North Central London Integrated Care System

Barnet Health and Wellbeing Board: Community and Mental Health 'Core Offer'

13th July 2023

Contents

North Central London Integrated Care System

Context and objective of this paper

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Context

- As a new integrated care system (ICS), we must quickly take action to focus on the design and delivery of place-based care, and take the **opportunity to further population health improvement at neighbourhood level** including through our Community and MH services, and collaboration with partners.
- NHS North Central London Integrated Care Board (NCL ICB) commenced a **collaborative review of NHS community and mental health services** 18 months ago. Implementing the review will ensure there is an equitable service available across NCL which promotes out of hospital care and prevention, improving outcomes for residents and reducing the pressure on acute services. The stages of the review have included a **Case for Change** (Baseline Review) followed by the articulation of a **co-produced "core offer"** – i.e. the level of service every resident in NCL should expect.
- This work has **engaged partners from all five boroughs**, including how we work most effectively at a system, place and neighbourhood level to improve outcomes. The "core offer" will support equitable access for all patients across NCL and support us to deliver our vision for integrated care in a way that responds to major national reviews such as the Fuller Review.
- The total **investment to implement the "core offer" for mental health is £25.1m**; for **community services it is £57.7m**. We expect this investment to be implemented over a 5-year timeline and make significant progress to implementation of the Core Offer and equity in investment across NCL . This investment requirement will be met through a combination of national funding (System Development Funding, Mental Health Investment Standard, Virtual Ward), ICB funding, system savings and productivity/efficiency requirements for providers. This will involve providers doing more within their current financial envelope and reconfiguring how current resources are used to deliver more efficient models of care.
- For **adult community services**, Barnet Borough Partnership identified Community Rehab services and Community Nursing services as the highest priority gaps to address in 22/23. As a result of investment to date, Barnet are now able to provide an 8-8 Therapies service 7 days a week through increased capacity, and improve levels of capacity and skills in nursing to support IVs, catheters and management of complex wounds/pressure ulcers. In **CYP community services**, there is variation across providers but Barnet has seen significant reductions in numbers of 5+ year old waits for Autism assessment.

Objectives of this Barnet Health and Wellbeing Board paper

1. **Provide an overview and update on the progress of the mental health and community service reviews and delivery of the "core offer";**
2. **Share Barnet investment areas and how this is benefiting citizens in Barnet;**
3. **Highlight actions taken to address local Barnet challenges across community and mental health services.**

This Core Offer is the desired minimum standard to be delivered for all residents across NCL

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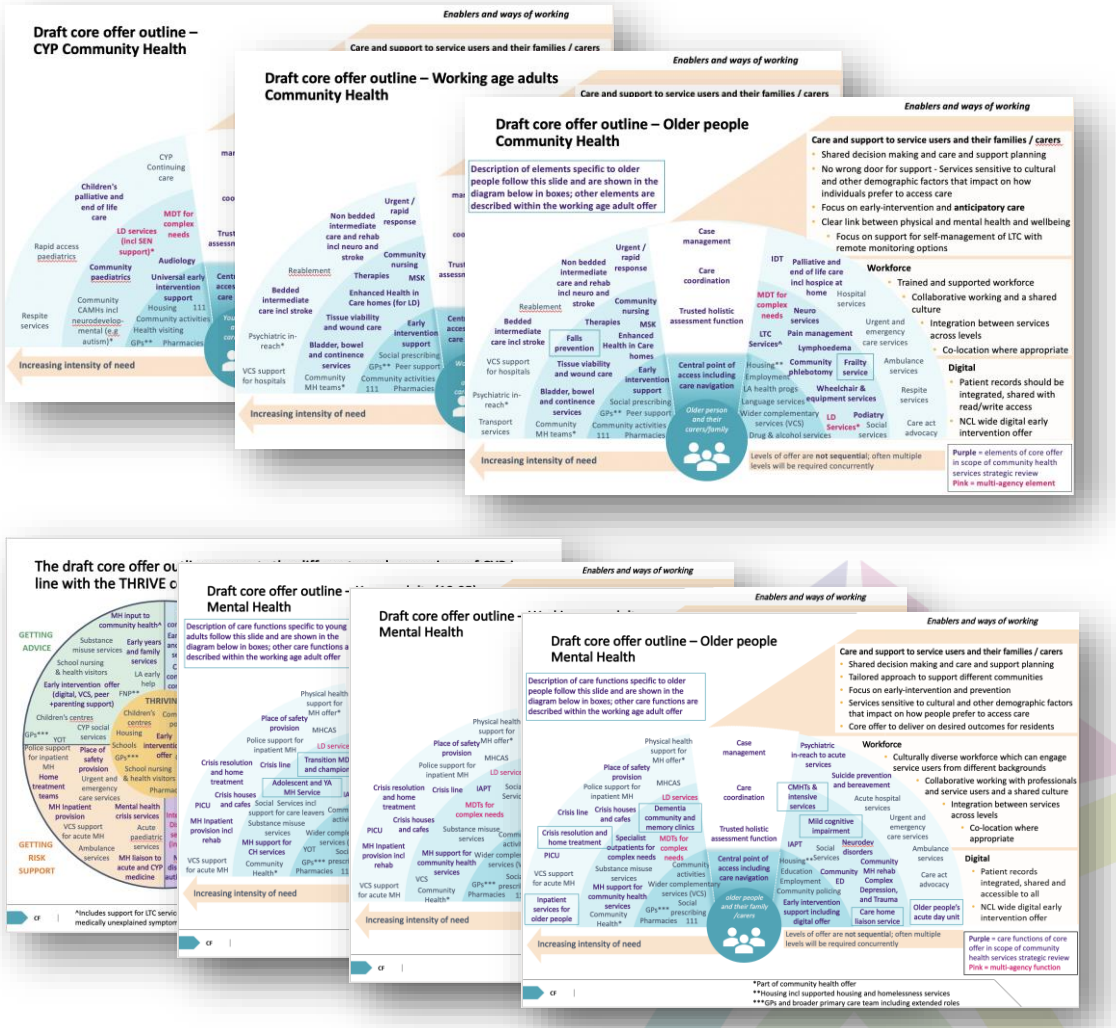
Community and Mental Health Services Core Offers

- The **Community Core Offe**r is described in line with the NHS Long Term Plan categories of Start Well, Live Well and Ageing Well
- The **Mental Health Core Offer** includes the transition 18-25 service
- The **Children and Young Peoples Core Offer** is structured differently to align to the THRIVE conceptual framework

Objectives 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.
- Address inequalities and inequities of access and health outcomes.
- Address user feedback received about the difficulty of navigating the health system and having to tell their stories more than once. 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.

Overview of Core Offer outlines



The journey of the Core Offer programme since the last update brought to Barnet HWBB

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Previous updates

Progress since last HWBB

Start of review
March 21

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

Mental Health
May 21

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

Design co-production
May - July 21

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

Core Offer
July 21

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

Gap analysis
August 21

A gap analysis was conducted by Borough colleagues against the Core Offer

Investment principles and KLOEs for prioritisation
April – May 22

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

Provider collaboration
May 22

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

Agree investment priorities for Y1 and profile multi-year investment plan
June 22

Programme Board agreed investment priorities based on gap analysis and correlation with investment and programme principles. NCL System Management Board (CEO level) endorsed approach

Provider completion of PIDs for collaborative projects
July – August 22

Benefits realisation and financial impact to be articulated for each project

Sign off at ICB Members Board of multi-year investment plan
September 22

Following system wide discussions during June – August 2022

Implementation workshops
July 22 – September 22

Borough Implementation workshops with place based partners in each borough

Local delivery of Y1 initiatives
October 22 – ONGOING

Investment has been mobilised and delivery tracked

Development of Project Delivery Plans for 23/24 initiatives
April 23 –June 23

Development of activity, finance and workforce plans for delivery of 23/24 initiatives

Agreement of 23/24 investment priorities
December 22 – May 23

Borough engagement to update gap analysis, co-design and agree investment priorities

Agreement of provider and system productivity contributions from 24/25
May 23 – ONGOING

Engagement with providers and system partners to jointly identify opportunity areas

Place-based Borough partnerships have a key role in delivering the core offer and supporting integration

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An NCL ICB *(Integrated Care Board)* system level Programme Team supports the Programme Boards, Implementation Steering Groups and Chief Finance Officer led Finance Subgroups to provide governance to "core offer" delivery, as well as benefits realisation and opportunities for collaboration. This **system coordination helps us define core offer, identify and share best practice, and map economies of scale for local reinvestment; while boroughs are best placed to understand and communicate the needs of populations, and the core offers are being delivered through place-based Borough Partnerships**.

Design Requirement:	Detail:	Enabling local delivery:
Co-design of services and vision with Borough partnerships	Strong and ongoing engagement of Borough partnerships in the identification of local gaps against the core offer and design and prioritisation of investment recommendations to address these. This includes partners across Primary Care, Local Authority and VCS.	**Ongoing local engagement and co-design.**
Implementation of "core offer" to report into place	Clear lines of sight into decision-making and risk-management processes with appropriate balance between central coordination of the "core offer" and local ownership and utilization of existing governance and reporting infrastructure.	**Prioritisation of local "core offer" delivery within local governance forums**
Place based transformation capacity	Many initiatives need to be delivered at place/neighborhood level in order that integration benefits are realised. Borough delivery resource facilitates delivery between system partners.	**Dedicated ICB transformation capacity working in place through Borough Partnerships**

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2. Progress in Barnet in delivering the Core Offer

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Adult Community Services

Overview of adult community investments in Barnet – 2022/23

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Scope	Programme area	Org	Recurrent investment	Core offer requirement	How this has investment has helped address the Core offer requirement
Barnet	**Therapy:** Increasing community rehab capacity from a 5 DAY to 7 DAY service to facilitate discharge and recovery	CLCH*	£ 230,000	• Provide a service 8:00-18:00 7 dpw and able to provide a response within 2 days, when appropriate	• As a result of the investment, Barnet now has a service that operates **8 am to 8 pm, 7 days a week.** • All posts within the service have been recruited to. This has allowed **increased weekend activity** and early signs of impact are being seen on discharges and in alleviating staff pressure.
Barnet	**Community nursing:** Boosting skill mix of staff for competencies like IV / Wound care/ PEG / Catheter to enable consistent provision	CLCH	£ 195,000	• Provide a response within 48 hours, 24/7 • Staff with sufficient capacity and skills/competencies to support pts e.g. IVs, catheters and management of complex wounds/pressure ulcers	• The investment has enabled a fully launched, running with x2 substantive staff. Interviews for the final post to was held on 12th June.
NCL	**Silver Line triage**: a pre-hospital telephone support scheme where geriatricians support the London Ambulance Service with clinical decision-making		£ 100,000	• 8-8 7 dpw with a 24/7 response available	• During Sep 2022 – July 2023 there were 339 Barnet cases The service has resulted in around 20% of the patients seen needing conveyance to hospital compared to 75% for similar patients in 2018. • The scheme has been supported by paramedics – 100 per cent of whom said they would use it again – and there have been calls to expand it to include other ambulance staff.

Additional NCL-wide investment or transformation initiatives that have impacted Barnet residents:

1. **Wound Clinics** (see slide 10)
2. **Virtual Wards** (see slide 10)
3. **Urgent Community Response/ D2A Therapy** (see slide 10)
4. **Frailty MDT** (see slide 11-12)

**CLCH: Central London Community Healthcare NHS Trust*

Resident impacts: Adult Community (1/2)

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What did the service historically look and feel like?

- **Wound Clinics:** No clear pathway for ambulatory patients with wounds, who were attending A&E, walk in centres, primary care and district nursing for dressing changes as no service to meet their needs.
- **Virtual Wards:** In line with national guidance, CLCH and system partners working to develop a Virtual Ward offer that supports patients both with early discharge as well as prevention of admission whilst meeting the core service offer being developed across NCL.
- **Urgent Community Response/ D2A Therapy**: Challenges in delivering a sustainable service across seven days due to staff capacity. This limited the ability of the service to support hospital discharges throughout the week.

With the Core Offer, what will the service look and feel like?

- **Wound Clinics:** Wound clinic launched in February 2023 working closely with TVN and Community nursing teams. Service received 87 referrals to date and made 235 contacts. Majority of referrals to date from Walk in Centres, improving experience of patients with wounds and capacity in Walk in Centres.
- **Virtual Wards:** Pathways developed that support different cohorts of patients to be treated at home safely, with care by appropriate clinical staff. Capacity is increasing across some pathways as staff have been recruited and new ways of working are being embedded. Barnet are progressing with their increase in bed capacity with acknowledgement that there is a lot more to do in 23/24. Different providers leading on integrated pathways to provide effective patient care, positive outcomes and reduces unnecessary hospital stays.
- **Urgent Community Response/ D2A Therapy**: The service is now supporting discharges and patient flow through the system 7 days per week. Patients on the D2A pathway are seen within 24 hours, including patients who are non-weight bearing, who have braces/collars as well as those needing case management. Staff have been able to flex across UCR services, supporting initiatives such as falls pick-up and the LAS/ UCR Car pilot.

Resident impacts: Adult Community (2/2)

North Central London Integrated Care System

What did the service historically look and feel like?

- **Frailty MDT**: Frailty MDT (Multi-disciplinary Team) was being piloted in PCN 2 *(Primary Care Network)*. This model provides personalised, proactive and holistic care for patients over 65 years who are identified as frail. The Frailty Working Group has now reviewed various models across the system and engaged with stakeholders to design a finalised model and workforce to take forward.

With the Core Offer, what will the service look and feel like?

- **Frailty MDT:** CLCH (Central London Community Healthcare NHS Trust) Barnet Frailty MDT launched in July 2022. GPs in Barnet can refer to the community service if they have adults who are aged 65 and over with moderate to severe frailty and / or who are identified as in the last 12 months of life expectancy. A member of the frailty team conducts a holistic geriatric assessment and develops a personalised care plan. The team hold two virtual Frailty MDTs per week. Since the service commenced we have held 54 virtual MDTs and discussed a total of 352 patients (164 new referrals and 151 reviews). The virtual MDTs are attended by the core frailty team, two alternating geriatricians, psychiatrist (monthly), the referring GPs and we invite the assigned social worker for specific cases. We currently have 131 patients on the frailty caseload with an average waiting time of 4 weeks for an initial assessment. Provisional manual audit of the caseload has demonstrated the following:
    - % CGAs completed (current caseload) – 95%
    - % EQ5D completed at initial assessment -66%
    - % Modified Barthel's completed at initial assessment- 86%

  We have obtained feedback from 32 service users between Sep 2022-May 2023. 75% of service users reported their experience with the service as very good and 25% as good.

CASE STUDY: CLCH Community Frailty Team: Patient story from the carer

North Central London Integrated Care System

Case study

My dad was having difficulty managing his personal care and preparing his meals. The frailty nurse did a referral to social services, and they provided a package of care and pendant alarm. My dad is now having regular carers three times a day, who help him with personal care, preparing his meals and medication. It was difficult at first, my dad was rejecting the support. The frailty nurse spoke to the care agency and now my dad is very happy, and he gets on well with his carer. We got help from Age UK and the team with LPA *(Lasting Power of Attorney)* and attendance allowance. Dad is now attending the day centre, and this makes him very happy. My sister is now receiving attendance allowance for my dad, and we have an LPA in place. My dad was smoking in the house; the fire service attended and did a risk assessment and fitted a smoke alarm in the house.

The frailty nurse helped arrange a continence assessment and my dad is now receiving incontinence pads. A physiotherapist from the team came and provided dad with a walking stick and had some grab rails installed. We are happy because dad feels more confident walking within the home. I was concerned about my dad's weight loss. The frailty nurse completed a referral to the dietitian. They visited and prescribed Ensure nutritional supplements for him. The team helped arrange a TREAT clinic appointment where he was seen by a geriatrician and helped get Dad to the memory clinic where he was diagnosed with dementia.

Currently, my dad is eating well and gaining weight and he has built up a good rapport with the carers. He enjoys attending day centres, he hasn't had any falls since. I am very happy with the frailty team.

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Mental Health

Mental health investment impact in Barnet – 22/23

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Scope	Programme area	Org	Recurrent investment	Core offer requirement	How this has investment has helped address the Core offer requirement
Barnet	Improved access to psychological therapies (adult and older adult)	BEH	£ 260,000	• ***Hours of operation:*** an 8 am to 8 pm service, Mon – Fri, with out of hours arrangements. • ***Response time (first contact):*** 75% people referred to the service should start treatment within 6 weeks, 95% within 18 weeks, • ***Follow ups:*** within two weeks	• 37k patients have received evidenced based psychological therapies (called Talking Therapies – previously IAPT services) in 22/23. **86% of which are being seen within 6 weeks, with a overall 53% recovery rate.**
Barnet	Adult community crisis (Crisis Cafe)	BEH	£ 138,000	• ***Service:*** 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. Opening hours vary.	• **Every NCL borough has a crisis café as an alternative to ED**. Barnet's was stood up in 21/22 during the pandemic.
Barnet	Adult Mental Health Liaison (Crisis/Liaison flexible funding)	BEH	£ 135,000	• ***Hours of operation:*** *24/7* • ***Response time: 1hr in ED, 4hr on wards*** • Timely psychiatric assessment for adults presenting to A+E and on acute wards with acute mental health presentations. Includes support for community intermediate care	• Target: 95% Core 24 response standard. • 1 hour A&E: 93% response standard • **24 ward: 96% response standard**
Barnet	Community mental health including new integrated models (adult and older adult, excluding dementia)	BEH	£ 1,133,000	• ***Hours of operation:*** 8 am to 8 pm with ability to arrange out of hours appointments • ***Response time (first contact):*** 4 week wait standard • ***Ongoing contact and response:*** to be agreed with service user and family including use of DIALOG+	• Access: 15,295 / 19,886 (77% - Q4) NCL residents benefit from at least receiving 2+ contacts from community mental health services for patients with a SMI. • **EIP** *(Early Intervention in Psychosis)***: Barnet achieved level 3 NCAP (National Clinical Audit of Psychosis) audit, only 2/5 NCL boroughs achieved level 3.**
Barnet	SMI *(Severe Mental Illness)* Physical Health Checks	BEH	£ 117,000	• ***Hours of operation:*** 8-6 Mon-Fri with some flexibility to meet needs of patients • 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.	• **NCL has overachieved** on the 22/23 target of 12,445 by 877 health checks, final performance equated to 13,322 health checks over the last 12 months. • **7,008 residents in Barnet** with an SMI benefit from accessing AHC *(Annual Health Check)* services in NCL.

Resident impacts: Adult Mental Health

North Central London Integrated Care System

What did the service historically look and feel like?

- **Community Mental Health Services:** Services were frequently not able to see patients for an initial appointment and the initiation of a care plan within 4 weeks and services lacked a holistic approach to assessment and care planning.
- **MH access in primary care:** Mental health specialists were not previously available in primary care, limiting the ability to provide a quick response to patients presenting in GP surgeries and increasing the need to refer into secondary care, with long wait times.
- **Wellbeing Pathway**: Historically there was a limited preventative wellbeing offer available within secondary care, resulting in more referrals to specialist services.
- **Adult Inpatients:** in 22/23 there were on average 1,300 out of area bed days.

With the Core Offer, what does the service look and feel like?

- **Community Mental Health Services:** Services are now achieving the maximum 4-week wait target for 85% of patients, seeing over 600 people a month and undertaking a holistic care planning using the co-created Dialog+ tool. The skill mix and remit of core community MH teams has also broadened, including the addition of 14 integrated voluntary sector workers to support reintegration into the community. A number are peer workers.
- **MH access in primary care:** Mental health practitioners are now embedded in PCNs and offer quick, direct access to specialist MH support within primary care. These staff work collaboratively with community-based services and can refer onward to the CORE teams or other specialist support as needed, creating a smoother journey for the patient.
- **Wellbeing Pathway**: The emerging wellbeing pathway will ensure that everybody approaching secondary care services receives an offer appropriate to their needs, which could be a group session delivered by one of our wellbeing practitioners.
- **Adult Inpatients:** Through investment in complex rehab repatriation and system flow initiatives, we have seen a 56% reduction of out of area bed days to 578 (Q1 2023/24)

**ARRS: Additional Roles Reimbursement Scheme*

Resident impacts: Adult Mental Health

North Central London Integrated Care System

What did the service historically look and feel like?

- **Mental Health Liaison Services perform well** achieving on the 95% response time of 1 hour in ED and 24 hours on wards.
- **Talking Therapies (IAPT):** in 22/23 there were 34k people accessing treatment against a target of 43k, with 86% being seen within 6 weeks, with a 53% recovery rate.
- **Eating Disorder**: Over a 9 weeks waiting time to receive an appointment at the height of the pandemic. CYP Eating Disorder services saw a 131% increase in referrals during the pandemic, identified nationally as a recovery priority.
- **Crisis services**: A limited number of service options were available to people presenting in crisis.
- **SMI health checks:** 9.6k patients with a severe mental illness had received their annual physical health check, missing the LTP target of 10.7k patients, by 1.1k checks (89%).

With the Core Offer, what does the service look and feel like?

- **Mental Health Liaison Services continue to perform well** achieving 93% of 1 hour in ED and 96% of the 24 hours on wards response standard (target 95%).
- **Talking Therapies (IAPT):** Overall Access to 1st treatment performance is significantly challenged. Even with a reduced 23/24 LTP recovery target from 56.8k, to 42.6k. NCL is behind on performance and has a waiting list of 2.7k patients. Activity has been relatively steady for a significant amount of time – April 21 to February 23. Q1 23/24 have seen 11k patients across NCL in comparison to the 44k target. NCL are achieving the recovery target of 50%.
- **Eating Disorder**: Additional investment has seen the average wait time for Routine Referrals reduce by 2 weeks from 6.8 to 4.6 wks
- **Crisis services:** whilst this remains an area for continuous improvement, investment in Barnet's crisis prevention house and crisis café offer alternatives to hospital attendance and admission, where people can be supported to make a wellbeing plan.
- **SMI health checks:** Investing in a dedicated SMI health check offer delivered by GP Federations, in partnership with VCS *(Voluntary and Community Sector)* organisations in collaboration with MH trusts, has led to NCL overachieving on the 22/23 target, final performance equated to 13,322 health checks (increasing from 89% to 93% target achievement). NCL are the second highest performer in London, with 3 of the 5 London ICS meeting the target.

How Tracey's care will be experienced differently as a result of the Mental Health Core Offer

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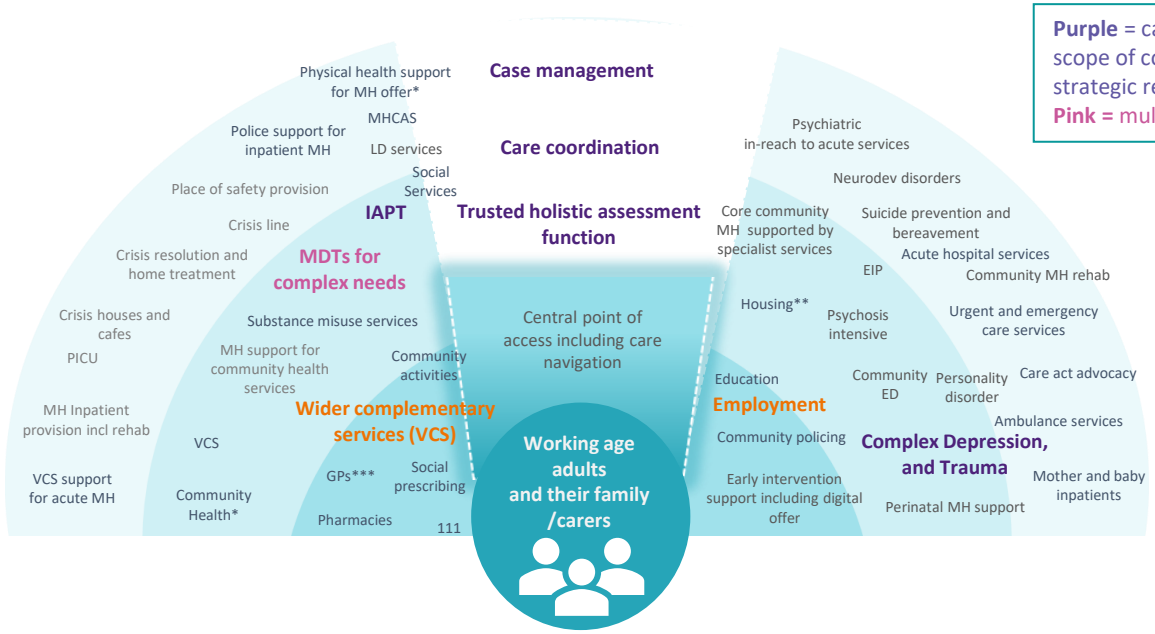
Young adult with mental health needs

Tracy has used mental health services for most of her life. She was abused as a child, has been in a violent relationship and has had periods of depression – now she is using that experience to help others.

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



What care will look like through the core offer

Tracy's story is truly inspiring. About 18 months ago, she was given support by The Network, a secondary care service created by Barnet Council with Barnet, Enfield and Haringey Mental Health NHS Trust (BEH). That changed her life and gave her mental and emotional stability and a new focus.

Last year, she joined BEH as a Peer Engagement Practitioner with our Barnet North Core Community Mental Health Team; she is employed by the charity Meridian Wellbeing, working in partnership with BEH, and currently supports 24 service users, with weekly appointments on the phone or face-to-face.

"I tell them that they can get better, because if I can do it then anybody can. It takes time and work but after a few weeks they feel the benefit."

She introduces people to activities and services that will help them to socialise, overcoming isolation and mixing with others who have shared experiences. She encourages people to join wellbeing sessions, including some at the Meritage Centre, in Hendon, where there is a Wellbeing Café, run by Meridian Wellbeing. Tracy works as part of a multi-disciplinary team, alongside psychologists, social prescribers, community engagement workers and other specialists. They work together to achieve the best outcomes for each service user, who is consulted at every step of the recovery journey.

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Children and Young People (CYP) Services

Overview of CYP community and mental health investments in Barnet – 2022/23

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Scope	Programme area	Org	Recurrent investment	Core offer requirement	How this has investment has helped address the Core offer requirement
Barnet	Therapy : increase children's therapy capacity	Whittington Health (NCL accelerator)	£150k (non-recurrent)*	•Offer of Early Intervention and identification in schools and community settings in all boroughs •First contact with therapy services within 6 weeks •Offer of advice, guidance, training for schools	Overall positive improvements in numbers of CYP waiting since the work of providers to target waits, despite significant increases in demand and higher referral numbers. • ***Occupational Therapy:*** Sept 22 there were 673 CYP waiting, whereas in March 23 there were 520 CYP waiting (22% reduction). • ***Physiotherapy:*** Sept 22 there were 822 CYP waiting, whereas in March 23 there were 598 CYP waiting(27.2% reduction). • ***SLT:*** Sept 22 there were 1,595 CYP waiting, whereas in March 23 there were 1,525 CYP waiting (4.3% reduction) • Focus on SLT waits to understand impact and opportunities to improve this
Barnet	Enuresis	RFL	£63K (non-recurrent)	• Address short term gap in provision	• Support to service gap in Enuresis
Barnet	CYP HTT	BEH	£ 338,000	• ***Hours of operation:*** To include evenings and weekends • ***Response time (first contact):*** 4 hours for emergency referrals, 48 hours for urgent transfer referrals, 1 week for routine referrals • ***Ongoing contact and response:*** Daily MDT review and daily therapeutic 1-1 and group input	• **90% HTT 4hr response for a crisis referral** • **80% 24hr response for an urgent referral.** • 80% 7 day for routine referrals. • 10% reduction in Occupied Bed Days
Barnet	Young adults (18-25)	BEH	£ 234,000	• 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	• **Transition workers recruited.** • Reduced variation across NCL, equality in WTE across 5 boroughs. • Young Adults Strategy and Model of Care still to be co-produced. • Training for CAMHs and AMHs to be delivered.
NCL	Autism : increase diagnostic capacity	Whittington Health (NCL hub)	£240k (non-recurrent)	• Assessment to start within 12 weeks of referral • Pre and post diagnostic support for CYP and parents/carers • Multi-disciplinary model of assessment and care	• **Over 5s:** Enfield have seen the greatest reduction, down from 535 in April 22 to 217 in Feb 23. Islington and Barnet have also seen quite significant reductions in numbers of CYP waiting, whilst Camden saw a relatively small increase in waiters. • **Under 5s:** Improvement in 4/5 NCL boroughs. Barnet remains an outlier due to capacity issues at RFL.

*In addition to Core Offer investment, a further 700k from carried over accelerator funding within WH, approx. 50% of total available went to Barnet to reduce waiting times

Resident impacts: Children Community and Mental Health

North Central London Integrated Care System

What did the service historically look and feel like?

- **CYP Home Treatment Teams:** CYP home treatment teams are a LTP *(Long Term Plan)* new model of care for CYP with Mental Health needs. This service did not operate in NCL.
- **Therapy services:** The Barnet Children's Integrated Therapy service was previously delivered by North East London Foundation Trust. The service transferred to Whittington Health.
- **CYP MH out of hours support:** Currently there is 24/7 crisis cover in RFH *(Royal Free Hospital)*, Whittington and UCLH *(University College London Hospital)*. At Barnet Hospital and NMUH *(North Middlesex University Hospital)* there has not been the required crisis assessment/response Between 12am – 9am required by the 24/7 CYP MH crisis pathway standards set out in the NHS Long Term Plan.
- **Looked After Children's services:** Staffing levels across NCL have historically fallen outside or RCGPH *(Royal College of General Practitioners)* staffing level recommendations.

With the Core Offer, what does the service look like today?

- **CYP Home Treatment Teams:** In 2022/23 the ICB invested to start the roll out of the HTT model, starting first with roll out in Barnet. The team saw 58 children between initiation and end of March 2023, and in the same time period we have seen a reduction in inpatient admission rates for Barnet 11-17s from 43.8 to 25 (per 100k CYP population).
- **Therapy services:** In 2022/23 the ICB invested £150k in addition to the Therapies accelerator programme funding to address waits in Therapy services across NCL. In addition, in 2023/24 the ICB will invest a further £323k recurrently for Barnet. In partnership with the Local Authority, the service was transferred to Whittington Health in February 2022. Since transfer we have seen staff in post go from 34.4 (31% vacancies) to 44 (12% vacancies) and waits for first appointment go from 3964 to 761.
- **CYP MH out of hours support:** From 2023/24 the ICB has invested £180k so that staff can be recruited to support services users to the required standard on all acute sites between 12am – 9am.
- **Looked After Children's services:** In 2023/24 the ICB has invested £94,832 to increase the staffing establishment in the Barnet CLA (*Children Looked After*) service to reach RCGPH standards.

CASE STUDY: Barnet Children's Continuing Care: Patient story from parents

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Case study

Myself and my wife have had a lot of involvement with the Barnet Children's Continuing Care team due to our son's health needs. Throughout our time working with them, the team have been very good and helpful with everything our son needs. The team provided all the relevant health equipment he needed at home, they helped with housing issues we were facing and they helped us get a care package in place for our son to support us with his care. They helped with everything and we are very grateful for this. Anything we needed, they helped us with. All the team were always doing their best for our son and we are really happy with every member of the team. We feel all of our son's needs were appropriately met by the team. Myself and my wife feel we were included in all the decisions made about our son and his health.

The communication with the team has been really good. They always give us enough time to discuss things and are always answering the phone anytime we have any concerns or issues. We know we can telephone them about anything and straight away they support us. Our allocated nurse especially has been really good at this. We understood all the information that was provided to us and all of our questions were answered. We are really happy with all of the team and what they have provided.

Overall, we are very happy with the service provided. We would recommend this service to anyone that was able to receive this service. There is nothing that this service could improve on as they were so helpful throughout. We are really happy that all of our sons needs have been met by the Barnet Children's Continuing Care team and they continue to support us.

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3. Addressing local challenges

- **Inequalities within Barnet**
- **Mental Health performance and access**: Talking Therapies (IAPT), SMI health checks, inpatient flow, MH Liaison Service
- **CYP performance and access**: Autism, Therapies, Eating Disorders service, receiving treatment

Addressing health inequalities in Barnet

North Central London Integrated Care System

There are stark inequalities in health needs and outcomes across NCL, and one of the **core principles for prioritisation for investment has been to address inequalities in access and outcomes across the 5 Boroughs**. As such, one of the financial principles for the programme is that "Investment should focus on historically underfunded areas and where there are historic inequities". However, alongside this investment, **there are also ongoing schemes to address inequalities within Barnet**, as set out below:

Initiatives

1	**SLT* for vulnerable families**	The project aimed to **increase access to SLT for vulnerable families who historically had not accessed services**. Services have been developed to deliver SLT via children's centres given that these spaces are accessed by families with high levels of needs and deprivation, as opposed to other under 5's settings within the borough. This was later extended to PVI *(Private, Voluntary and Independent)* settings across the borough to increase the project reach.
2	**Healthy Hearts**	The Healthy Hearts programme, which is jointly funded by the NCL ICB Health Inequalities fund and London Borough of Barnet Public Health provides peer led community engagement and education focused on developing awareness and understanding of the risks of high blood pressure. A key **aim is to support reduction in inequalities in CVD** *(Cardiovascular Disease)* **outcomes** through proactive outreach and targeted support in: Burnt Oak, Colindale, Edgware, Hendon & Golders Green.
3	**Barnet Young Brushers**	The Barnet Young Brushers project aims to reduce dental complications and increase regular tooth brushing through the provision of targeted supervised tooth brushing interventions in early years settings. The programme provided education and training in 47 early years settings in Barnet (**68% of settings fully or semi-engaged from deprived areas**). **73.50%(n=86) of parents agreed that toothbrushing at the setting has improved** their brushing habits at home.
4	**Art Against Knives**	This project is a collaboration between the Borough Partnership, BEHMHT and 'Art Against Knives' (AAK, a local VCS organisation), funded by the Borough Partnership. The aim of the project is to support young black males to **tackle the inequalities they experience**, through peer support and provision of creative spaces and activities. From July 2022 to January 2023, 78 young people engaged with the LAB (AAK's hub in Finchley), with 63 of those receiving one-to-one/mentoring support, with **82% demonstrating a significant increase in capabilities**.

**SLT: Speech and Language Therapy*

Mental Health performance and access: Talking Therapies, SMI Health checks, MH Liaison Service

North Central London Integrated Care System

SMI Health Checks

All people with SMI should be offered an annual physical health check. This explores the risk factors for CVD such as smoking, obesity and high blood pressure. Where such conditions are found, the person with SMI are offered appropriate support and treatment. With the aim to reach parity of esteem and reduce the 20yr gap in life expectancy for those with a SMI compared to the general population.

7,008 patients with an SMI had a physical health check in Barnet.

Talking Therapies (IAPT)

Overall Access to 1st treatment performance is significantly challenged. NCL did not meet the LTP ambition in 22/23. Even with a reduced 23/24 LTP recovery target from 56.8k, to 42.6k. NCL is behind on performance and has a waiting list of 2.7k patients. Activity has been relatively steady for a significant amount of time – April 21 to February 23. Q1 23/24 have seen 11k patients across NCL in comparison to the 44k target.

NCL are achieving the recovery target of 50%.

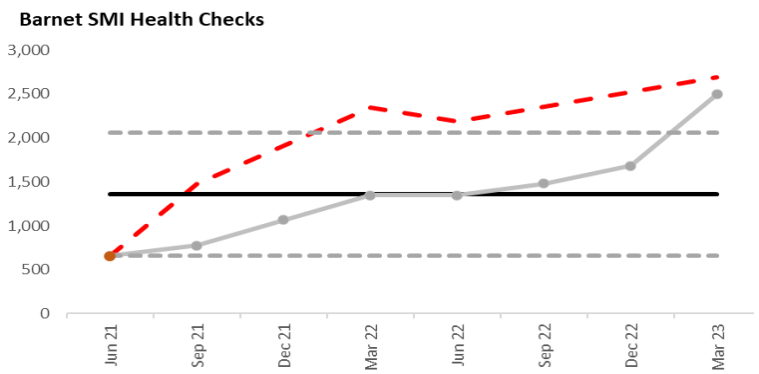
MH Liaison Service

The Mental Health Liaison Service are mental health professionals based in Acute Trusts to support MH assessment in Emergency Departments and on wards.

Barnet hospital is over achieving on the 95% response time of 1 hour in ED and 24 hours on wards.

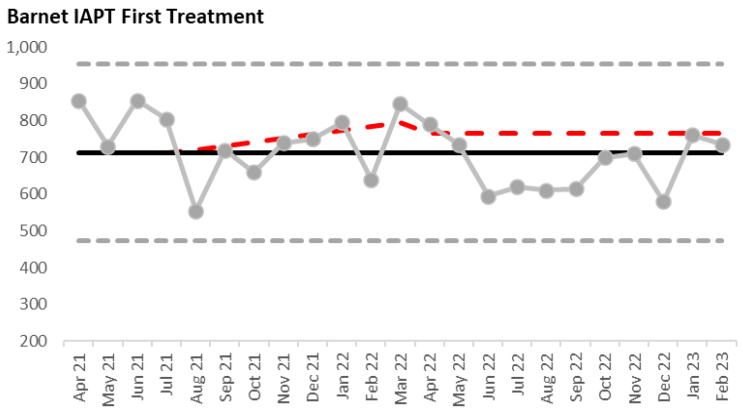
Barnet SMI Health Check Performance Jun 21 – Mar 23

Number of SMI Health Checks



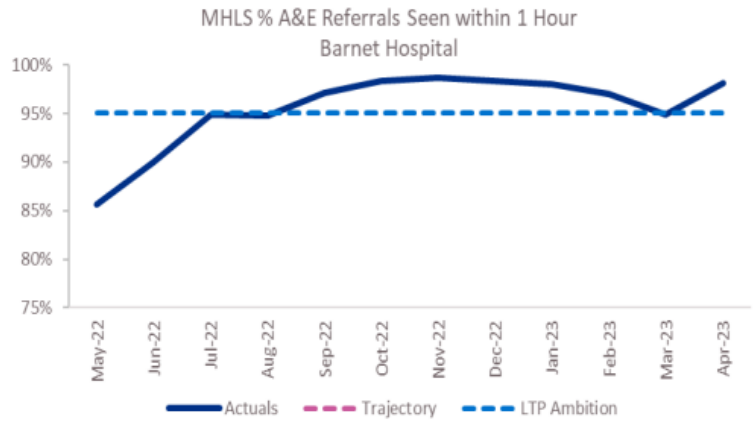
Barnet IAPT first treatment Performance Apr 21-Feb 23

Number of IAPT First Treatments



Barnet Hospital Referrals Seen within 1 hour May 22-Apr 23

% Referrals seen within an hour



Data Source: NCL Submission to NHSE

Upper/Lower Control Limit — Mean — NCL Recovery Target

Mental Health performance and access: inpatient flow and out of area placements (OAPs), Community MH Services

North Central London Integrated Care System

inpatient flow and out of area placements (OAPs)

NCL are seeing improvements in MH acute inpatient flow and a reduction of inappropriate out of area placements

Out of Area Placements (OAPs)

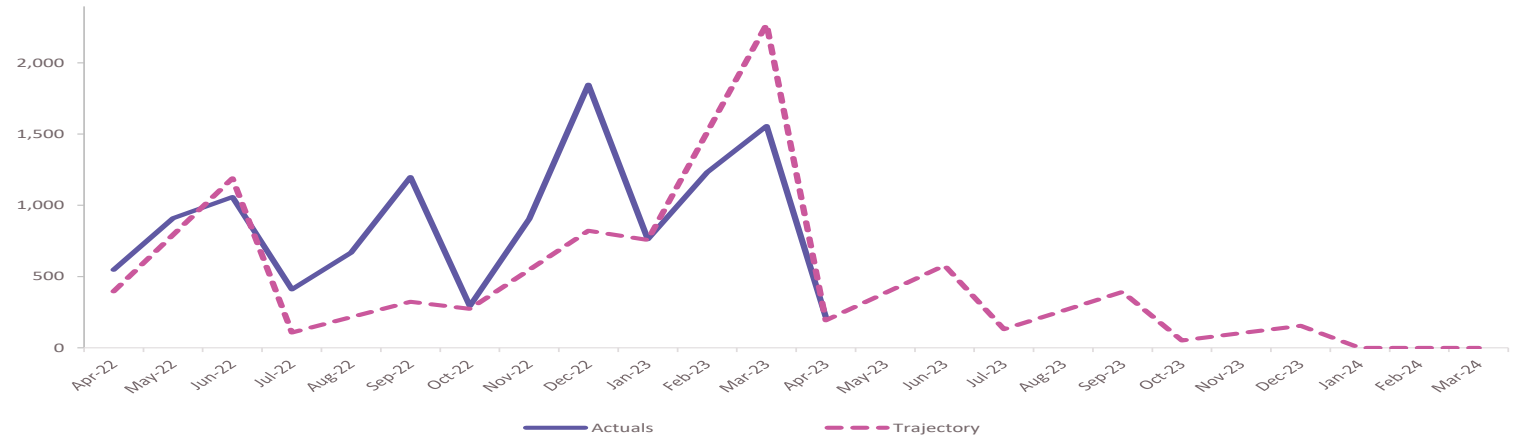
- **For 2022/23, the MH Trusts mean number of OAP patients** in BEH is 24, a slight increase from 22 in 2021/22, maintained from 2021/22.
- NCL submitted a compliant trajectory that met the national ambition to **achieve the zero target, by March 2024**
- **The MH Trusts mean number of occupied bed days in** BEH is 314 days and C&I is 86 days in 2022/23.

Length of Stay (LoS) (excl. leave)

- **Both MH Trusts Adult Acute LoS** is above the national average of 32 days.
- BEH average LoS is 39 days in 2022/23, increasing from 35 days in 2021/22
- C&I average LoS is 46 days in 2022/23, maintained from 2021/22.
- Reducing the **system average LoS to 32 days** should enable the system to operate within its core bed base

NCL Inappropriate Out of Area Beddays Apr 22 – Mar 24 *(trajectory)*

Total inappropriate out of area placements

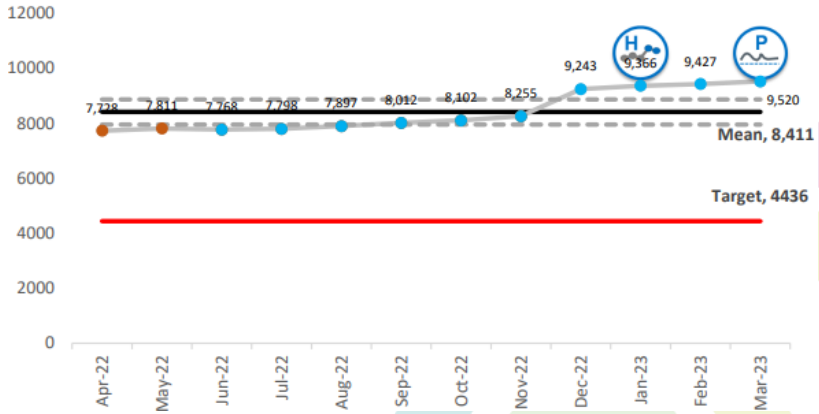


Community Mental Health Services

In 22/23 BEH have seen 9,520 patients in transformed adult community services and C&I have seen 4,706 patients. Services are now achieving the maximum 4-week wait target for 85% of patients, seeing over 600 people a month and undertaking a holistic care planning using the co-created Dialog+ tool. The skill mix and remit of core community MH teams has also broadened, including the addition of 14 integrated voluntary sector workers to support reintegration into the community. A number are peer workers.

BEH 2+ Attended Contacts

Number of unique clients



CYP performance and access: Autism, Therapies, Eating Disorders service

North Central London Integrated Care System

Autism Assessments

<7 waits for Autism assessment in Barnet is an outlier, issues with Consultant capacity at RFL have impacted the number of CYP able to access Autism assessment and numbers for Barnet have risen from 425 to 605 in March 23.

In >5 waits for Autism assessment, Barnet have seen quite significant reductions in numbers of CYP waiting. Barnet's number of waiters went from 173 Sept 22 – 67 in March 23.

Therapies

The CYP Therapy service in Barnet transferred to WH from NELFT in February 2022. At the time of transfer the service had high numbers of children and young people waiting for assessment and interventions, as well as a high vacancy rate. As part of the NCL Therapies recovery work led by WH in 2022/23 the service received additional funding to support a reduction in waiting times*. By the beginning of March 2023 the OT and Physio teams had only 3 CYP waiting over 18 weeks to be seen and significant improvements had been made to waiting times for SLT.

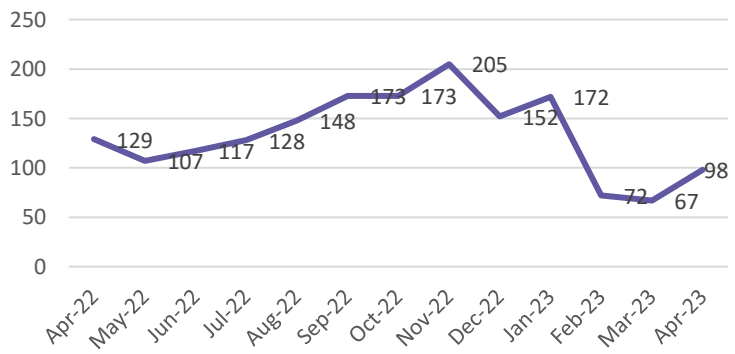
Eating Disorders

The Eating disorders service provided by Royal Free FT has seen a significant increase in demand throughout the last 3 years. The ICB have provided additional funding to support an increase in staffing.

The latest data from the service based on referrals in which assessments took place within Q4 2022-23 show that 19 out of 29 (65.5%), of accepted routine referrals were seen inside the 28-day target and 15 out of 18 (83%) of urgent referrals were seen inside the 7-day target.

Barnet waiting for Autism assessment over 5 years

Number on waiting list



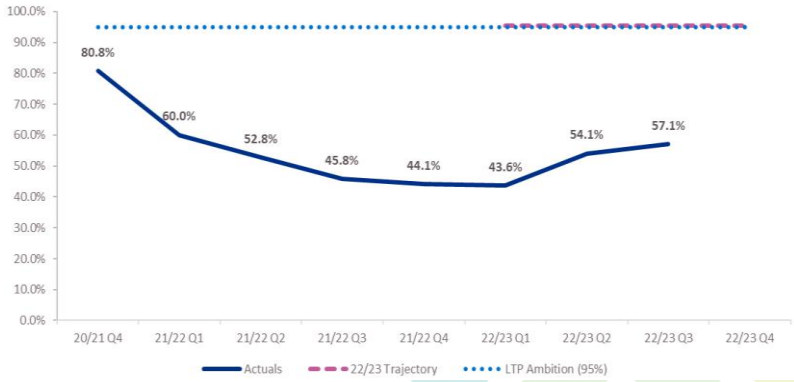
Total CYP waiting for initial assessments

Number waiting

	Feb 2022	Feb 2023	% reduction
Barnet OT	563	133	76%
Barnet PT	170	105	38%
Barnet SLT	2961	523	82%
Total	3964	761	81%

CYP with Eating Disorder seen within 1 week (Urgent)

% seen within 1 week



*Some of the initial waiting list was inflated due to outdated data which was corrected as part of the transfer to WH

CYP performance and access: Total CYP receiving treatment

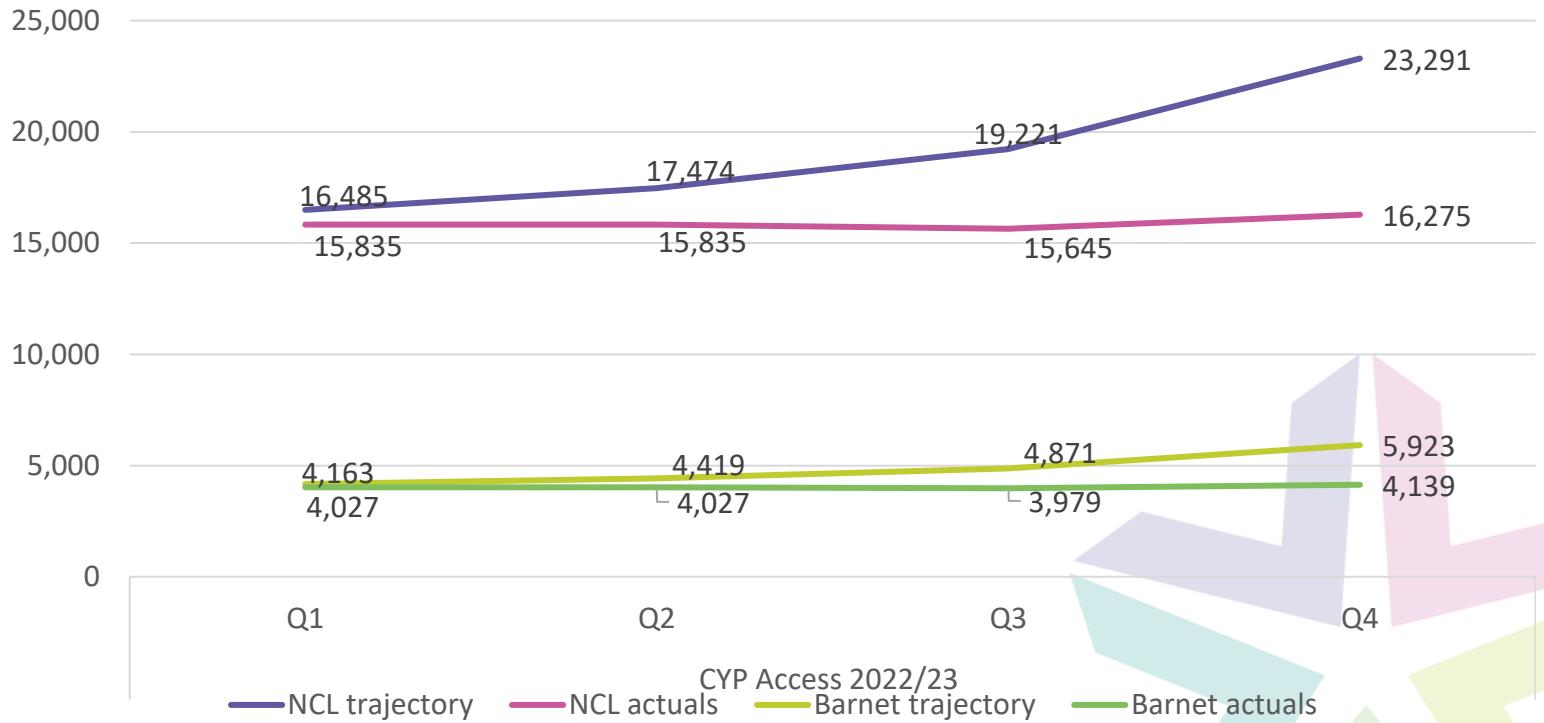
North Central London Integrated Care System

Total CYP receiving treatment

- As with other Integrated Care Systems in the London region, NCL do not currently meet the access target.
- Mental Health Support Teams in Schools (MHSTs) activity, which is below target contributes to underperformance, as well as wider data capture issues* since the change in metric definitions from 2021/22.
- Prior to MHST activity being included within the new Access metric, NCL consistently overperformed against the trajectory targets.
- Planned trajectories for 2023/24 take this into account.

CYP MH Access performance including Barnet Trajectory and Actuals for 2022/23

Number of CYP Receiving Treatment



*The data issues regarding the methodology for recording CYP MHST contacts have been raised with NHSE. A CYP attending a wellbeing session in assembly or a contact with a teacher / parent will not be recorded via MHSDS, it is unreasonable to expect all patient history to be recorded when it's a wellbeing session not a MH intervention. Therefore, the majority of prevention contacts are not recorded. As well as some providers not able to submit to MHSDS.

North Central London Integrated Care System

4.Conclusion

Overview of NCL Population Health Frameworks

North Central London Integrated Care System

As well as performance dashboards NCL ICS will be assured we are reaching the health outcomes for our populations by the creation of these outcome frameworks;

Population Health Outcomes Framework

NCL's ambitious Population Health Strategy sets out how our ICS will approach improving the health of local people and reduce health inequalities. A population health outcomes framework has been developed to understand the opportunities for improvement and reducing variation in outcomes at system and place, and where greater focus and investment may be required. This framework will play a key role in understanding the impact of delivery of the NCL Population Health Strategy on population outcomes. This will act as the overarching outcomes framework with the Community and Mental Health Outcomes Framework feeding into this.

Community Outcomes Framework (COF)

We have developed an outcomes framework as part of a wider benefits realisation framework to underpin the implementation of the core service offer for community services. The COF will sit under the NCL Population Health Improvement strategy and aims to demonstrate the role community services play in delivering the overall strategy.

Mental Health Outcomes Framework (MH)

We have developed a Mental Health outcomes framework which include outcomes we would be expecting from the delivery of the MH Core Offer. This will enable us to measure if the core offer is meeting the needs of the population. This framework will sit under the NCL Population Health Improvement Strategy and help us measure the contribution of MH services in delivering the population health outcomes.

Barnet Adult and CYP Community Investment 2023-24

North Central London Integrated Care System

Description	Barnet	NCL Wide
ADULTS	**£000**	**£000**
Barnet Catheters	294	
Barnet SLT capacity	291	
UCR Coordination Hub		375
P2 Core Offer Optimisation including Adams (CLCH)		280
CYP		
Therapies	323	
CLA	94	
Asthma nursing	77	
Autism	302	
Total Community	**1,381**	**655**

- Investment areas in the table on the left are still provisional pending the development of Project Development Plans (PDPs) and System Management Board (SMB) sign-off.
- Barnet has been shortlisted to receive the largest amount of additional funding through the Community Services Core Offer in 23/24, in recognition of historic inequitable investment in community services across NCL.
- All priority 1 gaps identified by the Barnet Borough partnership have received funding this year.
- Further gaps identified by the Royal Free in stroke rehab early intervention support and care coordinators identified through the Core Offer process are looking for funding from alternative sources.
- Alongside this, CLCH and the NRC (RF) will be continuing to bolster their Pathway 1 NHS Discharge offer.

Adult MH Investment by Borough 2023-24

North Central London Integrated Care System

Description	Barnet	Camden	Enfield	Haringey	Islington	NCL Wide	Total
ADULTS	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Adult Community Transformation	1,333	892	1,142	1,051	892		**5,310**
Perinatal	320	320	320	320	320		**1,601**
THINK 111 and Crisis Lines	260	260	260	260	260		**1,300**
NDD Enhance Clinical Model (MH Trusts)*	129	129	129	129	129		**645**
Additional Crisis Alternatives	93	93	93	93	93		**464**
Individual Placement Support(IPS) (employment) match provision across NCL	89	89	89	89	89		**445**
SMI	60	100	52	73	54	86	**425**
Neuro developmental disorder (NDD*) Enhance Clinical Model (SLAM activity)	118		118	118			**355**
Suicide Prevention*	63	63	63	63	63		**314**
IPS NHS specific SDF Allocation	36	36	36	36	36		**182**
Dementia support (NCL admission avoidance)	82						**82**
Rough Sleeping uplift only				11			**11**
Sub-Total Adults	**2,584**	**1,982**	**2,303**	**2,244**	**1,936**	**86**	**11,134**

- **Adult Community Transformation** is the largest area of investment across the investment portfolio (£5.3m). To ensure we are preventing crisis and inpatient admissions by focusing on supporting patients with a MH diagnosis earlier and based on MH need.
- ***Neuro Developmental Disorders** (which includes ADHD and Autism) is nationally recognised as a chronically underfunded service therefore £1m will be invested this year.
- **THINK 111 and crisis lines** investment (1.3m) is a significant 23/24 service development area.

** Subject to a PDP*

CYP MH Investment by Borough 2023-24

North Central London Integrated Care System

Description	Barnet	Camden	Enfield	Haringey	Islington	NCL ICB	Total
CYP	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
CYP MH Liaison Service (Crisis response in ED)	60		60	60			**180**
CYP Home Treatment Team (full roll out)	250	237	237	237	237		**1,196**
MH Suport Teams in Schools (MHSTs) Trailblazers + wave 1-6 - uplift		95			79	384	**558**
MHST wave 7&8 (MHST2022/23) - uplift plus FYE		242		233			**475**
MHST wave 9&10 (MHST2023/24) - PYE - but plan			155		161		**316**
CYP MH project management (incl. THRIVE, co-production and PMO) (NCL wide resource)	45	45	45	45	45		**225**
Looked After Children LAC - Haringey				260			**260**
Central Point of Access (BEH boroughs)	233		233	233			**700**
Early Years (0-5yr olds)	194		194	194			**583**
CYP Community Transformation	38	344	355	38	366		**1,141**
Sub-Total 23/24 MH CYP Investment	**821**	**963**	**1,279**	**1,300**	**888**	**384**	**5,634**

- The roll out of the **CYP Home Treatment Team** (£1.2m). Due to MH need, this started as a pilot in Barnet and will roll have a phased roll out across NCL. To ensure we are meeting the needs of the most complex CYP, addressing the rising acuity in MH presentations post pandemic and preventing inpatient admissions.
- C&I boroughs have a multi agency **single point of access for CYP**. In 23/24, we are investing in a SPA in the north of NCL (£700k).
- £1.1m is being invested into **Community CYP services and CYP MH** to increase access, reduce waiting lists and times.

North Central London Integrated Care System

Thank you for joining!