North Central London
Health and Care
Integrated Care System

NHS

JHOSC update

28th April 2025

Executive summary

North Central London Health and Care
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- This update provides a **summary of mental health pathways** in North Central London. It focuses on two important areas of ongoing work:
  - **Improving transitions from children and young people's (CYP) services to adult mental health services**, with new teams, earlier planning, and personalised support for those aged 18–25.
  - **Strengthening how information is shared across organisations**, so that care is better coordinated, people don't need to repeat their story, and decisions can be made more quickly and safely.
- These services are designed to support people with a **wide range of mental health needs**, from mild to complex and severe.
- Since 2022, we have taken **steps to reduce variation** in services between boroughs. A Core Offer for Mental Health Services has been developed and is being implemented across a multi-year programme to ensure more consistent, high-quality support across the area.
- **Significant investment has been made** to address historical gaps, particularly in Barnet, Enfield, and Haringey, where levels of variation have been higher.
- We have also made it **easier for people to access help**. Crisis services are available 24 hours a day, 7 days a week, through phone lines, walk-in Crisis Cafés, home treatment teams, and emergency support via the Mental Health Crisis Assessment Service (MHCAS).
- For those needing longer-term care, Community Mental Health Teams provide personalised support for mental, physical, and social needs, including therapy, medication, and help with housing and employment.
- We **recognise that challenges remain and that need continues to increase amongst our population.** Further challenges include the consistency of support and coordination between services. However, we are actively working to address these issues through improved planning, partnership working, and investment in neighbourhood-based care and digital tools.
- Our **aim is to create a joined-up, equitable, and proactive mental health system** that helps people get the right support at the right time, in a way that works for them.

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Adult mental health services

The Mental Health Core Offer

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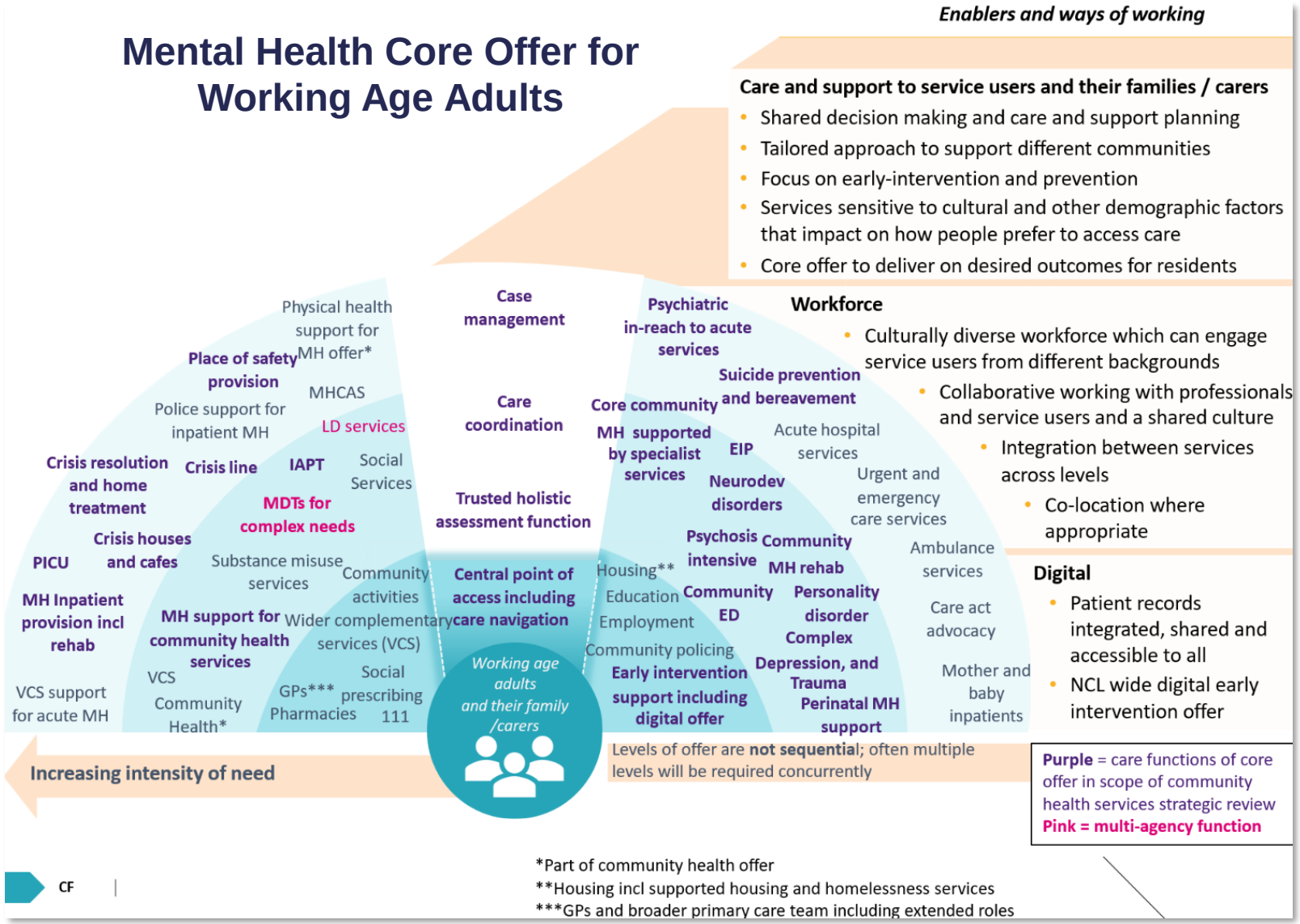
- In 2022 we conducted a review of services across boroughs which highlighted there was variation in service provision across these areas
- We developed a Core Offer for Mental Health with the aim of addressing this inequity in provision and improve the standardisation of services.
- Since the start of the programme we have invested c.£50m to meet growing need and start to reduce this variation, a large proportion of this has been directed towards services in Barnet, Enfield and Haringey to address historical gaps in funding.



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

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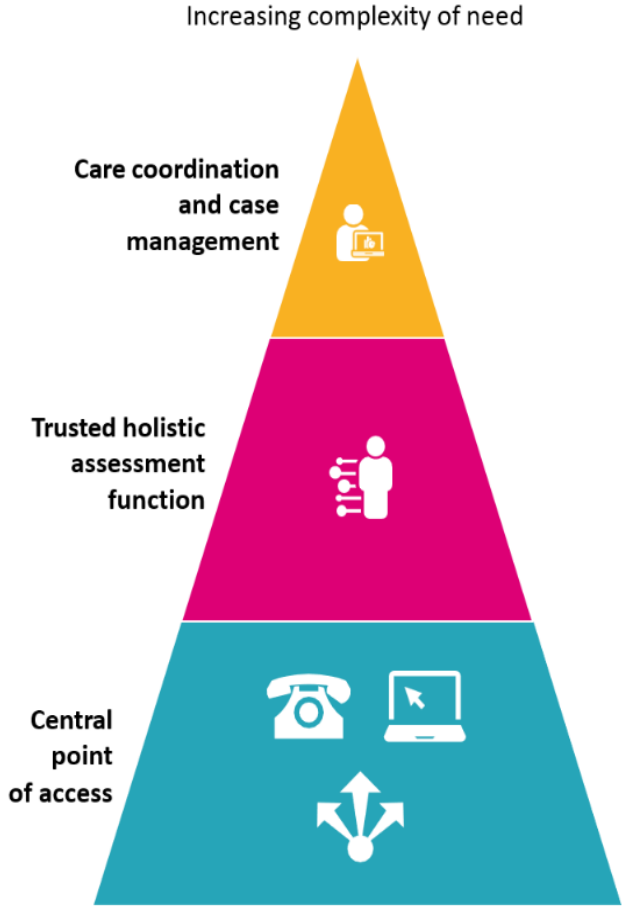
It is designed to be simple, supportive, and to make sure you get the right help when you need it

- There's a single point of contact (phone or email) to help you or someone you care for get in touch with the right mental health service quickly and easily.
- One Joined-Up Assessment – You only have to tell your story once. A senior professional will do a full assessment of your health needs, home situation, and preferences.
- Ongoing Support for Complex Needs – If you need more ongoing care, a dedicated case manager will help you create a personalised care plan and coordinate appointments and support.

The **Single Point of Access for Core Community Teams** that is in development is one such example. Further details are provided in on slide 20 of this pack.



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

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

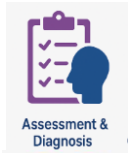
- Central point of contact at borough or NCL level for initial referrals and contacts with local community and MH health services
- Provides telephone and/or email hub which **directs referrals or queries to the right individual or service**
- Accessed by any health/care professionals, by service users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

There are a range of mental health services in NCL to support people with differing levels of need

Need	Early intervention and prevention	Mild or moderate to complex

Support available

Voluntary and community organisations, along with public health teams, offer local support that helps people stay well, spot early signs of mental health issues, and get help before things reach a crisis.



Understanding your mental health through in-depth conversations and evaluations to identify any conditions or concerns.

Creating a personalised care plan with you, including therapy, medication, and support focused on your recovery goals.

Creating a personalised care plan with you, including therapy, medication, and support focused on your recovery goals.

Helping you stay well by spotting early signs of struggle, planning ahead, and offering support after hospital stays.

Support with things like housing, employment support, money, and linking you with helpful local services.

Keeping an eye on your physical health as a way of integrating MH and physical health to reduce premature mortality

Support for people dealing with both mental health challenges and drug or alcohol use.

Listening to and supporting your family or carers, and involving them in your care when appropriate.

Support teams

- Talking Therapies
- Community mental health Core Teams
- Crisis Resolution Home Treatment Teams
- Homeless Community Mental Health Teams

Examples of conditions treated

- Common MH disorders (i.e. depression, anxiety)
- Eating disorders
- PTSD (where long-term community support is needed)

- Severe depression and anxiety Personality disorders
- Schizophrenia
- Bipolar disorder

Need

Support available

Complex to severe

By calling 111 * 2 you can speak to trained professionals who can listen, support you, and connect you with the right services. This support is available 24 hours a day, 7 days a week.

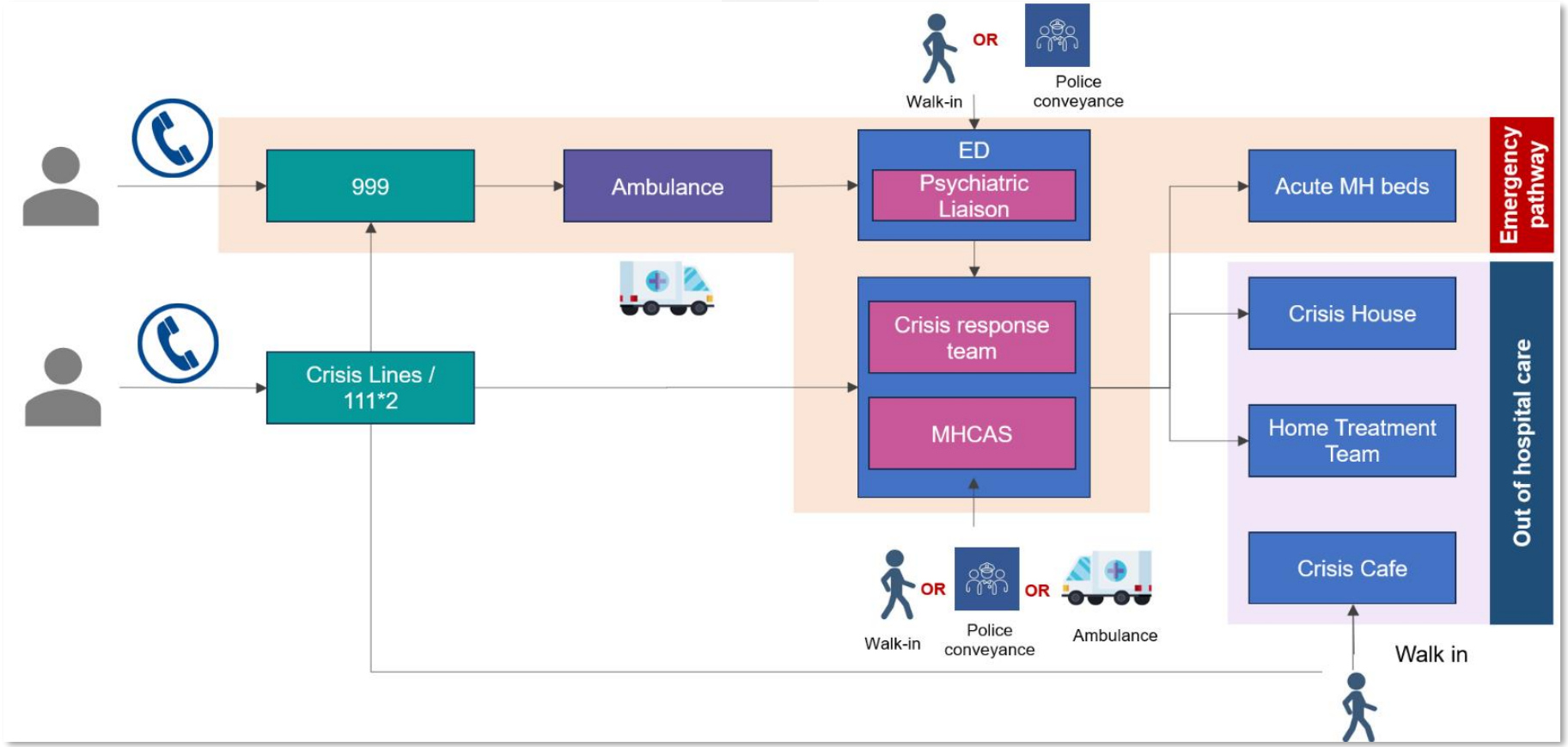
MHCAS provides emergency mental health assessments and care planning, staffed by a diverse team including support workers, peer coaches, nurses, and doctors. They handle various aspects of emergency mental health care, from GP referrals to Mental Health Act Assessment.

If you're struggling but don't need emergency hospital care, these are calm, welcoming places where you can speak to someone in person and get support. They're a great alternative to going to A&E

A safe place in the community where people can stay for up to two weeks if they're experiencing a mental health crisis or need extra support before returning home or moving into hospital care.

Some services can visit you at home to provide mental health support, helping you recover without needing to go into hospital.

Acute inpatient services provide round-the-clock care and treatment in hospital for people experiencing serious mental health crises. These services offer a safe and supportive environment to help individuals stabilise and begin their recovery.



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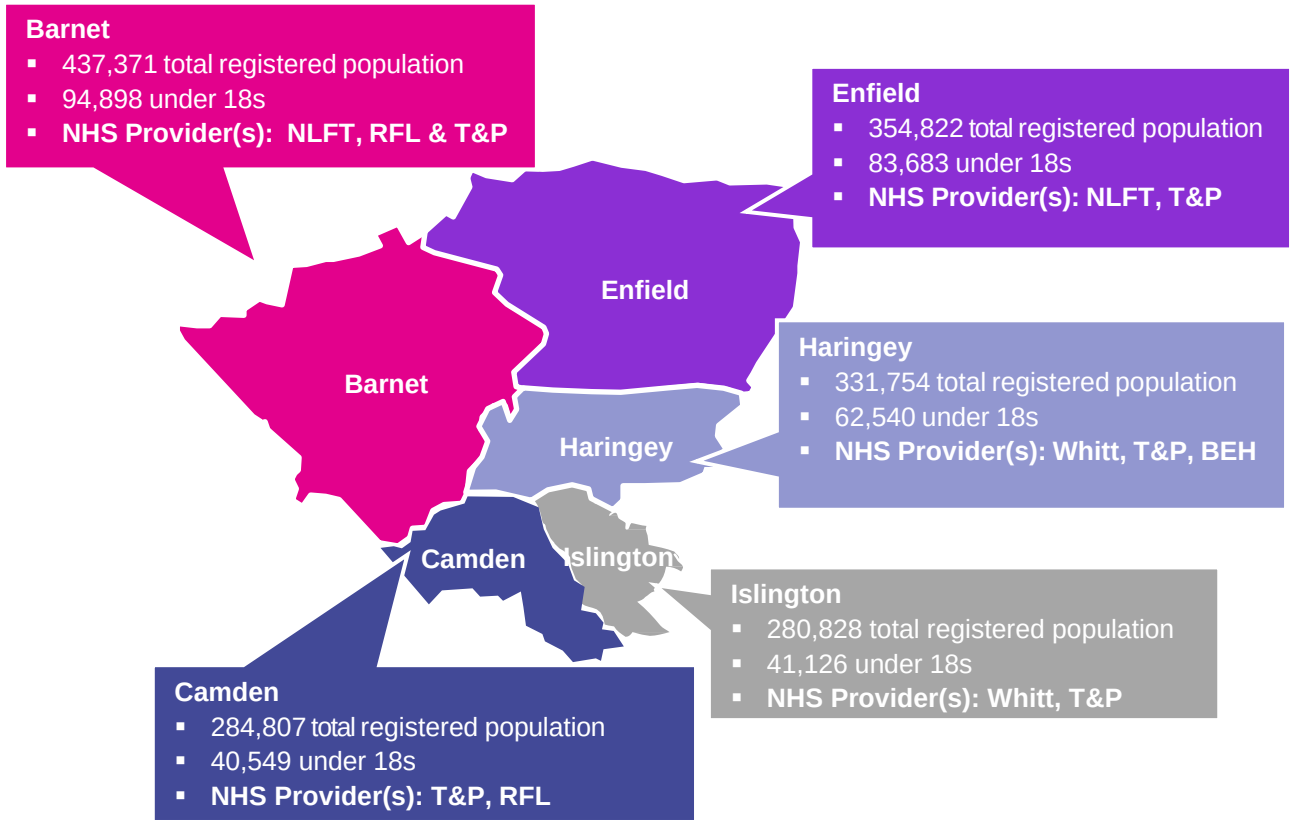
Children and young people's services (CYP)

Existing NHS CYP provider and service landscape

- North Central London (Barnet, Camden, Enfield, Haringey and Islington) has a population of approximately 1.7 million residents, of which 323,000 are under 18 years of age.
- Each borough has **multiple NHS providers and services** operating as a result of the five legacy CCGs commissioning in isolation Due to these legacy arrangements, no borough has a single provider of CAMHS.



**Child and Adolescent Mental Health Services*

Community CAMHS provision from NHS providers includes:

- Access teams and general Children and Adolescent Mental Health Services (CAMHS)
- Provision in schools, including Mental Health Support Teams (MHST) across 45% of schools and provision within Pupil Referral Units
- Services for assessment and treatment of neurodevelopmental needs, including Autism and ADHD
- Specialist provision for young adults and adolescents
- Specialist support for Looked After Children
- Provision within Youth Offending Services (YOS) and police custody
- Support for those with eating disorders
- Crisis provision
- Inpatient and outpatient support for children and young people under the care of acute providers

Transitions for young people aged 18–25

Why this matters

- Turning 18 can feel like a cliff edge for young people leaving CYP mental health services
- Without appropriate adult services, some fall through the cracks
- Continuity and developmentally appropriate support are critical
- Transitions are life-changing processes

Challenges for 18-25 yr olds

- Inconsistent service availability
- Disruption to therapeutic relationships
- Repetition of story due to poor info sharing
- Lack of tailored adult services (ASD, ADHD, emotional needs)
- Gaps for those not meeting adult mental health service thresholds ("missing middle")
- Variable planning and engagement

The NCL challenge

- Multiple children and young people's mental health providers feed into a single adult mental health provider this can lead to inconsistency
- Boroughs vary in policy, thresholds, and provision
- Some transitions are rushed and poorly coordinated
- Young people with special educational needs and disabilities (up to 25) need tailored pathways

Supporting Young People Aged 18–25 Through Transitions:

What we are doing to make the move to adult services easier

We're committed to making sure young people feel safe, supported and empowered as they move into adulthood

What we already have in place

- A clear plan to support young people moving from children's to adult mental health services, based on national guidance.
- Planning begins at age 17½ so there's time to get things right.
- Special teams focused on 18–25 year olds in both children's and adult mental health services.
- Extra help for young people with additional needs or disabilities.
- Joint planning meetings that focus on each young person's needs.
- Handovers are done gradually—with support—not suddenly or without preparation.

What's working well

- Professionals work together to create shared plans, so care is more joined up.
- 18–25 transition workers help young people stay engaged with services.
- A Youth Board helps shape training and policies—based on real experiences of young people who've been through it.

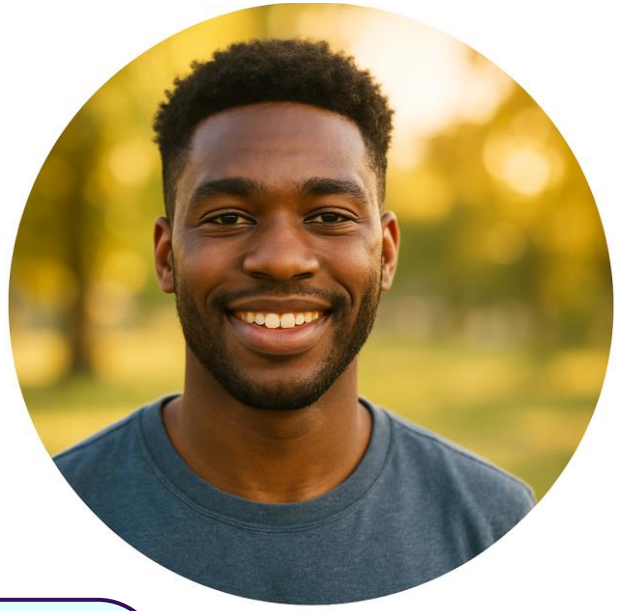
Improvements we are working on

- Getting different services to work more closely together via the CYP provider collaborative.
- Setting shared standards across all boroughs.
- Making the move into adult services smoother and more consistent.
- Coordinating services better across the whole system.

What's next

- SOON One single transition team for all five boroughs.
- SOON Training for staff that's co-designed with young people and families.
- SOON Keeping young people involved in shaping services and giving feedback.
- SOON Creating flexible, person-centred plans through the CYP collaborative
- SOON Providing clear and simple information for young people and families.
- SOON Making sure support is based on what someone needs, not just their age.

A young person's journey : Kwame



Kwame is a 17-year-old who has been supported by CAMHS (Child and Adolescent Mental Health Services) since he was 14. He has complex needs, including autism (ASC), ADHD, and has also spent time in care.

- As Kwame approached his 18th birthday, professionals became increasingly concerned about his safety and the risks he was taking.
- To help with the transition to adult services, a transitions worker joined a CAMHS meeting before he turned 18.
- This made sure that Kwame would see a familiar face in future appointments.
- A keyworker who knew Kwame and his family well was also involved and kept them informed every step of the way as his care was transferred.

About a month after his 18th birthday, Kwame was admitted to hospital after taking a serious overdose.

- During his time in hospital, his keyworker visited him every week to make sure there was continuity of care.
- The keyworker also pushed for Kwame to be given a long-term healthcare worker from the adult services team.
- They worked closely with a specialist in complex emotional needs to support Kwame in practising adapted Dialectical Behaviour Therapy (DBT) skills, which are particularly helpful for people who are neurodivergent.
- The keyworker also attended Kwame's discharge meeting and stayed in contact with him once he returned to the community.

Since then, Kwame has been doing really well. He has been living in the community without any incidents for over 12 months.

- His visits from the transitions keyworker have reduced from weekly to monthly.
- There is a plan in place for him to eventually move on from the transitions service, but he will still be able to attend the Creative Recovery Drop-in.
- Kwame is now regularly going to a DBT skills group and continues to receive support from the adult mental health team.

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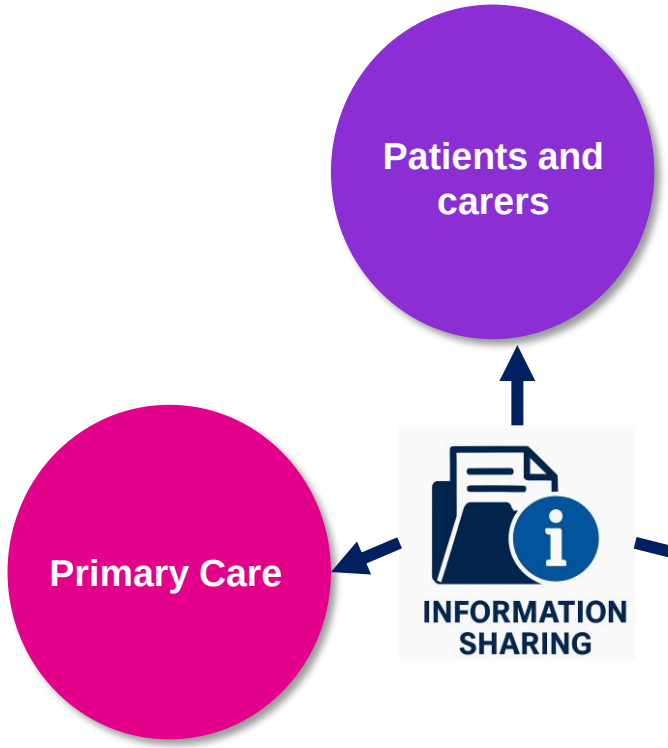
Information sharing

Effective information sharing

Good communication between services means people get better care. When professionals can easily share important information, it helps with quicker decisions, smoother care, and better health outcomes—especially when multiple services are involved



The triangle of care, developed by the Carers Trust, aims to foster collaboration in mental health care by involving carers, service users, and health professionals

GP interface meetings attended by medical director of NLFT, focused on identifying solutions that primary care face managing patients with mental health issues, improving communication and processes

Appropriate policies and procedures are in place to identify and address safeguarding concerns

DIGITAL ENABLERS

There are several initiatives in place to enable better sharing of information across organisations digitally

Making Support Better for Carers – A Simple Overview

Initiative	What it's about	Challenges	What's next
Triangle of care	**Helping carers be recognised and included right from the start.** ✓ Carers are identified early. ✓ Staff are trained to understand and support carers. ✓ Carers are introduced to the services available and included in care planning.	• Carers aren't always involved in decisions. • It can be hard to know who the carer is. • Policies don't always match what happens in real life.	Work together with carers, community groups, councils, and staff to improve and track progress.
North London NHS Foundation Trust's Carer Strategy	**Making sure carers get emotional, practical, and timely support.** ✓ Carers are supported early on. ✓ Staff are trained to work well with carers. ✓ Information is shared while still respecting privacy.	• Support isn't always offered soon enough. • Carers' voices aren't always listened to. • Services could be better signposted.	Continue co-designing improvements with carers, staff, councils, and local communities.
Working Together Across Health & Social Care	**Different services teaming up to give carers a smoother experience.** ✓ Strong partnerships across services. ✓ Better links between health and social care. ✓ Mental health services that work well for carers too.	• Some areas don't yet have formal agreements. • Staff face practical challenges working across services. • Social care teams are under pressure.	Create joint action plans with carers and local organisations to make services more joined up
Equality, Diversity & Inclusion (PCREF)*	**Making sure services are fair and accessible for everyone.** ✓ Services are designed to be inclusive. ✓ Help is available in different languages and formats. ✓ Action is taken to reduce bias and discrimination.	• Racial bias still needs tackling. • Outcomes aren't always fair for all groups.	Keep improving with the help of diverse voices—ensuring fairness is at the heart of everything.

Sharing Information Effectively: *digital enablers*

We are embedding and improving the use of digital tools to improve the way share and use information collectively across health and social care

Initiative	What it enables us to do
London Care Record (LCR)	Allows professionals across London view a person's health and care details (like test results, medications, allergies, and care plans) in one place—so everyone involved is on the same page.
GP Connect and MESH	These systems help send information directly to a person's registered GP practice automatically and securely.
Patient Knows Best (PKB)	Allows people see their own health information through the NHS app and share it with others—like a family member, carer, teacher or another healthcare professional.
NHS Wayfinder Services	It helps people and carers view appointments and referrals via their NHS app, linked with Patient Knows Best. NLFT is the first mental health trust to go live with this.
Lab Results Integration	Blood test results from labs like Health Services Laboratories and RiO can now be shared more easily between services through LCR and PKB—so nothing gets missed.

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Improvements for 2025/26 and beyond

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NFLT adult community single point of access (SPA)

An overview of the Single Point of Access

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What is the Single Point of Access?	• **Currently:** When a GP refers a patient to a mental health service the referral can be bounced between teams, delaying care by weeks • **With Community Adult SPA:** The referral will be processed efficiently through a single point of access, ensuring the referral is directed to the right service immediately.	
How will it will improve the experience for patients and staff?	**For patients:** ✓ Faster access: Quicker connections to appropriate services ✓ Less confusion: A single, clear referral pathway ✓ Improved outcomes: Timely and relevant care interventions	**For service teams:** ✓ Simplified referrals: One standard referral form ✓ Better co-ordination: No multiple handovers or hand back of referrals ✓ Quicker response times: A more streamlined process for faster decision-making
How will digital tools help make processes more efficient for patients and staff?	✓ Easier self-referrals & tracking using online tools ✓ Faster triage & response times ✓ More seamless care transitions	✓ More efficient resource allocation & productivity ✓ Data-driven improvements in care pathways ✓ Reduction in duplicate referrals
When will this be implemented?	• The plan is to establish this in Barnet by June 2025 • Lessons learned from the Barnet implementation will be incorporated into the extension of the service to the remaining five boroughs by the March 2026	

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NCL's neighbourhood model

We are working to translate and act on 2025/26 national guidance on neighbourhood health

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Core components of an effective neighbourhood services:

1. **Community-Based Care:** Shift services from hospital to community, enabling individuals to receive mental health support within their local areas, maintaining independence and reducing hospital admissions.
2. **Preventative Measures:** Implement early intervention programs that focus on preventing mental health deterioration
3. **Digital Integration:** Utilise digital tools and infrastructure to enhance care delivery

Systems are asked to build on current momentum for a neighbourhood health approach by:

- Standardising 6 core components of existing practice
- Bringing together the different components into an integrated service offer
- Scaling up
- Rigorously evaluating

With a specific focus on supporting individuals with complex health and social care needs who require support from multiple services and organisations

Core components of an effective neighbourhood services:

- Population health management
- Modern general practice
- Standardising community & mental health services
- Neighbourhood multidisciplinary teams
- Integrated intermediate care
- Urgent neighbourhood services

Evidence has identified elements critical for effective implementation of neighbourhood health:

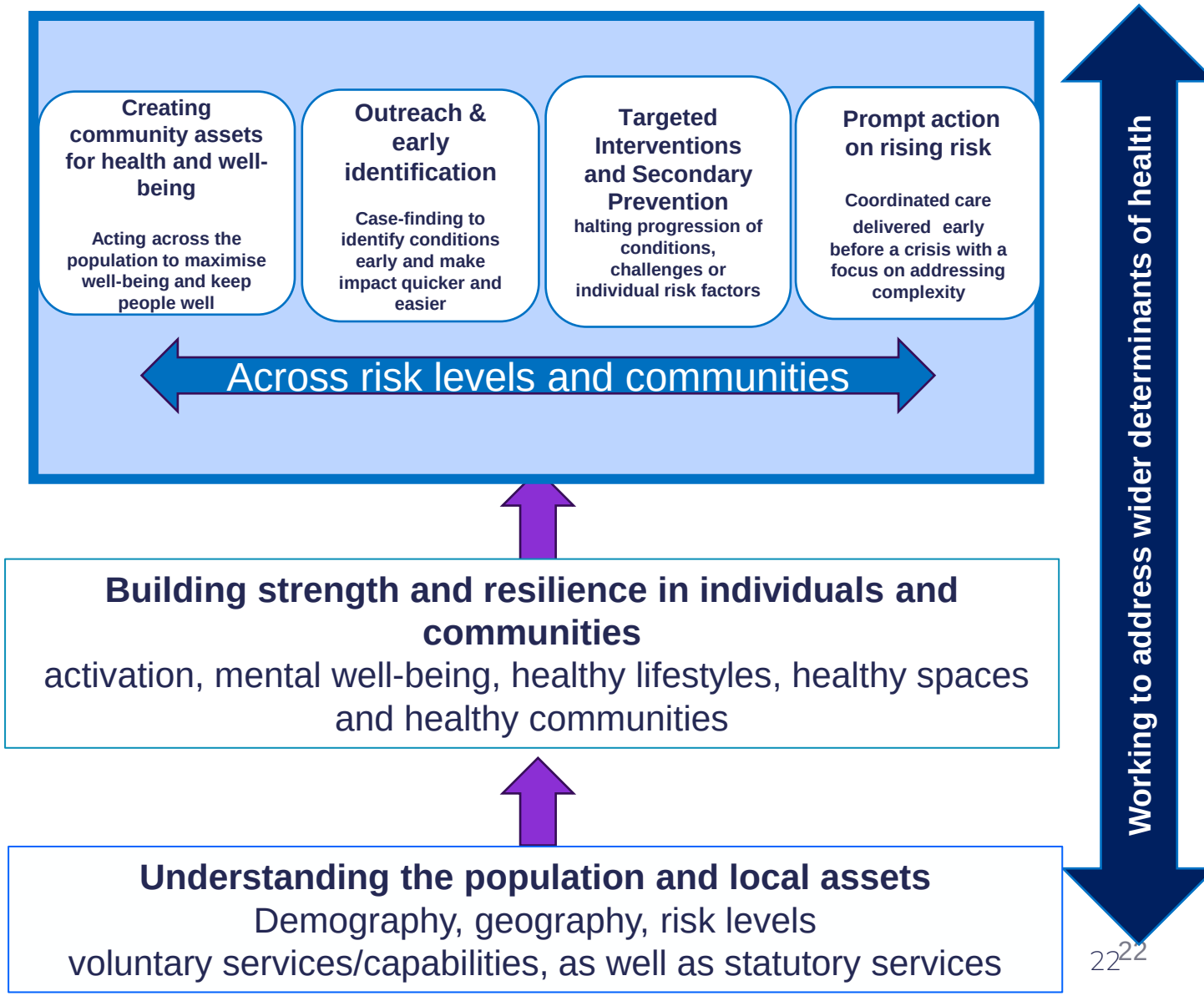
- **Mechanism for joint senior leadership** in each place
- **Collaborative high-support, high-challenge culture** supported by shared values, objectives, organisational structure and lines of accountability
- **Visible clinical and professional leadership** and management at all levels to co-develop the model
- **Effective processes and workforce development** to enable collaboration
- **Maximise shared incentives** to facilitate partnership working

Source: NHS England » Neighbourhood health guidelines 2025/26

The Vision for Neighbourhoods in NCL

What is going to be different; and how the integrated neighbourhood team is going to look and feel

- **Ring-fenced time** to focus on prevention, early intervention and proactive care – weekly at minimum – to focus on the four pillars
- **Teams that know each other and know local resources**
- A **leadership team** made up of statutory services across housing, employment, public health, community care, primary care, and nominated VCSE
- **Neighbourhood Manager** to facilitate and coordinate
- Able to deploy **range of case management/care coordination/health navigators**
- **Act as a place to problem solve**, unblock or take additional action
- **Able to connect with the Borough Partnership** to discuss gaps or strategic need
- **Links to local services** to coordinate action
- **Insightful integrated data** linked to each of the pillars which can be seen in aggregate to understand trends and at individual level to build targeted lists; risk stratified and segmented
- **Coordinated specialist input** to reduce duplication and provide streamlined support (eg geriatrician, LTC consultant)
- A growing **network of traditional sites moving toward becoming holistic, MECC-focussed neighbourhood hubs focussed on proactive care and early intervention**



What could this mean for residents accessing mental health services in NCL?

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Treating mental and physical health equally

Making care accessible and equitable for everyone, and targeted to those with the highest need

Looking after the whole person, not just their illness

Neighbourhood Working

Bringing different experts together to provide better care

Helping people with mental illness live longer, healthier lives

Making sure care is given by people with the right skills and knowledge

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Appendix

Abbreviations

NCL	North Central London
NLFT	North London Foundation Trust
T&P	Tavistock and Portman
RFL	Royal Free London
CYP	Children and Young People
SPA	Single Point of Access
MH CAS	Mental Health Crisis Assessment Services
CAMHS	Child and Adolescent Mental Health Services
DBT	Dialectical Behavioural Therapy
HCP	Health Care Practitioner
ASD	Autims Spectrum Disorder
ADHD	Attention Deficit Hyperactivity Disorder
MHST	Mental Health Support Teams in schools