North Central London Integrated Care Partnership

Tuesday 3 October 2023; 15:00-17:00

Council Chamber, First Floor, Crowndale Centre, 218 Eversholt Street, London, NW1 1BD

	Item	Page	Time	Lead
1.	**Welcome and Introductions**	*Oral*	15:00	Chair
2.	**Minutes and Actions**	Page 3	15:05	Chair
3.	**Population Health and Integrated Care Strategy – Delivery** **1. Borough Partnerships and ICP** **2. System-wide work**	*1. Oral* 2. Page 14	15:10	1. John Hooton 2. Penny Mitchell
4.	**SEND and Alternative Provision in North Central London**	Page 20	15:25	Chris Munday
5.	**Longer Lives – Improving the physical health of adults with severe mental illness in North Central London**	Page 47	16:00	Sarah Mansuralli
6.	**Heart Health – Verbal Update**	*Oral*	16:35	Will Maimaris and Amy Bowen
7.	**Family Help in Early Years – Verbal Update**	*Oral*	16:45	Jon Abbey

8.	**AOB**	Oral	16:55	Chair

Next meeting: Tuesday 16th January

North Central London ICS
Integrated Care Partnership Meeting
3 October 2023 - Action Log

North Central London Integrated Care System

On Agenda	
Needs Urgent Update	
In Progress	
Completed	

Meeting Date	Action Number	Minutes Reference	Action	Lead	Deadline	Update
18.04.23	1	**Paragraph 2.1.8**	**Childhood Immunisations – Test and Learn** To provide a summary of the immunisations work to the ICB Board.	Dan Glasgow	**TBC**	**11 July 23** - It is planned to take a summary to a future meeting of the Place Editorial Board.
18.04.23	2	**Paragraph 3.3.2**	**Discussion – challenges and opportunities for 2023/24** To bring a paper on the position with regards to the development of place based working and Borough Partnerships (opportunities and challenges) to a future meeting.	Sarah McDonnell-Davies/ Dawn Wakeling	**January 2024**	**3 October 23** - Borough Partnership Chairs have agreed to bottom-up approach to delivery of the Population Health and Integrated Care Strategy (linked to Action 9). Borough Partnership Chairs will be reconvened in Autumn 2023 to discuss areas of commonality and opportunities for scaling up.
18.04.23	3	**Paragraph 4.1.3**	**Population Health and Integrated Care Strategy** To facilitate a discussion on the Population Health and Integrated Care Strategy delivery plan, timescales and milestones.	Sarah Mansuralli/ Will Maimaris	**September 2023**	This action has been closed as it has been superseded by action 9.

11.07.23	4	**Paragraph 4.8**	**Minutes and Actions** To engage DCSs (Directors of Children's Services) on priorities for collaboration on 'School Readiness' ahead of the next meeting.	Richard Taylor-Elphick	**October 2023**	**3 October 23 –** Verbal update to be provided on 3 October, ahead of a substantive agenda item at next meeting on 16 January under the theme of Family Help in Early Years.
11.07.23	5	**Paragraph 4.8**	**Mental Health – CAMHS Deep Dive** To hold a discussion between DCSs and Sarah Mansuralli's team to map existing good practice on work that can be scaled up and applied across the system.	Richard Taylor-Elphick & Sarah Mansuralli	**October 2023**	**3 October 23 –** Agenda item on SEND and AP Change Programme on 3 October.
11.07.23	6	**Paragraph 4.9**	**Mental Health – Adult Mental Health Emergency Pathway** To apply the learning from work across mental health and inequalities in NCL. Next steps to be discussed by Mike Cooke, Richard Taylor-Elphick and Dan Sheaff.	Mike Cooke, Richard Taylor-Elphick & Dan Sheaff	**October 2023**	**3 October 23 –** Agenda item on Longer Lives Programme on 3 October. Work is ongoing between LA and NHS partners to address Right Care, Right Person directive.
11.07.23	7	**Paragraph 4.10**	**Mental Health – Adult Mental Health Emergency Pathway** To circulate to ICP members the datapack produced for the recent Right Care Right Person meeting.	Sarah Mansuralli	**July 2023**	**3 October 23 –** Action completed.
11.07.23	8	**Paragraph 4.11**	**Mental Health – Adult Mental Health Emergency Pathway** To brief Jinjer Kandola on the Mental Health discussion at the meeting on 11 July 2023	Sarah Mansuralli	**July 2023**	**3 October 23 –** Action completed.
11.07.23	9	**Paragraph 5.3**	**Delivery of the Population Health and Integrated Strategy** To reflect on the conversation regarding areas of focus for the ICP (for example, mental health and school readiness) and to meet with Borough Partnership Chairs	Mike Cooke, Cllr Kaya Comer-Schwartz	**October 23**	**3 October 23 –** Agenda item on 3 October.

			to shape local delivery planning for the Population Health and Integrated Care Strategy.			Action Completed. Borough Partnership Chairs were convened on 20 September.

North Central London Integrated Care System

Draft Minutes
Meeting of North Central London Integrated Care Partnership
11 July 2023 between 12pm and 2pm
Islington Town Hall

Present:	
Mike Cooke	Chair, NCL Integrated Care Board and Chair of Meeting
Cllr Kaya Comer-Schwartz	Leader, Islington Council
Cllr Peray Ahmet	Leader, Haringey Council
Cllr Georgia Gould	Leader, Camden Council
Cllr Alev Cazimoglu	Cabinet Member, Health and Social Care, Enfield Council
Cllr Alison Moore	Portfolio Holder, Health and Wellbeing, Barnet Council
Beverley Tarka	Director of Adults, Health and Communities, Haringey Council
John Hooton	Chief Executive, Barnet Council
Linzi Roberts-Egan	Chief Executive, Islington Council
Frances O'Callaghan	Chief Executive Officer, NCL Integrated Care Board
Will Maimaris	Director of Public Health, Haringey
Phill Wells	Chief Finance Officer, NCL Integrated Care Board
Dr Jo Sauvage	Chief Medical Officer, NCL Integrated Care Board
Jon Newton	Service Director, Adults and Older People, Enfield Council
In attendance	
Sarah Mansuralli	Chief Development and Population Health Officer, NCL Integrated Care Board
Sarah McDonnell-Davies	Executive Director of Place, NCL Integrated Care Board
Dan Sheaff	ICS Policy Lead, North London Councils
Richard Taylor-Elphick	Programme Director, North London Councils
Amy Bowen	Director of System Improvement, NCL Integrated Care Board
Penny Mitchell	Director for Population Health Commissioning, NCL Integrated Care Board
Sarah D'Souza	Director of Communities, NCL Integrated Care Board
Jose Acuyo	Head of Population Health Commissioning, NCL Integrated Care Board
Lauretta Kavanagh	Programme Director for Mental Health, Learning Disability and Autism, NCL Integrated Care Board
Apologies	
Cllr Nesil Caliskan	Leader, Enfield Council
Cllr Barry Rawlings	Leader, Barnet Council
Doug Wilson	Statutory Director of Health and Adult Social Care, Enfield Council
Jinjer Kandola	Chief Executive Officer, Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health NHS Trust
Nnenna Osuji	Chief Executive, NMUH
Baroness Julia Neuberger	Chair, UCLH and Whittington Health
Alpesh Patel	Chair, GP Provider Alliance
Dominic Dodd	Chair, UCL Health Alliance
Dr Chris Caldwell	Chief Nursing Officer, NCL Integrated Care Board
Richard Dale	Executive Director of Performance and Transformation, NCL Integrated Care Board
Minutes	
Vivienne Ahmad	Board Secretary, NCL Integrated Care Board

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1,	The Chair welcomed attendees to the Meeting. Apologies had been received from Cllr Nesil Caliskan, Cllr Barry Rawlings, Doug Wilson, Jinjer Kandola, Nnenna Osuji, Baroness Julia Neuberger, Alpesh Patel, Dominic Dodd, Dr Chris Caldwell and Richard Dale.
2.	**Minutes and Actions**
2.1	The ICP **AGREED** the minutes of the previous meeting on 18 April 2023 as an accurate record.
2.2	Members then reviewed the action log, which contained three 'open' actions. Frances O'Callaghan highlighted that the last meeting had discussed having school readiness on the agenda of the July meeting and assurance was given that this would be included on the agenda for the next meeting. Richard Taylor-Elphick agreed to pick this up with the Directors of Children's Services outside the meeting.
2.3	The ICP **NOTED** the action log.
2.4	Action: Richard Taylor-Elphick to engage Directors of Children's Services on priorities for collaboration on 'School Readiness' ahead of the next meeting.
3	**NCL Inequalities Fund – Evaluation**
3.1	Sarah D'Souza introduced the item, noting that the focus of the ICB's Communities Team is to make the ICB's commitment to reducing health inequalities a reality as both a moral imperative and to strengthen the ICB's financial sustainability going forward. In recognition of the fact that that the most deprived communities face significantly greater health challenges, the ICB developed a £5m Inequalities Fund. The Fund is a positive example of what can be achieved when place, partnerships and the system work together.
3.2	She then gave a summary of the progress of the Fund and future plans: • The fund is focused on innovating place-based solutions to entrenched health inequalities, with lived experience and co-production at the heart, based also on the principle of proportionate universalism. • The majority of funding was allocated to the Borough Partnerships, largely proportionate to levels of deprivation. • Over 60 schemes have been implemented to date, many of which are 'test and learn' • Evaluation has been challenging due to the variety of the schemes and the difficulty in measuring cause and effect, while also needing to measure what is important to communities. Analysis has therefore focused on direct impact and system impact to obtain a rounded understanding. Alongside this, Middlesex University are reviewing the effectiveness of the co-production work. • The evaluation shows that 83% of the schemes met their intended outcomes, ranging from 800 fewer A&E attendances to providing safer environments for young black men to discuss mental health issues. • The Fund has provided an early blueprint for future Borough Partnership and system working, such as combining strong data on need with local insights and delivery approaches, as well as sharing learning. It has also helped to develop community assets – more than 50% of these schemes are delivered by voluntary and community services. • The programme is being extended and is seen as a vehicle for building further investments and galvanising local thinking • Consideration is being given to how the current schemes might be scaled up and deepened and how the wider learning can be applied more systematically to the system, as well as applying an 'equity lens' to data on spend and performance to facilitate discussions on how resources are being used

	• It is recognised that poverty is one of the key determinants for poor health outcomes and in addition to the ongoing work on the London Living Wage, there is the opportunity to be more systematic about pathways into employment in health and care.
3.3	Sarah D'Souza then posed four key questions for the meeting to consider: • What actions should the Partnership take to develop an approach to aligning resources to need, building on the example of the Inequalities Fund? • What approaches should we use to demonstrate improvement in equity for our population at system, borough partnership and organisational level? • How can we apply the learning from the co-production approach and apply this more broadly to our system transformation work? • How should we build on the Inequalities Fund work as a system in the future?
3.4	ICP members then discussed the paper, making the following comments: • The quantity of work and the qualitative descriptions in the report were commended. However, it was noted that while some programmes 'flew' from the outset, others were slow to start or encountered barriers, so it would be helpful to think about what can be done to make future programmes more 'oven-ready'. • The report has taught valuable lessons around what can be done at hyper-local level to respond to communities' needs, as well as scaling-up different opportunities. The evaluation has also identified which initiatives will work best. Given this, what are the plans to do more scaling up, while also recognising that some of the hyper-local programmes are responding directly to the outcomes set in the strategy, such as helping people back into work and meaningful employment. • The funding and range of exciting projects was welcomed. However, it was questioned how the system will translate the experience that people have of these services into their experience of mainstream services. • It is important to understand the macro elements (such as cultural competency) while enabling the micro-elements to continue. • Concern was expressed about just continuing programmes as there is a risk of 'initiative-itis'. It would be helpful to know what worked and what did not, and then embed some of these approaches, turning them into 'business as usual'. In terms of co-production there are already a lot of assets in the Boroughs, such as health champions and existing health programmes which could potentially be made use of. It would also be useful to map the prevention and inequality spend across the patch to get a fuller picture of what is being invested in order to build on this in the future. • The principle of recognising the inequity of funding across NCL and the genuine sense of being listened to was welcomed. • It was questioned whether the Partnership understands the needs of its populations as well as it should, bearing in mind that some of the seldom heard communities have the greatest needs. • It was highlighted that although none of the most deprived wards across NCL are in Barnet, there is nevertheless considerable inequality at sub-ward level in the Borough. • There is strong synergy between the Inequalities Fund projects and the work that the ICB is planning to undertake with the Core20PLUS communities that have been identified as part of the Population Health and Integrated Care Strategy. The ICB is now able to refine in much greater detail the kinds of population groups that it wants to target and it may want to do that when looking again at future allocations • It was confirmed that the Borough Partnerships had also identified particular schemes which would not be continued, so this funding can potentially be re-invested elsewhere. • It was noted that the work on the Inequalities Fund had found the 'sweet spot' between shared system-level objectives, system level data and qualitative insight on the ground which can then be targeted, enabling learning at system, place and neighbourhood

	levels, while also modelling how the system might work differently together and with communities.
3.5	The Chair thanked members for their feedback and insights on the funding itself and the schemes it supports, particularly around investment and re-investment and what kind of learning can be applied. The discussion had also raised the issue of what macro learning ought to be applied to partnership working at both NCL and Borough levels. This point would be returned to under item 5.
3.6	The ICP **NOTED** the evaluation of the NCL Inequalities Fund.
4.	**Mental Health**
4.1	Sarah Mansuralli introduced the paper, which focused on Child and Adolescent Mental Health Services (CAMHS) and the Adult Mental Health Emergency Pathway. These elements would be taken in turn, so she highlighted initially the following points relating to CAMHS: • There are significant operational interfaces between the work that the NHS and local authorities do around mental health and the work of the Police and other agencies, so it is fitting that it is the focus of a partnership discussion, as there are multiple components which affect the pathway. • A discussion on the opportunities for further collaborations to improve outcomes for residents would be welcomed. • A large amount of work has taken place on developing the CAMHS 'core offer' since it was approved. Despite the demand for CAMHS services increasing exponentially across NCL and the progress made on implementing the key priorities, it is recognised that there are still significant variations in the offer and fragmentation in pathways can accentuate the waiting times experienced by residents. Multiple providers in each Borough adds to the diversity of the provision but the 'hand-offs' can add to waiting times. The system therefore needs to find a way of maintaining what is best while streamlining the pathway. • In addition to the aforementioned variations in offer, the presentation identified four other key challenges: Electronic Patient Records (EPR) systems, finance, performance and prioritising impact. • It is clear that the increased investment and trying to increase capacity against a backdrop of continuing workforce 'churn' will not be enough to hold the tide for long against increasing demand, which is being caused by a variety of factors, including greater awareness of mental health conditions, reduced stigma, the impact of the pandemic and the cost of living crisis. • There is therefore a clear need to think differently about innovation and collaboration to address these challenges.
4.2	ICP members then discussed the paper, making the following comments: • Concern was expressed about the scale of the increase in the prevalence data. It is clear that there needs to be a strong focus on prevention opportunities and it would be helpful to hear more about what is currently taking place in this area. Other contributory factors include social media, as well as drug and alcohol use and it was queried what targeted interventions are taking place to counter these. • The importance of learning from good practice within the system, such as the work in Camden around integrated transition for 16 to 25 year olds to avoid people getting lost in the system, was highlighted. • Issues around data need to be addressed in order to deepen partnership working and improve transition of people across services. • It was noted that Michael Holland, Chief Executive, Tavistock and Portman, recently reviewed the CAMHS services in Camden and was deeply impressed by the preventive work taking place. • It was queried whether there is wider learning that the ICP could consider which looks outside core therapies and has a strong evidence base that could be implemented at place and would have a significant impact. • It would be helpful to hear more about access for different communities. More broadly, it was also queried whether a medical model should be used to address children's mental health as anxiety can be provoked by a range of external factors such as the

	after-effects of not going to school during the pandemic, school tests and the fear of crime, which might be better tackled through early community-based interventions to build up resilience and avoid crises later on. • It was highlighted that a large number of schemes supported by the Inequalities Fund focus on mental health, particularly with regards to young people and BAME communities. Local authorities have the skill assets and engagement structures to be able to speak to young people and parents about mental health from a non-medical perspective. Young people need to be empowered to navigate this complex time of their lives and make decisions for themselves about whether they are medically depressed. This might also mean having different types of conversation at practice level. • It was confirmed that children's mental health is one of the top priorities for Directors of Children's Services (DCSs), so there is an 'offer' for joint work. It is clear that the case-load levels and need levels reflect more deprived communities, so there is a strong link with the previous item. • In terms of the social model, Boroughs are extremely focused on elements of the Thrive Framework and there is a general feeling that there is an opportunity to do more as a whole system in that space that would look across different types of support to address the need for preventive measures. Richard Elphick-Taylor offered to support engagement with Directors of Children's Services further outside the meeting. • The need for a targeted approach was highlighted as resilience will depend to an extent on young people's personal circumstances – those within the care system, for instance, will have very different experiences to those who have supportive families. • It was noted that this work is at the core of what the Borough Partnerships and the ICP are trying to do, as it encapsulates the mutuality between us and the need to understand prevention. • It was queried what proportion of children are having an episode and what proportion are going on to experience more severe longer-term mental health issues. Although there was a clear increase in terms of need after the pandemic, on the whole these did not become long-term pathologies. It would also be helpful to understand what the local authority commitments are in this area in order to gauge how much money is available to do things differently. If NCL succeeds in making progress in CAMHS. that would be a powerful testament to the commitment to achieving our goals. • The Mental Health Services review identified that more money is being spent on crisis than early intervention. Inroads have been made into early intervention and there is now at least one mental health support team in every Borough. However, although we are attempting to shift our funding 'downstream', this becomes increasingly difficult when confronted with rising levels of demand and acuity, so there needs to be a recognition that there is a balance to be struck. • Camden has had a slight head-start over other Boroughs through integrated provision and there are clear benefits from that model of care. Going forward, the challenge will be to replicate that model across health and social care in NCL and this will need to be worked through. • It would be helpful to build up a map of positive performance so that the learning can be extended. It would also be worth mapping the other universal support that is available – for instance, the Mayor of London is having a big push on investing in mentoring and it might be worth reflecting on this in a mental health context.
4.3	The Chair observed that Children's mental health is emerging as an important theme for the ICP to have oversight of, while recognising that the work will be done at Borough Partnership level. He welcomed Richard Taylor-Elphick's offer for the DCSs and Sarah Mansuralli's team to reflect on today's feedback, map what is happening now which is applicable more broadly and consider how we can build on the existing rich experience within the Boroughs in order to draw out from this some work that the ICP can sponsor. This would then be brought back to the next meeting and incorporated into any further reflections on our priorities as a partnership.
4.4	Sarah Mansuralli then gave an overview of the work taking place on the adult pathway, including the work with providers on inpatient services. She highlighted the following points:

	• There has been a strong focus on reducing the number of out of area placements as it is recognised that the breakdown in social and community connectiveness tends to delay recovery by lengthening the period of inpatient admission which can also lead to people 'de-conditioning' in a similar way to the negative impact of extended physical inactivity. • As a result of the above, there has also been a wider focus on admission avoidance as well as addressing hospital processes which impact on discharge and improving discharge planning. • The length of stay for 60% of admissions is below 30 days. However, the remaining 40% of admissions take up 80% of the available bed capacity and some of these acute admissions can last over a year, when they should actually be in an environment which can support their rehabilitation. If people remain inpatients for too long it can damage their ability to re-connect and lead more fulfilling lives, which in turn has multiple implications for the system. • The impact of Right Care Right Person will also have some negative consequences as there will be a tendency to be more risk-averse in terms of people going on leave from inpatient units. • The system needs to think through collaboratively whether there are things it could be doing differently, such as trying to support people coming into different kinds of discharge placements as well as looking at demand and capacity for supported living accommodation.
4.5	ICP members then discussed the paper, making the following comments: • It was noted that although people's experience of supported living is generally positive, the lack of regulation around this area has occasionally resulted in issues with providers due to the anticipated level of support not being present. • It was highlighted that new legislation around supported housing is in the offing and colleagues were encouraged to make submissions if they have any concerns. • A number of Councils had written to the Metropolitan Police regarding the way that the announcement that they will no longer routinely attend emergency calls related to mental health incidents had been made and the need for local authorities and the Police to work together, bearing in mind that the pilot which this decision was based on had received years of investment. • It was noted that Frances O'Callaghan had hosted a meeting with the three Borough Commanders and the Mental Health Trust Chief Executives the previous week, so assurance was given that work is taking place around the implications of Right Care Right Person at NCL and London level, supplemented by actions being taken at Basic Command Unit (BCU) level. It had been a positive meeting, with strong willingness by the Police to work with all parties to get this right. • A plea was made to avoid reinventing the wheel with respect to long term admissions as there has already been considerable research into this. The ICP needs to galvanise around early interventions and what keeps people thriving, building on evidence-based discussions around what works, • It was questioned whether NCL has the right partnerships in place with its community organisations with regards to prevention and early intervention, and furthermore, whether the investment in the Inequalities Fund matches our aspirations. • Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health Trust are working on a community rehabilitation review which includes looking at the support for people moving into supported housing and helping people move through the system. Mapping has taken place, including the clinical support in each Borough. NCL actually has more supported housing in NCL than it uses so it is a net importer of people from other ICPs. • A transfer protocol has been developed for people with learning disabilities that are moving to placements in other NCL boroughs and and a similar one is being developed for mental health to ensure placements can meet people's needs and that care is handed over effectively to local health teams. • Generally within NCL there is more supported housing than we directly commission (we are a net importer) and delayed transfers are largely caused by process issues so the community rehabilitation review should help to manage this. It is possible that

	there may be gaps around the more complex cohorts though this has not been identified through data analysis, despite attempts. The North London Forensic Service have expressed interest in developing new commissioning models for people with complex needs who have been in hospital for very long periods with funding following the resident. • Assurance was given that community models have been an active area of development in NCL (although not included in the slides). It was suggested that the type of need for supported accommodation is changing in light of the complexity and acuity that is being presented. The granularity of the data obtained through this focused piece of work will potentially allow us to look at the needs that are unable to be met through the current models and may result in the need to look at what is the intensive supported living offer for NCL and how we might do some market shaping to get that and then ultimately co-commission it. • A piece of demand and capacity work based on population needs is probably required for the long-term stays in hospital. • It was highlighted that the dataset produced for the Right Care Right Person discussions identified that a large number of black men are more likely to end up being detained in Section 136 suites or Emergency Departments. It was agreed that it would be helpful to circulate this datapack more widely with ICP members.
4.6	The Chair thanked members for their contributions which had highlighted a range of complicated issues and the large amount of work which is taking place. There has been a strong commitment in the meeting to keep partners informed on the changes around the Metropolitan Police. It would be helpful for Sarah Mansuralli to brief Jinjer Kandola on the discussion that has taken place in her absence. He also requested a piece of work on how we apply the learning from all of these issues to help to unpick the work at NCL and Borough level. The Chair, Richard Taylor-Elphick and Dan Sheaff would meet outside to discuss the next steps regarding this piece of work.
4.7	The ICP **NOTED** the Mental Health update.
4.8	Action: Richard Taylor- Elphick and Sarah Mansuralli to hold a discussion between DCSs and Sarah Mansuralli's team to map existing good practice on work that can be scaled up and applied across the system.
4.9	Action: Mike Cooke, Richard Taylor-Elphick and Dan Sheaff to discuss the next steps regarding applying the learning from work across mental health and inequalities in NCL.
4.10	Action; Sarah Mansuralli to circulate to ICP members the datapack produced for the recent Right Care Right Place meeting.
4.11	Action: Sarah Mansuralli to brief Jinjer Kandola on the Mental Health discussion at today's meeting.
5.	**Discussion on delivery of the NCL Population Health and Integrated Care Strategy**
5.1	John Hooton introduced the discussion. He noted that there is wide agreement across the Partnership on the quality of the Population Health and Integrated Care Strategy and the key next step is to turn the content into deliverable action plans to tackle health inequalities which are then progressed. To achieve this, it was proposed that Borough Partnerships be asked to lead on local action planning, led by the Borough Partnership Chairs and in partnership with Council leaders and Health and Wellbeing Boards. Plans would then be brought together at NCL level. This approach will ensure that the action plans contain what is important for NCL as a whole as well as at Borough level, which will probably vary to a degree.
5.2	ICP members then made the following comments in response: • There was broad enthusiasm for the proposal. • It was suggested that there would be value in bringing partners together for conversations on thematic issues to shape the development of action plans.

	• It was noted that the strength of the Population Health and Integrated Care Strategy is the broad level of engagement that went into its development. Because this is a shared document, the delivery plan requires us to work collectively, so we need to get into who is doing what at each level to make each of these pieces of work happen, given their interdependency. As part of that early planning, we need to get everybody on the same page about how we are going to plan and draw out clearly the expectation from an ICP perspective that partners can, will and are coming together at a local level to work in that way. There are also things happening at Borough level regarding population health, integration and inequalities which are not in the purview of the Borough Partnerships, so we will need to think about how we get a holistic view of everything which is happening that is feeding into the delivery of the strategy. • It was agreed that Mike Cooke, Cllr Kaya Comer-Schwartz, John Hooton, Frances O'Callaghan, Richard Taylor-Elphick and Dan Sheaff would meet to discuss the proposal outside of the meeting to shape how best to take the work forward in a ground-up way, led by the Borough Partnerships and complemented by work at system level where this adds value. • It was noted that strategies can feel fairly removed from the people on the ground that they impact, so it is important to maintain clear communication with the people on the front line who deliver them, as well as patients. • It was suggested it might be helpful to bring diverse groups of citizens together across the Boroughs to provide feedback as the work unfolds.
5.3	Action: Mike Cooke and Cllr Kaya Comer-Schwartz to reflect on the conversation regarding areas of focus for the ICP (for example, mental health and school-readiness) and to meet with Borough Partnership Chairs to shape local delivery planning for the Population Health and Integrated Care Strategy.
6.	**Any Other Business**
6.1 6.2	Frances O'Callaghan highlighted that the East Finchley ward in Barnet is one of the locations for the two year Universal Basic Income pilot and observed that it would be helpful to have a discussion about the direct outcomes from the project at a future meeting. John Hooton and Cllr Moore confirmed that this is not a Council project as such but the local authority is supporting it and offered to share any feedback in due course.
7.	**Date of Next Meeting**
7.1	3 October 2023.

North Central London Integrated Care System

North Central London Population Health and Integrated Care Strategy

System-wide work

October 2023

Introduction

North Central London Integrated Care System

- Work is ongoing to set out the draft system-leaning delivery plans that are contributing towards the delivery of the NCL Population Health & Integrated Care Strategy. It will describe how our system transformation programmes align with and contribute towards delivery of the key priorities that are identified in the strategy, drawing out how these programmes are driving a population health approach.

- Work is also ongoing to develop delivery plans for the NCL Population Health Risks, recognising that multiple programmes of work will contribute to their delivery.

- These plans will help us to track and align our monitoring processes, to ensure successful delivery of the Population Health & Integrated Care Strategy.

- This pack provides draft examples of a system transformation programmes (LTC LCS) and a population health risk (Cancer) to demonstrate how the templates work in practice.

- As the content for these system transformation programmes and population health risks is collated, we will continue to iterate with owners.

- The delivery plans outline:
    - **Ownership:** The exec sponsor, SRO and the forum/group that oversees the programme
    - **Time horizon:** First 18 months, aligned to horizon 1
    - **Alignment to delivery areas:** Key communities and population health risks
    - **Core deliverables:** Including sub-deliverables and respective timelines and owners
    - **Health inequalities:** How the programme is addressing health inequalities
    - **Programme outcomes:** Key outcomes (or outputs) that the programme will be aiming to impact over the first 18 months
    - **NCL Outcomes Framework:** The NCL outcomes/sub-outcomes that the programme will aim to contribute towards
    - **Baseline performance:** The baseline of the key NCL Outcomes Framework outcome that the programme is aiming to contribute impact towards *(baseline data to follow)*
    - **Borough Partnership dependencies:** It will also need to be considered where corresponding borough partnership action plans are required to align and support local change as part of the system transformation programmes and population health risks.

LTC LCS

Exec sponsor – Sarah McDonnell-Davies
SRO – Amy Bowen & Sarah McIlwaine
Primary forum – LTC LCS delivery group

Time Horizon (months)	**Short:** <18

DRAFT IN DEVELOPMENT

Delivery areas alignment

Key communities

- All adult key communities
- Children with Asthma
- Core20
- BAME not captured in Core20

Population Health Risks

Heart Health **Lung Health**

Across primary care in NCL, a single **Locally Commissioned Service (LCS) for Long Term Conditions (LTCs) is rolling out focussed on proactive care, personalised care and support planning, taking a multimorbidity approach and embedding population health management into delivery, monitoring and outcomes.**

Health Inequalities

How are health inequalities being addressed?

- The LTC LCS has a total cohort of over 318,000 with metabolic (e.g., Diabetes, Cardiovascular Disease, etc.) or respiratory (e.g. asthma or COPD) disease . Using our Population Health Management platform, we have created tools that allow practices, PCNs and boroughs to look at all aspects of delivery and outcomes applying demographic filters, including Core20PLUS groups to understand equity of access experience and outcomes. This will allow teams to understand where they may need to target efforts to address disparities highlighted by the data.
- Practices can generate case-finding lists based on clinical features but also demographic factors
- A weighted payment provides additional funding where there are more individuals with agreed demographic factors which reflect the differential effort needed to achieve outcomes with different communities. The payment, made to PCNs is to fund engagement activities, working closely with local VCSE partners to make sure we reach communities in ways that work for them
- Outcomes-based payments are set based on local starting points, so improvement goals are tailored to local need, with an aim to close disparities in outcomes and reduce variation

Programme outcomes

What are the key outcomes the programme will be measuring to identify impact over the first 18 months?

(to be updated)
5 outcomes from the LTC LCS outcomes framework (n=32) will be selected for incentivisation in 24-25 – 2 across NCL and 3 selected by each borough. These will be selected by end Q2 23-24

NCL Outcomes

What outcomes and sub-outcomes will this programme aim to contribute impact to?

Reduced deaths from cancer, cardiovascular disease and respiratory disease

- Reduced prevalence of key risk factors: Smoking, alcohol, obesity.
- Early identification and improved treatment of cancer, diabetes, high blood pressure, CVD and respiratory disease

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

- Improved outcomes for children with LTCs

People live as health and independent lives as possible as they age

- Early prevention, detection and management of LTCs, including dementia, in old people

Borough Partnership dependencies

What is the ask of BPs to make this programme a success?

- Partners within the BP will need to have an introduction to the LTC LCS model of care and implementation plan so that they understand how all the elements support population health improvement.
- BPs will then need to consider how they can support primary care to embed the model of care and deriving wider local system benefit from some of the deliverables within the programme, e.g. how to use the risk stratification to drive other integrated work programmes.
- BPs can support the Weighted Payment element of the LTC LCS and support PCN engagement work with key communities experiencing health inequalities, particularly focussing on how the VCSE can be a key partner in engagement
- BPs can also consider opportunities for how LA and other services could align their offer to the new model of care.

Baseline key NCL OF outcome

What is the baseline of the key NCL OF outcome you are aiming to contribute impact towards?

Early identification and improvement treatment of cancer, diabetes, high blood pressure, CVD and respiratory disease

Barnet	
Camden	
Enfield	
Haringey	
Islington	
NCL-wide	

Baselining to be added

LTC LCS

Exec sponsor – Sarah McDonnell-Davies
SRO – Amy Bowen & Sarah McIlwaine
Primary forum – LTC LCS delivery group

Time Horizon (months)	Short: <18

DRAFT IN DEVELOPMENT

Delivery areas alignment

Key communities

- All adult key communities
- Children with Asthma
- Core20
- BAME not captured in Core20

Population Health Risks

Heart Health

Lung Health

Core deliverables	Sub-deliverables	Timelines	Owner
What are the core deliverables that this programme will oversee?	**What are the parts that make up each core deliverable?**	**What are the anticipated key milestones for each deliverable?**	**Where does responsibility sit for delivery?**
Year of care model of care	**Delivered over year** -matching workforce, and frequency of contact, to level of risk. Patients will be invited based on their level of complexity. **Holistic** -includes personalised care and support planning, lifestyle interventions and care coordination alongside medical care. Will cover all the patient's LTCs, ensuring a 'whole person approach'. **Demand/capacity modelling** at practice or PCN level to support planning & optimise resources. **Not GP-centric** -wider primary care workforce contribute supporting deliverability and effective use of resources. **Complements –but does not duplicate** -NHS Health Checks, QOF etc. **Benefits primary, community and secondary care** and supports greater integration., stratification and care coordination	Launch is Q3 23-24 with remainder of the year focussed on: • embedding the model of care • PCN engagement work using the weighted payment • Case-finding (see below) • Improved recording of interpreter needed so this can be added to the weighted payment in 24-25	• GP practices and PCNs are responsible for delivery • ICB support from primary care and system improvement teams • NCL Training Hub supporting practice preparedness, including training on the model of care and PHM tools
Population Health payment model – Outcomes Framework	Payment model for the LCS is based on three elements: block, weighted and outcomes. Outcomes payment launching in 24-25	Outcomes will be incentivised from 24-25 – from the suite of 32 outcomes, 2 will be selected as system-wide and each borough will select an additional 3	• ICB supported by public health are developing the framework, tools and methodology for outcomes and goal setting
Risk stratification	Identifies patient cohorts, using nationally adopted UCLP proactive care framework, tailored for the LTC LCS with local clinical and population health input, with tools built into our population health management platform	Risk stratification is complete and all practices will be titrating model of care to individual risk level	• ICB primary care, UCLP and public health collaboration
Population Health Management tools	**Case-finding tool** – *This will generate instant patient lists reconciled across multiple LTCs, demographic and inequalities indicators which help practices stratify who to see first* **Multi-morbidity registry** – *Clinicians in MDT can use this when reviewing high-risk patients to identify at a glance which parameters are out of range for a patient across multiple LTCs.* **Outcomes dashboard** – *This will enable practices to see progress against outcomes and indicators against different demographic, geographic and clinical cohorts. The tool will also support practices to plan their workload to achieve their local outcome goals*	**Case-finding tool** – testing in August, training in September and launch in October 23 **Multi-morbidity registry** – testing in January 24, training in Feb and launch in March **Outcomes dashboard** - testing in January 24, training in Feb and launch in March	• ICB system improvement oversees development of PHM tools • Training Hub responsible for coordinating training practices on utilisation • Practices to use PHM tools as part of delivery
Case finding	Case-finding is an early priority of the programme to close the prevalence gap and bring more people with LTCs into the LCS cohort. Case-finding is prioritised and practices can use their wider workforce to reach the greatest number of people.	Focus in 23-24 will be on • CKD case-finding to support preparation for renal delegation, including a specific project on CKD and health inequalities in Enfield and Haringey • Higher priority patients identified through the case-finding tools (inc multimorbidity risk)	• ICB led clinical group responsible for defining case-finding criteria • ICB GPIT and analytics team responsible for building EMIS searches and embedding in the PHM tools

DRAFT IN DEVELOPMENT

Time Horizon (months) | **Short:** <18

Cancer

Exec sponsor – Ali Malik
SRO – Prof Geoff Bellingan
Primary forum – NCL Cancer prevention, awareness & screening delivery group, NCL Cancer Alliance Programme Board, NCL Cancer Alliance Board

North Central London Integrated Care System

Contribute towards achieving the diagnosis of 75% of cancers at stage 1 and 2.

Health Inequalities

How are health inequalities being addressed?

- Each of the deliverables have a key focus on targeting populations that have poorer cancer outcomes e.g. people with a learning disability, people with SMI, people that live in more deprived areas, to reduce the early diagnosis gap between population groups and across geographical areas.

Programme outcomes

What are the key indicators (outputs or outcomes) the programmes will be measuring to identify impact over the first 18 months?

Outputs from the primary care strategy delivery programme (e.g. recruitment of project manager, development of education prospectus etc).

Outputs from the prevention, awareness and screening strategy (e.g. inclusion of all screening programmes in annual health checks for PWLD)

Key indicators

- Screening uptake/coverage across the three programmes
- Uptake of lung health checks
- Uptake of NHS Galleri blood cancer test
- Number of people attending routine liver surveillance

NCL Outcomes

Which outcomes and sub-outcomes will this programme aim to contribute impact towards?

Reduced deaths from cancer, cardiovascular disease and respiratory disease

- Early identification and improved treatment of cancer, diabetes, high blood pressure, CVD and respiratory disease

Borough Partnership dependencies

What is the ask of BPs to contribute to delivery?

- Prevention, awareness and screening – to support the delivery of projects that are place leaning (e.g. amplification of cancer campaigns locally, utilisation of champions to promote breast screening participation).
- NHS Galleri cancer test – support the delivery to communications activities to build awareness of the pilot particularly in areas of high deprivation, which is a key focus.
- Primary care cancer strategy – formalise and strengthen links with people starting in newly appointed project roles as well as five borough GP leads; support and where needed and facilitate engagement with primary care (e.g. practices and PCNs) on cancer agenda; identify areas of collaboration within current work programmes.

Baseline key NCL OF outcome

What is the baseline of the key NCL OF outcome you are aiming to contribute impact towards?

Outcome	
Barnet	
Camden	
Enfield	
Haringey	
Islington	
NCL-wide	

Outcome and baselining to be added

Cancer

DRAFT IN DEVELOPMENT

Time Horizon (months) **Short:** <18

Core deliverable	Sub-deliverables	Timelines	Owner
What is the core deliverable that will contribute to cancer delivery?	**What are the parts that make up the core deliverable?**	**When are the anticipated key milestones for this deliverable?**	**Where does responsibility sit for delivery?**

Cancer primary care strategy delivery programme	• Place-based engagement
	  • Build a 'place based engagement function' to enhance engagement regarding health inequalities and variation
	  • Launch the HealtheIntent Cancer Care Registry
	• Data & analytics
	  • Enable a data driven Population Health approach through primary care and population based analytics tools.
	  • Standardisation and improvements to coding of cancer information in primary care
	• Creating a community of practice & enhancing a culture of learning & development
	  • Enhance cancer education for all staff working in primary care;
	  • Improve the sharing of clinical expertise between primary and secondary care
	• Contribute to the operational performance of the overall cancer pathway
	  • Support the delivery of the 2023-24 Cancer DES and QOF requirements
		Fully in place by end of Q3 2023
		
		Initial tools in place from Q3 2023/24
		Coding project currently being scoped out
		
		Learning and development plan finalised in Q3 2023-24. Implementation to follow.
		
		Underway.
			NCL Cancer Alliance
			
			NCL Cancer Alliance with support from ICB analytics and population health teams
			
			NCL Cancer Alliance
			
			TBC- currently with ICB but may change as a result

FIT (Faecal Immunochemical Test)	• FIT compliance
	  • The national target is 80% and so we're implementing some interventions such as educational webinars and using our GP Fellow to speak to those practices with particularly low compliance.
	• Fit <10 pathway
	  • NCL is evaluating a routine pathway in secondary care to see whether carrying out a repeat FIT test and FBC on those patients whose initial FIT test was <10 can reassure the GP and patient that their chance of having CRC is so low that a 2ww referral should be avoided.
		FIT compliance
		Educational webinars – September 2023
		Reaching 80% compliance – end of Q4 23/24
		FIT<10 pathway
		Evaluation complete – Q1 24/25
			NCL Cancer Alliance

Work at place-based and system level to drive cancer prevention, improve population awareness of the signs and symptoms of cancer, encourage early presentation and increase participation in the three national screening programmes, as well as the Targeted Lung Health Checks programme.	• Develop and embed a standardised Making Every Contact Count (MECC) approach across the system that includes cancer. • Develop and deliver activities that drive timely presentation to the health system when people have worrying symptoms. • Increase participation in the bowel, breast and cervical screening programmes towards the national targets and closer to the national average. • Fully roll out the Targeted Lung Health Checks programme and increase participation to achieve the national target.	**Timely presentation and screening** National campaigns – Sept '23 to Mar '24 **Targeted lung health check** Roll out to third site – Q4 23/24 Campaign to improve uptake – Q3 and Q4 23/24	NCL Cancer Alliance, NCL ICB, Local authorities, screening services NCL Cancer Alliance
Support roll out of the NHS Galleri cancer blood test across NCL as part of the national Interim Implementation Pilot	• Work with ICS partners and NHSE to establish the project using a national specification. • Develop a communications and engagement plan to ensure good uptake of the blood test in the areas of most need (i.e. areas of highest deprivation or cancer incidence).	Launch project – Q2 24/25	NCL Cancer Alliance
Support liver services to identify more people at high risk of liver cancer and provide routine surveillance to patients	• Establish whether local providers are consistently inviting patients with cirrhosis/advanced fibrosis for ultrasound surveillance. • Support providers to establish systems and processes to invite those eligible for liver surveillance where it does not exist.	Baseline data on liver surveillance available – Q3 23/24 Systems and processes to invite eligible patients to liver surveillance established – Q4 23/24	NCL Cancer Alliance NCL liver surveillance providers

SEND and AP Change Programme.

Whole NCL ICB Approach to Children and Young People with Special Education Needs and Disability

Summary of Key Information

- The Children and Families Act (CFA) 2014 intended to improve earlier identification of need for children and young people with SEND; for their families to be more involved in decisions affecting them and for better join up between education, health and social care.
- Since then, there has been much criticism about the system from families, Councils and wider professionals., including the National Audit Office report 2019 and the Inquiry by the House of Commons Select Committee.
- In response to the widespread concerns and findings, the DfE published a Green Paper in March 2022 'SEND Review: Right Support, Right Place, Right Time'. A year later in March 2023 the DfE published its SEND and Alternative Provision (AP) Improvement Plan. This included a set of key proposals which will be piloted on a national basis across the 9 DfE regions .
- In each region there will be a Change Programme Partnership (CPP) made up of 3 or 4 LAs led by a lead Local Authority who will be required to test and trial the proposals set out in the implementation plan over a 2 year period.
- High performing Local Authorities in each area were asked to submit an Expression of Interest (EOI). Following this process Barnet was selected to be the Lead Local Authority for the London region. Enfield, Camden and Islington are the other LAs in the CPP together with the NCL ICB.

Summary of Key Information

- There is alignment with the **The North Central London Population Health & Integrated Care Strategy** through delivery of the *Start Well* objective; *Every child has the best start in life and no child is left behind*, Specifically:

Delivery area 3 – Key communities – Children and Young People

Children with Special Educational Needs and Disabilities (SEND). Pupils with SEND face barriers that make it harder for them to learn than most pupils of the same age. They often experience poorer outcomes than their peers in educational achievement, physical and mental health status, social opportunities, and transition to adulthood.

- Through working together to test out the Key Proposals we will be able to redesign the system around the needs of children and young people. Together we can address the barriers that children and young people with SEND experience on a daily basis; giving them the best start in life and improve their outcomes and lived experience through to adulthood.

DfE £70m SEND and AP 'Change Programme'

1. **In order to test out the proposals for reforms the DfE identified the top high performing LAs in each region and asked them to submit an Expression of Interest (EOI) to be the lead partner for a Regional Expert Partnership (REP) area.**

2. **The successful lead LA will work in partnership with the other DfE chosen Authorities in its region and will receive funding of £5.8m over 2 years to use across its REP to support the testing and evaluation of the proposals.**

Role of Lead LA: Expertise to Deliver Change

We want LAs who can use their experience of delivering effectively within the current SEND system to lead the testing and refining of the SEND and AP reforms across each REP. Working closely with the Department, lead LAs will have a key role in shaping the direction of the Change Programme.

Provide leadership across the REP	Drive change and share practice and learning	Delivery and monitoring progress
• Set up and lead local REP Steering Group/ Board and develop the partnership • Ensure consistent testing across the REP to help us test for a national system • Facilitate the provision of experts from across the REP for expert groups and co-production e.g. National Standards	• Facilitate REP participation in a feedback loop with DfE - providing continuous insights on learning from testing • Take a lead role in helping influence and refine the SEND and AP reforms • Use expertise and strong practice to support other LAs in the REP and, in the Taskforce phase, other LAs in the Region.	• Development of the REP Strategic Delivery Plan • Monitoring and maintaining progress against the Strategic Delivery Plan. • Identifying and resolving or escalating barriers or challenges to delivery • Managing and monitoring the use of funding

Key proposals

National standards to increase consistency at a national level.

- These are wide ranging and include what provision should be in place for different need types, identification of need, casework, communication, complaints, what is ordinarily available for children and young people with SEND but who do not have Education, Health and Care Plans (EHCPs), Alternative Provision, transitions, co-production, as well as standards such as decision making, annual reviews and mediation which the DfE proposes to make mandatory.

Establish SEND and Alternative Provision (AP) Partnerships.

- To ensure the right people at the right level undertake a needs assessment of the local area and produce a Local Area Inclusion Plan which clearly sets out what is available and will be commissioned.

Introduction of a standardised EHCP and Digitise the process.

- A standardised template will make it easier for parents who move Boroughs, or where their child attends school in a different borough and for education providers. Concern remains about the digital divide for the digitisation of the Education Health and Care Needs assessment (EHCNA) processes, especially given the links between deprivation, Free School Meals and SEND.

Key proposals

A three-tiered approach to AP

- Direct support in mainstream, short term intensive off-site placements in a Pupil Referral Unit (PRU), longer term placement in PRU with the focus on reintegration into mainstream or Further Education (FE).

Introduction of Inclusion dashboards so parents and professionals can see how the SEND system is performing at local and national level.

- These will be publicly available. It is not clear what will be reported on the dashboards but, are likely to include data already being reported such as adherence to timescales for the issue of new EHCPs and annual reviews, and exclusion and attendance data for example.

Introduce a new national framework of banding and tariffs for funding matched to levels of need and types of education provision set out in the national standards.

- Nationally, there is widespread disparity in the cost of provision and the amount of funded support available to schools at both mainstream, Additionally Resourced Provisions (ARPs) and Special. This aims to have set tariffs or bands for differing types of provision and the Special educational needs a child or young person may have.

Key proposals

Provide tailored lists to parents of suitable placements.

- The LA will draw up lists of appropriate schools for parents/carers. There is concern from parents this will reduce statutory rights.

Improve staff training.

- Through the introduction of a new leadership level SENCo (Special Educational Needs Co-ordinator) NPQ (National Professional Qualification) for schools; fund up to 5,000 early years staff to gain an accredited Level 3 early years SENCo qualification; increase the capacity of specialists, including educational psychologists.

Trial the ELSEC Pathfinder in one LA in each CPP (Barnet has been selected for this).

- The Pathfinder aims to improve early identification and support of children and young people with SLCN)in early years settings and primary schools, to reduce exacerbation of need. Speech and Language Therapy Assistants, will improve capacity and knowledge of workforce that support children with emerging/mild to moderate SLCN in early years and school settings. And be co-funded and co-led by DfE and NHSE. The pathfinders will be funded by Integrated Care Boards (ICBs) and LAs who will pool money for pathfinders.

SEND and AP Change programme funding for the London CPP

Table 2: Funding per CPP from the DfE

Activity	Year 1	Year 2 Total	Total
CPP Testing of reforms and Taskforce activities.	£1,986,666.67	£3,909,833.33	£5,896,500.00
For ELSEC Pathfinder LA* (one LA only).	£251,653.11	£251,653.11	£503,306.22
Total	**£2,238,319.78**	**£4,161,486.44**	**£6,399,806.22**

Please note that NHSE and the ICB will also contribute funding to the ELSEC programme.

Broader context in NCL

- There is significant and increasing demand in relevant services for LA and the NHS in NCL, including:
  - Variation in therapy offer by borough (LA and NHS)
  - Increasing need for therapies and MH services resulting in long waits in some areas
  - Increasing number of children diagnosed with neurodiversity
  - Average weeks wait from referral to autism diagnosis for CYP <5 is highest in Barnet at 92 weeks. For >5s the highest weeks waiting is in Islington 109 weeks
  - Given system pressures and long waits it is difficult to have confidence that we're delivering the best outcomes for young people and families (or VFM) from our current health and social care investment
  - More information on specific challenges in appendix i

Recommendations and questions for the ICP

- Confirm support from key partners for the establishment of a senior sub-regional programme to oversee this work
- Comment on the proposal that the programme looks at opportunities to transform current spend to deliver better outcomes as well as overseeing new investment
- Views on the biggest partnership opportunities within the key proposals on slides 5-7
- How can we support the development of this programme to respond to the Population Health and Integrated Care Strategy, such as
  - Increased investment in prevention and early intervention
  - Focus on communities with poorer health and wellbeing outcomes?

Appendix i: NCL Context

1. Health, Education and Social Care Context

Therapies

Background 1/2

- The 2014 SEND (special educational needs and disabilities) reforms brought about changes across education, health and care and the implementation of education, health, and care plans (EHCPs).
- Over the last 5 years demand for therapy service has increased and this has put significant pressure on services across NCL:
- In some areas, meeting statutory responsibility for an increasing number of complex children has led to children experiencing very long waiting times for initial assessment and therapy intervention
- Some children with additional needs but without an EHCP are only seen within a universal service and/or wait a long time for assessment and intervention
- The Pandemic and post-Pandemic period has seen increased demand
- There are increasing numbers of children diagnosed with neurodiversity (e.g. autism and ADHD) and children with complex needs

Background 2/2

- Barnet has a high number of Tribunal and half include appeals with regard therapy provision.
- The increased number of children identified with SEND at SEN Support or EHCPs has increased at a much higher rate than the increase in the school population.
- This has meant increases in specialist provision such as Special Schools and Additionally Resourced Provision (ARPs) as well as increasing the number of children with SEN in mainstream schools.
- There are significant differences in the capacity, demand, identified need, service offer and existing investment from both health and LA's for CYP Therapy services between the boroughs within NCL. Barnet is a particular outlier in terms of the amount of capacity in post to deliver Therapy services.
- Therapy services are joint funded by the ICB and each local authority and there is variation in the relative contributions made by the ICB and LA's in each borough, as well as funding per head.

Existing NCL therapies offer 1/2

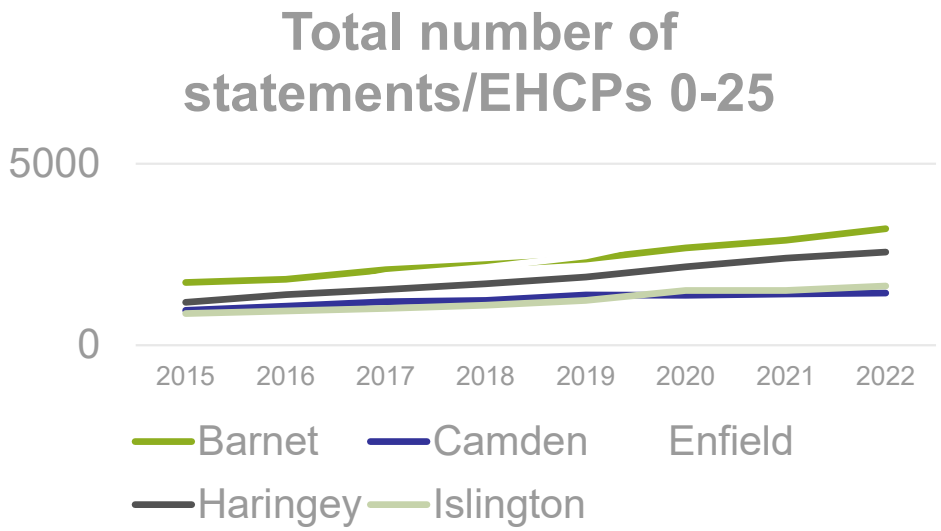
- There is an NCL core offer for therapies as part of the Community Services Review - and there is significant variation
- The offer includes speech and language therapy (SLT), occupational therapy (OT) and physiotherapy (PT).
- The offer is across early years, mainstream schools, special schools and specialist provision e.g. Pupil Referral Units, resource bases.
- All areas include a mixture of:
  - Universal Offer (borough level training; website resources; signposting, environment support)
  - Targeted support (group therapy, building capacity – e.g. training school staff, drop in sessions)
  - Individualised support (1-1; group therapy; referral triage; assessments and reports; individual group therapy).
  - Provision of services specified in EHCPs

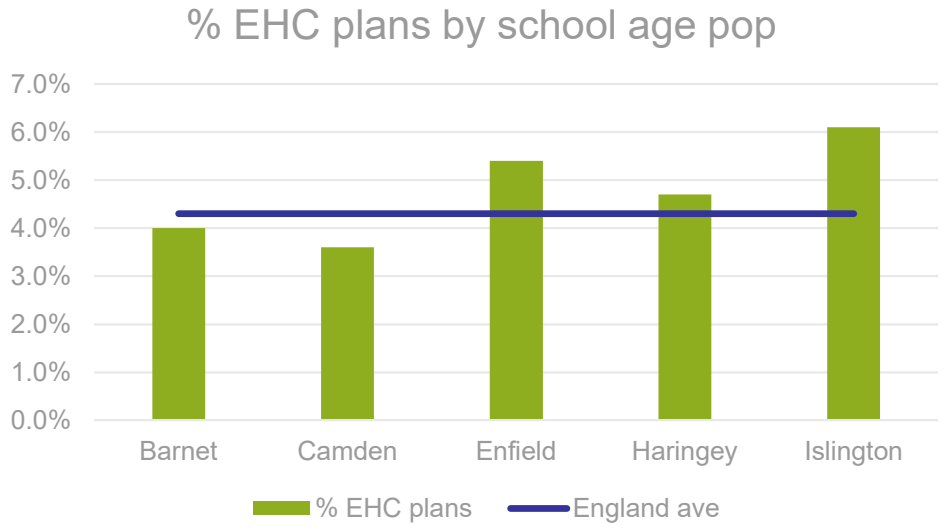
Existing NCL therapies offer 2/2

- There is variation in the models of delivery between these services, which makes it harder to compare provision. Examples of variation include:
  - In Haringey local partners agreed previously to focus on EHCP provision and a Universal Offer has not been provided
  - In Camden the waiting time target for initial assessment is 6 weeks, other areas work to a 13 or 18 week target
  - In Barnet there has been a termly approach to EHCP provision
  - In Islington there is a strong universal offer
  - In Enfield SLT education universal offer was disinvested in 2016 due to LA financial challenges and reinstated in 2020. Statutory interventions are a half termly or termly offer
- To deliver the NCL core offer for Therapies will require a sustained transformation programme over a number of years, and significant joint work between partners including NHS providers, the ICB and Local Authorities (given the interdependencies involved).

The no. of EHC plans has steadily increase since 2015

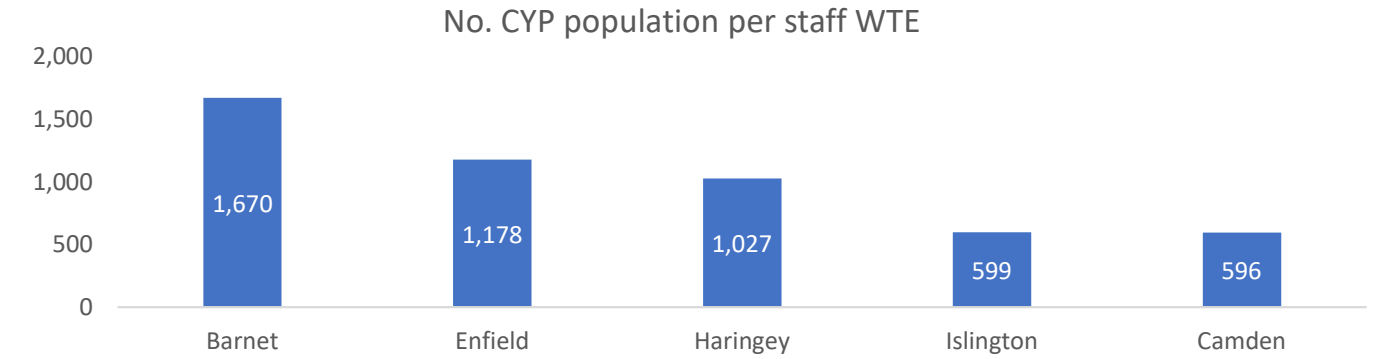
- There have been **yearly increases** in the number of children eligible for an **EHCP** across NCL, with the most significant increases seen in Enfield, Barnet and Haringey.
- There has been increase in need across the different populations of children requiring an EHCP, but the most **significant increases** are being seen in children with a diagnosis of **Autistic Spectrum Condition (ASC)** that go on to need an EHCP.
- Many of these children are now **transferring into mainstream schools** that would have previously been in special schools.

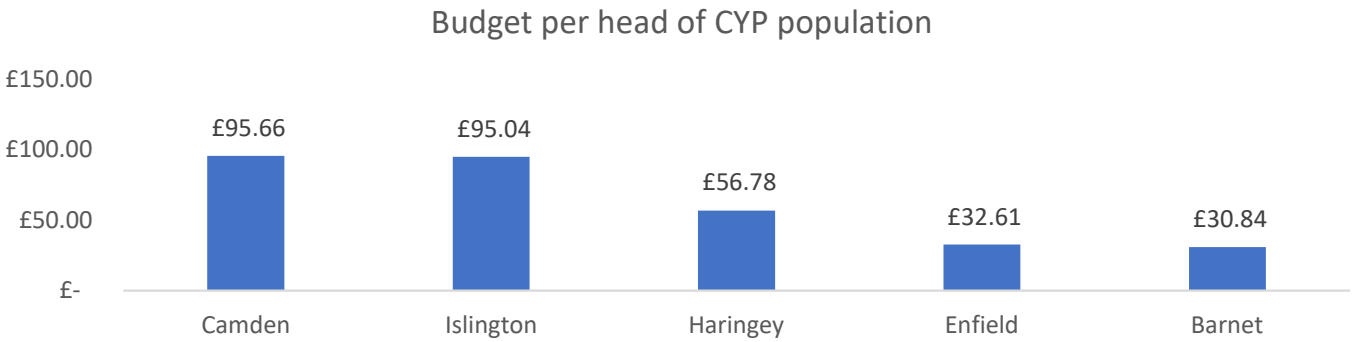




Draft for discussion

Barnet, Enfield and Haringey have fewer staff and funding to meet demand than Islington and Camden



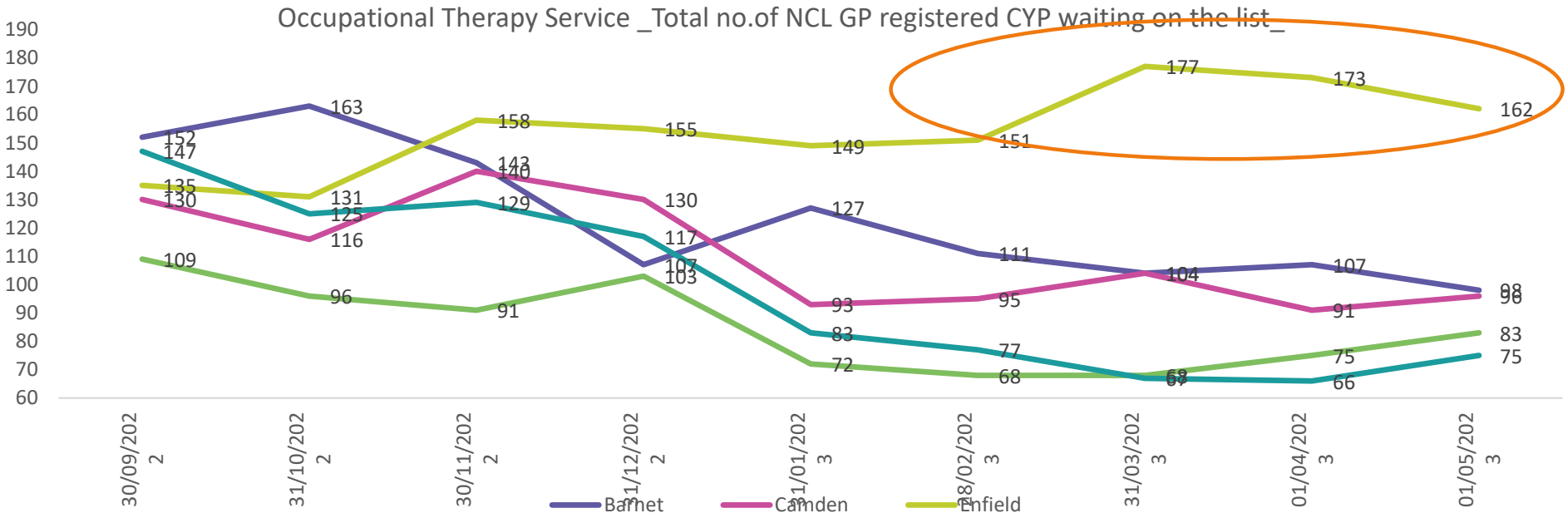


- Barnet has the least staff in NCL and the largest CYP population.
- Barnet and Enfield have the lowest pay budget in NCL despite having the highest CYP populations.
- Barnet and Enfield pay budgets are on average £2.8m, compared to £3.8m in Camden and £3.9m in Islington

Draft for discussion

Enfield's number of children waiting for an initial assessment in OT has increased since Sept 22

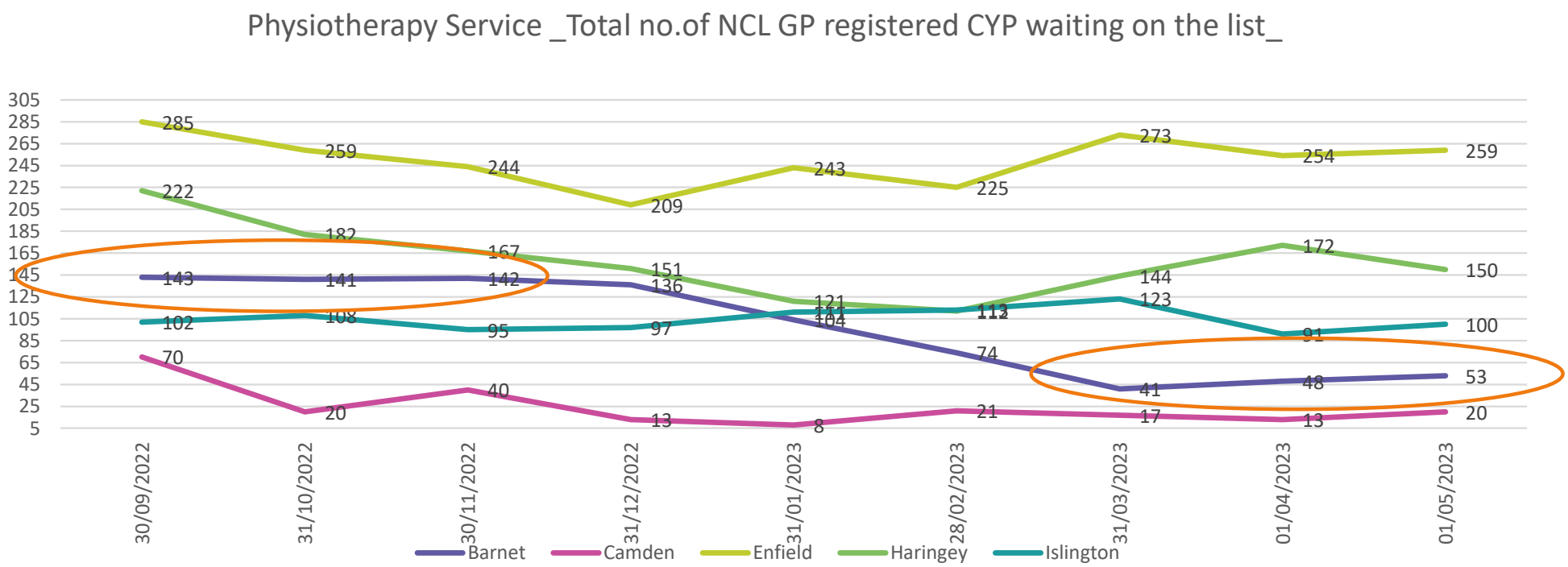
- Overall, the number of CYP waiting for initial therapy assessments across NCL has been trending down
- Numbers waiting for initial assessments in OT have significantly reduced in all but Enfield, whose numbers waiting in Sep were 135 CYP and in May there were 162 waiting.
- In Enfield this is due to workforce challenges (capacity as opposed to demand).



Draft for discussion

The number of CYP waiting for initial assessment in physio have reduced in Barnet, Camden and Haringey

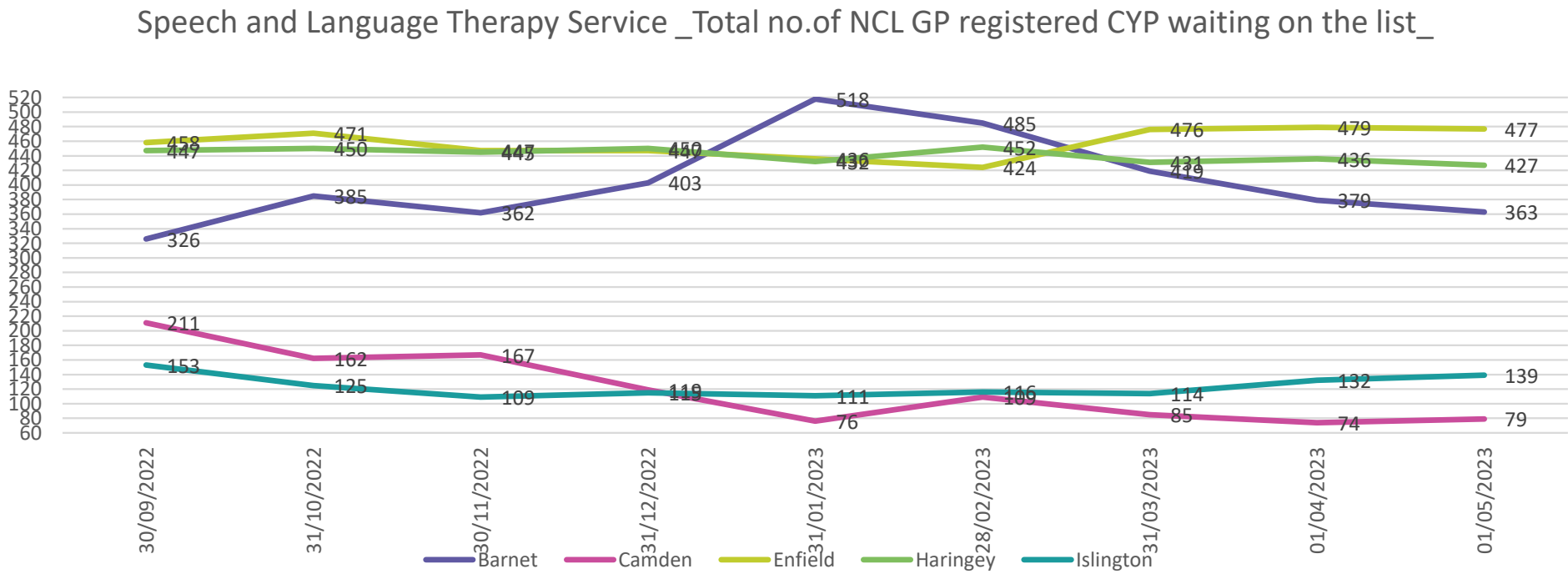
- For Physiotherapy, the numbers waiting for initial assessments have reduced since Sept 22. Barnet has seen the greatest change in overall numbers waiting



Draft for discussion

The reduction in numbers waiting for initial assessment in SLT has been more modest

- For SLT, the numbers waiting for initial assessments have remained stable with a minimal reduction. Barnet saw a significant uptick in the numbers waiting in Jan, however this has since trended downward.



Draft for discussion

NCL Context

2. Health, Education and Social Care Context

Mental Health

CAMHS Spotlight (1/2)

Note slides for internal use only

North Central London Integrated Care System

1 CYP Access

Compared to Operating Plan, NCL ICS achieved 81% as of June 23. As NCL's Operating Plan (20,579) is below our LTP target (25,478), our performance against LTP target is at 70% over a 12-month period. Our Operating plan target breaks down as:

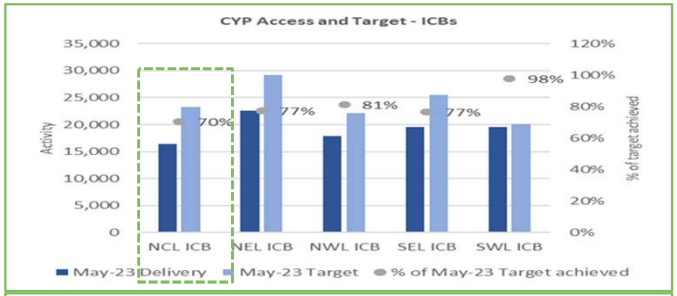
- Community: 14,989
- MHST: 5,590

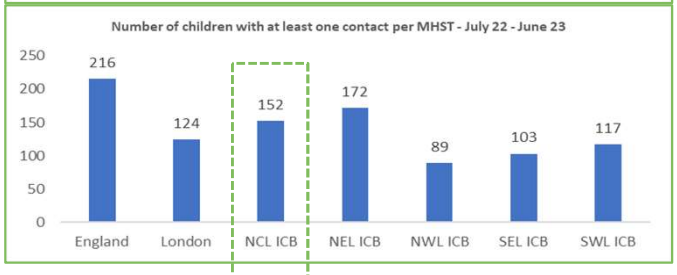
CYP Community:

- SWL ICS achieved 98% of their May 23 CYP access target, while the other ICSs each achieved between 70-81% of the LTP target.
- London is the 2nd lowest performing region, having achieved 80% of their rolling 12-month target in May 23 .

MHST:

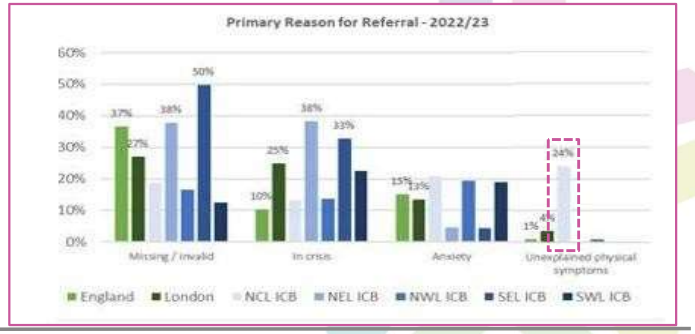
- NCL ICS had an average of 152 CYP seen per MHST, while NEL ICS had an average of 172.
- NCL ICS has seen 3,503 MHST by June 23 and remains on target to meet Operating Plan of 5,590.
- 9,400 CYP in London have accessed MHSTs in the last year, which is 10% of the total CYP seen by all CYP MH services in London (96,360). This is second lowest % of MHST contribution to the overall CYP access numbers compared to other regions.
- London had the lowest number of referrals seen per MHST in last year of the regions, at 124.
- There has been an improvement in the data flowing to MHSDS for MHSTs but there are some teams not yet submitting correctly. This is an area where work is continuing with a targeted support offer by the Regional team.





2 Referrals

- NCL has the highest proportion of referrals due to unexplained physical symptoms at 24%, compared to 0-1% for other ICSs.
- Other main reasons for NCL ICS being Anxiety (21%), Missing / Invalid (18%) and In Crisis (12%).
- NCL ICS accounts for 3,435 waiting list while SEL ICS has the largest at 7,620.



Data source: London's Mental Health Delivery Group Performance Pack

CAMHS Spotlight (2/2)

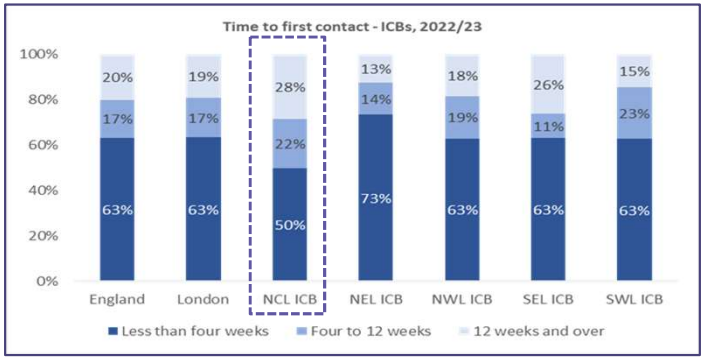
Note slides for internal use only

North Central London Integrated Care System

3 Wait time to first contact

NCL ICS is the lowest performing ICS with only 50% referrals seen within 4 weeks, 22% between four to 12 weeks and 28% waited over 12 weeks for first contact.

- Over the last year, 63% of referrals in London waited less than 4 weeks for a first contact, while 19% waited longer than 12 weeks. This is in line with the national average.
- ***Team Type:*** Autistic spectrum disorder services (20%), Neurodevelopment teams (27%) and Psychotherapy services (39%) had the lowest proportion of CYP receiving a contact within 4 weeks of referral. Crisis resolution teams and Paediatric and Psychiatric Liaison services each had between 96-97% of CYP receiving their first contact within 4 weeks of referral
- ***Demographics:*** Female CYP were more likely to have their first contact within 4 weeks of referral – 67%, compared to 57% of male CYP. Older children were more likely to have their first contact within 4 weeks of referral. 73% of 16–17-year-olds waited less than 4 weeks, compared to 46% of 0–5-year-olds, and 53% of 6–10-year-olds.



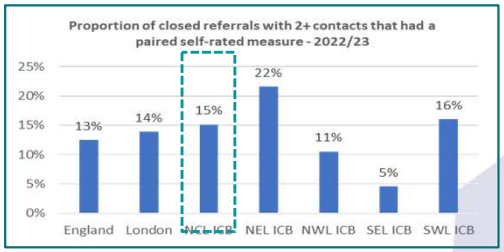
4 Outcomes

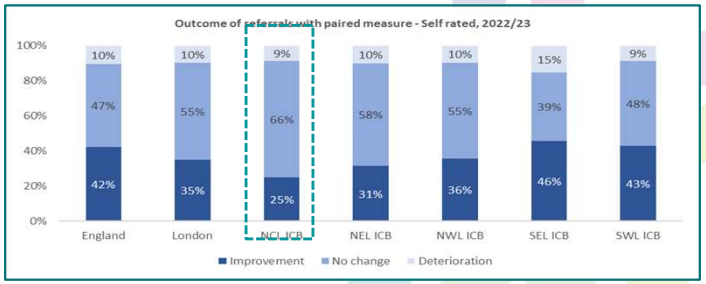
PAIRED SCORE RECORDING: Just 15% of closed referrals with 2+ contacts in NCL ICS had a paired score.

- The charts on the right show the proportion of closed referrals with a self-rated paired outcome measure, using the denominator as the closed CYP referrals that have at least two attended contacts, as it wouldn't be possible to get a paired measure with fewer contacts.
- Work needs to be done to improve this rate as we are moving to report more routinely on outcomes. However, it is worth noting that this data refers to many different pathways, some of which it may not be suitable to gather outcomes measures for – it would be useful to look further into sample sizes for different team types.

OTUCOMES: 25% of CYP living in NCL showed improvement on their paired score, compared to 43% and 46% in SWL and SEL respectively.

- London's improvement rates from self-rated measures (35%) were below the national average (42%) last year.
- The variations could be due to the different service types offered in each region/ICS, different demographics, or the different outcome measures used. Data quality should be improved in this area before conclusions should be drawn, and before further investigation can be done.





Data source: London's Mental Health Delivery Group Performance Pack, 20th September 2023

Appendix ii: Background information on national SEND and AP programme and links

The 9 DfE Regions and ICBs

Table 1: the 9 DfE regions with lead LA, CPPs and ICB.

Region	Lead LA	Supporting LAs	ICB
North East	Hartlepool	Gateshead, Durham, Stockton on Tees	North East, North Cumbria
North West	Manchester	Oldham, Rochdale, Trafford	Greater Manchester
Yorkshire & Humber	Wakefield	Bradford, Calderdale, Leeds	West Yorkshire
West Midlands	Telford & Wrekin	Shropshire, Herefordshire, Worcestershire	Shropshire, Telford & Wrekin
East England	TBC	Bedford, Central Bedfordshire, Luton	Hertfordshire, West Essex
South East	Portsmouth	West Sussex, Brighton and Hove, East Sussex	Hampshire, Isle of Wight
South West	Swindon	Gloucestershire	Banes, Swindon & Wiltshire
London	Barnet	Camden, Enfield, Islington	North Central London
East Midlands	Rutland	Leicester, Leicestershire	Leicester, Rutland, Leicestershire

Links

- National Audit Office report in SEND 2019. https://www.nao.org.uk/wp-content/uploads/2019/09/Support-for-pupils-with-special-education-needs.pdf
- Local area SEND inspections: one year on', Ofsted and Care Quality Commission, October 2017;
- https://www.gov.uk/government/publications/ofsted-annual-report-201920-education-childrens-services-and-skills
- Ofsted Annual Report 2019/20: education, children's services and skills', Ofsted, December 2020 https://www.gov.uk/government/publications/ofsted-annual-report-201920-education-childrens-services-and-skills
- Inquiry by the House of Commons Select Committee October 2019 https://publications.parliament.uk/pa/cm201919/cmselect/cmeduc/20/2002.htm
- SEND Review - right support, right place, right time (publishing.service.gov.uk)
- Special Educational Needs and Disabilities (SEND) and Alternative Provision (AP) Improvement Plan (publishing.service.gov.uk)

DfE Minister responsible for SEND and AP

Cabinet Reshuffle31 August 2023.

- New minster for SEND is David Johnston OBE MP - GOV.UK (www.gov.uk) who replaced Claire Coutinho MP - GOV.UK (www.gov.uk) (held the post for 10 months).
- Minister Johnston is the 5th minister in 2 years.

North Central London Integrated Care System

Longer Lives

Improving the physical health of adults with severe mental illness in North Central London

- **Lauretta Kavanagh**, Programme Director for MH, LD and Autism, NCL ICB
- **Ed Beveridge**, UCLP Clinical Lead for Mental Health
- **Gemma Copsey**, UCLP Implementation Manager
- **Tim Miller**, AD Commissioning Haringey Council and NCL ICB

Why this plan?

North Central London Integrated Care System

People with severe mental illnesses* are dying much earlier than the general population. Psychotic illness is strongly linked with health, race and social inequalities: prevalence is 3x higher in most deprived areas compared to the least.

In NCL, men with psychotic illness die 18 years earlier, and women die 14 years earlier

NCL has the highest prevalence of psychotic illness of any Integrated Care System in England (21,000 people)

People are dying largely from preventable, physical, health conditions (i.e. not suicide / homicide)

The ICS already is implementing the NCL Core Offer and the NHS Long Term Plan, which set out approaches to improve physical health amongst people with SMI.

However, NCL's Population Health Strategy identifies adults with SMI as a 'key community'. To shift the deep inequalities and complex issues that drive such poor outcomes, we require a more focused programme of work to deliver our population health ambition.

* e.g. schizophrenia or bi-polar disorder

The NCL Population Health Strategy set **5 key delivery areas** where we can create the biggest impact in NCL. The highlighting shows the alignment to this programme.

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Focus on the **20% most deprived communities**.

- understanding of the needs of our most deprived communities
- providers will tailor services and approaches to maximise their opportunities
- strengthen links between statutory health and care services and wider support

Adult NCL communities who experience greater health inequalities and poorest outcomes.

Key Communities

- Inclusion Health Groups
- Black, Asian and Minority Ethnic (BAME) groups experiencing inequalities
- Adults with severe mental illness & adults with learning disabilities

Additional DASS priorities

- Family carers
- Older adults with care and support needs
- Supporting residents at risk of hospital admission
- Supporting residents to recover following hospital admissions

Focusing on the root causes of poor health.

- **Working with our communities**
- **Working with the VCSE**
- **Social Prescribing**
- **Embedding tackling wider determinants across all priority areas**

Heart Health
Cancer
Lung Health
Mental Health and Wellbeing across all ages
Childhood immunisations

Where we are now?

North Central London Integrated Care System

NCL has made major progress in scaling up services and community outreach across NCL.

The ICB has led **investment in excellent services** in each borough: **Primary Care / GP Federation led enhanced services in neighbourhoods, co-delivered with MH Trust teams including peer support, and strengthened by VCSE community outreach programmes.**

In 22/23 we completed **annual health checks for 13,322 residents** with SMI, exceeding the national target and a 3.4x rise from only 3,821 two years ago.

Some our services achieve excellence; one was nominated for an HSJ award

The plan started as a mental health service area improvement project but has been able to tap into and **galvanise ambition from a wide range of partners** to do better for this population.

UCL Partners were asked to support NCL and to:

- Articulate a clear vision and ambition
- Develop a set of key areas for action based on NCL population's priorities and the evidence base
- Build commitment to action across the wider system, including community physical health services, public health and wider partners

* e.g. schizophrenia or bi-polar disorder

How did we develop this plan?

UCLP brought together diverse people and sources of information – research, residents and clinical leaders – and used an iterative, feedback process.

1. Co-production: delivering what people across NCL say is important to them

- Longer Lives Expert by Experience reference group for extensive co-development work
- Surveys, interviews and focus groups across the five boroughs, including inpatient and community visits

2. Professional Input: using the expertise of our NCL professionals

- Wide stakeholder consultation including all key clinical networks and leaders (GP federation, respiratory consultants, diabetes network, cancer alliance, public health)
- Co-ordinated through SMI Clinical Network from primary and secondary care

3. Research: rooted in the evidence base

- Publicly available data to inform clinical focus areas
- Scoping of national and local research, innovations, and strategies

What people told us

North Central London Integrated Care System

Lived experience contributors describe some key themes around their experience of health care and support

- They do not regard physical and mental health as separate
- They can struggle to trust professionals and sense that they are "judged" not helped
- They are angry about side effects of psychiatric medications, particularly weight gain, and want earlier, more effective support for this
- They experience the GP as hugely important in their care but experience challenges when trying to access them

"[Physical conditions] mean that everything I do takes 10x the energy and time as for a regular person. Nothing is straightforward."

"I don't ask for physical health support because I feel that I'm being a burden."

"[There is an] assumption that everyone wants to be helped, but if a person has low self-esteem or life is hard, what is their motivation to live longer?"

"We need more services like Mind – where there's integration of all different types of people, these groups help us feel much better about ourselves."

Longer Lives Delivery Plan

North Central London Integrated Care System

***The Vision:** High quality care is accessible to everyone with a severe mental illness in NCL*

4 Guiding Principles

Ways to improve the quality and experience of care

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

5 Focus Areas

Improve key care and treatment pathways

i. Living well with SMI
ii. Heart disease and diabetes
iii. Lung disease
iv. Cancer
v. Reaching the extra 20% of people

1 Annual Health Check

People get consistent assessment and guidance

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

Implementation and impact

North Central London Integrated Care System

We will reduce premature mortality and multi-morbidity, to **increase the quality of life as well as its length**, enabling opportunity for people and reducing need for the services for avoidable, early frailty.

Against each area, the plan sets out

- areas for action and implementation.
- outputs and outcome measures proposed.
- prioritisation and a high-level timetable

We are developing the delivery prioritisation, planning and the governance for the programme at the moment.

Aligning health improvement activity alongside the plan – smoking cessation, health improvement, weight management etc – is key, as is ensuring people with SMI have the right, rapid and personalised access to housing, financial and social support.

What will we do?

North Central London Integrated Care System

We will reduce premature mortality and multi-morbidity, to **increase the quality of life as well as its length**, enabling opportunity for people and reducing need for the services for avoidable, early frailty.

Deliverable areas	What will be delivered in the first two years?	How will the experience be different?
Living Well with SMI	• Adults with SMI have a comprehensive physical health check each year • That health-check includes health coaching, screening and other elements • Co-produced, tailored information is available for service users deployed across ICS • Increased offer and uptake of physical health and wellbeing groups	More consistent and positive experiences in General Practice
Cardio-metabolic health	• All patients who need treatment identified in their physical health check will receive it. • All patients will be offered high impact, holistic support and peer work • Increased access to prediabetes and diabetes support programmes • Include diabetes in the mental health risk assessment for people with comorbid diabetes • All MH staff working with people at risk of diabetes trained on diabetes prevention & care • Cross-referral pathways in place between MH, Diabetes and Substance misuse	More health conditions identified and treated – reducing disability
Lung Disease	• NCL staff will be offered treating tobacco dependence training • Implement smoke-free policy and offer NICE recommended treatment in all MH hospitals • Improve access to respiratory hublets and pulmonary rehab	People feel better supported to tackle health / lifestyle challenges
Cancer	• All cancer screening and treatment services will adopt trauma-informed approaches • Review, improve & standardise the support offer for patients with SMI at cancer diagnosis • Information & training on screening & symptoms to services supporting patients with SM • Improve data collection around screening engagement for people with SMI	Mental health and physical health / disability teams integrate and work together
Reaching the most marginalised 20%	• Proactive engagement plans for DNAs or non-responses • Clearer pathways and information sharing between NHS and VCS • Expand the role of VCS and grassroots organisations to deliver health promotion activities • Develop the role of neighbourhood MDTs as a route for escalation of patients	Less socially / professionally acceptable for SMI to be exclusionary

Delivery of this as an ICP / ICS programme

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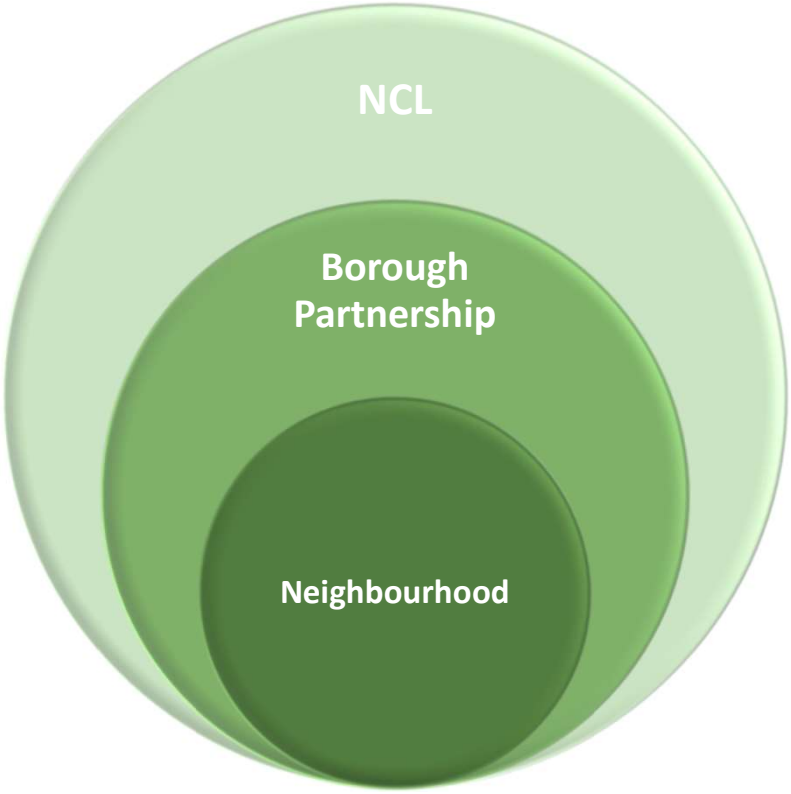

Purpose in Pop Health Strategy	Application in Longer Lives
System • Focuses on activities that are better undertaken at an NCL level where a larger planning footprint increase the impact of effectiveness • Creates conditions for local delivery of population health improvement through the borough partnerships	• NCL wide recurrent investment based on borough need • Engage NCL wide networks to plan delivery across system • Co-ordination of NCL wide clinical pathways • Develop resources and protocols once for NCL • Programme management and leadership • Analytics and oversight • Co-ordinate codesign
Borough Partnership • Focussed on bringing together partners to develop, integrated and co-ordinate services based on agreed priorities • Work with wider sector partners • Drives hyper local delivery	• Co-ordinates local integration across mental and physical health care services; primary and secondary care services • Prioritises this population in physical health, prevention and wellbeing plans to ensure access • Delivers workforce change and training • Oversees neighbourhood level integration and delivery • Ensure anti-stigma work addresses the needs of the most marginalised • Coproduce local implementation
Neighbourhood • Builds on the core of primary care networks through integrated multi-disciplinary teams delivering a proactive population-based approach to care at a community level	• Delivers consistent, stronger health checks & local wellbeing and support groups • Integrates support with VCSE & other partners • Draws on local MDTs to wrap care around a person • Addresses social, housing and finance barriers to health • Make every contact count

“Living Well with SMI in NCL”

North Central London Integrated Care System

One of the 5 focus areas in the Plan is ‘Living Well with SMI in NCL’. It covers a range of clinical and non-clinical actions that will make a difference to people’s lives and outcomes, and a good example of where we will require joint action across the system. Deliverables are: -

- Annual health checks will reliably prompt physical health care planning and interventions.
- Care planning is provided from the point of the health check which is holistic and uses a coaching approach, with longer appointments and peer work involvement as appropriate.
- UCLP-Primrose will roll out across NCL.
- There is information for residents with SMI which provided by all services on issues such as side effects and specific health conditions, co-produced with people with lived experience, tailored to account for health condition, ethnicity, culture, socioeconomic status, literacy, language etc. We will start with information tailored to particularly high-risk communities, e.g. Heal-D (Healthy Eating & Active Lifestyles for Diabetes in African and Caribbean communities).
- Regular (at least annual) psychiatric medications reviews will be offered to all SMI patients by a suitably experienced professional, with a holistic focus. Consideration of weight gain will be a top priority for clinicians.
- Regular mental health training and expert support available in ‘physical health’ settings e.g. acute trusts and primary care.
- Regular community health and wellbeing groups offered, with access to free exercise in a range of settings. The focus will be enjoyable activities, groups and peer support, with strong links with VCS and community groups to enable this. E.g. Inclusion Sports, run by LISA (London Inclusion Sports Academy).

Harnessing commitment to action across public heath functions, leisure and wellbeing, and care planning / delivery in adult social care people to help achieve their outcomes will be critical

Potential Asks of the ICP

North Central London Integrated Care System

1. Prioritising this delivery plan will involve all parts of our system working differently – particularly in the way that primary care, mental health/community, local authority and secondary care services work together and to support this population group. What are the next steps for borough partnerships in strengthening this important work further?
2. To explore the prioritisation of this work as an ICP priority within the delivery of the Population Health strategy
3. To discuss the opportunities of delivering change at scale and via Borough Partnerships to tackle inequalities and deliver new ways of working in neighbourhoods.
4. To consider the opportunity of partners co-leading areas of work in the programme, such as the "*Living Well with SMI in NCL*" strand.