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Delivering the NHS Long Term Plan in North Central London:

Developing our collective plans

September 2019

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Context and purpose of paper:

Building on local work with partners through the STP programmes, it is clear there is a collective commitment to deliver changes that will improve the health and wellbeing of residents living in Barnet, Camden, Enfield, Haringey and Islington ('North Central London').

Earlier this year, across NCL, health and care system partners took part in a series of "Inter-great" events. These resulted in a consensus on the need to work together in news ways, build on the close working of our local NHS and councils, with residents, to focus on delivering patient-centred care closer to home, based on individuals' whole needs.

The NHS Long Term Plan, published in January 2019, aligns closely with this direction of travel and current system transformation programmes. Developing a collective response to this provides an opportunity for us to work with partners to begin to design health services around residents needs, rather than organisations.

These plans are currently a work in progress, and we now require the engagement and involvement of all local partners, stakeholder and residents over the next few months. In this time, they will also be cross referenced, finically costed and refined for final agreement in November.

This paper summarises the requirements of the NHS Long Term plan, the high level approach being taken to developing collective plans and shares summaries of key areas for discussion.

The board is asked to:

- **Note** the alignment to current plans and direction of travel
- **Note** that working drafts of chapters are available for comment and input: http://www.northlondonpartners.org.uk/ourplan/the-nhs-long-term-plan.htm

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There a chance to build on existing, ongoing work

Following the Inter-great events held across North Central London, work has been progressing with partners to develop new ways of working with the aim of having the greatest positive impact for the health and lives of North Central London residents.

This work is developing collective plans for and integrated care system, which would a move to planning services based on populations and individuals rather than institutions to maximise the impact we can have. It will support the reduction of health inequalities across North Central London through working to support borough based integration of services to increase the focus on residents, communities and prevention.

This direction of travel is closely aligned to that set out in the NHS Long Term Plan and means as a system, we are well placed to use this opportunity to refresh plans in areas that may need strengthening or additional focus.

Following a review of the Long Term Plan requirements, it is clear that many of the ambitions and clinical priorities set out are already being progressed or are a logical next step for our current partnership programmes of work. For example:

- Developing integrated networks based around 30-50k population through our Health and Care Close to Home programme
- Simplification of the emergency care system across NCL
- Radical transformation of planned care and outpatients

In addition, to this, the LTP's strong focus on workforce and digital as drivers for change is reflected by the dedicated North Central programmes established locally to deliver change in these areas.

We want to work with partners to refresh plans to take account of the latest context and support the tangible changes required across the health system as we move to integrated care.

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Process for developing our collective plans

July and August

Critical system inputs:

- Local population health profile
- Existing STP and Org plans
- Requirements from LTP Plan
- Key themes from resident engagement
- London Vision
- Priority areas from benchmarking
- Outputs of "Inter-great" events

Plan sections drafted based on LTP implementation framework in line with principles:

- ✓ Clinically-led
- ✓ Locally owned
- ✓ Realistic workforce planning
- ✓ Financially balanced and supports delivery of MTFS
- ✓ Delivers all LTP commitments and national access standards
- ✓ Phased - based on local need
- ✓ Reducing health inequalities
- ✓ Focussed on prevention
- ✓ Builds on existing work and programmes and engages with Local Authorities
- ✓ Drives innovation

Drafted by authors, reviewed by clinical leads SROs and review groups (see slide 13)

Sept and October

Coordinated engagement with partners boards and resident on:

- Priority areas
- Risks
- Alignment with organisational plans

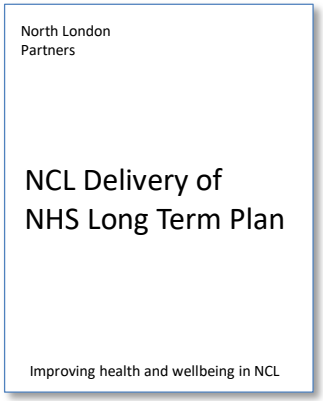
Work to cross referencing sections for:

- Interdependencies
- Alignment with activity and finance

Drafts sections shared on websites for review by staff, partners and residents

November

Final plan for submission



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Long Term Plan Implementation Framework: summary

The LTP Implementation Framework (LTPIF) sets out the approach health systems are asked to take to create their plans. It included further details and information to help local system leaders refine their planning and prioritisation and detail about whereadditional funding will be made available to support specific commitments. It sets out the requirements in the sections listed below:

Seven sections on service changes. Two are national 'fundamental service changes' delivered in line with national timetablesand trajectories:

- Transformed 'out-of-hospital care' and fully integrated community-based care
- Reducing pressure on emergency hospital services
- Giving people more control over their own health and more personalised care
- Digitally-enabling primary care and outpatient care
- Better care for major health conditions: Improving cancer outcomes
- Better care for major health conditions: Improving mental health services
- Better care for major health conditions: Shorter waits for planned care
- Increasing the focus on population health

Five section on the themes below. With Local freedom to set priorities / agree pace of delivery based on need; all LTP commitments must be delivered by the end of the five-years:

- More NHS action on prevention
- Delivering Further progress on care quality and outcomes
- Giving NHS staff the backing they need
- Delivering digitally-enabled care across the NHS
- Using taxpayers' investment to maximum effect

https://www.england.nhs.uk/wp-content/uploads/2019/06/NHS-LTP-Implementation-Framework.pdf

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Our plans must support the delivery of the Medium Term Financial Strategy currently being developed

The NCL Health system has an underlying deficit of £200m per year. Work is underway to develop a medium term financial plan which will outline the work needed to support the financial sustainability of the health service, with a plan across multiple years to reduce and remove costs out of the system through a set of collective actions across NHS partners.

The financial principles will need to underpin the deliver of the MTFS, which is plan is still in development but has the following emerging themes:

- Focus on organisational recovery plans in light of the constrained income environment
- Reduce demand and activity growth particularly non elective
- Limit acute trust income growth to less than 2% from 2020/21 - 2023/24
- Implementation of new models of care that support the three core themes above

These themes will need to be reflected in the NCL Long Term plan response.

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Working with Local Authorities to develop plans

Working collectively with local authorities is critical to the delivery of changes that will improve the health and wellbeing of residents across North Central London.

To support us in developing these plans, we have worked with local authorities in the early stages of developing draft sections. We have done this through:

- Local authorities representatives have been involved in early system review groups to comment on and improve the draft sections
- We have had a dedicated Public health leads for all sections
- Some of the section SROs are Local Authority senior leaders

In addition to this, over the next months, we will be working with local authority colleagues to review the drafts and develop the next iteration of these plans. We will do this through:

- Cross referencing the drafts against key themes of local authority plans strategic plans.
- Review of the working drafts by senior Local Authority colleagues.
- Review of sections by new borough partnerships, of which local authorities are a key member.

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We are already engaging with our residents on plans

Engaging residents in the development of these plans will lead to better plans, more tailored to our local communities needs. We are working with HealthWatch as partners in engaging and involving local people in different ways as the plans develop.

For the first phase (April to June): The five Healthwatch organisations across NCL were commissioned to undertake a range of engagement activities with residents, including a survey and series of focus groups. Headline areas coming out of this engagement include: access to services, patients being involved in decision-making, use of technology and access to information for residents (please see next slide for these).

Phase two (July to September): includes further engagement across NCL and at a local level to engage with residents on these specific issues in more detail as well as a detailed review of existing engagement work for gaps to understand where further conversations are needed. This will also include targeted engagement with specific seldom heard in each borough.

Phase three (September to November): will be further engagement on our overall Long Term Plan and the London vision ahead of the full submission of our plan in November 2019.

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The following themes from resident engagement will be used to guide the development of our plans:

From the HealthWatch surveys and focus group north central London residents told us about their priorities which we will include as themes throughout the sections of our plans:

- Increased access to services
- Importance of involving patients in discussions and decisions about their care
- Availability of clear and accessible information for patients, including easy read versions and access to interpreters
- Patients provided with the knowledge to keep themselves well and promote wellbeing
- Integrated personalised care
- Use of technology both to increase access to services and to health information
- Better joint working between health and social care
- Focus on prevention and early interventions
- Everyone gets the same care, regardless of where they live

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Approach to drafting sections: chapter authors, SROs and system review groups

To ensure local plans respond to the requirements of the LTP implementation framework, we are drafting sections to cover each of the sections of the framework. To support a system approach to these, we have identified an senior responsible officer, clinical care lead, author and a system review group for each one. In addition, we have also nominated a public health lead to support the drafting of these.

The outline of these roles is listed below and the individuals responsible for each section are detailed on the following slide.

Section SRO: A nominated senior lead responsible for ensuring the completion of the content for the section and the appropriate level of engagement as required across organisations. They are responsible for ensuring a system response, rather than an organisational one.

Clinical/Care Lead(s): A nominated clinical or care lead who can provide professional input into the clinical and care professional elements of the plan. They are responsible for ensuring the clinical and care models align with the direction of travel and the needs of local populations.

System Review group: This is the current system group – or specifically nominated group that contributes, develops and reviews the section. It does not have final sign off, so does not need to be representative of all organisations but its member should be confident that engagement has happened with the key organisations as required and the section aligns with the systems direction of travel.

Section author: This is the management lead nominated to draft the section based on the guidance from the change team. They will liaise with SROs, clinical leads and the review groups to draft the proposed content for the section. They will work with those identified by the review group to engage and test the sections ahead of submitting the section to the change programme team.

Theme	SRO	Clinical Lead(s)	System review group	Author	Public Health Lead
Section 2 Delivering A New Service Model For The 21st Century: Themes And Leadership					
Fully integrated community-based health care	Tony Hoolaghan	Dr Katie Coleman	Nominees from Health and Care Close to Home Board	Sarah McIlwaine	Will Maimaris
Reducing pressure on emergency hospital services	Sarah Mansuralli	Dr Chris Streather, Dr Shakil Alam	Nominees from STP UEC board	Alex Faulkes	Will Maimaris
Giving people more control over their own health and more personalised care	Kay Mathews	TBC	NCL CCG SMT	Shelia O'shea and Sarah D'Souza	Lilly Barnett Seher Kayikci Sue Hogarth
Digitally-enabling primary care and outpatient care	John-Jo Campbell	DrZuhaib Keekeebhai, Dr Cathy Kelly	STP Digital Board, STP planned care steering group	Martyn Smith	Sarah Dougan
Improving cancer outcomes	Paul Sinden	Dr Clare Stephens	Cancer Alliance Board	Naser Tarubi	Mary Orhewere, Aparna Keegan
Improving mental health outcomes	Sarah Mansuralli and Paul Jenkins	Dr Alex Warner, Dr Jonathan Bindman, Dr Vincent Kirchner	STP Mental Health Board	Chris Dzikiti	Tamara Djuretic
Shorter waits for planned care	Paul Sinden	Dr Dee Hora, Dr John Connolley	STP Planned Care Steering Group and NCL Performance meeting	Edmund Nkrumah and Donal Markey	Glenn Stewart
Section 3 Increasing The Focus On Population Health					
Moving to integrated care systems everywhere	Will Huxter	Dr Jo Sauvage, Dr Chris Streather	NCL ICS design group	Richard Dale	Tamara Djuretic
Section 4 More NHS Action On Prevention					
Focus on prevention	Julie Billet	Directors Of Public Health/Public Health Consultants	Directors of public health	Dr Hannah Logan	-
Section 5 Delivering Further Progress On Care Quality And Outcomes					
A strong start in life for children and young people	Charlotte Pomery	Dr Oliver Anglin	STP Children's Board	Sam Rostom	Susan Otiti, Duduzile Sher-arami
Learning difficulties and autism	Paul Sinden	TBC	NCL CCG SMT	Kath McClinton	
Better for major health conditions – Cardiovascular, Stroke, Diabetes, Respiratory	Will Huxter	Dr Will Maimaris, Dr Julie Billet	NCL CVD steering group, NCL Diabetes Group, NCL Respiritory group	Richard Dale	Will Maimaris, Stuart Lines,Julie Billett
Research and innovation to drive future outcomes improvement	London wide section				
Genomics	London wide section				
Volunteering	Will Huxter	Directors of nursing	TBC	Richard Dale	-
Wider Social Impact and move to Population Health	Will Huxter	TBC	TBC	TBC	Sarah Dougan
Section 6 Giving NHS Staff The Backing They Need					
Feeding Back In Line With The Themes from the interim NHS People Plan	Siobhan Harrington	Dr Jo Sauvage	STP Workforce Steering Group and NCL Local Workforce Action Board	Sarah Young	Tamara Djuretic
Section 7 Delivering Digitally-Enabled Care Across The NHS					
Increase the use of digital tools to transform how outpatient services are offered and provide more options for virtual outpatient appointments	John-Jo Campbell	Dr Zuhaib Keekeebhai, Dr Cathy Kelly	STP Digital board	Martyn Smith and Hasib Aftab	Sarah Dougan
Section 8 Using Taxpayers' Investment To Maximum Effect					
Financial & Planning Assumptions, Improving Productivity and Reducing Variation	Simon Goodwin	TBC	STP Directors of Finance	Gary Sired	-

Appendix 1:
Summary of plans and links to working drafts

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Notes on drafts

The next slides summarise some of the sections in development – to support discussion at CCG Governing Bodies in September. In addition, we are making all of the full working drafts available on our website for review and comment. These can be found here: http://www.northlondonpartners.org.uk/ourplan/the-nhs-long-term-plan.htm

Please note:

- The documents are intended as a 'system' documents (i.e. a working draft to be shared between partners) which are in the public domain, rather than a document designed for the public. A public version will be developed as part of the next stage of the process.
- These sections build on local plans and are being shared early on with partners and in public in the spirit of transparency and for constructive comment and iterative development.
- These are the first working draft of the sections and are the output of discussion and debate through a series of system review groups.
- These sections have not yet been fully cross referenced with each other for interdependencies.
- These are yet to be fully costed and financially modelled although have been developed in line with current funding assumptions.
- This draft does not yet represent finalised policy positions. The document will undergo significant change through a series of drafting iterations.

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Delivering a service model for the 21st century:

PCN development and building community capacity

Health and Care Closer to Home brings together system partners from primary, community, and acute services, local authority, commissioning and the voluntary sector via its Programme Board.

Development of PCNs

All mainstream primary care services are included in PCNs. There is now full coverage across NCL, with 30 PCNs (Barnet 7; Camden 7; Enfield 4; Haringey 8; Islington 4), based on geographical contiguity between practices; many are on the same footprint as the earlier CHINs/ neighbourhoods. As integrated care partnerships develop at borough level, community providers will configure teams on the same footprints and develop a roadmap to ensure readiness to deliver the anticipatory care PCN DES specification from April 2020.

PCNs are at varying stages of maturity. Clinical Directors are currently diagnosing the support they will need to develop the PCN, which will inform how development funding is allocated. The emerging themes are:

- Organisation development and change
- Leadership development support (inc Clinical Directors)
- Supportive collaborative working (MDTs)
- Population health management
- Social prescribing and asset-based community development
- Identifying, evaluating and sharing learning

Developing workforce and capacity in the community

Our NCL workforce programme, and specific Health and Care Closer to Home workforce action plan, describe our plans to develop, retain and recruit our workforce. We are using tools such as e-rostering, standardisation of shift patterns and the adoption of Care Hours per Patient Day to better understand our staffing requirements.

Our digital programme includes the introduction of a population health management approach, a health information exchange across NCL, and the development of a patient-facing digital record, and the development of digital and telephony-based services, which will increase capacity and support delivery of more efficient care In one borough, work is underway to align the community health care service system with that of GPs to include e-referrals, e-care plans and shared care planning. HealtheIntent is a local digital solution to support effective anticipatory care at a population level, which will integrate near real time data to deliver actionable analysis for anticipatory or proactive care.

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Delivering a service model for the 21st century: community crisis response and anticipatory care

Community health crisis response within 2 hours and reablement care within 2 days

We have established a crisis response model from 8am-8pm, 7/7, and are working with our three community providers to ensure a high degree of consistency including standard approaches to referral, eligibility criteria and operating hours. This is already being achieved in some boroughs, but not all. **We will seek to include a standard contract KPI across the 5 boroughs from 20/21.**

We are working with local authorities to ensure reablement care is delivered consistently within 2 days. Health-based community reablement is delivered same day in some but not all of our boroughs currently. We are seeking to increase the speed that patients access community-based rehabilitation**. A transition plan for contractual KPIs will see a shift from an expectation of a 2 week wait to a 2 day wait by 2023.**

Bed-based rehabilitation has varied, and significant work has taken place to embed an effective Discharge to Assess model with an emphasis on 'home first'. Further work is being undertaken in each borough with local authorities. Bed-based rehabilitation is often dependent on local authorities locating appropriate accommodation for patients deemed to require a supported care arrangement.

Anticipatory care by integrated primary and community services, together with local authority and voluntary sector providers

We have developed effective models of practice around a number of different patient cohorts (e.g. frailty, long term conditions, SMI), and each borough has developed MDT working with key elements of the health and care closer to home approach embedded (population segmentation / development of register, proactive case finding based on risk, outreach, care planning, MDT review and proactive case management, support to self care and self manage. Further work in 19/20 will develop the contribution of community providers, including caseloads, and operating policies. Some community health services are exploring operating from GP premises, including services for MSK, diabetes and asthma Self care is central to the plans. We have introduced the Patient Activation Measure (PAM) in one borough, focussing first on all care planned patients. This links to wider work on embedding the personalised care to spread best practice on the different elements of the universal personalised care model across NCL. **We will further review the models of care as further detail of national specifications are published.**

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Delivering a service model for the 21st century:
Enhanced health in care homes

Enhanced health in care homes

The 230 care homes in NCL are an important part of our health and care infrastructure, with care homes providing homes to 6,000 of our frailest residents outside of hospital (there are more care home beds than NHS beds in NCL). There is uneven distribution of care homes across NCL; around 90 care homes in Barnet (>70% of care home beds in NCL are in Barnet and Enfield), only 8 within Islington. There is a range of locally commissioned services for care homes across NCL, including GP in-reach, MDT support and a range of quality and workforce initiatives to support care homes. There are different models of care in each borough and some gaps, for example, benchmarking identified considerable variation in primary care input to care homes between boroughs, such as access to a named GP. NCL's care home residents experience high acute admissions and LAS call outs, costing our CCGs £42m in 2017/18. This is above peer benchmarks and the London and national averages.

Working in partnership with the Local Authorities, NCL CCGs are working to join up health and social care and dedicated services in this area. The intention is to shift the reactive, expensive reliance on acute care, to a pro-active community based model that delivers better outcomes and meets the LTP ambition for consistent service delivery against the EHCH Framework by 23/24. This includes:

- an innovative workforce programme that is supporting social care providers to recruit and retain staff, develop progression pathways that increase staff skills and leadership capacity, which will support the NHS to meet the health care needs of care home residents.
- actions that will support PCNs, including commissioning a care home dashboard to give us up to date information on activity levels and quality; contributing to the development of the national PCN DES specification for EHCH, (some parts of NCL are likely to commission above this already).
- a Darzi fellow starting in September 2019 focusing on care homes to bring the system together to co-design and implement a new model for primary care input in line with the EHCH framework. This will strike a balance between standardisation of systems and processes, and necessary adaptation to local context, to address unwarranted variation.

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A focus on prevention:

Smoking and Alcohol

Smoking

Around 14% of people across NCL smoke, varying from 10% in Barnet to 17% in Haringey. It is the single largest cause of health inequalities and premature death. There is significant variation in the availability and capacity of smoking cessation services; each borough commissions smoking services differently, both in the community and secondary care. Services are accessed through a range of providers, and residents can access the London-wide Stop Smoking portal.

We are developing a system-wide map of current investment, service delivery, and stop smoking activity and outcomes across secondary care providers in NCL, alongside LA-commissioned community cessation services to identify gaps and investment requirements, ranging from the identification of smokers, provision of brief advice, provision of pharmacotherapy, and onward referral into community stop smoking support. We are exploring opportunities to reduce variation through initiatives such as developing a NCL smoke free policy and options to standardise very brief advice training. Smoking in pregnancy has already been identified as a priority and a joint programme of work is being delivered by a partnership of maternity services, public health, service users, and stop smoking services across NCL.

Alcohol

NCL has some of the highest rates of alcohol specific admissions in London with Camden and Islington significantly worse than London and England. Haringey, Camden and Islington also have some of the highest death rates for alcohol related mortality across NCL.

There are some excellent alcohol support services (including preventative and treatment services) across community, primary and secondary care, like commissioned online support (Barnet, Camden, Haringey and Islington), community outreach teams (Camden, Haringey and Islington), formalised detox and recovery services (Barnet, Camden, Haringey and Islington). The LTP highlights ACTs as being an effective approach to preventing alcohol related harm. Within NCL, services for alcohol liaison play a similar rde to ACTs (in Camden, Haringey and Islington), funded by boroughs and situated in the local acute trusts, which are improving outcomes and a good return on investment. However, there is variation across NCL and where there are good services being provided, there are opportunities to upscale and reach a larger proportion of those in need.

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A focus on prevention:

Obesity, Air pollution and Antimicrobial resistance

Obesity

Being overweight is partly responsible for more than a third of all long term health conditions in NCL, with two of the five NCL boroughs (Enfield and Haringey) having a higher obesity prevalence (those with BMI of 30+) amongst 16+ than the London average. NCL's National Diabetes Prevention Programme is now provided by a single provider, which includes a more comprehensive face-to-face behaviour change programme and a digital platform. Local public health teams will support general practice to maintain referrals into the programme and improve equity of access, particularly to reduce variation and inequalities with 'at risk' groups. Adults and children have access to NICE recommended Tier 1 and Tier 2 weight management support in four out of five NCL boroughs through community and primary care initiatives, funded by local public health teams. There are no Tier 3 specialist support in NCL. We will look to develop a system business case for tackling this. There are system approaches targeting the obesogenic environment through sugar reduction, nutrition advice, physical activity schemes and promoting a healthy urban environment.

Air pollution

The fraction of mortality attributable to air pollution particulate matters in NCL vary from 6.3% in Barnet to 6.9% in Islington, compared to 5.1% in England. Specific projects across NCL include work with schools, focus on Active Travel plans linked with local Transport Strategies and Local Implementation Plans, Healthy Streets approach, AirText messaging to residents that link with primary care, installing new electric charging points, and a health and care wide partnership on paediatric asthma pathways. Additional work will look at supporting NHS Trusts to sign up to the Clean Air Hospital Framework, and reduce business mileage and fleet air pollutant emissions.

Antimicrobial resistance

NCL CCGs are prescribing significantly below the national target of reducing antimicrobial use by 15% from the current national rate. Camden is the only borough achieving the target of broad spectrum antibiotics of less than 10% of the total antibiotics prescribed. 2018/19 AMR CQUIN data for NCL Trusts demonstrated improvements in total antibiotic usage - many found it difficult to reduce total carbapenem usage. The future focus will build on this and include: GP prescribing of broad spectrum antibiotics; healthcare associated Gram-negative blood stream infections and reducing UTI infections; evolving the Antimicrobial Pharmacists Group to become a multidisciplinary strategy group providing system wide leadership; establishing and improving antifungal stewardship; education & training; scoping work with all providers to support delivery.

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Improving mental health outcomes (i)

Ambitions

NCL's vision for mental health support is based on the principles established by our Expert by Experience Board. The ambitions are:

- **Improved access to care and support** (embedding "no door is the wrong door"; addressing significant areas of unmet need; provide support in the interim where people are on waiting lists for complex care treatment,; better coordination of access to specialist support once patients are discharged from secondary care, and develop fast track access to specialist mental health teams in a crisis)
- **Service provision and development** (reducing variation in support services; a greater community support offer and Crisis Cafes; stronger support and funding for the Voluntary and Community Sector, while subject to the same outcome measures as statutory services; transparency in addressing gaps in service provision and supporting people who require "complex care/the level above IAPT but below crisis intervention", expanding the workforce particularly peer support roles)
- **Outcomes and monitoring** (increased focus on patient-centred goals like patient recovery outcomes, housing and employment, patient and public participation in evaluation and monitoring of services)

Strategic approach

- **Provider collaboratives**: there are three NHS Provider Collaboratives in development that are aiming to take over NHSE Specialised Commissioning budgets. The main objectives are to ensure: care closer to home through the elimination of external placements; incentives for community care; joined up pathways with secondary / primary care; providers in North London working as a system not in competition. All three have had their interview with NHSE following the first stage of the approval process and are awaiting feedback. If they progress into the fast track, they will need to submit a final business case by November with a start date of April 2020. They will be engaging with local authorities, CCGs and the NCL Transforming Care Partnership.

- **Stabilising and expanding community teams**: (i) implementing a new digital system across NCL, including a registry for physical health checks for adults with Serious Mental Illness, and automating identification of GP practices with low completion rates of health checks for this cohort, improving the support available for these practices and their patients through existing QUIST initiatives; (ii) expanding primary care workforce and further upskilling, including links to specialist support from mental health trusts, enabling the expansion of health checks and looking at further evidence of effective interventions that can be facilitated in part with Personal Health Budgets for this group; (iii) Individual Placement and Support services are available across NCL. The access standard for Early Intervention in Psychosis is already met across NCL and Service Development and Improvement Plans are now in place to ensure all services achieve Level 3.

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Improving mental health outcomes (ii)

- **Initiatives via additional fair share funding to expand access:**
  - **CYP aged 0-15 services:** NCL has good examples to learn from, including an open access / voluntary service models called 'HIVE' in Camden and 'Choice' in Haringey, with principles, which could be replicated across the STP.
  - **access to specialist community perinatal mental health services:** NCL is collaborating to deliver a specialist community perinatal mental health service for women with severe or complex mental health needs. Evidence-based care pathways operate locally and there are examples of initiatives that continue to inform the development of the new service, which will continue to focus resources and engage people who find help harder to access including teenagers and mothers from some BME groups including those for whom English is not their first language.
  - **24/7 adult crisis resolution and home treatment teams (CRHT):** there is 100% coverage of CRHT services which operate on a 24/7 basis and include Crisis Single Point of Access functions in addition to Home Treatment and Assessment teams. Camden and Islington also have a specialised Older Adults Home Treatment Team. CRHT provision will be able to deliver a high-fidelity service by 2021, maintain high-fidelity coverage of UCL Core Fidelity scales to 2023/24. There is a commitment to review Crisis Pathways in BEH; strengthening CRHT Teams and providing care closer to home will be critical to managing the increasing pressures on inpatient beds and to reducing out of area placements.
  - **CYP mental crisis services:** NCL will develop a local integrated pathway for children and young people with higher tier mental health needs, including rapid community-based and out-of-hours responses to crisis. Investment will focus on expanding the crisis workforce and training for the crisis response team, with a focus on Dialectical Behaviour Therapy (DBT).
  - **Alternative crisis provision:** current provision across NCL is varied. The planned transformation funding will evolve alternative crisis services to become increasingly uniform and equitable across the STP to all age groups for people, and their carers.
- **Initiatives via additional targeted funding allocations (to be agreed with NHS England and NHS Improvement):**
  - **Salary support for IAPT trainees:** IAPT trainee numbers have been agreed across NCL, with contract variations in place to provide salary support in line with regional funding requirements.
  - **CYP mental health support teams:** all five boroughs in NCL had successful bids for Mental Health Support Teams in schools trailblazer sites. Camden and Haringey went live in late 2018, Enfield go live in September 2019, and Islington and Barnet will go live in January 2020.
  - **Maternity outreach clinics in 2020/21 and 2021/22**

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Improving mental health outcomes (iii)

- **Initiatives that could be funded via additional targeted funding allocations (to be agreed with NHS England and NHS Improvement):**
  - **New models of integrated primary and community care for adults and older adults with SMI:** this is central to the joint clinical strategy by our mental health trusts over the next six months. Developments in community provision will continue over the next two years through transformation funding, using devolved specialised commissioning budgets, and expanding Primary Care Mental Health services across NCL.
  - **Mental Health Liaison Services:** these are delivered 24/7 in all 5 Acute sites in NCL, with a commitment to consolidate and expand MHLS. Partners have adopted a MHLS Collaborative Agreement, Core 24 service specification and associated KPIs. This system wide approach has attracted Wave 2 MHLS transformation funding to enhance provision and ensure all hospitals in NCL meet Core 24 Standards for adults and older adults by 2021.
  - **Individual Placement Support (IPS):** services are available across NCL following close working between health and social care, and a further two-year expansion will be supported through Wave 2 funding to extend access in primary and secondary care.
  - **Testing of clinical review of standards in 2019/20** (TBC)
  - **Model for problem gambling:** NCL was not successful in securing problem gambling funding in 19/20. It is considered a future ambition due to established existing services and ability to expand the model.
  - **Specialist Community Forensic Care and women's secure:** North London Forensic Consortium will be a wave 2 pilot site for the new specialist community forensic team model, which will be rolled out over a 2-3 year period, initially covering Barnet, Enfield and Haringey, expanding to Camden and Islington from 2022/23. It will support development of accommodation pathways by co-commissioning housing providers, which will reduce length of stay for forensic inpatients, improve housing pathways and increase community resource.
  - **Enhanced suicide prevention initiatives and bereavement support services:** NCL successfully bid for PHE funding to develop a post-intervention suicide bereavement support service. Procurement will take place by March 2020.
  - **Mental health services to support rough sleepers:** Haringey is a national pilot site and has taken an integrated multi-disciplinary approach to co-produce services for rough sleepers. It will integrate existing homelessness services in a co-located outreach teams. It will further integrate with health services (including GPs, Psychiatrists and Psychologists, occupational therapists, peer support workers) and integrated substance use treatment pathways to ensure effective holistic support. An MDT led by public health developed a funding proposal for Camden and Islington but was unsuccessful. It is a priority for future funding.

Appendix 2:

- Summary of the Long Term Plan
- Fair Shares allowances
- London Vision

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Headlines from the NHS Long Term Plan (Jan 2019)

The NHS will increasingly be:

- more joined-up and coordinated in its care
- more proactive in the services it provides
- more differentiated in its support offer to individuals.

Five major, practical changes to the NHS service model over the next five years:

- Boost 'out-of-hospital' care and reduce primary and community health services divide
- Redesign and reduce pressure on emergency hospital services
- People will get more control over their own health, and more personalised care
- Digitally-enabled primary and outpatient care will go mainstream across the NHS
- Local NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere.

The NHS Long Term Plan describes transition to Integrated Care Systems.
This would be supported by a single CCG in the North Central London area.

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Fair shares allocations and Targeted funding

The framework sets out the national funding which will be allocated to systems on a fair shares basis and provides an indication of the national total for targeted funding, to support specific projects.

The details of the requirement linked to the fair shares distribution and targeted funding are on the following slides.

System plans must set out how they will use their resources to deliver the commitments within the NHS long-term plan and meet the financial tests set out within it. This will include detail on the NCL Medium Term Financial plan required as the NCL system is in deficit.

Plans must also incorporate system actions to maximise efficiencies and support appropriate reductions in growth of demand.

In addition, spending plans must be consistent with the commitments to increase investment in certain areas such as mental health, primary medical and community health services.

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LTP allocations: Fair Share detail on requirements

The commitments to be delivered through the fair shares funding are as follows:

Mental Health	The expansion of community mental health services for Children and Young People aged 0-25; funding for new models of integrated primary and community care for people with SMI from 2021/22 onwards; and specific elements of developments of the mental health crisis pathways. See 2.27.
Primary Care	This funding includes the continuation of funding already available non-recurrently to support Extended Access and GP Forward View funding streams, (e.g. practice resilience programme), and associated commitments must be met. Additional funding is also included to support the development of Primary Care Networks.
Ageing Well	Deployment of home-based and bed-based elements of the Urgent Community Response model, Community Teams, and Enhanced Health in Care Homes.
Cancer	Rapid Diagnostic Centres funding in 2019/20 only; Cancer Alliance funding to support screening uptake delivery of the Faster Diagnosis Standard and timed pathways, implementation of personalised care interventions, including personalised follow up pathways and Cancer Alliance core teams.
CVD, Stroke and Respiratory	Increased prescribing of statins, warfarin and antihypertensive drugs; Increased rates of cardiac, stroke and pulmonary rehabilitation services; increased thrombolysis rates; and early detection of heart failure and valve disease.
CYP & Maternity	Local Maternity Systems funding; Saving Babies Lives Care Bundle funding from 2021/22; postnatal physio funding from 2023/24; funding for integrated CYP services from 2023/24.
LD Autism	Funding for rollout of community services for adults and children and keyworkers from 2023/24.
Prevention	Tobacco addiction - inpatient, outpatient/day case and Smoke Free pregnancy smoking cessation interventions.

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LTP allocations: Targeted funding detail on requirements

The commitments to be delivered through targeted funding are as follows:

Mental Health	Includes: - funding for continuation of previous waves such as mental health liaison or Individual placement support funding; pilots as part of the clinical review of standards, and other pilots such as rough sleeping. - funding to be distributed in phases in consultation with regional teams including: funding for testing new models of integrated primary and community care for adults and older adults with severe mental illness, community based integrated care, rolling out mental health teams in schools and salary support for IAPT trainees.
Primary Care	Digital First Primary Care support funding; the Investment and Impact Fund; and Estates and Technology Transformation Programme.
Ageing Well	Targeted funding to accelerator STPs to rollout the Ageing Well models.
Cancer	Development and roll out of innovative models of early identification of cancer (starting with lung health checks); funding for the development of Rapid Diagnostic Centres from 2020/21 onwards; support for further innovations to support early diagnosis.
Technology	Revenue funding for Provider Digitisation and Local Health and Care Records.
Cardiovascular Disease, Stroke and Respiratory	Pilots for improving access to cardiac, stroke and pulmonary rehabilitation services and early detection of heart failure and valve disease.
Maternity and Neonates	Continuity of carer for BME and disadvantaged women from 2021/22; funding to support the UNICEF Baby Friendly Initiative; funding to support the expansion and improvement of neonatal critical care services from 2021/22; funding from 2020/21 for Family Integrated Care; funding to support the rollout of postnatal physiotherapy and multidisciplinary pelvic health clinics from 2021/22 to 2022/23.
Diabetes	Funding to pilot the use of low calorie diets from 2019/20 until 2022/23; funding to support delivery of recommended treatment targets; funding for multi-disciplinary foot care teams and diabetes inpatient specialist nurses (see 4.31).
Learning Disabilities and Autism	Funding to pilot and develop community services for adults and children and keyworkers from 2020/21 to 2022/23; piloting of models to expand Stopping Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes from 2020/21 to 2023/24; testing the model for ophthalmology, hearing and dental services to children and young people in residential schools from 2021/22; funding to reduce the backlog of the Learning Disabilities Mortality Review Programme (LeDeR).
Personalised Care	Targeted transformation funding to deliver the NHS Comprehensive Model for Personalised Care from 2019/20–2021/22.
Prevention	Alcohol Care Teams from 2020/21 to 2023/24; Tobacco addiction services early implementer sites from 2020/21; targeted support for weight management service improvements from 2020/21.

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The London Vision (2019)

The London Vision will focus on areas that only a partnership at London level can address, to make sure:

- Londoners get better outcomes regardless of who they are or where they live
- Mental health is treated with the same importance as physical health
- Londoners have greater control and choice of their health and care
- People receive good joined up care throughout their life regardless of which organisation provides the service

Over the coming months priorities and goals will be set. The work being undertaken across London and will feed into the plans in North Central London.

Emerging Priorities

1. Reducing childhood obesity
2. Improving mental health of children & young adults
3. Reducing inequalities and preventing illness
4. Improving air quality
5. Improving sexual health
6. Reducing the impact of violent crime
7. Improving mental health
8. Improving the quality of specialised care
9. Making health and care more personalised and joined up at every stage of a Londoner's life from birth to end of life
10. Improving the health of homeless people

Appendices 3:
Detail on resident engagement

NCL Long Term Plan: Engagement Plan