions
- Collated national requirements
- Deep dive workshops as initial input on offer including existing best practice

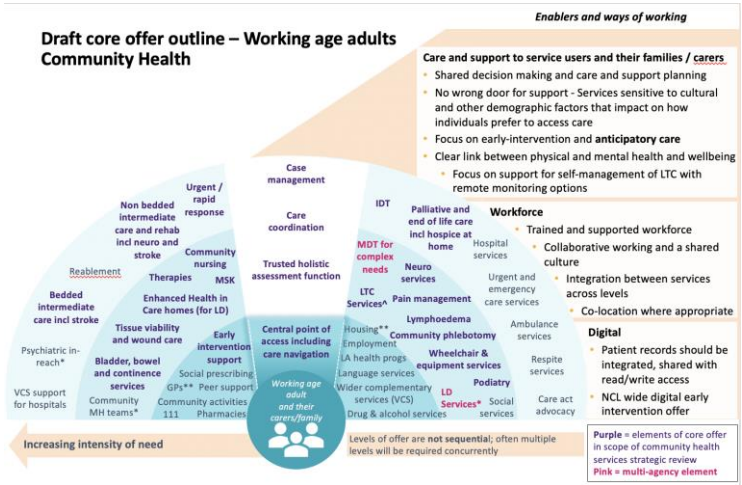
Development of the outline core offer

- Collated initial design inputs
- Developed initial draft, setting out the care functions of the core offer for different age cohorts
- Included critical links to wider services
- Design workshop 2 and 3

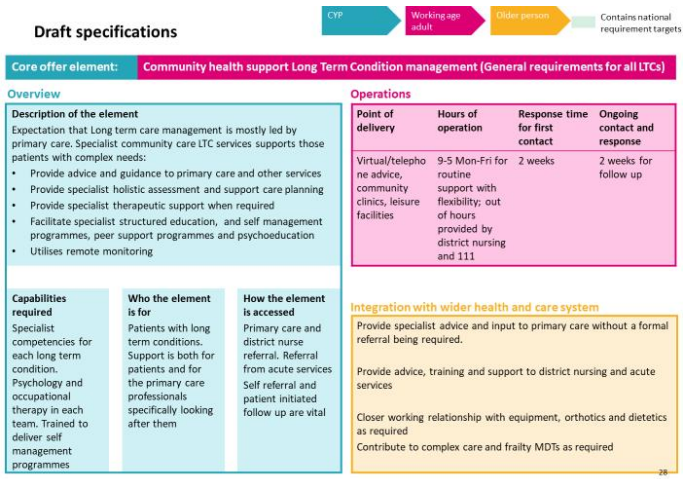
Iterated core offer and developed specifications

- Collated feedback from design workshops 2 and 3
- Iterated core offer based on feedback
- Further developed offer alongside commissioners and providers

Through this process, a core offer outline was developed for different age segments of the population and specifications were drafted for each care function of the core offer



Example core offer outline showing all services



Example specification for single service

The purpose of the core offer is to set out a commitment to the support the NCL population can expect to have access to, regardless of their borough of residence

Purpose of the core offer

The purpose of the core offer is to address the inconsistency of service provision across NCL by setting out a commitment to the NCL population of the support they can expect to have access to regardless of their borough of residence.

The core offer will provide clarity to the population, clinicians and professionals in the system on what support is available, when it is available and how to access it.

The core offer is:

- A description of care functions and services that should be available across NCL for different age segments of the population and how these care functions integrate with the wider health and care system
- In particular, the core offer provides a brief specification for each care function that describes:
  - What the care function is and what it aims to deliver
  - Operating hours and any out of hours provision
  - Response times for first contact with service user and ongoing contact (in line with national requirements)
  - Who the care function is for and how the care function is accessed
  - Links/ integration with other services and agencies
  - Workforce capabilities required
  - Point of delivery (e.g. in person, virtual)

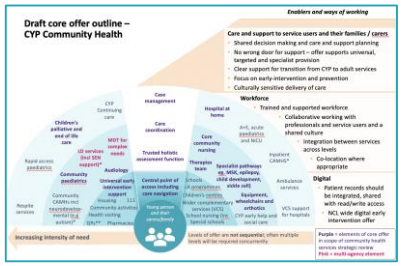
The core offer is not:

- A detailed specification for how providers should deliver care
- A description of how providers should organise workforce, facilities etc. in order to deliver the core offer

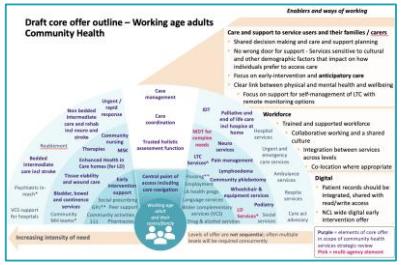
Contents

A core offer has been developed for different age segments of the population and consists of core offer outlines, coordinating functions and specifications for services

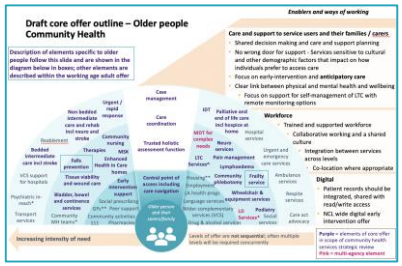
Core offer outlines provide a summary of care functions and services that are part of the core offer for each age profile. The outlines also show care functions not within scope of the review but that should be linked in with the core offer, as well as enablers.



Children and young people

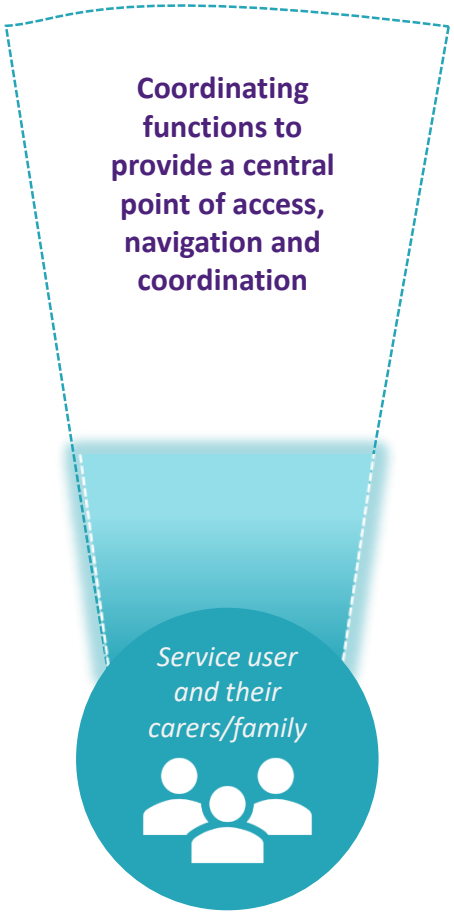


Working age adults

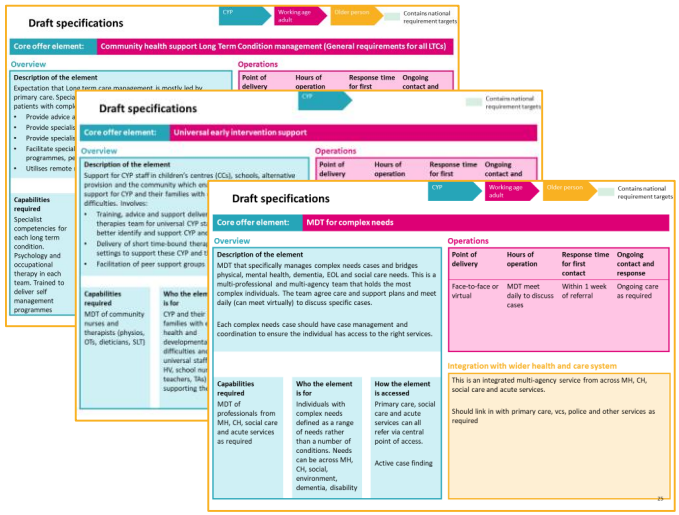


Older people

Each outline also contains a set of **coordinating functions** encompassing a central point of access, care coordination and case management.



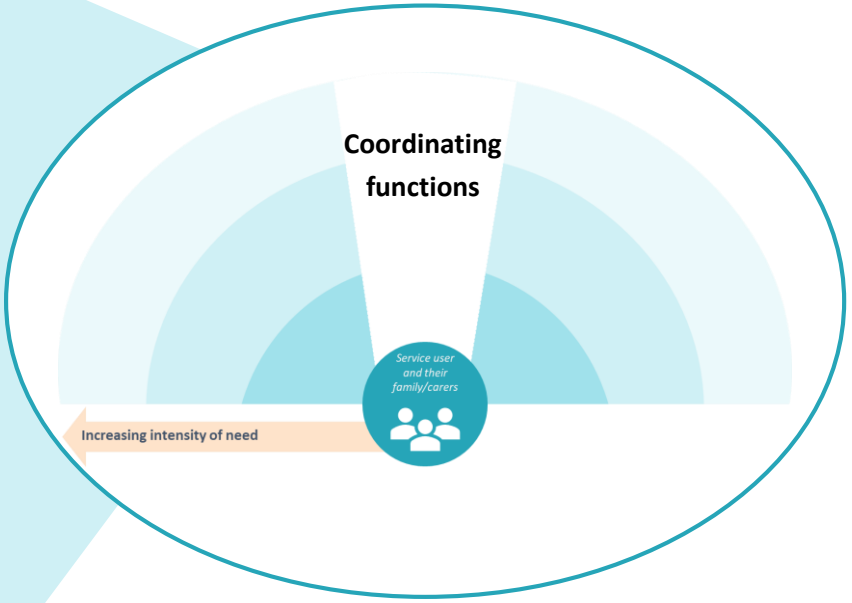
Following each core offer outline, in-scope care functions are further detailed in a set of **specifications**. These provide a description of the care function and lay out access criteria, hours of operation, capabilities required, where the care function should be delivered, waiting times and how the care function should link in with the wider health and care system.



The core offer outlines summarise the care functions that should be delivered by community health services with the service user at the heart of the design

Core offer care functions

- Each of the core offer outlines provides a **summary of key care functions** of community health services that should be part of a core offer for age segments of the population
- The care functions are arranged across layers with the **service user and their family / carer at the centre of the offer**
- The further away from the service user, the more intensive the need that the core offer care function provides for
- **Movement between the layers is not necessarily sequential**. Care **delivery can be fluid** and should be delivered where is best for the service user and **as close to home as possible**
- Care functions of the core offer that are in scope of the community services strategic review are shown in **purple and bolded**. The other elements are shown to highlight how services should be integrated across and within the layers
- A set of **coordinating functions run across the layers** helping to coordinate, integrate and navigate care for service users



Enablers and ways of working

- Alongside the core offer outlines, key enablers and ways of working are called out in three areas; care and support to service users and their families / carers, workforce and digital
- These enablers will be further examined and expanded upon through transition and implementation planning

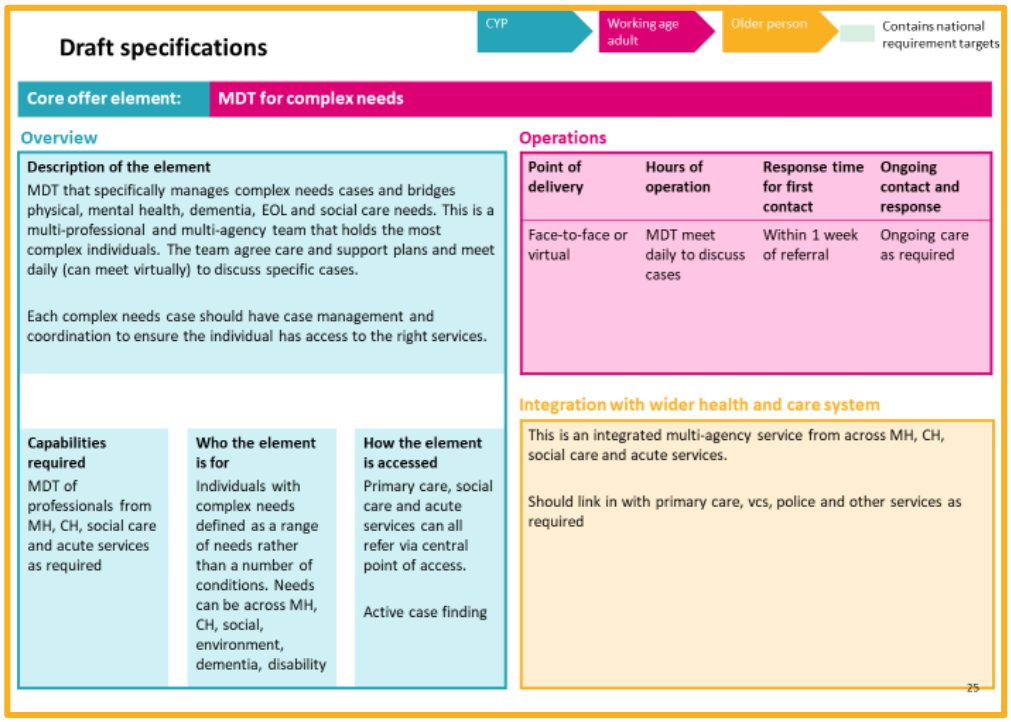
Care and support to service users and their families / carers

Workforce

Digital

Specifications for each care function of the core offer follow the outlines. A description of the coordinating functions is in a separate sectio

Specifications for each care function of the core offer provide an overview of what the care function is and the minimum requirements for its delivery NCL-wide



Draft specifications

CYP | Working age adult | Older person | Contains national requirement targets

Core offer element: MDT for complex needs

Overview

Description of the element

MDT that specifically manages complex needs cases and bridges physical, mental health, dementia, EOL and social care needs. This is a multi-professional and multi-agency team that holds the most complex individuals. The team agree care and support plans and meet daily (can meet virtually) to discuss specific cases.

Each complex needs case should have case management and coordination to ensure the individual has access to the right services.

Capabilities required

MDT of professionals from MH, CH, social care and acute services as required

Who the element is for

Individuals with complex needs defined as a range of needs rather than a number of conditions. Needs can be across MH, CH, social, environment, dementia, disability

How the element is accessed

Primary care, social care and acute services can all refer via central point of access.

Active case finding

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Face-to-face or virtual	MDT meet daily to discuss cases	Within 1 week of referral	Ongoing care as required

Integration with wider health and care system

This is an integrated multi-agency service from across MH, CH, social care and acute services.

Should link in with primary care, vcs, police and other services as required

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- The aim of the specifications is to **provide a level of consistency and equality of access across NCL**
- The specifications **do not detail how providers should deliver the service**, but rather describe minimum standard requirements around:
  - Where the care function should be delivered
  - When the care function should operate
  - Waiting times for first and ongoing contact
  - Thresholds for service user access
  - Capabilities of the workforce
  - How service users can access the care function
- The specifications also provide an overall description of the care function and how it should link in with the wider health and care system
- It should be recognised that there will **be differences in the scale of provision at a local level**, to align with variation in need at a local level and to integrate with local models of care delivery (e.g. through PCNs), but these minimum standards described in the specifications remain consistent across NCL

Digital is a fundamental enabler to the delivery of the core offer

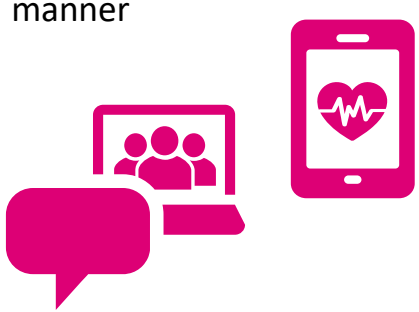
A digital element forms part of the core offer and is integrated throughout the specifications. This could include:

Digital self-help, support and advice services for service users

- NCL wide digital early intervention offer
- Advice, sign-posting, and self-help information for service users, their family / carers and other professionals
- Digital care and support planning to enable individuals to identify goals that matter to them

Virtual services and technology to help patients manage their conditions

- Option to have consultations and triage virtually, building on capabilities implemented during COVID
- Virtual MDTs and staff meetings to increase efficiency
- Technology-enabled solutions (including remote monitoring) that help patients better manage their conditions and receive support when needed in a timely manner



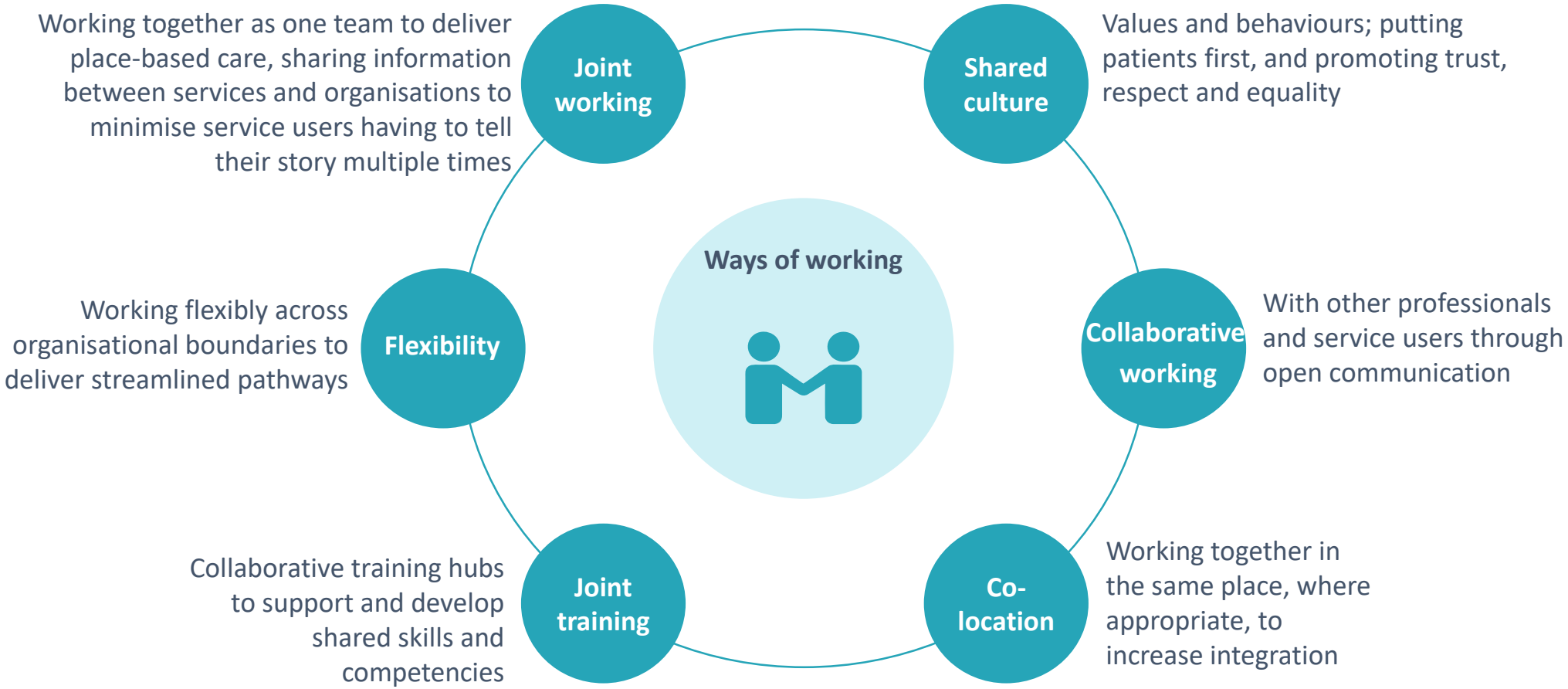
Shared care records and interoperable systems

- Patient records that are integrated, and shared between services and organisations
- Accessible to service users and the appropriate professionals in a timely manner to enable informed individual care planning
- Common structures around digital data across providers

Further work will be required at implementation planning stage to develop the plans to deliver digital transformation to support the core offer. This could be supported by the development of a digital workstream to support the Community and Mental Health Strategic Reviews.

Integrated ways of working across community health, mental health and other agencies will be central to implementation of the core offer

Workforce transformation to support delivery of the core offer could include:

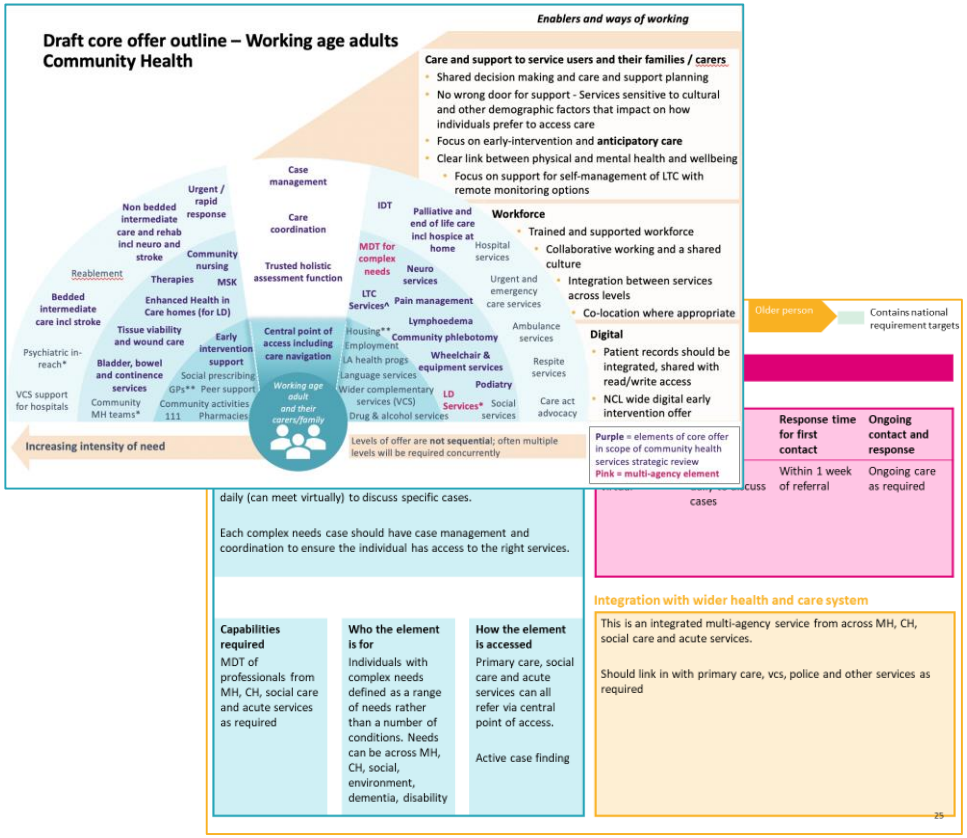


Further work will be required at implementation planning stage to develop the plans for workforce transformation to support the core offer.

The core offer is aligned to other programmes focused on transforming community services in NCL

- Development of the core offer for community services has **not been done in isolation**, with co-production with other programmes of work that are related to the community health services transformation
- The purpose of this review is to **bring together the aspiration for NCL-wide Mental Health and Community Health Services into one place**
- This **supports ongoing areas of work** that are looking at specific aspects and services, for example:
  - Ageing well
  - P2 bed planning
  - Children's therapies and community nursing
- These and other areas of related work will be further **progressed in response to the strategic level core offer**

The core offer will be taken forward to feed into an impact assessment and planning for transition

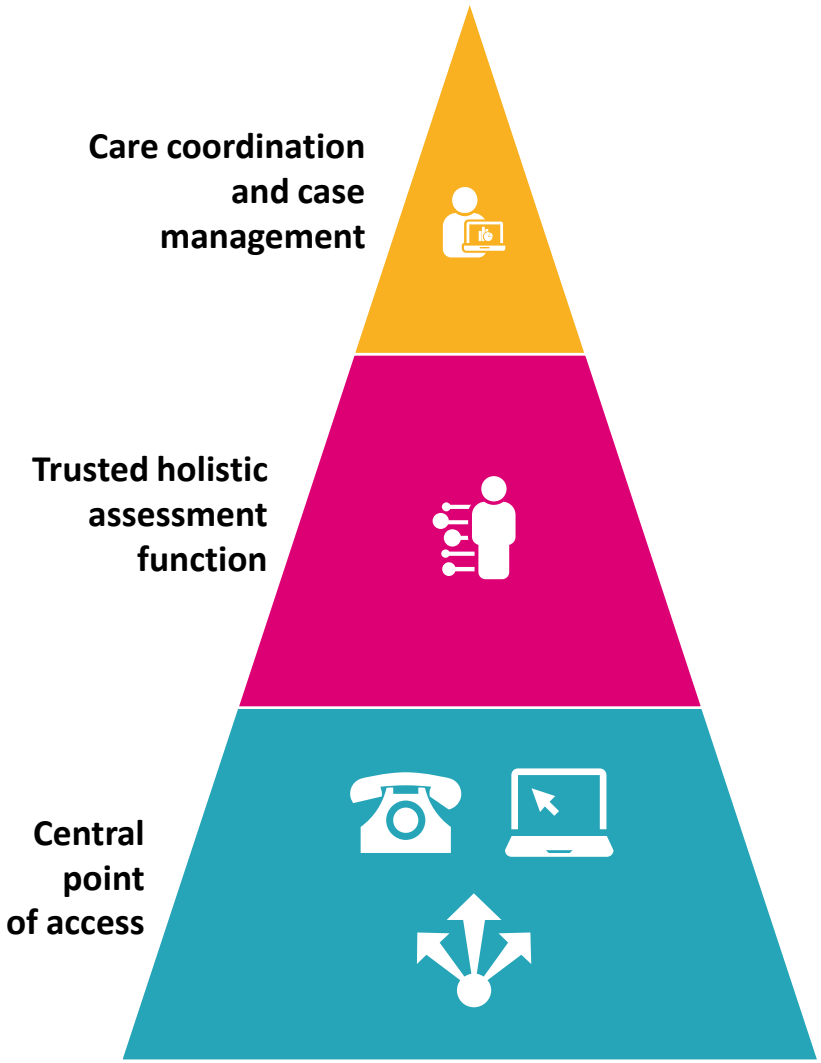


- The core offer outlines, coordinating functions and specifications that have been developed are intended to be carried forward into:
  - An impact assessment which will be a comparison of the core offer against current provision across several domains including access and finance
  - A transition plan that will cover:
    - The level of delivery of different care functions of the offer i.e. PCN, place, ICS
    - Requirements for enablers to deliver at PCN, place and ICS level
    - Roadmap for transition
    - Recommendations for commissioning
- The core offer will not prescribe to providers how they should deliver against the requirements or how providers should organise themselves to deliver the offer

Contents

A set of coordinating functions act to support, integrate and navigate care for service users across the layers of the core offer

Increasing complexity of need



- Service users with complex needs are allocated a clinical **case manager**. This individual leads the development of a **holistic care plan and its delivery**
- Care coordinators support this through **organising MDT meetings** and supporting service users and their families and carers to **navigate health and care appointments**

- Service users have **a single up front holistic assessment of their health needs, functioning, living environment & preferences**
- This is conducted by a senior professional with trusted assessor competencies who has the trust of the full MDT
- Service users and their families and carers **only have to tell their story once**

- Central point of contact at borough or NCL level for initial referrals and contacts with local community and MH health services
- Provides telephone and/or email hub which **directs referrals or queries to the right individual or service**
- Accessed by any health or care professionals, by service users and families / carers
- Administrators have access to directory of local services and assets and are able to **help service users and professionals navigate the wider available support**

Further detail around the coordinating functions

Function	Access	Purpose	Components	Capabilities	Care functions supported
Central point of access (including care navigation)	Health and care professionals referring service users to community health services or seeking advice and guidance Service users and their carers and families self referring	Acts as a single point of contact at a borough or NCL level for initial referrals and contacts with local community services The main purpose of the central point of access is to move people seamlessly through services Services also have the ability to move service users to another service (e.g. where a service identifies a patient need that can be covered by another core offer care function)	Telephone and/or email hub which can direct referrals or queries to the right individual or service Borough level Care navigators help people making contact to understand what community health services and wider health and care and VCS services are available and would be most appropriate	Administrators with clear standard operating procedures Non-clinical care navigators who have a directory of services and excellent working knowledge of available services and assets within the borough Central point of access needs to be the most responsive with the ability to provide crisis assessment and request crisis response (if required) in a timely manner	All care functions of community health offer

Further detail around the coordinating functions

Function	Access	Purpose	Components	Capabilities	Care functions supported
Trusted holistic assessment function	Service users with complex health and care needs	Ensure that service users with complex health and care needs can have a single up front assessment of their health and care needs to enable an initial holistic care plan to be co-developed. Ensures that service users and their families and carers don't have to keep telling the same story	Senior professionals within community health services working with service users with complex needs are able to deliver holistic assessments which are trusted by professionals from other services Important to note that subsequent assessments are likely to be necessary to refine diagnosis and/or support further development of treatment plans	Capability to assess the different health and care needs of service users and for this assessment to be trusted by other members of the MDT involved in the service user's care	Management of service users with complex health and care needs

Further detail around the coordinating functions

Function	Access	Purpose	Components	Capabilities	Care functions supported
Care coordination	Service users with complex health and care needs who require the support of multiple community health services	Ensure that the multiple services and individuals involved in the care of a service user with complex needs are aware of what each are doing and are able to deliver holistic joined up care	Support the administration of MDT meetings and discussions Support service users and their families and carers to navigate appointments and to understand the role of each	Administrators who are able to support both service users and their families and liaise with different professional stakeholders	MDTs for service users with complex needs
Case management	Service users with complex health and care needs who require the support of multiple community health services	Support service users with complex health and care needs to have joined up holistic care	Lead the co-development of holistic care plans for service users with health and care needs Accountable for ensuring that different services and professionals are supporting the delivery of this plan	Senior health or care professional who is allocated to patients. Can be from any professional health and care background but must be able to provide trusted holistic assessments	Service users with complex health and care needs

Patient initiated follow up could be a tool to support service users to navigate the core offer and access support when required

Following an appointment, it is often necessary to arrange follow-up appointments for ongoing care. Traditionally, these appointments are offered at routine intervals but in some cases, patients might need a follow-up appointment sooner than their scheduled session or they may agree with their clinician that a follow-up is not required unless their symptoms flare up or their circumstances change.

Patient initiated follow-up (PIFU) is giving patients and their carers the **flexibility to arrange their follow-up appointments** as and when they need them. PIFU can be used with **patients with long or short-term conditions** and following treatment or surgery. This gives patients access to care and support when they need it, whilst avoiding unnecessary trips to hospitals and clinics, saving them time, money and stress.

Contents

CYP

Draft core offer outline – CYP Community Health

Care and support to service users and their families / carers

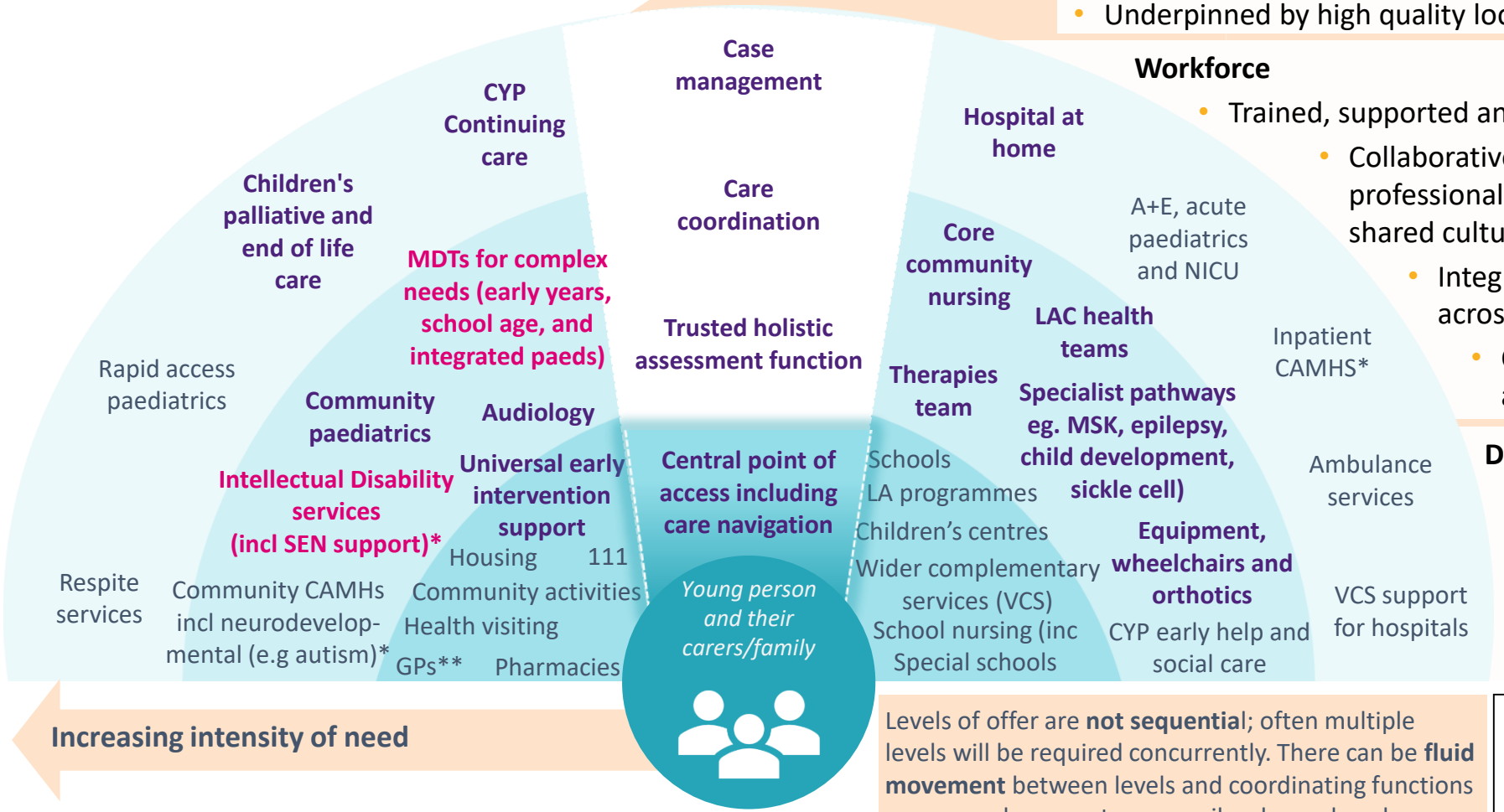
- Shared decision making and care and support planning
- No wrong door for support – offer supports universal, targeted and specialist provision. Therapy / care delivered where needed in a culturally sensitive manner
- Clear support for transition from CYP to adult services
- Focus on early-intervention and prevention
- Underpinned by high quality local offers

Workforce

- Trained, supported and developed workforce
  - Collaborative working with professionals and service users and a shared culture
    - Integration between services across levels
      - Co-location where appropriate

Digital

- Patient records should be integrated, shared with read/write access
  - NCL wide digital early intervention offer



Increasing intensity of need

Levels of offer are **not sequential**; often multiple levels will be required concurrently. There can be **fluid movement** between levels and coordinating functions run across layers not necessarily where placed.

Purple = care functions of core offer in scope of community health services strategic review
Pink = multi-agency function

*Described as part of mental health core offer
**GPs and broader primary care team including extended roles

CYP community health services are delivered under universal, targeted and specialist offers

Universal offer

Description

The universal offer describes a way of working at the earliest opportunity in order to prevent escalation of needs. This offer is universally available to all CYP and their families / carers. The offer focuses on early intervention and prevention and is delivered through training and support to CYP staff (universal professionals, e.g. in schools, children's centres, early years settings, etc.) in a variety of settings. The universal offer helps to support CYP staff with early identification of need and provides direct training and assistance in how to manage those early needs. Qualified professionals are embedded within CYP settings and can be easily accessed for advice, assessment and short, direct interventions. Examples of short interventions include sensory playgroups, where CYP staff can be trained to deliver these interventions following on from the first intervention. The universal offer also includes health visiting and school nursing (although these are out of the scope of this core offer)

The universal offer has a dual role to support the child / young person and to upskill staff working with CYP so that they can recognise early need, deliver short interventions themselves and prevent escalation. Identification of and safeguarding children from harm underpins the universal, targeted and specialist offers. Designated Safeguarding and LAC Dr and Nurse roles help ensure effective safeguarding is embedded into practice. Practitioners from across disciplines take part in multi-agency Team Around the Child care planning. Designated Clinical Officers and Drs for SEND help ensure compliance with SEN statutory requirements.

Capabilities required

Workforce available in all areas to deliver universal offer. Qualified professionals available to train, give advice, support, help with escalating need and referrals

Who the care function is for

All CYP and their families

How the care function is accessed

Open access, no referral needed (integrated working; part of a team, MDT at a universal level).

Universal setting (no wrong door)

Early-help hubs

Draft specifications

Contains national requirement targets

Universal offer care function: Early intervention support

Overview

Description of the care function

Support for CYP staff in children's centres (CCs), schools, alternative provision and the community which enables early identification and support for CYP and their families with developmental and health difficulties. Involves:

- Training, advice and support delivered by community nursing and therapies team for universal CYP staff which enables them to better identify and support CYP and families at an earlier stage
- Delivery of short time-bound therapeutic interventions in these settings to support these CYP and their families
- Facilitation of peer support groups

Capabilities required

MDT of community nurses and therapists (physios, OTs, dieticians, SLT)

Who the care function is for

CYP and their families with early health and developmental difficulties and the universal staff (incl Health visitors, school nurses, teachers, TAs) supporting them

How the function is accessed

Early intervention MDT allocated to group of CC, schools and alternative provision at a PCN footprint

CYP and their families can also self refer

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
CCs, schools, alternative provision, virtual / telephone advice	Mon-Fri 9-5 with some flexibility for training and support	1 week response	As required

Integration with wider health and care system

Early intervention team provides support and training to universal professionals across CC, schools and alternative provision

It links into core targeted community and therapies support and specialist pathways as required removing need for formal referral

Draft specifications

Contains national requirement targets

Universal offer care function: CYP Audiology (Universal and specialist)

Overview

Description of the care function

Universal newborn hearing screening teams which are based within the acute paediatric departments across NCL.

Assessment, management and treatment and rehabilitation of children and young people presenting with a hearing loss, tinnitus and balance disorder

Capabilities required

Audiologists and technicians

Who the care function is for

All newborn children (universal)

CYP with concerns about hearing loss or balance disorders (specialist)

How the function is accessed

Postnatal wards, paediatric teams

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Postnatal wards, vlinic rooms	8-8 Mon-Sun	Same day for new born screening	As required, but up to twice weekly review

Integration with wider health and care system

Close links with paediatric teams. Work closely with specialist ENT services required at the Royal National ENT hospital.

Works alongside health visitors and school nursing teams as well as CYP social work teams. Contributes to SEND assessments and MDT discussions and planning

CYP community health services are delivered under universal, targeted and specialist offers

Targeted offer

Description

The targeted offer provides a range of services for children and young people that require further support beyond or in addition to the universal offer. The offer provides assessments, that can be face-to-face or virtual, of a child's overall strengths and needs in relation to the reason for their referral.

The targeted offer also provides interventions in various settings and formats including group, family, parent, schools etc. Both assessments and interventions are delivered in a timely manner as set out in the detailed specifications following this page.

These targeted interventions can be individual or thematic for a particular target group.

The aim of the targeted offer is to provide support for physical needs in the community and work together with mental health services in order to prevent escalation of needs.

Identification of and safeguarding children from harm underpins the universal, targeted and specialist offers. Designated Safeguarding and LAC Dr and Nurse roles help ensure effective safeguarding is embedded into practice. Practitioners from across disciplines take part in multi-agency Team Around the Child care planning.

Designated Clinical Officers and Drs for SEND help ensure compliance with SEN statutory requirements.

Capabilities required

Community nurses, paediatricians, OT, SLTs, PTs, dietitians

Who the care function is for

CYP (and their family) identified as having a need that cannot be supported only through universal offer

How the care function is accessed

Referral through central point of access

Draft specifications

Contains national requirement targets

Targeted offer care function: CYP core community nursing

Overview

Description of the care function

- Core community nursing provides holistic assessments and co-develops treatment plans for CYP and families that require support beyond the universal offer
- Core community nursing support includes wound care including tissue viability, administering drugs, passing NG tubes and respiratory support
- Core community nursing support includes bowel and bladder care (including night time enuresis care)
- The team contributes to Team around the Child and MDT discussions
- The team links in with specialist community pathways as required
- Provide training to manage community based ventilators and other specialist breathing equipment

Capabilities required

Community nurses can give IV antibiotics, manage IV bloods, manage and access Hickman's lines / ports, administer controlled drugs and catheterize and manage ventilators and specialist breathing equipment

Who the care function is for

CYP incl LAC and their families with short and longer term additional and complex needs (These CYP may also need additional support from specialist pathways)

How the function is accessed

Primary care, school nurses, health visitors and social care and acute paediatrics can all refer via central point of access. CYP and families can also self refer

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, family homes, school and Children's Centres, acute wards	Community nursing 8-10pm Mon-Sun	1 day for urgent response, 1 week for non urgent	Up to daily review as required

Integration with wider health and care system

Team needs to link in with the universal community health offer. It can access specialist CYP community health pathways when CYP and their families need additional specialist input

Team works alongside wider professional network support CYP and their families including social care (and early help), school and Children's Centre staff, acute paediatrics and primary care

Each team is linked to a group to primary care networks

Draft specifications

CYP

Contains national requirement targets

Targeted offer care function: **CYP therapies delivered by AHPs (also supports universal and specialist)**

Overview

Description of the care function

Occupational therapy, physiotherapy, dietetics and speech and language assessments and interventions for CYP with functional impairment or disability. This is for both those with long term conditions and with urgent health and care needs. The therapies service also provides training and support to empower and help build the resilience of CYP and their families / carers and to enable them to help support and provide care. May work with specialist pathways eg to undertake some diagnostic assessments of children with neurodevelopmental concerns eg autism

Key role contributing to SEND assessments and delivery within EHCPs.

Capabilities required

Range of assessment and therapeutic competencies across AHPs

Who the care function is for

CYP and their families with LTCs, those with urgent care needs and those requiring rehabilitation support (These CYP may also need additional support from specialist pathways)

How the function is accessed

Schools, children's centres (CCs), Health visiting, primary care, community nursing, school nursing and Paediatrics can access via single point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, family homes, school and CCs, acute wards	9-6 Mon-Fri with some flexibility	First contact 4-6 weeks or 12 weeks for ASD assessment Urgent appointments for those with dysphagia/eating/drinking concerns	Up to daily review as required, dependent on CYP's needs

Integration with wider health and care system

- Daily working relationships with community nursing, primary care health visitors and school nursing, early years, education, social care and voluntary sector teams.
- Integrated health and mental health teams around locality networks
- Integrated working with Local Authority SEND teams contributing to assessments and MDT discussions and reviews
- Works with orthotics and equipment service and Local Authority transport team

Draft specifications

CYP | Working age adult | Older person | Contains national requirement targets

Targeted offer care function: **Equipment, wheelchairs and orthotics**

Overview

Description of the care function

Wheelchair

Clinic and home assessments of CYP and adults with ongoing disabilities.

Equipment and Orthotics

Functional assessment of CYP with short term and ongoing disabilities. Assessment and provision of equipment and wheelchairs and implementation of required home adaptations. Support and training to use equipment. Regular review of changing needs. Includes orthotic assessment of CYP with disability and provision of appropriate orthoses. Community Equipment covers a range of items that are provided in people's homes to support independence. It includes commodes, hoists, grab rails and other items.

The service does not have hours of operation, but is rather contracted to deliver equipment within specified timeframes, e.g. 1-7 days, depending on the urgency of the request.

Capabilities required

OTs, physiotherapy rehab engineers, equipment and orthotists and prosthetists

Who the care function is for

CYP with a disability

How the function is accessed

Community health services, social care practitioners, education facilities rehab facilities, paediatrics, CYP social care and primary care can access service for patients

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community, clinic and care homes. Able to deliver to patient homes	**Urgent Equipment** 7 day service **Wheelchairs and orthotics** 9-5 Mon-Fri out of hours emergency repair service 7 days	Same day for urgent referrals (excluding orthotics) Rest dependent on service and level of need	Reflecting individual pathways and care plans

Integration with wider health and care system

Works alongside all community, acute, social care VCS and primary care services. Also links to Hospital at home and palliative care services

Draft specifications

CYP

Contains national requirement targets

Targeted offer care function:	Community paediatrics (also supports specialist offer)

Overview

Description of the care function

Provision of medical assessments and interventions in the community for CYP and their families with developmental delays and disorders including conditions such as epilepsy, autism, Down Syndrome and cerebral palsy.

Community paediatrics works closely with other members of the community targeted and specialist offers, early years, schools and primary care to assess and meet the health needs of CYP with developmental disorders, disabilities or special needs. They also work alongside and provide medical advice to Local Authority special educational needs services and social care services. This includes advice regarding potential safeguarding concerns. Deliver safeguarding medical assessments and undertake health assessments and reviews for Looked After Children

Capabilities required

Consultant and trainee community paediatricians

Who the care function is for

CYP and their families with targeted of specialist community health needs who require medical assessment and intervention

How the function is accessed

Via community nursing and therapy teams; via specialist pathways; via central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community paediatric clinics, wellbeing hubs,	9-5 with out of hours on call provision for emergency safeguarding concerns	12-18 weeks for first appointment	As required

Integration with wider health and care system

Core member of Team around Child MDTs supporting CYP with targeted and specialist needs

Provide advice and support to universal professionals including primary care, CAMHS, health visitors and school nursing

Integrated with local acute paediatric services and social care

Draft specifications

CYP

Contains national requirement targets

Targeted offer care function: **Looked After Children's Health teams**

Overview

Description of the care function

Provision of nursing and medical assessments and reviews for Looked After Children.

- Undertaking and/or quality assuring Initial Health Assessments and Review Health Assessments in line with statutory timescales,
- Diagnosis, health management and promotion, referral and follow up
- Liaison with other health, education and social care pathways including CAMHS and primary care
- Training on health needs for foster carers, education, social care and other partners

Capabilities required

Consultant and trainee community paediatricians, nursing

Who the care function is for

Looked After CYP and their carers

How the function is accessed

Via social care referrals; via specialist pathways; via central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community paediatric clinics, wellbeing hubs,	9-5 with out of hours on call provision for emergency safeguarding concerns	IHAs within 20 days Reviews 6 monthly for U5s / annual CYP 5+	As required

Integration with wider health and care system

Close joint working with social care.

Provide advice and support to universal professionals including primary care, health visitors and school nursing. Advising GPs and other practitioners on outstanding immunisation and child health surveillance programmes for children. Integrated with local acute and wider community paediatric services

CYP community health services are delivered under universal, targeted and specialist offers

Specialist offer

Description

The specialist offer generally provides more long-term support to children and young people and their families / carers with ongoing and / or complex needs. However, the specialist offer can also provide acute, intensive and short-term interventions where required. The offer provides specialist assessments and direct therapeutic interventions.

CYP with needs requiring specialist input do not necessarily have to cycle through the offers sequentially from universal, to targeted to specialist. For example, a premature baby would require immediate specialist care.

The specialist offer also acts to provide advice and input to other agencies and services, particularly primary care and helps to support self-management. Delivered with and through settings and schools where the infrastructure has been developed to support children with additional, specific or complex needs

The aim of the specialist offer is to provide support to CYP and their families / carers in the community to prevent escalation and maximize potential. Identification of and safeguarding children from harm underpins the universal, targeted and specialist offers. Designated Safeguarding and LAC Dr and Nurse roles help ensure effective safeguarding is embedded into practice. Practitioners from across disciplines take part in multi-agency Team Around the Child care planning.

Designated Clinical Officers and Drs for SEND help ensure compliance with SEN statutory requirements.

Capabilities required

Specialist knowledge and skills. Clinical nurse specialists (CNSs) and therapists. Specialist knowledge across teams to include mental health, substance misuse, young parents and sexual health issues. Must know Local Offer and local services.

Who the care function is for

CYP (and their family) identified as having a need that cannot be supported through universal and targeted offers (driven by complexity of need that requires number of professionals to help support those needs)

How the care function is accessed

Referral through central point of access and/or from community professionals already providing targeted support, , or progression through a multidisciplinary pathway of care

Draft specifications

CYP

Contains national requirement targets

Specialist offer care function:	Specialist CYP Community health pathways

Overview

Description of the care function

Specialist community health pathways for CYP and their families with specialist needs beyond) that provided by core targeted team

- Pathways include specialist MSK, epilepsy, diabetes, sickle cell, specialist school nursing and child development, hospital at home
- Provide advice and guidance to primary care and other services
- Provide specialist assessment and therapeutic interventions
- Facilitate specialist structured education, and self management programmes, peer support programmes and psychoeducation
- Support the emotional and physical wellbeing of CYP and their families
- Includes support to enable CYP to be supported in community as opposed to paediatric outpatients

Capabilities required

MDT of community nurses and therapists (physios, OTs, dieticians, SLT)

CYP clinical psychologist for appropriate pathways

Who the care function is for

CYP and their families with short or long term health conditions needing support from specialist teams

How the function is accessed

Core team "steps-up" to specialist pathways as required. Also can be accessed directly for advice and assessments by primary care, health visitors and school nursing

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, family homes, school and CCs, acute wards	9-5 Mon-Fri for routine support with flexibility; out of hours provided by core team	2 weeks	As required

Integration with wider health and care system

Teams work at borough or NCL level and need to work closely with core (targeted) teams working with each group of PCNs. They also need to link in the early intervention (universal) community health offer and universal services.

Team works alongside wider professional network support CYP and their families including social care (and early help), school and CC staff, acute paediatrics and primary care. May be delivered through age related pathways.

Draft specifications

CYP

Contains national requirement targets

Specialist offer care function:	CYP Continuing care

Overview

Description of the care function

- Core specialist nursing in the community provides holistic **assessments, develops care plan, undertakes annual reviews, lead on quarterly quality reviews of care and provide training for professionals who care** for CYP with complex needs in line with the national Continuing Care Framework. This includes CYP who have a PHB.
- Where contracted, the continuing care service will also deliver high quality packages of individualsied care and support to CYP in the community
- Nurse led service
- Integrated panel for decision making for provision across health, social care and education
- The team links in with specialist community pathways as required

Capabilities required

Community nurse led

Trained in use of Children's Continuing Care Framework

Who the care function is for

CYP and their families with significant, longer term additional and complex needs who meet continuing care criteria. (These CYP may also need additional support from specialist pathways

How the function is accessed

Referral for assessment against criteria in Children's Continuing Care Framework

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Family homes	Community nursing 8-10pm Mon-Sun	In line with NCL Children's continuing care policy. Continuing Care DST tool completed within 6 weeks.	Up to daily review as required, depending on clinical need and in line with care plan.

Integration with wider health and care system

Team needs to link in with a variety of professionals across health, education and social care. The team will access specialist CYP community health pathways when CYP and their families need additional specialist input or support. This may include end of life care and bereavement support.

Panel works alongside wider professional network to support CYP and their families including social care (and early help), school and Children's Centre staff, acute paediatrics and primary care

Draft specifications

Contains national requirement targets

Specialist offer care function: CYP Disability and Complex Needs MDT Pathways: Early Years

Overview

Description of the care function

Specialist multi-disciplinary health pathways for CYP and their families with emerging or diagnosed developmental and/or neurodevelopmental concerns and disabilities, closely integrated with social care and education. Often known as Child Development teams or services:

- Provide advice and guidance and joint consultations to primary care and other services
- Provide specialist multi-disciplinary assessment and review plus interventions eg therapies, feeding/eating support, continence, sleep, whole family mental health support
- Access to keyworking/case co-ordination function
- Facilitate specialist structured education, self management, peer support programmes and psychoeducation
- Support the emotional and physical wellbeing of CYP and their families

Capabilities required

MDT of paediatricians, therapists (physios, OTs, dieticians, SLT), specialist nursing, CAMHS clinicians. Multi-agency liaison function.

Who the care function is for

CYP and their families with developmental and/or neurodevelopmental concerns or disabilities

How the function is accessed

Core team "steps-up" to specialist pathways as required. Also can be accessed directly for advice and assessments by primary care, health visitors and school nursing

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, family homes, school and CCs, acute wards	9-5 Mon-Fri for routine support with flexibility; out of hours provided by core team	2 weeks	As required

Integration with wider health and care system

Teams work at borough level and need to work closely social care and education. They also need to link in the early intervention (universal) community health offer and universal /targeted services.

Teams undertake assessment of children undergoing Statutory Assessment for SEN needs.

Also work with wider professional network supporting CYP and their families including early help, school and CC staff, acute paediatrics and primary care.

Draft specifications

CYP

Contains national requirement targets

Specialist offer care function:	CYP Disability and Complex Needs MDT Pathways: School Age

Overview

Description of the care function

Specialist multi-disciplinary health pathways for disabled CYP and their families and/or for those with complex LD, autism and/or behavior that challenges. Based predominantly in schools or closely integrated with education and social care for this group:

- Provide advice, guidance and training to schools, primary care and other services
- Provide specialist joined up multi-disciplinary assessment and review plus interventions
- Develop, implement and monitor health input into Education, Health and Care plans including a single Health outcomes-based support plan
- Facilitate specialist structured education, and self management programmes, peer support programmes and psychoeducation
- Support the emotional and physical wellbeing of CYP and their families

Capabilities required

Specialist school nurses paediatricians, therapists (physios, OTs, dieticians, SLT), CAMHS clinicians /LD &MH nurses

Who the care function is for

CYP and their families with developmental and/or neurodevelopmental concerns or disabilities

How the function is accessed

Core team "steps-up" to specialist pathways as required. Also can be accessed directly for advice and assessments by primary care, health visitors and school nursing

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Schools, community clinics, family homes	9-5 Mon-Fri for routine support with flexibility; out of hours provided by core team	2 weeks	As required

Integration with wider health and care system

Integrated health Teams work at borough level and need to work closely with education and social care and to support transition into adult services. They also need to link in the early intervention (universal) community health offer and universal services. Also work with wider professional network supporting CYP and their families including early help, school and CC staff, acute paediatrics and primary care.

Draft specifications

CYP

Contains national requirement targets

Specialist offer care function:	Paediatric Integrated Care MDTs

Overview

Description of the care function

Locality based multi-disciplinary working arrangements that specifically guide cases where needs are complex or in need of multi-agency input. Bridges physical, mental health, education and social care needs. This is a multi-professional and multi-agency meeting that provides advice and guidance. The team shape care and support plans and meet (can meet virtually) to discuss specific cases.

Each case should have case management and coordination to ensure the individual has access to the right services.

Capabilities required

MDT of professionals from Primary Care, MH, CH, social care and acute services as required

Who the care function is for

Individuals with complex needs defined as a range of needs rather than a number of conditions. Needs can be across MH, CH, social, environment, disability

How the function is accessed

Primary care, social care and acute services can all refer via central point of access.

Active case finding

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Face-to-face or virtual	MDT meet daily to discuss cases	Within 1 week of referral	Ongoing care as required

Integration with wider health and care system

This is an integrated multi-agency service from across MH, CH, schools, CYP social care, primary care and acute services.

Should link in with VCS, police, YOT and other services as required

Draft specifications

Contains national requirement targets

Specialist offer care function: **Hospital at home (Specialist community health pathway)**

Overview

Description of the care function

Enhanced nursing model embedded within existing Children's community nursing team. It supports both hospital avoidance and more effective and speedier discharge into the community across a range of conditions by providing acute care at home

This involves home based acute care delivered by children's nurses with acute paediatrician supervision. It includes support and education for families to enable them to support care provision

Capabilities required

Advanced nurse practitioners with advanced assessment skills, who can take bloods, cannulate and give IV antibiotics, Acute paediatrician supervision.

Who the care function is for

CYP at high risk of requiring hospital admission who can be managed at home as an alternative to hospital

How the function is accessed

Referrals from primary care, paediatric A+E, rapid access paediatrics and inpatients

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Face to face in CYP's home Or other community venue	8am-10pm 7 days/week	2 hours (*as per LTP targets)*	Daily MDT case discussion and home CYP review up to 3 /day. Support patients for up to 1 week

Integration with wider health and care system

Daily working relationship with rapid access paediatrics, paediatric A+E and inpatient wards, Midwives and other children's community nursing services and continuing health care teams.

Liaison as required with CYP's GP practice and regular communication with GP.

Working relationship with CYP social care, early help, therapies, Continuing Care, community paediatrics, palliative care and General Practice.

Draft specifications

Contains national requirement targets

Specialist offer care function:	CYP End of life and hospice care (Specialist community health pathway)

Overview

Description of the care function

- Symptom management support, holistic support, pre and post bereavement support to parents and siblings, anticipatory care planning, support for families
- Provides families with choice of provision. This includes:
- Hospice at home care which involves MDT provision of care within patient's home including support for family, play and work with siblings
- Bedded hospice care provides intensive symptomatic support and care to patients and their family on palliative care pathways. This includes provision of respite care and family facilities.
- Equipment loans
- Therapeutic and holistic support for children with life limiting illnesses and end of life care needs (located in Barnet children's hospice)

Capabilities required

Can administer IVs and prescribe controlled drugs, set up syringe drivers; palliative care consultant supervision, therapy, psychology and social worker input, CHC assessor

Who the care function is for

CYP with life threatening conditions where curative treatment may fail, CYP where premature death is inevitable, those with progressive or severe non progressive conditions

How the function is accessed

Primary care, CYP community nurses and acute inpatient and outpatient services can phone for advice and support and to make referrals. Also accessed via central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
CYP's home, hospices, support on acute and wards, or other community venue	8am-8pm 7 days/week for advice and visiting. Out of hours provision 8pm-8am Hospice beds 24/7	Two hour response for urgent referrals, 7 day non urgent	2 hour response for urgent escalations

Integration with wider health and care system

Available for advice, support and provision of training to primary care, CYP community nurses, acute services and care homes

Dedicated contact for each primary care network with team for each borough

Involve primary care in anticipatory care planning

Close relationships with non-NHS funded hospice and community end of life care and play and bereavement specialists enabling involvement at earliest opportunity

Close working relationships with equipment services and pharmacies. Need to have access to input from therapies

Working age adult

Draft core offer outline – Working age adults Community Health

Care and support to service users and their families / carers

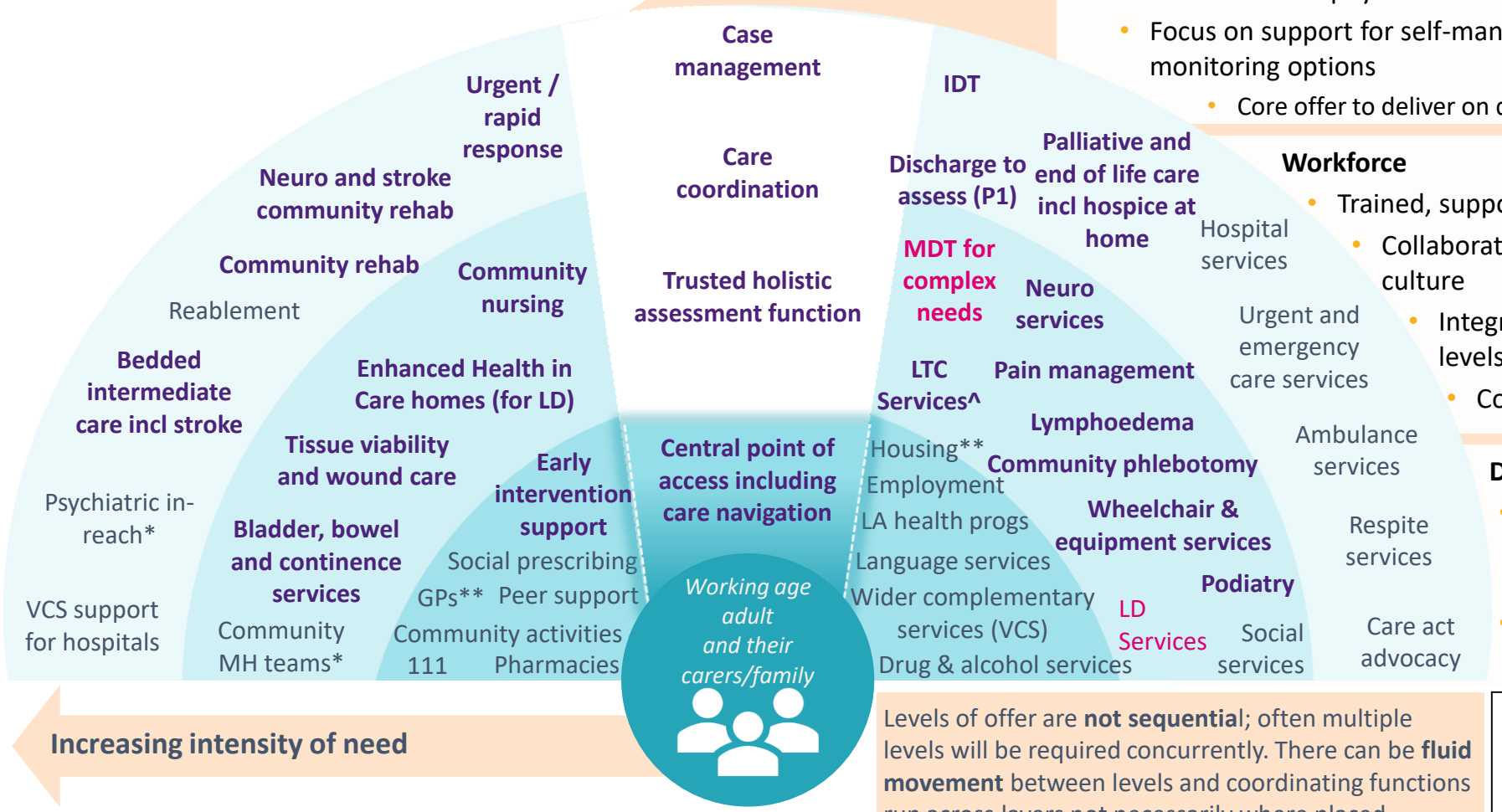
- Shared decision making and care and support planning
- No wrong door for support - Services sensitive to cultural and other demographic factors that impact on how individuals prefer to access care
- Focus on early-intervention and **anticipatory care**
- Clear link between physical and mental health and wellbeing
  - Focus on support for self-management of LTC with remote monitoring options
    - Core offer to deliver on desired outcomes for residents

Workforce

- Trained, supported and developed workforce
  - Collaborative working and a shared culture
    - Integration between services across levels
      - Co-location where appropriate

Digital

- Patient records should be integrated, shared with read/write access
- NCL wide digital early intervention offer



Increasing intensity of need

Levels of offer are **not sequentia**l; often multiple levels will be required concurrently. There can be **fluid movement** between levels and coordinating functions run across layers not necessarily where placed.

Purple = care functions of core offer in scope of community health services strategic review
Pink = multi-agency function

^Details for management of specific LTCs are shown in subsequent slides

**Housing including homelessness services
***GPs and broader primary care team including extended roles

In the following specifications, the term ‘housebound’ for service users refers to the draft definition set out below

This draft **definition of ‘temporary housebound’ guidelines** aims to ensure that community nurses teams are providing routine clinical appointments in the home setting only when it is appropriate. It is acknowledged that an individual’s needs may change and therefore eligibility for a home visit should be reassessed on a regular basis.

If patients meet the criteria set out below they are eligible for a home visit for routine treatment:

- A patient is unable to leave their home due to physical or psychological illness
- Post-operative patients who are temporarily unfit to travel
- Patients who require palliative care – this is irrespective of mobility status as it is appropriate for these patients to have care delivered within their home.
- Patients who are undergoing chemotherapy, radiotherapy or who have a health condition where travel or attendance at a community clinic would be detrimental to their health or recovery.
- Patients defined as ‘transport housebound’ - either permanently or temporarily are unable to leave their home unaccompanied to complete purposeful tasks.
- For those patients temporarily housebound, there will be an expectation that once mobile, they will be discharged from service and referred back to GP Practice team should on-going care be required.
- In exceptional cases, receiving teams may use discretion where a patient is assessed as unlikely to engage in any other form of health care. This will need senior approval and be closely monitored.

An individual will generally not be eligible for a home visit if they **are able to leave** their home environment on their own or with minimal assistance to visit public or social recreational public services (including shopping).
Wherever possible patients are encouraged to attend local community venues for their care.

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **Early intervention support**

Overview

Description of the care function

Support for staff in community centres, alternative provision and the community which enables early identification and support for individuals and their families / carers with developmental and health difficulties. Involves:

- Training, advice and support delivered by community nursing and therapies team for staff which enables them to better identify and support individuals and families / carers at an earlier stage
- Delivery of short time-bound therapeutic interventions in these settings to support these individuals and their families / carers
- Facilitation of peer support groups and support to self manage health and outcomes, supported by psychology/counselling input where needed

Capabilities required

MDT of community nurses and therapists (physios, OTs, dieticians, SLT)

Health trainers, psychology

Who the care function is for

Adults and their families / carers with early health and developmental difficulties and the universal staff supporting them

How the function is accessed

Early intervention MDT allocated at a PCN footprint

Adults and their families / carers can also self refer

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community centres, service users' home, places of work and study, virtual/ telephone advice	Mon-Fri 9-5 with some flexibility for training and support	1 week response	As required

Integration with wider health and care system

Early intervention team provides support and training to universal professionals across Community Centres, alternative provision and other venues as required.

It links into core targeted community and therapies support and specialist pathways as required removing need for formal referral.

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **Community/District nursing**

Overview

Description of the care function

Provide 24 hour care to housebound* patients including routine bladder and bowel care, wound care including post surgical wound care, pressure ulcers and leg ulcers, LTC management, IV and controlled drug administration. Provide support for families and carers alongside formal care workers to maintain independence and unnecessary prevent hospital admission.

To provide specialist clinics for leg ulcer care for ambulatory and non ambulatory patients (exact cohort to be defined).

Supported by specialist input from other community services (e.g. bowel and bladder services and tissue viability) as required

On the assumption that national funding is agreed ; to provide vaccinations to 'housebound patients and those living in a care homes

Capabilities required

Leg and Pressure Ulcer Care, Wound care, PEG and NG management. Phlebotomy, Palliative care, syringe drivers, Catheterisation, give IV antibiotics, administer controlled drugs, skill mix needs development with NMPs and ACPs to provide accountability & continuity 24/7

Who the care function is for

Over 18 housebound patients and ambulatory patients with leg ulcers (cohort to be defined)

How the function is accessed

Primary care referrals, referrals from other community services, referrals from intermediate care via integrated discharge team.

Linked into central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Service user's home Including Care Homes and in hostels and other homeless accommodation. Leg Ulcer Clinics	24/7 Ambulatory Leg Ulcer Clinics 9-5 Mon - Fri	Within 48 hours prioritised on need	As by clinical assessment and care plan

Integration with wider health and care system

Aligned to geographical localities. Work alongside primary care and practice/PCN extended roles with expectation of named point of contact in team for each GP practice.

Close working relationship with specialist nursing, palliative care and other community health services, community beds, adult social care and community Mental Health Services as well as the voluntary sector.

Work closely with acute services in particular, elderly care wards.

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **Enhanced health in care homes (EHCH)**

Overview

Description of the care function

- Community service contribution to EHCH requirements as per national specification and NCL May'20 model of care
- The focus is on anticipatory and proactive care provision to prevent acute deteriorations
- When residents are deteriorating the team is able to quickly assess these patients and provide appropriate support to avoid them requiring hospital admission
- When residents do require hospital admission, the EHCH team works with the IDT, intermediate care and the care home to support speedy discharge back to their place of residence
- Support for holistic end of life care for care home residents
- Support care home staff through training and specialist advice

Capabilities required

Community nursing (including providing trusted assessment, enhanced wound care and tissue viability), PT and OT input, end of life care input, geriatrician and psychiatry input

Who the care function is for

CQC registered Care home residents

This includes working age adults with learning disabilities, mental health conditions an/or substance misuse

How the function is accessed

Care homes each have a dedicated EHCH team which includes community health staff in MDT. Care home residents are proactively reviewed

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
In CQC Registered Care homes	Core offer Mon-Sun 8- 8 (with flexibility). 24/7 out of hours provision including therapies to be provided by Rapid Response if required.	On-call geriatrician Within 7 days of discharge/ admission for proactive care	As clinically required

Integration with wider health and care system

EHCH for each care home is led by the local primary care network (PCN) with contribution from community nursing and therapies to the MDT with named nursing and therapy clinical leads for each care home.

EHCH Teams works closely with wider community and mental health services including LD, rapid response, IDT and intermediate care, core and specialist mental health teams (including dementia and memory loss) and adult social care.

Draft specifications

CYP | Working age adult | Older person | Contains national requirement targets

Core offer care function: Equipment, wheelchairs and orthotics

Overview

Description of the care function

Community Equipment covers a range of items that are provided in people's homes to support independence. It includes commodes, hoists, grab rails and other items.

The service does not have hours of operation, but is rather contracted to deliver equipment within specified timeframes, e.g. 1-7 days, depending on the urgency of the request.

Wheelchair

Clinic and home assessments of CYP and adults with ongoing disabilities.

Equipment and Orthotics

Functional assessment of CYP and adult with short term and ongoing disabilities. Assessment and provision of equipment and wheelchairs and implementation of required home adaptations. Support and training to use equipment. Regular review of changing needs. Includes orthotic assessment of CYP and adults with disability and provision of appropriate orthoses

Capabilities required

OTs, physiotherapists, rehab engineers, rehab/therapy assistants, orthotists, podiatrists and prosthetists

Who the care function is for

CYP and adults with disability

How the function is accessed

Community health services, social care practitioners, education facilities rehab facilities, care homes and supported environments, acutes and primary care can access service for patients

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community, clinic and care homes. Able to deliver to patient homes	**Urgent Equipment** 7 day service **Wheelchair and orthotics** 9-5 Mon-Fri out of hours emergency repair service 7 days	Same day for urgent referrals (excluding orthotics) Rest dependent on service and level of need	Reflecting individual pathways and care plans

Integration with wider health and care system

Works alongside all community, acute, social care VCS and primary care services. Also links to IDTs, rapid discharge and palliative care services

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **Community health support Long Term Condition management (general requirements for LTCs)**

Overview

Description of the care function

Expectation that Long term care management is mostly led by primary care. Specialist community care LTC services supports those patients with complex needs:

- Provide advice and guidance to primary care and other services
- Provide specialist holistic assessment and support care planning
- Provide specialist therapeutic support when required
- Facilitate specialist structured education and self management programmes, peer support programmes and psychoeducation to support patients/families/carers to be more empowered in their own health management / health outcomes, including psychology and counselling input where needed
- Maximise delivery of care to patients home through remote monitoring

PIFU: Patient initiated follow-up (PIFU) is giving patients and their carers the flexibility to arrange their follow-up appointments as and when they need them. PIFU can be used with patients with long or short-term conditions and following treatment or surgery. Patients get care and support when they need it, whilst avoiding unnecessary trips to hospitals and clinics, saving them time, money and stress.

Capabilities required

Specialist competencies for each long term condition. Psychology and occupational therapy in each team. Trained to deliver self management programmes, physiotherapy where appropriate

Who the care function is for

Patients with long term conditions. Support is both for patients and for the primary care professionals specifically looking after them

How the function is accessed

Primary care and district nurse referral. Referral from acute services

Self referral and patient initiated follow up are vital

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, leisure facilities, service users' homes and places of work/study, virtual or face to face	9-5 Mon-Fri for routine support with flexibility; out of hours provided by district nursing and 111	2 weeks	2 weeks for follow up or as clinically required Patient initiated follow up

Integration with wider health and care system

Provide specialist advice and input to primary care without a formal referral being required.

Provide advice, training and support to district nursing and acute services.

Closer working relationship with equipment, orthotics and dietetics as required.

Contribute to complex care and frailty MDTs as required.

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **Diabetes (LTC management)**

Overview

Description of the care function

Specialist community diabetic support for adult patients which enables development of enhanced self care and management. Includes 1-1 clinic appointments, home visits and group education sessions.

Support the use of technology to help patients manage their condition

Capabilities required

Specialist diabetic and podiatry nurse competencies, clinical psychology input who can carry out assessments and deliver short term psychoeducation; delivery of DESMOND

Who the care function is for

Adults diagnosed with Type 1 and 2 diabetes who require support beyond that provided by primary care

How the function is accessed

Via primary care (via central point of access) and diabetic clinic. Patient initiated follow up

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, leisure facilities, service users' homes and places of work/study, virtual or face to face	9-5 Mon-Fri. with some flexibility to meet needs of patients and families	Same day for advice to primary care; two weeks for initial patient contact	Four week follow up Patient initiated follow up

Integration with wider health and care system

Integrated with acute diabetic clinics; available for advice and support to primary care, community nursing, other community health services. Contributes when required to complex care MDTs

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **Musculoskeletal (LTC management)**

Overview

Description of the care function

Assessment of treatment of a range of musculoskeletal disorders. Includes both urgent and routine provision. Includes specialist MDT support for complex musculoskeletal disorders. Work with podiatry as necessary
Enhanced clinical triage to minimize inappropriate referral into secondary care MSK services
Includes specialist MDT support for complex musculoskeletal disorders e.g. Spinal, Rheumatology and Pain
Support the use of technology to help patients manage their condition and support the use of technology to help patients manage their condition

Capabilities required

Specialist musculoskeletal physiotherapists and MSK Advance Practice Physiotherapists; clinical psychology input for MSK Pain Management Programme *(NICE requirement)*

Who the care function is for

Adults with musculoskeletal disorders

How the function is accessed

Via primary care and and acute MSK clinics. Patient initiated follow up

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, leisure facilities, service users' homes and places of work/study, virtual or face to face	8-6 Mon-Fri with some flexibility;	Same day for advice to primary care; 2 weeks for initial contact for urgent. 6 weeks for routine	As clinically indicated Patient initiated follow up

Integration with wider health and care system

- Works closely with all secondary care MSK services incl pain management, Orthopaedics and Rheumatology
- Enhanced clinical triage to minimize inappropriate referral into secondary care MSK services
- Links to falls service
- Provides advice and support and works with podiatry services
- Promotes self care for MSK disorders
- Appropriate use of diagnostic testing eg MRI , blood tests for MSK disorders

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **Heart failure and cardiac rehabilitation (LTC management)**

Overview

Description of the care function

Provision of short term rehabilitation support and education to patients recovering from heart attacks and cardiac surgery.

Support for chronic management of heart failure. This includes support to self manage, anticipatory care planning and support for families and carers.

Includes mental health assessment and support for heart failure patients

Provide advice and education to other community health services and primary care

Capabilities required

Cardiac nurse specialist

Physio

Clinical psychologist

Who the care function is for

Adults who have suffered acute myocardial event and those with heart failure

How the function is accessed

Via acute services, via primary care and district nursing

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Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Acute wards, service users' Community clinics, leisure facilities, service users' homes and places of work/study, virtual or face to face	9-5 Mon-Fri with some flexibility to meet needs of patients and carers	Meet national target that 85% of eligible patients received support 2 day response	Up to daily review as required to support cardiac rehab in the community; Patient initiated follow up

Integration with wider health and care system

Daily working relationship with acute inpatient wards and cardiology outpatients.

Work alongside community nursing, rapid response and intermediate care. Work closely alongside palliative care and are involved in anticipatory care planning

Provide advice and support to primary care

Contribute to complex care MDT discussions

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Respiratory service (LTC management)

Overview

Description of the care function

Provision of specialist support, education, co-ordination of care and treatment to optimise quality of life and functioning for adults with chronic respiratory disease and to promote self management.

Support for respiratory rehabilitation.

Provision of spirometry and lung function tests.

Home oxygen service.

Support the use of technology to help patients manage their condition

Capabilities required

Respiratory nurse specialist

Physio

Clinical psychologist

Respiratory physiologist

Who the care function is for

Adults with COPD, asthma and other chronic respiratory conditions where there is functional impairment

How the function is accessed

Via acute services, via primary care (via central point of access) and community nursing

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Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Acute wards, service users' Community clinics, leisure facilities, service users' homes and places of work/study, virtual or face to face	9-5 Mon-Fri with some flexibility to meet needs of patients and carers	2 weeks for urgent referrals 4 weeks for non urgent spirometry	Up to weekly review as required Patient initiated follow up

Integration with wider health and care system

Daily working relationship with acute inpatient wards and respiratory outpatients.

Work alongside district nursing, rapid response and intermediate care

Provide advice and support to primary care

Work closely alongside palliative care and are involved in anticipatory care planning

Contribute to complex care MDT discussions

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **Post-Covid (LTC management)**

Overview

Description of the care function

Unique integrated rehabilitation pathway for individuals with post-COVID 19 syndrome (aligned to NHS England five-point plan, national guidance April'21). Service delivers comprehensive medical assessment and rehabilitation interventions for patients in the community. The service consists of a specialist MDT, community nursing and supports development of self-management.

The team treats not only individuals discharged from hospital but also those in the community who did not require inpatient care. Support the use of technology to help patients manage their condition

Capabilities required

Online resources for self management, MDT consisting of PTs, OTs (including neuro OTs), specialist consultants as required, respiratory nurses and dieticians

Who the care function is for

Adults with a set of persistent physical, cognitive and/or psychological symptoms that continue for over 12 weeks after COVID and are not explained by an alternative diagnosis.

How the function is accessed

Primary care, social care and acute services can all refer via central point of access.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, service users' own home, place of work/study, face to face and virtual	9-5pm Mon-Fri with some flexibility of hours	1 week	As clinically required Patient initiated follow up

Integration with wider health and care system

Team works alongside wider professional network to support service users and their families / carers including social care, acute and primary care as well as any other specialist services (e.g. Respiratory LTC service).

Service works closely with IAPT offers including an IAPT presence at every specialist MDT to triage patients and offer advice and assessment.

NCL has a system wide vocational rehabilitation offer provided by the RFH specialist team.

Draft specifications

CYP | Working age adult | Older person | Contains national requirement targets

Core offer care function: **MDT for complex needs – Anticipatory care (read in conjunction with Frailty; EoLC)**

Overview

Description of the care function

Locality based MDT that specifically manages identified cases with complex needs cases and bridges physical, mental health, dementia, end of life, housing and social care needs. This is a multi-professional and multi-agency team that holds the most complex individuals. The team agree care and support plans and meet daily (can meet virtually) to discuss specific cases. Team able to use technology to support virtual MDT's and ensure availability of shared records.

The team complete a care needs assessment and care and support plans and meet regularly (can meet virtually) to discuss specific cases.

Each complex needs case should have case management and coordination to ensure the individual has access to the right services.

Capabilities required

MDT of professionals from MH, CH, social care and acute services as required

Who the care function is for

Individuals with complex needs defined as a range of needs rather than a number of conditions. Needs can be across MH, CH, social, environment, dementia, disability

How the function is accessed

Primary care, social care and acute services can all refer via central point of access.

Active case finding

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Face-to-face or virtual	MDT meet daily to discuss cases	Within 1 week of referral	Ongoing care as required

Integration with wider health and care system

Integrated care partnership will be key to ensure a single borough plan and to enable delivery.

This is an integrated multi-agency service from across MH, CH, social care and acute services.

Should link in with primary care, VCS, police and other services as required (for example housing and safeguarding).

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **Community phlebotomy**

Overview

Description of the care function

Provision of phlebotomy service for housebound patients for diagnostic testing and monitoring purposes

Additionally, provision of phlebotomy service to support other community health care functions including rapid response and intermediate care

Capabilities required

Phlebotomists

Who the care function is for

Housebound patients

Patients under care of other care functions of community health offer

How the function is accessed

Accessible from primary care, other community health services and has regular sessions on community bedded wards. Integrated part of enhanced health in care homes team

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Patients' homes, care homes	9-5 Mon-Sun with some flexibility to meet service and patient needs	Same day availability	N/a

Integration with wider health and care system

Integrates with other care functions of community health offer; works alongside primary care with identified contact for each PCN and for each enhanced health in care homes team

Key care function of intermediate care teams and rapid response

It is anticipated that phlebotomy for care home patients will be provided by trained care home staff.

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **Podiatry**

Overview

Description of the care function

The podiatry service provides assessment, diagnosis, advice, treatment and referral for a wide range of foot conditions although the expectation is that most patients will have high risk Type 1 diabetes. Nail cutting is only provided for patients with high risk foot conditions (eg sensation loss and reduced circulation

Supports individuals with compromised tissue viability associated with vascular disorders, diabetes and other underlying medical conditions that affect their feet, and support wound management.

Works closely as part of the Diabetes team given interface with management of diabetic patients.

Service users and their families and carers trained and supported to actively participate in the management of their condition.

Capabilities required

Podiatrists and foot care assistants

Who the care function is for

Adults requiring assessment, treatment and advice on foot conditions.

How the function is accessed

Referral through central point of access by GP or other health professional. Can also be through self-referral

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics or in service user's home if house-bound	9-5 Mon-Fri with some flexibility	New patients within 4 weeks Urgent referrals within 1 week	As required up to twice weekly review

Integration with wider health and care system

Provide expert advice and support to primary care, community nurses, and other specialist services including diabetes, MSK and AHPs.

Integration with orthotics services.

Direct referral for podiatric surgery as required

Support acute hospitals with ward in-reach for high risk podiatry referrals

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Bladder and bowel and continence services

Overview

Description of the care function

Range of advice and support to help people self-manage complex continence issues and remain independent.

Support when necessary to adapt and modify their lifestyles to adjust to increasing dependence.

Provide advice, guidance and training to community nurses and primary care. Provide support and education to families, carers and nursing home staff.

Continence Nurse specialists can be contacted directly by patients for ongoing advice/support.

Capabilities required

Continence nurse specialists

Catheterisation

MDT as required with continence nurses, nephrologist, urologists, gastroenterologist etc.

Who the care function is for

Adults with complex continence issues who need additional support beyond that provided by community nurses

How the function is accessed

Can be contacted for support by community nurses, intermediate care, primary care and EHCH team as well as self-referrals; via central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinics, telephone advice, patients homes and nursing homes	9-5 Mon-Fri with some flexibility	1 week for urgent 6 weeks if routine	As required up to twice weekly review or as clinically required

Integration with wider health and care system

Provided expert advice and support to primary care, community nurses, intermediate care team and enhanced health in nursing homes team

Provides advice and support when required to reablement and other social care teams

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **Neurology community services**

Overview

Description of the care function

Specialist holistic community support for patients with chronic and acute on chronic onset neurological conditions. This includes multiple sclerosis, Parkinson's disease and epilepsy. Provision of evidence based interventions to support self care and management, improve functioning, support vocational rehabilitation and improve emotional wellbeing. Includes support for families and their carers.

Works alongside primary care, district nursing and community rehabilitation and where necessary brings in other community health expertise

Facilitates expert patient programmes and peer support groups

Capabilities required

Nurse specialists

Occupational and Physiotherapists

Clinical psychologist

Who the care function is for

Adults with active onset neurological conditions

How the function is accessed

Via primary care (via central point of access) and neurology clinic

Utilises patient initiated follow up

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinic face to face, telephone / virtual support; in patients home where necessary	9-5 Mon-Fri with some flexibility around patients needs	1 week for initial urgent reviews; otherwise 4 weeks	As required but up to weekly review

Integration with wider health and care system

Works closely with Community Rehabilitation Services, community nursing and primary care

Contribute to complex care MDTs as required and provide assessments to support social care reviews as required

PCS services will review on for specialist input from neurological teams when required.

Draft specifications

Working age adult | Older person | Contains national requirement targets

Please note: this draft spec is under review.

Core offer care function: Lymphoedema

Overview

Description of the care function

Assessment and treatment of patients with lymphoedema whether this is the primary problem of related to underlying cancer, infection or other cause

Support and education for patients and their carers to support self management of their condition.

Advice and support for other healthcare professionals and care home staff on how to manage and support patients with lymphoedema

Capabilities required

Lymphoedema nurse specialists

Who the care function is for

Patients with primary or secondary lymphoedema

How the function is accessed

Via acute services, district nursing or primary care

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
In hospital clinics and on wards; remotely via phone; in patients homes as required	Mon-Fri 9-5 with some flexibility to meet needs of patients and their families	Palliative: 10 days Cancer: 6 weeks Non-cancer: 8 weeks	As required but up to daily review

Integration with wider health and care system

Advise and support community nursing nursing, intermediate care teams, palliative care and primary care as required. Input to enhanced health in care home teams as required. Work closely alongside tissue viability service

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **Pain management**

Overview

Description of the care function

AHP-led multidisciplinary service. Advice provided by both acute and community clinicians, offering guidance and treatment for patients with persistent pain in the community. The service conducts assessments of a patient and co-produces a pain management plan. This could include the provision of medical interventions e.g. spinal injections, exercise and psychological interventions. Where possible, the service empowers patients to self manage their pain.

Capabilities required

Pain consultant competencies, advanced Physiotherapy pain specialists and clinical psychologists, substance misuse nurses, physiotherapists, pharmacists and IAPT practitioners

Who the care function is for

Patients with persistent or recurrent pain not adequately managed in primary care with significant distress or functional impairment

How the function is accessed

Primary care, LTC services and acute services, including MH services, can engage service for advice and support and can refer patients for review

Patient initiated follow up as appropriate.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Telephone/ virtual advice and support, community clinic, MH ward reviews.	9-5 Mon-Fri with some flexibility.	Within a week for most urgent; otherwise 1 month	Routine or regular review within 2 months and/or patient initiated follow-up as appropriate

Integration with wider health and care system

Advises and supports primary care to prevent need for referral to specialist pain management services. Also advises and supports other community teams, such as long term condition services.

Contributes to MDT with Pain Management consultants in secondary care and to complex care MDTs as required.

Also offers advice and support to clinicians in other acute specialties and on inpatient MH wards.

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Tissue viability and wound management

Overview

Description of the care function

Provide specialist advice and support to health care professionals on the management of patients who are at risk of developing or have chronic wounds, including assessment, developing a management plan and delivering first treatment if necessary.

Chronic wounds may include post surgical wounds, leg ulcers and pressure ulcers. Provide specialist advice for the management of wounds associated with diabetes and/or vascular disease.

Provide specialist advice on the management of complex wounds and specialist clinics for complex ambulant patients.

Provide education and training for staff in the community and mental health trusts, practice nurses, nursing homes staff and carers.

Provision of advanced wound care treatment such as debridement and negative pressure in the community reducing unnecessary hospital admission.

Capabilities required

Assessment, first treatment if needed and care plan for complex wounds. Utilisation of specialist dressing and treatments, Training to other professionals.

Who the care function is for

Adults with complex wounds who live at home or homeless accommodation (including rough sleepers), live in care homes or are in-patients in a Mental Health ward or community beds.

How the function is accessed

Primary Care, other CH services, end of life care and acute services, including MH, can ask for advice & guidance and assessment, a management plan and direct highly specialised care from a TV nurse.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Remote advice and guidance; patients' homes, including care homes MH wards, GP practices or other settings e.g. homeless hostels	9-5 Mon-Fri with some flexibility	1 day for urgent reviews	As per clinical assessment

Integration with wider health and care system

Provide advice, support and guidance to community nurses, primary care, physical and mental health acute ward teams, extended PCN roles, diabetic specialist nurses, nutrition and dietetics teams.

There will be a clear pathway to and from Tissue viability services for patients with chronic wounds. Clinical staff with responsibility for ongoing management of the patient's wound will be supported to develop the appropriate competencies and skills level.

There will be clarity about levels of specialism, skills and responsibility expected across the system, including for TV nurses, for delivering wound care management

Link in with equipment and wheelchair team, and podiatry teams as required.

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **Integrated discharge Team (IDT)**

Overview

Description of the care function

The community component of the Integrated Discharge Team provides the operational leadership for the IDT and a proportion of the case managers. The role of the team is to be fully integrated with the hospital discharge team enabling:

Early identification of people at risk of discharge delay

Case management to mitigate those risks

Same Day Discharge

Home First Ethos

Case Management post discharge to optimise recovery and independence

Capabilities required

Proactive case manager

Who the care function is for

Adults requiring support to enable them to be discharged home (P1), to recovery/rehab beds (P2) or to long term residential care (P3)

How the function is accessed

Hospital staff identifying that someone is a risk for discharge.

Hospital staff completing NCL Discharge Referral Form within 1-2 hours of becoming Medically optimised

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Whilst people are in hospital At the point of discharge At home until Care Act/CHC Assessment completed	Mon-Sat 08:00-18:00 Sun 08:00-13:00 Ability to flex up to max 08:00-20:00	Daily review of patients who are clinically safe to discharge at ward board round	P1 Assessment same/next day P2 participating in discharge planning from unit

Integration with wider health and care system

Daily working relationship Acute Complex discharge team, D2A resources, CHC, LA brokerage, VCS,

Close working relationship with other IDTs, housing, homeless services, equipment services

*Close working relationship with social care partners to ensure an aligned and integrated seamless service for local residents

Daily working relationship Acute Complex discharge team, D2A resources, CHC, LA brokerage, CIC VCS. This includes complex pathways such as delirium, braces and NWB, which are under review across NCL for alignment.

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Rapid response/Urgent Response

Overview

Description of the care function

Rapid holistic assessment of patients experiencing a deterioration of health and wellbeing and at risk of hospital admission within the next 2-48 hours. The MDT will develop a personalised care plan and provide a seamless offer that typically involves elements such as nursing, emergency care from a paramedic and functional therapeutic support to prevent avoidable admissions. The service will aim to optimise independence and confidence, enable recovery and prevent a decline in functional ability. All services will meet the 'Community health services two-hour crisis response standard guidance' and NICE Guideline NG74.

Capabilities required

GP, geriatrician, nursing, physio, OT, and health and care support staff. Ability to administer IV antibiotics, prescribe, deliver point of care testing and arrange access to packages of care.

Who the care function is for

Adult (+18) resident in NCL (or within a mile with NCL GP) experiencing a crisis (sudden deterioration in a person's health and wellbeing) and **at risk of hospital admission** within the following 2-to-48-hour period. The adult does not have to be housebound to be eligible.

How the function is accessed

Via a single point of access with referrals from GPs, NHS 111, A&E/SDEC, frailty units, ambulance services, self-referral, carer referral or care homes.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Usual place of residents (home or care home)	24/7 7 days a week by 2024 for 2hr UCR response	2 hour for urgent needs; up to 1 day for non urgent.	Daily MDT case discussion and in person or virtual patient review. Short-term intervention based on the treatment plan.

Integration with wider health and care system

Full alignment with:

- Access to range of community services available in the borough
- Unplanned care programmes eg. NHS111, UTCs, Same Day Emergency Care and 999 Crisis response care
- Primary care such as GP out of hours, GPs and PCNs.
- IDT

Closer relationship with services that will be required to provide ongoing support for patients including adult and older adult mental health services, proactive care services, community nursing teams, core and specialist community services, social care* and reablement services.

**Close working with adult social care partners to ensure an aligned and integrated seamless care for resident.*

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **Discharge to Assess Pathway 1**

Overview

Description of the care function

Delivery of immediate support following discharge on day medically optimized

Provides a holistic assessment of need and determines the appropriate level of recovery or reablement care required to support someone safely at home.

Ensures appropriate equipment is in place and safe to use

Resolves any issues that emerge once home

Tweaks care plan and equipment over time to fit level of need

Identifies point where patient has recovered from hospital stay and is ready to be assessed for long term care if required

Capabilities required

Occupational therapists
Physiotherapists
Pharmacy assistant
Rehabilitation Assistants
Social Care Practitioners*
Reablement providers*

Who the care function is for

People discharged from hospital who need support to be able to manage at home

How the function is accessed

Integrated Discharge Team will make referral to the SPA

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Patients' homes	8am-8pm 7 days a week	High risk within 2 hours of discharge Low risk- next day	Daily contact, often by telephone to monitor levels of care required

Integration with wider health and care system

Daily working relationship IDTs and wards, LA brokerage, VCS,

Close working relationship with other IDTs, housing, homeless services, equipment services

*Close working relationship with social care partners to ensure an aligned and integrated seamless service for local residents

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **Community rehabilitation**

Overview

Description of the care function

Intermediate, 6 weeks home-based care to improve or maintain independence. Provided consistently across NCL. This includes:

- To avoid hospital admission
- To continue rehabilitation after D2A P1 completed if required
- To enable a multidisciplinary approach to recovery, reablement or rehabilitation to enable optimal physical health and wellbeing (risk of admission not required)

Capabilities required

Community AHP including: Physiotherapy, OT, SLT, dieticians, podiatry. Clinical psychology, Social Care Practitioners*, Community Nursing, Pharmacists

Who the care function is for

Adults requiring home based prevention, rehabilitation, and care plans to optimise health and wellbeing. Consistent thresholds across NCL for P2 step-down

How the function is accessed

Referrals accepted from Pathway 1, primary care, adult social care and community based services

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
In patients' homes, place of work/study, remotely or face to face	08.00-18.00 with some flexibility 7 days/week	2 days, where appropriate	Defined by individual care plan

Integration with wider health and care system

Daily working relationship with reablement services, Integrated discharge teams (IDT), community nursing, primary care and acute care, rehabilitation facilities, neuro-navigators, frailty leads and PCNs . Contributes to broader MDT discussions

Close working relationship with rapid response/IDT teams regarding assessment of patients and appropriate handover.

*Close working relationship with social care partners to ensure an aligned and integrated seamless service for residents

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **Neuro and stroke community rehabilitation**

Overview

Description of the care function

Intermediate 12 week home-based care to improve or maintain independence. Provided consistently across NCL. This includes:

- To avoid hospital admission
- To provide Early Supported Discharge for Stroke
- To enable a multidisciplinary approach to neuro rehabilitation to enable optimal physical health and wellbeing (risk of admission not required)

Includes neurological conditions and stroke (e.g. MND, MS, PD, Huntington's, TBI) which meet national stroke standard requirements. This includes vocational rehabilitation.

Capabilities required

Community AHP including: Physiotherapy, OT, SLT, Clinical psychology, Social Care Practitioners*

Who the care function is for

Adults requiring home based rehabilitation, and care plans to optimise health and wellbeing. Consistent thresholds across NCL for P2 step-down

How the function is accessed

Referrals accepted from HASU, acute hospitals, neurorehabilitation facilities, primary care, adult social care and community based services

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
In patients' homes, place of work/study, remotely or face to face	08.00-18.00 with some flexibility 7 days/week	ESD same day discharge Urgent 1 week Routine 4 weeks	Defined by individual care plan

Integration with wider health and care system

Daily working relationship with reablement services, Integrated discharge teams (IDT), Hyper acute stroke units, community nursing, primary care and acute care, rehabilitation facilities, neuro-navigators, Community Neurological services, Palliative Care Services and PCNs . Contributes to MDT discussions

Close working relationship with HASU and rehabilitation units to ensure rapid handover and acceptance .

*Close working relationship with social care partners to ensure an aligned and integrated seamless service for residents

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: Bedded intermediate care incl stroke and neuro rehab (P2)

Overview

Description of the care function

Intermediate community based bedded care for up to 6 weeks to avoid hospital admission or to facilitate rehabilitation after discharge Includes specialist neuro and stroke rehabilitation beds.
Offers holistic specialist multidisciplinary assessments, evidence based interventions and supports homefirst approach. Incorporates self management approach early within rehabilitation pathway. Provides specialist signposting for patients with ongoing rehabilitation and disability management needs. Ensures patients have a Joint Care Plan at point of discharge.

Capabilities required

MDT - clinical frailty consultant, stroke and neuro consultants, geriatricians, psychology, rehabilitaion nurses, pharmacy, dietitian, SLT, physio, OT and activity coordinator Rehabilitation competencies including neuro rehab; ability to assess acutely deteriorating patient

Who the care function is for

Adults requiring bedded rehabilitation support to avoid hospital admission or to enable subsequent safe discharge with onward appropriate package of care where needed

How the function is accessed

Via Integrated Discharge Team; Rapid response team can also refer

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community bedded wards	24/7 nursing care with rehab therapeutic input 9-5 7 days/week	Same day response	Therapeutic rehab input up to twice daily/ 7 days/ week

Integration with wider health and care system

Daily working relationship with Reablement services, Integrated Discharge Teams (IDT), Community Nursing, non-bedded P1 Rehab Teams, Primary Care and Acute Care. Contributes to broader MDT discussions. Daily working relationship with residential transition and short term care beds as well as local care homes via enhanced health in care home teams (P3)

Close working relationship with Rapid Response team regarding assessment of patients and appropriate handover.

Close working with IDTS, care navigators, Specialist Nurses and AHP.

Mental health in-reach from MH teams – integration with MH core offer. Close working with Level 1 neuro rehab beds and other bedded care.

Draft specifications

Working age adult | Older person | Contains national requirement targets

Core offer care function: **End of life and hospice care**

Overview

Description of the care function

- Symptom management support, holistic support, pre and post bereavement support, anticipatory care planning, support for loved ones & carers
- Provision of hospice at home care which involves MDT provision of care within patient's home including support for family and carers
- Bedded hospice care provides intensive symptomatic support and terminal care to patients and their loved ones on palliative care pathways. This included provision of respite care

Capabilities required

Can administer IVs and prescribe controlled drugs, set up syringe drivers; palliative care consultant supervision, therapy, psychology and social worker input

Who the care function is for

Over 18s and loved ones when patient has life limiting illness or is at the end of their lives

How the function is accessed

Primary care, community nurses and acute inpatient and outpatient services can phone for advice and support and to make referrals

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Patients homes, hospices, support on acute and community wards	8am-8pm 7 days/week for advice and visiting. Out of hours provision 8pm-8am Hospice beds 24/7	Six hour response for urgent referrals, 7 day non urgent	2 hour response for urgent escalations

Integration with wider health and care system

Available for advice, support and provision of training to primary care, community nurses, acute services and care homes

Dedicated palliative care team for each borough with clear links to each PCN in the borough.

Anticipatory care planning done jointly with primary care

Close relationships with non NHS funded hospice and community end of life care

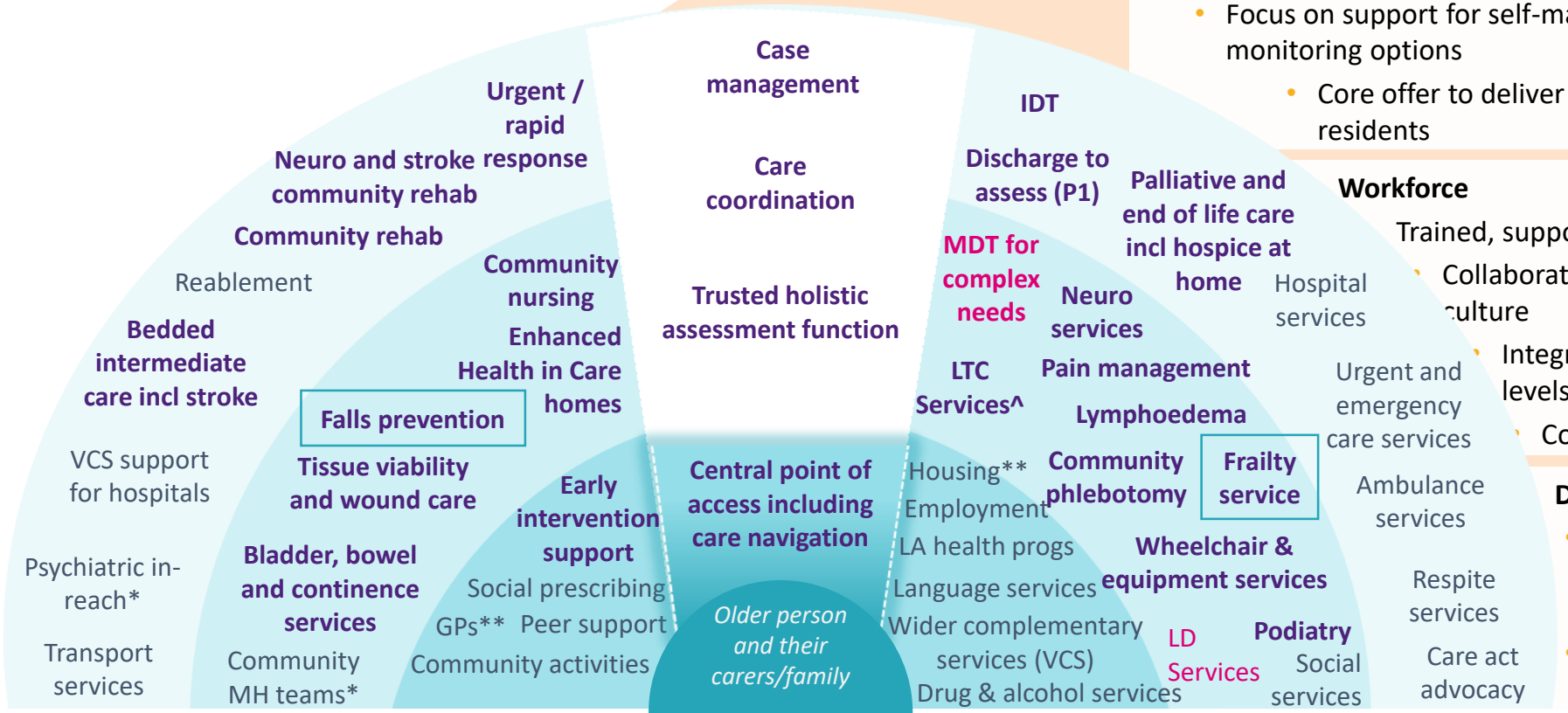
Close working relationships with equipment services and pharmacies. Need to have access to input from therapies

Every GP practice to hold EOLC MDT meetings with palliative care team and community nurses on a quarterly basis

Older people

Draft core offer outline – Older people Community Health

Description of care functions specific to older people follow this slide and are shown in the diagram below in boxes; other care functions are described within the working age adult offer



Increasing intensity of need

Levels of offer are **not sequential**; often multiple levels will be required concurrently. There can be **fluid movement** between levels and coordinating functions run across layers not necessarily where placed.

Purple = care functions of core offer in scope of community health services strategic review
Pink = multi-agency function

Care and support to service users and their families / carers

- Shared decision making and care and support planning
- No wrong door for support - Services sensitive to cultural and other demographic factors that impact on how individuals prefer to access care
- Focus on early-intervention and **anticipatory care**
- Clear link between physical and mental health and wellbeing
  - Focus on support for self-management of LTC with remote monitoring options
    - Core offer to deliver on desired outcomes for residents

Workforce

Trained, supported and developed workforce

- Collaborative working and a shared culture
- Integration between services across levels
- Co-location where appropriate

Digital

- Patient records should be integrated, shared with read/write access
- NCL wide digital early intervention offer

^Details for management of specific LTCs are shown in subsequent slides

**Housing including homelessness services
***GPs and broader primary care team including extended roles

Draft specifications

Older person

Contains national requirement targets

Core offer care function: Falls prevention

Overview

Description of the care function

Delivered as a standalone service or in partnership with local agencies, depending on patients' needs & circumstances. Functions include:

- Providing advice, signposting & exercise support for people who need to improve balance, as part of an integrated support network
- Assessment of medical, functional & environmental needs (including bone strength) and preferences - part of a holistic joint assessment with other partners
- Support planning & prescribing of solutions (e.g. equipment) to mitigate risk of falls - part of integrated recovery/LT care plan
- Support patients who have fallen/repeat fallers to recover, rebuild strength, improve balance, confidence and independence
- Provide advice, guidance and training on falls to professionals and others, including as part of integrated MDTs
- Modifiable falls risks have personalised care plan shared across the wider MDT
- Ensure non-modifiable falls risks are mitigated
- Support and empower service users to self-manage
- Able to support those with dementia living at home and at risk

Capabilities required	Who the care function is for	How the function is accessed
Physiotherapy competencies, OT competencies; dietetic input. Capability to work in integrated multi-agency care & support settings	Individuals screened, known or judged to be likely at higher or 'rising' risk of falls, including those with osteoporosis; individuals with history of falls	'Trusted referrer' routes: PC, acutes, social care, other named referrers, including integrated care partners; OR self referral; patient initiated follow up

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Service user homes or in local clinics	Mon-Fri 9-5 with some flexibility	1 week for urgent referrals	4 week follow up

Integration with wider health and care system

This is one element of multi-agency network with primary care, NHS Trusts, public health, social care, Councils & VSC to:

- Support community solutions to improve balance for those at risk of falling or as part of an 'Ageing Well'
- Routine multi-agency screening to identify those at risk, and patient management within primary care and PCNs
- Supports those at 'rising risk' of falls in conjunction with others, and those who had a fall or repeat falls
- Specialist secondary medical intervention for those with more complex syncope or who were hospitalised

Works alongside:

- Joint Intermediate care services to support people to recover following crises or hospitalisation, including rapid response.
- Frailty/multi-morbidity MDTs or Enhanced Health in Care Home models as a component of proactive and holistic care planning;
- Primary care, community health, social care & voluntary sector

Draft specifications

Older person

Contains national requirement targets

Core offer care function: **Frailty service**

Overview

Description of the care function

The aim of the frailty service is to identify people with moderate and severe frailty (any age) with frailty and improve their care by offering targeted support for their physical and mental health needs. The service follows the British Geriatric Society's model of Find, Recognise, Assess, Intervene, Long-term (FRAIL).

A comprehensive clinical assessment is undertaken which includes memory screening, a medications review and a discussion about wishes and preferences for individual's future care. The service identifies priority areas in a frail person for quality improvement and risk areas for reduction.

Joint care plan developed in partnership with those living with frailty

Support the adoption of virtual ward models, adopting digital tools to support effective care delivery of remote care

Capabilities required

Frailty practitioners linked in with consultant geriatricians

Who the care function is for

Individuals screened, known or judged to be frail or at risk of frailty (frailty register)

How the function is accessed

Referrals from GP's, other community services and the local acute hospitals through the central point of access.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Service user homes	Mon-Fri 9-5 with some flexibility	1 week for urgent referrals	1-6 visits over a period of 4 to 6 weeks depending on need

Integration with wider health and care system

Works alongside:

- Joint Intermediate care services to support people to recover following crises or hospitalisation, including rapid response.
- MDTs for complex needs
- Enhanced Health in Care Home models as a component of proactive and holistic care planning;
- Falls prevention team
- Memory clinic and older people's core mental health teams
- Primary Care, community health, social care & voluntary sector

Contents

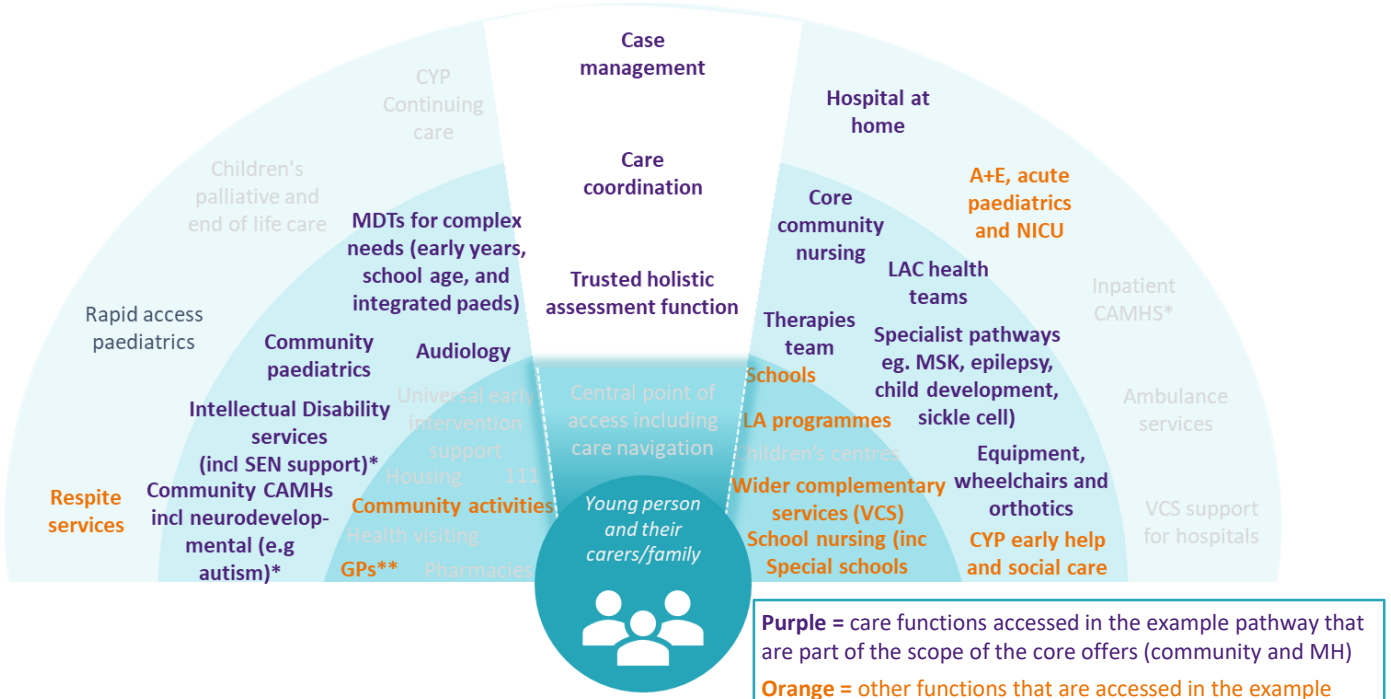
Pen portraits

Increasing holistic needs

 Children & Young People	**1. Freya** is a white 14-year-old teenager whose academic performance at school has been deteriorating and appears withdrawn and tired in class. She has stopped playing in the band she was formerly a member of. She lives in cramped accommodation with not much money at home, her parents are separating, and she is being bullied at school.	**2. Patrick** is a 7-year-old Black Caribbean boy. He has a diagnosis of autism and also suffers from anxiety. He suffers from language and cognitive impairment and attends a special school. He is cared for by his parents who have two other children. His father has had to give up work to provide the additional support required for Patrick.	**3. Jack** is a British Asian 8-year-old with cerebral palsy. He walks with the support of walking sticks and leg braces. He has difficulties talking and swallowing. He also suffers from moderate learning difficulties and attends a special school. He has regular admissions to hospital suffering from pneumonia. He also has significant hearing loss. His single mother suffers from periodic episodes of depression. They receive support from their extended family.
 Working age adult	**4. Asha** is a British Asian 22-year-old and has suffered from ADHD since primary school. She lives with her family in Archway and is studying economics part-time at London Met university. Her ADHD impacts her performance at university. She has struggled to maintain a job because of her impulsiveness.	**5. Daniel** is a Black 48-year-old man and lives in Tottenham. He suffers from schizophrenia and has been in and out of mental health inpatient facilities including PICU since he was 17. He lives in supported accommodation and is unemployed. His two brothers and mother are supportive but cannot contact him when in crisis. He usually turns up in A&E when he is in crisis. He has asthma but does not reliably take his medication.	**6. Melissa** is a 55-year-old Black woman from Kentish Town with poorly controlled Type I diabetes, and chronic diabetic foot ulcers. These frequently become infected, and she requires hospital admission for treatment of sepsis. She suffers from chronic back pain, is obese and has episodes of depression. She has an opioid addiction. She frequently has to have time off work. She lives with her partner.
 Older people	**7. Vera** is 70, white, lives alone in Bounds Green and is in hospital having fallen over and fractured her hip. She is isolated and lonely. While in hospital, she is very anxious and tells staff that the night team have been stealing her possessions. The ward physio does not feel that she can safely be discharged home because of her poor mobility and her previous history of falls.	**8. Paul** is 72, recently widowed, lives in Edgeware and is Black Caribbean. He has high blood pressure and is now partially sighted. His son noticed he has lost interest in activities and is withdrawn, confused and finds it hard to engage in conversation and he has been getting lost. Paul does not think there is a problem and declines any help.	**9. Yasmiin** is 87, from Somalia and a long-term resident of Camden but now lives in a Care Home in East Barnet nearer to her family. She has mild dementia, breast cancer, heart failure and is thought to be in last 6 months of her life. She has had four hospital admissions in the last six months with breathlessness related to her heart failure.

Example pathway:
Child with complex needs

Jack is a British Asian 8-year-old with cerebral palsy. He walks with the support of walking sticks and leg braces. He has difficulties talking and swallowing. He also suffers from moderate learning difficulties and attends a special school. He has regular admissions to hospital suffering from pneumonia. He also has significant hearing loss. His single mother suffers from periodic episodes of depression. They receive support from their extended family



Purple = care functions accessed in the example pathway that are part of the scope of the core offers (community and MH)

Orange = other functions that are accessed in the example pathway but are out of scope of the core offers

What care will look like through the core offer

Jack is cared for by an integrated community health team of children's community nurses, a community paediatrician and therapists. He has a case manager who co-ordinates his care and supports the family to navigate his different appointments and wider support available to him. This team regularly reviews Jack's holistic needs getting input via regular MDT from his primary care team, school nurses in his special school, the intellectual disability team and his early help social worker.

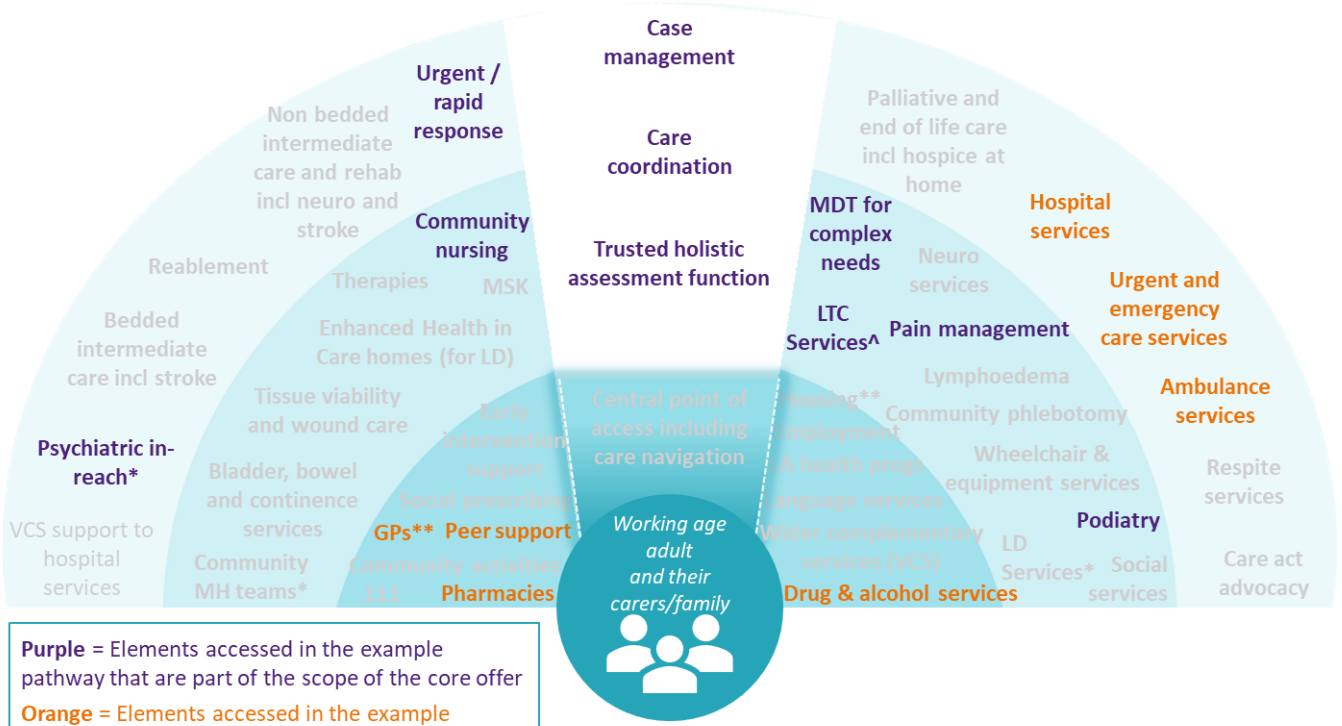
He has regular physiotherapy and the physio also links in with the orthotics and equipment team to provide support. He has regular support from a speech and language therapist for both his swallowing and his speech. A dietician works with him to ensure that his nutrition is maximised and suitable. An occupational therapist works with Jack and his family and teachers to maximise his independence and also his self-esteem. He has a regular medication review with a community paediatrician. The team links in with the NCL audiology team to ensure that Jack is having reviews for his hearing. Jack has a regular review with the learning disability team who contribute to "Team around the child" discussions. Jack and his family have a dedicated early help social worker who provides support regarding school transport, respite care and also regularly reviews if there are any safeguarding concerns at home. Jack has a regular holistic review of his mental health by a clinical psychologist who is attached to the community health team. His mother receives support from primary care and IAPT for her depression and is also supported to attend a peer support group for cerebral palsy carers.

In conjunction with the Hospital at Home team, a crisis plan has been developed which enables Jack to be assessed and cared for at home (when appropriate) as an alternative to hospital admissions when he suffers from episodes of pneumonia. This is supported by same day acute paediatric assessment when required from the Rapid access paediatric service.

Example pathway: Working age adult with multiple and complex Long term conditions

Melissa is a 55 year old Black woman from Kentish Town with poorly controlled Type I diabetes, and chronic diabetic foot ulcers. These frequently become infected, and she requires hospital admission for treatment of sepsis.

She suffers from chronic back pain, is obese and has episodes of depression. She has an opioid addiction. She is a teaching assistant at a local school, but frequently has to have time off work. She lives with her partner.



Purple = Elements accessed in the example pathway that are part of the scope of the core offer

Orange = Elements accessed in the example pathway that are out of the scope of the core offer

What care will look like through the core offer

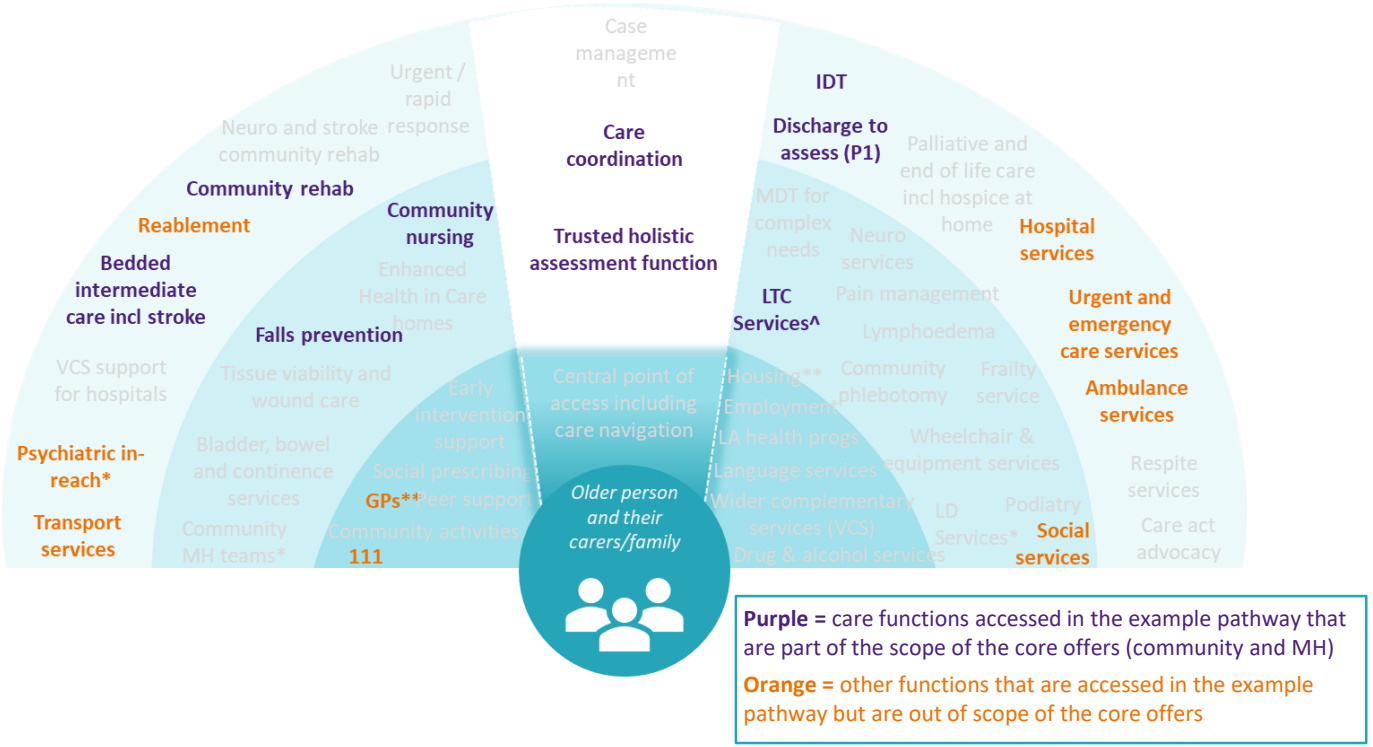
Melissa is supported by the community diabetes team who have carried out a holistic assessment of her needs and preferences. A clinician from the team case manages her care bringing together input from the professionals and services involved in her care. A regular MDT reviews her care utilising the digital health record. In the past Melissa has chosen not to engage with many NHS services and consequently has had very poor diabetic control with severe vascular complications. However, the involvement of a peer support practitioner from Melissa's local community has greatly helped with improving trust and Melissa's blood sugar control has improved. Melissa was also diagnosed with depression by a psychologist in the diabetes team who has been working with the peer support worker to provide support. Melissa has now agreed to start an anti-depressant which has greatly helped her mood. She had been reluctant to attend the pain management service when it was based at the local hospital, but when instead she was offered a consultation based at her GP practice from the pain management specialist this greatly helped. She is now being supported in conjunction with input from the substance misuse local team to withdraw from her opioids and to switch to alternative pain management medication alongside a pain management course

A community nurse visits Melissa twice weekly to change her foot ulcer dressings with advice from the diabetic and podiatry teams. When these ulcers get infected, the rapid response team is able to provide daily assessment and IV antibiotics which has prevented a number of likely hospital admissions.

Example pathway: Older adult with acute and rehabilitation needs

Vera is 70, white, lives alone in Bounds Green and is in hospital having fallen over and fractured her hip. She is isolated and lonely. While in hospital, she is very anxious and tells staff that the night team have been stealing her possessions.

The ward physio does not feel that she can safely be discharged home because of her poor mobility and her previous history of falls.



Purple = care functions accessed in the example pathway that are part of the scope of the core offers (community and MH)

Orange = other functions that are accessed in the example pathway but are out of scope of the core offers

What care will look like through the core offer

Vera, whilst in hospital, is seen by the psychiatric in-reach team the morning of the referral who confirm via shared care record (which includes primary care) that she has no previous history of mental illness. She is assessed as having delirium and they provide treatment advice to the ward team including regarding adequate pain management. Her delirium settles and she is reviewed by the integrated discharge team (IDT). The team agrees with Vera that she would benefit from a period of intensive rehabilitation in a community rehab bed. This is organised promptly and she is discharged the following day. Whilst in the community rehab bed, she has intense twice daily physio support and a home assessment with an OT early on. The OT links up with the equipment team to arrange required home adjustments. The holistic assessment of the IDT has also identified Vera's loneliness and a social worker is able to support Vera in the rehab bed to review local activities. This includes a tea and chat drop-in at her local church, a peer support group and an arts and crafts group. She also receives a follow-up review by the MH in-reach team who link in via the shared care record with the primary care MH nurse attached to Vera's GP. Vera is subsequently discharged home being seen by a carer to support her with her activities of daily living and by a community nurse alternate days to review her wound. She continues to be seen 2x weekly at home by the physio and OT from the non bedded rehab team. They organise for her to be assessed by the falls prevention team who arrange diagnostic tests to rule out likely causes of falls. After two weeks of non-bedded rehab, Vera is discharged back to primary care management with a full written handover on the shared care record and continued input from the falls prevention team.

Example pathway: Older adult with likely dementia

Paul is 72, recently widowed, lives in Edgware and is Black Caribbean. He has high blood pressure and now partially sighted.

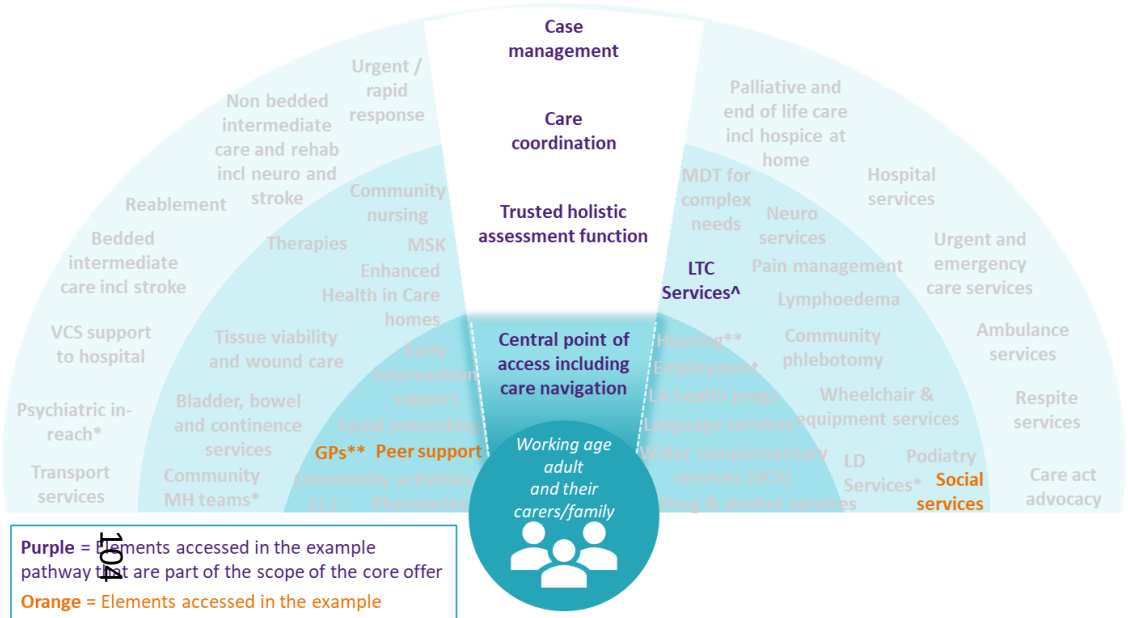
His son noticed he has lost interest in activities and is withdrawn, confused and finds it hard to engage in conversation and he has been getting lost.

Paul does not think there is a problem and declines any help.

What care will look like through the core offer

The GP carries out an initial mental health assessment having received specialist training and support from the memory clinic and contacts the central point of access. This arranges for Paul to have an assessment at the local memory clinic with an older adult psychiatrist or geriatrician. Both Paul and his son's ideas, concerns and expectations are considered and a full assessment of Paul's social and living arrangements is made. The memory clinic MDT reviews the results in conjunction with the assessment and a mild-moderate dementia diagnosis is made. A holistic care plan is developed with input from Paul (as appropriate), his son, and from a social worker linked to the team who assesses the home circumstances and level of risk. Paul is allocated a case manager who acts as a point of contact for Paul, the family and any professionals and supports Paul and his family to understand the condition and make shared decisions, which prioritise Paul's preferences where appropriate, and to access local support groups (e.g. peer support). The case manager gets input from community cardiovascular team to develop a care plan and supports Paul to have a review of his sight at the optician. Paul is encouraged to join local wellbeing activities of his preference and to take part in cognitive rehabilitation therapy and stimulation therapy. Paul agrees with some encouragement from his son to start taking some dementia medication on the advice of the Memory clinic. Paul has three monthly reviews with the Memory clinic and a monthly review with his case manager. A package of care is arranged to support Paul to manage safely at home alongside support from his son. A social worker regularly reviews how Paul and his son are getting on with the potential to increase the level of carer support and/or provide respite care if required.

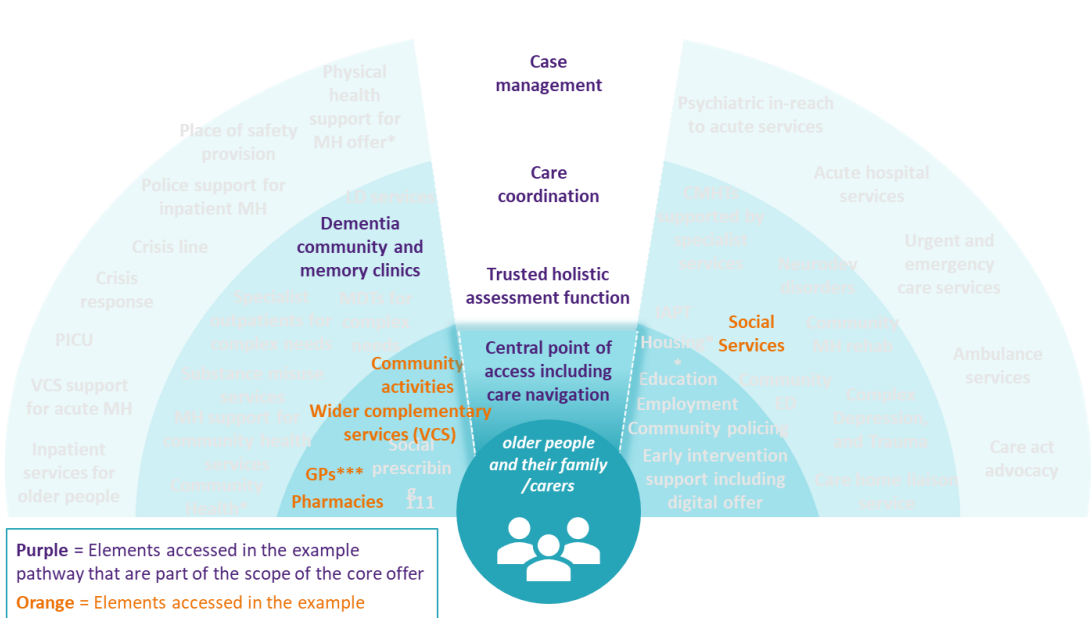
Community health offer



Purple = Elements accessed in the example pathway that are part of the scope of the core offer

Orange = Elements accessed in the example pathway that are out of the scope of the core offer

Mental health offer



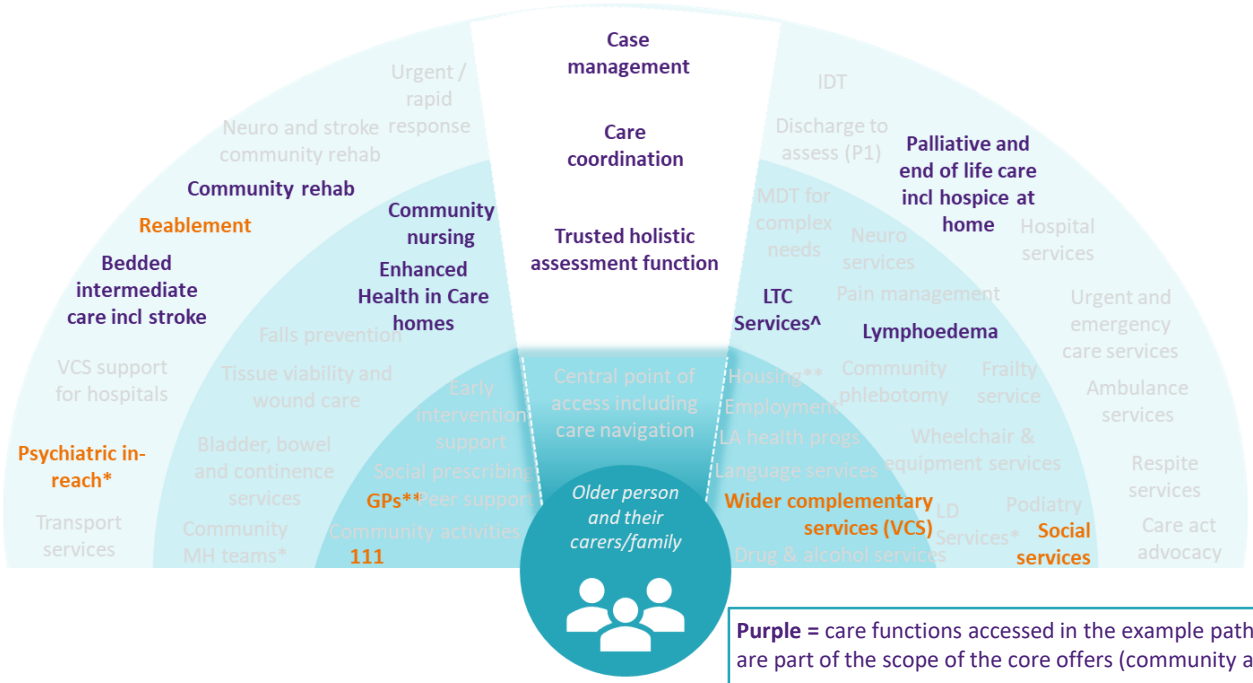
Purple = Elements accessed in the example pathway that are part of the scope of the core offer

Orange = Elements accessed in the example pathway that are out of the scope of the core offer

Example pathway: Older adult with palliative care needs

Yasmiin is 87, from Somalia and a long-term resident of Camden but now lives in a Care Home in East Barnet nearer to her family. She has dementia, breast cancer, heart failure and is thought to be in last 6 months of her life.

She has had four hospital admissions in the last six months with breathlessness related to her heart failure



Purple = care functions accessed in the example pathway that are part of the scope of the core offers (community and MH)

Orange = other functions that are accessed in the example pathway but are out of scope of the core offers

What care will look like through the core offer

Yasmiin is reviewed weekly by the enhanced health in care homes (EHCH) team linked to her care home. A GP in the team is her case manager and regularly carries out a holistic assessment of her needs and preferences together with her family. Yasmiin has complex and multiple needs which involve care from a number of members of the EHCH and input from wider services. The end of life care team regularly review Yasmiin and advise the EHCH on symptomatic support for Yasmiin and provide support to Yasmiin's family. They have put together an anticipatory care plan, with co-agreed limits to acute escalation of her care. Community nurses, the geriatrician and a respiratory physio from the EHCH together with end of life nurse specialists support the care home staff to look after Yasmiin when she develops worsening breathlessness from her heart failure and avoid hospital admissions. The community nurse on the team with specialist input from the lymphoedema service manage the complications of Yasmiin's leg lymphoedema. The geriatrician linked to the EHCH team advises the care home team on how best to manage Yasmiin's dementia. These members of the EHCH and wider team meet collectively review Yasmiin's care monthly at MDT led by her case manager. Yasmiin's family are supported to access local voluntary sector carer support in the community and Yasmiin is supported to join a music group weekly in the community which she enjoys.

When Yasmiin's condition does deteriorate, the end of life nurse specialist is able to set up a syringe driver in the nursing home and provide bereavement support to her family.

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NCL Mental Health Services Strategic Review: Core offer report

September 2021

Contents

Introduction and purpose of this report

Introduction

Before the formation of the NCL CCG, services were commissioned by each of the 5 legacy CCGs in isolation, leading to **substantial variation in the way services are commissioned and delivered across NCL**. The NCL Mental Health Services Strategic Review seeks to create a **sustainable and affordable model** across NCL that **addresses inequalities, spreads good practice** and **improves outcomes** for residents.

This review brings together **stakeholders from mental health services, primary care, acute care, social care and community health services** to develop the interfaces and collaborative working across pathways. A **review of community health services** is running in parallel, with integrated workstreams.

The review comprises of four elements: understanding the **current baseline**, co-development of an **outcomes framework**, co-development of a **'core offer' for mental health services** and co-development of a **transition plan**. Subsequently, further work will take place to deliver transformation over the short to medium term.

Purpose of this report

This report contains the **outputs from the development of the core offer for mental health services.** The core offer was developed through an iterative engagement process through workshops, small working groups, one-on-ones and written feedback and input. The purpose of the report is to present the NCL-wide core offer for mental health services across Children and Young People, Young Adults, Working-Age Adults and Older People. The core offer is intended to be **aspirational** and to reflect a **consistent** offer that **any resident of NCL can expect to access**, whichever borough they reside in. For each care function of the core offer, a specification is shown that aims to describe broad criteria for **delivery of a consistent and equitable offer across NCL.** Select pen portraits have been used to **highlight example pathways through the core offer.**

Aim, objectives and scope for the community and mental health services review

Aim

The aim of the reviews 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 accessible as possible
- Ensure we deliver on national Must Dos for community and mental health services

In 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).
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.
The scope also includes services such as Discharge (Integrated Discharge Teams), End of Life Care, **services for people with Long Term Conditions where these are funded by the NHS** and delivered outside an acute episode of care.

Approach to development of the core offer for mental health services

Baselining work

A case for change for mental health services across NCL was developed based on:

- Baseline analysis of data
- As-is service mapping
- Stakeholder interviews

Initial design

- Aligned on population focused approach and pen portraits for initial design discussions
- Collated national requirements
- Deep dive workshops as initial input on offer including existing best practice

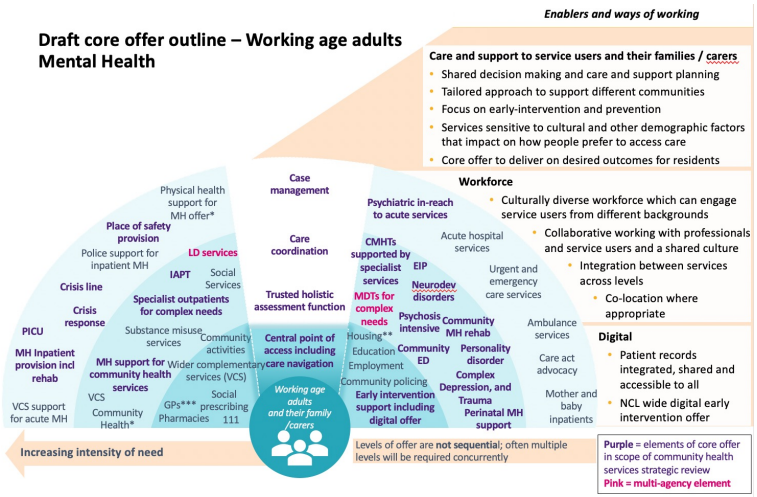
Development of the outline core offer

- Collated initial design inputs
- Developed initial draft, setting out the care functions of the core offer for different age cohorts
- Included critical links to wider services
- Design workshop 2 and 3

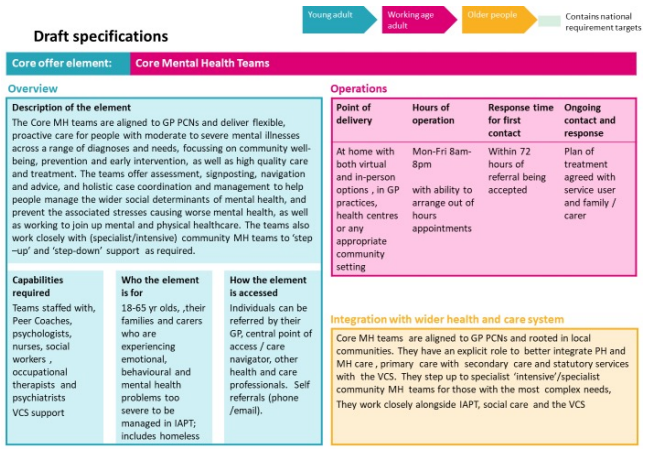
Iterated core offer and developed specifications

- Collated feedback from design workshops 2 and 3
- Iterated core offer based on feedback
- Further developed offer alongside commissioners and providers

Through this process, a core offer outline was developed for different age segments of the population and specifications were drafted for each care function of the core offer



Example core offer outline showing all services



Example specification for single service

The purpose of the core offer is to set out a commitment to the support the NCL population can expect to have access to, regardless of their borough of residence

Purpose of the core offer

The purpose of the core offer is to address the inconsistency of service provision across NCL by setting out a commitment to the NCL population of the support they can expect to have access to regardless of their borough of residence.

The core offer will provide clarity to the population, clinicians and professionals in the system on what support is available, when it is available and how to access it.

The core offer is:

- A description of care functions and services that should be available across NCL for different age segments of the population and how these care functions integrate with the wider health and care system
- In particular, the core offer provides a brief specification for each care function that describes:
  - What the care function is and what it aims to deliver
  - Operating hours and any out of hours provision
  - Response times for first contact with service user and ongoing contact (in line with national requirements)
  - Who the care function is for and how the care function is accessed
  - Links/ integration with other services and agencies
  - Workforce capabilities required
  - Point of delivery (e.g. in person, virtual)

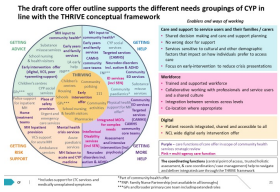
The core offer is not:

- A detailed specification for how providers should deliver care
- A description of how providers should organise workforce, facilities etc. in order to deliver the core offer

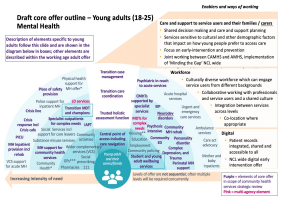
Contents

A core offer has been developed for different age segments of the population and consists of core offer outlines, coordinating functions and specifications for services

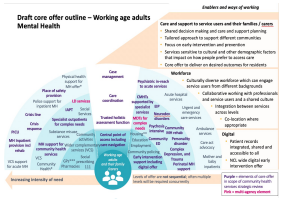
Core offer outlines provide a summary of care functions and services that are part of the core offer for the below age segments. The outlines also show complementary care functions that should be linked in with the core offer and a set of enablers.



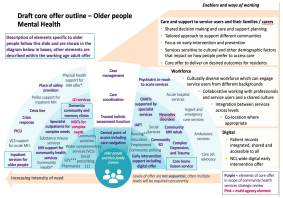
Children and young people



Young adults

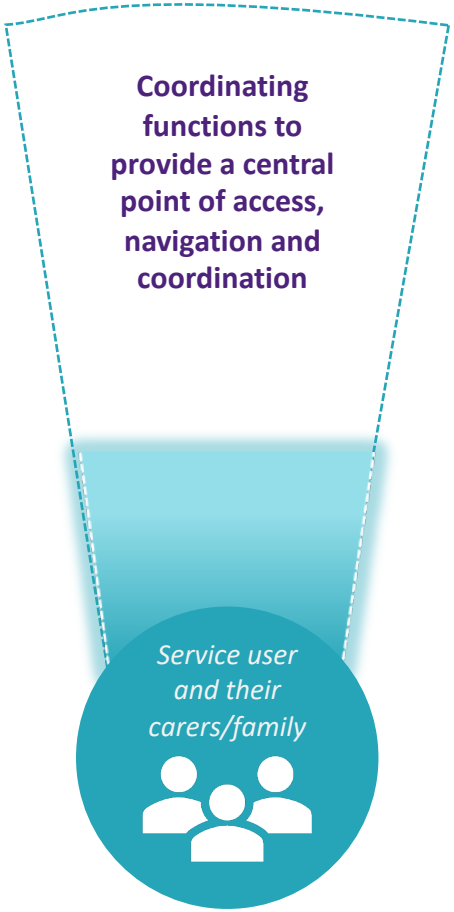


Working age adults

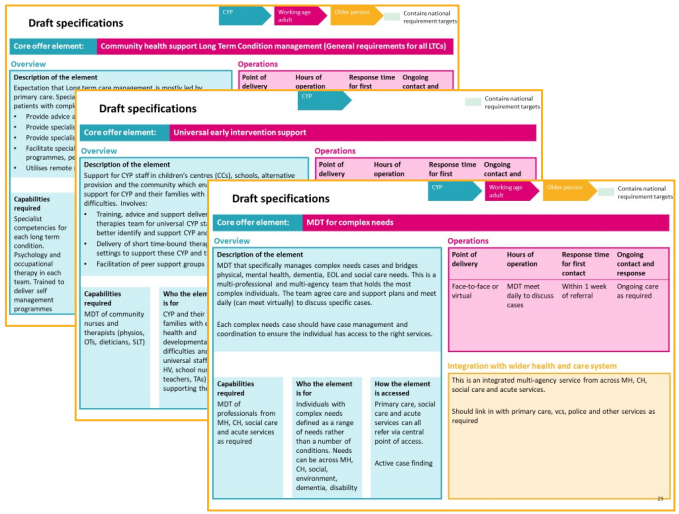


Older people

Each outline also contains a set of **coordinating functions** that are described in further detail in a following section and encompass a central point of access, care coordination and case management.



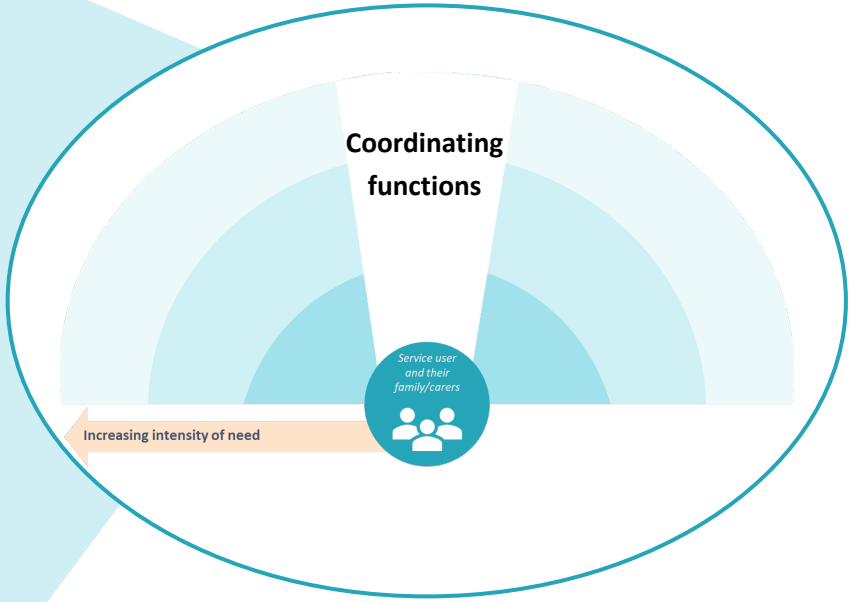
Following each core offer outline, in-scope care functions are further detailed in a set of **specifications**. These provide a description of the care function and lay out access criteria, hours of operation, capabilities required, where the care function should be delivered, waiting times and how the care function should link in with the wider health and care system.



The core offer outlines summarise the care functions that should be delivered by mental health services with the service user at the heart of the design

Core offer care functions

- Each of the core offer outlines provides a **summary of key care functions** of mental health services that should be part of a core offer for age segments of the population
- The care functions are arranged across layers with the **service user and their family / carer at the centre of the offer**
- The further away from the service user, the more intensive the need that the core offer care function provides for
- **Movement between the layers is not necessarily sequential**. Care **delivery can be fluid** and should be delivered where is best for the service user and **as close to home as possible**
- care functions of the core offer that are in scope of the mental health services strategic review are shown in **purple and bolded**. The other care functions are shown to highlight how services should be integrated across and within the layers
- A set of **coordinating functions run across the layers** helping to coordinate, integrate and navigate care for service users



Enablers and ways of working

- Alongside the core offer outlines, key enablers and ways of working are called out in three areas; care and support to service users and their families / carers, workforce and digital
- These enablers will be further examined and expanded upon through transition and implementation planning

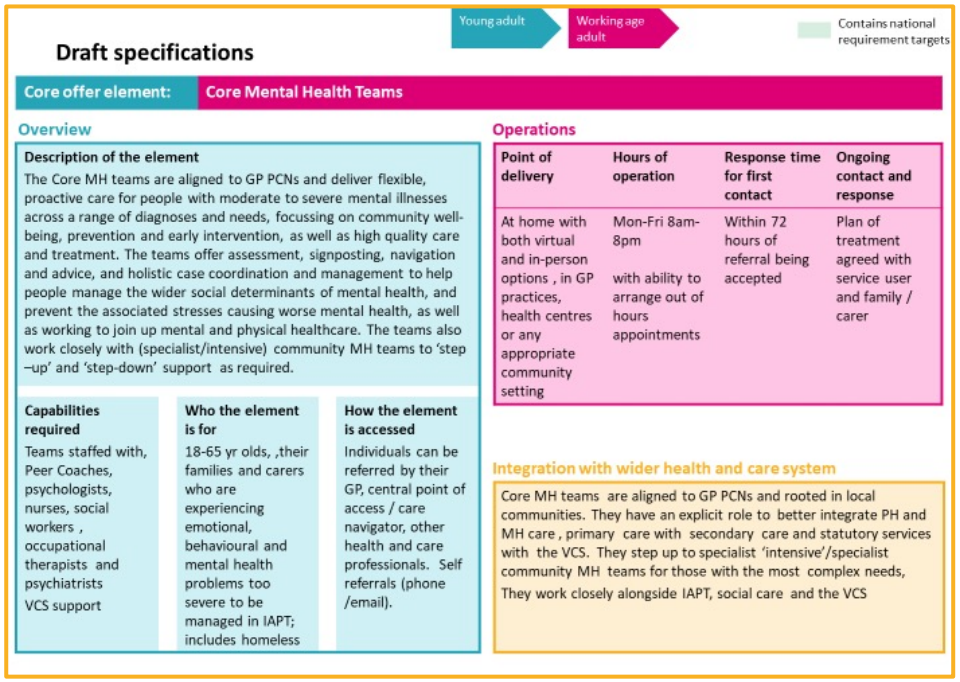
Care and support to service users and their families / carers

Workforce

Digital

Specifications for each care function of the core offer follow the outlines. A description of the coordinating functions is in a separate sectio

Specifications for each care function of the core offer provide an overview of what the care function is and the minimum requirements for its delivery NCL-wide



Draft specifications

Young adult | Working age adult | Contains national requirement targets

Core offer element: Core Mental Health Teams

Overview

Description of the element

The Core MH teams are aligned to GP PCNs and deliver flexible, proactive care for people with moderate to severe mental illnesses across a range of diagnoses and needs, focussing on community well-being, prevention and early intervention, as well as high quality care and treatment. The teams offer assessment, signposting, navigation and advice, and holistic case coordination and management to help people manage the wider social determinants of mental health, and prevent the associated stresses causing worse mental health, as well as working to join up mental and physical healthcare. The teams also work closely with (specialist/intensive) community MH teams to 'step –up' and 'step-down' support as required.

Capabilities required	Who the element is for	How the element is accessed
Teams staffed with, Peer Coaches, psychologists, nurses, social workers , occupational therapists and psychiatrists VCS support	18-65 yr olds, ,their families and carers who are experiencing emotional, behavioural and mental health problems too severe to be managed in IAPT; includes homeless	Individuals can be referred by their GP, central point of access / care navigator, other health and care professionals. Self referrals (phone /email).

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home with both virtual and in-person options , in GP practices, health centres or any appropriate community setting	Mon-Fri 8am-8pm with ability to arrange out of hours appointments	Within 72 hours of referral being accepted	Plan of treatment agreed with service user and family / carer

Integration with wider health and care system

Core MH teams are aligned to GP PCNs and rooted in local communities. They have an explicit role to better integrate PH and MH care , primary care with secondary care and statutory services with the VCS. They step up to specialist 'intensive'/specialist community MH teams for those with the most complex needs, They work closely alongside IAPT, social care and the VCS

- The aim of the specifications is to **provide a level of consistency and equality of access across NCL**
- The specifications **do not detail how providers should deliver the service**, but rather describe minimum standard requirements around:
  - Where the care function should be delivered
  - When the care function should operate
  - Waiting times for first and ongoing contact
  - Thresholds for service user access
  - Capabilities of the workforce
  - How service users can access the care function
- The specifications also provide an overall description of the care function and how it should link in with the wider health and care system
- It should be recognised that there will **be differences in the scale of provision at a local level**, to align with variation in need at a local level and to integrate with local models of care delivery (e.g., Through PCNs), but these minimum standards described in the specifications remain consistent across NCL

Digital is a fundamental enabler to the delivery of the core offer

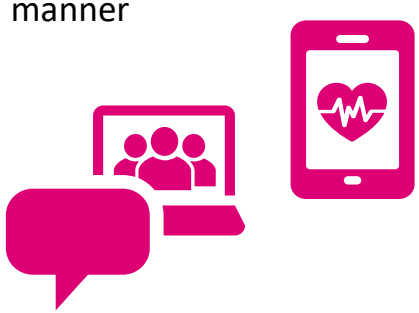
A digital element forms part of the core offer and is integrated throughout the specifications. This could include:

Digital self-help, support and advice services for service users

- NCL wide digital early intervention offer
- Advice, sign-posting, and self-help information for service users, their family / carers and other professionals
- Digital care and support planning to enable individuals to identify goals that matter to them

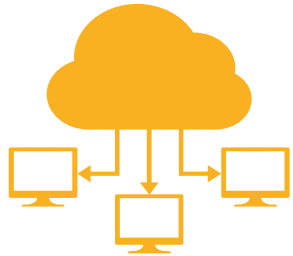
Virtual services and technology to help patients manage their conditions

- Option to have consultations and triage virtually, building on capabilities implemented during COVID
- Virtual MDTs and staff meetings to increase efficiency
- Technology-enabled solutions (including remote monitoring) that help patients better manage their conditions and receive support when needed in a timely manner



Shared care records and interoperable systems

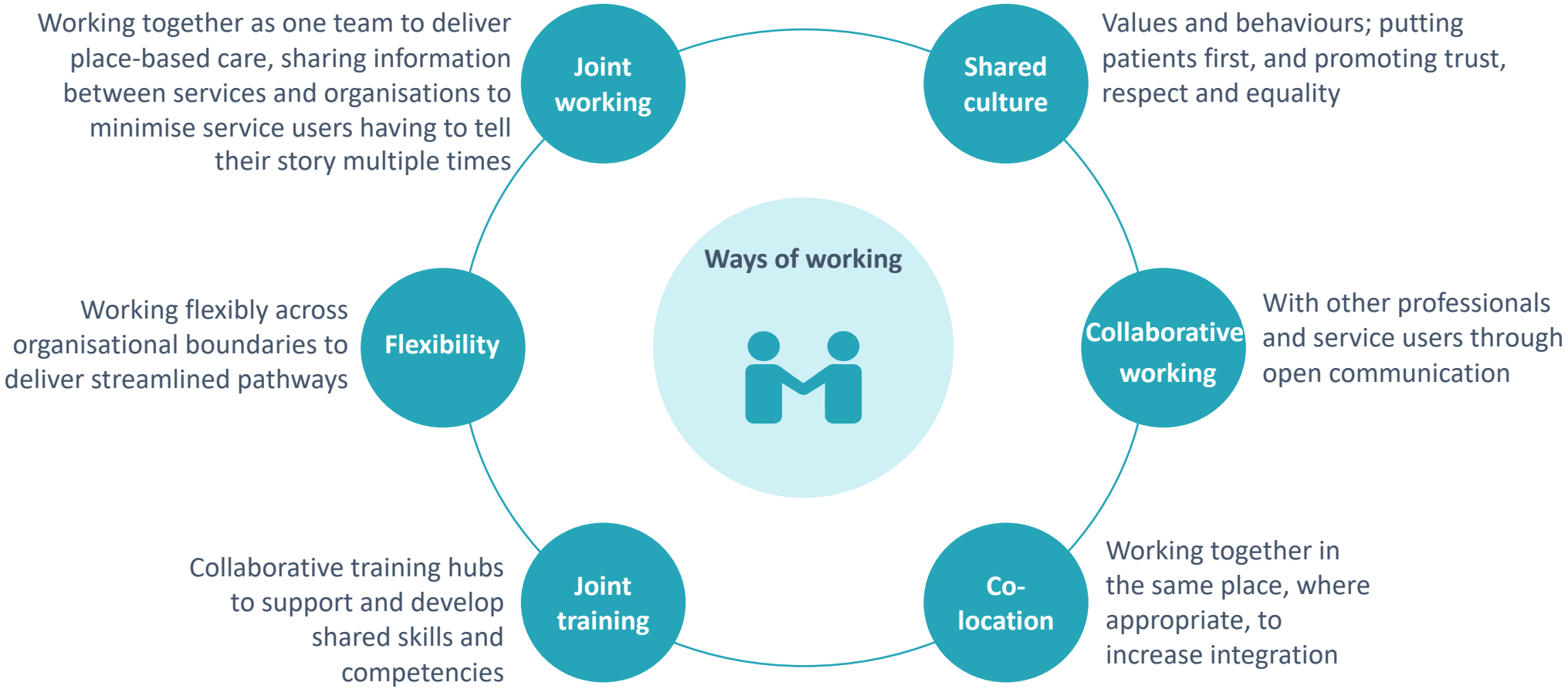
- Patient records that are integrated, and shared between services and organisations
- Accessible to service users and the appropriate professionals in a timely manner to enable informed individual care planning
- Common structures around digital data across providers



Further work will be required at implementation planning stage to develop the plans to deliver digital transformation to support the core offer. This could be supported by the development of a digital workstream to support the Community and Mental Health Strategic Reviews.

Integrated ways of working across community health, mental health and other agencies will be central to implementation of the core offer

Workforce transformation to support delivery of the core offer could include:

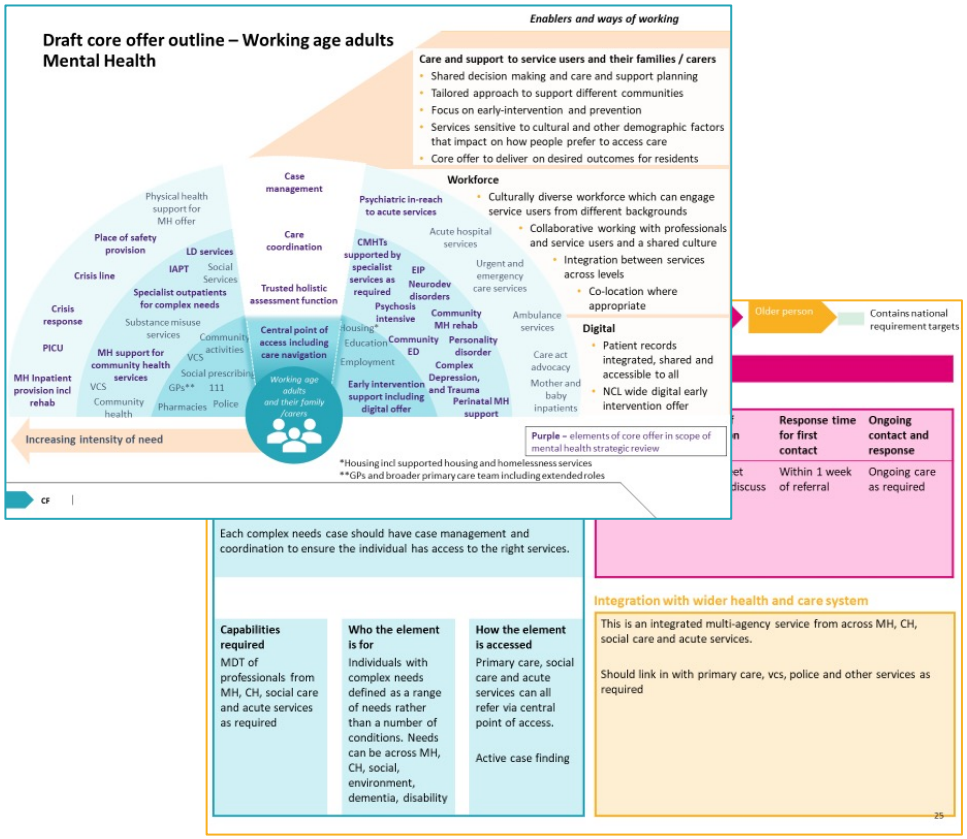


Further work will be required at implementation planning stage to develop the plans for workforce transformation to support the core offer.

The core offer is aligned to other programmes focused on transforming mental health services in NCL

- Development of the core offer for mental health services has **not been done in isolation**, with co-production with other programmes of work that are related to the mental health services transformation
- The purpose of this review is to **bring together is aspiration for NCL-wide Mental Health and Community Health Services into one place**
- This **supports ongoing areas of work** that are looking at specific aspects and services, for example:
  - Community transformation programme
  - CYP models of care
  - Crisis programme
  - IAPT
  - Mental health inpatient programme
- These and other areas of related work will be further **progressed in response to the strategic level core offer**

The core offer will be taken forward to feed into an impact assessment and planning for transition

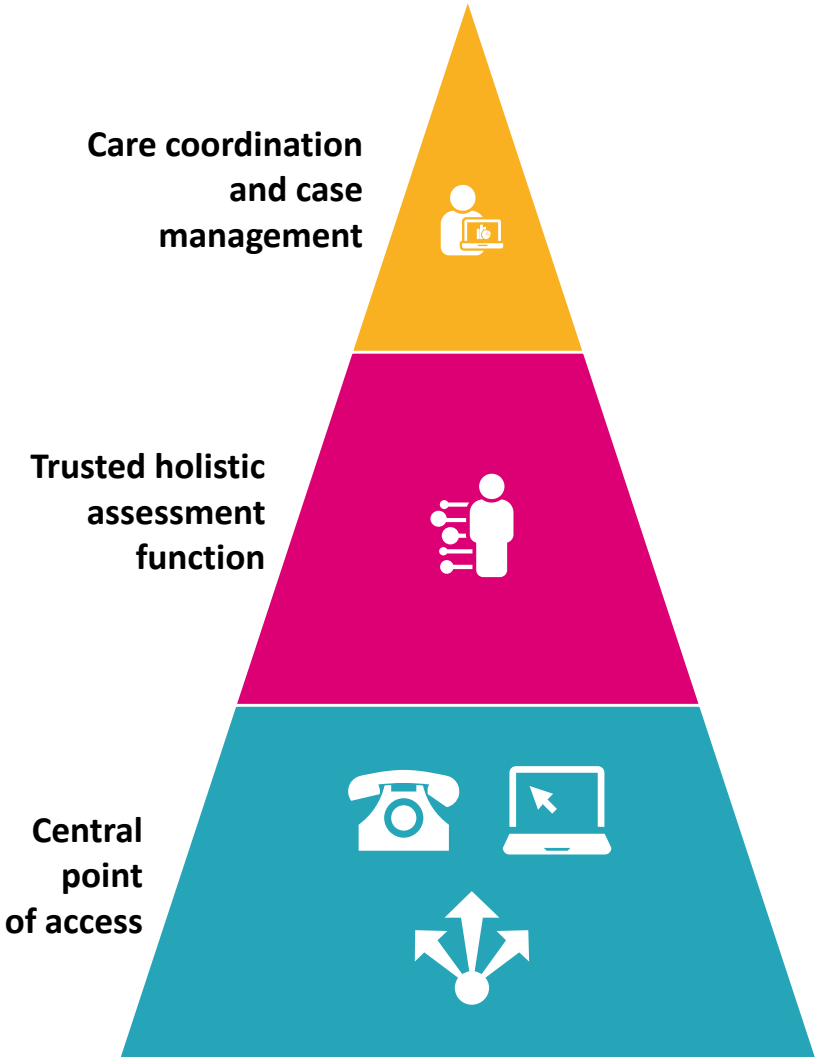


- The core offer outlines, coordinating functions and specifications that have been developed are intended to be carried forward into:
  - An impact assessment which will be a comparison of the core offer against current provision across several domains including access and finance
  - A transition plan that will cover:
    - The level of delivery of different care functions of the offer i.e. PCN, place, ICS
    - Requirements for enablers to deliver at PCN, place and ICS level
    - Roadmap for transition
    - Recommendations for commissioning
- The core offer will not prescribe to providers how they should deliver against the requirements or how providers should organise themselves to deliver the offer

Contents

A set of coordinating functions act to support, integrate and navigate care for service users across the layers of the core offer

Increasing complexity of need



- Service users with complex needs are allocated a clinical **case manager**. This individual leads the development of a **holistic care plan and its delivery**
- Care coordinators support this through **organising MDT meetings** and supporting service users and their families and carers to **navigate health and care appointments**

- Service users have **a single up front holistic assessment of their health needs, functioning, living environment & preferences**
- This is conducted by a senior professional with trusted assessor competencies who has the trust of the full MDT
- Service users and their families and carers **only have to tell their story once**

- Central point of contact at borough or NCL level for initial referrals and contacts with local community and MH health services
- Provides telephone and/or email hub which **directs referrals or queries to the right individual or service**
- Accessed by any health/care professionals, by service users and families / carers
- Administrators have access to directory of local services and assets and are able to **help service users and professionals navigate the wider available support**

Further detail around the coordinating functions

Function	Access	Purpose	Components	Capabilities	Care functions supported
Central point of access (including care navigation)	Health and care professionals referring patients to mental health services or seeking advice and guidance Service users and their carers and families self referring	Acts as a single point of contact at a borough or NCL level for initial referrals and contacts with local mental health services The main purpose of the central point of access is to move people seamlessly through services Services also have the ability to move service users to another service (e.g. where a service identifies a patient need that can be covered by another core offer care function)	Telephone and/or email hub which can direct referrals or queries to the right individual or service. Borough level Care navigators help people making contact to understand what MH and community health services and wider health and care and VCS services are available and would be most appropriate	Administrators with clear standard operating procedures Non-clinical care navigators who have a directory of services and excellent working knowledge of available services and assets within the borough. Central point of access needs to be the most responsive with the ability to provide crisis assessment and request crisis response (if required) in a timely manner.	All care functions of mental health offer

Further detail around the coordinating functions

Function	Access	Purpose	Components	Capabilities	Care functions supported
Trusted holistic assessment function	Service users with complex health and care needs	Ensure that service users with complex health and care needs can have a single up front assessment of their health and care needs to enable an initial holistic care plan to be co-developed. Ensures that service users and their families and carers don't have to keep telling the same story	Senior professionals within mental health services working with service users with complex needs are able to deliver holistic assessments which are trusted by professionals from other services Important to note that subsequent assessments likely to be necessary to refine diagnosis and/or support further development of treatment plans	Capability to assess the different health and care needs of service users and for this assessment to be trusted by other members of the MDT involved in the service user's care	Management of service users with complex health and care needs

Further detail around the coordinating functions

Function	Access	Purpose	Components	Capabilities	Care functions supported
Care coordination	Service users with complex health and care needs who require the support of multiple mental health services	Ensure that the multiple services and individuals involved in the care of a service user with complex needs are aware of what each are doing and are able to deliver holistic joined up care	Support the administration of MDT meetings and discussions Support service users and their families and carers to navigate appointments and to understand the role of each	Administrators who are able to support both service users and their families and liaise with different professional stakeholders	MDTs for service users with complex needs
Case management	Service users with complex health and care needs who require the support of multiple mental health services	Support service users with complex health and care needs to have joined up holistic care	Lead the co-development of holistic care plans for service users with health and care needs Accountable for ensuring that different services and professionals are supporting the delivery of this plan	Senior health of care professional who is allocated to patients. Can be from any professional health and care background but must be able to provide trusted holistic assessments	Service users with complex health and care needs

Contents

CYP

The draft core offer outline supports the different needs groupings of CYP in line with the THRIVE conceptual framework

Enablers and ways of working

Care and support to service users and their families / carers

- Shared decision making and care and support planning
- No wrong door for support
- Services sensitive to cultural and other demographic factors that impact on how individuals prefer to access care
- Focus on early-intervention to reduce crisis presentations

Workforce

- Trained and supported workforce
- Collaborative working with professionals and service users and a shared culture
- Integration between services across levels
- Co-location where appropriate

Digital

- Patient records integrated, shared and accessible to all
- NCL wide digital early intervention offer

Purple = care functions of core offer in scope of community health services strategic review
Pink = multi-agency care function

The coordinating functions (central point of access, trusted holistic assessment, & care coordination / case management) help to navigate and deliver integrated care through the THRIVE framework

^Includes support for LTC services and medically unexplained symptoms

*Part of community health offer
**FNP: Family Nurse Partnership (not available in all boroughs)
***GPs and broader primary care team including extended roles

The principles of the THRIVE framework should be applied throughout the implementation of the CYP core offer

1. **Common language:** using the five needs-based groupings across NCL (thriving, getting advice and sign posting, getting help, getting more help, getting risk support)
2. **Needs-led:** approach led by meeting need rather than diagnosis or severity. Being explicit about the plan of care and everyone's role within the plan
3. **Shared decision making:** this process is core to giving young people, children and their parents a voice and empowering them to take part in their care decisions.
4. **Partnership Working: e**ffective cross-sector working, with shared responsibility, accountability and mutual respect based on the five needs-based groupings
5. **Proactive Prevention and Promotion:** helping to enable the whole community to support mental health and wellbeing. Proactively working with the most vulnerable groups.
6. **Outcome-Informed:** Clarity and transparency from outset about children and young people's goals, measurement of progress movement and action plans
7. **Reducing Stigma:** Ensuring mental health and wellbeing is everyone's business
8. **Accessibility:** advice, help and risk support available in a timely way for the child, young person or family, where they are and in their community.

Source: http://implementingthrive.org/about-us/i-thrive-principles/

Contains national requirement targets

Draft specifications

Core offer care function: **CYP Early intervention and prevention offer**

Overview

Description of the care function

A locally tailored but consistent approach to 'Getting Advice and 'Getting Help' that uses community-based services including VCS, schools, Children's Centres and youth centres to identify and address need early and prevent MH concerns escalating. The model includes:

- Online counselling and peer support
- Advice and support for parents and self-help resources for CYP
- Mental health in Schools Teams supporting whole school approaches
- A 'universal offer' of training and support for health, education and care staff
- VCS and LA provided community based emotional health and wellbeing programmes including those incorporating arts, sports etc.
- Personalised approaches such as personal budgets, social prescribing etc.
- A CAMHS liaison and in-reach function into every school
- Tailored ways to address inequalities including those related to deprivation, ethnicity, gender, sexuality, disability and any other factor

Capabilities required

Digital offer. MH in schools team. VCS and LA wellbeing progs. CAMHS and MH (VCS and NHS), psychologists, psychiatrists, family therapists, child psychotherapists. Peer workers.

Who the care function is for

All CYP. Support for CYP and their families with early emotional and behavioural concerns

How the function is accessed

Self referral where appropriate. Through MH in school teams, school and social workers, primary care. Through central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Schools (inc alt provision), children's centres, community, online	24/7 for online; 9am-5pm for range of offer with some out of hours provision where appropriate	Immediate access to some support; up to four weeks for 1-1 counselling or other support	As required

Integration with wider health and care system

- Offered through a network of integrated health, education and care services. Offer ensures that all professionals working with CYP and their families with early mental health difficulties are able to identify and support these CYP and are able to support them to access effective early mental health support
- The care functions of the early intervention offer are all linked in with the CAMHS core community mental health teams so that if CYP need getting help or more help support this can be promptly accessed
- Key interdependency with safeguarding and social care.
- Services will be integrated with community services for CYP such as SALT, OT, social workers, school councillors, health visiting, public health.

Contains national requirement targets

Draft specifications

Core offer care function: CAMHS community core teams

Overview

Description of the care function

Holistic assessment of referred CYP with emotional and behavioural difficulties and co-development of plan based on THRIVE principles and following NICE guidance (QS48) & QNCC standards

- Intake, clinical assessment and triage undertaken quickly to identify needs early
- Advice, guidance and support for CYP, their families and other professionals working with CYP.
- Delivery of a range of best practice therapeutic and psychiatric interventions focused on achieving individualised outcomes for the child and family
- Participation in range of MDTs regarding how to support child and family and identify and manage risks and/or concerns.
- Integrated with schools and other settings where possible
- Step down and step up where needed from/to crisis services

Capabilities required

Teams staffed with psychologists, psychiatrists, family therapists, child psychotherapists, social workers, nursing, SLT and/or OT, CYP IAPT trainees. Peer workers.

Who the care function is for

CYP (up to 18 years), their families, parents and carers who are experiencing emotional, behavioural and mental health problems.

How the function is accessed

Individuals can be referred by GP, mental health in schools team, social workers and any other professional via central point of access. Also accepts self referrals

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinic setting in person and virtual delivery. Home and school based visits as required	40 hour week with provision of some evening and weekend sessions Out of hours provided by crisis team	Severe depression + high risk suicide = 24 hr Severe depression + low risk suicide = 2 weeks *(NICE QS48)* Routine referral: within 4 weeks *(LTP goal)*	Plan of care agreed with child and family / carer Urgent; 7day follow up Routine: max 6 week follow up *(NICE QS48).*

Integration with wider health and care system

- Part of a network of integrated health, education and care services. Teams must provide support to early intervention offer, primary care and complex care MDTs. Must link up with other CAMHS teams including Mental health in schools teams as well as schools, LA social care, Early Help, youth, youth offending, VCS providers and others.
- Key interdependency with safeguarding and social care.
- Services will be integrated with community services for CYP such as SALT, OT, school councillors, health visiting, public health.

Contains national requirement targets

Draft specifications

Core offer care function: **Targeted Services**

Overview

Description of the care function

CAMHs provide integrated support into CYP LAC, social care, Youth, youth offending and Early Help teams. CYP receive holistic assessments in conjunction with the care practitioners and plans are co-developed in line with THRIVE principles.

- CYP and their families are provided with therapeutic time bound multiagency and multidisciplinary interventions
- CAMHS contribute to the planning and implementation of risk reduction and management interventions

To include the development of integrated social care, Early Help and CYP MH intake assessment and triage models that identify the most appropriate NHS or VCS services, teams or preventative interventions to support CYP.

Capabilities required

Teams staffed with psychologists, family therapists, child psychotherapists, nurses, social workers and child and adolescent psychiatrists, CYP IAPT trainees. MHST, peer workers

Who the care function is for

CYP and their families with mental health difficulties under the care of social care and/or YOT and/or subject to a care plan.

How the function is accessed

Locality LA teams are able to access support directly and promptly via integrated support

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Locality community settings, families homes, schools and virtually	40 hour week with provision of some evening and weekend sessions	Bespoke to the needs of the child (4 weeks routine)	As required

Integration with wider health and care system

Team links with core community CAMHS teams, specialist teams and crisis provision. Out of hours crisis plans must be readily accessible to social care, CYP, families and the CAMHs crisis team.

Ensuring consistency of provision especially for LAC who may move between boroughs.

Team contributes to Team around Child meetings, complex care MDTs and other network meetings.

Key interdependency with Local Authority provision.

CYP

Contains national requirement targets

Draft specifications

Core offer care function: **CYP community, intensive home and inpatient eating disorder service**

Overview

Description of the care function

Provides holistic assessment and co-production of care plans for CYP and families following NICE guidance (NG69):

Community – early identification and support:

- Specialist trained staff embedded within community CAMHS teams
- Provide advice, interventions for ARFID etc and other complex EDs
- Support and training to other MH and wider community services
- Liaison and MDT care planning for lower risk YP, with EDIS, acutes, primary care and others

EDIS – supporting YP with higher levels of need, helping avoid admissions

- Individualised approach bespoke to family delivered by an MDT in home, hospital or clinic as appropriate
- Includes MDT support for day or short-term acute admissions
- Step down from inpatient units
- Network co-ordination, liaison, risk identification and management

Inpatient units – intensive inpatient work built on evidence-based practice

Capabilities required

MDT able to deliver specialist ED interventions; psychiatrists, psychologists, nurses, dietetics, paediatrics, psychological therapists and peer workers

Who the care function is for

CYP aged 17 or under who have a suspected or confirmed eating disorder diagnosis. Service also open for advice, consultation and support

How the function is accessed

Individuals can be referred through their GP, central point of access / care navigator, school, college, other health professionals.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Informed by initial assessment. Community clinic, in schools, At home with both virtual and in-person options	EDIS 7 days a week 8am to 8pm Community delivery 40 hour week.	*LTP target*: urgent within 1 week and routine within 4 weeks. *NCL target* for urgent : within 5 days and emergencies within 24 hrs	Bespoke plan of care agreed with child and family / carer. *Follow NICE guidance NG69 for follow-up therapy (full details in appendix)*

Integration with wider health and care system

Part of a network of integrated health, education and care services: MDT from ED service should link with GP, any MDT for complex needs children, CYP specialist learning disability, autism and ADHD pathways, social care, schools and school nursing, A+E and acute wards, community paediatrics, MH inpatient care and community mental health teams, acute inpatient, Crisis services

Key interdependency with safeguarding and social care.

CYP

Contains national requirement targets

Draft specifications

Core offer care function: **Early years service and family services**

Overview

Description of the care function

NHS and voluntary sector teams working with children's centres, health visitors, nurseries, midwifery, perinatal mental health and other local services to carry out child and whole family assessments and co-develop intervention plans across the THRIVE framework and following NICE guidelines (PH40, PH12, PH20, QS128, QS31) include:

- Providing training and support to families and professionals including health visiting, parent infant psychotherapy and other Early Years teams around children's emotional and behavioural development and family relationship issues.
- Advice, liaison and training for assessment, triage and delivery of interventions for families needing additional support and provision of family drop-ins
- Contribute to MDT planning across CAMHS, LA services, Primary and secondary care, perinatal and adult mental health services

Capabilities required

Specialist child psychiatrists / psychiatric nurses, family therapists, psychologists, psychotherapists and other CAMHS and adult MH clinicians, parent peer workers

Who the care function is for

Children under 5 years where there is concern about attachment or behaviour or emotional development or family emotional wellbeing or MH

How the function is accessed

Referral can be through GP, midwife, health visitor, early years setting or other services working with the family.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
In community setting, at home, in a children's centre or virtually	40 hour week with provision of some evening and weekend sessions	Triage within 24 hrs. Urgent; 7day follow up Routine: 6 week follow up.	Follow up 2 weeks after initial appointment

Integration with wider health and care system

Part of a network of integrated health, education and care services: Early years and family services integrated at locality level with early years settings, midwives, health visitors, CAMHS teams, child social services, perinatal services and PCNs primary care practitioners.

CYP and young adult

Contains national requirement targets

Draft specifications

Core offer care function: **Adolescent assessment and intensive interventions including psychosis**

Overview

Description of the care function

Intensive support services operating across the 'Getting More Help' and 'Risk Support' THRIVE domains. For young people and families, aged 11–18, who need extra support to help manage complex and severe mental health presentations. Should follow NICE guidelines (CG155, QS102) and include:

- In reach into secondary care to facilitate discharge to the community
- In reach into inpatient bed management function (Tier 4) to facilitate early discharge
- MDT care planning with Community, Liaison, other specialist MH teams and social care to support admissions avoidance
- Intensive short to medium term interventions for complex and severe MH presentations with high levels of risk.
- EIS model for psychosis – delivered either through standalone EIS teams or through AOTs.

Capabilities required

Child and and adolescent psychologists and psychiatrists, psychotherapy, mental health nursing and family therapy , youth peer workers

Who the care function is for

CYP (11-18) presenting with a range of severe MH concerns eg Psychosis, Bipolar disorder, severe Depression etc

How the function is accessed

In A+E and on hospital wards, referrals from other CAMHS teams, social care, youth services, primary care

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
In A+E, acute hospital wards, inpatient bed management function (Tier 4), community	40 hour week including some evening and weekend sessions	2 weeks (*NICE CG155, QS102)*	Bespoke to needs of the individual

Integration with wider health and care system

Part of a network of integrated health, education and care services: Link with A+E, acute physical health wards, community MH teams inpatient mental health wards, bed management systems, crisis and home treatment teams and primary care, social care, schools and colleges, youth services, youth offending services. Will also need to link with police and place of safety.

Key interdependency with physical health services through PCN Primary Care Practitioners and Community Services.

Contains national requirement targets

Draft specifications

Core offer care function: CYP specialist intellectual disability, autism and ADHD pathways

Overview

Description of the care function

Provision of specialist services to support CYP with intellecutual disabilities, and their families/carers in line with NICE guidance (QS142 and QS51). An MDT of psychologists, psychiatrists, ID nurses, SLT, physios, occupational therapists, dieticians and social workers provide:

- Help, support and advice to families/carers and professionals
- Co-production of care plans and developing services
- Assessment and care management
- Multi-disciplinary neurodevelopmental and/or cognitive assessments including through Child Development Teams for early years
- Liaison and joint working/integration with school, SEND and CYP Disability Social Care teams as well as community health services
- Pre and post diagnostic parenting and psychoeducational support
- Bespoke needs-led psychiatry, psychology, psychotherapy and family therapy
- Challenging behaviour support including Positive Behaviour Support models
- Keyworking and co-ordination function, including MHA care coordination
- Admissions and residential placement avoidance MDT planning eg CETRS
- Therapeutic and Physical health support including postural management
- Dietician support and support for PEG feeding
- Transitions planning with adults' services, including period of transition between services to ensure information is fully handed over

Capabilities required

Integrated teams; psychologists, family therapists, child psychotherapists, social workers and child and adolescent psychiatrists, CYP IAPT trainees, nurse, community paediatrician, SLT, OT, Physio, dietician, health lead for mental capacity. Peer workers.

Who the care function is for

Children, young people (up to 25 years), their families, parents and carers who are have suspected or diagnosed neurodevelopmental concerns and/or intellectual disability concerns.

How the function is accessed

CYP referred via central point of access and also from core CYP mental health teams who ask for specialist opinion and input. GPs, school staff, other MH teams, social care

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinic setting in person and virtual delivery. Home and school based visits as required	40 hour week including some evening and weekend sessions	Within 4 weeks for intellectual disability Within 3 months for autism diagnostic assessment *(NICE QS51)*	Plan of care agreed with child and family / carer Annual health check including review of MH *(NICE QS142)*

Integration with wider health and care system

Part of a network of integrated health, education and care services: Work in an integrated model with CYP community core physical and mental health teams, CYP Disability Services, any MDT for complex needs children, schools, colleges, social care, youth workers, community paediatrics, and MH inpatient care as well as any other specialist MH teams (e.g. CYP eating disorders) and the VCS. Work with primary care specifically regarding regular medication reviews e.g. for ADHD. Integrated with Child Development Teams for early years. Primary care liaison within CYP intellectual disability team to coordinate annual health checks for 14-18 year olds and subsequent health action planning

CYP | Working age adult | Older person | Contains national requirement targets

Draft specifications

Core offer care function: **Integrated MDT for complex needs**

Overview

Description of the care function

MDT that specifically manages complex needs cases and bridges physical, mental health, learning and intellectual disabilities and social care needs over the life span. This is a multi-professional and multi-agency team that holds the most complex individuals. The team agree care and support plans and meet daily (can meet virtually) to discuss specific cases.

Each complex needs case should have case management and coordination to ensure the individual has access to the right services, including education and employment support.

Capabilities required

MDT of professionals from MH, CH, social care and acute services as required

Who the care function is for

Individuals with complex needs defined as a range of needs rather than a number of conditions. Needs can be across MH, CH, social, environment, dementia, disability

How the function is accessed

Primary care, social care and acute services can all refer via central point of access.

Active case finding

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Face-to-face or virtual	MDT meet daily to discuss cases	Within 1 week of referral	Ongoing care as required

Integration with wider health and care system

- This is an integrated multi-agency service from across MH, CH, social care and acute services.
- Should link in with primary care, vcs, police and other services as required
- Key interdependency with physical health services through PCN Primary Care Practitioners and Community Services.
- Key interdependency with safeguarding and social care.

CYP and young adult

Contains national requirement targets

Draft specifications

Core offer care function: CYP mental health crisis services

Overview

Description of the care function

Provides in and out of hours advice, support and short term interventions to CYP and their families presenting in MH crisis.

Crisis line: 24/7 telephone support. Urgent mental health helplines for people of all ages provided across NCL. Able to triage mental health calls and navigate callers and their families to the right source of support.

Crisis hubs: Crisis support delivered by a flexible workforce most suited to the need of the presentation: Staff navigate young people's needs and link with local services and/or offer intensive support if required, delivering immediate risk management for CYP in MH crisis

OOH NCL Crisis Service: In and outreach crisis input to acute and CS, including face to face assessments and short term interventions in A&Es and hubs.

Psychiatry OOH: Psychiatry on call provision

Capabilities required

Teams staffed with psychologists, family therapists, psychotherapists and psychiatrists, nurses, social workers, CYP IAPT trainees, specialist crisis enabled including trauma and DBT, peer workers

Who the care function is for

CYP in crisis up to age 18 yrs and support for families, carers and support for professionals

How the function is accessed

Crisis line – Self / parent / carer/ friend referral

Others - Referral from crisis line, A+E, liaison service.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Where CYP present - Hospital, hubs, face-to-face and virtual and telephone support. Education, social care setting	Crisis line: 24 / 7 (*LTP)* Crisis hubs: 9am-12am 7 days a week OOH Crisis 24/7 OOH Psychiatry: 24/7	1 hr emergency 4 hrs urgent 24 hrs routine (crisis response)	Assessment, risk management and care planning and liaison with other services within 1 week, ongoing crisis line support

Integration with wider health and care system

Part of a network of integrated health, education and care services: Service should link with GP, any MDT for complex needs, social care including accommodation providers, A+E and hospital, community nursing teams, inpatient bed management function (Tier 4), MH inpatient care and community mental health teams, education, police, youth services and other youth specialist teams.

Crisis response links directly to psychiatric in-reach.

Key interdependency with physical health services through PCN Primary Care Practitioners and Community Services.

Key interdependent with safeguarding and social care.

CYP and young adult

Contains national requirement targets

Draft specifications

Core offer care function: **Multidisciplinary mental health liaison to acute A+E and CYP medicine**

Overview

Description of the care function

Timely multidisciplinary mental health assessment for CYP presenting to A+E, on acute wards & paediatric clinics with various mental health and psychosocial presentations, both primary acute mental health disorders and psychological, emotional and behavioural difficulties associated with physical health. Includes mental health liaison and/or community mental health team assessments to support facilitation of timely acute discharges and ongoing paediatric care (Examples include support for parents of medically unwell neonates, care of those with life-limiting conditions or complex medically unexplained symptoms). Mental health input also built into CYP community health multidisciplinary Long term condition teams (e.g. weight management, diabetes and epilepsy)

Capabilities required

Psychologists, psychiatrists, psychotherapists, mental health nurses, family therapists, play specialists/activity coordinators, occupational therapists, social workers, peer workers

Who the care function is for

CYP mental health presentations in A+E, on wards and out-patient clinics in each acute site

How the function is accessed

Available for telephone advice /support and in-person assessments, care planning and treatment in A+E, on wards, day care and out-patient clinics.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
In A+E, acute hospital wards, MDT discussions, community bedded rehab, out-patient clinics	24 / 7 for emergency & urgent presentations. 9-5 Mon-Fri for non-urgent.	According to national NHSE target for liaison care – 1 hr response to emergency referrals and 24 hr response to urgent inpatient ward referrals	Up to twice daily review as required with 2hr response for escalations. Weekly – monthly for non-urgent.

Integration with wider health and care system

Part of a network of integrated health, education and care services. Multidisciplinary mental health input (in-reach or 'in-house') should link with A+E, acute physical health wards, inpatient mental health wards, crisis and home treatment teams, paediatric clinics and primary care. Will also need to link with police, social care teams and place of safety.

Mental Health Liaison teams should link directly to crisis response teams, paediatric teams, community CAMHS & primary care.

CYP and young adult

Contains national requirement targets

Draft specifications

Core offer care function: **CYP MH Home treatment and Inpatient provision**

Overview

Description of the care function

Home Treatment Teams: Aimed at supporting CYP with severe mental illness otherwise requiring inpatient admission, in their homes. Provides home-based intensive 1:1 support. Includes in reach to inpatient bed management function (Tier 4) to facilitate early discharge. To minimise hospital admissions and shorten length of stay, keeping families together wherever possible. To include specialist treatment such as DBT and MBT.

Inpatient: Short and medium care for voluntary and MHA CYP admissions. Provision of safety and 24/7 therapeutic support, linking with community care planning. A detailed care plan and assessment are co-produced with the service user and their family / carers. Physical health needs of CYP are also managed with support of physical health in-reach provision

Capabilities required

The team includes psychiatrists, nurses, health care assistants, occupational therapists, psychologists, social workers, peer workers

Who the care function is for

Mental health patients with crises requiring informal or MHA admissions

How the function is accessed

Home Treatment Teams: Via referral from other CAMHS teams or inpatient units

Inpatient: Either voluntary or MHA admissions

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Homes (plus some other clinic or non-clinical locations as appropriate/ CYP Inpatient unit	Inpatient: 24 / 7 (*LTP)* HTTs: To include evenings and weekends	Emergency referrals respond within 4 hours, admission within 24 hrs; Urgent transfer referrals within 48 hrs; Routine referrals within 1 week (*LTP targets)*	Length of stay dependent on progress Daily MDT review and daily therapeutic 1-1 and group input

Integration with wider health and care system

Part of a network of integrated health, education and care services. Home Treatment Teams and Inpatient MH teams should link with GP, Crisis, AOT and Community teams, acutes, social care, youth services, Team around the child meetings and wider network meeting and regional provision if required.

Young adults (18-25)

Draft core offer outline – Young adults (18-25) Mental Health

Description of care functions specific to young adults follow this slide and are shown in the diagram below in boxes; other care functions are described within the working age adult offer

Care and support to service users and their families / carers

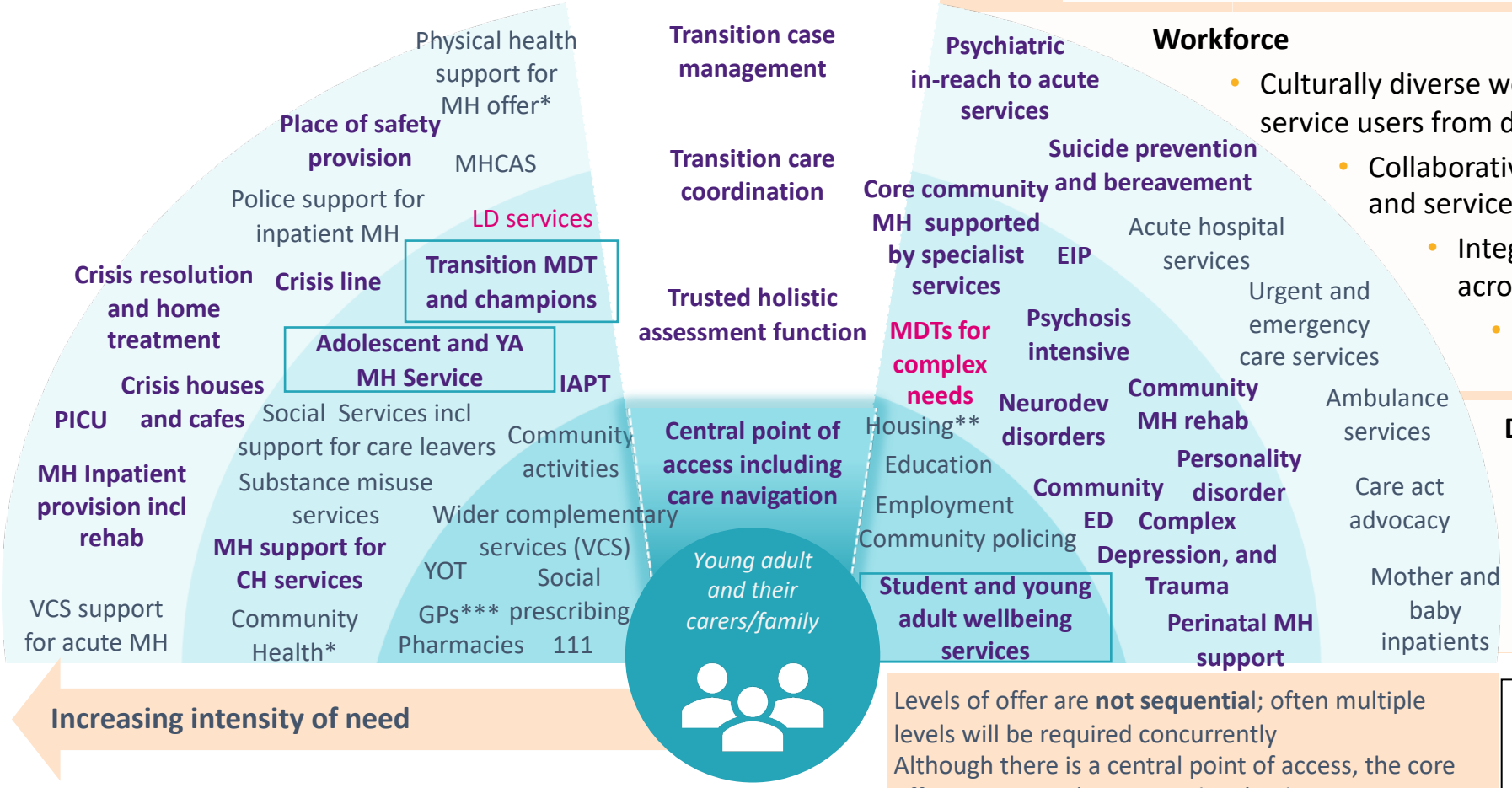
- Shared decision making and care and support planning
- Services sensitive to cultural and other demographic factors that impact on how young people prefer to access care
- Focus on early-intervention and prevention
- CAMHS and AMHS adapt to meet 18-25 needs
- Implementation of 'Minding the Gap' NCL wide and THRIVE

Workforce

- Culturally diverse workforce which can engage service users from different backgrounds
- Collaborative working with professionals and service users and a shared culture
- Integration between services across levels
- Co-location where appropriate

Digital

- Patient records integrated, shared and accessible to all
- NCL wide digital early intervention offer



Levels of offer are **not sequential**; often multiple levels will be required concurrently
Although there is a central point of access, the core offer operates a 'no wrong door' policy

Purple = care functions of core offer in scope of community health services strategic review
Pink = multi-agency function

*Part of community health offer
**Housing incl supported housing and homelessness services
***GPs and broader primary care team including extended roles

The principles of the THRIVE framework should be applied throughout the implementation of the young adult's core offer

1. **Common language:** using the five needs-based groupings across NCL (thriving, getting advice and sign posting, getting help, getting more help, getting risk support)
2. **Needs-led:** approach led by meeting need rather than diagnosis or severity. Being explicit about the plan of care and everyone's role within the plan
3. **Shared decision making:** this process is core to giving young people, children and their parents a voice and empowering them to take part in their care decisions.
4. **Partnership Working: e**ffective cross-sector working, with shared responsibility, accountability and mutual respect based on the five needs-based groupings
5. **Proactive Prevention and Promotion:** helping to enable the whole community to support mental health and wellbeing. Proactively working with the most vulnerable groups.
6. **Outcome-Informed:** Clarity and transparency from outset about children and young people's goals, measurement of progress movement and action plans
7. **Reducing Stigma:** Ensuring mental health and wellbeing is everyone's business
8. **Accessibility:** advice, help and risk support available in a timely way for the child, young person or family, where they are and in their community.

Source: http://implementingthrive.org/about-us/i-thrive-principles/

Contains national requirement targets

Draft specifications

Core offer care function: **Student and young adult wellbeing support**

Overview

Description of the care function

Consistent wellbeing and counselling support available for young adults and students in community and online - full range of services from getting advice through to getting help and risk support:

- Online counselling, peer support and self-help resources
- Training for primary care, university health professionals and employers so that they can support young adults
- VCS or LA provided locality based wellbeing hubs that provide mentoring, peer and coaching support for young adults with early mental health difficulties
- University provided counselling and student support
- Substance misuse support (LA provided)

Capabilities required

NCL wide evidence based digital offer

Locality based young adult wellbeing hubs

Trainers to deliver training for primary care, educational and social care professionals

Who the care function is for

Support for young adults and their families with early emotional and behavioural difficulties

How the function is accessed

Self referral and walk in; anonymous digital access; through primary care, student health hubs, transition service; can also be accessed through central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Locality wellbeing hubs, online, face-to-face	24/7 for online; 9am-5pm for range of offer with some out of hours provision where appropriate	Immediate access to some support; up to four weeks for 1-1 counselling or other support	As required with links to other services (e.g. IAPT) for further support

Integration with wider health and care system

- Offer ensures that all professionals working with young adults with early mental health difficulties are able to identify and support them and are able to support them to access effective early mental health support
- The care functions of the early intervention offer are all linked in with the CYP and adults core community mental health teams so that if young adults need more specialist support this can be promptly accessed (e.g. IAPT, MH core teams)
- Links in with adult safeguarding

Contains national requirement targets

Draft specifications

Core offer care function: **Adolescent and Young Adult Mental Health Service***

Overview

Description of the care function

Offer in line with LTP ambitions (to extend current service models to create a comprehensive offer for 0-25 year olds) and covers:

- Provision of specialist time bound support by a skilled multidisciplinary team, including clinical psychology, psychiatry, psychotherapy, family therapy and social work, offering a range of range of assessments and interventions using multimodal and multidisciplinary approaches. Treatment may be delivered individually or in groups.
- Working to support people to have positive outcomes to enable them to step down from services / prevent need for ongoing or high intensity adult treatment
- Planning and implementation of transition from CYP to adult MH services in line with NICE guidance (QS140, NG43)

Capabilities required

Integrated multi-agency pathways with teams including; psychologists, family therapists, child psychotherapists, social workers and child and adolescent psychiatrists, CYP IAPT trainees, E by E

Who the care function is for

Young people between the ages of 14 and 25 who;

- Require transition from any CYP MH service to an adult pathway
- Are in youth justice, are LAC and may also have SEND / NDD

How the function is accessed

Individuals can be referred through their GP, college, university, other health and social care professionals or by self referral; can also be accessed through central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinic, with both virtual and in-person options Digital offer to support engagement	Mon-Fri 8am-6pm with ability to arrange out of hours appointments.	Within 4 weeks	Plan of care agreed with young person and family / carer if applicable, bespoke to needs of the young person based on their goals

Integration with wider health and care system

- Part of a network of integrated health, education and care services. Link with GP, schools and colleges, social and community services, youth workers, MH inpatient care
- Links with adult safeguarding.
- Support for parents with mental health needs

**Potential care function for later-phase implementation*

Contains national requirement targets

Draft specifications

Core offer care function: Transition MDT (case discussion) and transitions champions

Overview

Description of the care function

- Support to facilitate care planning for young people transitioning from CAMHS and non-statutory services to adult mental health services
- Fortnightly case discussions with senior representatives from CAMHs, adult mental health and non-statutory young people's services. Suitable AMHS care pathways are identified and referrers are linked up with the relevant services
- Additionally a transitions champion is based within a specific adult team and provides direct clinical support to young people during the transition phase and supports other professionals in working in a developmentally-attuned way.
- People will be supported through the transition MDT to the level appropriate to their needs
- Should meet NICE guideline standards (QS140, NG43)

Capabilities required

Appropriately trained transition champions, psychologists, family therapists, child psychotherapists, social workers and child and adolescent psychiatrists

Who the care function is for

Young adults between 17-24 years old known who have come to the attention of CAMHS, AMHS or non-statutory providers and where a clear care pathway is not easily identified

How the function is accessed

Professionals working with young people can book case discussions; the transitions champion is accessed via the transitions case discussion forum

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Team meets in various locations across NCL or virtually	Meetings at least fortnightly, 1.5 hours	Cases discussed within 4 weeks	Referrers are promptly linked up with relevant AMHS services; prioritisation of young people for assessment and allocation within AMHS

Integration with wider health and care system

The case discussion forum has representatives from CAMHs, statutory and non-statutory adult mental health services, social care, housing, education and non-statutory young people's services.

The transitions champion is fully embedded in a secondary care adult mental health service.

Working-age adults

Draft core offer outline – Working age adults Mental Health

Care and support to service users and their families / carers

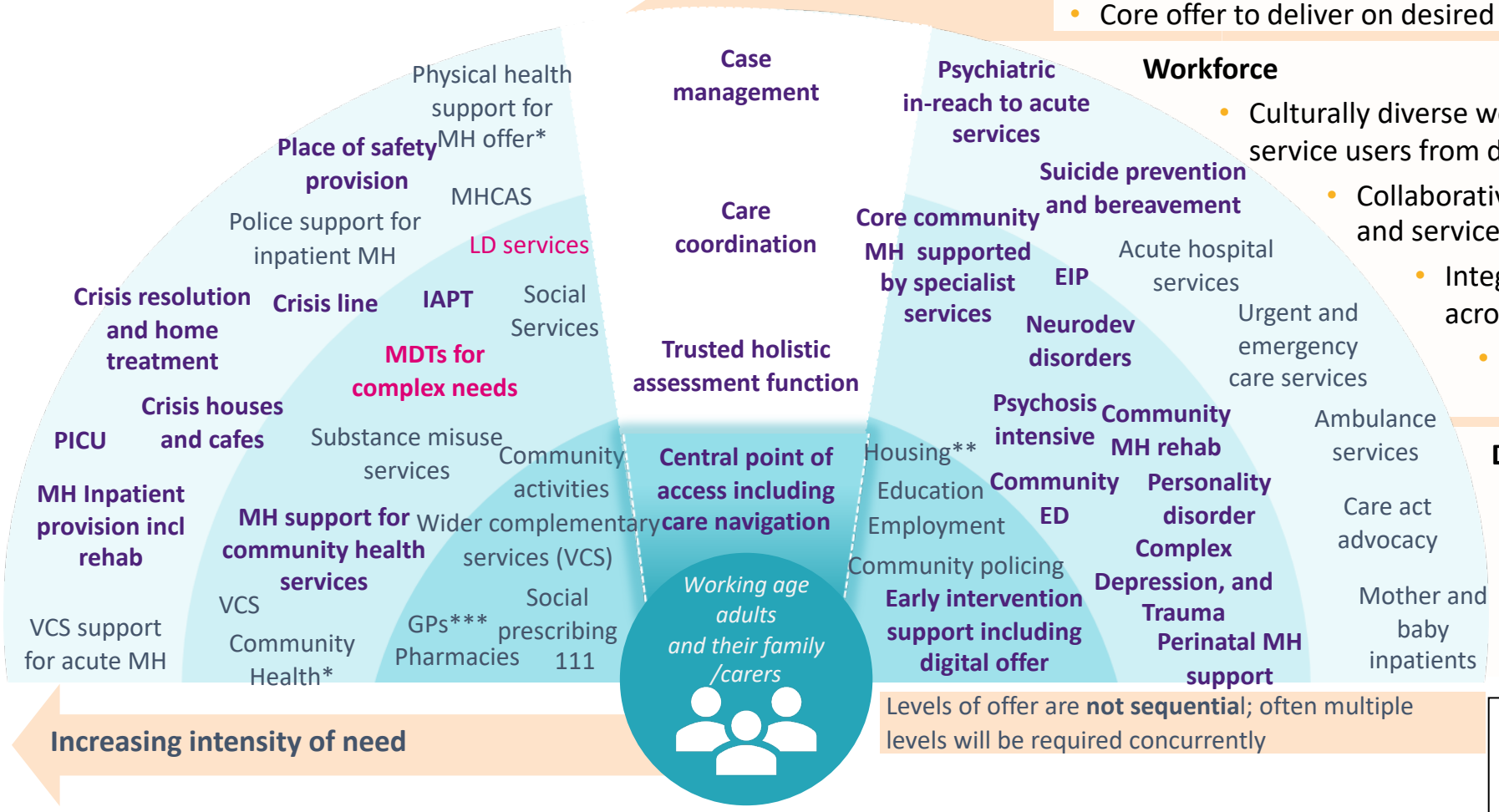
- Shared decision making and care and support planning
- Tailored approach to support different communities
- Focus on early-intervention and prevention
- Services sensitive to cultural and other demographic factors that impact on how people prefer to access care
- Core offer to deliver on desired outcomes for residents

Workforce

- Culturally diverse workforce which can engage service users from different backgrounds
- Collaborative working with professionals and service users and a shared culture
- Integration between services across levels
- Co-location where appropriate

Digital

- Patient records integrated, shared and accessible to all
- NCL wide digital early intervention offer



Increasing intensity of need

Levels of offer are **not sequential**; often multiple levels will be required concurrently

Purple = care functions of core offer in scope of community health services strategic review
Pink = multi-agency function

*Part of community health offer
**Housing incl supported housing and homelessness services
***GPs and broader primary care team including extended roles

Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Early intervention support including digital**

Overview

Description of the care function

Consistent wellbeing support available for adults in community and online; helps to ensure that adults have ”no wrong door”

- Online peer support, counselling and self help resources
- Training for primary care, and employers so that they can support adults with mental health
- VCS or LA provided locality based wellbeing activities that provide peer support and resilience building activities for adults from different communities and cultures

Capabilities required

NCL wide evidence based digital offer

Locality based adult wellbeing hubs

Trainers to deliver training for primary care and employers

Who the care function is for

Support for working age and older peoples and their carers with early mental health difficulties

How the function is accessed

Self referral and walk in

Anonymous digital access

Through primary care, and employers

Can also be accessed through central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Locality wellbeing hubs, online	24/7 for online; 9am-5pm for range of offer with some out of hours provision where appropriate	Immediate access to some support; up to four weeks for 1-1 counselling or other support	As required

Integration with wider health and care system

- Offer ensures that all professionals working with adults and older peoples with early mental health difficulties are able to identify them and are able to support them to access effective early mental health support
- The care functions of the early intervention offer are all linked in with core community mental health teams so that if adults need more specialist support this can be promptly accessed

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Core Community Mental Health**

Overview

Description of the care function

The Core MH teams are aligned to PCNs and deliver flexible, proactive care for young adults through to older adults with moderate to severe mental illnesses across a range of diagnoses and needs in line with NICE guidance QS8, QS53 and:

- focusing on community well-being, prevention and early intervention, as well as high quality care and intervention
- the teams offer trusted holistic assessment and consultation, signposting, navigation and advice, and holistic case coordination and management to help people manage the wider social determinants of mental health, and prevent the associated stresses causing worse mental health
- work to join up mental and physical healthcare
- the teams also work closely with (specialist/intensive e.g. ED, EIP, PD) community MH teams to 'step-up' and 'step-down' support as required.

Capabilities required

Teams staffed with, Peer Coaches, psychologists, nurses, social workers, occupational therapists and psychiatrists

VCS support and EbyES

Who the care function is for

Adults approaching 18 & older, their families and carers, experiencing emotional, behavioural and MH problems too severe to be managed in IAPT; includes homeless

How the function is accessed

Individuals can be referred by their GP, central point of access / care navigator, other health and care professionals. Self referrals (phone /email).

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home with both virtual and in-person options , in GP practices, health centres or any appropriate community setting	Mon-Fri 8am-8pm with ability to arrange out of hours appointments	4 week wait standard of referral to commence intervention (*LTP ambition, being testing currently)*	Plan of intervention agreed with service user and family / carer including the use of DIALOG+

Integration with wider health and care system

Core MH teams are aligned to GP PCNs and rooted in local communities. They have an explicit role to better integrate PH and MH care , primary care with secondary care and statutory services with the VCS. They step up to specialist 'intensive'/specialist community MH teams for those with the most complex needs,

They work closely alongside IAPT, social care and the VCS

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **IAPT (Improving access to psychological therapies)**

Overview

Description of the care function

Holistic assessment and subsequent delivery of NICE approved therapeutic interventions including CBT for depression, anxiety and other common mental health disorders

Available both face to face and virtually available in a variety of languages . Includes offering NICE-recommended psychological interventions for people with LTCs and integration with physical health services. Service users are supported to access ongoing support from local community mental health if required

Capabilities required

Psychological therapists and psychological wellbeing practitioners trained to deliver the range of IAPT/NICE approved psychological interventions for adults with common mental health problems

Who the care function is for

Adults over 16 presenting with common mental health problems and wanting focused psychological interventions.

Exclusions: individuals with complex / severe mental illness or who are a risk to themselves /others

How the function is accessed

People can self refer through website or can be referred by primary care, social workers and other health and care professionals

or through website

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Face-to-face in IAPT locations or virtual or over the phone and GP practices, community venues.	Mon-Fri 8am-8pm with out of hours arrangements	*LTP target*: access within 6 weeks (75% of people referred to IAPT services should start treatment within 6 weeks of referral and 95% within 18 weeks)	Follow up within 2 weeks

Integration with wider health and care system

IAPT service is linked with primary care, local community mental health teams, community health long term condition services and a wide range of community support organisations.

IAPT services are co-located with primary care and community hubs / networks and reduce stigma by being in everyday health settings.

IAPT services can prescribe different kinds of mindfulness and wellbeing apps, for example Headspace

Young adult | Working age adult

Contains national requirement targets

Draft specifications

Core offer care function: **Early Intervention Psychosis**

Overview

Description of the care function

Early Intervention in Psychosis is a service dedicated to the assessment and management of people who have presented to specialist mental health services with a first episode of psychosis.

The service should deliver a NICE recommended package of care (CG178) to:

- Help to prevent the full-onset of illness for persons in a high-risk state; and
- Improve long-term outcomes for those who have already had a first episode of psychosis.
- Deliver At Risk Mental States provision as per NICE guidance
- Meet NCAP standards

Capabilities required

Psychiatrists, occupational therapists, psychologists, nurses, social workers, welfare rights advisors and support workers, pharmacists, peer coaches and EbyEs.

Who the care function is for

Individuals between 14-64 years experiencing early psychotic symptoms with no established diagnosis and period is not considered drug-induced

How the function is accessed

Individuals can be referred through their GP or central point of access / care navigator

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
EIP practices across NCL. Appointments face-to-face. If service user unable to leave home, initial appointments can be virtual	Mon-Fri 8am-8pm with ability to arrange out of hours appointments	National target: access within 2 weeks *(LTP)* NCL target: initial assessment within 5 working days	8-week comprehensive assessment then if accepted, 3 years' worth of treatment or signposting to appropriate service

Integration with wider health and care system

Key interdependency with physical health services through PCN Primary Care Practitioners and Community Physical Health Services.

Named individual coordinating assessment to link to GP, central point of access and care navigator. For service users with complex needs, named individual should also link with care coordinator / case manager and any acute services (e.g. psychiatric in-reach, MH inpatients and physical health in-reach) and social care.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: Psychosis intensive function

Overview

Description of the care function

Psychosis Intensive Teams offer community treatment and support to people with severe psychotic illness with very complex needs who require specialist MDT support beyond which CMHT can provide. This includes provision of clozapine clinics and depot clinics and bespoke assertive outreach for these service users and their carers.
The psychosis intensive function should deliver care in accordance with NICE guidance QS95, QS80 and CG178; Adults with psychosis or schizophrenia are offered cognitive behavioural therapy for psychosis, family intervention, antipsychotic medication, supported employment programmes, comprehensive physical health assessments, healthy living support

Capabilities required

Teams staffed with psychiatrists, occupational therapists, psychologists, nurses, social workers, welfare rights advisors and support workers, with support from pharmacists. Peer Coaches and EbyEs.

Who the care function is for

Adults (18 years or over) their families, parents and carers with severe psychotic illness who require additional support beyond which their CMHT can provide

How the function is accessed

Referred by CMHT

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At community team bases, at home and with both virtual and in-person options. The approach includes assertive outreach	Mon-Fri 8am-8pm with ability to arrange out of hours appointments.	Within 4 weeks	Plan of intervention agreed with service user and family / carer *LTP:* people with a SEMI should receive an annual physical health check

Integration with wider health and care system

Intensive Psychosis community teams should link with GP, Core Teams, adult social care, and mental health inpatient care as well as any other specialist MH teams and the VCS

Works closely alongside community rehabilitation team and substance missuse. Depot is offered as part of primary care offer when individuals have stabilised with shared Care protocol. This is part of offering ongoing recovery treatment in a normalised setting

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: Personality disorder function

Overview

Description of the care function

Provision of specialist support for service users with personality disorders who could benefit from intensive interventions in line with NICE guidance QS88, CG77, CG78:

- A range of psychosocial interventions to meet the needs of this diverse group, offered in a stepped care approach.
- The pathway for this group would typically include locality-based community mental health teams (Core teams), MDT for Complex Emotional Needs (PD and Psychotherapy services)
- These therapies can be delivered individually or in group settings making use of digital offers where possible
- The list of therapies and diversity of the offer should reflect the diversity of need as well as the diversity in the population with a focus on providing evidence-based interventions where available
- The pathway should focus on ensuring an accessible and responsive whole population approach that addresses gaps in services and improves outcomes
- Provision of consultation, advice and training to core teams and other parts of the system as required

Capabilities required

Clinical Psychology, Psychiatry, Social Workers, Nurse, Psychotherapists, OT and EbyE able to deliver specialist PD interventions. Refer to NICE quality spec and related capabilities

Who the care function is for

Adults with severe personality disorder (EUPD, NPD and ASPD) for time bound specialist support.

Support for carers and family

How the function is accessed

Referrals from core mental health teams as well as referrals from other teams (crisis pathway, inpatients and other intensive teams)

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home with both virtual and in-person options Or In PD services across NCL	Mon-Fri 8am-8pm with ability to arrange out of hours appointments.	Within 4 weeks	Plan of intervention agreed with service user at set intervals *LTP:* people with a SEMI should receive an annual physical health check

Integration with wider health and care system

MDT from PD service should link with GP and CMHT, any MDT for complex needs, social care including accommodation providers, A+E and the police as required

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Neurodevelopmental diagnostic and treatment service including autism and ADHD**

Overview

Description of the care function

NICE * adherent Integrated specialist assessment, diagnosis, treatment and provision of therapeutic interventions/support, including CBT, for adults with autism and ADHD. Additional support will include employment and vocational support.

* Autism spectrum disorder in adults: diagnosis and management Clinical guideline [CG142], and quality standard [QS51] and Attention deficit hyperactivity disorder: diagnosis and management NICE guideline [NG87]

Capabilities required

Teams staffed with suitably trained and experienced psychiatrists , nurses, non-medical prescribers occupational therapists, psychologists, and EbyEs

Who the care function is for

Adults with diagnosed or query neurodevelopment disorders who do not have a severe global intellectual disability

How the function is accessed

Can be referred via the core MH teams and specialist MH services, GPs, Social Workers or central point of access

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community clinic setting in person and virtual delivery. Home based visits as required	9-5 Monday to Friday Out of hours provided by crisis team	Within 4 Weeks of referral	Plan of intervention agreed with service user and family / carer

Integration with wider health and care system

Work alongside Core MH teams, LD services, neuro-rehab, sheltered housing, VCS, social care and primary care.

Key interdependency with physical health services through PCN Primary Care Practitioners and Community Physical Health Services. Develop their awareness and competencies in working with people who have NDD.

Key interdependency with physical health services through PCN Primary Care Practitioners and Community Physical Health Services.

Young adult | Working age adult

Contains national requirement targets

Draft specifications

Core offer care function: Adult community eating disorder services

Overview

Description of the care function

The adult ED service provides specialist assessment and treatment to adults who have an eating disorder in line with NICE guidance (NG69, QS175).

A day programme is also available via an intensive therapeutic group programme.

They work alongside the patient's core mental health team where co-existing other mental health conditions are present
They also offer consultation, advice and support to other organisations including primary care and Community Mental Health Recovery Services and to families and carers of service users

Capabilities required

MDT able to deliver specialist community eating disorder interventions; should include psychiatrists, psychologists, nurses, a dietician, occupational therapist and psychological therapists

Who the care function is for

Adults aged 18 or over who have a suspected or confirmed eating disorder diagnosis.

Service also open for advice, consultation and support

How the function is accessed

Individuals can be referred through their GP, central point of access / care navigator, CMHT, college, university, other health professionals. Self referrals from adult their families or carers (phone or email).

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home with both virtual and in-person options	Mon-Fri 8am-6pm with ability to arrange out of hours appointments. Intensive day programme Mon-Fri 10am-3:30pm	Urgent referrals within 1 week and routine referrals within 4 weeks	Plan of intervention agreed with service user, usually covers 1 year of treatment *LTP:* Intensive day patient treatment: 4-5 times per week

Integration with wider health and care system

MDT from ED service should link with GP, any MDT for complex needs, social care, A+E, community nursing teams, MH inpatient care and community mental health teams

Key interdependency with physical health services through PCN Primary Care Practitioners and Community Physical Health Services.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: Community MH rehabilitation

Overview

Description of the care function

Multidisciplinary community team with specialist rehabilitation skills working in line with NICE guidance (NG181):

- Care co-ordinate people with complex psychosis living in supported accommodation.
- Work closely with supported accommodation staff to tailor people's care plans to their needs and clarify which staff are responsible for providing different components of treatment and support.
- Facilitate the person's progression through the rehabilitation pathway by providing flexible personalised support taking account of wider determinants, and enabling the person to gain independent living skills, vocational skills, and confidence to manage in more independent accommodation and participate in the wider community.

Capabilities required

Rehabilitation psychiatrists, nurses, health care assistants, occupational therapists, social workers, AMHPs, Psychologists and Peer Workers, Dual diagnosis workers

Who the care function is for

People with complex psychosis living in 24 hour supported accommodation or their own homes / other settings, based on need.

How the function is accessed

Transferred to team from other community teams if eligible (complex psychosis and living in 24 hour supported accommodation).

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home (usually supported accomm-odation). Face-to-face	Mon-Fri 9am-5pm with weekend support to access community	At transfer meeting	6 monthly MDT care reviews and 2-4 weekly visits from care co-ordinator

Integration with wider health and care system

Community MH rehab teams should link with GP, inpatient rehabilitation teams and social care including accommodation providers, Dual Diagnosis Workers, A+E, and the police as necessary. They will work closely alongside the VCS and employment support services who can often provide wider support.

Community Rehab should inreach to Acute MH settings to support discharges to reduce LOS/DTOC.

Young adult | Working age adult

Contains national requirement targets

Draft specifications

Core offer care function: **Perinatal service**

Overview

Description of the care function

The perinatal MH team works with pregnant and postnatal women with moderate to severe mental health needs who have been referred for specialist input. The team carries out holistic assessment and provides timebound therapeutic interventions in line with NICE guidance (CG192, QS115). This includes providing advice and support to promote self management.

Works alongside health visitors, midwives and adult and CYP social care to manage both risk to mother and baby. Work with women for longer, up until 24 months postnatally and extended work with fathers and partners.

Capabilities required

Perinatal psychiatrists, clinical nurse specialists, clinical psychologist, OT

Who the care function is for

Pre, peri or postnatal women with moderately to severe mental health needs

How the function is accessed

Referral by GP, core MH teams, midwives, obstetrics team, health visitors

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Outpatient clinics in maternity centres, service user's home, virtual	Mon-Fri 9am-5pm with out of hours arrangements	Assess for treatment within 2 weeks of referral and provide psychological interventions within 1 month of initial assessment (*NICE CG192, QS115)*	Follow up for up to 24 months postnatal *(LTP)*

Integration with wider health and care system

Perinatal services should be linked with GPs, midwives, health visitors, mother and baby units, physical health in-reach, core MH teams, specialist MH teams

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Complex Depression, Anxiety and Trauma**

Overview

Description of the care function

Provision of specialist time bound support for service users referred from their core mental health team, IAPT or GP who require more intensive and complex interventions for their depression, anxiety or trauma then cannot be provided by IAPT. Treatment may involve evidence based psychological therapies (e.g. CBT, EMDR) delivered individually or in groups, medication reviews and provision of other bio-psychosocial interventions including psychotherapy and cranial stimulation. Individually tailored therapeutic interventions which may span several years. Other types of help include information and advice about mental health conditions, explanations about medication and support to help with employment or education. Provide advice and support to other agencies around trauma informed care and support. Delivered in line with NICE guidelines (NG116, CG90)

Capabilities required

Psychiatric nurses and psychiatrists, clinical psychologists, EbyEs

Who the care function is for

Adults (over 18) with complex depression, anxiety and / or trauma where the individual would benefit from extra support over IAPT

How the function is accessed

Referral through GP, psychological therapies, core MH teams and social care professionals

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Service clinic face-to-face or virtual; Hospital day case setting for ECT	Mon-Fri 8am-6pm with out of hours arrangements	Within 2 weeks of referral	As agreed in treatment plan

Integration with wider health and care system

The service should work closely with general practitioner, core MH teams, IAPT services, specialist mental health teams, MH inpatients

Work closely with VCS and other statutory / non-statutory partners recognising diversity of trauma and wider determinants

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Electroconvulsive Therapy (ECT)**

Overview

Description of the care function

ECT remains a safe and effective treatment for patients with the most severe and life-threatening depressive illness where alternative therapies have not worked or rapid treatment is needed to maintain safety. Treatment is offered to inpatients and a small number of outpatients, some of whom are receiving maintenance treatment.

ECT is delivered on twice a week, in a dedicated Suite with new, state of the art equipment and a multidisciplinary and multispecialty clinical team.

NICE guidance on the use of electroconvulsive therapy should be followed (TA59)

Capabilities required

ECT Nurse, Lead Psychiatrist for ECT,

Consultant Anaesthetist,

Operating Department Practitioner

Who the care function is for

Primarily, inpatients with severe affective disorders where drug and psychological therapies ineffective.

Small number of people with schizoaffective disorder or catatonia.

How the function is accessed

Standard referral process to cover treatment eligibility, fitness for anaesthetic and consent/MHA considerations.

Lead Nurse and Psychiatrist by email and telephone.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
ECT Suite	10-12 Twice a week	Within 24 hours	Until recommended course of ECT is completed

Integration with wider health and care system

The service should work closely with general practitioner, core MH teams, IAPT services, specialist mental health teams, MH inpatients

Work closely with VCS and other statutory / non-statutory partners recognising wider determinants.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **NCL mental health crisis line**

Overview

Description of the care function

Urgent mental health helplines for people of all ages provided across NCL. Able to triage mental health calls and navigate callers and their families and carers to the right source of support. For callers known to mental health services, responder will be able to ensure an appropriate and timely response from the CYP or adult local crisis team or community teams. For unknown callers, will be able to carry out clinical risk assessment and direct to liaison and crisis response if urgent or to book in for review with their community mental health or CYP mental health team if less urgent.

Capabilities required

Staffed by both adult and CYP mental health practitioners who can assess severity of presentation and triage appropriately

Has access to directory of available in and out of hours support and access

Who the care function is for

People experiencing a mental health crisis

How the function is accessed

Self / parent / carer/ friend referral by phone

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Phone	24 / 7 (*Nice guideline CG136)*	95% of calls answered in 60s (THINK 111 call response times)	N/A

Integration with wider health and care system

Should be integrated with MH community teams and crisis response.

Have access to integrated care record with crisis plans

Link with 111

Link to core mental health teams, primary care and cyp and adult social care emergency teams

Have direct booking functionality into primary care and MH teams

CYP and young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Place of safety provision**

Overview

Description of the care function

Place of safety is a staffed section 136 suite with psychiatric assessment and care provision. They also provide police liaison and diversion provision as well as MHA assessment provision. The team supports service users whilst they undergo assessment and help them to feel safe in the Place of Safety. The teams works together with service users, their family / carers, doctors and Approved Mental Health Professionals (AMHPs) to facilitate efficient assessments and to minimise the length of time people are detained in the suite. Delivered in line with NICE guidance (QS14)

Capabilities required

Psychiatric nurses, AMHPs, psychiatrists, S12 doctors, Peer workers

Who the care function is for

Adult 18+ yrs old identified in the borough by Police Officers who require urgent mental health assessment under s136/135 MHA

How the function is accessed

MHA, S135, S136

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Health based place of safety suite in ICS	24 hours	On patient arrival	Work has to be concluded within 12 hours

Integration with wider health and care system

Place of safety should be integrated with police, MH inpatients, primary care, social care, physical health in-reach (emergency departments), MH core teams, other specialist MH teams

Key interdependency with physical health services through PCN Primary Care Practitioners and Community Physical Health Services.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Crisis houses and crisis cafes**

Overview

Description of the care function

In line with the LTP:

Crisis Houses serve as a safe alternative to hospital admission and support discharge from inpatient settings, they provide trauma informed support and treatment to resolve current crises. Admissions are for short-term intensive care and support.

Crisis cafes are welcoming places where people can go instead of A&E or other urgent services, adults can self present when a crisis escalates.

Capabilities required

Integrated team of VCS, Peer workers, EbyEs, with access to mental health professionals, social care

Who the care function is for

Crisis houses: adults who are in crisis who require 24-hour intensive support in a residential setting.

Crisis cafes: adults and their carers in acute mental health distress or mental health crisis who need a safe, supportive space to manage the crisis.

How the function is accessed

Referral can be through Core MH teams, GP, single point of access, place of safety, liaison or by inpatient wards.

Self-referral

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home, face-to-face	Crisis Houses: 24/7 Crisis Cafes: Mon-Sun times TBC	On presentation	MDT daily review in crisis houses. Therapeutic support whilst present. Length of stay maximum of 2 weeks

Integration with wider health and care system

Service should link with GP, any MDT for complex needs, social care including accommodation providers, A+E, MH inpatient care and community mental health teams, social care, substance misuse services, police.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Crisis resolution and home treatment**

Overview

Description of the care function

Mental health team offering short-term intensive care and support for those experiencing mental health crisis. Crisis Resolution and Home Treatment Teams (CRHTs) are based in the community and provide a safe and effective, home-based mental health assessment and treatment service in order to reduce the need for inpatient care.

CRHT should meet CORE fidelity and be delivered in line with NICE guidance (QS14)

Capabilities required

Integrated team of mental health professionals and social care

Who the care function is for

Adults with a mental health crisis where community care is viewed as viable and safe alternative to inpatient care

How the function is accessed

Referral can be through CMHT, GP, single point of access, place of safety, liaison or by inpatient wards.

Self-referral

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home, face-to-face. Location based on need	Accessible 24 / 7 (LTP)	4 hrs for emergency referral and within 24 hours for urgent referrals in community mental health crisis services *(LTP)*	MDT daily review, home based assessment and therapeutic support up to twice daily

Integration with wider health and care system

Service should link with GP, any MDT for complex needs, social care including accommodation providers, A+E, MH inpatient care and community mental health teams, police.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Psychiatric in-reach (liaison) to acute A+E and acute wards**

Overview

Description of the care function

Timely psychiatric assessment for adults presenting to A+E and on acute wards with acute mental health presentations. Includes support for community intermediate care

Includes psychiatric liaison and/or community mental health team assessments to support facilitation of timely acute discharges

Mental health input also built into adult community health Long term condition teams (e.g. weight management, diabetes and epilepsy)

Meet the CORE24 and PLAN accreditation standards

Capabilities required

Liaison Nurses, Adult and Old Age Psychiatrists, Psychologists. Peer support workers

Who the care function is for

Adult mental health presentations in A+E and on wards in each acute site

How the function is accessed

In A+E and on hospital wards

Available for telephone advice and support as well as in person assessments and care planning

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
In A+E, acute hospital wards, acute MDT discussions (e.g. D2A), community bedded rehab	24 / 7 (*CORE 24)*	1 hr for emergency department; 24 hrs for medical ward (*LTP targets currently being tested)*	4 hourly reviews in ED and as required on medical wards 12 sessions of follow up post self-harm

Integration with wider health and care system

Psychiatric in-reach should link with ED (inc HIU group), acute physical health wards, alcohol and substance misuse services, inpatient mental health wards, crisis and home treatment teams, perinatal mental health services, and primary care, as well as voluntary. Will also need to link with police and place of safety.

Psychiatric in-reach links directly to crisis response teams

Duplicative with psychiatric liaison & CRHT

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer element: **Mental Health Crisis Assessment Service (MHCAS) – alternative to ED**

Overview

Description of the element

Emergency psychiatric assessments delivered in a bespoke mental health setting outside of A+E. Delivers therapeutic emergency assessments (response time 1 hour) as A+E diversion and via attendance at front door by LAS, Police and walk-ins.

Diverts majority of presentations from ED to MCHAS for therapeutic intervention and crisis de-escalation.

Meets the relevant CORE24 and PLAN accreditation standards

Capabilities required

Adult and old age liaison Nurses, support workers, psychiatrists, social workers and peer coaches (peer support workers)

Who the element is for

Emergency adult mental health presentations

How the element is accessed

By transfer from A+E (A+E diversion), walk ins and direct conveyance by LAS and Police

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Bespoke facility	24 / 7	1 hr	4 hourly reviews in MHCAS department

Integration with wider health and care system

Close working with EDs, MH liaison teams, crisis teams and inpatient mental health wards.

Regular meetings with LAS and police across NCL.

Young adult | Working age adult

Contains national requirement targets

Draft specifications

Core offer care function: MH inpatient rehabilitation

Overview

Description of the care function

Inpatient rehabilitation for people with complex psychosis in line with NICE guidance QS14, NG53 – includes high dependency inpatient rehabilitation units, longer term high dependency inpatient rehabilitation unit and community rehabilitation units for voluntary and MHA admissions. Provision of 24/7 specialist rehabilitation, linking with community care planning.

A detailed care plan and assessment are co-produced with the service user and their family/carers

Capabilities required

Team includes psychiatrists, nurses, health care assistants, OT, Psychologists, Arts therapists, Activity Workers, Dual Diagnosis workers, Peer support workers. Bed management team. Formalised discharge teams.

Who the care function is for

People with severe treatment resistant psychosis with functional impairments. Co-existing physical health and mental health conditions are commonly present.

How the function is accessed

Majority of referrals from acute wards (80%) and forensic inpatient mental health services (20%).

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Inpatient rehabilitation wards and community rehabilitation units	24 / 7 (*NICE QS14)*	Assessment for eligibility within 2 weeks of referral.	Length of stay on average, 1 year for high dependency unit, 1-3 years for longer term high dependency unit and 2 years for community rehab unit.

Integration with wider health and care system

Close links with community rehabilitation team, social care, other community teams and physical health colleagues including GPs who ensure appropriate physical health care and facilitate move-on to next step in rehab pathway (from higher to lower supported settings).

In reach from community and crisis teams.

Young adult | Working age adult

Contains national requirement targets

Draft specifications

Core offer care function: MH inpatient services

Overview

Description of the care function

Inpatient short and medium care for voluntary and MHA admissions. Provision of safety and 247 therapeutic support, linking with community care planning. Inpatient care for forensic patients requiring secure 24/7 input.

A detailed care plan and assessment are co-produced with the service user and their family / carers

Inpatient care including comprehensive assessments in mental and physical health and treatment including the provision of ECT.

Meet AIMs accreditation standards

Capabilities required

Team includes psychiatrists, nurses, HC assistants, OT, Psychologists, Arts therapists, Activity Workers, Dual Diagnosis workers, Peer support workers. Bed management team. Formalised discharge teams. MHA administration.

Who the care function is for

Adults in crises needing informal or MHA admissions. Too severe to be managed in IAPT or the core CMHTs.

How the function is accessed

Crisis and Liaison Teams gatekeep all admissions

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Inpatient ward	24 / 7	Acute Beds available to CMHT same day and A+E within 4 hrs;	LOS dependent on progress Daily MDT review and daily therapeutic 1-1 and group input 48 hr follow-up*

*48 hr follow-up based on NCISH toolkit 2021

Integration with wider health and care system

Inpatient services should link with core mental health team, GP, any MDT for complex needs, social care including accommodation providers, A+E and flow from acute medical wards, VCS, substance misuse and police. Integration into wider health and care system for community and crisis. Provision of equipment for safe admission. Key interdependencies with Local Authorities; e.g. Care Act assessments, reviews, SGA enquires and with physical health services through PCN Primary Care Practitioners and Community Physical Health Services. Access to physiotherapy, SALT, tissue viability, incontinence, podiatry, spirituality in-reach.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: PICU

Overview

Description of the care function

Specialist wards that provide secure inpatient mental health care, assessment and comprehensive treatment to individuals who are experiencing the most acutely disturbed phase of a serious mental disorder. Outreach support to other wards.

Inpatient care including comprehensive assessments in mental and physical health.

To meet NAPICU standards.

Capabilities required

The team includes psychiatrists, nurses, health care assistants, OT, Psychologists, Arts therapists, Activity Workers, Dual Diagnosis workers, Peer support workers. Bed management team. Formalised discharge teams. In reach from community and crisis teams.

Who the care function is for

Patients with very high level of risk to themselves or others

How the function is accessed

Only people detained under the MHA can be admitted through hospital or community.

Forensic and Prison population specific pathways

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Inpatient ward	24 / 7	Within 1 hours	Length of stay dependent on progress *(NAPICU guidance: 7-22 days)* Daily MDT review and daily therapeutic 1-1 and group input

Integration with wider health and care system

PICU services should link with core mental health team, GP, any MDT for complex needs, social care including accommodation providers, A+E, VCS, substance misuse and police.

Integration into wider health and care system for community and crisis. Provision of equipment for safe admission.

Key interdependency with physical health services through PCN Primary Care Practitioners and Community Physical Health Services. Access to physiotherapy, SALT, tissue viability, incontinence, podiatry, spirituality inreach.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: **Physical health checks for SEMI**

Overview

Description of the care function

All MH services will support people with SMI to receive their annual physical health screening, to access appropriate physical health care and to offer preventative support to reduce risk factors for long term conditions. A population health approach and shared information systems such as HIE and HealtheIntent will enable Core MH teams to collaborate with primary care to increase the take up of full physical health checks in the SMI population (including severe depression and personality disorders). People with SMI are at higher risk of poor physical health compared with the general patient population. Physical health checks should be carried out at least 1/ year. Screening should be linked to clear and accessible physical health care interventions to reduce the excess in long term conditions and the mortality gap for people with SMI.

Capabilities required

Perform and interpret annual physical health check: BP, HR, Diabetes, Lipids, ECG, Weight, Alcohol. Provide preventative interventions to reduce risk factors in this population.

Who the care function is for

Adults over 18 with a diagnosis of a Severe and Enduring Mental Illness (on GP registers)

How the function is accessed

Self / parent / carer/ friend referral by phone, GP

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Primary or secondary care sites	8-6 Mon-Fri with some flexibility to meet needs of patients	*LTP target*: 60% of people with SEMI should have a full physical health check once / 12 months	Regular yearly review or more as required

Integration with wider health and care system

Should be directly integrated with primary care. Work alongside core mental health teams

Links in with all mental health services for people with SMI or LD.

Young adult | Working age adult | Older people | Contains national requirement targets

Draft specifications

Core offer care function: Suicide prevention and bereavement*

Overview

Description of the care function

Specialist suicide crisis services to provide brief therapeutic intervention and support in the community for people experiencing a suicidal crisis (in line with NICE guidance NG105) who may otherwise not access/be eligible for MH care. Proactive flexible compassion-based approach focussed on continuity of care. **Safe from Suicide Services** within MH organisations to provide intensive community input for those with recurrent self-harm or at high risk of suicide. **Specific support services for those affected and bereaved by suicide or other unexpected death. Specific 1/1 and group provision required for:**

- Families, friends, young people.
- Organisations such as schools/universities (in-reach), targeted training for key staff, including non-MH staff
- Healthcare staff such as first responders, GPs, ED & MH staff.

Awareness raising & training provision - to create Suicide Safer Organisations, reduce stigma and reduce barriers to help-seeking to prevent suicide; enhanced suicide-specific assessment, intervention and safety planning skills among professionals at different levels. **Safe from Suicide Team providing** oversight and guidance, responsible for MH organisation and inter-organisation service delivery and training, learning from incidents, support across teams, review of protocols (e.g., on transition from A&E, hospital, prison) and competency.

Capabilities required

Psychological therapists, Counsellors, Group therapists, Peer workers, Psychiatrists, Suicide bereavement liaison and support counsellor, suicide prevention trainers, Community risk specialists.

Who the care function is for

People with, and at risk of, suicidality

People impacted by suicide or other unexpected deaths

Organisations in the wider community, including non healthcare

How the function is accessed

In community settings, within MH trusts, in people's homes, within organisations impacted by suicide (eg schools).

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Community settings, within MH Trusts, people's homes, organisations.	Suicide prevention services – 24/7 Support after Suicide – 9-9pm 7	Based on need	Based on need

Integration with wider health and care system

Provision of support for schools and other organisations would be best delivered as in-reach, co-designed and co-delivered with leadership teams within the institutions. Specialist suicide crisis service will need to interface with other MH, NHS and local authority services such as housing. Safe from Suicide services should be integrated within MH provider organisations and have close links with other services for those with complex needs.

Given that multifactorial nature of suicide, it is essential that prevention approaches are designed, developed and overseen by a collaborative partnership including community partners, commercial partners, public health, mental health and those with lived experience. Support after suicide for MH trusts should be integrated within the organisation.

**Potential care function for later-phase implementation*

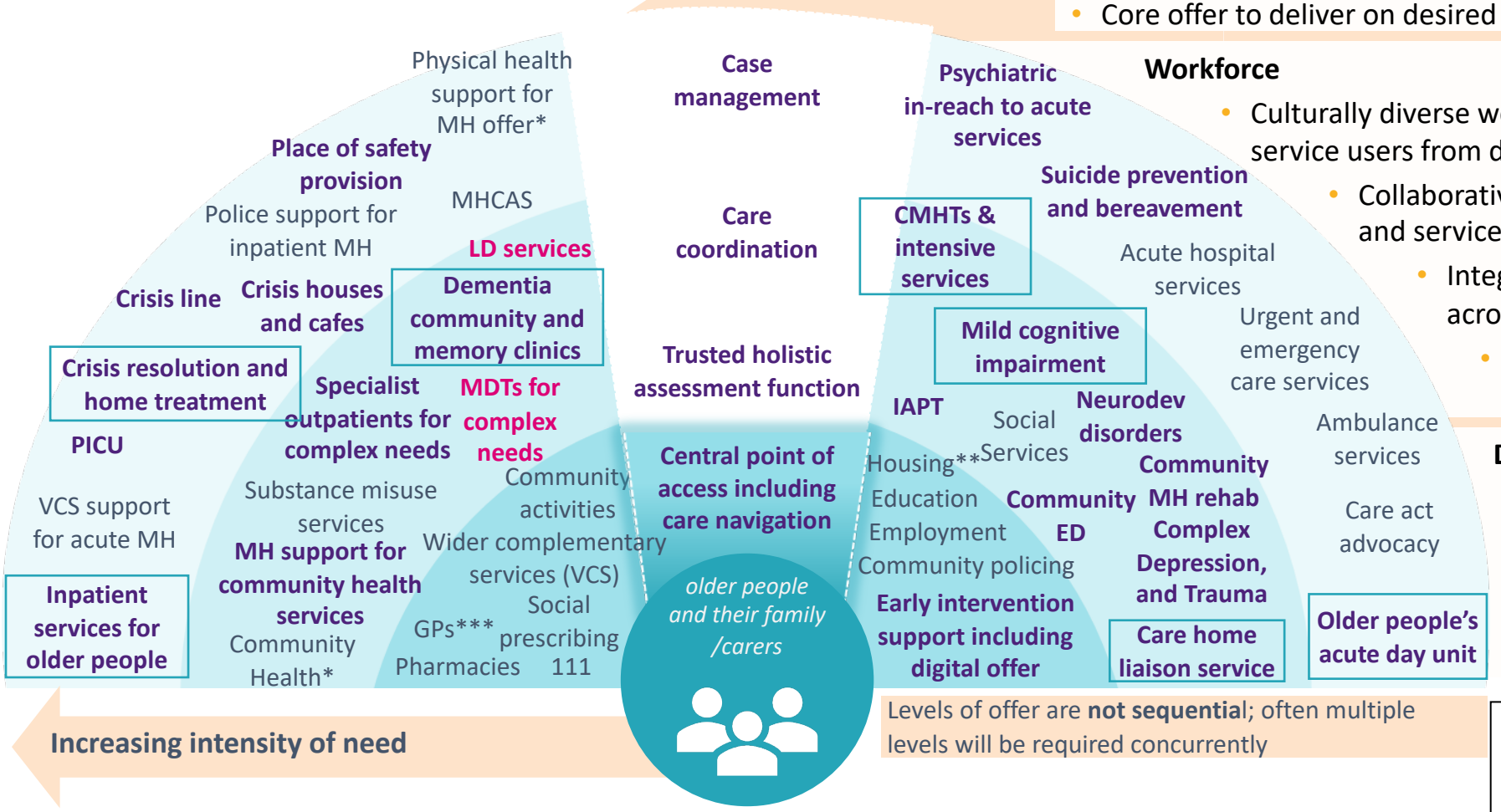
Older people

Draft core offer outline – Older people Mental Health

Description of care functions specific to older people follow this slide and are shown in the diagram below in boxes; other care functions are described within the working age adult offer

Care and support to service users and their families / carers

- Shared decision making and care and support planning
- Tailored approach to support different communities
- Focus on early-intervention and prevention
- Services sensitive to cultural and other demographic factors that impact on how people prefer to access care
- Core offer to deliver on desired outcomes for residents



Workforce

- Culturally diverse workforce which can engage service users from different backgrounds
- Collaborative working with professionals and service users and a shared culture
- Integration between services across levels
- Co-location where appropriate

Digital

- Patient records integrated, shared and accessible to all
- NCL wide digital early intervention offer

Increasing intensity of need

Levels of offer are **not sequential**; often multiple levels will be required concurrently

Purple = care functions of core offer in scope of community health services strategic review
Pink = multi-agency function

*Part of community health offer
**Housing incl supported housing and homelessness services
***GPs and broader primary care team including extended roles

Draft specifications

Core offer care function: CMHT / Intensive Services for Older People

Overview

Description of the care function

Older people's mental health and dementia assessment, treatment and care management for patients living in the community, whose needs are too intensive to be met within a core team. Supporting patients with earlier discharge from hospital and/or to move to appropriate ongoing care.

This service works closely with the Core MH teams aligned to PCNs to 'step –up' and 'step-down' support as required. In order to deliver flexible, proactive care for people with moderate to severe mental illnesses to provide high quality care and interventions.

Capabilities required

Older people psychiatrists, psychologists, mental health nurse, social work occupational therapy

Who the care function is for

Older adults' and those experiencing age related frailty, with mental illness and/or dementia whose needs are too great to be met in a Core Team or Memory Service

How the function is accessed

Individuals can be referred by the Core MH Team, GP, ASC or other secondary mental health service or carer/self referral

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home, in clinic, hospital or community	Monday Friday 09.00 to 17.00	Assessment within 4 weeks of referral *(LTP ambition being tested currently)*	Treatment, Care Coordination, onward referral, Social Care Assessment

Integration with wider health and care system

Will work alongside inpatient services and in close liaison with with Core Teams and Crisis/Home Treatment Teams. Will work closely with ASC, Physical Health Services and GPs, housing services, carers and voluntary sector.

Draft specifications

Core offer care function: Dementia community and memory clinics

Overview

Description of the care function

Specialist service that provides **both** holistic assessment and diagnosis and also treatment of people suspected of developing dementia, including young onset dementia in line with NICE guidance (NG97). Patients diagnosed with dementia will be reviewed regularly to monitor the progression of the condition and to offer therapeutic support, psychological interventions advice and signposting.

Service also provides advice and support to both the service user and their family/carer, advice and support to access local and national support services, and liaison and feedback to their GP

Capabilities required

Team consisting of nurse, independent nurse prescriber, occupational therapist, adult social worker, consultant psychiatrists, psychologists, peer support workers

Who the care function is for

Adults with a history of symptoms associated with Dementia or with a formal diagnosis of dementia

How the function is accessed

Individuals can be referred through their GP, primary and secondary MH or community teams or other specialist services.

Families / carers can also refer to this service

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home or in memory clinic. Face to face appointments	Mon-Fri 9am-5pm with ability to arrange out of hours appointments	Referral to diagnosis within 6 weeks	Treatment and support plan developed with service user and nominated individual (family, friend, or carer)

Integration with wider health and care system

Dementia community and memory teams should link with primary care, acute medicine for the elderly teams, adult social care, CMHTs, enhanced care in nursing homes teams and MDTs for people with complex needs

Should support and work alongside acute psychiatric in-reach into hospital care (liaison) and IDTs (Integrated discharged teams) to support safe discharges

Draft specifications

Core offer care function: **Mild cognitive impairment***

Overview

Description of the care function

Specialist service that provides assessment and diagnosis as well as:

- Regular follow-up to monitor possible progression of cognitive deficit.
- If symptoms deteriorate, service users should be referred to the dementia and memory clinic for specialist assessment and management.
- Active engagement with primary care to manage any other physical conditions (MCI is more likely to progress to dementia if the person has a poorly controlled heart condition or diabetes, or has strokes)

Capabilities required

Team consisting of nurse, independent nurse prescriber, occupational therapist, adult social worker, consultant psychiatrists, psychologists, peer support workers

Who the care function is for

Adults with minor problems with cognition that do not fulfil the diagnostic criteria for dementia.

How the function is accessed

Individuals can be referred through their GP, primary and secondary MH or community teams or other specialist services.

Families / carers can also refer to this service

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home or in memory clinic. Face to face appointments	Mon-Fri 9am-5pm	Referral to assessment within 2 weeks	Support plan developed with service user and nominated individual (family, friend, or carer)

Integration with wider health and care system

Mild cognitive impairment service should link with dementia and memory clinics, primary care, acute medicine for the elderly teams, adult social care, CMHTs, enhanced care in nursing homes teams and MDTs for people with complex needs

Should support and work alongside acute psychiatric in-reach into hospital care (liaison) and IDTs (Integrated discharged teams) to support safe discharges

**Potential care function for later-phase implementation*

Draft specifications

Core offer care function: **Care home liaison support**

Overview

Description of the care function

Older people's mental health and dementia input to local primary care led enhanced health in care home teams (EHCH) and in line with NICE guidance (NG32, PH16, QS159, QS50). Provide support for care home residents with known mental health conditions and dementia and for residents with new presentations

Provide mental health assessments, support development of treatment plans and link to local older people's CMHT as required

Provide training and support to care home staff and other members of EHCH team as required

Capabilities required

Older people psychiatrists, psychologists, mental health nurse and occupational therapy

Who the care function is for

Care home residents for diagnosis and treatment of known or suspected complex mental health conditions including dementia.

Care home staff - Supporting staff to provide care

How the function is accessed

As part of enhanced health in care homes teams which each support a number of care homes

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Care homes, virtual, EHCH MDTs	Mon-Fri 9-5 Crisis resolution and home treatment teams to pick up outside of working hours	Same day response for urgent reviews, otherwise 1 week	Treatment and support plan developed with service user and nominated individual (family, friend, or carer) ongoing contact with staff

Integration with wider health and care system

As part of Enhanced health in care home teams, work alongside primary care, community health and social care. Provide link between EHCH and the servicer's users older people's CMHT as required. Important to have access to IAPT services, primary care mental health services.

Draft specifications

Core offer care function: **Older Adults Crisis resolution and home treatment***

Overview

Description of the care function

Mental health team offering short-term intensive care and support for older adults (aged 70 years and above OR under care of an older adult community team OR have a diagnosis of dementia) experiencing mental health crisis. Crisis Resolution and Home Treatment Teams (CRHTs) are based in the community and provide a safe and effective, home-based mental health assessment and treatment service in order to reduce the need for inpatient care.

Working with and supporting carers to manage with confidence.

Advice and guidance to care homes and other providers.

Meets Core fidelity and NICE guidelines (QS14).

Capabilities required

Integrated team of nurses, a consultant Psychiatrist, psychiatry trainee, Assistant Practitioner and Occupational Therapist.

Who the care function is for

Older adults with a mental health crisis where community care is viewed as viable and safe alternative to inpatient care or I order to facilitate discharge from hospital

How the function is accessed

Referral can be through CMHT, Social Worker, GP, single point of access, MHCAS, place of safety, liaison or by inpatient wards or self referral.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At home, face-to-face, location based on need	Mon-Fri 8am-7pm. Weekends/ bank holidays 8am-4pm	4 hours and 24 hours	MDT daily review, home based assessment and therapeutic support up to twice daily

Integration with wider health and care system

Service should link with GP, any MDT for complex needs, social care including accommodation providers, A+E and liaison, MH inpatient care, acute medical inpatient care, community mental health teams, memory services, care home liaison teams, other trust teams and services, police.

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**Potential care function for later-phase implementation*

Older people

Contains national requirement targets

Draft specifications

Core offer care function: **Inpatient services for older people**

Overview

Description of the care function

Inpatient short and medium care for voluntary and MHA admissions. Provision of safety and 247 therapeutic support, linking with community care planning. Inpatient care for forensic patients requiring secure 24/7 input. A detailed care plan and assessment are co-produced with the service user and their family / carers

Inpatient care for dementia patients including comprehensive assessments in mental and physical health; particularly in cognition, delirium, pain, continence and nutritional needs and treatment including the provision of ECT.

Capabilities required

The team includes older people psychiatrists, nurses, health care assistants, OT, Psychologists, Arts therapists, Activity Workers, Dual Diagnosis workers, Peer support workers. Bed management team. Formalised discharge team & MHA admin

Who the care function is for

Older people with needs related to ageing in crises (including dementia) needing informal or MHA admissions.

Too severe to be managed in community.

How the function is accessed

Crisis and Liaison Teams gatekeep all admissions

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
Inpatient ward	24 / 7	Acute Beds available to CMHT same day and A+E within 4 hrs;	Length of stay dependent on progress Daily MDT review and daily therapeutic 1-1 and group input

Integration with wider health and care system

Inpatient services for older people should link with core mental health team, GP, dementia community and memory clinics, any MDT for complex needs, social care including accommodation providers and care homes, A+E and flow from acute medical wards, VCS, substance misuse and police. Integration into wider health and care system for community and crisis. Provision of equipment for safe admission. Key interdependencies with Local Authorities; e.g. Care Act assessments, reviews, SGA enquires and with physical health services through PCN Primary Care Practitioners and Community Physical Health Services. Access to physiotherapy, SALT, tissue viability, incontinence, podiatry, spirituality inreach.

In reach from community and crisis teams.

Draft specifications

Core offer care function: **Older People Acute Day Unit***

Overview

Description of the care function

An Older adult Day unit which provides a period of time-limited, recovery goal orientated treatment for up to 6 months for older adults with functional mental health diagnoses. The service supports older adults in mental health crisis as an alternative to hospital admission, or to facilitate discharge from hospital. This service offers highly skilled holistic treatment by a very experienced multidisciplinary team offering a tailored care plan to address the needs of the individual, to include psychological therapy, art therapy and a variety of activities and groups. Care is overseen by a Consultant Psychiatrist and involves close liaison with other teams and services, GPs and patient families.

Capabilities required

Team consisting of nurses, occupational therapist, psychologist, art therapist, consultant psychiatrist and trainee doctors.

Who the care function is for

Older adults in mental health crisis as an alternative to hospital admission, or to facilitate a discharge from hospital.

How the function is accessed

Referral can be through CMHT, liaison teams, inpatient wards or other trust teams.

Operations

Point of delivery	Hours of operation	Response time for first contact	Ongoing contact and response
At the Day unit, home assessments and outreach work t home, face-to-face	Monday-Friday 9am-5pm	Assessment offered within 7 days of referral	MDT regular review. Therapeutic support whilst present. Length of stay maximum of 6 months

Integration with wider health and care system

Service should link with should link with primary care, acute medicine for the elderly teams, adult social care, older people's CMHTs and MDTs for people with complex needs

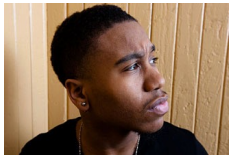
Should support and work alongside acute psychiatric in-reach into hospital care (liaison) and IDTs (Integrated discharged teams) to support safe discharges.

**Potential care function for later-phase implementation*

Contents

Pen portraits

Increasing holistic needs

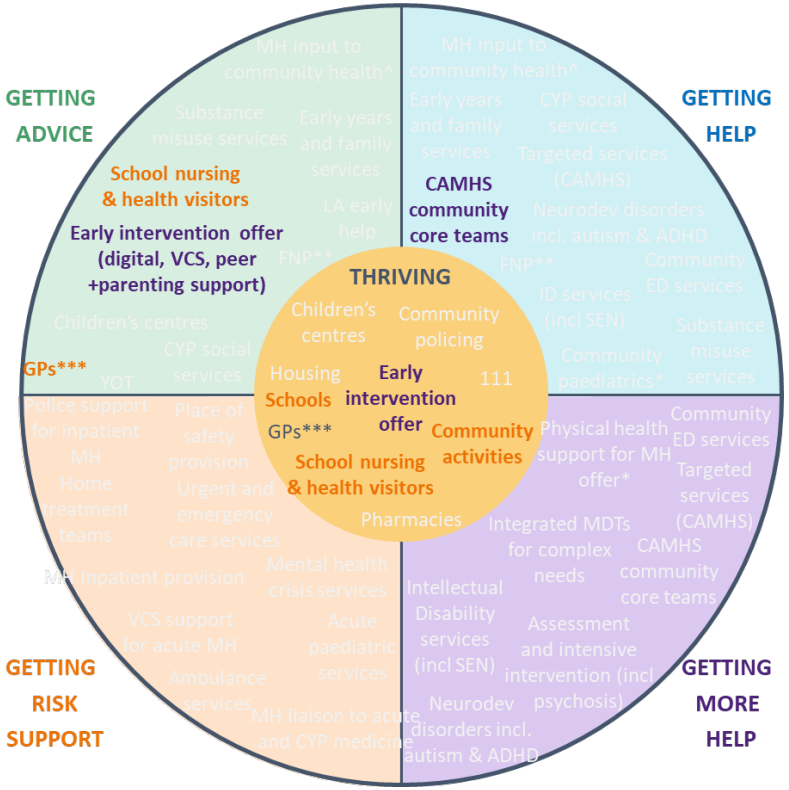
 Children & Young People	**1. Freya** is a white 14-year-old teenager whose academic performance at school has been deteriorating and appears withdrawn and tired in class. She has stopped playing in the band she was formerly a member of. She lives in cramped accommodation with not much money at home, her parents are separating, and she is being bullied at school.	**2. Patrick** is a 7-year-old Black Caribbean boy. He has a diagnosis of autism and also suffers from anxiety. He suffers from language and cognitive impairment and attends a special school. He is cared for by his parents who have two other children. His father has had to give up work to provide the additional support required for Patrick.	**3. Jack** is a British Asian 8-year-old with cerebral palsy. He walks with the support of walking sticks and leg braces. He has difficulties talking and swallowing. He also suffers from moderate learning difficulties and attends a special school. He has regular admissions to hospital suffering from pneumonia. He also has significant hearing loss. His single mother suffers from periodic episodes of depression. They receive support from their extended family.
 Working age adult	**4. Asha** is a British Asian 22-year-old and has suffered from ADHD since primary school. She lives with her family in Archway and is studying economics part-time at London Met university. Her ADHD impacts her performance at university. She has struggled to maintain a job because of her impulsiveness.	**5. Daniel** is a Black 48-year-old man and lives in Tottenham. He suffers from schizophrenia and has been in and out of mental health inpatient facilities including PICU since he was 17. He lives in supported accommodation and is unemployed. His two brothers and mother are supportive but cannot contact him when in crisis. He usually turns up in A&E when he is in crisis. He has asthma but does not reliably take his medication.	**6. Melissa** is a 55-year-old Black woman from Kentish Town with poorly controlled Type I diabetes, and chronic diabetic foot ulcers. These frequently become infected, and she requires hospital admission for treatment of sepsis. She suffers from chronic back pain, is obese and has episodes of depression. She has an opioid addiction. She frequently has to have time off work. She lives with her partner.
 Older people	**7. Vera** is 70, white, lives alone in Bounds Green and is in hospital having fallen over and fractured her hip. She is isolated and lonely. While in hospital, she is very anxious and tells staff that the night team have been stealing her possessions. The ward physio does not feel that she can safely be discharged home because of her poor mobility and her previous history of falls.	**8. Paul** is 72, recently widowed, lives in Edgeware and is Black Caribbean. He has high blood pressure and is now partially sighted. His son noticed he has lost interest in activities and is withdrawn, confused and finds it hard to engage in conversation and he has been getting lost. Paul does not think there is a problem and declines any help.	**9. Yasmiin** is 87, from Somalia and a long-term resident of Camden but now lives in a Care Home in East Barnet nearer to her family. She has mild dementia, breast cancer, heart failure and is thought to be in last 6 months of her life. She has had four hospital admissions in the last six months with breathlessness related to her heart failure.

Example pathway: Teenager with early mental health difficulties

Freya is a white 14-year-old teenager whose academic performance at school has been deteriorating and appears withdrawn and tired in class. She has stopped playing in the band she was formerly a member of. She lives in cramped accommodation with not much money at home, her parents are separating, and she is being bullied at school.

Purple = care functions accessed in the example pathway that are part of the scope of the core offers (community and MH)

Orange = other functions that are accessed in the example pathway but are out of scope of the core offers



What care will look like through the core offer

Freya's school tutor (who has received training under the universal mental health offer) is concerned and has a 1-1 catchup with Freya and asks the local mental health in schools team to see her via the central point of access. The school tutor also provides support with the bullying in line with the school's whole school approach. Freya is seen within two weeks by a mental health in schools practitioner, has a full holistic assessment and is diagnosed with mild anxiety and depression. She is signposted (THRIVE getting advice) to some self-help materials and information re sleep hygiene and anxiety management. She is encouraged to engage with the NCL online digital mental health counselling and peer support offer. Freya's parents are both engaged with group based parenting support. She is also encouraged to sign up to a local resilience building music activity based at local youth club run by the VCS. Freya's mood and anxiety improve and her grades start to improve. Her GP is kept updated via the digital integrated care record.

Subsequently however, her mood does worsen, she starts withdrawing again from activities she previously enjoyed and reports not being able to get to sleep at night. She reports this to the school nurse when having a routine vaccination. The school nurse gets in touch with the mental health in schools practitioner who reviews Freya again. She assesses that Freya's anxiety and depression has worsened and arranges for Freya to be reviewed together with her parents by the core CAMHS community team within two weeks. They co-produce a treatment plan with Freya and her parents together with the school mental health practitioner. This involves a course of cognitive behavioural therapy alongside the ongoing digital support and the support for her parents. Freya's mood improves and she is able to return to her normal level of functioning.

Example pathway: Child with autism and cognitive impairment

Patrick is a 7-year-old Black Caribbean boy. He has a diagnosis of autism and also suffers from ADHD. He suffers from language and cognitive impairment and attends a special school. He is cared for by his parents who have two other children who do not have Autistic Spectrum Disorder.

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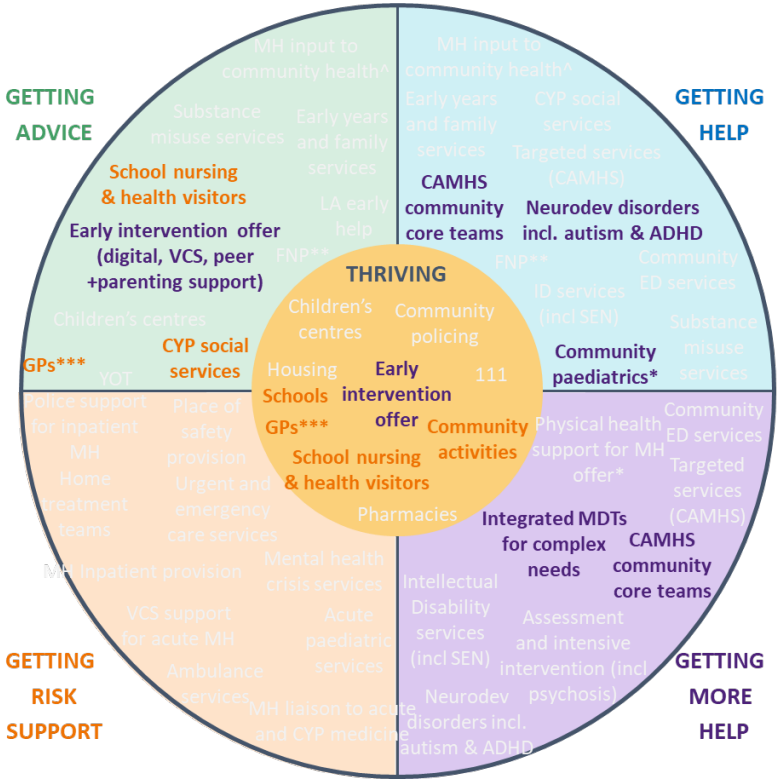


What care will look like through the core offer

Patrick's care is case managed by the neurodevelopmental diagnostic and treatment service and a joint care plan has been developed. His care is regularly reviewed at an MDT involving his parents, his teachers, early help social worker, community paediatrics and members of the neurodevelopmental team. All professionals utilise a digital shared care record which primary care and social care also have access to.

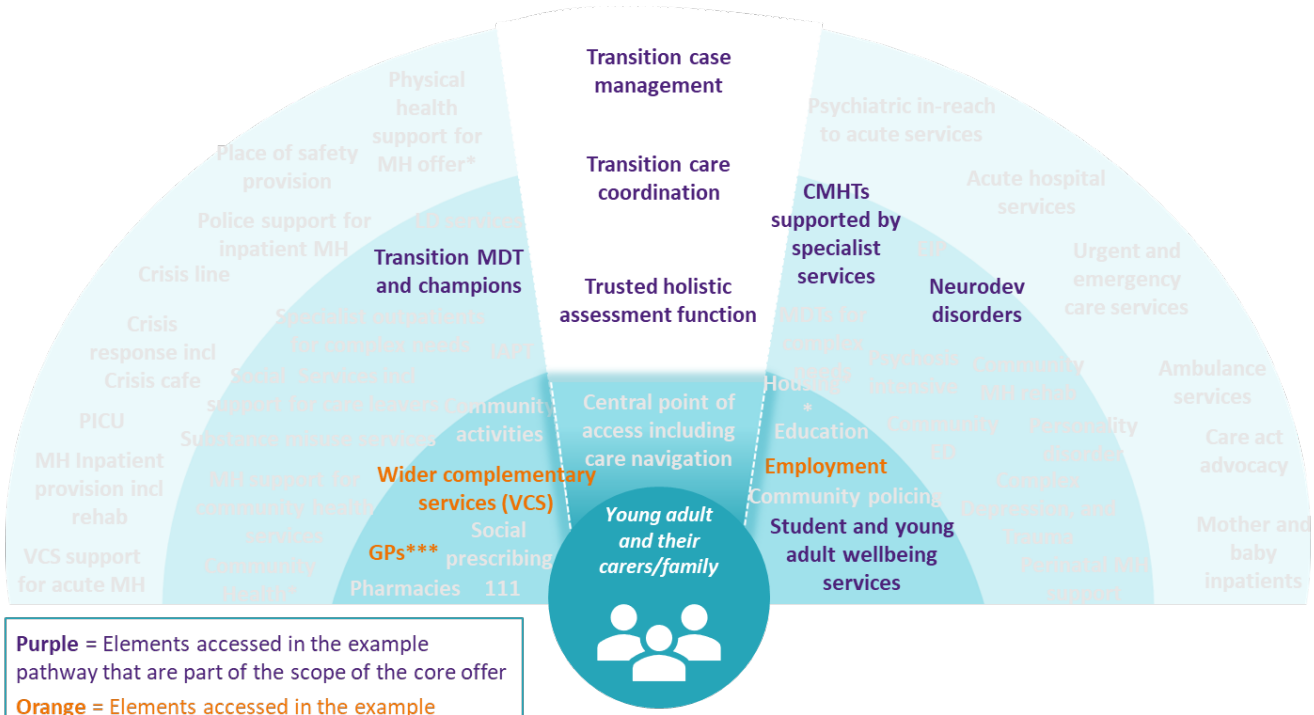
Patrick and his parents are supported to navigate the support available to them. His parents have a number they can contact to get in touch with his case manager during normal hours and an out of hours crisis plan. Teachers and support staff at the school also receive regular training in how to support management of autism. This includes how to best support his education.

Therapeutic support includes delivery of played based and behavioural support in conjunction with training and support for parents and teachers.

He has regular reviews by a child and adolescent psychiatrist, this was how his anxiety was originally diagnosed. His anxiety is managed through a mix of therapy and medication. His parents are supported by CYP social care early help who have arranged for episodes of respite care (short breaks). Regular holistic reviews include assessment of the emotional and practical support requirements for parents and siblings.

Example pathway: Young adult with mental health needs

Asha is a British Asian 22-year-old and has suffered from ADHD since primary school. She lives with her family in Archway and is studying economics parttime at London Met university. Her ADHD impacts her performance at university. She has struggled to maintain a job because of her impulsiveness.



Purple = Elements accessed in the example pathway that are part of the scope of the core offer

Orange = Elements accessed in the example pathway that are out of the scope of the core offer

What care will look like through the core offer

Asha's care is case managed by the local adult core mental health team with the support of a transition clinician from the CAMHs neurodevelopmental team. Her transition from being supported by CAMHs to the adult team was smooth because of regular discussions by the transition MDT. She has a regular review for her ADHD and has the support of an occupational therapist who supports her with both studying and provides vocational support

She accesses a local young adult wellbeing hub in Holloway through which she joins a peer support group and vocational training courses. She also accesses online self help resources through the NCL digital offer

When she sees her GP practice nurse for a contraceptive checkup, she asks how Asha is getting on, as she has access to Asha's integrated digital care record.

Example pathway: Working age adult with severe and enduring mental illness

Daniel is a Black 48-year-old man and lives in Tottenham. He suffers from schizophrenia and has been in and out of mental health facilities since he was 17.

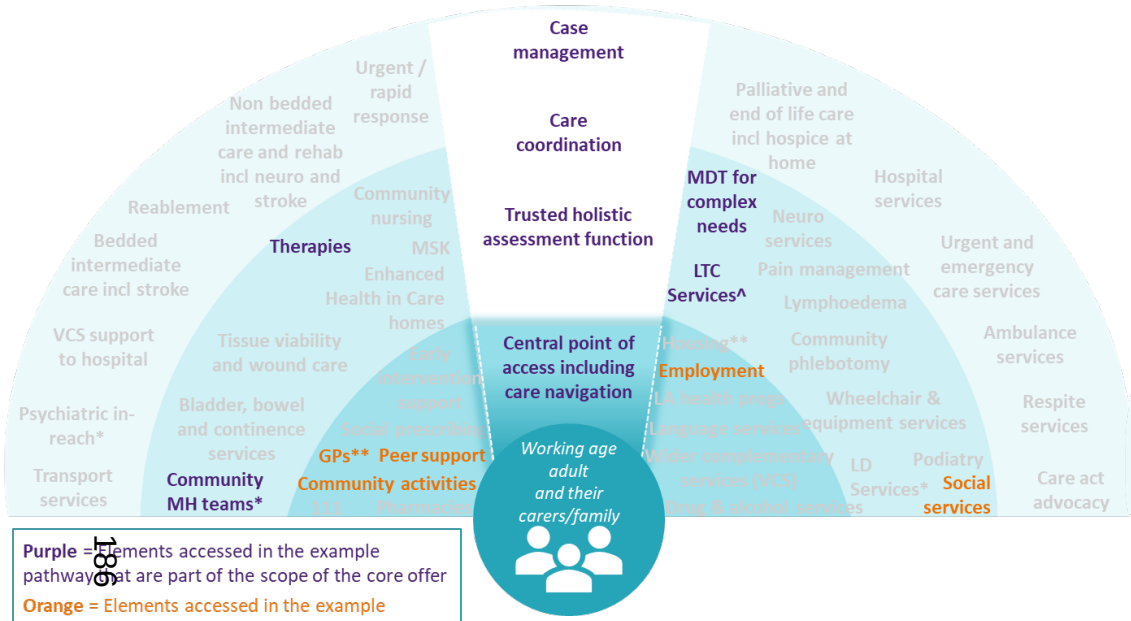
Daniel lives in supported accommodation and is unemployed. His two brothers and mother are supportive but cannot contact him when in crisis. He usually turns up in A&E when he is in crisis.

He has asthma but does not reliably take his medication.

What care will look like through the core offer

Daniel's care is coordinated by his core mental health team, where he has a case manager. Daniel, his family and other health and care professionals can contact his case manager with any queries about his care. He regularly receives his antipsychotic depot injection. The core team regularly reviews Daniel's mental state and gets input from his wider team including his social worker, housing worker and specialist mental health teams as required. He is supported by an occupational therapist regarding his home functioning and is currently being supported to attend an adult learning course. He has just completed a period of intensive support with the community rehabilitation team following his previous mental health admission. This has enabled him to move successfully into his current supported accommodation and to start the course. He is supported to attend a peer support group at the local mosque of which he is a member. Fortnightly reviews with Daniel mean that deteriorations in his mental health state can be quickly picked up and the Crisis home treatment team can provide support to avoid Daniel reporting in crisis to A+E or the place of safety. When the Imam at his mosque becomes concerned about his deteriorating mental health, he is able to contact the crisis line who is aware of Daniel's crisis plan and arranges for an urgent Home treatment team review together with his case manager. He has a yearly full physical health check from the community nurse embedded in the core team. He is supported by his case manager to attend regular reviews with the respiratory nurse who comes to see him at his supported accommodation alongside his case manager. The respiratory nurse is able to access and contribute to Daniel's shared care record.

Community health offer



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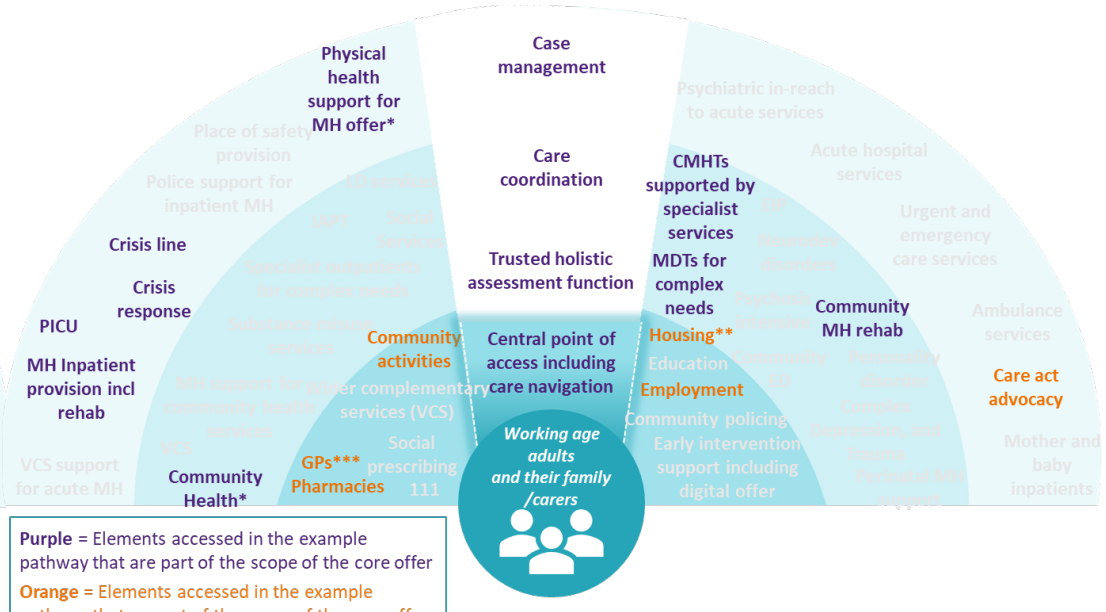
Mental health offer



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Example pathway: Older adult with likely dementia

Paul is 72, recently widowed, lives in Edgware and is Black Caribbean. He has high blood pressure and now partially sighted.

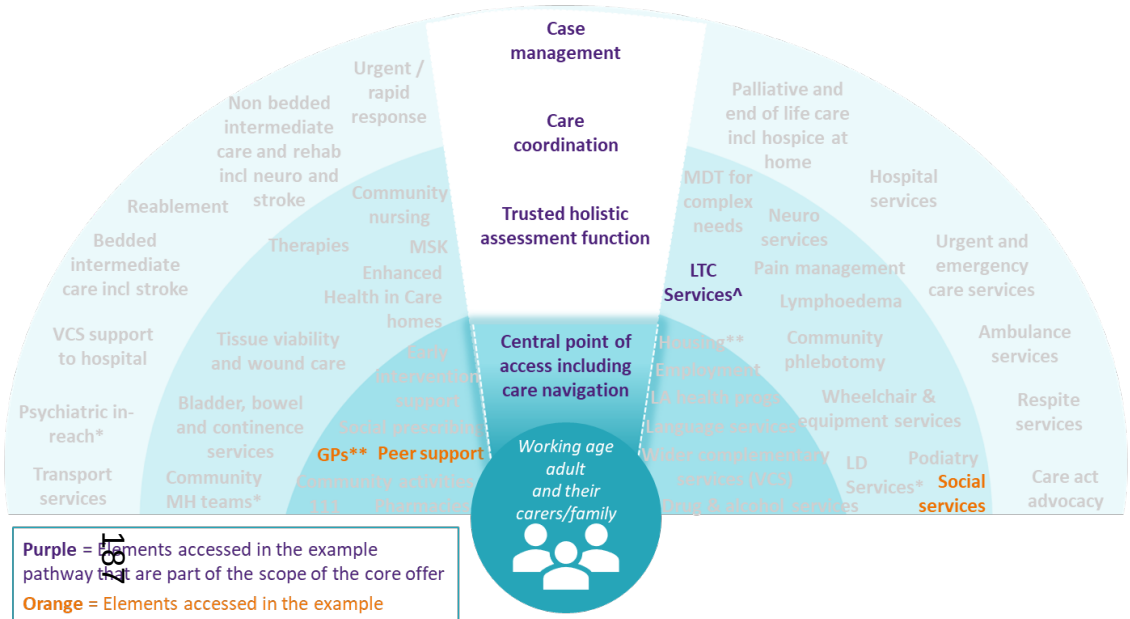
His son noticed he has lost interest in activities and is withdrawn, confused and finds it hard to engage in conversation and he has been getting lost.

Paul does not think there is a problem and declines any help.

What care will look like through the core offer

The GP carries out an initial mental health assessment having received specialist training and support from the memory clinic and contacts the central point of access. This arranges for Paul to have an assessment at the local memory clinic with an older adult psychiatrist or geriatrician. Both Paul and his son's ideas, concerns and expectations are considered and a full assessment of Paul's social and living arrangements is made. The memory clinic MDT reviews the results in conjunction with the assessment and a mild-moderate dementia diagnosis is made. A holistic care plan is developed with input from Paul (as appropriate), his son, and from a social worker linked to the team who assesses the home circumstances and level of risk. Paul is allocated a case manager who acts as a point of contact for Paul, the family and any professionals and supports Paul and his family to understand the condition and make shared decisions, which prioritise Paul's preferences where appropriate, and to access local support groups (e.g. peer support). The case manager gets input from community cardiovascular team to develop a care plan and supports Paul to have a review of his sight at the optician. Paul is encouraged to join local wellbeing activities of his preference and to take part in cognitive rehabilitation therapy and stimulation therapy. Paul agrees with some encouragement from his son to start taking some dementia medication on the advice of the Memory clinic. Paul has three monthly reviews with the Memory clinic and a monthly review with his case manager. A package of care is arranged to support Paul to manage safely at home alongside support from his son. A social worker regularly reviews how Paul and his son are getting on with the potential to increase the level of carer support and/or provide respite care if required.

Community health offer



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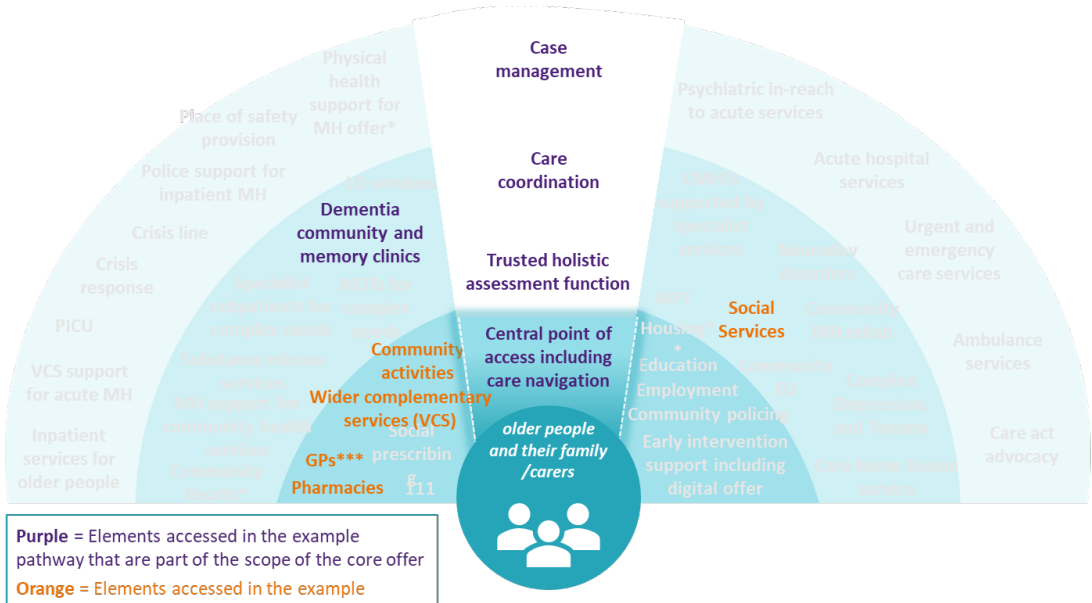
Mental health offer



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Life Chances Action Plan 2020-2024

AGENDA ITEM 7

Summary Highlight Report: Sep/Oct 2021

Priority 1: Strengthening families and early years
• *The continued expansion of eligibility for all free entitlement offers has been further extended to include those with No Recourse to Public Funds (NRPF). Publicity continues to be developed through various routes including social media and events. More under 5's have been able to get their free education entitlement and 30 hours funding which has supported parents to access training and employment and for children to be ready for school.* • *All Children's centres now distribute food bank vouchers. Four centres (Fairway, Silkstream, Parkfield and The Hyde) have small food banks in house and links have been made with voluntary organisations that provide food for different cultures (Kosher and Halal). Families are able to access food from food banks and also from local venues at short notice* • *The launch for the digital scheme for Healthy Start is planned for November 2021 and public communications will be circulated around this time and a toolkit for boroughs launched. It will help to combat food poverty experienced by some families through increasing the uptake in those eligible to access healthy start.* • *There are ongoing parenting programmes taking place across the hubs including SFSC and AVA groups. More staff have been trained in parenting programmes. The EYs parenting hub is live and will deliver specialist parenting for parents of under 5's with higher level needs within the CSC framework and targeted work for parents with needs beyond those that can be met in universal groups. Staff delivered a range of parenting programmes that has prevented escalation of need requiring statutory services intervention.* • *The childhood immunisation action plan is currently being implemented and lays down our vision for Barnet to improve coverage of childhood and school aged immunisations. The Healthy Intent dataset will be used to monitor immunisation coverage across PCNs, wards and GP practices in Barnet.* • *The Perinatal Mental Health pathway guidance has been finalised, shared and published. It is a live document and updated bi-annually to ensure all partners are represented and their details of the services they offer is current and accurate. Professionals are now more aware of the pathway and understand the importance of good perinatal mental health.*

Priority 2: Developing resilience and improving education

- *To strengthen further the percentage of good or outstanding schools in Barnet, Monitoring, Challenge and Support processes have been updated as part of revised School and Settings Improvement Strategy. 96.5% of schools are currently Good or Outstanding with Barnet the 8th best local authority out of 151.*

- *Attendance rates were being monitored daily in September, moving to weekly from October using the DfE Education Settings Status Form which is completed by the schools. Individual schools followed up by the Learning Network Inspector if attendance is a concern. Sharing best practice is part of attendance discussions at key meetings e.g HT, DHT, SENCO etc. The school attendance rate was around 93% at the start of the Autumn Term '21 but dropped to 91% by mid-September due to increasing numbers of Covid cases in schools.*

- *Package of support for schools began in Summer Term 2021 and continues throughout this academic year regarding impact on mental health and well-being as a result of the pandemic. This involves training and support from the EP Service and Inclusion and Advisory Team on pupil and staff wellbeing/mental health. There has been good attendance at events and engagement in projects to support Recovery, Reset and Renaissance.*

- *Continuing to run training through Barnet Partnership for School Improvement (BPSI) to support schools in blended learning approaches. Learning Network Inspectors giving advice (and challenge where necessary) on school approaches. The monitoring of schools demonstrates strong blended learning approaches are in place.*

- *The Risk of NEET (RON) programme has been devised to minimise the number of young people who become NEET aged 16-19 years. Schools and colleges already have in place interventions to support learners who are vulnerable or likely to disengage. However, there is a hard to reach cohort of young people who, after these interventions, are still at high risk of being NEET by the age of 19 and therefore are likely to be become dependent on state benefits. The post-16 team will continue to work with local secondary schools to develop and refine data system for early identification of young people at risk of becoming NEET at the end of Year 11 and to create programmes for students from Year 10 upwards aimed at ensuring those at risk progressing to a sustainable destination of employment, education or training (particularly learners with SEND and young men from black heritage backgrounds and white British backgrounds). In the Spring term will also work closely with the Youth Offending Service to identify those at risk with suitable programmes. Over 250 young people have received support since April 2021, with 133 sustaining or moving into EET.*

- *Work continues to develop and produce the Barnet Vocational Prospectus so that young people are aware of the opportunities within Barnet. This should lead to more young people embarking on vocational qualifications nearer to home without feeling the need to travel to other boroughs to access vocational pathways. The prospectus has been accessed by over 4,000 young people in Barnet. A daily careers line is available in Barnet to young people and parents. Careers events and the Apprenticeship Roadshow has been offered to schools. The last Apprenticeship Roadshow organised with Middlesex University was accessed by over 3000 young people.*

- *The Virtual School continues to work with schools to ensure looked after children receive excellent provision and improve achievement. Barnet is just above the national average in the Attainment 8 measure. The rank in Attainment 8 between 2019 and 2020 improved from 99th in 2019 to 74th in 2020. NEET figure was 10.8% in March '21 (well below target of 20%). Attendance of LAC remains a concern and therefore a priority.*

- *During the pandemic a range of libraries online events were developed including STEM and Lego clubs, Arts and author events as part of extra-curricular activities developed for children. As restrictions have eased the service has delivered Wild World Heros, the annual Summer Reading Challenge, encouraging children to keep reading over the summer holidays. As libraries reopen fully, face to face events and activities are being reinstated starting with half-term events in October 2021. 1198 child attendances at library events between April and September 2021. 1,577 children participated in the Summer Reading Challenge. 131,000 items for children and young people were borrowed from libraries between April and September 2021.*

- *Barnet has maintained above average engagement for London within our schools and early year settings for the Healthy Schools London (HSL) and Healthy Early Years London (HEYL) award programmes respectively. Through HSL and HEYL, settings have improved their student health and wellbeing through creating health promoting environments and developing healthy behaviours tackling health inequalities at the earliest opportunity. For HSL in Barnet as of July 21: 118 registered;73 Bronze awards; 52 Silver awards:27 Gold awards. For HEYL in Barnet as of July 21: 88 First steps awards;38 Bronze awards; 11 Silver. Barnet is among the top boroughs for awards.*

- *Health Education Partnership (HEP) have introduced Primary and Secondary frameworks to support schools delivering PSHE and the RSE components including a Secondary school PSHE leads network. Sexual health education and healthy relationship support is provided through Brook which operates a number of sexual health and wellbeing services across the UK. HEP have supported in depth 13 Secondary schools with their RSHE curriculum delivery and provided all secondary school PSHE leads with ongoing support through the network. Brook have supported over 2000 young people through delivery of RSE workshops and support services. Brook have also delivered training and support to 13 schools, 3PRUs and 2 colleges over this year.*

- *Expansion continued of the Schools Resilience Programme through communications, invites and presentations at Head Teachers, Deputy Head Teachers, Senco and Parent*

Carer Meetings. Resilience Schools expanded during Covid and further expansion for September 21 to a total of 76 schools. Schools having a better understanding and recognition of poor wellbeing and the confidence to access support for themselves and others. It is creating environments for more Mental Health conversations and reducing stigma, allowing early intervention in a young person's support.

- *Targeted projects support schools in their recovery, reset and renaissance (RRR). £0.65m of funding from Barnet Council and BELS is enabling RRR projects to make a significant difference to the work in schools. Over £230,000 of this funding has been allocated to fund or part-fund projects identified by schools, or partnerships, which will have significant impact on the recovery of their school community. More than 80 schools bid for a share of that funding. 20 bids were successful, reaching 54 primary, secondary and special schools. An additional £50,000 was also allocated to fund speech and language therapists across 8 schools.*

- *Barnet Public Health are working with Middlesex University to undertake research into the physical literacy impact of the Mayors' Golden Kilometre Golden Kilometre. Schools play a pivotal role in helping to develop positive physical activity habits in children and young people. Currently 77 Schools are part of the Resilient schools programme and as part of this implement an additional 20 minutes of extra daily activity. As of January 2021, 11 Barnet schools have signed up to MGKM and a further 27 schools are listed as supporting other similar physical activity schemes. In Barnet currently 118 schools are signed up to the Healthy Schools London Award Programme and national evaluation shows this results in increased participation of children in physical activity in and out of school.*

Priority 3: Delivering equal access to opportunities

- *Healthy start vouchers and vitamins are distributed from the centres (though there is a shortage of these currently). The infant feeding strategy has been launched. Through the Covid Winter Fund Scheme (CWFS) we provided support to vulnerable households and families with children particularly affected by the pandemic throughout the winter period where alternative sources of assistance may be unavailable. From the youngest age children have access to vitamins as well as parents having these antenatally. Through the CWFS it was possible to deliver support to 9,965 children in the December/ January payment, 9,938 in February and 13,866 in March.*

- *Work is underway with four different Supported Internship Providers to offer supported internships to learners with Education Health & Care Plans (EHCP's). The aim is to prepare young people aged 16-24 with complex needs for paid employment by: supporting them to develop the skills valued by employers. 25% of the last cohort moved into employment with the majority of the remaining cohort moved into education training. 1 learner will remain NEET due to mental health difficulties. We have increased the numbers of young people entering Supported Internships. In September 2021, the cohort has 30 young people registered across four supported internship providers.*

- *A dedicated careers and information telephone line has been developed to provide support to young people. Specialised 'pathways' have been established leading to employment for long-term NEET young people, taking into account the impact of COVID on the employment prospects for young people aged 18-24 years. Tracking has been extended of young people to those aged 18. The impact of this intervention has resulted in a reduction of NEET's currently at just over 1%. Careers team are working in 15 schools in Barnet providing personalised careers sessions.*

- *'Open Spaces' has been well evaluated, with families of children with special learning needs using it reporting a high level of satisfaction. 247 sessions have been used by 81 families. This includes 33 swimming sessions (60-minute duration). Outdoor play sessions continue to run every Sunday at Greentops.*

- *Children and young people with complex special educational needs who require an EHCP have their needs accurately represented in the EHC Plans, along with their views, the views of their parents and carers, and the support and provision they need to access a suitable social and learning curriculum and make progress. Timeliness of EHCPs has been maintained. Barnet ranks in the top 10% nationally for completing EHCPs within the statutory 20-week timescale. For 2021/22, 98% of EHCPs have been completed within 20 weeks. There is an established EHCP auditing process to assess the quality of Plans undertaken on quarterly. For 2021/22, 60% of all new EHCPs have been audited. 60% of audited plans have been graded "good" or "outstanding".*

Priority 4: Targeting support

- *A food security resource hub webpage has also been created that contains information for the public on food banks and other related services available to them. Further resources such as healthy eating videos has been published on our website.*

- *The council have worked with the Young Barnet Foundation to provide the Barnet Active, Creative Engaging (BACE) holidaying scheme which is DfE funded for all free school meal children and vulnerable children to access fun activities with a hot meal, activities include learning about healthy eating and exercise. The summer scheme was accessed by over 3,000 children who undertook a wide range of fun and learning activities that promoted healthy eating and exercise and all children attending had a hot meal and health snacks plus fruit bags to take away. Planning for the Christmas holidays is now underway.*

- *Working with the council's Regeneration team (S106), the post-16 team has established and has been delivering the Routes into Construction programme since 2019. The project is designed to align with employers' needs and is designed predominantly to support young people who are NEET at Post-16. Over 70 young people have joined the programme. To date, in terms of outcomes there has been 16 young people entering Apprenticeships, 18 people gaining job starts and 9 young people returning to education or university for further training.*

- *Close cooperation with S106 Officers has helped to identify apprenticeships generated by S106 obligations and targeted to the hardest to reach young people supporting them into sustainable employment. To date 14 young people have benefited from apprenticeship opportunities generated by s106 obligations.*

- *The Care Leavers Participation Project was designed with the aim of increasing Education, Employment and Training (EET) levels amongst care leavers aged 16-25 in line with Barnet's Corporate Parenting priorities. To date 22 care leavers have moved into employment or apprenticeships with a further 20 moving into education either higher education for further education.*

- *Barnet Homes provides a tenancy sustainment service and BOOST who deliver employment and benefit support services have been working to help those households facing difficulties which will aim to reduce homeless demand. Homeless Prevention Outcomes achieved by the Housing Options Service and BOOST- 1264 achieved in 2020/21 against target of 1250 and April 21-August 2021 achieved 533 against target of 550*

- *Barnet Homes has a joint protocol with Family Services to ensure that 16- and 17-year-olds at risk of homelessness are supported with joint assessments of their needs. During the pandemic these assessments have been conducted remotely but this has not hindered the provision of assessments and accommodation when needed. In 2020/21 only 2, 16/17-year-olds approached as homeless one of who had settled accommodation and the other was not eligible for housing support. In 2020/21, 213 young people aged 16-24 approached as homeless of which 92 were rehoused and only 4 were rough sleeping. Barnet Homes has not evicted any secure or flexible tenants during the pandemic.*

- *Let2barnet procure private sector properties for homeless households and despite the challenges of the pandemic have continued to outperform targets set. Open Door Homes (ODH)the registered housing provider within The Barnet Group completed new build properties on site despite challenges with construction sites being closed during the pandemic. Let2Barnet procured 647 properties in 2020/21 against a target of 610. 141 ODH new build properties were let and 62 new acquisitions were purchased and let. Numbers of households in temporary accommodation (TA) have reduced from 2471 in April 2020 to 2245 at the end of August 2021. The number of families in TA have reduced from 1302 in February 2021 - 1161 in August 2021. The average number of weeks families spend in TA has reduced from 74 weeks at April 2021 to 66 weeks in August 2021.*

- *The embedding of Mental Health Support Teams (MHSTs) and voluntary sector projects within Barnet has progressed for children and young people with mild to moderate mental health needs. Rollout to further 21 education settings in two more localities have been completed. A £40k grant has been made available to VCSE and taken up by five projects, 12-month period started in December 2020. MHSTs are fully implemented and practitioners now present in 56 education settings (primary, secondary, college, all-through) across the three localities in the borough.*

- *Work has continued to embed the Barnet Integrated Clinical Service offering mental health support to children, young people and their families. Integration within community through dialogue and partnership with schools, GPs, libraries, youth centres, child centres, and the RAF Museum to establish bases for BICS practitioners to be even more accessible to families. BICS being established as a household name with increasingly referrals from self/carer and GPs. Family Therapy Clinic established in community centres for equitable and accessible service. Groups, workshops accessed by Barnet CYP, families and professionals online pathways reaching the whole community*

- *The Moving Forward Project has enabled care experienced young people to live independently with targeted supported to enable them to develop the necessary independent skills and confidence to transition into their own property and manage a tenancy. So far, 7 care experienced young adults have been supported; 3 of whom have moved into their own tenancy and a further 3 remain in the property. The young adults continue to access support through their Personal Advisors and targeted floating support to develop the necessary skills to enable them to live independently.*

- *Every young person with an EHCP has a SEN caseworker - this person is the 'link' contact for families in relation to the EHCP. For children and young people in receipt of SEN Support, the link person is in school - usually the SENCo. As result of the 'link' person for CYP with EHCPs, and for those at SEN support, children and young people with SEND and those supporting them, including parent carers and professionals, are better informed about appropriate provision in Barnet.*

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