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NCL Community and Mental Health Strategic Reviews

Barnet Health and Wellbeing Board: 9th December 2021

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Recap on rationale, context and ambitions for strategic reviews

- Earlier work undertaken by NCL CCG identified a significant range of service variations in access, availability, quality and cost of current provision as well as substantial fragmentation, which was considered a barrier to providing more care in community settings and impacting on the delivery of care for key groups e.g. CAMHs.

- This was confirmed by both clinical feedback and patient feedback which highlighted the variation in access, criteria and availability per borough of specific services resulted in greater reliance on acute care for community services and more admissions under the Mental Health Act for those with a mental health illness. Patient feedback also highlighted the view that nobody should have to navigate the system in order to receive care.

- For example, one variation is criteria for step down or rehabilitation pathway beds across NCL. If you reside in Camden, you have access to high quality rehabilitation bedded care. If you reside in Haringey you have access to step down bedded capacity without the same rehabilitation focus. This complexity and variation has a huge impact on length of stay and quality of discharges.

- The development of a core consistent and equitable offer for community and mental health services would therefore achieve the following ambitions:

  - ❑ A core consistent equitable offer for community and mental health provision that could be easily accessed and navigated by other services and patients themselves
  - ❑ Contribute to addressing the need for health equity recognising the key role local community and mental health services play at place level
  - ❑ Reduced reliance on inpatient care and improve the quality and equality of community based pro-active and preventive services
  - ❑ Provide the foundation for integrated care and a population health improvement approach to service delivery at place level
  - ❑ Reduce unnecessary back office and overhead costs associated with fragmentation and duplication
  - ❑ Ensuring a sustainable and resilience workforce and at scale solutions for fragile services
  - ❑ Contribute to mitigating the impact of Covid in terms of increased demand and backlogs

Work to date and headline findings

- NCL CCG currently spends £250m on community services. Across the 5 Boroughs there are differing levels of NHS spending on Community services from £117 in Haringey to £232 in Islington. The Barnet spend is £158 (figures based on NHS community spend per capita unweighted 21/22). The current disposition and availability (opening hours, range of services etc.) is largely based on the historic funding available to the 5 legacy CCGs in NCL and not generally related to need of populations based on age, deprivation, ethnicity etc.

- The reviews have identified examples of where variation including staff competencies, thresholds for admission to services etc. have led to different service experiences for patients. These variations have wider implications as well and impact on other partners including the Acute sector, London Ambulance Service etc.

- For Mental Health, NCL currently spends £350m. The variation in spend per head is between £160 in Barnet to £264 in Camden (figures based on NHS Mental health spend per capita unweighted 21/22). Analysis of finance and activity shows that service provision and investment do not correspond with level of need. For example in Haringey Children & Young People (CYP) have a higher mental health need relative to other boroughs and have the highest number of CYP presenting at A&E with a mental health need, but spend per head in on CYP is lower than NCL average.

- There are a number of examples of specific workforces under pressure, especially small services e.g. Looked After Nurses in Enfield, Special school nursing in Enfield, Bowel & Bladder nursing in Barnet, as well as community paediatrics and CAMHs nursing across all 5 Boroughs. All of the 5 Boroughs have examples of these small services which generally have longstanding vacancies, limited clinical leadership and little skill mix.

- There are increasing workforce challenges with local Providers competing for staff with resulting costs as staff seek higher grades. This also limits opportunities for larger and more resilient teams able to benefit from skill mix etc.

- Current fragmented arrangements in NCL do not easily facilitate a collective approach to delivery and there is a danger of a lack of alignment with different IT systems, shared records and equipment which will reduce the opportunities for a more coherent offer.

- Equally, the fragmented disposition of services potentially increases costs, particularly where these are duplicated or overlapping.

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Work to date and headline findings

- Analysis shows that not only are services fragmented, but service provision and investment do not correspond to the level of need: For example:
  - ❑ 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
  - ❑ For children's nursing Barnet has 0.4 FTE per 10,000 0-18s, whereas Islington has 2 FTEs per 10,000 population. In Barnet 22% of population are aged between 0-18, in Islington it is 15% aged between 0-18
  - ❑ For District Nursing Barnet had 19 registered FTEs undertaking 4435 average contacts per month; Islington had 30 Registered FTE undertaking 6602 average contacts a month. Barnet's over 65 population is 14% compared with Islington's over 65 Population at 9%
- Provision is fragmented; For Community; BEH providing Enfield, Whittington providing Haringey and Islington with CNWL providing Camden and CLCH providing Barnet.
- Gap analysis shows that Barnet has gaps in the existing core service offer e.g. early intervention, or for Children Hospital at Home as well as the proposed new services e.g. Central point of access and trusted assessor function. However, the gap analysis does not show a more detailed position on service gaps i.e. vacancies or where services, although provided, do not deliver the broader aspects of core service offer.
- NCL CCG is already investing in Barnet via the Ageing Well Programme, for example, by investing in an expanded permanent Extended Care Home Teams, intended to support care homes and reduce emergency admissions etc.

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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

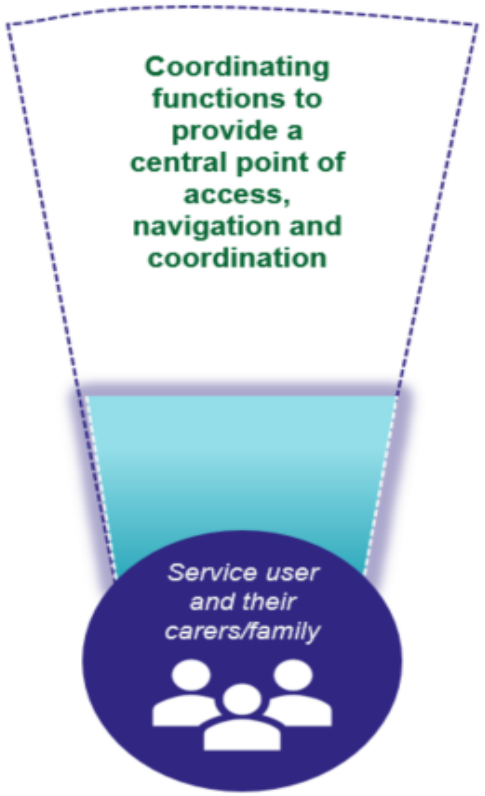
Core offer outlines provide a summary of elements and services that are part of the core offer for each age profile. The outlines also show elements not within scope of the review but that should be linked in with the core offer, as well as enablers.

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.

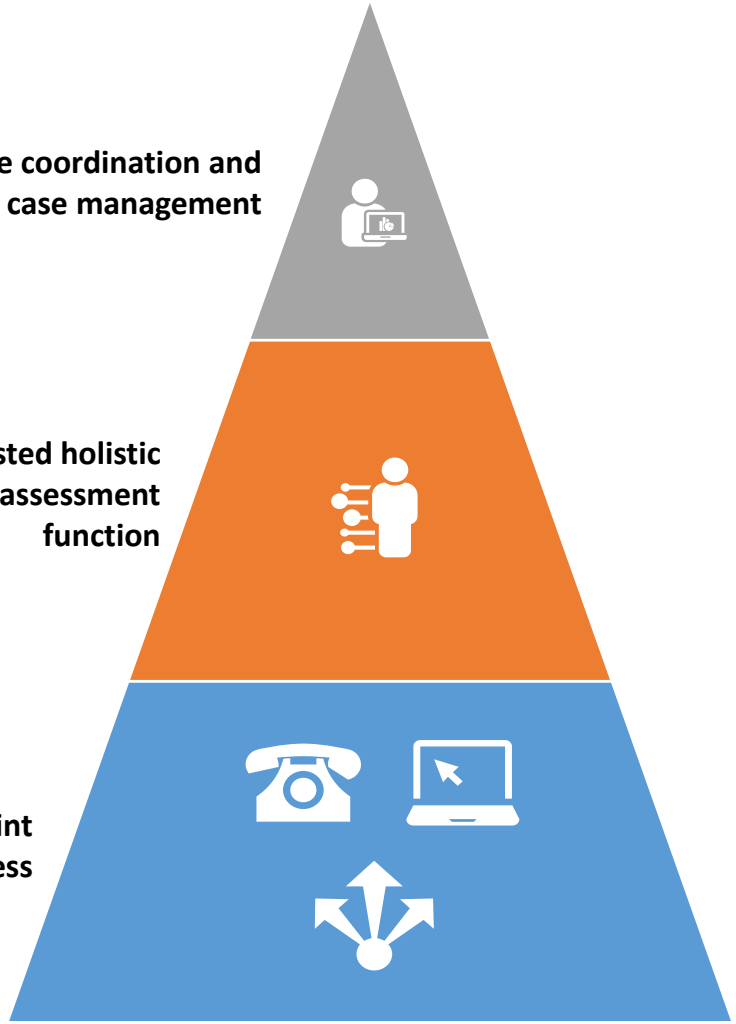


Following each core offer outline, in-scope elements are further detailed in a set of service descriptions. These provide a description of the element and lay out access criteria, hours of operation, capabilities required, where the element should be delivered, waiting times and how the element should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

The Core Offer – Coordinating Functions

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**

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Implementation of the coordinating functions will be key to delivering the full potential benefits of the core offer

The **coordinating functions** are **key to realising the potential benefits** from implementing the core offers for both community and mental health services. The coordinating functions act to support, **integrate and navigate care** for service users across the layers of the core offer.

The coordinating functions consist of:

- **A central point of access, including care navigation:**
  - The main purpose of the central point of access is to move people seamlessly through services by acting as a central point of contact. The care navigation function acts to give advice, information and signposting.

- **A trusted holistic assessment function**
  - Acts to ensure that service users with complex health and care needs can have a single up-front assessment to enable an initial holistic care plan to be co-developed

- **Care coordination and case management**
  - Care coordination links service providers, ensuring effective communication, monitoring service delivery, preventing duplication of services, identifying gaps in care, and assuring better health outcomes, particularly for service users with complex medical or behavioural health needs.
  - Case management helps to integrate services around the needs of individuals with long-term conditions and complex needs. It is a targeted, community-based and pro-active approach to care that involves case-finding, assessment, care planning, and care co-ordination.

Case studies have shown that implementing a set of coordinating functions like these can lead to benefits realised in several areas, including acute savings.

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Example; Draft specifications

Working age adult | Older person

Contains national requirement targets

Core offer care function: **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, naso-gastric and PEG feeding management. Phlebotomy, Palliative care, syringe drivers, Catheterisation, give Intravenous antibiotics, administer controlled drugs, skill mix needs development with other community staff 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.

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Benefits of Implementing the Core Offer

- The benefits associated with the core offer are multiple and the COVID pandemic has resulted in a context of significant increased demand on all parts of the health and care system.

- This has resulted in large numbers of patients waiting for both elective treatment and cancer diagnosis/treatment. Although part of the national accelerator programme, NCL still has a large backlog of people waiting over 52 weeks for Treatment as well as waits within community, primary care and mental health services which are addressing unmet demand.

- To be able to truly focus on elective recovery and restoration, Acute Trusts have to be confident that they have capacity both from a bed perspective, but also from a clinical and managerial perspective to focus on this important recovery task. However there are pressures on acute beds from more emergency admissions, as well as pressure on A&E.

- To support system recovery community services must keep more people at home, support people in the community (including care homes) better manage their long-term conditions, and when necessary support and enable the clinically safest and earliest discharge possible. This work is starting with investment in Care Home Teams, but further investment is needed to reduce activity before it reaches a hospital.

- There is evidence to suggest that there is a link between community investment and acute activity. For example Camden & Islington's higher spending on community services seems to be linked to smaller number of avoidable admissions, 9.6 based on 1000 weighted population 2019/20 Islington rates when compared with Haringey at 10.2.

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Early work on the impact assessment shows there are benefits to be taken from implementing the core offer . Example for Community Services

Access

- Standardised service provision aligned to clinical best practice
- Extended opening hours and access to OOH services – more convenient access to services
- Standardised waiting times (e.g., to first contact and follow up)
- Improved access through central points of access

Quality

- Following clinical best practice and national guidance
- Focus on prevention and early intervention
- Help service users stay well and avoid hospitalisation
- Support timely and safe discharge from hospital
- Enhanced service offer for older people

Equity and equality

- Consistent and standardised offer so all NCL residents have equitable support
- Interdependencies with other agencies so residents receive holistic, joined-up support that focuses on wider determinants of health
- Resource distribution aligned with need

Workforce

- Collaborative ways of working with other professionals across agencies and organisational boundaries
- New roles and skill mix, with staff working at the top of their license
- Improved staff satisfaction, supporting recruitment and retention

This work is also linked into our review of costs so we can get a fuller picture of both non financial and financial impact of fully implementing the core service offer

Next steps

- Moving into new phase focused on understanding financial implications of delivering core service offer consistently across all Boroughs.
- This will include benchmarking across a range of domains and testing for value for money, efficiency potential to support reinvestment into core offer delivery.
- Further discussion on deliverables and outcomes in relation to the core offer, exploring options for some at scale provision to achieve efficiencies and reduce overhead costs and a consistent outcomes framework across NCL which measures the impact of the core offer.
- Starting a round of discussions with Local Authority Officer leadership to explore the reviews and discuss local delivery.
- Further discussions with Local Authorities and integrated care partnerships to explore their role in the implementation of the core offer as the foundation for integrated care delivery between primary, community, mental health, social care at place.
- Planning a process to review priority areas e.g. fragile services because of clinical risk. Should changes drive a different delivery model and determining whether there needs to be prioritisation between service resilience and clinical quality in comparison to a more local service which lack these.
- Working with Mental Health Providers to look at opportunities to reduce inconsistency and service fragmentation e.g. CAMHS services across NCL have a range of different providers who are struggling to come to grips with challenges such as workforce and rising demand
- Determining pace of change and what are the risks that might need mitigation as part of this.
- Developing realistic financial plans underpinning implementation of the core offer that considers the context of national planning guidance requirements and the developing ICS.
- Next phase communications and engagement to ensure continued coproduction and collaboration with patients/carers and partners. This will include an updated comms and engagement plan to ensure appropriate engagement input and discussion

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