NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

Wednesday, 16th March, 2022, 2.00 pm - 40 Cumberland Road, Wood Green N22 7SG (watch the live meeting here and watch the recording here)

Members: Please see list attached under item 2

Quorum: 3

1. FILMING AT MEETINGS

Please note this meeting may be filmed or recorded by the Council for live or subsequent broadcast via the Council's internet site or by anyone attending the meeting using any communication method. Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on. By entering the 'meeting room', you are consenting to being filmed and to the possible use of those images and sound recordings.

The Chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual, or may lead to the breach of a legal obligation by the Council.

2. WELCOME AND INTRODUCTIONS (PAGES 1 - 2)

3. APOLOGIES

To receive any apologies for absence.

4. URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business. (Late items will be considered under the agenda item where they appear. New items will be dealt with at agenda item 14).

5. DECLARATIONS OF INTEREST

A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Register of Members' Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct.

6. QUESTIONS, DEPUTATIONS, AND PETITIONS

To consider any requests received in accordance with Part 4, Section B, Paragraph 29 of the Council's Constitution.

7. MINUTES (PAGES 3 - 10)

To confirm and sign the minutes of the Health and Wellbeing Board meeting held on 26 January 2022 as a correct record.

8. NORTH CENTRAL LONDON COMMUNITY AND MENTAL HEALTH SERVICES REVIEW (PAGES 11 - 26)

To note a presentation on the North Central London Community and Mental Health Services Review.

9. NORTH CENTRAL LONDON INTEGRATED CARE SYSTEM, HEALTH AND CARE INTEGRATION WHITE PAPER AND ADULT SOCIAL CARE REFORM WHITE PAPER

To receive a verbal update on progress on the North Central London Integrated Care System and note the new integration white paper and adult social care reform white paper. For reference links to the integration white paper and social care white paper are below:

Health and social care integration: joining up care for people, places and populations - GOV.UK (www.gov.uk)

People at the Heart of Care: adult social care reform - GOV.UK (www.gov.uk)

10. LONG COVID-19 (PAGES 27 - 42)

To note a presentation on Post COVID-19 Syndrome.

11. UPDATE ON WORK TO TACKLE RACISM AND INEQUALITIES IN HARINGEY

To receive an update on work to tackle racism and inequalities in Haringey.

12. COVID-19 AND VACCINATIONS UPDATE

To receive a verbal update on the Covid-19 pandemic and the vaccination programme

13. NEW ITEMS OF URGENT BUSINESS

To consider any new items of urgent business admitted at item 4 above.

14. FUTURE AGENDA ITEMS AND MEETING DATES

Members of the Board are invited to suggest future agenda items.

To note the dates of future meetings:

TBC

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Fiona Alderman
Head of Legal & Governance (Monitoring Officer)
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Tuesday, 08 March 2022

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Agenda Item 2

Membership of the Health and Wellbeing Board

* Denotes voting Member of the Board

Organisation		Representation	Role	Name
Local Authority	Elected Representatives	3	* Cabinet Member for Health, Social Care, and Wellbeing – Chair	Cllr Lucia Das Neves
			* Cabinet Member for Early Years, Children, and Families	Cllr Zena Brabazon
			* Cabinet Member for Environment, Transport, and the Climate Emergency	Cllr Mike Hakata
	Officer Representatives	4	Director of Adults and Health	Beverley Tarka
			Director of Children's Services	Ann Graham
			Director of Public Health	Dr Will Maimaris
			Chief Executive	Andy Donald
NHS	North Central London Clinical Commissioning Group (CCG)	4	* Governing Board Member – Vice Chair	Dr Peter Christian
			Governing Board Member	John Rohan
			Chief Officer	Paul Sinden
			* Lay Member	*Vacancy*
Patient and Service User Representative	Healthwatch Haringey	1	* Chair	Sharon Grant
Voluntary Sector Representative	Bridge Renewal Trust	1	Chief Executive	Geoffrey Ocen
Haringey Local Safeguarding Board		1	Interim Independent Chair	David Archibald

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MINUTES OF MEETING HEALTH AND WELLBEING BOARD HELD ON WEDNESDAY, 26TH JANUARY, 2022, 2:00PM TO 4:00PM

PRESENT:

Cllr Lucia Das Neves, Chair – Cabinet Member for Health Social Care and Wellbeing*

Cllr Mike Hakata – Cabinet Member for Environment, Transport, and the Climate Emergency*

Cllr Zena Brabazon – Cabinet Member for Early Years, Children, and Families*

Sharon Grant – Healthwatch Haringey Chair*

Beverley Tarka - Director of Adults and Health^

Ann Graham - Director of Children's Services^

Dr Will Maimaris – Director of Public Health^

Charlotte Pomery – Assistant Director for Commissioning^

Geoffrey Ocen – Bridge Renewal Trust Chief Executive^

Dr Peter Christian - NCL Clinical Commissioning Group (CCG) Board Member^*

Rachel Lissauer – Director of Integration, Clinical Commissioning Group (CCG)^

IN ATTENDANCE:

Frances O Callaghan, - Integrated Care System (ICS) CEO for North Central London^

Jonathan Gardener – Whittington Trust Director of Strategy and Corporate Affairs^

Lynnette Charles – MIND Haringey^

Sarah McDonnell-Davies- NCL CCG^

Cassie Williams – Chief Executive Officer, NHS Haringey CCG^

Jackie Difolco - Assistant Director for Early Help and Prevention^

*Voting Member ^Joining Virtually

ALSO ATTENDING:

1. FILMING AT MEETINGS

The Chair referred to the filming of meetings and this information was noted.

2. WELCOME AND INTRODUCTIONS

The Chair welcomed everybody to the meeting.

3. APOLOGIES

Apologies were received from Mr David Archibald and Ms Zina Etheridge.

4. URGENT BUSINESS

There were no items of urgent business.

5. DECLARATIONS OF INTEREST

There were no declarations of interest.

6. QUESTIONS, DEPUTATIONS, AND PETITIONS

None received.

7. MINUTES

RESOLVED: That the minutes of the meeting held on 24 November 2021 be confirmed as a correct record.

8. COVID-19 AND VACCINATIONS UPDATE

Dr Will Maimaris informed the Board that:

- The situation appeared to be more positive since Christmas 2021.
- Cases of coronavirus were still high in the borough, in the city and in England due to the Omicron variant (which was also now starting to fall).
- There were 800 cases per 100,000 people per week. There was also a decline in positive test results.
- There was still pressure on the health care system and it appeared that the peak of admissions had passed in early January 2022.
- There were 90 patients in Whittington with in eight Intensive Care.
- There were 128 in North Middlesex Hospital with four people in Intensive Care.
- Whilst there were a significant number of cases, there was not a significant number of deaths resulting from cases.
- Cases should be decreasing in the next four to six weeks.
- It was important to emphasise washing hands, social distancing and wearing of masks, despite the government's relaxation of coronavirus regulations.

- Over 65% of eligible patients have had their booster vaccine. In the over 80s category, the figure rose to 80%.
- Considerable attempts were being made to engage with various communities.
- In relation to compulsory vaccination on health and care workers, the issue had become a national issue in terms of its implications. There was a lot of work going on locally to plan and mitigate for any risks.

In response to questions, the Board heard that:

- Rates of coronavirus in primary school children were high and there was an increase following the Christmas holidays. Rates were expected to decline.
- There was focus on the second dose of vaccinations being administered to secondary school children.
- It was appropriate to remove some of the restrictions as the impact of the severity of the coronavirus was lower. The coronavirus crisis had an impact on vulnerable people and it was somewhat important to return to normality as soon as possible as the NHS was strained in providing services and the coronavirus crisis was putting additional strain on health and care staff.
- In relation to 5 to 11-year-olds, there was good capacity to accommodate those in the age group on some NHS sites in Haringey and pharmacies were offering appointments explicitly for 5 to 11-year-olds. However, not all sites could do this. Some ‘at-risk’ 5-11 year olds were being vaccinated. Appointments could be made on the weekend and after school.
- Vaccinations for children under 12 amongst the wider community was most likely to take place in April 2022.
- The formal paediatric dose had not yet been received. This would occur starting from the end of the week to the beginning of the next week as invites should start to be sent to families from their GP. Alerting special schools would be a useful way to maximise the opportunity. It needed to be clear which children were eligible for which doses.
- A weekly bulletin was sent to all schools in Haringey. This had been done since March 2020. This contained a public health section.
- Work had been done with food poverty and extensive communication had been ongoing to ensure that information on council websites and other websites were fully up-to-date and this methodology could be followed further.
- There was a strategic group that had been coordinating on vaccines with schools. There were challenges regarding the categorisaton with those who were clinically vulnerable but the coordination that had been done was very good in relation with the Communications team to help update the website.
- Lateral flow tests were being made more available by the government and pharmacies were in greater supply of testing kits.

- It was not yet clear what the policy would be on testing on the wider community as the government was still reviewing its policies on testing and isolation.
- Many of the positive coronavirus tests had been received from lateral flow tests.
- There may be some pressures on individuals to be able to go into work and therefore may be inclined to report a negative test. More could be done to facilitate the testing process such as ensuring that the results of any tests be reported to the NHS.

The Chair felt that it was important to note the impact of coronavirus in various communities across Haringey.

RESOLVED:

That the update be noted.

9. HARINGEY SEND STRATEGY 2022-2025 AND AREA SEND INSPECTION

Ms Jackie Difolco presented the item.

In response to questions from the Board, the meeting heard that:

- The Parent-Carer forum was functioning very well. It had originally started with under 10 members and now the forum was now closer to 60 members. A steering group had been established and a chair and vice-chair was in place. There was a drive to ensure that the group was inclusive and diverse including a range of special needs and disabilities. An engagement plan was being developed.
- A 52 week wait for an autism assessment was too long and it was something professionals were conscious of going into the Special Educational Needs and Disabilities (SEND) inspection and was something that had arisen from the parent-carer feedback. It was, however, an improvement from a maximum of a 85 week wait for children who were 11 years and older. A recurrent investment was going into the area and would help meet the demand. There would be a commitment of a maximum of 40 week average and 52 week wait for those aged 0 to 18.
- The workshop has been held and the feedback was that further support and communication was required. So work was being done with SEND DS and providers so that service users would be aware of the process in general.
- It was important to note that there were various other services that were in place to support children with Special Educational Needs was under considerable strain. Speech and language therapy, physiotherapy and school nursing services were amongst the services that were provided. Therefore, it was important to recognise that the commitment to the children in local schools had good level of ambition, but community services generally were under strain. There was also a shortage of staff, many of whom were working at full capacity.
- The SEND inspection was fair and accurate. The effort and the amount of work completed in order to make progress in the service was considerable. The service had improved in the last three months. The written statement of action had actions which had been taken. The work with health specialists and the CCG coming forward with more money for autism assessment was long overdue. A parallel review of Early Years

was being completed and it was important to campaign with the government for more resources.

- The relationship with the Parent-Carer forum had improved. Various people were involved with meetings of the SEND executives in the sub-groups. The Chair of Parent-carer forum was a member of SEND executive.
- The Steering Group had informed that they were pleased with the progress and felt that they were engaged. Approximately £800,000 worth of funding had gone into the SEND service, including increasing educational psychology resources, quality assurance and Educational Health and Care officers.
- In relation to the three written statement of action areas; one of which was preparing for adulthood, it was important to note that what happened in the early years of development would affect adulthood.
- For about six months, teams that had been doing autism assessments had brought additional people to provide assessments and hospitals had been looking at ways to assist one another. There had also been use of online assessments and work was being done to reduce backlog. Where there was insufficient capacity to meet demand, there needed to be a redress of the balance on an ongoing basis and there would be some more resource to allow the borough to meet demand at an improved level. However, as it was a growing population it would be difficult to meet demand absolutely.

The Chair stated that the issue of addressing various community services in the borough and a further update on the item would be brought forward to a future meeting of the Health and Wellbeing Board.

RESOLVED:

That the contents of the report be noted.

10. NORTH CENTRAL LONDON INTEGRATED CARE SYSTEM AND HARINGEY BOROUGH PARTNERSHIP

Ms Frances O Callaghan introduced the item and stated that:

- The Health bill was still moving through Parliament. The date had been delayed for statutory formation of the Integrated Care System (ICS) from 1 April 2022 to provisionally 1 July 2022, subject of that bill to go through Parliament.
- She thanked Zina Etheridge for her help and support she had given into the developing ICS.
- An Integrated Care Board and Integrated Care Partnership Forum needed to be created. There was also a Community Partnership forum which was not as part of the legislation.
- A major task was to create a leadership team for the Integrated Care Board (ICB). It needed to have a fair and transparent process relating to any CCG changes.
- Non -executive appointments would be made for the ICB.

- The Integrated Care Partnership (ICP) would work with the Integrated Care Board (ICB) to set the strategy with the ICB having the responsibility of delivering the strategy.
- The ICP would be broadly representative around elected members.
- Local authority representation would be made to the ICB.
- A white paper was due to be published on the integration at place level.
- A significant emphasis was being place on clinical and professional leadership in the ICB. The CCG has been a clinically led body and care would be taken to not lose the clinical and professional leadership already established.
- There would be a formal medical and nursing appointment but via local authority engagement, it was important to note the public health work and ensure a public health voice.
- The development of the borough partnership was important and the work of the Population Health Committee would be important for understanding priorities. It was important to address inequalities and wider determinants of health.

In response to questions, the Board heard that:

- There was a commitment to create strategies that were effective that meant something to the local population.
- Any proposals created would be better if they were informed by the local view, local authorities and other stakeholders.
- Some things needed to be done differently. Some ideas in the NHS about how the services were best delivered did not meet the needs of the local population due to location or lack of information.
- Patients at hospitals, for example, needed to be worked with more closely via the primary care teams to ensure the right steps were being taken.
- There was a significant rise in demand on primary care in terms of the number of appointments available. It was at least a 10% increase from two years ago.
- There was the Winter Access Fund which would help primary care to increase opening hours to provide more support to patients. Online consultation was useful and it was important to maintain face to face contact.
- Whilst the CCG would lose some of the clinical leadership, it was important to ensure that there was a safeguard against any wider change that would result in a diminution of the primary care voice.
- The mental health review was underway and was examining the expenditure of funds in the area across the five North Central London boroughs.
- Mental health investment would be protected going forward, but a balance would have to be struck around community hospital and mental health spend.

- It was important to ensure staff members were supported and that their wellbeing was considered.
- Primary Care already had difficulties regarding service user access, before the coronavirus crisis. Primary Care was entering into a very difficult time. Many GPs in Haringey were over the age of 55 and would be retired in the next five to ten years. There was also an issue around attracting young GPs to come to live and stay in Haringey.
- Wood Green would be opening a diagnostic hub, which would be more community centric.
- There was a lot of positive work that the Community and Mental Health teams had done on the review to expose certain inequalities and in a manner that people can accepted.
- There was more delegation around dentistry and optometry and community pharmacy who could potentially release some of the burden on primary care.
- Some GP's had a better administration and digital infrastructure. The role of a GP was not the same in all areas. There was also work to make access to dentistry more accessible.
- There was a commitment to bringing care closer to residents to addressing the wider determinants.
- It was important to that the independent voice of patients was still heard.
- There were other issues that were integral and circumstantial to health and wellbeing such as quality of housing.
- In May 2021, the borough had an opportunity to bid for around £580,000 worth of investment helping the borough work on mental health within in the east of the borough.
- Funding applications had been made for around £850,000 which was also going into the east of the borough assisting peer support for people with mental health issues, long term conditions and mentoring for families.
- There has been work around localities to consider the neighbourhood infrastructure. This would help the borough to have a neighbourhood level profile to address the specific needs of the locality.
- The North Central London developments on NHS had a focus on population health. The Population Health Committee was focused on tackling inequalities, prevention and looking at the wider determinants of health. As part of that work, an outcomes framework was being developed across North Central London that would feed into the plans for the integrated care system.

RESOLVED:

That the update be noted.

11. UPDATE ON WORK TO TACKLE RACISM AND INEQUALITIES IN HARINGEY

Ms Charlotte Pomery provided an update to the Board. She noted that the Great Mental Health Day was on 28 January 2022 and the first Somali Community Network would take place on 24 February 2022.

A separate update would be circulated to the Board.

RESOLVED:

That the update be noted.

12. ENSURING THE VOICE OF DISABLED RESIDENTS IN TRAFFIC AND PARKING MATTERS

Ms Beverly Tarka stated that she had met with the Assistant Director of Services, Mark Stevens, who had made a commitment to work with stakeholder groups. Officers would support the work with LTNs and the challenges with the digitalisation of parking and an update would be provided in the future.

RESOLVED:

That the update be noted.

13. NEW ITEMS OF URGENT BUSINESS

There were no items of urgent business.

14. FUTURE AGENDA ITEMS AND MEETING DATES

The next meeting would be held on 16 March 2022.

Potential future agenda items included Metal Health, Speech and Language, Transition and Preparing for Adulthood and Dentistry.

CHAIR: Councillor Lucia das Neves

Signed by Chair ……..

Date ……

Update on Community & Mental Health Service Review; Haringey Health & Well Being Board

16 March 2022

Update on the Progress of the Community and Mental Health Review

The following slides update the Haringey Health & Well Being Board on the progress of the Community & Mental Heath Services Review

They note the work that has been undertaken to develop the core service offer and set out a brief description of what the core services offers will cover

The slides note how service user/resident feedback has been incorporated into the core service offer and how this work is also being used to support the delivery of some specific community and mental health service outcome indicators which will help measure progress and show if the core service offer is making an impact e.g. in terms of reducing variation, improving access etc.

The slides then note the range of current discussions to help find identify funding to implement the core services offer. That includes discussions with providers on productivity and on how for example some services might be organised (not delivered) on a pan NCL basis

Some funding to start implementation will be agreed as part of finalising 2022/23 contracts but as yet how much and what that means for Haringey is still being worked up

Further discussions are also needed to agree how the core services offer will be delivered at a place level in conjunctions with Borough partners

It is anticipated that at the next Health & Well Being Meeting a much more detailed report will be available for discussion

Introduction and Background

NCL CCG has committed to conducting a strategic review of community services and mental health services to **address long-standing inconsistencies** in **service offer**, **access** and **outcomes** for our population. The mental health and community services review are running in **parallel**, with **integrated workstreams**, to ensure that physical and mental health services are joined-up. Both reviews have taken a consistent **three stage approach**. **We have agreed the baseline review findings and the core offer that addresses issues and patient/service user feedback** and are now working on the plan for implementation.

1. Understand the case for change (complete)	2. Develop the proposition (complete)	3. Implementation (current)
Aim • Understand current community and mental health services in north central London (NCL) and the variation between boroughs • Develop a powerful case for change for community and mental health services; available on the CCG website	**Aim** • Clinically-led, population need focused, design of a new core offer for community and mental health services, that will be a consistent minimum standard across NCL • Impact assessment to understand the implications of delivering the core offer (benefits and affordability)	**Aim** • Engagement with system partners to plan for implementation and set ourselves up to deliver the core offer

Through this process, a core offer was developed for different age segments of the population and descriptions were drafted for each component of the core offer

Programme Governance, Engagement and Co Design

Mental Health Services Review Programme Board Membership

- CCG including Accountable Officer, Clinical Responsible Officer, Governing Body GP and Lay member
- Mental Health Trust Chief Executives; Barnet, Enfield and Haringey Mental Health NHS Trust / Camden and Islington NHS Foundation Trust, Tavistock and Portland and Whittington Health
- Local Authority; Chief Executive, Directors of Adults, Children and Public Health
- 2 Experts By Experience
- Voluntary Sector Representative

Community Services Review Programme Board Membership

- CCG including Accountable Officer, Clinical Responsible Officer, Governing Body GPs and Lay member
- Community Trust Chief Executives; Barnet, Enfield and Haringey Mental Health NHS Trust, Whittington Health, Central and North West London NHS Foundation Trust (CNWL) and Central London Community Healthcare NHS Trust (CLCH)
- Acute Trust Chief Executive Officer representative
- Local Authority; Chief Executive, Directors of Adults, Children and Public Health
- Voluntary Sector Representative

Engagement

- Residents Reference Group
- Residents Survey
- Borough Meetings e.g. with Healthwatch In Islington, Bridge Renewal Trust in Haringey
- Specific focused meetings e.g. Mencap in Barnet, Camden Parents of Children with Special Needs

Co Production and Co Design

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

NORTH LONDON PARTNERS
in health and care

NHS

Baseline findings – consistent across community and mental spend

The baseline findings from both community and mental health service reviews have confirmed that there is a powerful and compelling case for change

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

Enfield has over **twice the prevalence** of diabetes as Camden; but **half the** diabetes **resource**
NCL is the CCG in England **with the most number of people with a severe and enduing mental illness**

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

Camden's in-reach to care home beds is **25% higher** than Barnet's
Dementia services in North and South of NCL are very different and services in the North provide less on going support

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

Children in Barnet wait **20 more weeks** than children in Camden for initial SLT assessments
Islington has the highest number of CYP waiting **over 18 weeks** from 1st referral to 2nd contact

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

Community: In Haringey **£98 / head** is spent **vs. £192 / head** in Islington
Mental Health: In Barnet **£157**/per head vs. **£247/** head in Camden

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

Feedback from residents via our Reference Group, along with discussions with residents e.g. from Camden's Citizen Assembly, and data from Health watch notes the distress caused by constant repetition of histories and stressed need for shared records with consent etc.

NORTH LONDON PARTNERS in health and care

NHS

Core service offers for community and mental health services

The core offer has been co-produced to respond to the case for change with the aim of providing a holistic and transformational minimum service offer for both mental health and community services

The purpose of the core offer is to address the inconsistency of service provision across NCL by setting out a **commitment to the NCL population** of the support they can expect to have **access to regardless of their borough of residence**. The core offer will be **holistic and transformative** in the way care is delivered and take a **preventive and proactive approach which focuses on delivery in the community, in peoples homes etc.**

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

The core offer contains:

- **A description of care functions and services** that should be available across NCL and how these integrate with the wider health and care system. The components of the core offer include **services delivering care**, as well as **coordinating functions** which will help navigate and integrate services for service users. The core offer describes:


Operating hours and out of hours provision


Response time for first contact and ongoing contacts (in line with national guidance)


Access to the care function and criteria


Description of the service, including requirements to meet best practice guidance


Integration between the care function and other services and agencies


Workforce capabilities required


Point of delivery (e.g. in person, virtual)

The core offer will be the minimum service standard across NCL.

NORTH LONDON PARTNERS in health and care

NHS

The Core Offer

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

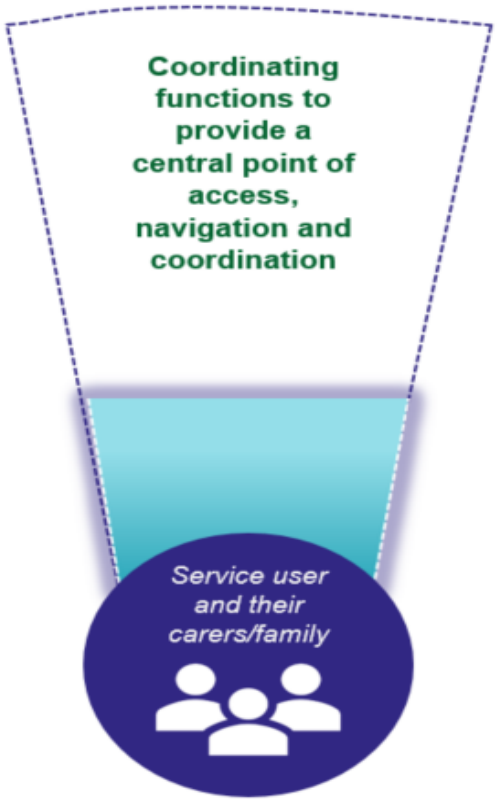
Core offer outlines provide a summary of elements and services that are part of the core offer for each age profile. The outlines also show elements not within scope of the review but that should be linked in with the core offer, as well as enablers.

Children and young people

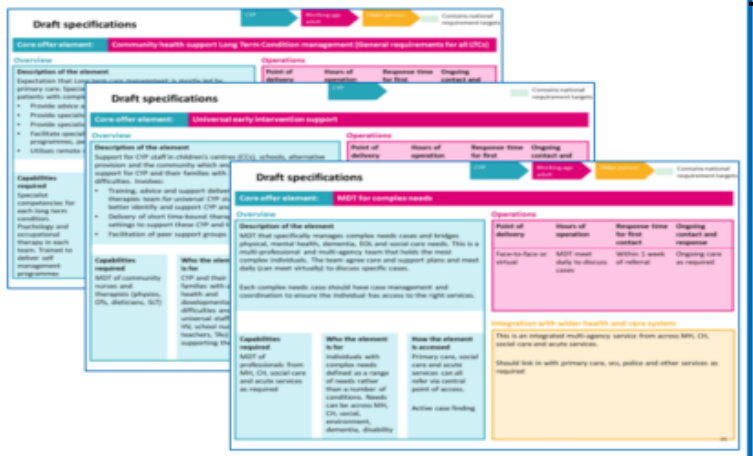
Working age adults

Older people

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



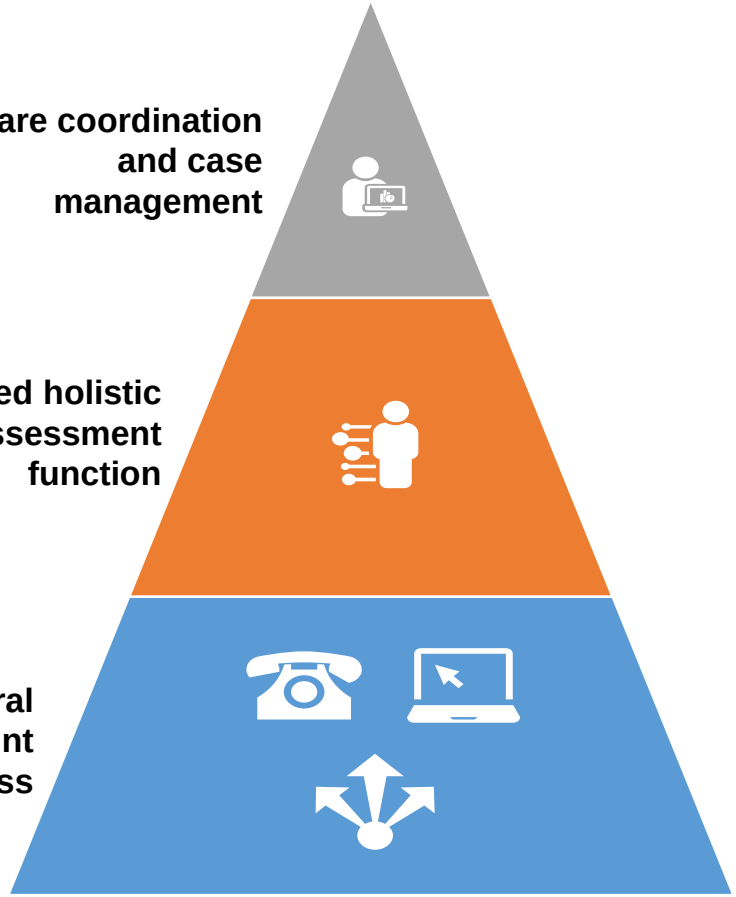
Following each core offer outline, in-scope elements are further detailed in a set of **specifications**. These provide a description of the element and lay out access criteria, hours of operation, capabilities required, where the element should be delivered, waiting times and how the element should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



The Core Offer – Coordinating Functions

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

Increasing complexity of need



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

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

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

Summary of other benefits of delivering the core offer for community health

Access:

- Standardised service provision
- Extended opening hours and access to OOH services – **more convenient access to services**
- Enhanced services
- **Standardised waiting times** (e.g., to first contact and follow up)
- **Simplified referrals** processes through a central point of access

Quality:

- Focus on **prevention** and **early intervention**
- **Enhanced response times** to help service users stay well - **minimise need for hospitalisation**
- Standardised and enhanced step-down services to **support timely and safe discharge of patients from hospital**
- **Enhanced older people services**

Equity and equality:

- **Consistent and standardised offer** so that all NCL residents have **equal support**
- Links and interdependencies with other agencies and support that **focus on wider determinants of health**
- Core offer will require a **resource redistribution that is aligned with need** - residents have health **equity**

Workforce:

- Support staff to **operate at the top of their license**
- **Collaborative working** with other professionals and service users
- **Improve staff satisfaction** levels
- Increased **joint working** to deliver place-based care
- Defined and **shared culture**
- **Co-location** where appropriate
- **Joint training**

- The ICS is committed to investing in preventative and proactive services that support reduced reliance on inpatient care and to avoid the need for admission. Delivery of the core service offers to achieve these benefits will require net investment.
- A financial impact assessment which estimates the cost envelope required to deliver the core offer, including investment and savings, based upon individual Borough needs and the cost of delivering a full core offer is being developed and discussed with finance colleagues.
- Unlike mental health services where there is a stronger correlation between overall population need and spend, community health services investment is not proportionate to need.
- Analysis of impact that the community services core offer could have on acute activity demonstrates the potential for significant reductions in non elective (emergency) activity has been prudently calculated and shared with NCL system directors of finance.
- The analysis further demonstrates a correlation between increased spend in community services and reduced acute activity as well as improvements in flow. More recently, we have seen first hand how acute hospitals with greater access to community provision have been able to more effectively manage surges during the pandemic.

How Feedback from Resident Engagement Discussions Has Helped Shape the Core Service Offers

As part of the service reviews the CCG has developed a comms and engagement strategy. Some of the feedback we have received is set out below and how this has been incorporated into the core services offer. This work will also feed into our discussions on the community and MH population health indicators

Feedback/Comments from resident engagement discussions:

- Both community and mental health services need to improve access. This includes waiting times, time for first contact and ability to communicate - especially the availability of interpreting services, including British Sign Language.
- Both community and mental health services need to be more dementia friendly and think more about those with other needs, especially sensory problems.
- Both community and mental health services need to reduce the number of hand offs and make better use of technology to avoid people having to frequently repeat their details/stories.
- Both community and mental health services need to improve communications with patients especially when appointments are changed, cancelled etc. and have better processes for responding to patient enquiries etc.
- A move to digital was welcomed by some, but there was a strong counter view that the digital divide was widening and that health services must offer a mix of delivery mechanisms and not just rely on a digital approach.
- All patients wanted services to be personalised and for their care to be considered in the context of their lives and circumstances as well as wanting to be involved in any decisions on their care.
- Transition planning especially from children to adult services was highlighted as problematic and requiring an earlier start than is currently happening.
- Services must be culturally competent and providers need to work with their communities to recruit more local people and use their experience and knowledge to work more effectively with diverse local populations.

How this feedback has been incorporated into the core services offer

- Core service offers include response times, but we will need to address backlog of patients waiting especially in CAMHS. Work has already started in other areas e.g. Therapy waiting times in Barnet, or access to autism/ACHD assessments.
- Core service offer designed around central point of access (or SPA) which could support better direction for some patients to both NHS and local authority / voluntary sector services.
- Core service offer proposes more services with direct access, reducing the need for referral.
- Core service offer supports the personalisation agenda with more care plans, case managers and greater requirement for patient led decision making.
- Core services offer seeks to be more community based and offer pro-active care to reduce number of patient first contact being via A&E or inpatient services etc.
- Core services offer has some integrated working between mental health and community services but this needs more discussion as part of thinking through how the core offer is delivered at a place level.
- Core offer includes focus on transition planning and development of more specific 18-25 services to bridge between CAMHs and adult services.
- Other feedback for providers included further discussion needed on culturally competent services and digital offer, dementia friendly approach etc.

Proposed principles to developing the NCL Population Health outcomes and Population Health Improvement strategy

- Tackling health inequalities
- Prioritising prevention and early intervention
- Empowering communities
- Co-production and personalisation
- High quality of and equitable access to services
- Adding value
- Integration and doing things differently
- Sustainability and greener NHS
- Subsidiarity
- Sharing responsibility and accountability
- Maximising use of enablers: finance, workforce, digital, anchor institutions, Population Health Management

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DRAFT FOR DISCUSSION

NHS

Proposed NCL Population Health outcomes framework ; Specific community & MH outcome indicators will contribute to the delivery of the overall work on population health outcomes.

Start well

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

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

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

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

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

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

Live well

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

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

Reduced unemployment and increase in people working in good jobs

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

Parity of esteem between mental and physical health

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

Age well

Older people live healthy and independent lives as long as possible

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

Older people are connected and thriving in their local communities

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

Funding the Core Offer

NOTE: Due to Borough level differences our approach to delivering an equitable core offer will vary.

The 5 Approaches to funding the delivery of the Core Services Offer

Efficiency

- Providers improve productivity to meet system 'best in class' to release funds for Core Offer.
- Using technology to stretch the productivity further through such processes as remote monitoring.

Opportunities of Scale

- Providers asked to work together to review services and agree which could be organised at scale i.e. over a larger footprint than 1 or even 2 Boroughs

Examples:

- New Services; Virtual wards
- Large Services; Musclo-Skeletal Services
- Fragile Services e.g. Specialist nursing
- Children's Services e.g. continuing and palliative care

This is for organisation only. Point of delivery remains local

System Savings

- We seek to reinvest savings from reducing Non-Elective activity arising from a consistent Core Offer.
- This effectively supports the flow of funds from Acute Providers to Community Providers.

Redistribution of Resources

- Providers change the footprint over which they deliver services and/or share resources to effectively increase investment in areas that are under-invested. For example how Whittington Health works differently across Haringey & Islington

Growth Monies

- Growth monies to be allocated differentially with more growth going to areas needing more investment.

- We would need use a mix of these 5 approaches and for example Providers will need to make productivity savings to reinvest in the core service offer.
- For MH the LTP MH Investment standard will support delivery for MH investment. To a lesser degree Ageing Well funding will support the delivery of the community services core offer given the overlaps along with a system investment . How much the system can invest is currently being agreed by NCL Directors of Finance

Progress on implementation planning

- The CCG has taken a broadly similar approach to understanding what a core service offer should contain and what benefits a consistent delivery of the core service offer would bring local people for both community and mental health services.
- The core service offer reflects the minimum service offer and incorporates requirements of the mental health Long Term Plan as well as the requirements of the NHS England Ageing Well programme for community services.
- To implement the core service offer we will need to invest differently in both community and mental health services and differently by borough. How much money is available to be invested in Haringey in year 1 of our 3 year delivery plan is still being determined.
- For both community and mental health services we are looking at services at scale to address issues with clinical fragility, workforce vacancies and resilience and the ability to contribute to efficiency savings.
- Addressing workforce issue in NCL especially for community services will be challenging and how to do this is being discussed as part of discussions with the 4 Community on collaboration at scale.
- Providers of community services are working together to develop a plan to achieve greater collaboration and delivery of services at scale e.g. for new services such as virtual wards or for fragile clinical services such as specialist nurses. This relates to organisation and possible management, delivery remains at a local level.

Summary and next steps

- In summary, there is a compelling and powerful case for change underpinning the ambition to deliver a core community and mental health service offer for residents in north central London.
- For community services there are a number of approaches being used to test out the most effective and affordable approach to delivering the core service offer e.g. via vertical or horizontal working or through working at scale etc.
- The focus for system leadership during the next stage of review is to conclude the values that can be attributed to pillars of work e.g. system efficiency to bridge the affordability gap or options to re-profile the implementation of the core offer and benefits realisation plan to achieve this. Implementation plans will include arrangements for monitoring of core offer cost, activity and outcomes to ensure the project remains within affordability and delivers planned clinical benefits.
- For mental health services we are working with Providers to look at opportunities for more collaborative working that will support the delivery of the core service offer.
- For both community and mental health services we will continue to develop an outcomes framework to measure the impact of change and improvements to population outcomes.
- Borough based implementation plans will be developed with borough partnerships once the work on financial planning has concluded.
- Service user and partner engagement will be critical to embed and integrate the core offer with wider place based services. To progress this, we are starting a series of discussions with other partners e.g. NCL Experts By Experience group to talk through how the core service offer can be best delivered and what for example improved health outcomes would show progress.

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NHS

Post Covid Syndrome

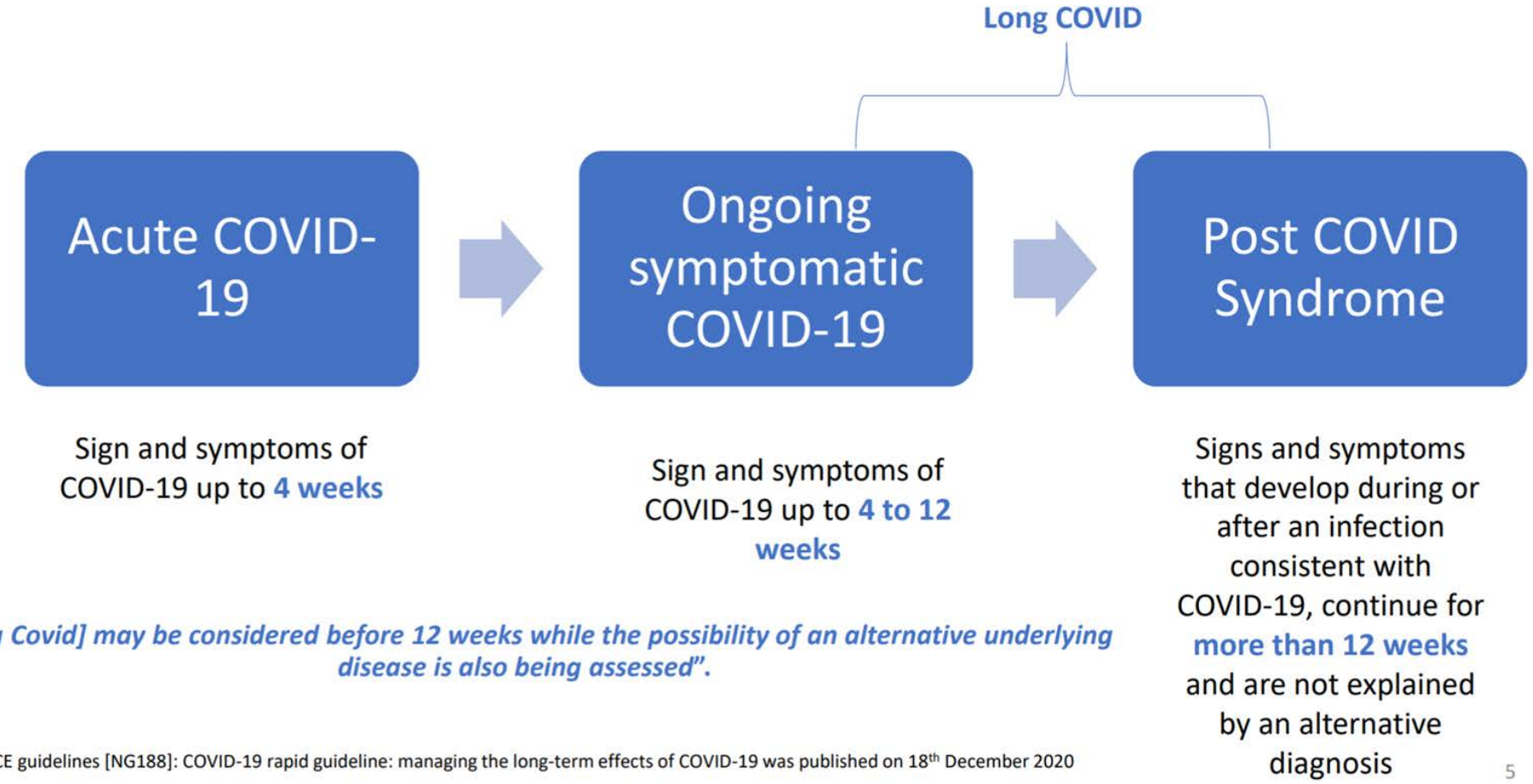
North Central London: Summary, Mar-22

1. Background

- Post Covid Syndrome (PCS) is a term used to describe the signs and symptoms caused by Covid-19 infection that persist beyond 12 weeks.
- A very wide range of symptoms and syndromes have been reported with PCS, and the pathology and biological mechanisms underlying these are poorly understood.
- Patients require a wide range of services and support, with a proportion experiencing significant impacts on their health, daily life and functioning.

Diagnostic Classification

NICE Guidance (NG188) describes the following clinical definitions for the initial and ongoing illness from Covid-19.

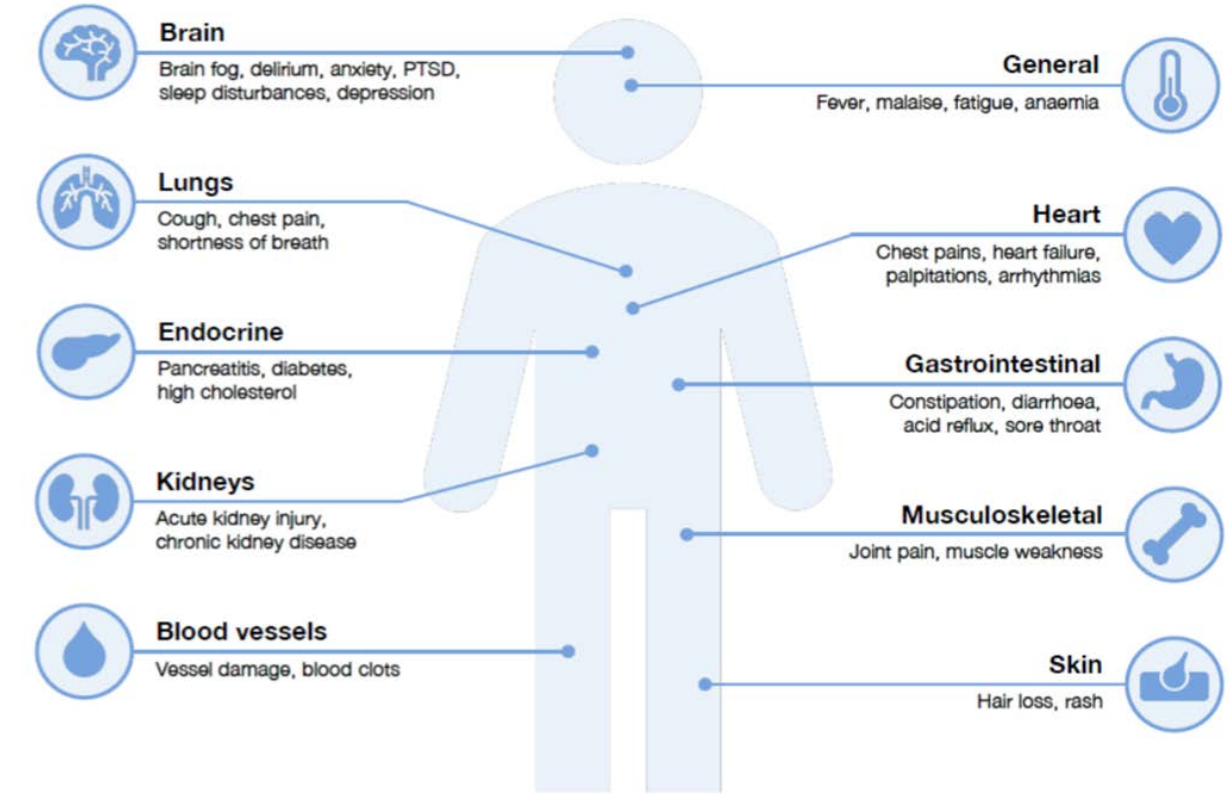


[Long Covid] may be considered before 12 weeks while the possibility of an alternative underlying disease is also being assessed".

NICE guidelines [NG188]: COVID-19 rapid guideline: managing the long-term effects of COVID-19 was published on 18th December 2020

Symptoms of PCS

- Patients who experience Long COVID have reported **> 200 symptoms** which come and go over time
- The most common symptoms are fatigue, breathlessness, difficulty concentrating, loss of smell, muscle ache



Picture credits: Dr Marilena Korkodilos

Potentially multiple underlying causes (NIHR)

- Continuing Covid-19 symptoms
- Post-intensive-care syndrome
- Lasting organ damage to the lungs and heart
- Post-viral fatigue syndrome

Mechanisms under investigation include autoimmune responses to the viral infection, microvascular injury and clotting, mitochondrial dysfunction, and other end-organ effects due to direct viral damage

How many people have Long Covid?

National prevalence

As of October 2021, 1.2 million people (1.9% of the population) self reported Long Covid

Prevalence rates of self-reported long Covid were greatest in ages 35-69, female patients, those living in the most deprived areas, health and social care workers, and those with a pre-existing, activity limiting health condition.

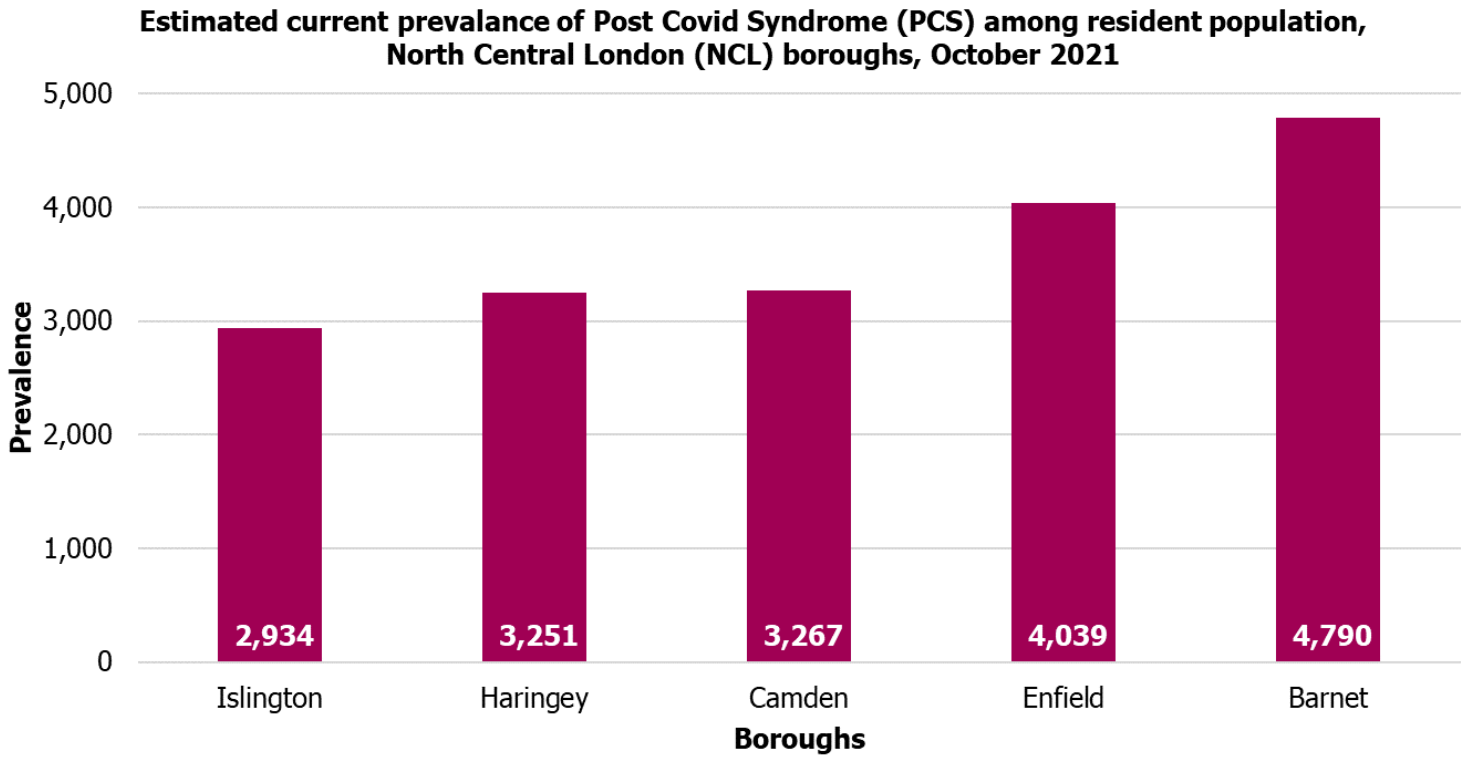
71% of respondents said that Long Covid was affecting family life, and 80% said it affected their ability to work

Prevalence in North Central London

Using the ONS data, we estimate that between 12,000 – and 18,000 people in NCL have long covid. (For Haringey, we expect 2,000 – 3,000 people).

NCL Public Health teams have completed an in-depth needs assessment (Updated Nov-21) which provides detail on a wide range of expected prevalence including demographics, gender, age, deprivation

NCL estimated prevalence, by borough

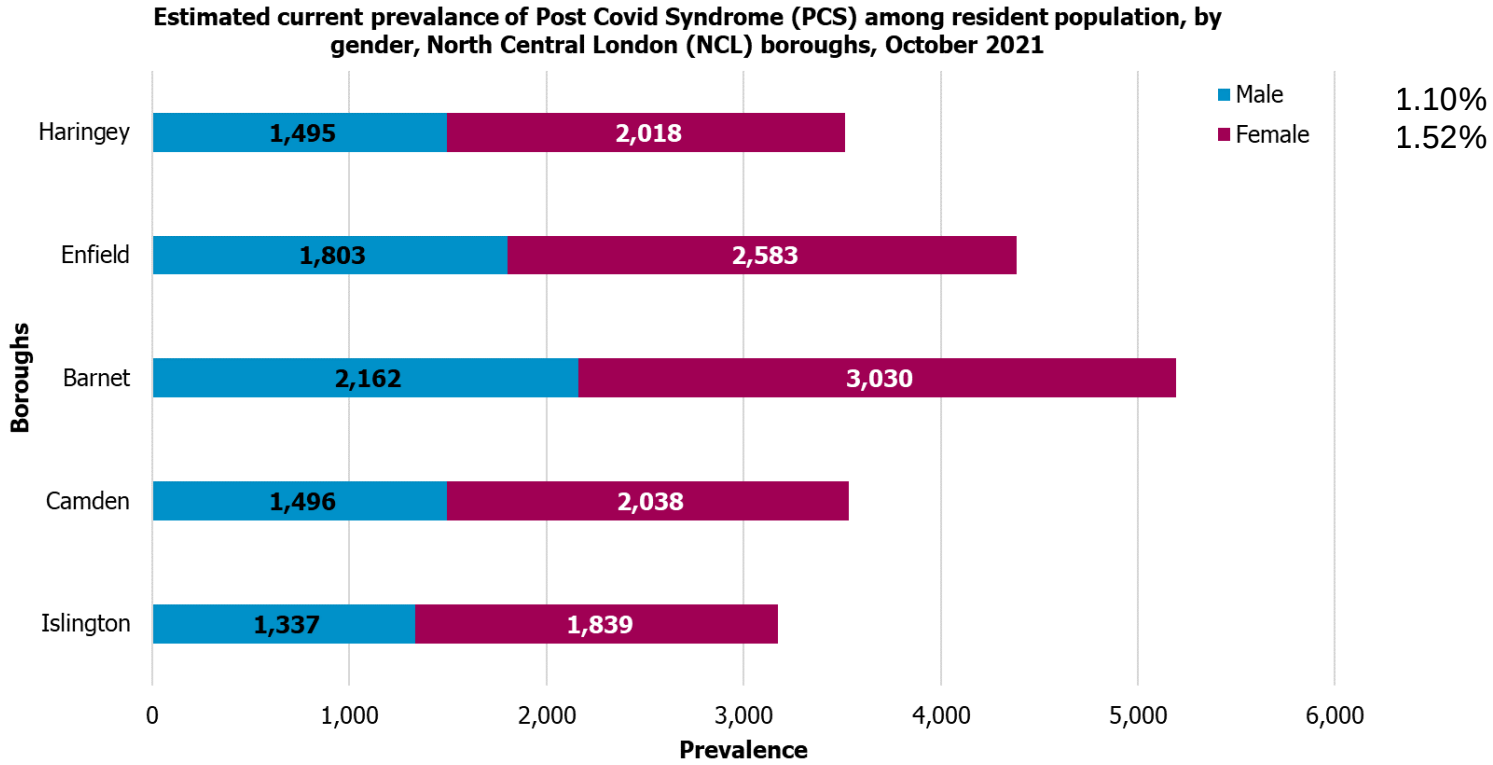


- According to the ONS Infection survey data, the estimated prevalence of PCS among the population is **1.21% in the London Region** as of October 2021.
- **Note**: The regional estimate has been applied to the local population estimates in the NCL boroughs to derive local PCS estimates by borough.

Note: Modelling of current prevalance is based on Office for National Statistics (ONS) Infection Survey data

Source: ONS population estimates, mid-2019; ONS COVID-19 Infection Survey data, November 2021

NCL estimated prevalence, by gender

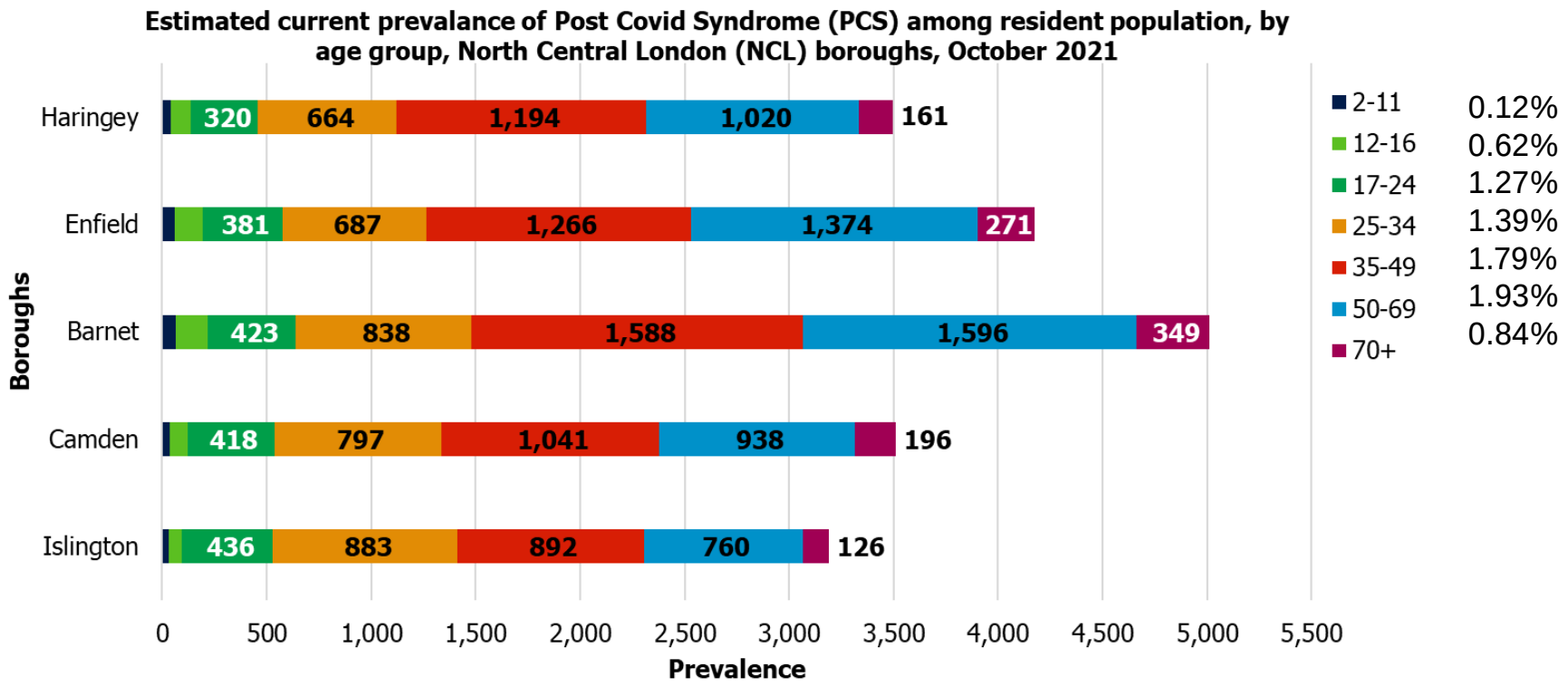


Note: Modelling of current prevalance is based on Office for National Statistics (ONS) Infection Survey data

Source: ONS population estimates, mid-2019; ONS COVID-19 Infection Survey data, November 2021

- PCS prevalence is estimated to be **higher in women than men.**
- According to the ONS Infection survey data, the estimated prevalence of PCS is **1.10% among males** and **1.52% in females** (UK, October 2021).
- **Note**: The UK estimates by gender have been applied to the local population estimates in the NCL boroughs to derive local estimates of PCS by gender.

NCL estimated prevalence, by age

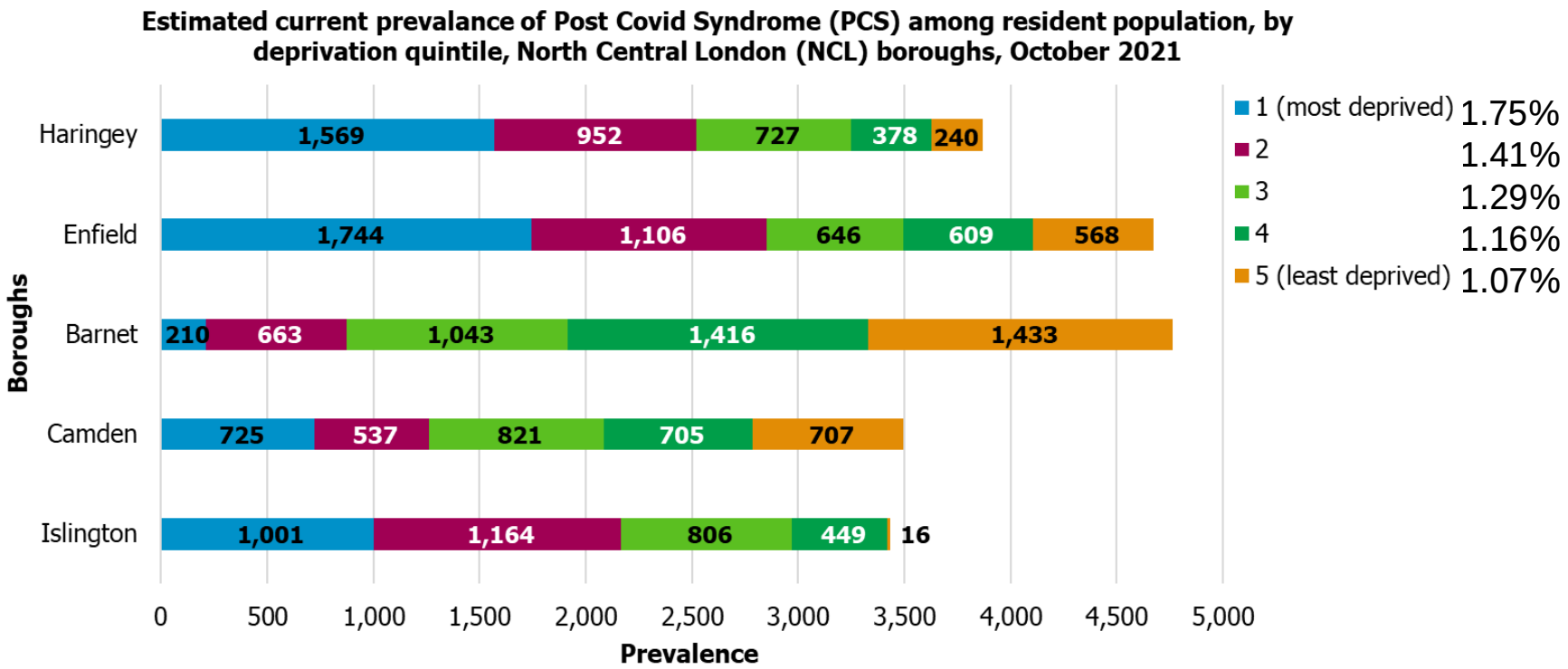


- PCS prevalence is estimated to be **highest in working age adults**.
- According to the ONS Infection survey data, prevalence of PCS rises from 0.12% in children 2-11 to **1.93% in those aged 50-69**, falling to 0.84% in the age 70+ (UK, October 2021).
- **Note**: The UK estimates by age group have been applied to the local population estimates in the NCL boroughs to derive local estimates of PCS by age.

Note: Modelling of current prevalance is based on Office for National Statistics (ONS) Infection Survey data; 0-1 age group has been excluded

Source: ONS population estimates, mid-2019; ONS COVID-19 Infection Survey data, November 2021

NCL estimated prevalence, by deprivation

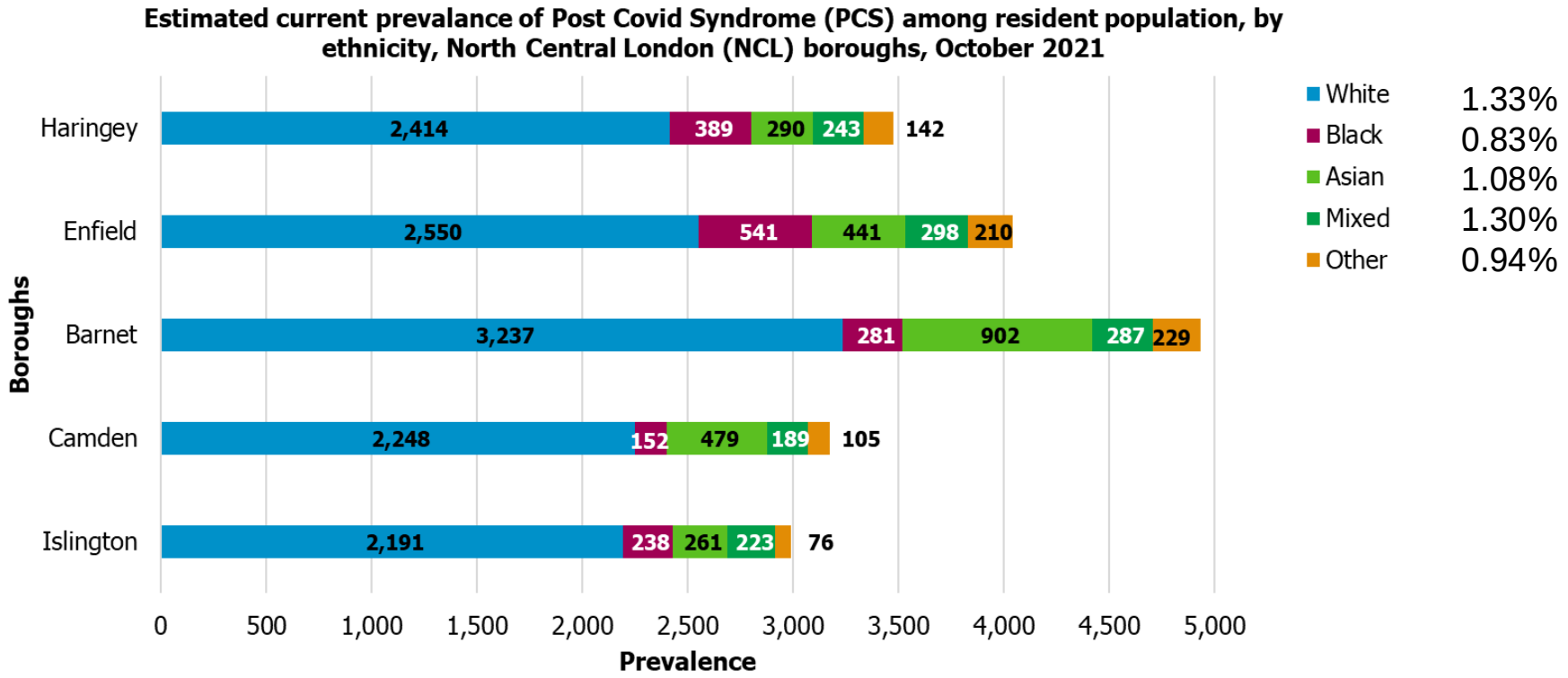


Note: Modelling of current prevalance is based on Office for National Statistics (ONS) Infection Survey data; Deprivation groupings based on IMD (2019) deciles, converted to quintiles as follows: Most deprived = 1, Second most deprived = 2, Third more deprived = 3, Second least deprived = 4 and Least deprived = 5.

Source: ONS population estimates, mid-2019; ONS COVID-19 Infection Survey data, November 2021; English Indices of Deprivation, 2019

- PCS prevalence is estimated to be **higher in more deprived areas.**
- According to the ONS Infection survey data, prevalence of PCS rises from **1.07% in the least deprived areas** to **1.75% in the most deprived areas** (UK, October 2021).
- **Note**: The UK estimates by deprivation have been applied to the local population estimates in the NCL boroughs to derive the local PCS estimates by deprivation.

NCL estimated prevalence, by ethnicity



Note: Modelling of current prevalance is based on Office for National Statistics (ONS) Infection Survey data

Source: GLA 2016-based ethnic group projections for 2020; ONS COVID-19 Infection Survey data, November 2021

- According to the ONS Infection survey data, the estimated prevalence of PCS ranges from **0.83% - 1.33%** among various ethnic groups (UK, October 2021), though there is considerable uncertainty in these estimates.

- **Note**: The UK estimates by ethnic group have been applied to the local population estimates in the NCL boroughs to derive local PCS estimates by ethnicity.

Building Long Covid Services

To respond to residents needs, NCL has developed a pathway of care to support people with Post-Covid symptoms, working with national guidance, best practice and drawing on regional support.

It is important that this pathway is accessible to people regardless of whether they have had a positive diagnosis of Covid-19.

The NCL Post Covid Syndrome Pathway described here covers the patient journey from first presentation with symptoms to referral to onward support, specialist care and self-management. It describes the care of:

- Patients who present to their GP practice with symptoms consistent with Post-Covid Syndrome
- Patients being supported in the community
- Patients being followed up in an outpatient clinic after a hospital admission

Patient care may be provided by:

- General Practice
- Community services
- Specialist hospital clinics
- Mental health services

These services come together in each borough in a regular Multidisciplinary Team (MDT) who meet regularly to review patients whose care planning would benefit from a group clinical discussion.

The following slides describe how the NCL patient pathway works and how services work together.

Pathway

Patients identified in the community

Patients identified following a hospital admission and followed up in an outpatient clinic

Primary Care (General Practice)

Patients will carry out a self assessment of their symptoms and goals before they speak to a health professional for an assessment of their symptoms. Where appropriate, diagnostic tests including blood tests and examinations will be carried out in primary care. Clinicians will also discuss self-management of symptoms. If needed, they will make a referral for specialist or ongoing care and treatment.

Community Provider Offer

Community providers offer rehabilitation services to patients including fatigue and breathlessness management. This includes input from specialist physiotherapy and occupational therapy services and community nurses, alongside dedicated vocational rehabilitation if appropriate.

NCL Post-Covid Syndrome Clinic

Our specialist clinic is held at University College London Hospital (UCLH). It brings together experts from a number of hospital teams to assess and care for patients using and has access to more specialist diagnostic tests. This clinic sees the most complex cases and will not be required for all patients.

NCL Post-Covid Syndrome MDT

Attendees: GP, NCL Post-Covid Consultants, Care Navigator, Community therapists, Specialist Community nurses, Psychology

Where is care provided?

Provider(s)	Offer	What do they provide?	Geography / referral pathway
General Practice	Post-Covid support	Registered cohort. Agreed pathway to self-management tools, community services or direct to specialist clinic. Option to refer to local acute if single specialty input needed	Will identify patients within their own registered practice list
All community providers	Co-ordinated Community rehabilitation	Integrated offer linking rehabilitation and mental health services for both Post-Covid Syndrome cohort and people who have been discharged after a Covid related admission. Additional support through app. NCL wide vocational rehabilitation service provided by Royal Free.	Borough based. Will take referrals from primary care, acute hospitals or specialist clinic
All mental health providers	Mental health support to patients with Post-Covid Syndrome	Increasing Access to Psychological Therapies (IAPT) services see patients identified out of hospital as needing mental health support.	Borough based. Takes referrals from primary care, community or hospital clinics or self-referrals
All acute hospital sites	Post-discharge Covid clinic (for hospitalised patients)	Post discharge support for all patients following Covid related admission. Some of these patients may require referral to NCL Post-Covid Syndrome Clinic. Can refer on to community or discharge to primary care	Will see patients post-hospital admission in an outpatient clinic
University College London Hospital	Specialist NCL Post-Covid Syndrome Clinic	Complex Post-Covid Syndrome symptoms requiring specialist, multi-disciplinary support for people who have ongoing Covid related needs. In-reach from Community and Primary Care	Covers all of NCL. Takes referrals from primary care, community or hospital clinics

What happens at an assessment?

After initial contact with the GP practice, if it is felt that the patient has symptoms consistent with Post-Covid Syndrome, the patient will be sent a self-assessment questionnaire (this asks about severity and impact of symptoms and includes patient reported outcome measures) to complete. In addition any relevant investigations will be initiated.

Once completed, the questionnaire should be returned to the practice. The results of the investigations and the questionnaire are reviewed by the assessing clinician and the questionnaire responses and results entered into the NCL Post-Covid assessment template. The patient will then be invited in to the practice for a physical assessment.

Once the full assessment has been completed, the clinician will:

- Discuss the findings with the patients
- Agree what is important to the patient regarding their health and wellbeing. Complete a personalised care and support plan
- Add the diagnosis of Post-Covid Syndrome to patient record.
- Signpost the patient to the Your Covid recovery website
- Agree the most appropriate management.

This may include:

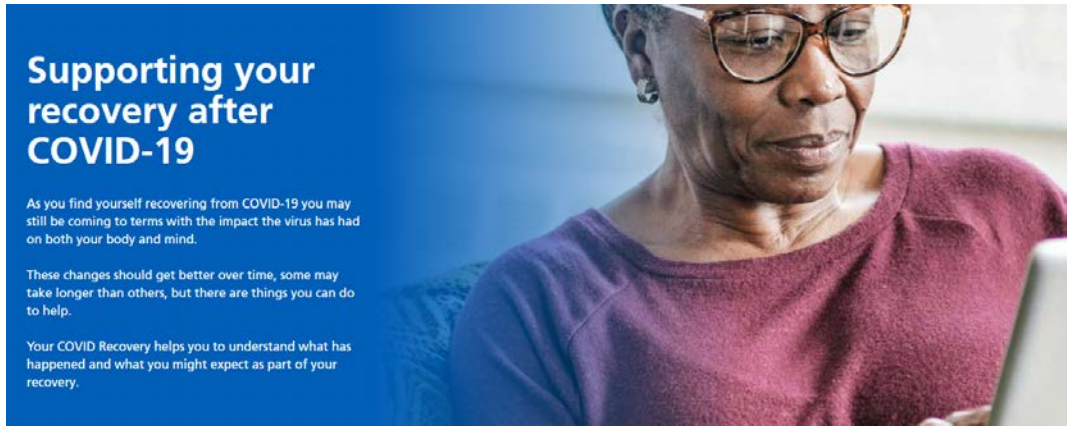
- Referral to the UCLH Post-Covid specialist clinic
- Discussion at the Post-Covid MDT meeting
- Referral to the Post-Covid community therapy services

Supporting Self Care

There is a wide range of support available to patients with symptoms to help them manage their own care. Some of this can be freely accessed, others require patients to be referred our supported by a health professional.

Your Covid Recovery is an open-access online portal for self-guided recovery – encouraging General Practice to refer patients to self manage online where appropriate.

https://www.yourcovidrecovery.nhs.uk/



The Haringey Long Covid Project commences in Feb-22. This project will support a minimum of 350 people disproportionately impacted by Covid and least likely to use statutory services, including Black, Asian and minority ethnic, older people, and those unemployed due to long Covid.

The delivery partners are Royal Free Charities, The Bridge Renewal Trust and 9 voluntary and community organisations in Haringey. The project will run until 31 August 2023

- LONG COVID Independence and personal goals – undertake community outreach and engagement events, establish referral pathways with GP and other specialist health services and engage individuals in a range of activities including setting personal goals, social prescribing and motivational support activities, employment, education and community activity.

- Improved mental and physical health and wellbeing and reduced isolation and reliance on emergency services – engaging individuals in physical and mental health and wellbeing early intervention and prevention activities such as community, social prescribing and other lifestyle improvement activities.

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