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Principal Scrutiny Officer

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13 March 2024

To: All Members of the North Central London Joint Health Overview and Scrutiny Committee

Dear Member,

North Central London Joint Health Overview and Scrutiny Committee - Monday, 18th March, 2024

I attach a copy of the following reports for the above-mentioned meeting:

7. NCL COMMUNITY AND MENTAL HEALTH CORE OFFER (PAGES 1 - 26)

This report is an amended version of the report that was originally published for Item 7. The changes are minor corrections only.

Yours sincerely

Dominic O'Brien,
Principal Scrutiny Officer

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North Central London Integrated Care System

Joint Health Overview and Scrutiny Committee: NCL Mental Health and Community Core Offer Implementation Update

18th March 2024

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Executive summary

North Central London Integrated Care System

Context

- The Core Offer programmes for Community and Mental Health services across North Central London (NCL) were established to address the baseline reviews of the service, completed in 2021. These established a compelling case for change based on the level of inequity and need against access to services and historic levels of funding. To respond to the case for change, a core offer was co-produced and agreed which specifies what services should be available to everyone in NCL.
- The Core Offer programmes will drive improvement in our population health outcomes associated with mental health and community services. We have developed a Community and Mental Health Outcomes Framework, aligned to NCL's Population Health and Integrated Care Strategy to track benefits and enable us to target where additional focus is required.
- The expected impact on residents' experience of care have been set out. Some of the major areas of transformation is in improved community mental health services, where there is increased collaborative working between GPs, community groups and adult social care. This includes increased support for children transitioning to adult services and older people, linking together physical health and social drivers with mental health. Another important service launched was the section 136 hub which went live in October 2023 which is delivering the much needed improvements for people who experience mental health crisis in London. The Community Services core offer was featured as a national best-practice example of a community services transformation programme which highlighted the system-wide impact that our investment make.
- There are still some challenges to be addressed, including tackling autism and ADHD diagnostic waits, but both the Community and Mental Health core offer programmes are improving population health through advancing early intervention and prevention, improving coordinating functions, integrating physical and mental health and reducing pressure on acute services so that more people can be cared for outside of acute hospital settings.

Purpose of this Joint Health Overview and Scrutiny Committee Paper

1. Provide an overview and update on the progress of the community and mental health service reviews to date;
2. Outline the benefits that the core offer has brought for residents in 23/24;
3. Highlight some important successes and challenges
4. Set out the next steps for community and mental health core offer implementation in 24/25 and beyond.

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Recap and overview of the programme

There is a strong case for changing community health and mental health services

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A case for change for mental health and community services across NCL was developed in March 2021. The case for change centred around inequalities, provision, access, spend and resident feedback. Below, are examples from 2021 that illustrate these issues.

Inequalities

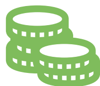
There are stark inequalities in health needs and outcomes across NCL

Provision

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

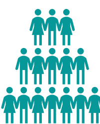
Access

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 servicer users to repeat their stories

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

18% of people on the NCL mental health services caseload are Black/Black British, however, Black/Black British people accounted for 27% of NCL mental health inpatient admissions in 2019/20.

20% of children referred to mental health services in Islington wait over 18 weeks from referral to their first contact with services, compared to 1.2% of children in Barnet and 1.6% of children in Camden

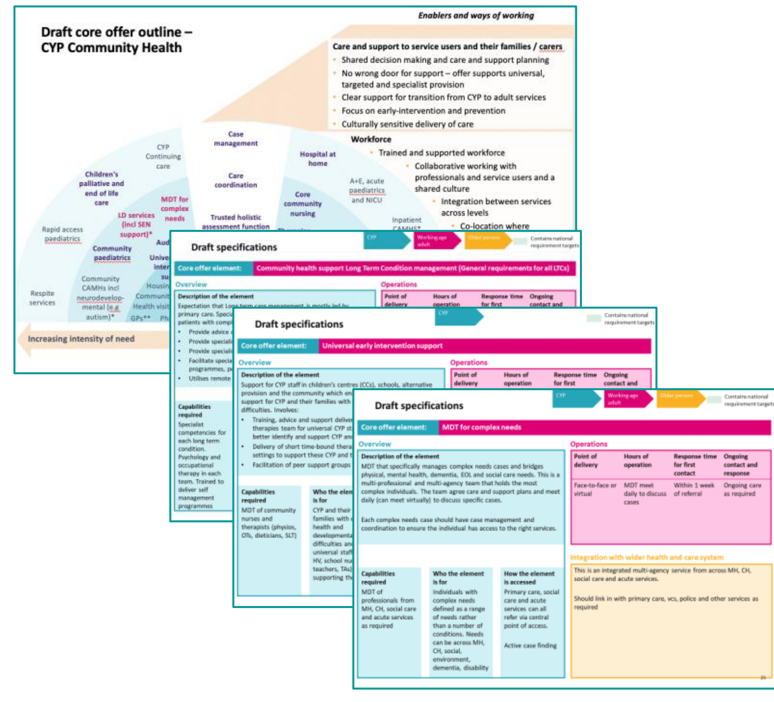
Much of our mental health services are geared to a crisis response rather than prevention.

In Haringey £98 per head is spent on community health services vs. £192 per head in Islington. This results in less capacity in core services, meaning community health services would struggle to be full participants in population health improvement work.

Feedback from residents via our Resident Reference Group notes the distress caused by constant repetition of histories and stressed the need for shared records.

To respond to the case for change a core offer was agreed which specifies what services should be available to everyone in NCL

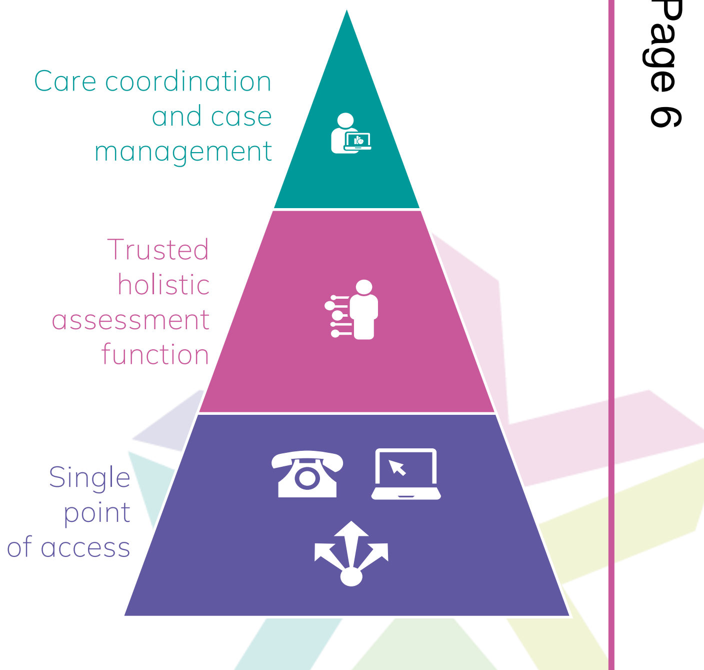
The purpose of the core offer is to address the inconsistency of service provision across NCL by setting out a commitment to the NCL residents of the support they can expect to have access to regardless of their borough of residence.



Each core offer outline provides a description of the care function for the services and lays out access criteria, hours of operation, capabilities required, where the care function should be delivered, waiting times and how the care function should link in with the wider health and care system.

- Operating hours and out of hours provision
- Integration between the care function and other services and agencies
- Access to the care function and criteria
- Response time for first contact and ongoing contacts (in line with national guidance)
- Point of delivery (e.g.. in person, virtual)
- Workforce capabilities required
- Description of the service, including requirements to meet best practice guidance

Each outline also contains a set of coordinating functions which links service providers, ensuring effective communication, preventing duplication of services, identifying gaps in care, and assuring better health outcomes.



Delivering the core offer is a key part of NCL's Population Health and Integrated Care Strategy.

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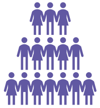

NCL Population Health and Integrated Care Strategy describes our vision for an integrated system focused on prevention, early intervention and proactive care.

We have developed a Community and Mental Health Outcomes Framework, aligned to the strategy. This allows us to track outcomes at both an NCL and borough level to measure the impact of implementing the core offer, to understand if we are meeting population needs and to ensure that we are improving equity across North Central London.

How will delivery of the core offer contribute to improving population health for NCL residents?

Population Health and Integrated Care Principle	Equity An environment in which everyone has a fair opportunity to thrive, regardless of who they are.	Population Health Improving the physical and mental health and wellbeing of people within and across a defined population, while reducing health inequalities.	Integrated care Joining up the health and care services required by individuals, to deliver care that meets their needs in a personalised way.	Aligning resources to need Focusing our resources and delivery capabilities in proportion to the degree of need.
Core Offer Deliverable	Improve access to services and reduce inequalities of access	Improve population health outcomes related to Community and MH services	Increase integrated working at a system and local level to ensure integrated delivery	Establishing a sustainable model of funding
Description of core offer work	• Work with system partners (local authority, primary care, Trusts and VCS) to understand gaps • Target resources to the highest areas of need • Develop robust implementation plans	• Develop a core set of metrics for how services contribute to improvement in our NCL population health outcomes (Start Well, Live Well and Age Well) • Embed data collection & review processes • Report outcomes at key governance forums	• System partners are represented at key programme governance forums • Anticipatory care and community mental health teams are delivered in place through multiple agencies working together	• Community investment reduces overall system cost and relieves pressure on our acute hospitals. Providers are also focusing on productivity improvement initiatives • Ensure the Mental Health Investment Standards funding is deployed effectively to increasing the capacity and quality of mental health services to treat more people amidst rising need.

Significant investment into Community and Mental Health Services has been made since 22/23

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	Programme ambition	22/23	23/24
Community	In addition to the £c.225m baseline expenditure in 21/22, community-based services have received an additional £17.1m of investment in 2022/23 and 2023/24	• *CYP non-recurrent investment:* £1.9m • *Adult recurrent investment:* £3.9m	• *CYP recurrent investment:* £2.5m • *Adult recurrent investment:* £1.9m • *Virtual Wards:* £6.9m
Mental Health	In addition to the £c.400m baseline expenditure in 21/22, further planned recurrent investment of £28m has been invested since 22/23 in line with the national MHIS target and SDF allocation for targeted improvement.	• *CYP recurrent investment :* £2.6m • *Adult recurrent investment :* £8.5m *Recruitment:* NHS Mental Health workforce in NCL increased by +6.4% in 22/23	• *CYP recurrent investment : £5.7m* • *Adult recurrent investment : £11.1m* *Recruitment:* If all 219 planned net additional posts are recruited to by year end, there will be a further +4% increase in the MH workforce this year.

MHIS - Mental Health Investment Standard
SDF - System Development Funding

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Improvements for residents in 2023/24

Overview of the 23/24 Core Offer Priorities and Impact: *Adult Community Health*

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The priority investment areas for the 23/24 Adult Community Health Core Offer are outlined in the table below. Investment in community services, as a result of the core offer, has improved the health and experience of residents in 23/24.

**Hypothetical resident case study*

Vera* is 70 and lives alone in Bounds Green and is in hospital having fallen over and fractured her hip. She is isolated and lonely. While in hospital, she is very anxious and tells staff that the night team have been stealing her possessions. The ward physio does not feel that she can safely be discharged home because of her poor mobility and her previous history of falls.

Due to new investment, there is additional bedded capacity for pathway 2 discharge and virtual ward care at home for Vera to be discharged to. Vera will be less likely to fall and fracture her hip again increasing her confidence, independence and quality of life. If she does have a fall again, there will be a faster urgent response to her home that will mean that she can receive the care she needs without being admitted to hospital.

CORE OFFER	IMPACT OF INVESTMENT	WHAT THIS MEANS FOR PEOPLE LIKE VERA
P2** Optimisation / Standardisation	Reduced P2 length of stay from 34 days to 18 days and reduced referral to admission times from 5.7 days (in August) to 3.4 days.	Reducing the time spend away from home and increasing the speed of recovery
Virtual Wards	The number of virtual ward beds in NCL increased from 118 beds in January to 175 beds in December	Allow patients to get hospital-level care at home safely and in familiar surroundings, helping speed up their recovery
UCR*** Hub	Increased referrals from all sources (GP, silver triage, LAS & 111)	Reduced likelihood of being taken to hospital unnecessarily
UCR Capacity	NCL continued to exceed the national 70% target for 2-hour referrals	Faster response for urgent care delivered at home avoiding a hospital admission
Falls Prevention	Providing a range of services to prevent likelihood of falling as part of an integrated support network, moving from 5-day to 7-day service	Better support to improve balance, empower service users to self-manage where appropriate and reduce risk of injury by falling
Speech and Language Therapy	Offer 6 weeks home-based care to adults requiring SLT services to improve or maintain independence	Increased access and shorter waiting time for care at home for residents suffering from difficulty swallowing /aspiration /chest infection
Catheter Skill Mix	Provide 24 hour care to housebound, help people manage complex incontinence issues and rapid assessment of patients	Faster response to catheter issues at home, reducing risk of infection and complications that could lead to a hospital admission

***P2 – Pathway 2, intermediate care for rehabilitation* ****UCR – Urgent Community Response*

Overview of the 23/24 Core Offer Priorities and Impact: *Children and Young People (CYP) Community Health*

The priority investment areas for the 23/24 CYP Community Health Core Offer are outlined in the table below. Investment in community services, as a result of the core offer, has improved the health and experience of residents in 23/24. **Hypothetical resident case study*

Jamie* is 7 years old. He displays symptoms of autism but has not received a diagnosis and also suffers from asthma. He suffers from language and cognitive impairment and attends a special school. He is cared for by his parents who have two other children. His father has had to give up work to provide the additional support required for Patrick.

Due to new investment, Jamie will receive an autism diagnosis more quickly which will enable him to access the support that he requires. There will also be additional support for him at school which will connect together his different needs holistically. Patients like Jamie will have access to an Asthma specialist nurse in the community without the need to travel to hospital to receive specialist support for their Asthma.

CORE OFFER	IMPACT OF INVESTMENT	WHAT THIS MEANS FOR PEOPLE LIKE JAMIE
Asthma nursing	Work between the acute and primary care to ensure that 48 hr follow up happens and that patients and families are equipped to self-manage.	Patients like Jamie will have access to an Asthma specialist nurse in the community without the need to travel to hospital to receive specialist support for their Asthma
Autism	Streamline assessment pathways, moving towards model delivery of a needs-led, holistic neurodiversity pathway for CYP	Childen and Young People in NCL are waiting long periods of time for an Autism diagnosis. By investing in additional staff to deliver assessments we expect waits to reduce
Children's Looked After (CLA)	Improve % of CLA receiving Initial and Review Health Assessments within statutory timescales	By investing in this area children will reveive timely initial and review health assessments when placed in care.
Therapies	Move towards a stronger universal therapies offer, supporting an overall reduction in waiting times	Children in NCL will not need to have an education, health and care plan (EHCP) before they can access CYP therapies services
CYP Special School Nursing	Specialist community health pathways for CYP and their families with specialist needs beyond) that provided by core targeted team	Increased support for CYP in special schools to ensure CYP's health needs are supported, and they can thrive in their school setting
Hospital at Home	Enabling children and young people to be discharged earlier and cared for in their own home.	The hospital at home service brings specialist hospital care into the child or young person's home, meaning they can be discharged earlier.

Overview of the 23/24 Core Offer Priorities and Impact: *Adult Mental Health*

The priority investment areas for the 23/24 Adult Mental Health Core Offer are outlined in the table below. Investment in mental health services, as a result of the core offer, has improved the health and experience of residents in 23/24.

**Hypothetical resident case study*

Mel* is a 55-year-old and lives in Kentish Town. She lost both of her parents to Covid-19 in quick succession. She has been through periods where she feels extremely anxious and has flashback. Mel's mental health is impacting her ability to work and means she sometimes needs to get urgent help.

Due to new investment, there is more wrap-around support when she feels she is at breaking point and needs urgent help. She can walk into her local crisis café, which is now open for longer hours, and be provided with a safe, supportive space to manage the crisis. If appropriate for her needs, she can also be admitted to a crisis house which will provide therapeutic support and 24-hour intensive support in a residential setting. In future, with the new Think111*2, her partner will also be able to call and be signposted to support, to make sure Mel has access to the urgent support she needs.

CORE OFFER	IMPACT OF INVESTMENT	WHAT THIS MEANS FOR PEOPLE LIKE MEL
Community Transformation	Reduction in waiting times for community mental health services	Access to timely treatment closer to where people live that is joined up with adult social care and the voluntary and community sector, providing people with holistic support
THINK 111 and Crisis Lines	All age crisis hub will respond to all 111 (2) mental health calls for the 5 Boroughs in the NCL Partnership	Easier and quicker for people of all ages, their families and carers to receive urgent mental health support
Perinatal	Expansion of specialist service - new staff recruited into the service and additional clinical and group space secured	Pregnant and post-natal people with moderate to severe mental health needs can access the specialist input for an extended period of pre-conception to 24 months after birth
Crisis	Increased investment in all crisis cafes across NCL so they can open for longer and see more peoples	Access to immediate help that is a safe alternative to emergency departments in a time of crisis. Accessible to people outside of core working hours including weekends
Length of stay in hospital	The number of days people need to spend in hospital is reducing	Recovery time is quicker with the right support when in hospital. Fewer people will need to go out of area for a hospital admission

Overview of the 23/24 Core Offer Priorities and Impact: *Children and Young People (CYP) Mental Health*

The priority investment areas for the 23/24 Adult Mental Health Core Offer are outlined in the table below. Investment in mental health services, as a result of the core offer, has improved the health and experience of residents in 23/24.

**Hypothetical resident case study*

Freya* is 14-years-old. She appears withdrawn and tired in class. She has stopped playing in the band she was formerly a member of. She lives in cramped accommodation with not much money at home, her parents are separating, and she is being bullied at school. They are grateful to be referred to the Early Years team who offer them strategies and home visits.

Freya's school has a mental health support team (MHST) with a range of individual, group and parent education offers on subjects including bullying and family issues, designed to encourage resilience in CYP and parents. Freya's teachers access advice from the team about how they might help given the challenges. Freya's parents each joined one of the MHST parent wellbeing coffee mornings. A referral to the central point of access facilitated access to suitable local offers for Freya and her parents based on their need at the time. Freya is able to access digital, voluntary sector and local authority offers designed to help her navigate her challenges and family circumstances. If her emotional wellbeing is impacted further, Freya can be assessed within a few weeks for a more specialist community CYP MH intervention, and if accepted receive evidence based professional counselling or a CBT based individual or group offer.
If Freya experiences a mental health crisis, professionals e.g. school staff, her GP team, and her parents understand what crisis support is available, including 111 press 2. If the need arises, Freya can be referred for intensive support from the Home Treatment Team as a preference to inpatient admission, to enable a faster recovery with better outcomes.

CORE OFFER	IMPACT OF INVESTMENT	WHAT THIS MEANS FOR PEOPLE LIKE FREYA
Home Treatment Team	Significant reduction in the need for mental health inpatient admissions	Hospital at home support avoids unnecessary disruption of life, education and relationships
School Support Teams	Prevention and early support for mild to moderate mental health that takes a whole school approach	Understand their emotions, resilience in the face of hardships, and empowered to ask for help
Community Transformation	Increased access, reduced waits, and reduced variation in CAMHS provision	Improved access, experience and outcomes for CYP and families across all NCL boroughs
Central point of access	Integrated front door identifies need and facilitates effective social, emotional and mental health (SEMH) response(s)	Advice, signposting and triage of need across the full range of social, emotional and mental health support
Early years	Multi-agency 0-5 CYP/family assessments and co-developed intervention plans	Parents / young children receive wrap around support from the right agencies at the right time

How Paul's access and experience of care is different because of the new MH Core Community Teams

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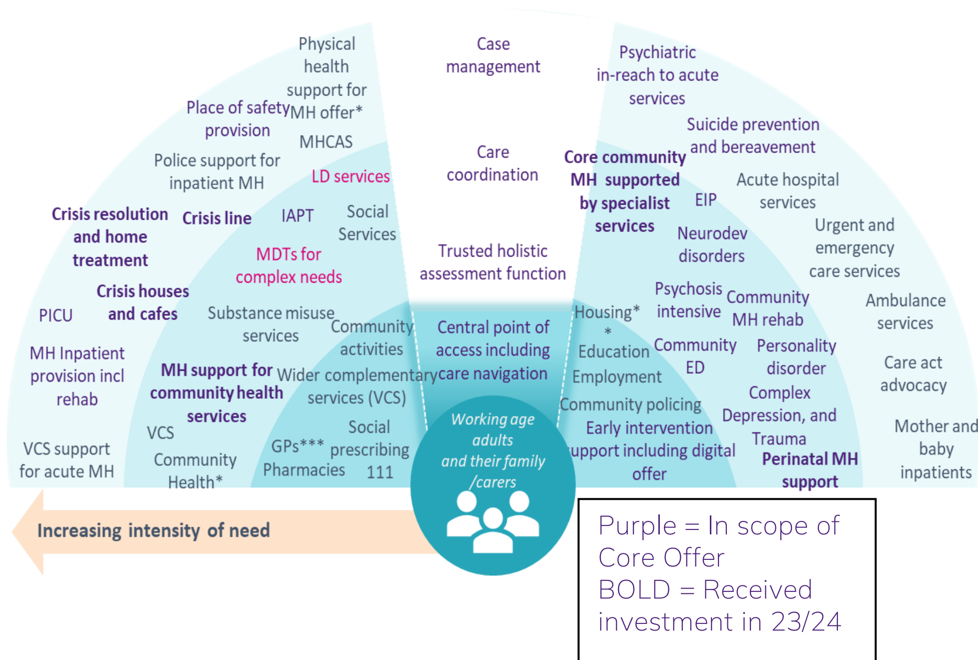
*Hypothetical resident case study



Purple = In scope of Core Offer
BOLD = Received investment in 23/24

Paul* is a 28-year-old male who had been referred to the Early Intervention Service when he was just 19 years old. He has a serious mental illness and has been in and out of services for the last 8 years including several spells in an acute mental health hospital. Paul left school with no qualifications and has very few friendships, he has been estranged from his family and is very isolated.

Due to new investment and the development of the Core Community teams Paul has been able to address some of the social issues which have kept him in poor mental health. While being cared for clinically by his psychiatrist and care coordinator he has also engaged with the voluntary sector element of the service and has joined a few social activities including a gardening club. Paul's self-confidence has grown, and he feels ready to think about work. He is now in contact with the employment support worker in the Core team who is helping him to develop his skills and find paid employment.

For the first time in many years Paul is adhering to his medication and has not had a hospital admission for over 12 months. His support worker his helping him to re-connect with his family

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Key successes and challenges

Improvements in community services mean that residents avoid unnecessary hospital admissions

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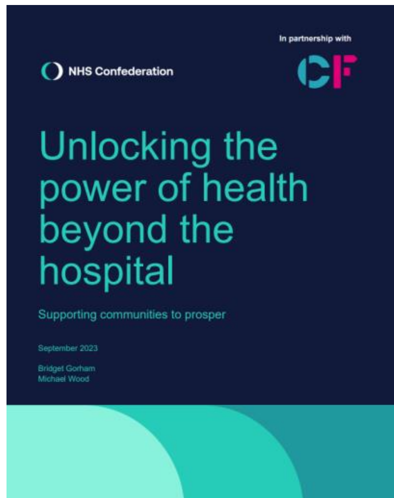
In 2023, NCL was in an NHS Confederation landmark paper



On average, systems that invested more in community care saw

- 15% lower non-elective admission rates
- 10% lower ambulance conveyance rates

The reduction in acute demand associated with this higher community spend could fund itself through savings on acute activity

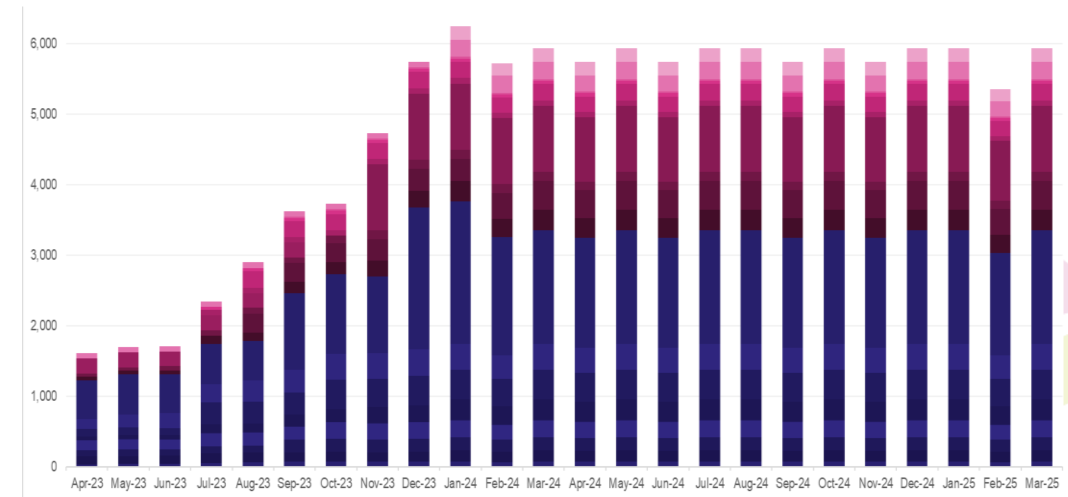
To help leaders to put theory into practice, we have included a case study encompassing the five legacy CCGs that now make up North Central London (NCL) ICS. The place-specific example illustrates a need to streamline inconsistent service offers and develop a clearer community care offer for the wider system. It also provides tangible steps that systems can take to realise these ambitions, namely understanding the existing services, developing a refined offer, creating a means to track impact and building a plan for practical implementation

NCL total avoided time in hospital

The community services programmes will create an estimated benefit of 66k occupied bed days (equivalent to 180 beds) released by 24/25 vs a do-nothing situation. This will help us ease the pressure on acute services across North Central London.

Forecast Occupied Bed Days saved by scheme, Year 1 & 2

Acute bed days saved[1]



Resident impact of Enhanced Health In Care Homes

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Overview of Enhanced Health In Care Homes (EHCH) service:

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

Patient case study:

Context

Dementia patient with delirium. Referral from Older People Mental Health Team (BEH) to EHCH on a Friday

Response

EHCH team discussed with care home > urgent referral to Rapid Response Team. Visit by RR team and continue review over the weekend.

Outcome

Avoided hospital admission. Referred to Mental health to review medication after the acute infection was treated.

Feedback:

"It is always a privilege and a learning process each time you visit our home with your team. Thank you for your support."
Care Home Manager

"Many thanks to all of you, really amazing to have your help and support with elderly patients"
From: Haematology Consultant

"Your swift action is truly valued. We highly regard the invaluable assistance provided by you and the EHCH team to our home"
Care Home Manager

The Longer Lives Plan focuses on improving life expectancy, reducing illness and inequalities

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4 Guiding Principles

Ways to improve the quality and experience of care across the NHS & partners

1. Take time
2. Make every contact count
3. Warm handovers
4. Involve supportive others

5 Focus Areas

Improving key care and treatment pathways

1. Living well with Severe Mental Illness (SMI)
2. Heart disease and diabetes
3. Lung disease
4. Cancer
5. Reaching the extra 20% of people

1 Annual Health Check

People get the treatment and care they need through a consistent service

- A high-quality check in all boroughs
- Clear processes and outcomes
- Linking services together around the patient

Patient Feedback:

"There was a smoking cessation clinic at The Morris House Practice on Lordship Lane and it was fantastic. The feeling of achievement when you had also completed another week smoke free because you had promised the other clients that you would go through the same hardship quitting as they had and endure in your support of each other"

"The BME wellbeing advocates in the service are amazing – they reach people. Making that first contact extremely relatable, not just seeing a doctor in a white coat, but someone relatable and who can communicate in a relatable way

Section 136 Hub (1/2)

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The s136 hub has been developed to strengthen our NCL Crisis pathway. It is already demonstrating a positive impact on residents, as a result of partners across the system (police and healthcare staff) working more closely together to support people in a mental health crisis.

Section 136

Section 136 is part of the Mental Health Act that gives police emergency powers. Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. At the place of safety, the person's mental health will be assessed, and care will be provided. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern.

Section 136 Hub Context & Aims

In 2017, a single phone line was established for the Metropolitan Police Service (MPS) to receive mental health advice and connect with the nearest Health Based Place of Safety (HBPoS). However, this solution did not always function as intended.

1. HBPoS staff did not always answer calls in a timely manner
2. Mental Health professionals were not always available to give advice
3. Many patients were conveyed by officers to a place of safety (whether ED or HBPoS) which many not have been the most appropriate setting.
4. Both patients and officers experienced lengthy waiting times at various stages of the pathway
5. While waiting, some patients were detained in MPS vehicle

All of the above led to a poor experience for the individuals with thousands of frontline policing hours lost.

New Section 136 Model

On the 30th October, a north and south s136 hub was launched serving the whole population of London. The north hub is based at St Annes hospital staffed by a team of clinicians operating 24/7. It supports officers from all of London's principal police forces in managing individuals who are detained or at risk of being detained under section 136 of the Mental Health Act. The developed service is tasked to:

1. Execute a comprehensive triage and assessment drawing on all accessible records.
2. Ascertain the nearest accessible Health Based Place of Safety (HBPoS) for those already under detention.
3. Direct individuals to an appropriate service after clinical assessment, which could be the nearest HBPoS or, if suitable, an alternative care setting.

The objective is to facilitate prompt, specialised evaluation and care, thus reducing the impact on A&E departments and advancing outcomes for patients.

So far, the programme has improved communication with officers by issuing Post Event Messages, and by providing access to more robust service performance data to inform service and quality improvement initiatives.

Section 136 Hub (2/2)

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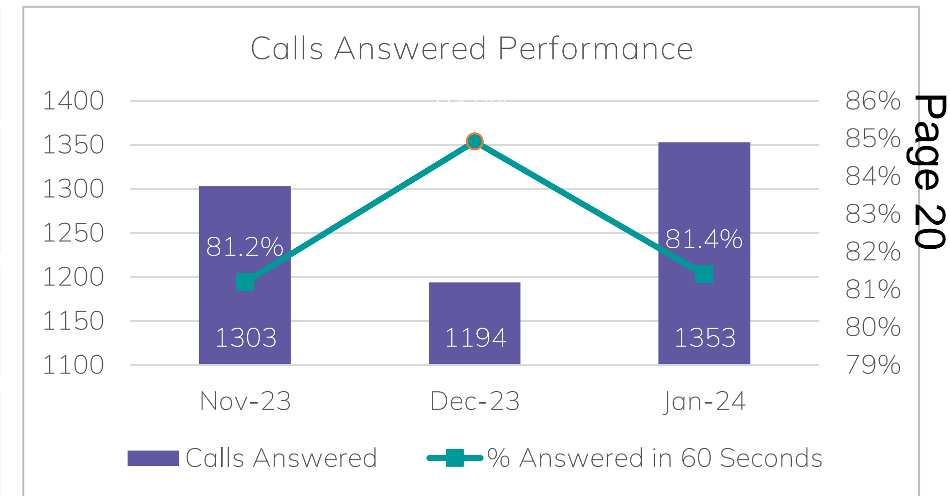
The Impact

Implementation of the hub has led to optimised utilisation; expedited patient access to appropriate care; a significant decrease in the time police spend with patients, resulting in an enhanced experience for those most vulnerable.

Early data is showing that this service is delivering the much-needed improvements for people who experience mental health crisis in London
The following data covers the period 30th October 23 – 31st January 2024 across London. Aggregating/using the averages of the data between this period. The baseline is the weekly average from the previous 3 months, 31st July 2023 to 29th October 2023 (random dates to capture full weeks).

296 total average calls made weekly to the pan-London s.136 Hub	A 28% reduction in the total number of patients detained under section (pan-London)
A 101% increase above the forecasted 147 calls to the service each week	An average of 62% of patients who were not under section prior to hub contact were referred to alternative pathways
Police contact the service for an average of 139 unique individuals per week	56% reduction in the number of patients presenting at the Emergency Department
59% of individuals the hub was contacted about were already placed on a section by the calling officer	An average 37% reduction in time spent by police managing patients at risk of detention under section (7 vs. 11 hrs)



The Next Phase

The next phase of this programme will see increased work with police colleagues to ensure officers are contacting the centralised hub before application of a section to further reduce the numbers of individuals detained. The month-by-month data is showing that police officers are increasingly calling the hub before a s136 is applied.

NCL residents are still however facing long waiting times for neurodiversity services

CYP

Under 5s:

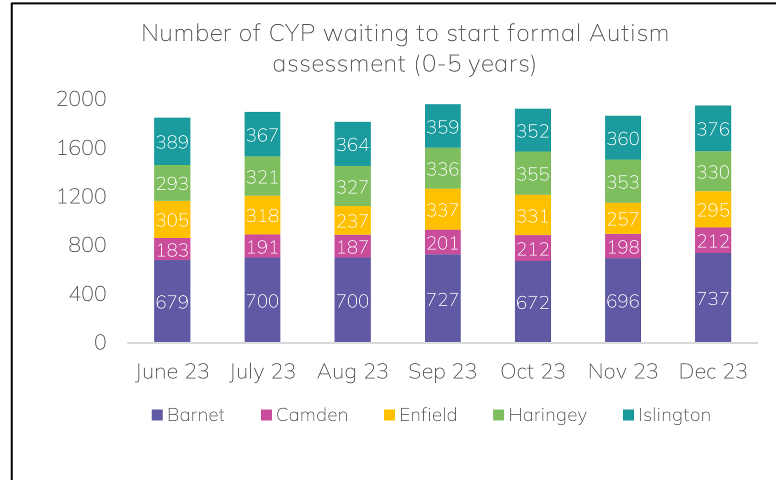
- The NCL Average waiting time for Autism's initial referral to completing the assessment was 68 weeks in December 2023. Camden and Barnet are above the NCL average at 79 and 68 weeks, respectively.

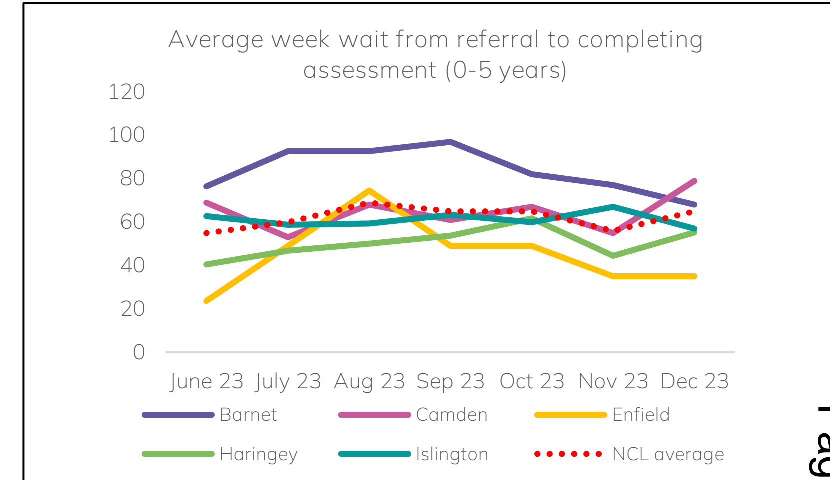
Over 5s

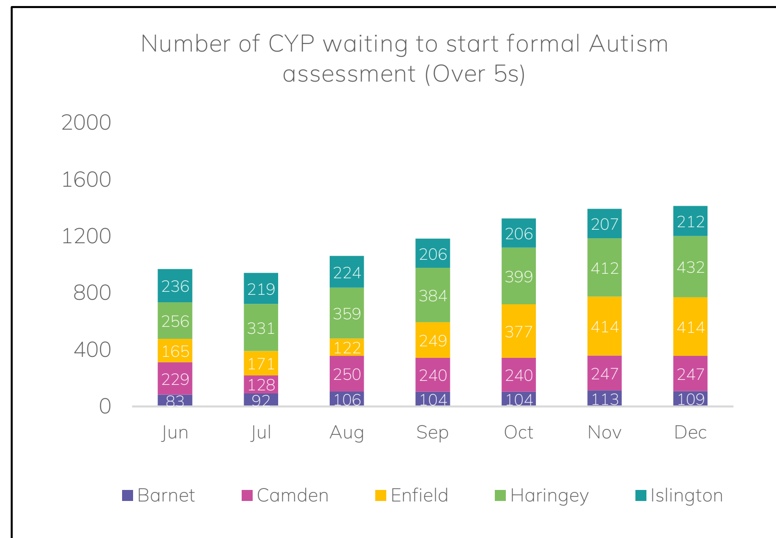
- The total number of CYPs (over 5s) waiting on the neurodiversity pathway in NCL continues to grow; and is at 1582 in December 202.
- The average week wait from referral to assessment completion for over 5 is higher in Camden and Islington than in the NCL average of 76 weeks.

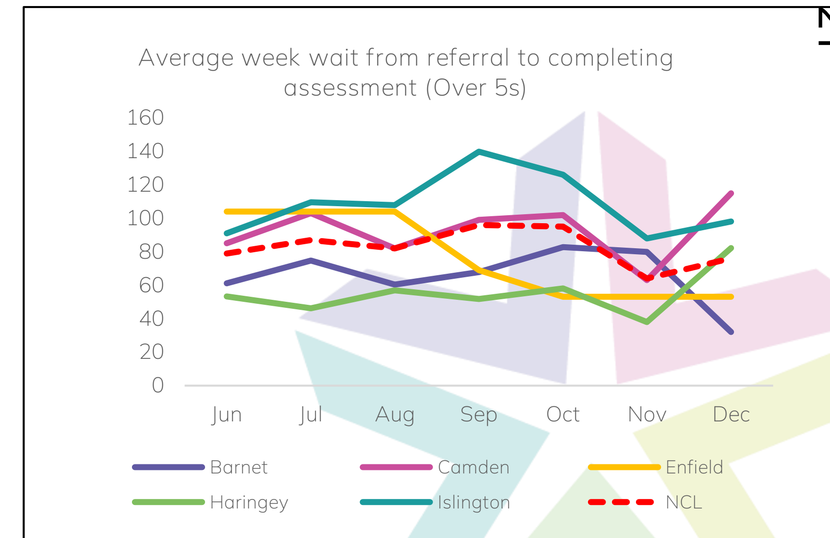
Adults

- As of December 2023, 7102 adult residents of NCL are awaiting an ADHD diagnostic assessment, and a further 1750 are awaiting an Autism diagnostic assessment. In many cases people are waiting over 2 years.









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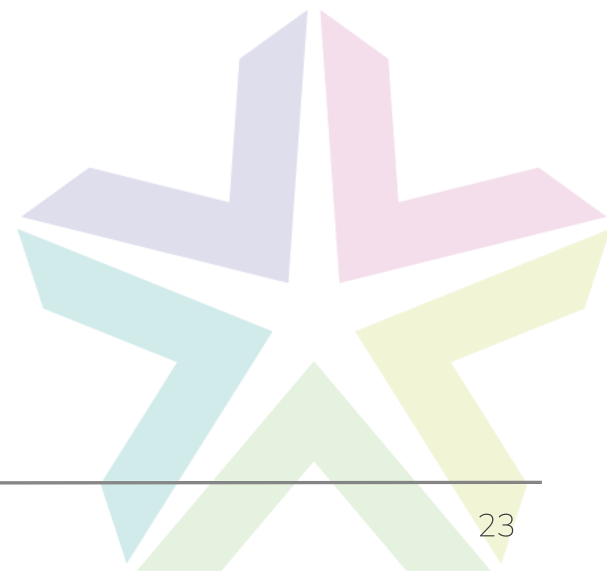
Actions are being undertaken to address growing demand and long waits for neurodiversity services, but challenges remain

CYP Actions Underway	Adults Actions Underway

• NCL implemented an Autism hub which has mitigated over 1,000 assessments being added to the waiting list.
  • For all completed cases, full reports are sent to families and local teams.
  • Ongoing treatment and support (including any medication) is taken over by local teams.
  • Where a diagnosis has been made, families are signposted to locally-available services; and provided with post-diagnostic support videos and online resources.
  • Of the 724 assessments that have been completed to date, 573 resulted in a diagnosis (79%)
• The CYP MH Clinical Network have organised workshops to review the 0-5s and 6+ neurodiversity pathways, with a view to reducing fragmentation and agreeing standard practices/models
• NCL are in the process of carrying out a demand and capacity analysis which will seek to identify the areas of greatest pressure.
• We are hoping to target further funding at this growing areas of demand through the core offer planning process for 2024/25
	• Work is underway to review, design and standardise neurodevelopmental diagnostic disorder (NDD) pathways to increase capacity
	• New adult NDD data reporting processes to improve understanding of the population demographics accessing neurodiversity services, and provide a clearer picture of provider performance, to drive service improvements.
	• A 'diagnostic pathway support' offer is being developed with the voluntary sector, to support people who are waiting for an ADHD or Autism Diagnostic Assessment
	• Collective work with the London region of NHS England to tackle challenges around ADHD assessment and treatment faced across London and to build solutions together.
	• Working with Primary Care colleagues to consider ways in which GPs can support NDD services

2024/25 Vision



Community Services Key Priorities in 24/25 and beyond

There are opportunities to deliver an equitable community services offer aligned to need and keep patients well closer to home.

1. DELIVERING COMMUNITY SERVICES CORE OFFER

Investing in priority gaps

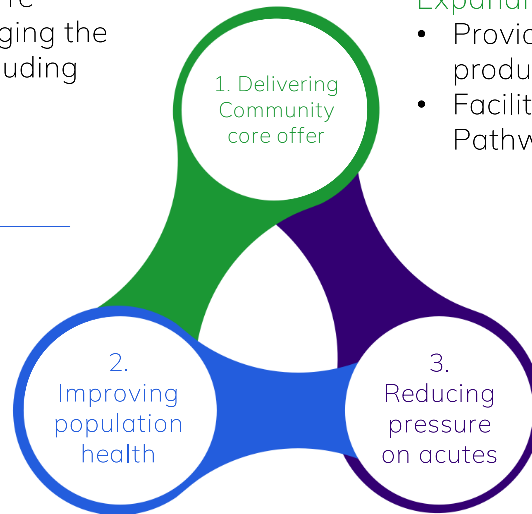
- Investments will be made based on Borough gap analysis against the Core Offer services and focus on historically underfunded areas and areas where there are persistent and historic inequities (in particular Barnet, Enfield and Haringey).
- Realising productivity improvements will enable resource re-allocation into core offer community service gaps i.e. changing the way services run in order to make them more efficient, including through digital enablers

Supporting integrated care

- Many initiatives (such as delivering proactive care and coordinating functions of the core offer) need to be delivered at place/neighbourhood level in order that integration benefits are realised.
- Align with Integrated Neighbourhood Teams as they develop

Expanding collaboration between providers

- Providers to lead on collaborative workstreams e.g. joint recruitment and productivity
- Facilitating collaboration around services across NCL including Rapid Response, Pathway 2, Virtual Wards and Tissue Viability.



2. IMPROVING POPULATION HEALTH

Outcomes Framework

- NCL will continue to develop its outcomes framework as part of a wider benefits realisation framework to underpin the implementation of the core service offer.
- Develop measures that demonstrate the progress the programme makes at reducing inequality and inequity.

Proactive Care

- Deliver personalised, coordinated multi professional tailored support and interventions for people living with complex needs, aligning holistic assessment and care coordination with Core Offer coordinating functions

3. REDUCING PRESSURE ON ACUTE SERVICES

Optimise integration between acute and community services

- Continue to realise the strategic advantages of vertically integrating services between the community and acute settings within NMUH and WH for UCR, community nursing, pathway 2 discharges and virtual wards to reduce admissions and support faster discharge

Evaluate system impact

- Develop a System Planning and Evaluation Tool to enable sustainable targeted investment to improve population health, address health inequality and improve financial sustainability

UCR Hub

- Build on single telephony service via consultant connect to implement a UCR Single Point of access with a trusted assessor to navigate the NCL community unplanned care system to access UCR services

NCL Vision for Mental Health Services, including key priorities in 24/25

There are opportunities to integrate tiers of service delivery, including within CAMHS, and strengthen integration with physical health/social care

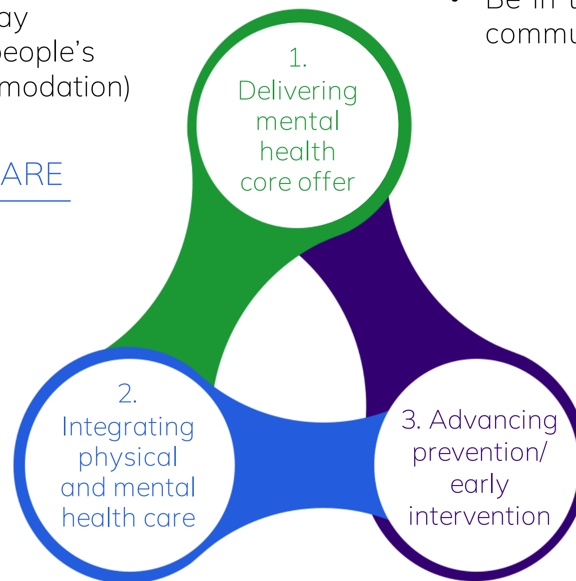
1. DELIVERING MENTAL HEALTH CORE OFFER

Inpatient Mental Health Services

- New MH inpatient commissioning framework
- Reviewing configuration of inpatient services to optimise length of stay, flow and sustainable staffing levels for rising demand for inpatient care, and deliver the Strathdee Review recommendations while accommodating impact of further policy initiatives (RCRP)
- Shared focus with partners on reducing long lengths of stay (including improving suitable alternative services to meet people's needs, e.g., complex rehab and intensive supported accommodation)

Community-based service access, wait times and quality improvement

- Streamlining and simplifying pathways for improved CYP access, services/system navigation, clinical effectiveness.
- Improvement in waiting times; new standards in development for Urgent and Emergency Care and all age community mental health;
- Be in the top quartile nationally for improved outcomes recording for CYP, community and perinatal mental health services.



2. INTEGRATING PHYSICAL AND MENTAL HEALTH CARE

Longer Lives

- Optimise through local implementation of NCL 'Longer Lives' at place: Improving life expectancy, reducing ill-health and advancing equalities for adults with severe mental illness, including through annual health checks

Population segmentation and risk stratification across both physical and mental health

- Exploring common mental illness or severe mental illness (SMI) as entry conditions to LTC LCS*
- Including a mental health component in NCL's population segmentation

Mental Health Core Offer for homeless people

- Developing our NCL Core Offer for homeless people on basis of NICE guidelines and building on the learnings from the pilot in Camden - providing integrated health and social care services for people experiencing homelessness

3. ADVANCING PREVENTION AND EARLY INTERVENTION

Prevention Concordat for Better Mental Health

- Committing to the Prevention Concordat for Better Mental Health to promote evidence-based planning and commissioning, and for advancing mental health equalities

Promote public awareness

- Developing a delivery plan for enhancing and implementing the early prevention and intervention offer for working age adults and older adults
- Increase public understanding of NCL direct access MH services
- Creating public comms resources to increase mental health literacy, support self-help and self-referral to direct access services

Suicide prevention

- Reducing deaths by suicide through applying (at scale) best and good practice+ and finding different and unique solutions where necessary

*Long Term Conditions Locally Commissioned Service

+NCISH (National Confidential Enquiry into Suicide and Safety in Mental Health) and IMV (Integrated Motivational – Volitional) model for suicidal behaviour

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