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NHS

Barnet Health and Wellbeing Board

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

14th July 2022

Recap: The journey so far…

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

Start of review

Agreement was reached for a strategic review of Community Health Services and a case for change was created

Mental Health

A parallel review of Mental Health Services has been conducted concurrently based on a case for change

Design co-production

Co-developed case for change, service offer, inequalities identification, gap analysis against Borough, through interviews, surveys and workshops with a focus on Local Authority

Partners Involved In Design Workshops
Primary Care
Community providers
Local Authority
Acute providers
Commissioner Borough& Strategic
Voluntary Sector
Residents/Users/Carers

Gap analysis

A gap analysis was conducted by Borough against the Core Offer

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

Investment principles and KLOEs for prioritisation

Investment priorities and KLOEs agreed at CH and MH programme Boards respectively

Provider collaboration

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

Agree investment priorities

Review gap analysis and start to form a shared view on how closing the gaps might be prioritised in Y1, which will subsequently be tested with place

Future Programme Delivery

Programme Governance, Engagement and Co-design

Mental Health Services Review Programme Board Membership

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

Community Services Review Programme Board Membership

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

Engagement

- Residents Reference Group
- Residents Survey
- Borough Meetings e.g. with Healthwatch In Islington, Bridge Renewal Trust in Haringey, Wellbeing Steering Group; Patient Partnership Network meeting; Voluntary Community Sector Forums in Barnet
- Specific focused meetings e.g. Mencap in Barnet, Camden Parents of Children with Special Needs,

Co-production and co-design

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

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

Inequalities
There are stark inequalities in health needs and outcomes across NCL

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

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

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

Service user / resident feedback
Services are difficult to navigate and require service users to repeat their stories

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

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

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

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

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

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

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

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

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Community and Mental Health Services Core Offer

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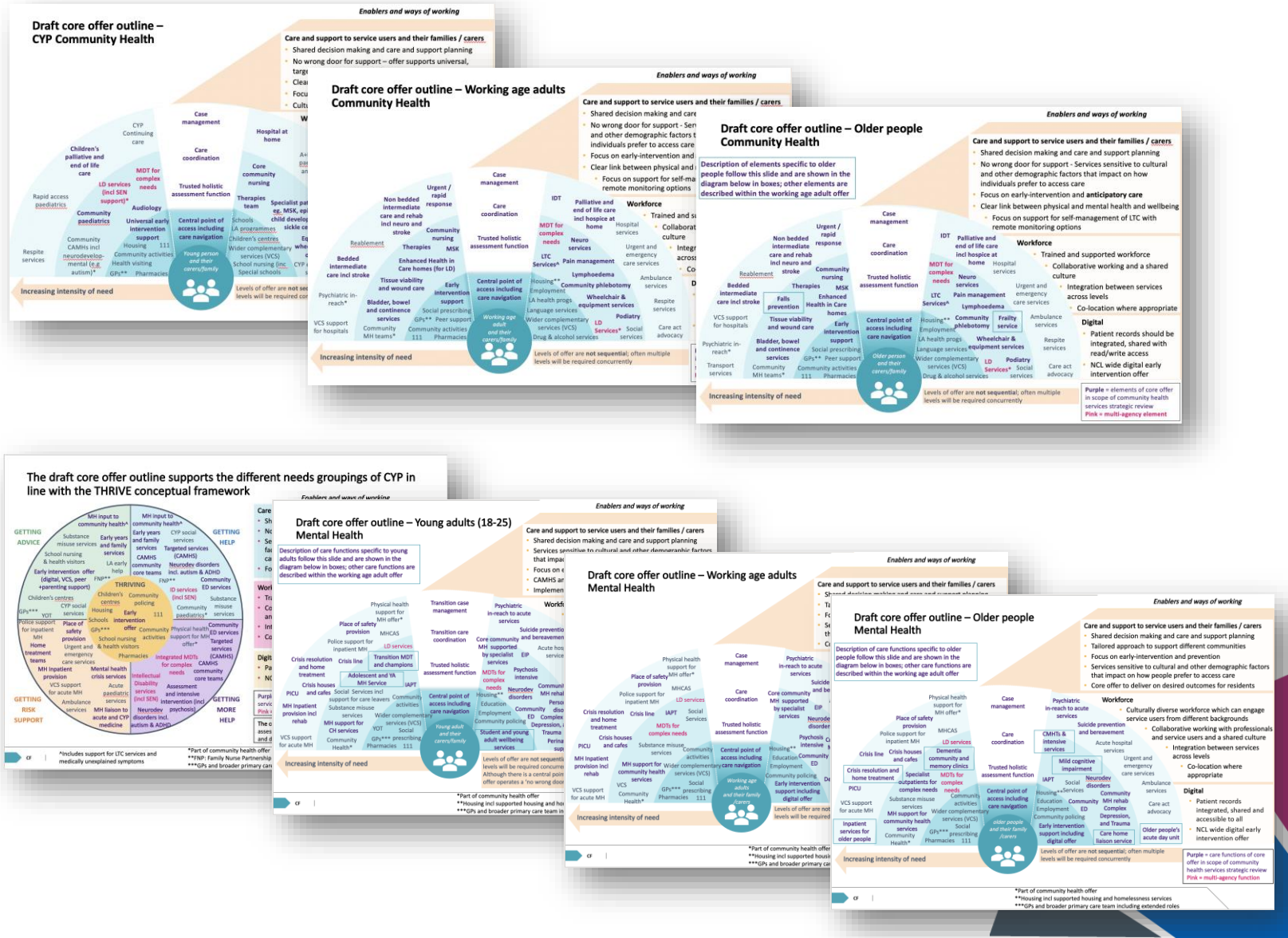
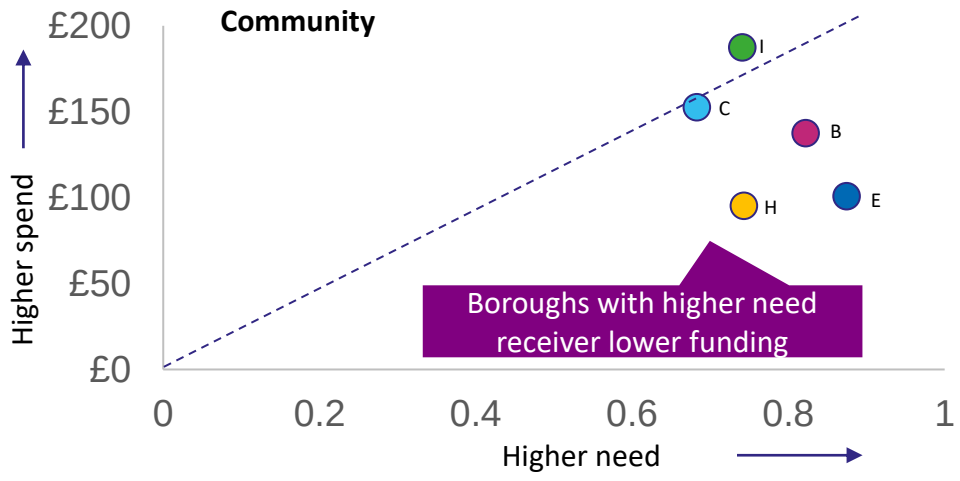
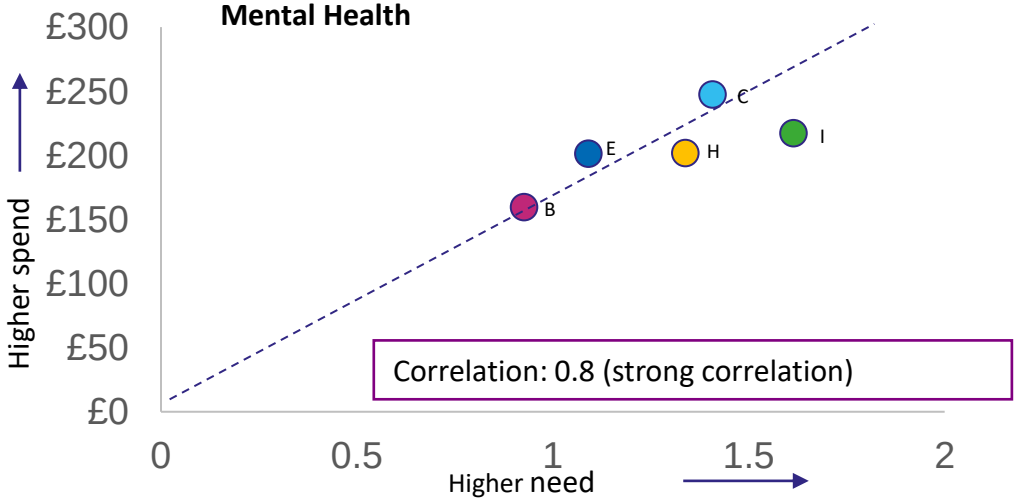
- The Offer represents the desired minimum standard to be delivered for all residents across NCL
- The Community services Core Offer is described in line with the NHS Long Term Plan categories of Start Well, Live Well and Ageing Well
- Additionally, the Mental Health services core offer includes the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



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

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





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

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

In terms of understanding spending based on 2020/21 (unweighted per head of population) for community services spend is £137 per head in Barnet against a range of £101-187 per head of population

For Mental Health in Barnet spends £159 per head of unweighted population against a range of £159-247 per head of population

B Barnet C Camden E Enfield H Haringey I Islington

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In order to sustainably implement the 'core offer' across NCL, the following mix of funding levers will be utilised

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

Mental Health Service Update

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

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

Core Offer Themes	Examples of current challenges in our Mental Health system highlighted through the gap analysis	Examples of service developments being implemented in 22/23.
Prevention and Early Intervention	Prevention and Early Intervention is a key priority for LTP, core services offer highlighted from engagement and discussion with local people	Delivery is linked to the rollout of transformed core MH community teams as well as for CAMHS
NCL Inequalities and Population Health improvement strategy	Recognition of the disproportionate impact that Covid has had on many deprived and marginalized communities	Delivery of the NHSE MH inequalities strategy and NCL inequalities and population health improvement strategy
Long waiting times and access	Addressing long waiting times and access challenges which have worsened as a result of Covid and the increase in referrals especially in CAMHs services	Additional CAMHs staffing to reduce waiting times. Additional capacity in eating disorder specialist and community service and MH support in schools.
Workforce challenges	Addressing workforce challenges including developing new support role as part of developing innovative ways to expand service access	Strengthening MH work closer working with Vol Sector, Local Authorities, wrapped around primary care linked to primary care networks and local communities
Transition from childrens' to adult services	Addressing the issue of transition from children's to adult services. This was highlighted during our engagement events and has led to the development of an 18-25 offer	Strengthening and increasing capacity for transitioning young people and roll out of a young adults model of care.

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Priorities for mental health investment

NHS

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

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

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DRAFT: Adult MH programme structure

NHS

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

Provider/ICS-led delivery

Provider Collaboration / ICS led Transformation

- Crisis – Single Point of Access, THINK 111, MH CAS, Crisis pathways, Liaison and MH JRC.
- Inpatients – Provider Led (inc OAPs and Complex Care Rehab)
- IAPT
- Perinatal

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

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

Borough Working & Transition to Place-based Delivery

- Adult Community
- Young Adults
- Early intervention and prevention
- Crisis: Houses and Cafes
- IAPT - local
- Suicide Prevention & Bereavement
- Borough specific projects: e.g. Dementia, Ken Porter, Camden Day Unit, Enfield Wellbeing Centre, rough sleepers

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

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

ICB-led delivery

Planning, Investment & Contracting

- Defining Mental Health outcomes framework with PHI strategy
- Strategic Planning, Investment & Contracting
- Performance and outcomes
- Overarching programme management office

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

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

Enabling workstreams

Data	Finance	Workforce	Digital	Comms and engagement
Lead: Anita Garrick / MH Trusts **Support:** Dhiraj Sardana	**Lead:** Anthony Browne **Support:** Carolyn Piper	**Lead:** Clare Scott **Support:** TBC	**Lead:** Sarah Wilkins **Support:** TBC	**Lead:** Carolyn Piper **Support:** Mary Morgan

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DRAFT: CYP MH implementation programme structure

NHS

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

Provider/ICS-led delivery

Provider Collaboration / ICS led Transformation

Crisis –
- Crisis pathway / SPA
- Crisis Home Treatment / DBT
- Eating Disorders (specialist)

Community –
- Recovery and Transformation
- Eating Disorders (Community, ARFID)
- Digital support options

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

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

Borough Working & Transition to Place-based Delivery

- CAMHs
- ASD / ADHD pathways
- Early intervention and prevention
- Integrated Targeted Services *LAC
- CYP MH in Schools / Support Teams
- Young Adults 16-25
- Borough specific projects: e.g. Minding the Gap, VCS provision

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

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

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MH Programmes	CYP	IAPT	Community	Crisis	Inpatients
Borough					
• Borough specific projects (e.g. Barnet Ken Porter Ward) • Rough sleeping • Suicide • Bereavement care • Dementia • Co-production* • Quality* • Health inequalities* • Early intervention and prevention*	• Gap analysis delivery of THRIVE model • LAC borough gaps • WSOA (Haringey) • H@H (exc.Islington)	• GP referrals • LTC development pathways / Covid recovery* • VCS offer • Specific Health Inequalities outreach programme	• SMI Health Checks • Individual Placement Support • Borough co-production and implementation of Community Transformation Prog	• Crisis cafes • Crisis houses	• Integrated discharge teams and flow into LA placements
• Workforce • Digital • Perinatal • NDD	• Provider led review • Therapies accelerator • Autism hub	• NCL digital • HLP system maturity tool • Group sessions / publicity • Staff health and well-being hub	• NCL SMI Physical Health Clinical Network • Overarching Framework for Community Transformation 1. Personality Disorder 2. Rehab 3. Community Eating Disorders 4. EIP 5. Older / Young adults*	• Crisis lines / Think 111 / SPA • MH Joint Response Car • MH Liaison Services	• OAP • Length of stay • Quality • Winter schemes
NCL ICB					

Community Health Service Update

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

- Community Providers including Central London Community Services (CLCH) have agreed a programme of collaborative and transformational work to support working at scale, and the clinical and workforce opportunities this will bring.
- This includes collaborative work on areas such as community beds, the development of virtual wards, diabetes and tissue viability. These were areas identified by Community Providers as areas they wished to work on collaboratively to deliver NCL wide transformation
- CLCH are scoping a collaborative piece of work with other community providers to agree how best to implement the 'core offer' for tissue viability services across NCL. Other Providers are leading different work streams e.g. Central London North West London (CNWL) are leading work on community beds.
- Work has continued with colleagues from community services including CLCH to deliver the Ageing Well Programme which in 21/22 resulted in a recurrent investment **of £2,120k** into Barnet for urgent community response, community provider staffing for anticipatory care and for sustainable funding of the One Care Homes team. The size of this investment reflected population need and particularly the need to support our residents in care homes.
- Subject to ICB governance, funding is being identified for children and young peoples services and will initially focus on rolling out a children's hospital at home service and reducing waiting times for therapies and autism assessments.
- In terms of next steps we are starting to look at opportunities to reshape some services via a lead provider role. This would allow a focus on workforce which along with funding is the biggest challenge for the health and care system. However point of delivery will remain local i.e. either in a patient's home or locally in a clinic.
- We will also need to agree a series of new projects to provide a pipeline for transformation across NCL to ensure we can generate funding to recycle into community services along with system investment.

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

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

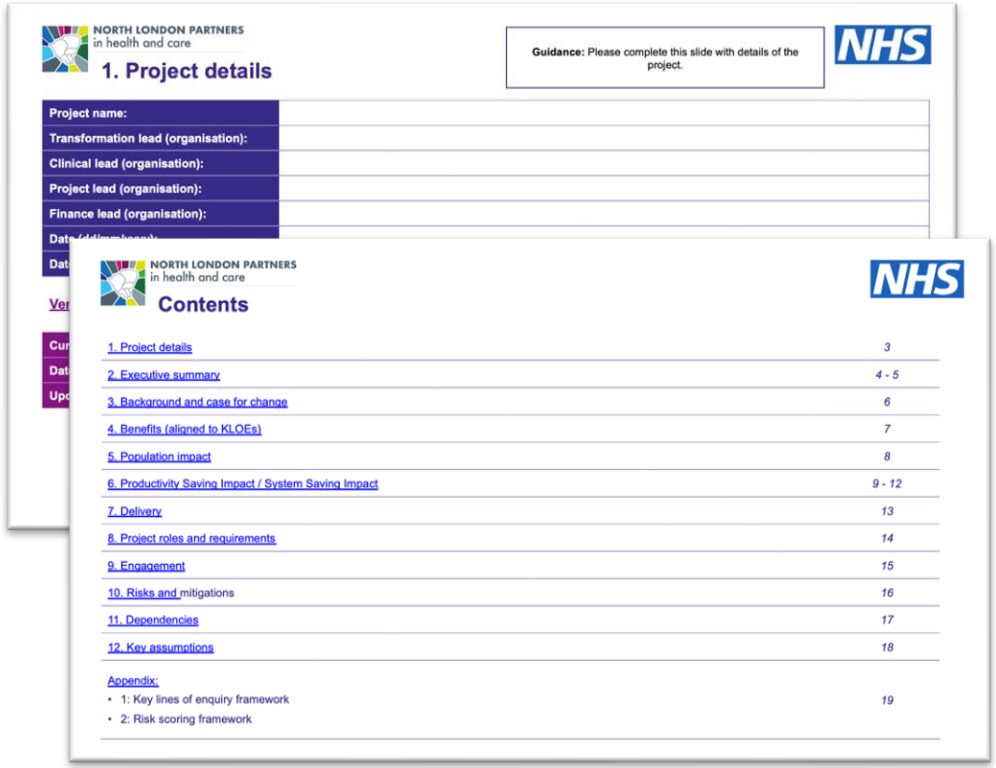
1st tranche

- CYP
- Virtual wards
- P2 Beds
- Single Point of Access (subject to workshop discussion)

2nd tranche

- Diabetes
- Tissue viability

Project documentation is being completed for each of these areas



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1. Project details

Guidance: Please complete this slide with details of the project.

Project name:	
Transformation lead (organisation):	
Clinical lead (organisation):	
Project lead (organisation):	
Finance lead (organisation):	

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Example of a Virtual Ward In Barnet

History

Collaboration between secondary and community is now creating new innovative ways of supporting patients outside of hospital.

Pathway builds on the strengths of the senior nurse led single point of access in the Acute Admissions Unit (AAU)

Inclusion/exclusion criteria

- Patients who live in the Barnet Borough
- Patients that either require no community input, or once a day (nursing) visits (up to 5 days)

Referral pathways

- Patients identified in the Ambulatory Single Point of access; either on an emergency or acute pathway
- Initial screening call to rapid Unplanned care team number
- Referral form sent to Unplanned Care Team

Clinical leadership

- Patient remains ultimately under the care of the secondary care consultants
- Community teams provide in reach care
- Remote monitoring provided by the Hospital team in the AAU Hub

Capacity

- **Up to 20 patients or more**
- Pathways runs from AAU Hub which is open Mon – Fri 8am – 8pm; Sat & Sun 8am – 6pm

Care activities

Nursing and social care for patients at home (with support from the acute site) including:

- Triage and monitoring
- IV antibiotics
- Repeat bloods
- Chronic conditions

Workforce

- Senior nurse single point of access triage
- Consultant Acute and Geriatrician
- Community Nurses
- Advanced care practitioners

Key interdependent services

- Barnet Hospital AAU Hub
- CLCH Unplanned Care Team (which includes Rapid Response)
- West Herts and Enfield for onward referral

Patient diagnostic cohorts

- Patients who need ongoing care following emergency or acute attendance, but can be managed at home without admission

Digital

- Telephone appointments will be used to monitor ongoing pathways
- Potential use of wearable devices and apps being explored

Future planning

To expand patient cohorts/pathway numbers; expand community capacity/cohorts which don't require community

Commission digital solutions across NCL in terms of remote monitoring.

Evaluation

Electronic Patient Record system in use in management of the virtual ward

Activity metrics available

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Update on Community Services: Funding Approach to Barnet

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

Plans for Children and Young People for 2022/23 Against Core Services Offer

Progress to date

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

Plans being developed For Implementation ;

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

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

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	"Gap"	Rational and benefits
1	**Community rehabilitation service**	Investment would help establish a seven day community rehab service in line with the core offer. The gap analysis outlined that the current service is only available five days a week, creating a further opportunity to expedite discharge and enhance recovery.
2	**Community nursing: skill mix and capacity gaps**	Investment would boost skills and capacity gaps within community nursing to contribute to filling core offer "gaps" associated with having the right skill mix for IV/PEG/Catheter and TV to keep people well at home, inc. overnight response.
3	**Silver Line (NCL Wide)**	Expanding our silver triage geriatrician advice line to LAS staff to 8-8pm, 7 dpw, following a successful pilot. This service allows an LAS staff member to gain consultant level advice at the point of potential conveyance from a care home. Our pilot avoided conveyances in over 80% of occasions that the silver triage phone was utilised.

Population Health Outcomes Framework

Proposed NCL Population Health outcomes framework

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

Start well

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

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

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

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

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

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

Live well

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

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

Reduced unemployment and increase in people working in good jobs

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

Parity of esteem between mental and physical health

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

Age well

Older people live healthy and independent lives as long as possible

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

Older people are connected and thriving in their local communities

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

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

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