NCL Community Services Strategic Review: Baseline Report

July 2021

Version history

Version	Summary of amendments	Reviewed by
First drafts	1. Updated executive summary (slides 3-5) 2. Updated deprivation analysis (slides 11, 12, 36, 69, 70) 3. Added information on projected population growth in NCL (slide 14) 4. Updated data on prevalence of SEN (slide 17) 5. Updated description relating to service provision (slide 19) 6. Included service targets into waiting times information and clarified services included (slide 24) 7. Added page on variation in provision for older people with frailty and updated chart to show older people's care home beds per 10,000 population aged 65+ (slide 25) 8. Expanded note to explain methodology of P2 modelled historic bed demand and clarified current capacity bed numbers (slide 26) 9. Added note to be clear that variation in acute length of stay in patients from different boroughs at the same hospital site can be due to multiple factors as well as step-down processes (slide 34) 10. Added note to be clear that completion of diabetic care processes is linked to primary care capacity but recognising the interdependencies with community health services (slide 39) 11. Outcomes of community health services - caveated that there is other investment that is not captured here because our scope is only community services (slides 40-41) 12. Clarified throughout where prevalence is based on diagnosed GP practice registered list size, and where weighted populations are standardised for age 13. Updated service mapping (slides 52-54)	Community services review baseline workshop (15/04/2021) Steering group (12/05/2021) Fortnightly NCL Community Providers Meeting (19/05/2021) Community Services Strategic Review Programme Board (28/05/2021)
This version (30/06/2021)	Final draft for approval by Programme Board	Community Services Strategic Review Programme Board (07/07/2021)

Contents

Executive summary (1/3)

Introduction

Before the formation of the NCL CCG, services were commissioned by each of the 5 legacy CCGs in isolation, leading to **substantial variation in the way services are commissioned and delivered across NCL**. This disparity is closely related to different levels of **historic funding** within the CCGs. The NCL Community Services Strategic Review seeks to create a **sustainable and affordable community model** across NCL that **addresses inequalities, spreads good practice** and **improves outcomes** for residents.

Community services would ideally be the **glue across our system** that help patients **stay well and support them to recover**. The review brings together **stakeholders from community services, primary care, acute care, social care and mental health services** to develop the interfaces and collaborative working across pathways. A **review of mental health services** is running in parallel, with integrated workstreams.

The review comprises four elements: understanding the **current baseline**, co-development of an **outcomes framework and KPI dashboard**, co-development of a **'core offer' for community health services** and co-development of a **transition plan**. Subsequently, further work will take place to deliver transformation over the short to medium term.

Purpose of this report

This report contains the **findings of the baseline review** of community health services across NCL and concludes the first stage of the NCL Community Services Strategic Review. The picture of community health service provision in NCL is extremely complex and this report is not an exhaustive review of every community health service. The purpose of this report is to highlight the **key themes in the case for change** and **align stakeholders on the key issues** we need to tackle as a system as we commission and deliver community health services in the future. The content of this report focuses on NHS commissioned community health services, although recognising crucial interdependencies with primary care, acute care, mental health services and social care services. The analysis reflects the status of the community health services in NCL at a point in time, based on the information available for this review.

Executive summary (2/3)

Case for change

Developing the case for change has involved analysis and synthesis of three sources of information: themes from **1:1 interviews** with NCL stakeholders, outputs of an **online survey** conducted with wider stakeholders and **analysis of national and local data**. Stakeholders have **aligned around the case for change to redesign community health services** reflecting there is a clear need to **tackle health inequalities**, **optimise use of resources** and develop **system working**. There are four main conclusions from the baseline analysis which inform the case for change:

1. There is significant **demographic variation** across and within NCL boroughs which is associated with **different levels of need** for support from community health services.
   - *Barnet and Enfield have higher % of both children and older residents*
   - *Haringey and Islington overall are most deprived, yet Enfield and Haringey have the highest % of LSOAs in the two most deprived deciles*
   - *Age and deprivation are key factors affecting health and likelihood of developing long-term conditions*
2. However, **service provision and investment do not correspond to the level of need**, with **disparity between service offer and resource**. For example:
   - *Waiting times for children's therapy assessments are between 5-7 times as long in Barnet as Camden*
   - *Enfield has over twice the prevalence of diabetes as Camden yet the community diabetes resource is less than half the size*
   - *Barnet has 3 times as many care home beds per 65+ population as Haringey. However, Barnet also has the lowest coverage of care home in-reach*
3. This disparity appears **related to levels of historic and current funding**.
   - *Camden spends 1.2 times as much on community health services per weighted head of population compared to Enfield*
   - *Increased investment in community services does appear to contribute to overall system performance, associated with lower A&E attendances, fewer avoidable admissions and shorter non-elective acute length of stay in Camden and Islington*
   - *In boroughs with lower levels of community spend, survey respondents felt patients were less likely to be effectively supported*
4. Disparity in service offer and the gap between provision and need leads to **inequity in outcomes**; however, higher investment alone does not deliver better outcomes.
   - *Enfield has the lowest % of diabetics receiving the 8 care processes or attending structured education. However Enfield, has lower rates of admissions for hypo- and hyper-glycaemia*

Executive summary (3/3)

Vision for community health services

Stakeholders from across NCL have initially reflected how the 'core offer' should address the case for change. The 'core offer' itself must be **equitable** and **based on best practice and innovation** from within and outside NCL, with **standardisation of access and offer for population groups with the same needs**, and achievement of **nationally mandated targets and standards**. This should deliver **patient satisfaction**, improved **outcomes**, improved **ways of working together** and **sustainable targets from national service models**.

An objective of the review is the provision of community health services that **optimise the delivery of care across the system** linking with NHS Primary, Secondary, Tertiary services and Local Authority and Voluntary & Charitable Sector partners and services. The core offer will aim to **support NCL residents to live healthier, independent and high quality lives** within their communities. The offer will also **focus more on prevention and early intervention** to enable people to live independently and in good health for as long as possible.

Next steps

The findings of this baseline report will inform the subsequent stages of the NCL Community Services Strategic Review to design a **new 'core offer'** for community health services. The aim of the review is to have a **consistent and equitable core offer** for our population that is delivered at a neighborhood/PCN level based on identified local needs and that is fully integrated into the wider health and care system ensuring outcomes are optimised as well as ensuring our services are sustainable in line with our financial strategy and workforce plans.

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

The design of the 'core offer' will be informed by the **key themes from this baseline report** and **vision for community health services,** as well as by development of understanding of **nationally mandated requirements** for services, of **best practice** examples from within and outside NCL, of **design principles** and of an agreed, shared **outcomes framework**.

Contents

Background and context for the NCL Community Services Review

- Before the formation of the NCL CCG, services were commissioned by each of the 5 legacy CCGs in isolation, leading to substantial variation in the way services are commissioned and delivered across NCL. This review presents an opportunity to work together to address inequalities, spread good practice and continue improving outcomes for NCL residents.
- An initial review was undertaken in 2020 and identified variance in service specifications, thresholds for treatment and differences in reporting. This inevitably leads to different outcomes for NCL residents.
- This current review needs to enable us to create a sustainable community model that improves outcomes, addresses inequalities and inequities and also drives better value from current spend on community services (£270m a year across NCL).
- Community services should be the glue in the system that helps people to stay well and supports them to recover. In terms of our residents, community services should be at the heart of our neighbourhood teams.
- A review of mental health services is being run in parallel to this work, with integrated workstreams in place between the two reviews.
- We are at the start of an iterative process and seek to encourage conversations and thinking.
- It is really important that this review is not done in isolation from what is happening in primary care, acute care, mental health and social care – the interfaces and collaborative working across pathways are key.

In scope:

- NHS funded Community Services (Adult and CYP services delivered outside hospital not as part of an acute spell) delivered by:
  - NHS Community Providers
  - NHS Acute Providers
  - Private / other Providers (eg. VCS)
  - Primary Care (services that are not part of a Primary Care Core Contract, LCS/DES or similar)

Out of scope:

- Continuing Health Care
- Care Providers / Care Homes
- NHS Acute Services
- Primary Care contracts incl. GMS/PMS and APMS/LCS/LIS/DES programmes
- Homelessness
- Local Authority Commissioned Services with the NHS (except where joint funded)
- Local Authority 0-19 Services

Although these services are out of scope, it is important that the review recognises the overlap and integration between community and mental health, primary care and social care provision. A number of residents have complex co-morbidities that include physical, mental health and other needs, such as substance misuse.

The baseline report brings together qualitative and quantitative analysis from three sources to develop the case for change; findings were tested with NCL stakeholders

Data sources

1

1:1 and group interviews

We explored the case for change, future desired outcomes and opportunities with stakeholders from Community and Acute providers, Primary Care, Local Authorities and the CCG

Organisation	Interviewees
Primary care	4
Community provider	12
Local authority	21
Acute provider	7
Commissioner	10
Other	2
Total interviewees	**56**

2

Survey

We conducted an online survey of wider stakeholders, exploring perceptions of current service provision across NCL, outcomes and the case for change.

Organisation	Responses
Primary care	63
Community provider	91
Local authority	39
Acute provider	14
Commissioner	42
Other	14
Total respondents	**228**
(respondents can work across multiple organisations)	

3

Data analysis

We have conducted analysis of local and national data focused on:

- Understanding population demographics and health needs
- Levels of community health activity and capacity, including mapping of available service provision
- Variation in financial investment
- Levels of acute activity

Findings from the analysis and the resulting case for change have been tested in line with the programme governance:

- Community Operational Group
- Finance Group
- Steering Group
- Programme Board
- Further stakeholders from across NCL at the Baselining Workshop on 15 April 2021

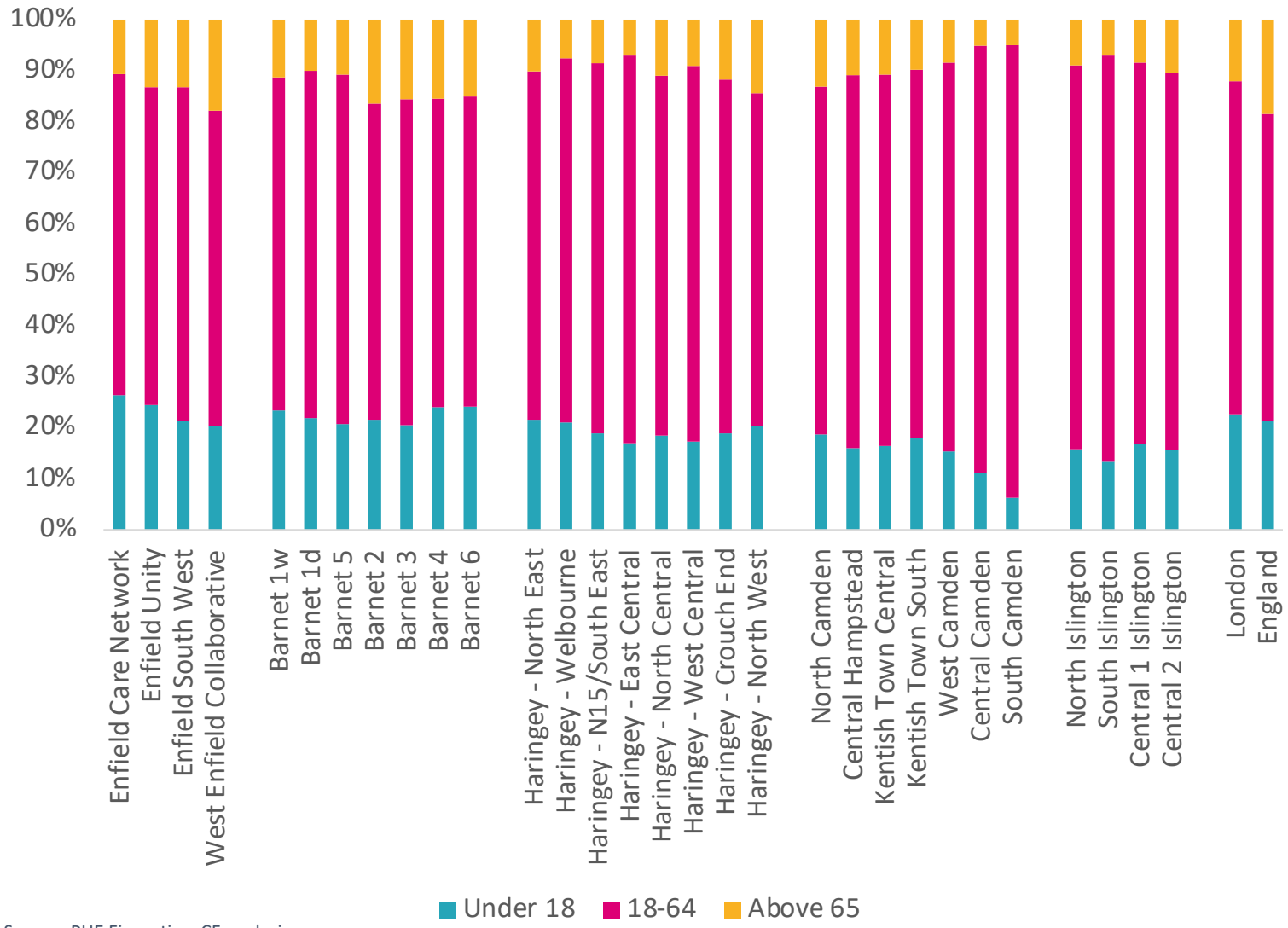
In accordance with programme governance, this report has been signed off by the:

- Steering Group (12 May)
- Programme Board (28 May)

Contents

Age profile varies across NCL boroughs and between PCNs; Barnet and Enfield have a higher proportion of both children and older residents, compared to other boroughs

Proportion of PCN* population by age group, 2020



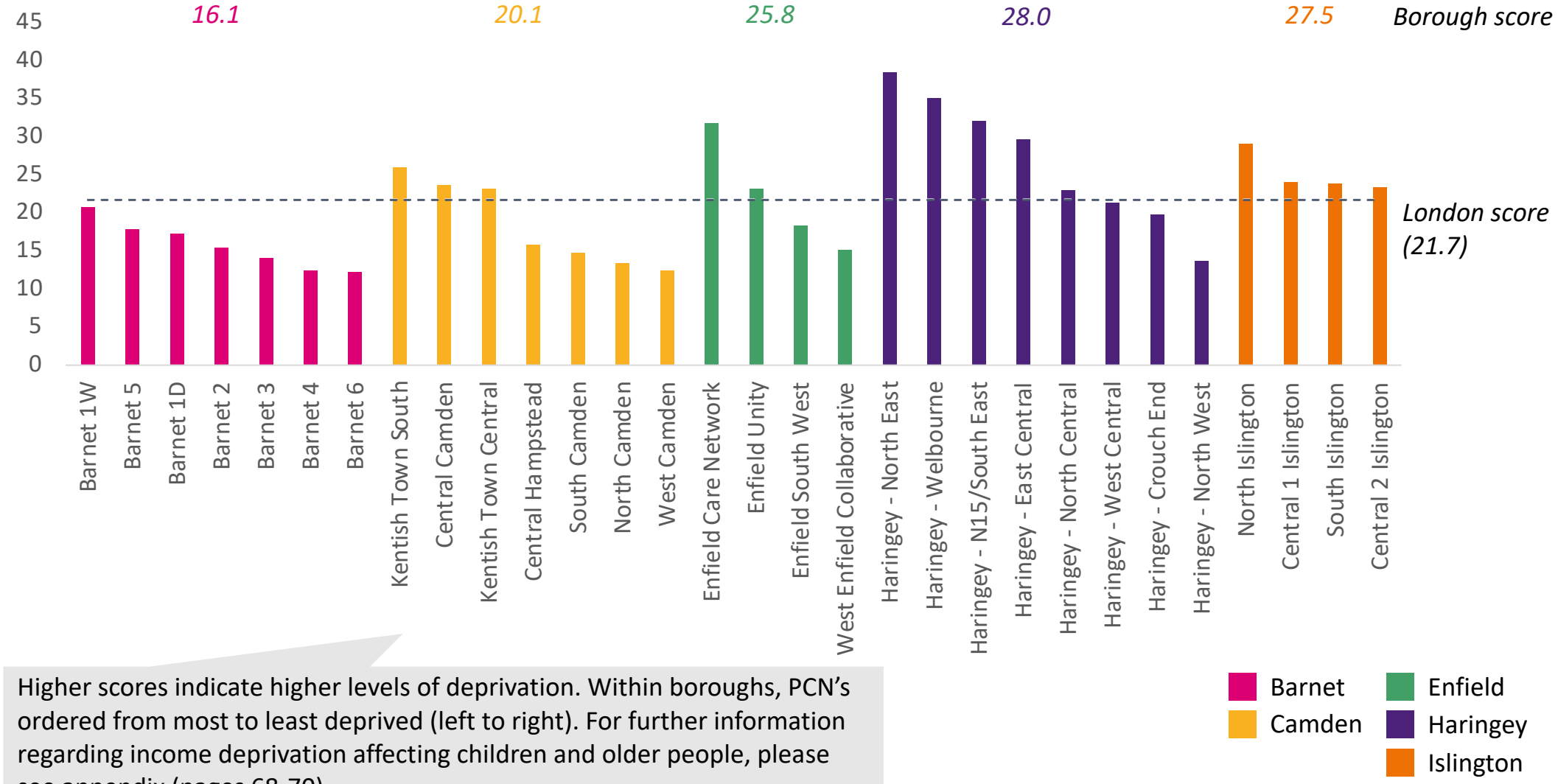
Source: PHE Fingertips, CF analysis

Area	<18	18-64	65+
Barnet	22%	64%	14%
Camden	15%	76%	9%
Enfield	23%	63%	14%
Haringey	19%	71%	10%
Islington	15%	76%	9%
NCL total	19%	70%	11%
London	23%	65%	12%
England	21%	60%	19%

*See appendix slide 60 and following for maps showing PCN locations. Note that analysis contained within this document reflects current configuration of PCN's at time of development.

Across NCL there are high levels of deprivation although there is significant variation across and within boroughs

Weighted deprivation score of NCL PCNs, 2019

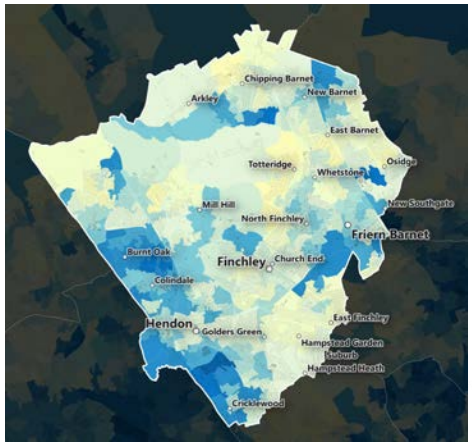


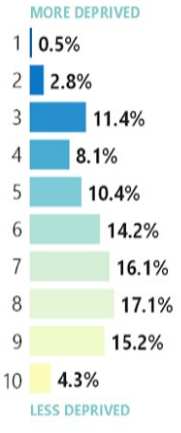
Higher scores indicate higher levels of deprivation. Within boroughs, PCN's ordered from most to least deprived (left to right). For further information regarding income deprivation affecting children and older people, please see appendix (pages 68-70).

Source: Index of Multiple Deprivation (IMD), England, 2019 (ONS). PCN mapping based on 2019 groupings

At LSOA level, we see a more detailed picture of variation within boroughs; Enfield and Haringey have the highest % of LSOAs in the 2 most deprived deciles (30% and 33%)

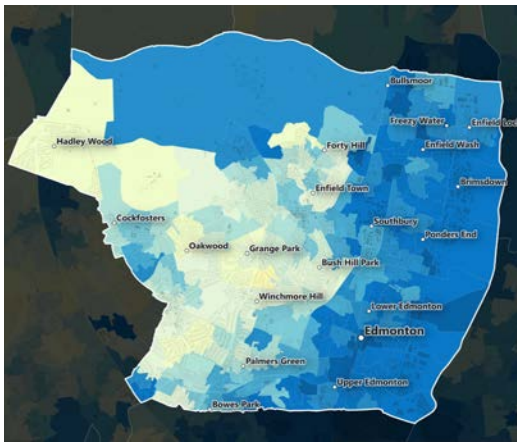
Barnet

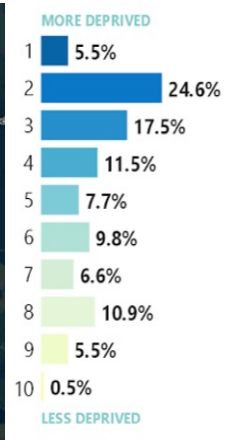




41,943 people living in 3 most deprived deciles

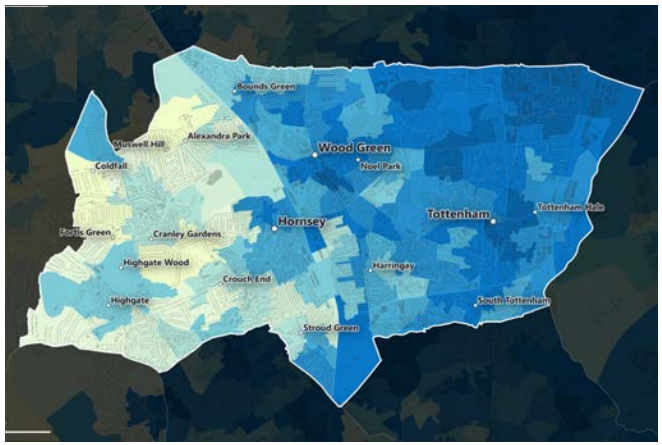
Enfield

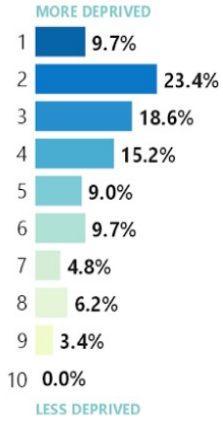




181,221 people living in 3 most deprived deciles

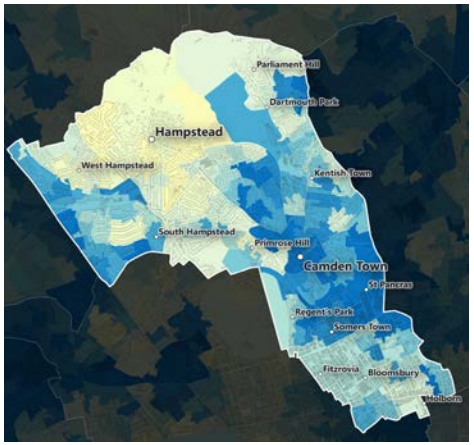
Haringey

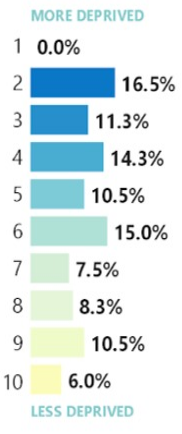




131,850 people living in 3 most deprived deciles

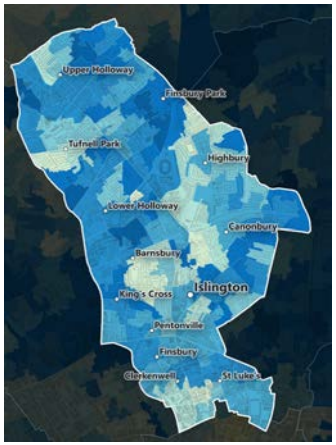
Camden

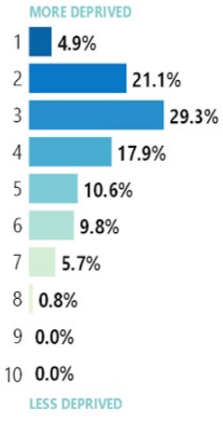




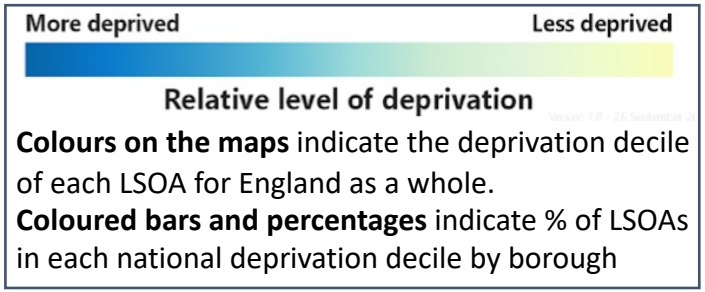
64,898 people living in 3 most deprived deciles

Islington





110,160 people living in 3 most deprived deciles

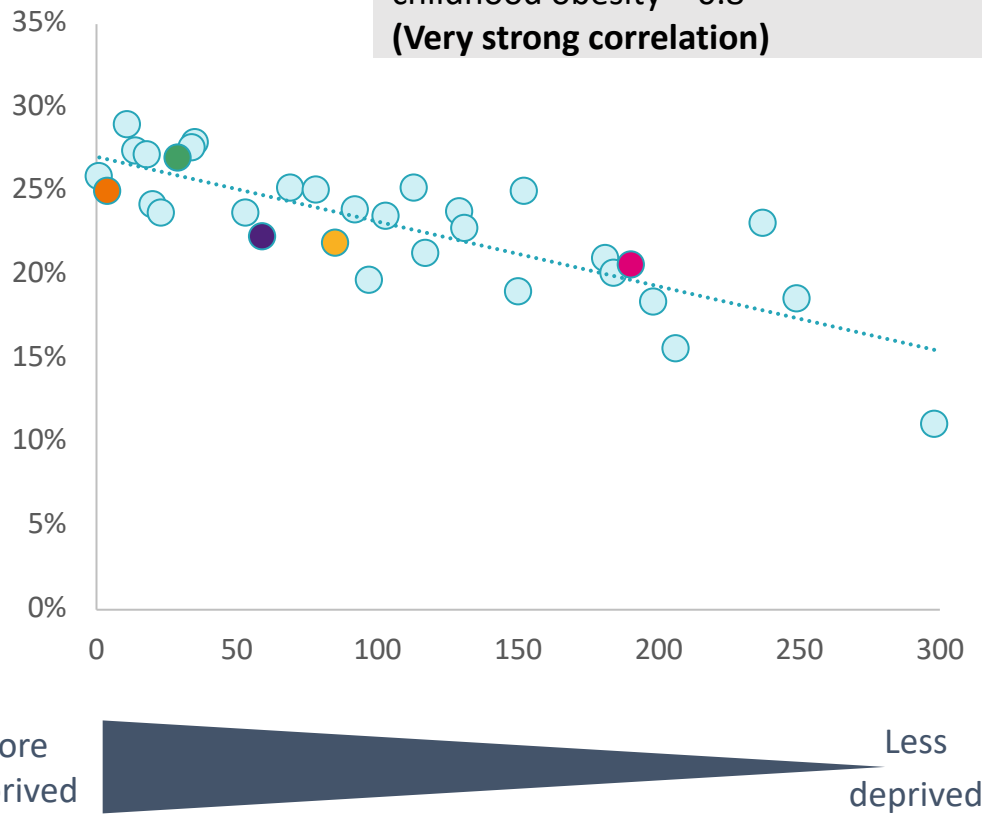


Source: https://imd2019.group.shef.ac.uk

Boroughs with higher levels of deprivation have higher rates of childhood obesity and a higher proportion of pupils requiring support for special educational needs

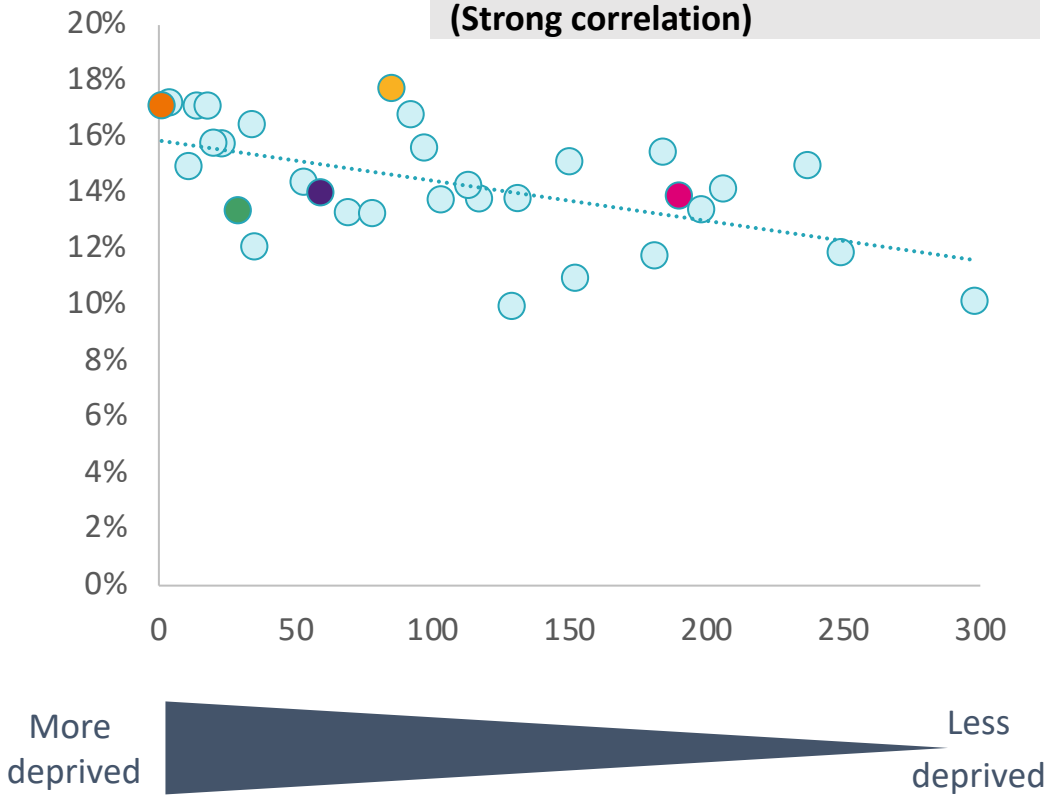
Percentage of children in Year 6 with childhood obesity, London boroughs 2019/20, against national **Income Deprivation Affecting Children rank***, 2019 (London boroughs)

Correlation between deprivation and childhood obesity = 0.8
(Very strong correlation)



Percentage of primary school pupils with special educational needs (SEN) support by borough, against national **Income Deprivation Affecting Children rank***, 2019 (London boroughs)

Correlation between deprivation and % of pupils with SEN support = 0.6
(Strong correlation)

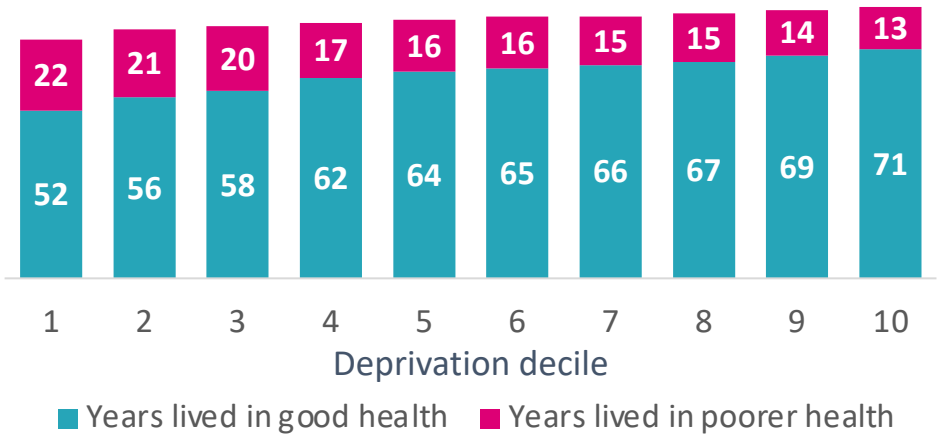


*Rank of average rank
Source: NHS Outcomes Framework, IMD 2019, Department for education 2020, CF analysis

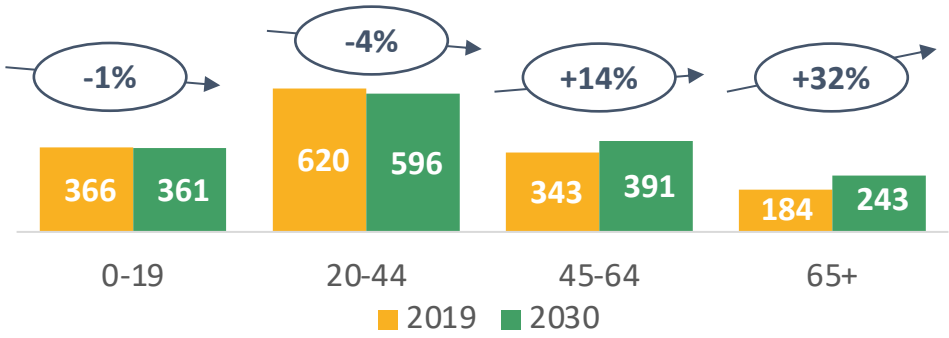
Deprivation is linked with increased prevalence of long-term health conditions and with lower life expectancy

- ONS analysis has shown that those living in more deprived areas overall have a shorter life expectancy compared to those living in less deprived areas
- People living in more deprived areas tended to have the lowest proportion of years of life lived in good health
- Research has shown that more deprived groups are likely to have higher prevalence of long-term conditions, with increased severity of disease
- Research has shown that people in the most deprived areas develop long-term conditions approximately at least 10 years earlier than people living in less deprived areas and they were more likely to develop multiple long-term conditions
- The population in NCL is projected to grow overall by 5% from 2019 to 2030. This growth is driven by the 65+ age group, with this population projected to grow overall by 32% (max. 39% in Camden; min. 27% in Enfield). A growing aging population has implications for NCL health and care services; more people are likely to have needs from services, and may be living for longer, although spending more years in poorer health.

Life expectancy and healthy life expectancy in England, by deprivation decile, 2017-19 (males)



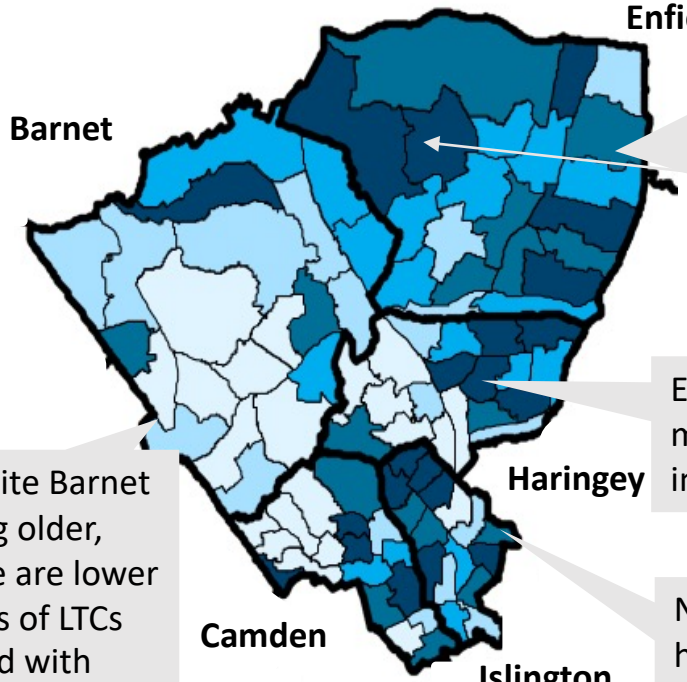
NCL population growth, 2019 to 2030, population projected by age band, 1000s, NCL total



Source: ONS, https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/2017to2019, https://www.kingsfund.org.uk/publications/what-are-health-inequalities#long, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60240-2/fulltext

Prevalence of long-term conditions is associated with age, as well as with deprivation

Proportion of ward patients who report having a long-term illness or disability



East Enfield has high levels of deprivation. The west of the borough has higher % of older residents

East Haringey is the most deprived area in the borough

North Islington has high levels of deprivation

Despite Barnet being older, there are lower levels of LTCs linked with lower levels of deprivation

Colour scale:

Lower proportion reporting long-term illness or disability

Higher proportion reporting long-term illness or disability

Source; NCL Locality profile reports based on ONS 2011 census

Prevalence of diabetes, in select PCNs compared to levels of deprivation and over 65 populations, 2019

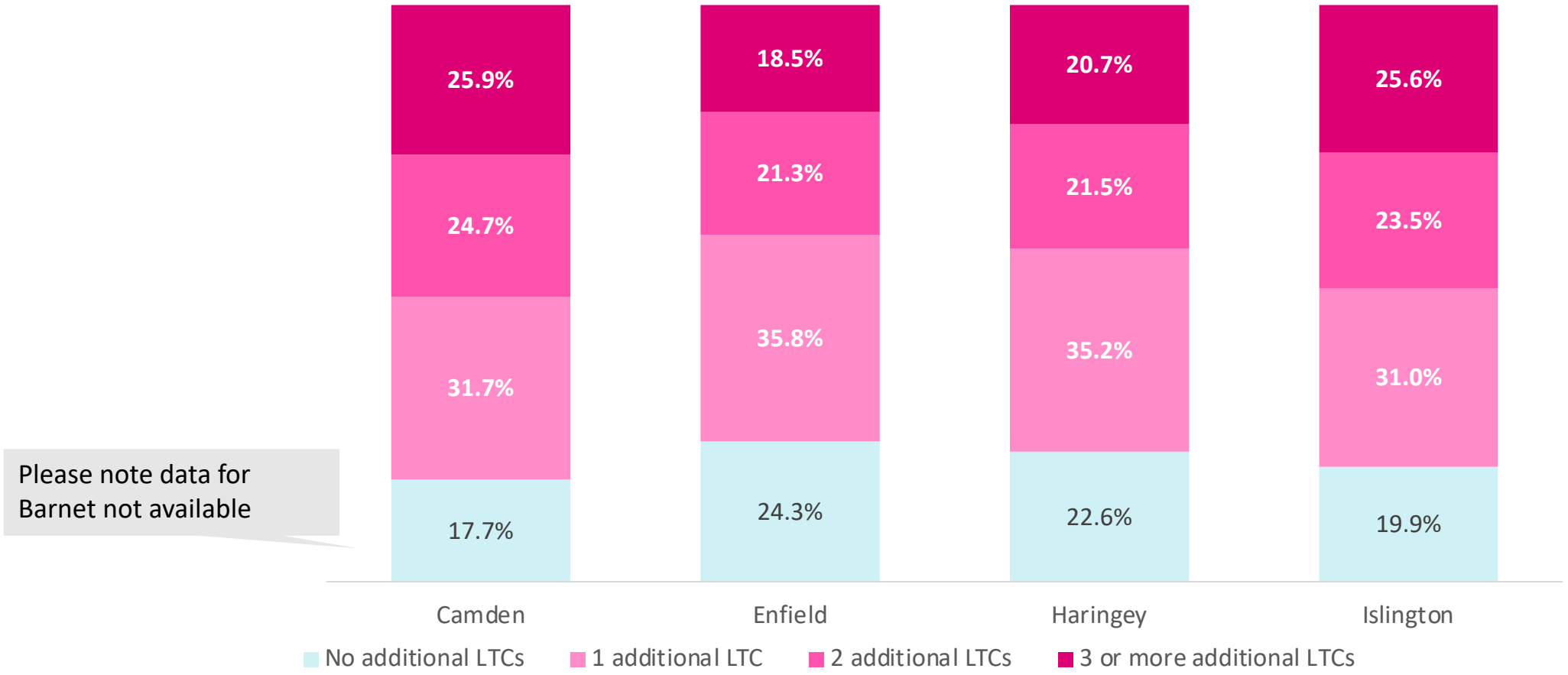
Diabetes prevalence is the % of GP practice registered patients who have a diabetes diagnosis. Prevalence not adjusted for age.

PCN	Prevalence diabetes (%)	Over 65 population (%)	Deprivation score (weighted)
Enfield Unity	12.2%	13.2%	26.5
Enfield Care Network	9.3%	10.7%	32.8
Haringey NE	9.1%	10.1%	38.5
Barnet 1W	8.3%	11.3%	23.7
Haringey N15	7.8%	8.0%	37.2
Barnet 2	6.8%	16.0%	15.5
West Camden	3.9%	8.0%	12.4
South Camden	2.3%	5.0%	22.3

Diabetes here is used an illustrative example of how prevalence of an LTC can be linked to age and deprivation.

Over 70% of patients diagnosed with diabetes are also comorbid with other long-term conditions

Proportion of patients diagnosed with diabetes comorbid with other long term conditions (LTCs), 2020, Patients aged 17+, NCL boroughs (excluding Barnet).



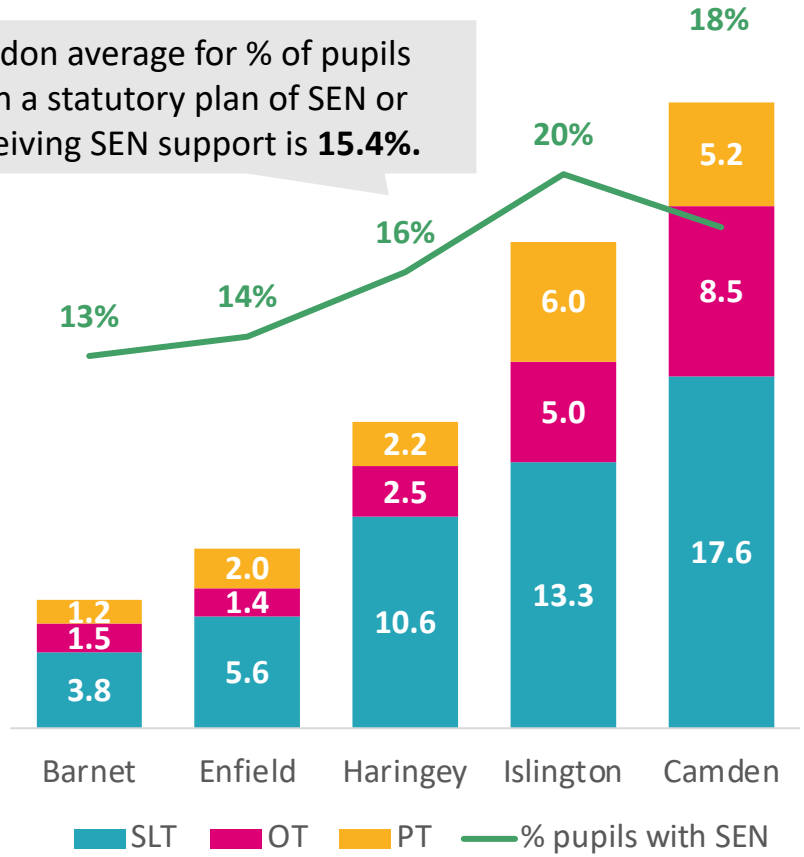
Please note data for Barnet not available

Source: NEL Specialist Business Intelligence, Patients comorbid with diabetes and Long Term Conditions (LTCs)

There is significant variation in children's therapy resource across NCL; Barnet has the lowest levels of resource and the longest waiting times for initial assessments

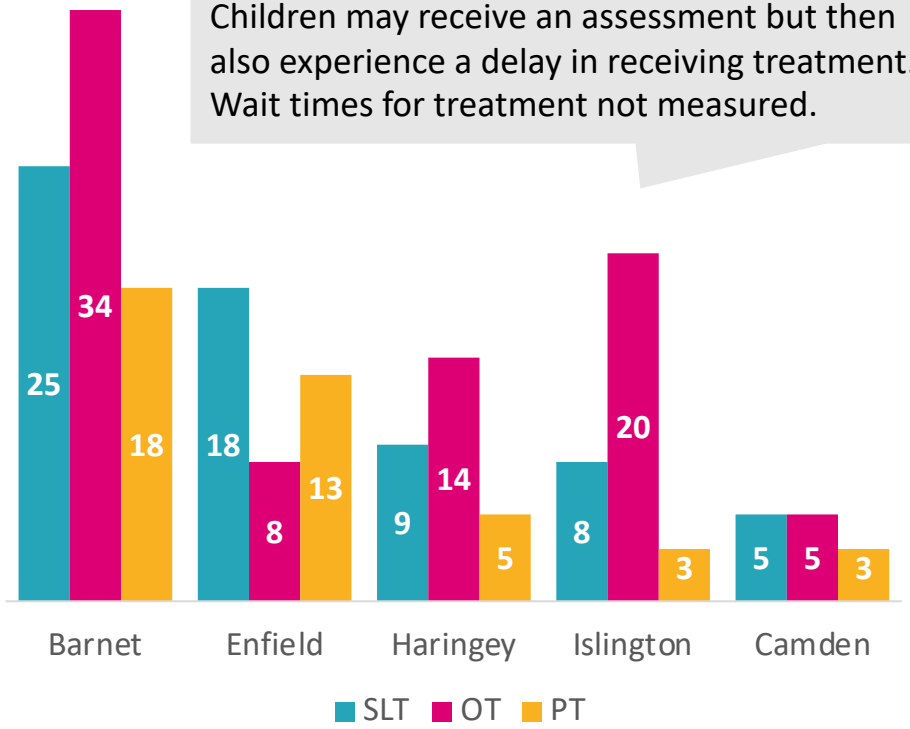
FTE for children's therapies services, FTE per 10,000 school age pupils, 2020/21, **% of pupils with a statutory plan of SEN or receiving SEN support**, 2019/20 academic year

London average for % of pupils with a statutory plan of SEN or receiving SEN support is **15.4%.**



Average wait for initial assessment, weeks, as of end of March 2021

Average waiting time to initial assessment is not necessarily the full picture of waiting times. Children may receive an assessment but then also experience a delay in receiving treatment. Wait times for treatment not measured.



Note: detailed work is in progress by NCL CCG on the variation in service offer and provision of children's therapies services across boroughs.

Source: NCL CCG Therapy services for CYP Current position, https://lginform.local.gov.uk/reports/view/send-research/local-area-send-report?mod-area=E09000003&mod-group=AllBoroughInRegion_London&mod-type=namedComparisonGroup#LA%20SEND Note: SLT (Speech and Language Therapy), OT (Occupational Therapy), PT (Physio Therapy)

There is variation in resource for children's community nursing (CCN) services; service offer and hours of operation are inconsistent, with Islington having an increased offer

Children's Community Nursing, FTE per 10,000 population aged 0-18, 2020

Note: detailed work is currently in progress by NCL CCG on the variation in service offer and provision of children's community nursing services

Source: NCL CCG, NHSD GP practice populations

Borough	Offer	CCN Hours
Barnet	• Barnet CCN provides generic nursing service • Hospital-based Epilepsy and Diabetes CNS and enuresis nurse • CCN works with GOSH and RFH to deliver palliative care • CLCH provide special school nursing and Integrated Specialist Children's Nursing Service for CYP with complex health needs	Mon-Fri 8am-6pm Sat-Sun 9am-5pm
Camden	• RFH CCN Team provides generic nursing service, palliative care (Life Force) and special school nursing • Continuing care is provided by the Islington CCN team • Community CNS's for Atopy and Epilepsy • Hospital based Diabetes CNS who does community work	Mon-Fri 8am-6pm Sat 9am-4pm
Enfield	• Enfield CCN provides generic nursing service • Asthma, Epilepsy and Enuresis CNS's • Enfield CCN provides palliative care	Mon-Fri 8am-6pm Sat-Sun 9am-5pm
Haringey	• NMUH CCN Team • Hospital CNS's for Atopy, Diabetes, HIV, Sickle Cell and Epilepsy • CCN provide palliative care (Life Force)	Mon-Sun 9am-5pm
Islington	• Islington CCN provides generic nursing service and sees children with long-term conditions; continuing care for children with complex needs and palliative care (Life Force) • Community CNS's for Atopy, Epilepsy • Hospital CNS's for Atopy, Diabetes, Haemoglobinopathy • Hospital @ home service treats higher acuity patients • Paediatric primary care nurse clinics for asthma, viral induced wheeze, constipation and eczema	Mon-Sun 8am-6pm Hospital @ Home 7 days 8am-10pm

Commissioners report that adults in Enfield, Haringey and Barnet with LTCs have access to less comprehensive community health services than elsewhere

District nursing	All boroughs have district nursing provision, but there is variation in terms of scope and resource.	District nursing provision in **Enfield** is scaled back in comparison to other boroughs, in terms of staff numbers and skill mix.	Variation in how criteria for 'housebound' patients are implemented between boroughs.	Variation in levels of integration with GP practices, as well as variation in overnight nursing and cross-border provision.
Rapid response	The enhanced virtual ward offer in **Islington** and **Haringey** is unique in NCL. It bridges the gap between ambulatory care and rapid response.	The services operate consistently 7 days per week at least 8am-8pm, but there is variation in when last referrals are accepted ranging from last referrals received at 8pm to referrals accepted 24/7.	There is a need to ensure that pathways are consistent and enable staff to operate at the top of their license to maximise support for people at home.	
Long Term Conditions	**Enfield** has gaps in Long term condition teams and provision for structured education in heart failure, diabetes and respiratory.	There is a gap for community pain management services in **Haringey**.	There is limited structured education for patients in **Enfield** and **Barnet**. The Whittington's expert patient programme is not replicated elsewhere.	
Neuro-rehab and Stroke rehab	Pressure for neuro-rehab beds across NCL.	Neuro-Rehab Centre and St. Pancras beds now an NCL-wide offer.	Different non bedded offers. Camden, Haringey and Islington: integrated stroke and neuro community teams. Barnet: CLCH stroke services and RFH community neuro-rehab, Enfield: Community Stroke and general physio teams, some private neuro-rehab	Islington and Enfield do not have community MS nurses.
Tissue viability	There is a gap for leg ulcer care for ambulatory patients in **Haringey**. Additionally, tissue viability **Home visits** are not offered in Haringey.	The tissue viability service in **Barnet** is more specialist than the service in other boroughs. There is a gap for patients in Barnet who require less specialist care.	In **Enfield** district nurses doing more routine wound care. The specialist service is fragile. In **Islington and Haringey,** leg ulcer clinics are delivered by district nursing.	

The following slides provide a number of illustrative examples to show how provision for community health services varies across NCL, and how this provision does not align to need.

Source: Service mapping developed based on review of service specifications and review of service mapping with borough commissioning leads, NCL CCG Neuro-rehab pathway demand and capacity April 2021

Further service mapping in appendix (pg 54-56).

The next five pages show a few illustrative examples of how adult community health service provision varies across NCL and does not align to need

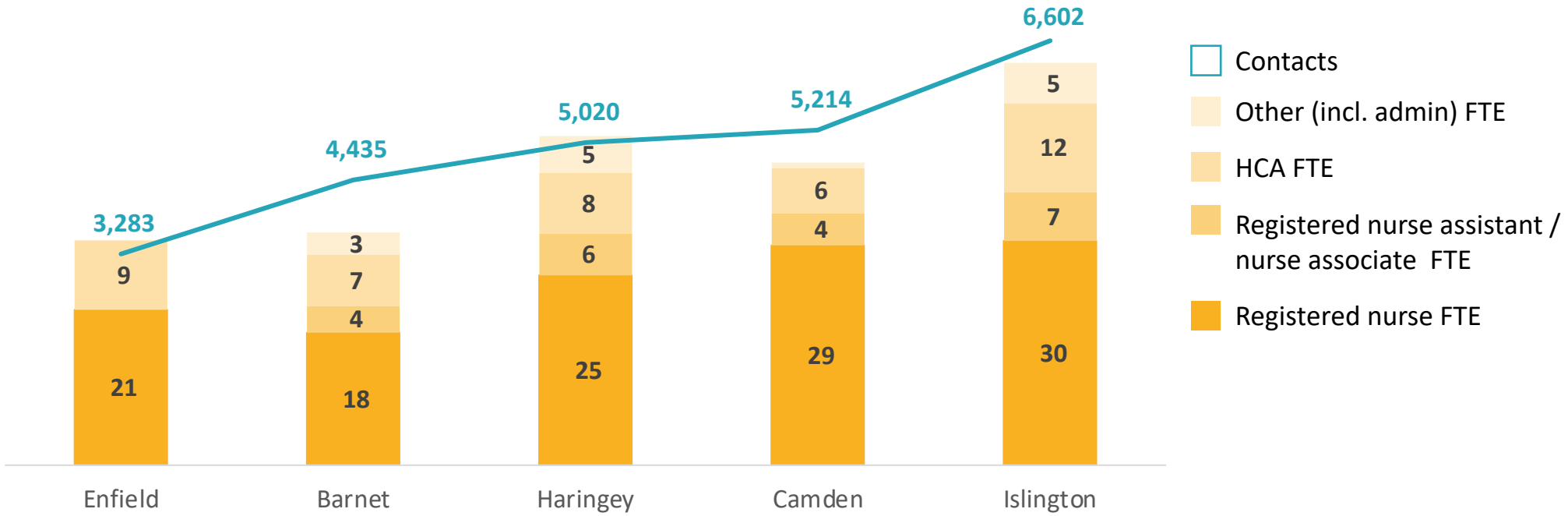
The examples relate to the following services:

- District nursing
- Community respiratory teams
- Community diabetes teams
- Older people and frailty

There is disparity between rates of district nursing resource and activity across NCL; Enfield has the lowest rate of district nursing activity

Average district nursing service contacts per month by borough, **average district nursing FTE,** per 100,000 community weighted population, 2019-20

There is a link between rates of district nursing contacts and community spend: Higher community health investment and higher activity in Islington and Camden, compared to lower investment and activity in Enfield. There is a need to ensure there are consistent pathways to maximise support at home. All services operate 24/7, Monday-Sunday.

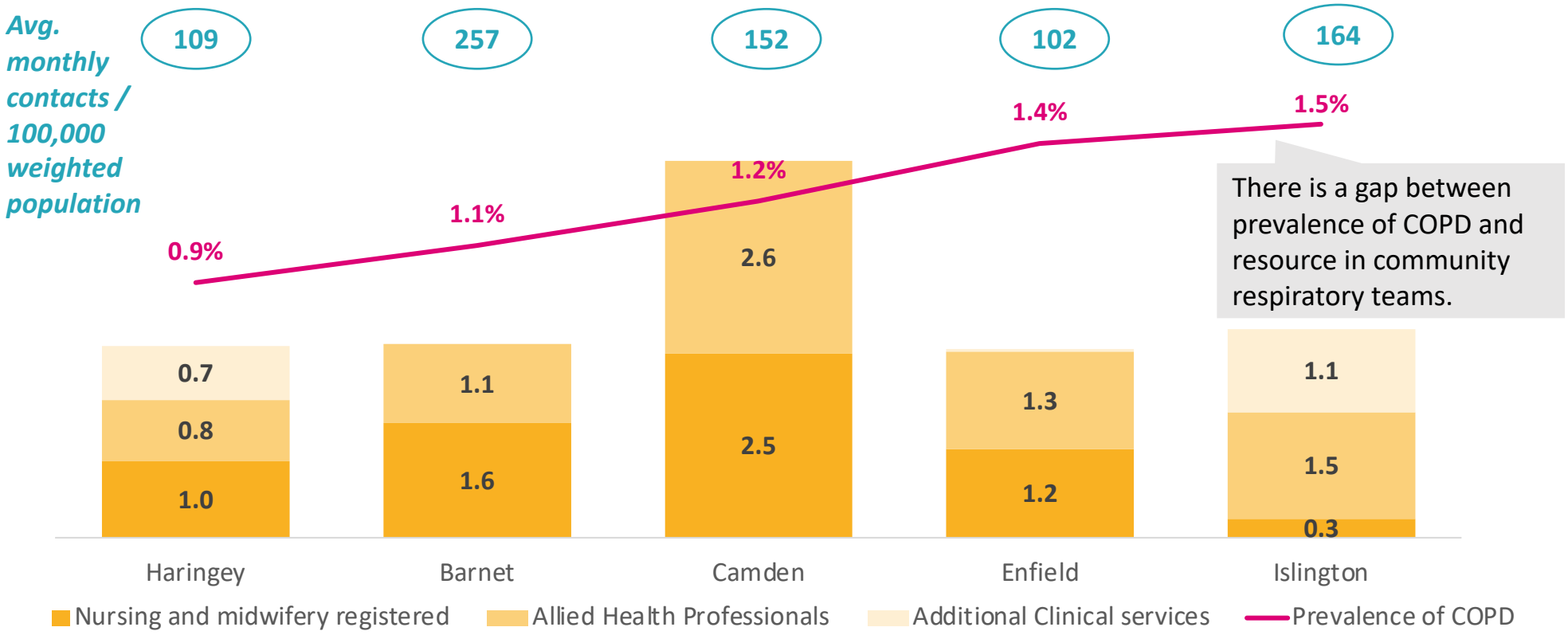


Note: There is a data limitation as what is provided by different 'district nursing' services varies. Eg. WH service includes ambulatory leg ulcer clinic and continence assessments. CLCH service to Barnet, Camden, Enfield and Haringey includes Community nursing phlebotomy. Activity and FTE shown per CCG community weighted population (NHSE). This weighting takes into account age and level of need.

Sources: C3.1 WH Monthly Community Report 1920 M09, CNWL Camden CCG Performance Report M11 19/20, ECS CCG Dashboard 19-20 (BEH), 4a. BIPA-BAU-003_Barnet SLA 19 20 M10 CLCH Final, Provider workforce returns, 2021, CCG and GP community services weighted populations. NHSE CCG populations weighted for community health need, 2019/20,. Notes: Monthly average of 19/20 months 1-9 or 1-11 from WH, CLCH and CNWL. Monthly average of 19/20 months 1-3 from BEH. Added together activity from all providers for all boroughs.

Resource is not aligned with need in community respiratory services

Community respiratory service budgeted FTE per 100,000 community weighted population by borough, 2019/20
% prevalence of COPD, per GP registered population by borough, 2019/20, and **average monthly contacts with community respiratory teams,** per 100,000 community weighted population by borough, 2019/20
COPD prevalence is the % of GP practice registered patients who have a COPD diagnosis. Prevalence is not adjusted for age.



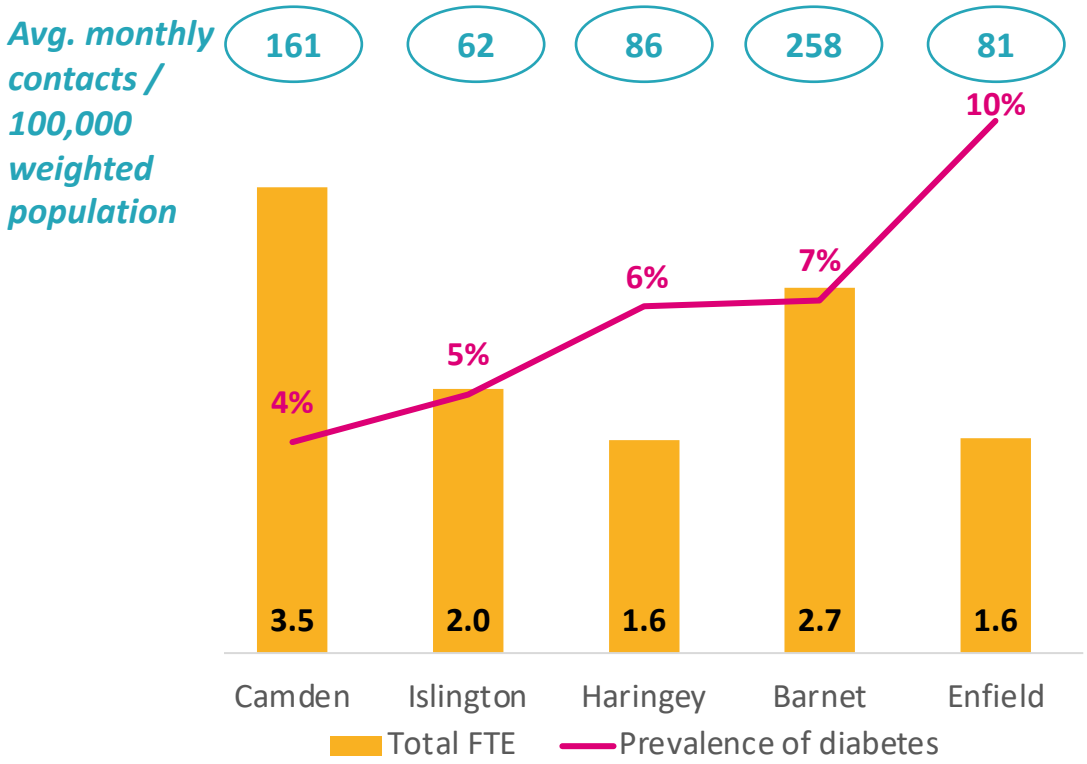
Note: Barnet (CLCH) service includes spirometry. Community spirometry provided by WH in Haringey, but not in Islington. Prevalence of COPD based on GP practice registers used as a proxy measure for demand, as there will be some patients who are not yet formally diagnosed. Activity and FTE shown per CCG community weighted population (NHSE). This weighting takes into account age and level of need.

Sources: C3.1 WH Monthly Community Report 1920 M09, CNWL Camden CCG Performance Report M11, ECS Commissioning report 2019-20 Q1, 4a. BIPA-BAU-003_Barnet SLA 19 20 M10 CLCH Final, CCG and GP community services weighted populations, Quality and Outcomes Framework 2019 data by GP practice, Provider workforce returns 2021, Community recovery dashboard 2021.

Community health provision does not correspond to level of need. Enfield has the highest diabetes prevalence, but the lowest level of community diabetes resource

FTE of diabetes team staff, per 100,000 community weighted population, 2021, and **Prevalence of diabetes**, 2019/20

Diabetes prevalence is the % of GP practice registered patients who have a diabetes diagnosis. Prevalence is not adjusted for age.



Composition of the community diabetes service by role type

Staff group	Camden (CNWL)	Islington (WH)	Haringey (WH)	Barnet (CLCH)	Enfield (BEH)
Nursing	✓	✓	✓	✓	✓
Dietetics	✓	✓	✓	✓	✓
Podiatry	✓			✓	
Pharmacy	✓			✓	
Medical	✓			✓	
Psychology	✓				

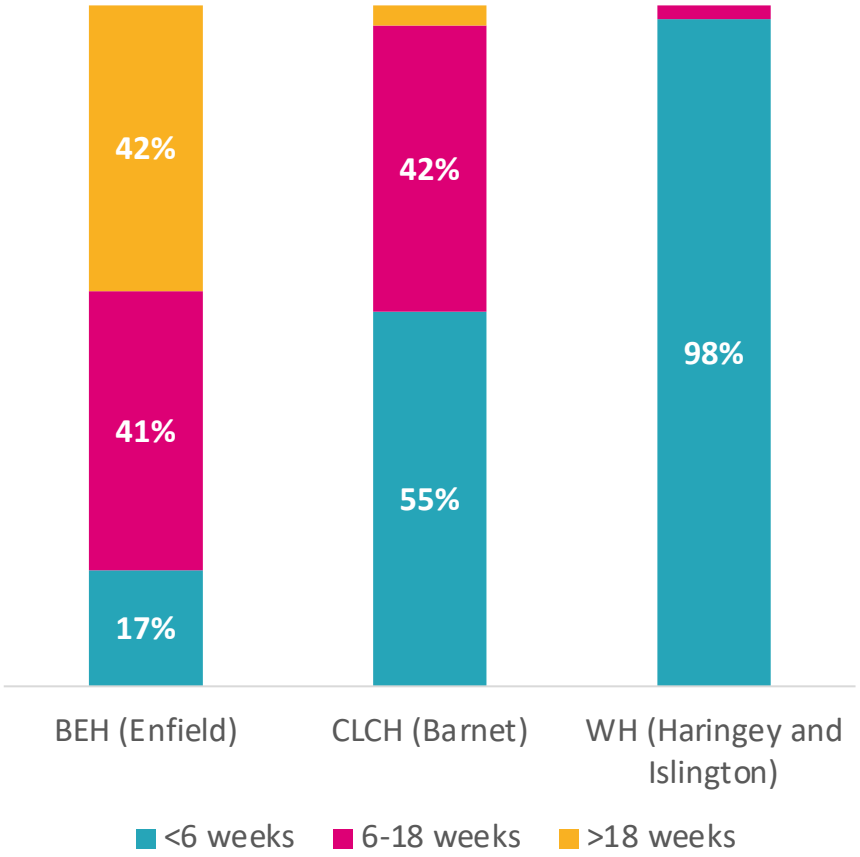
The teams in Haringey and Enfield where there is higher need are missing key members of the diabetic MDT. Barnet has a multi-disciplinary service. Camden diabetes service is integrated with separate Nutrition & Dietetics and Podiatry teams. Other borough community diabetes teams are not integrated with podiatry/other roles.

- Whittington Health share workforce across Haringey and Islington to meet need. This leads to higher activity in Haringey.
- RFH is lead provider for Camden integrated diabetes service. FTE includes CNWL, GP Federation and hospital consultant staff.
- Activity and FTE shown per CCG community weighted population (NHSE). This weighting takes into account age and level of need.

Sources: C3.1 WH Monthly Community Report 1920 M09, CNWL Camden CCG Performance Report M11, ECS Commissioning report 2019-20 Q1, 4a. BIPA-BAU-003_Barnet SLA 19 20 M10 CLCH Final, CCG and GP community services weighted populations, Quality and Outcomes Framework 2019 data by GP practice, Provider workforce returns 2021, NHSE CCG populations weighted for community health need, 2019/20

As a result of lower levels of resource and higher levels of need, Enfield community diabetes services have longer waiting times compared to other providers

Patients waiting for first appointments with the community diabetes service, proportion by waiting time, March 2021



Note: Waiting time data is from March 2021. This data therefore has some limitations due to extended waiting times as a result of Covid-19. We are looking to compare waiting times in 2019/20 to overcome this.

Data is for community diabetes services, including diabetes education.

CNWL unable to retrieve waiting times data from EMIS for RFH-led integrated diabetes service. However, they review the majority of patients within 6 weeks.

Service target waiting times vary by Trust:

- BEH: within 8 weeks
- CLCH: within 18 weeks
- WH: within 6 weeks

Sources: NCL Community recovery dashboard 2021.

There is variation in models of care to support older people across NCL; There is also variation in models of care to support residents in care homes across NCL

Models of care to support older people

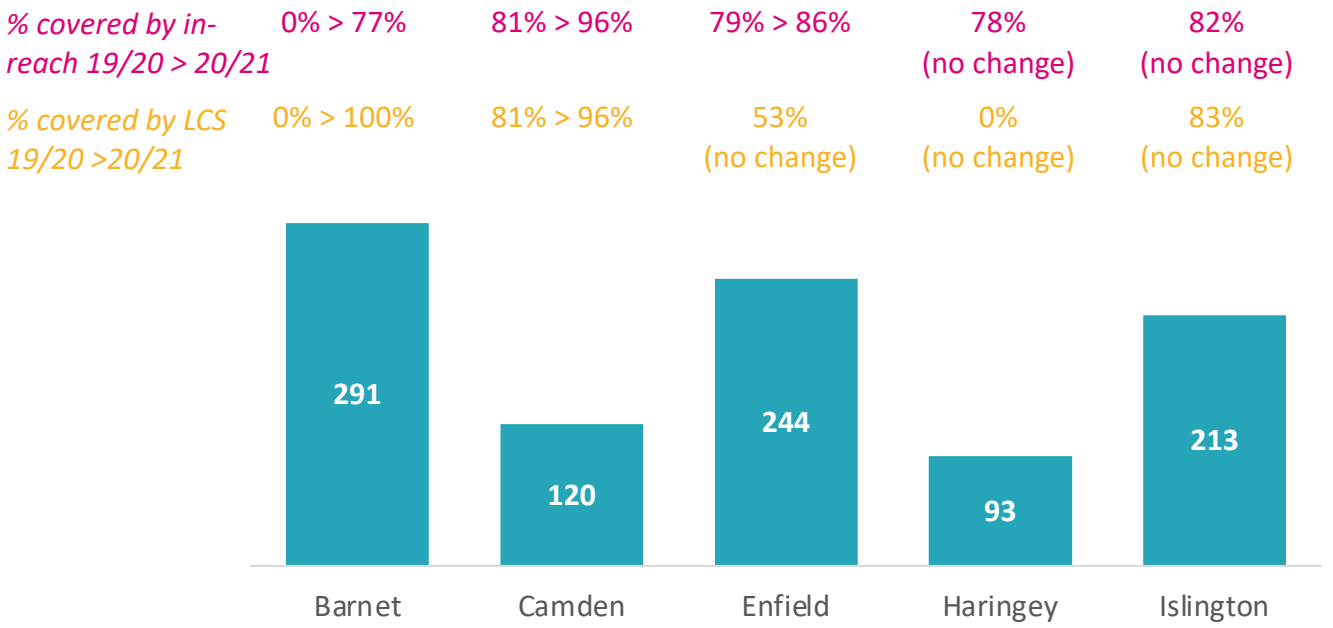
Models of care:

- Integrated models of care to support frail older people in Haringey and Islington
  - Haringey Anticipatory Care Service: MDT works with GP Federation, LA and Mental health services to prevent deterioration
  - Islington developing similar service comprising Integrated Care Ageing Team, Proactive Ageing Well Team, Community matrons and MDT coordination team
- Barnet has an MDT frailty offer in one PCN and are looking to scale up.

Falls prevention services:

- Enfield has a unique bone health and fracture liaison service. Age UK provides falls prevention
- Service for falls prevention in Barnet is small and specialist
- Camden service provides assessment and rehabilitation to reduce falls risk
- Haringey and Islington falls services provided by older people's teams and REACH (Islington) and ICTT (Haringey).

Number of older people's care home beds by borough, per 10,000 population aged 65+, 2021 and **% of beds covered by Community in-reach services or primary care Locally Commissioned Services (LCS),** 19/20 to 20/21



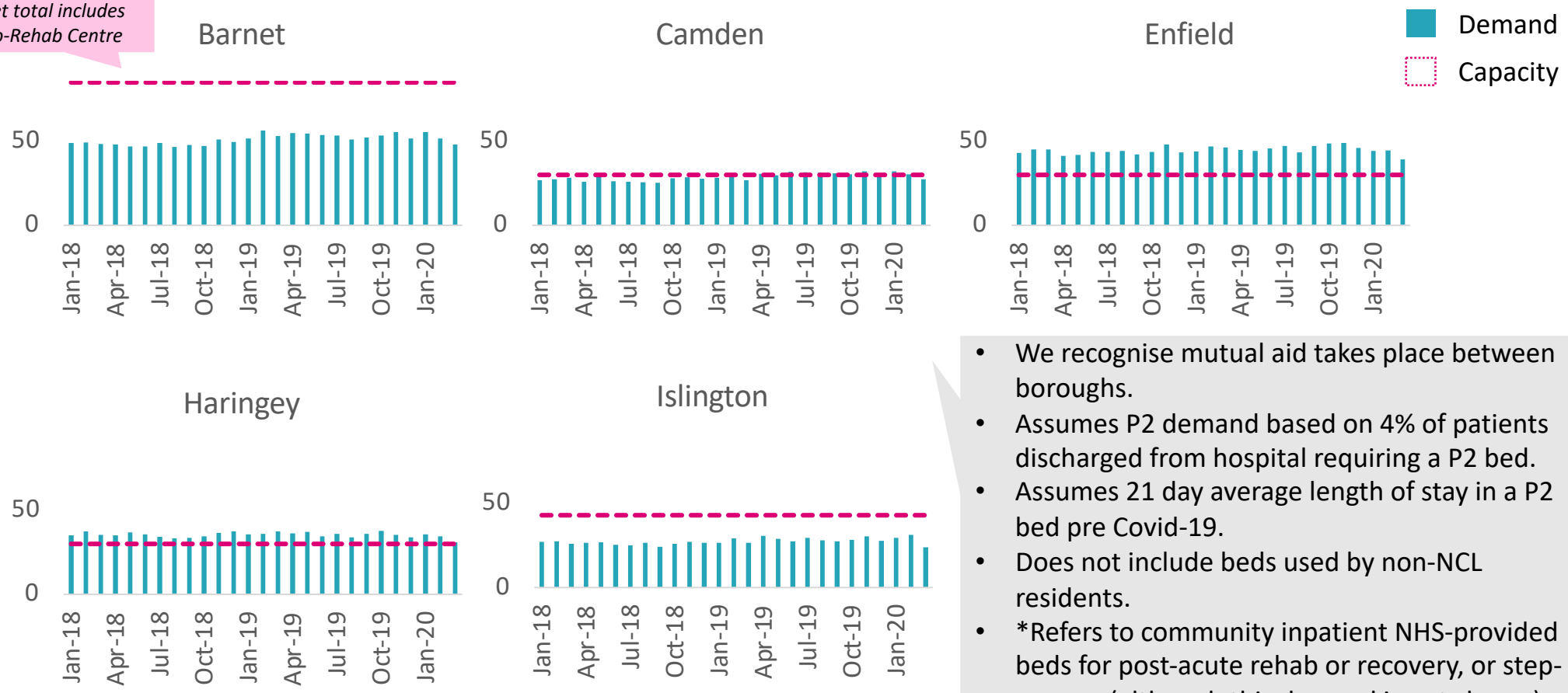
- Prior to Covid, Barnet did not have in place either LCS or in-reach services. The model of care is not sustainably funded.
- Service offer and access are currently inequitable. Not all residents in care homes across NCL have access to the same support-offer.
- Funding is also inequitable: Service more expensive to implement in Barnet and Enfield due to bed numbers. Current spend per bed on LCS varies from £450-£539 and current spend per bed on community in-reach varies from £333-£748.**
- NCL CCG work is currently in progress on the Enhanced Health in Care Homes offer.

Note: "Other care home beds" refers to Learning disabilities, Mental health, Mixed including older people and Mixed excluding older people **LCS cost information provided does not include Enfield and Haringey. In-reach service cost per bed does not include Barnet. Source: NCL CCG EHCH benchmarking

Across NCL there is variation in demand for community pathway 2 beds compared to capacity; recently this has been resolved through mutual aid

Historic modelled demand for community pathway 2 beds* compared to **pathway 2 bed capacity,** NCL borough by month, 2018-20

Barnet total includes Neuro-Rehab Centre



- We recognise mutual aid takes place between boroughs.
- Assumes P2 demand based on 4% of patients discharged from hospital requiring a P2 bed.
- Assumes 21 day average length of stay in a P2 bed pre Covid-19.
- Does not include beds used by non-NCL residents.
- *Refers to community inpatient NHS-provided beds for post-acute rehab or recovery, or step-up care (although this demand is not shown)

Note: In February/March 2021, there were on average **5 patients** who were medically optimised with a delayed transfer of care (of 2+ days) awaiting a neuro-rehab bed. There were also on average **9 patients** who were medically optimised with a delayed transfer of care (of 2+ days) awaiting a rehab bed.

Sources: HES data for acute discharges from NCL sites between Jan-18 – Dec-20, CF analysis, Provider Trust data, NCL CCG Neuro-rehab pathway system demand and capacity April 2021
. Bed demand calculated as follows: number of bed days / days in month (n.b. number of bed days = n admissions x average length of stay

Lack of clarity of offer, insufficient capacity and unclear referral pathways are seen as key barriers to effective community health support across NCL

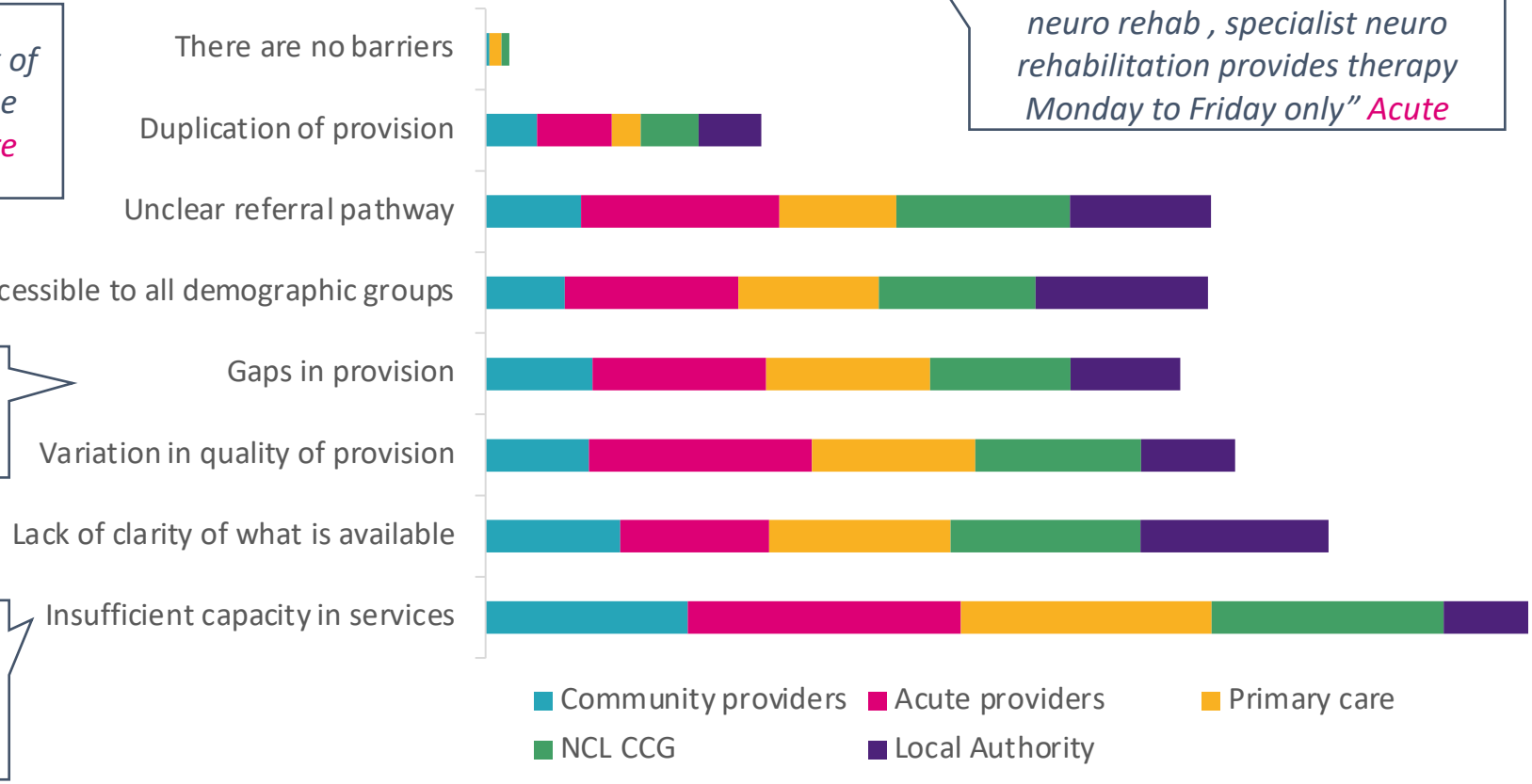
Barriers preventing service users and carers from accessing and receiving effective community health care. View of answers by organisation, based on organisation respondents primarily work in. Respondents could select multiple answers

"it is very fragmented and lack of integration. Should have singe point of access ." Primary Care

"Waiting list for level 2 specialist neuro rehab , specialist neuro rehabilitation provides therapy Monday to Friday only" Acute

"Shortages of OT, rehab, rapid response " Local Authority

"Often referral criteria mean pts slip through the net and its difficult to know who to refer pts to." Primary Care

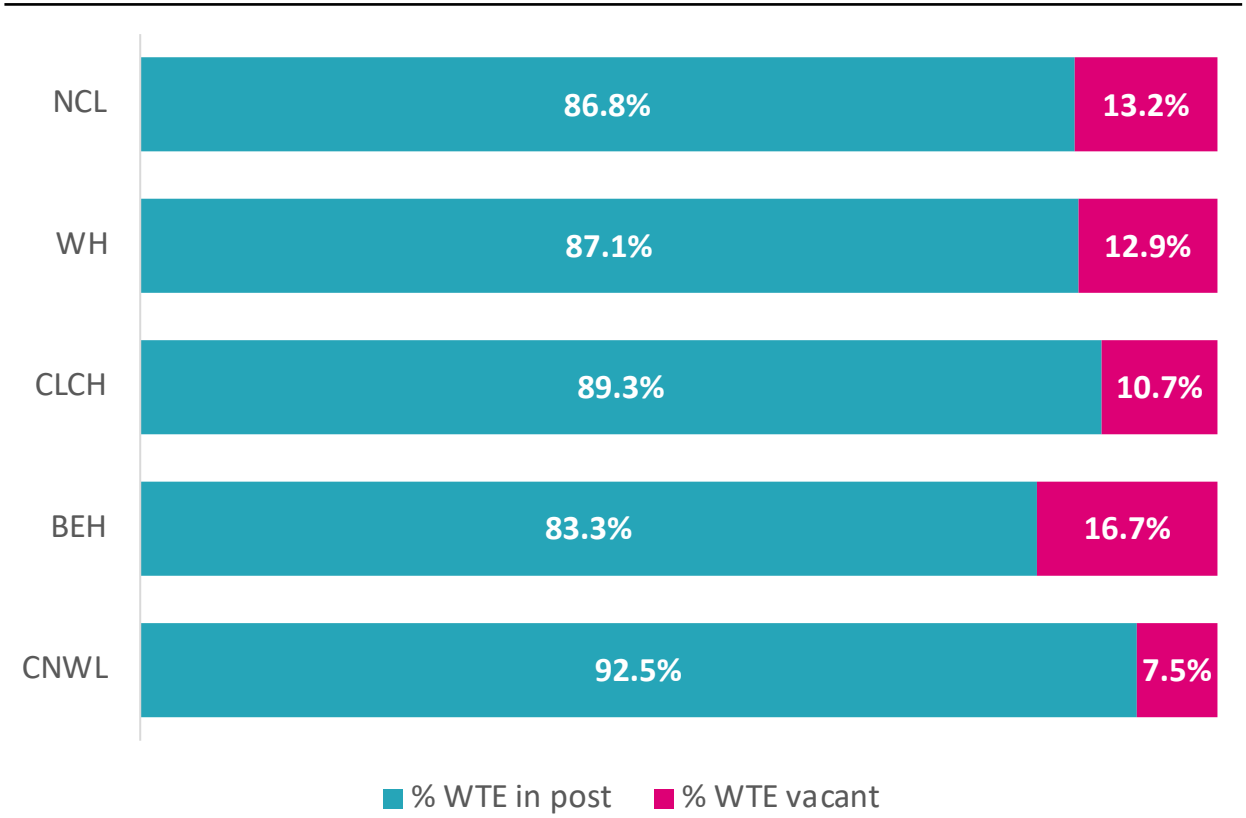


Source: NCL Community services review survey, 2021

Note: Size of bar corresponds to % of respondents from borough who mentioned this barrier. Respondents were able to select multiple answers.

Current workforce challenges include high vacancy rates and fragile services; this compounds service gaps and variation in provision

% of community health workforce FTE posts filled and vacant, March 2021



Fragile services identified by commissioners and providers include:

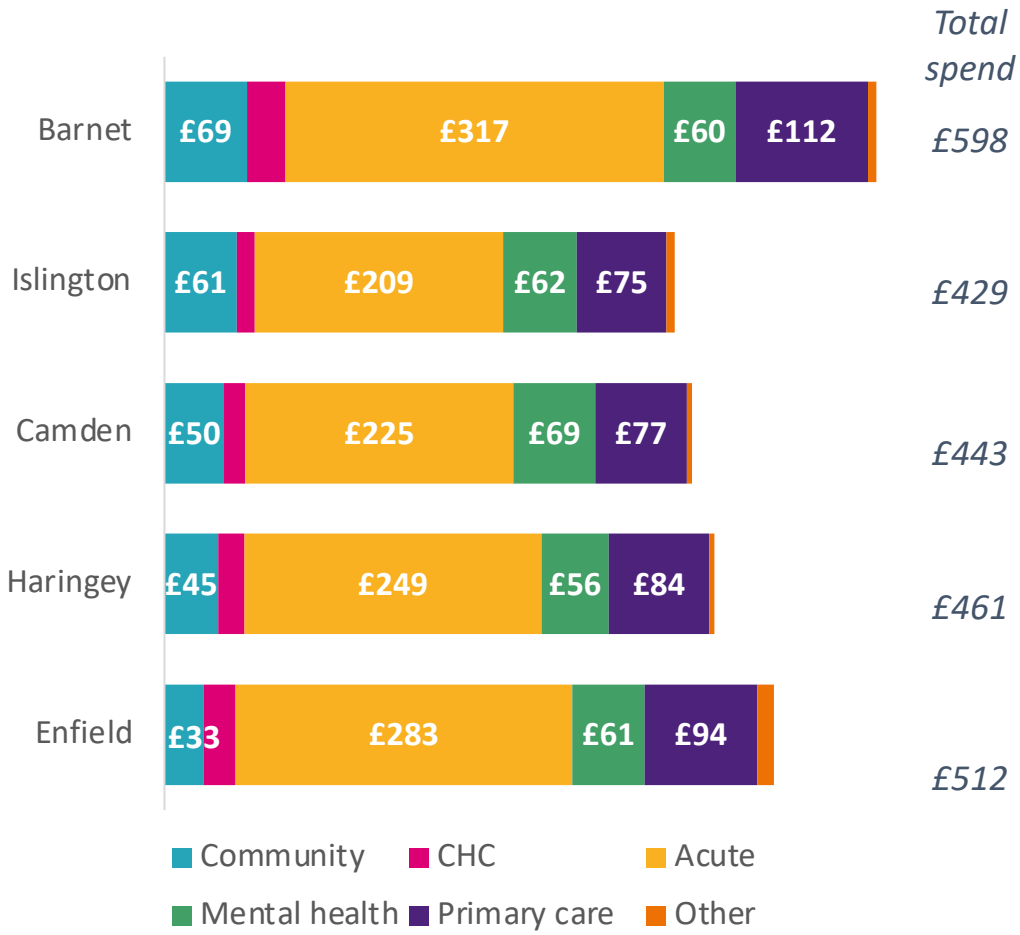
- BEH MSK
- BEH Lymphoedema
- BEH Heart failure
- BEH Diabetes

Fragile services are ones where there could be issues with workforce and vacancies, quality standards, efficiencies of scale, or where there may be gaps in provision.

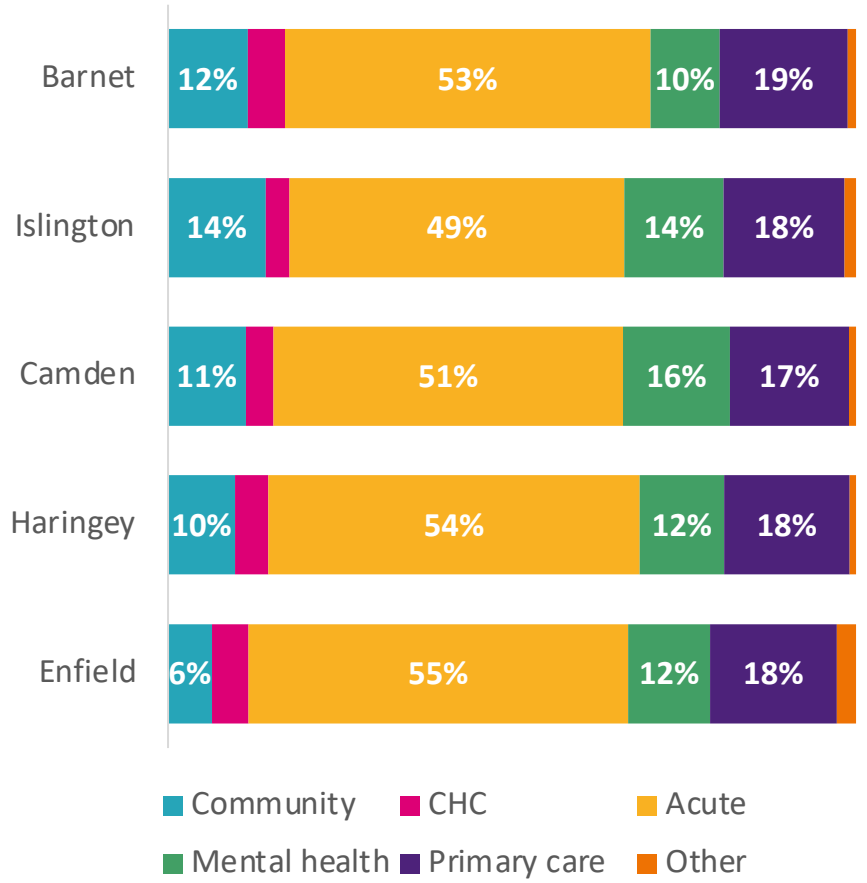
Source: NCL Community provider workforce returns, 2021, CF analysis

Barnet and Islington had the highest absolute expenditure on community services in 2019/20, and the highest proportion of total spend on community services

CCG spend by service type, total spend, £M, 2019/20



CCG spend by service type, proportion of total spend, 2019/20

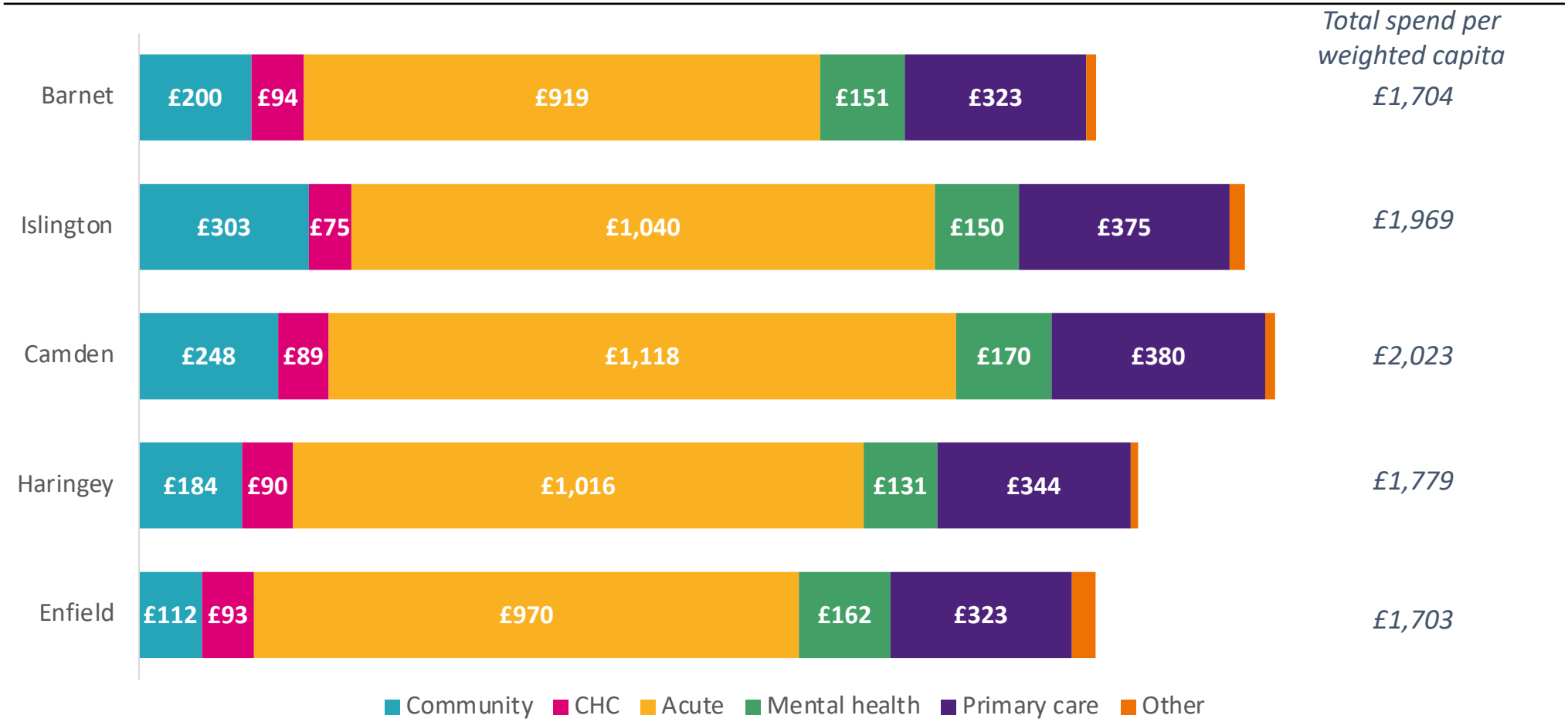


Note: Primary care includes primary care, primary care co-commissioning and primary care prescribing. Other denotes other programme services, excluding running costs.

Source: NHSE CCG general and acute, community health services and mental health services weighted populations 2019/20, NCL CCG finance data, CF analysis

However, Camden and Islington have the highest overall spend per weighted capita, and the highest spend per weighted capita on community health services

CCG spend per head by service type, spend per weighted capita, £s, 2019/20

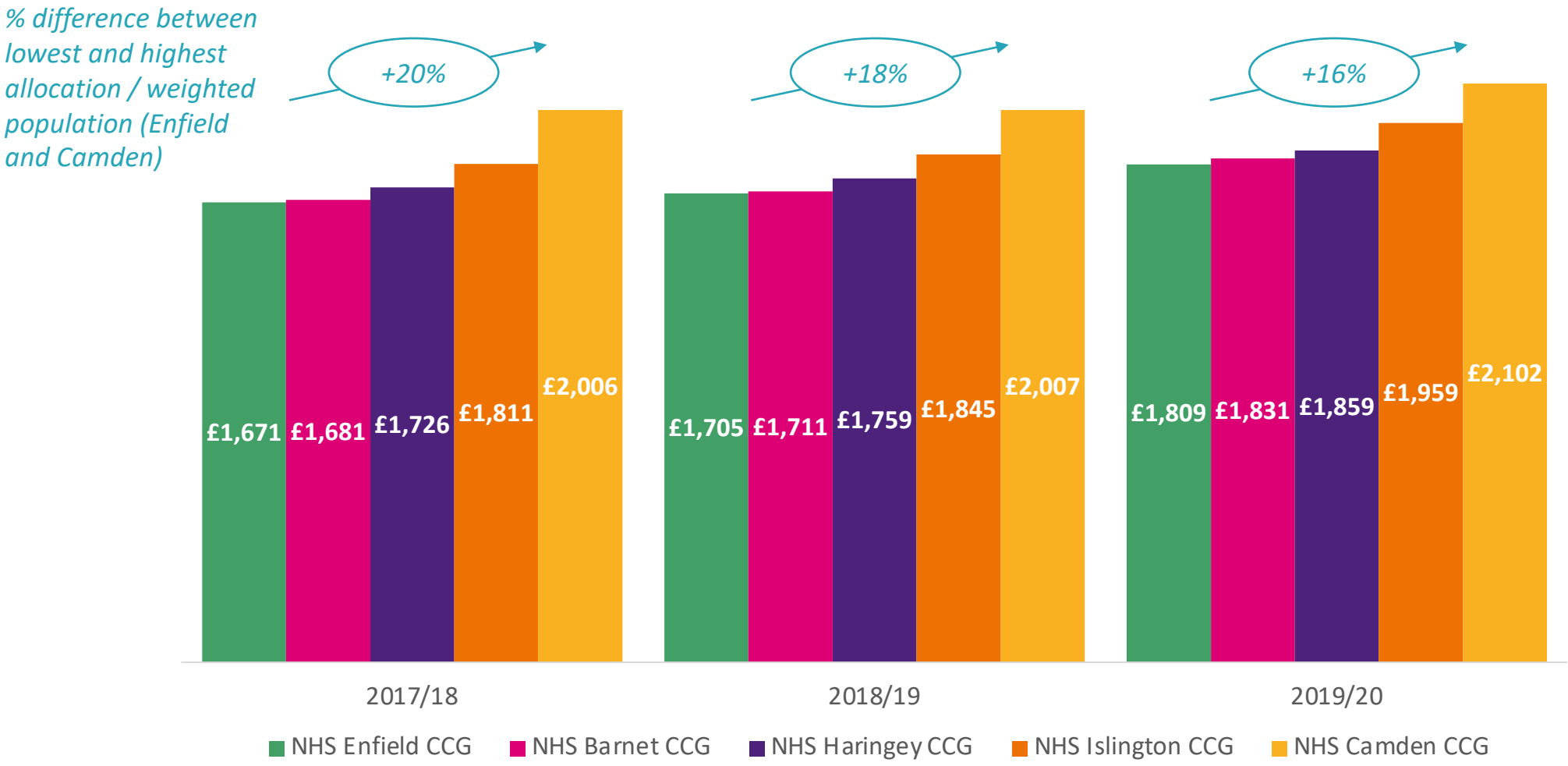


Note: Spend by service type per head of population, weighted for that service type (ie. NHSE Community Services weighted CCG population General and Acute weighted CCG population, Mental Health weighted CCG population, Overall CCG weighted population). Weighting takes into account age and level of need.

Source: NHSE CCG general and acute, community health services and mental health services weighted populations 2019/20, NCL CCG finance data, CF analysis

This pattern is evident historically as Camden and Islington received higher allocations per weighted capita compared to the other CCGs in NCL from 2017/18-2019/20

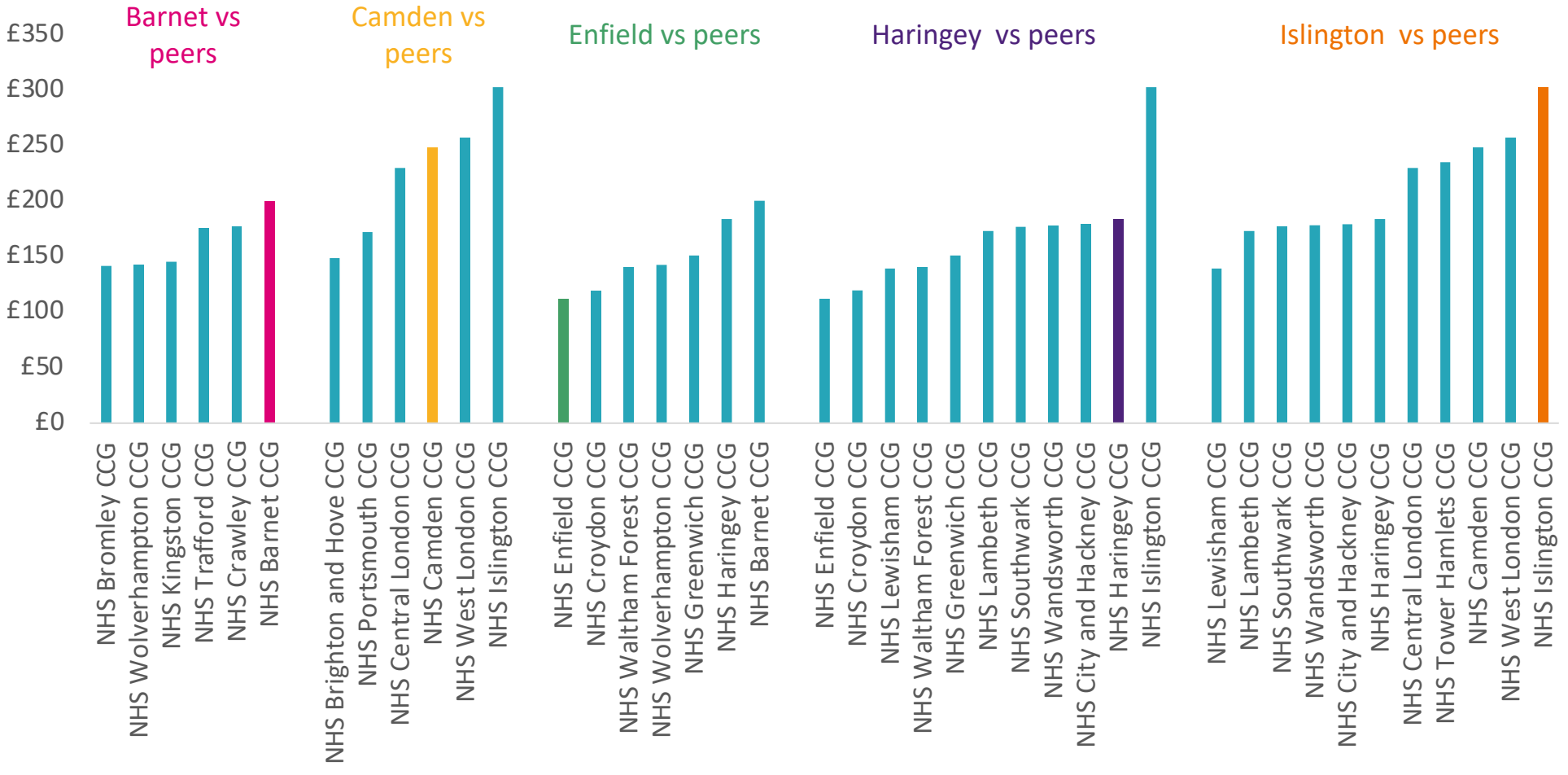
CCG allocations, total place-based allocation per overall weighted population, 2017/18 – 2019/20



Source: NHSE CCG allocations, NHSE CCG overall weighted populations (published with 2016/17 – 2020/21 allocations), CF analysis

Relative to CCG peers, NCL CCGs are spending a higher amount on community health services with the exception of Enfield which spends the least compared to its peers

CCG spend on Community health services, total spend per weighted capita, NCL CCGs compared to RightCare peers, 2019/20



Note: Some RightCare peer CCG accounts do not provide their spend information in a format which would enable us to separate out spend on community health services.

Source: CCG accounts 2019/20, NHSE CCG community health services weighted population 2019/20, CF analysis

There is a link between community investment and acute activity; Camden and Islington's higher investment seems to be linked with relatively lower acute activity

Borough	Community health expenditure *(per weighted capita, 2019/20)*	Weighted deprivation scores *(2019)*	GPs *(FTEs / 10,000 registered population, 2019)*	A&E attendances *(per 1000 weighted population, 2019/20)*	Avoidable admissions *(per 1000 weighted population, 2019/20)*	Non-elective admissions *(per 1000 weighted poplation, 2019/20)*	Non-elective length of stay *(average days, 2019)*
Islington	£303	27.5	6.0	500	9.6	124	4.6
Camden	£248	20.1	7.4	489	9.1	131	4.0
Barnet	£200	16.1	5.3	450	9.9	149	4.0
Haringey	£184	28.0	5.0	534	10.2	126	4.5
Enfield	£112	25.8	3.6	618	11.9	134	4.4

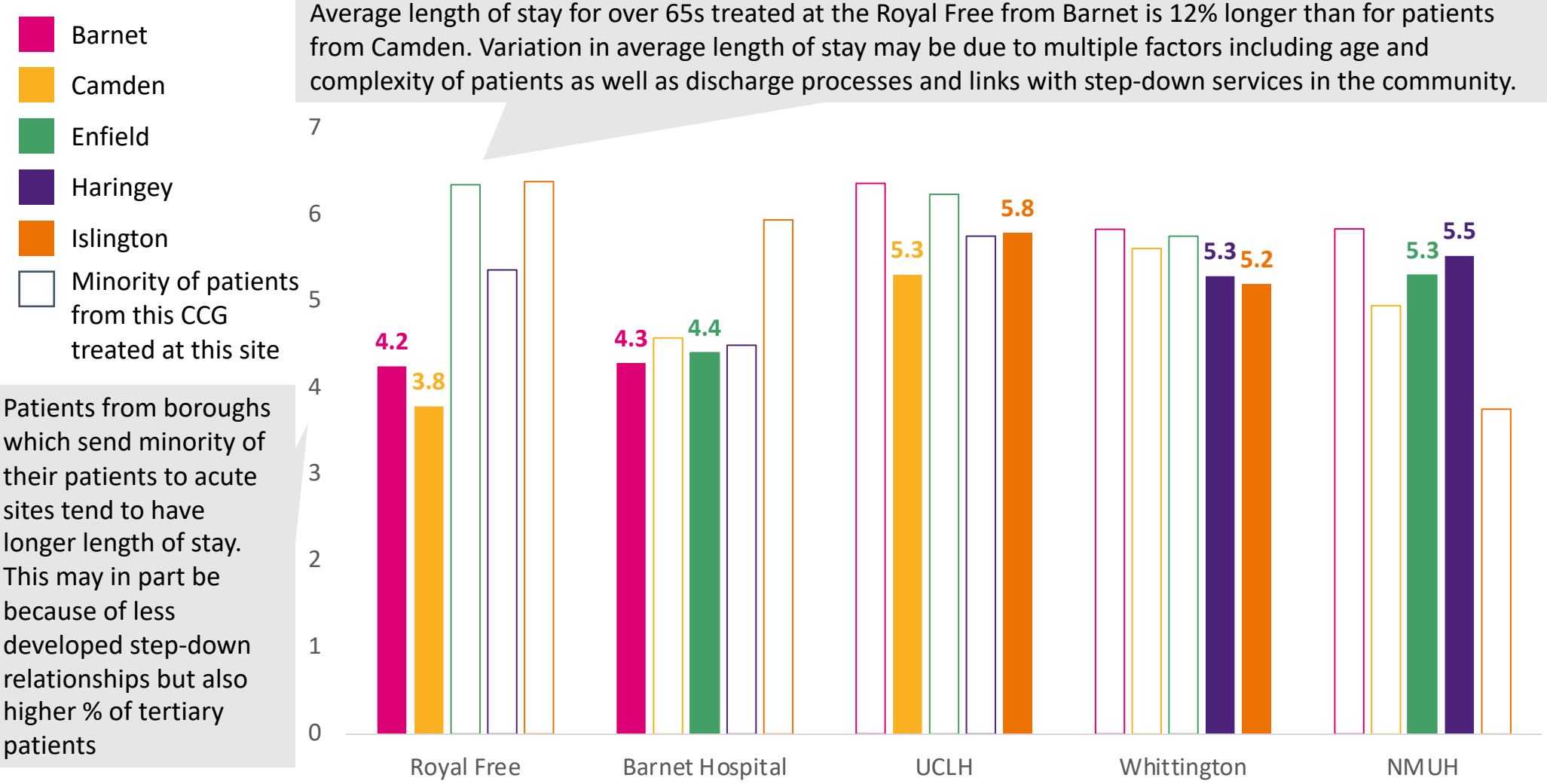
Compared to Camden and Islington, the other boroughs have a higher pro rata acute spend.

Source: NHS digital, HES 2019 data, NHSE CCG general and acute weighted populations 2019/20, NCL CCG finance data, CF analysis

Patients from Camden, where there is relatively high level of community investment, spend less time in the same hospital than patients from other boroughs

Average length of stay for non-elective inpatient admissions for over 65s, by provider and by CCG of residence, average days, 2019

Average length of stay for over 65s treated at the Royal Free from Barnet is 12% longer than for patients from Camden. Variation in average length of stay may be due to multiple factors including age and complexity of patients as well as discharge processes and links with step-down services in the community.

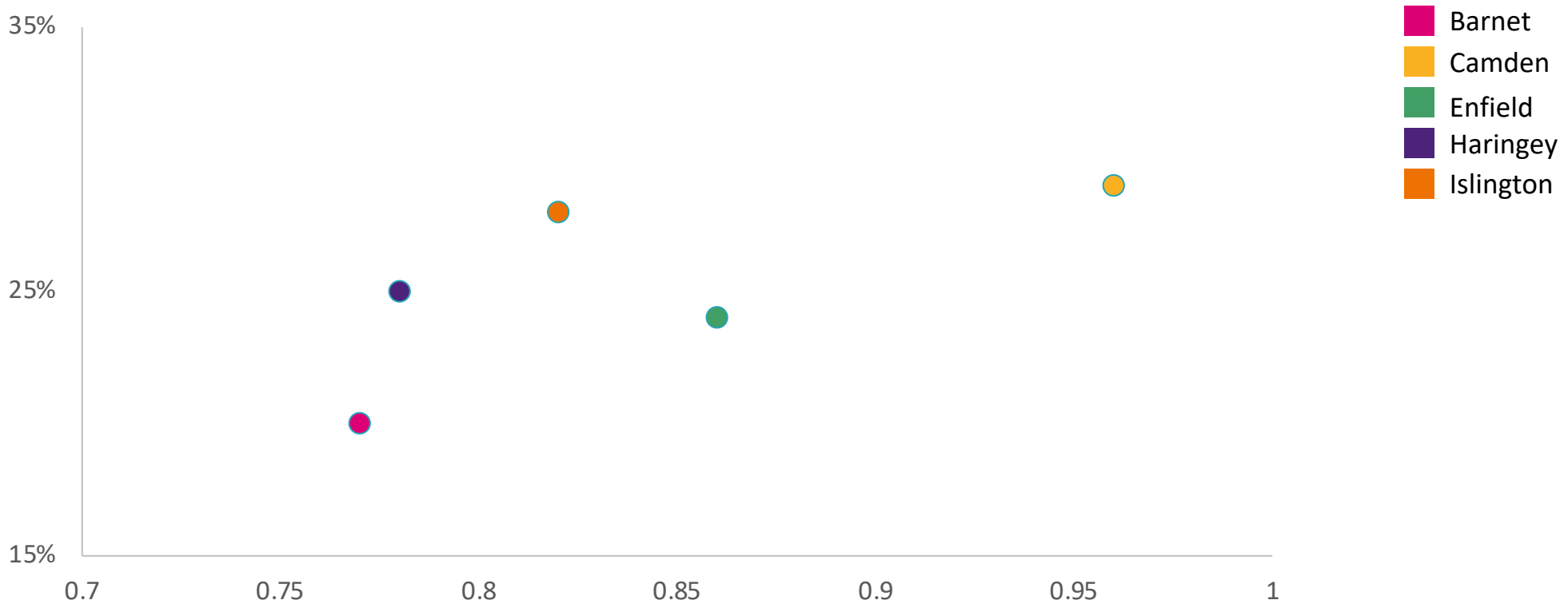


Patients from boroughs which send minority of their patients to acute sites tend to have longer length of stay. This may in part be because of less developed step-down relationships but also higher % of tertiary patients

Source: HES, 2019, CF analysis

There is an observed trend in NCL that care homes with a high proportion of beds covered by community in-reach services have a lower % of LAS conveyances

% of care home beds covered by community in-reach services (x axis), % LAS calls non-conveyed (y axis), by borough 2020/21

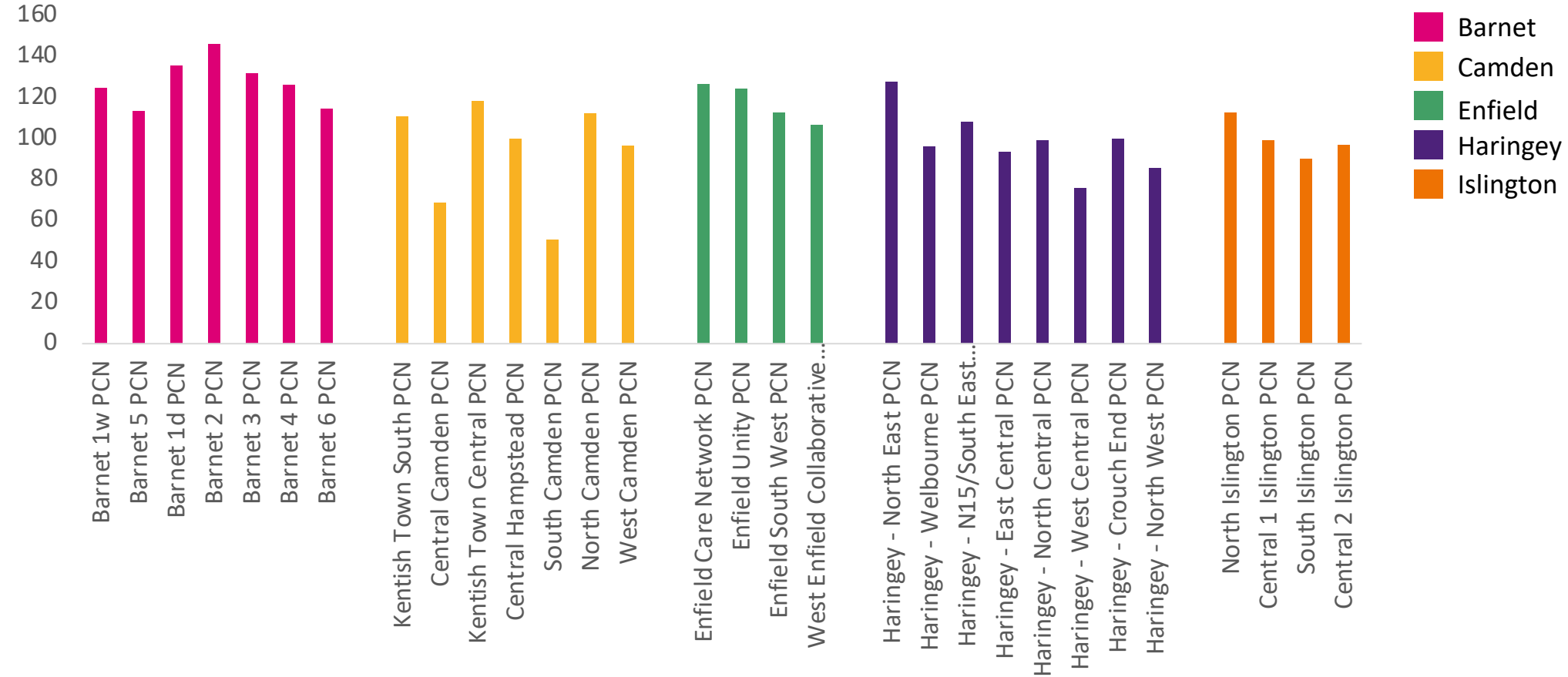


Note: All boroughs except Barnet had a community in-reach service established prior to Covid-19. In-reach to care homes was implemented in Barnet as a result of the Covid-19 pandemic, however this model of care is not sustainably funded. The trend that care homes with a higher proportion of beds covered by in-reach services and a lower proportion of LAS calls non-conveyed is observed from NCL data during 2021. Further work may be required to evaluate impact of in-reach services.

Source: NCL EHCH Benchmarking

Within boroughs, more deprived PCNs have higher rates of non-elective admissions; resources could be better targeted within boroughs to support those with most need

Non-elective admissions by PCN, non-elective admissions per 1000 registered population, 2019

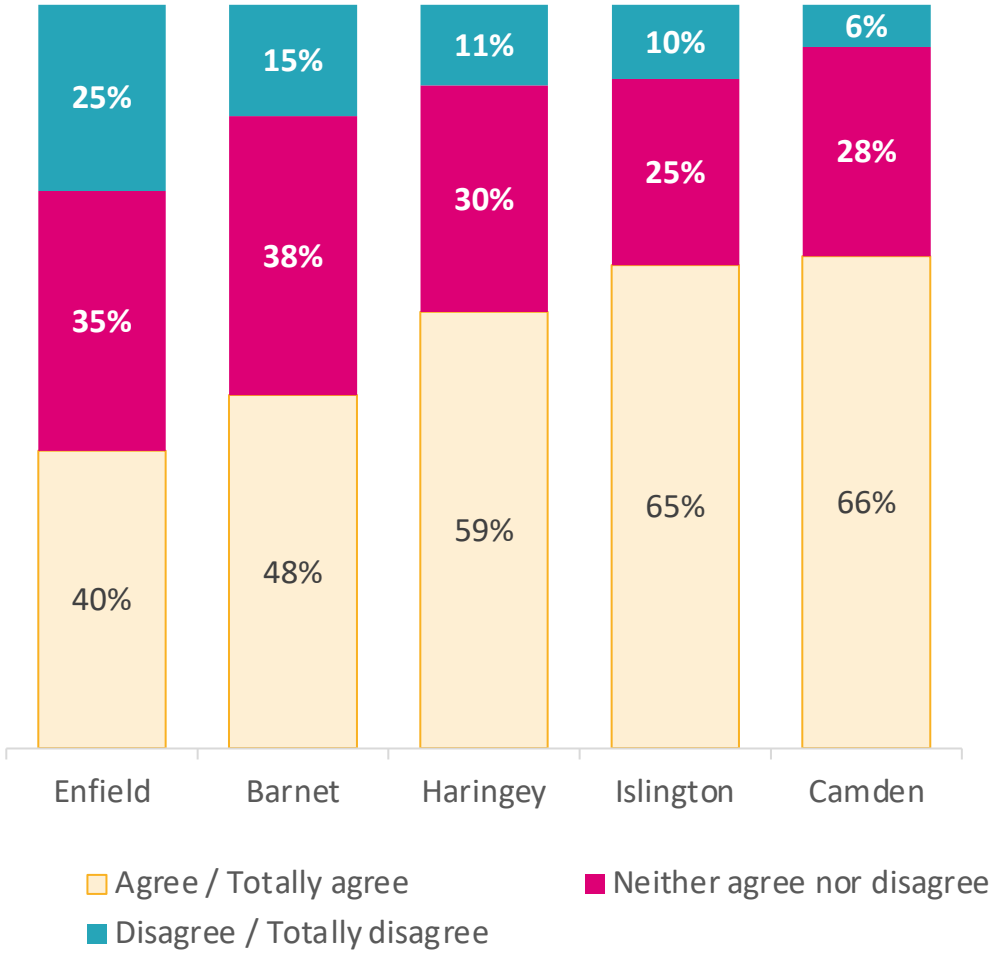


Note: PCN's within each borough ordered in terms of decreasing deprivation. Left to right – more deprived to least deprived.

Source: Index of Multiple Deprivation (IMD), England, 2019 (ONS). PCN mapping based on 2019 groupings

In boroughs with lower levels of community spend, survey respondents felt that patients were less likely to be effectively supported with their long term conditions

Do you agree with the statement 'Community services effectively support service users with long term conditions to avoid going into an acute hospital when their health needs escalate'? View of survey answers by borough, based on geography respondents primarily work in



"There is variation between boroughs, maybe generally we are less good at upstream prevention" NCL wide

"Lack of step-down, prevention and admission avoidance." NCL wide

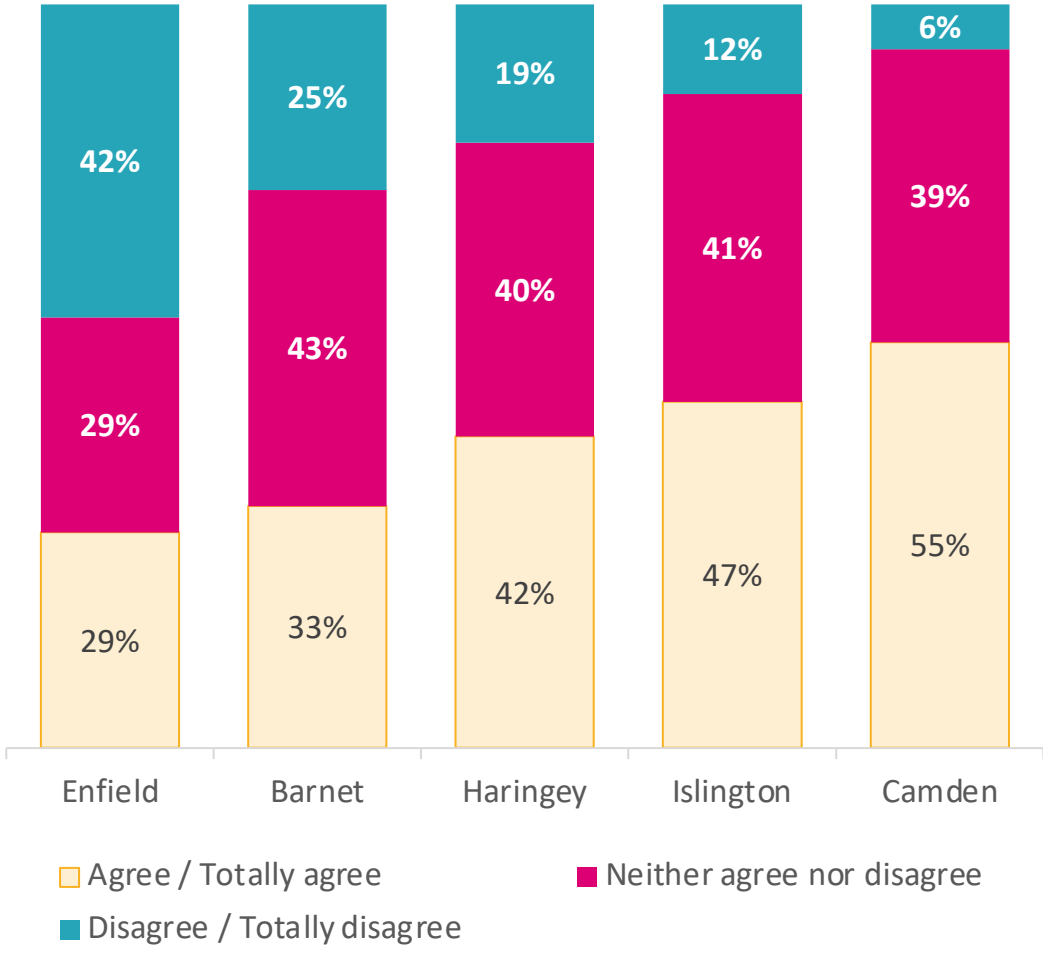
" Services for long term conditions are very under resourced and staffed" Enfield

"There is a deficit in specialist nurses for the area I work in to support patients at home and avoid hospital admissions." Camden

Source: NCL Community services review survey, 2021

In boroughs with lower levels of community health spend, survey respondents also felt that children were less likely to be effectively supported with their complex needs

Do you agree with the statement 'Effectively support children and their families with complex health and care needs'? View of answers by borough, based on geography respondents primarily work in



Source: NCL Community services review survey, 2021

"There is increasing complexity and numbers of children and young people with complex needs" Camden

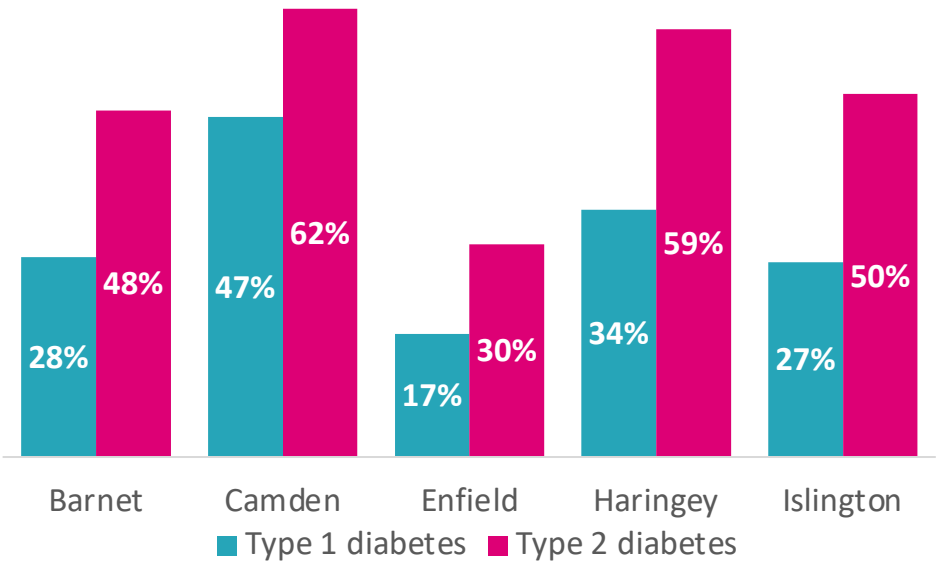
"For C&YP across NCL there are strengths across some areas (e.g. community based step down) but it is not equitable." Enfield

"Gaps in provision of children's services between Haringey and Islington. Lack of clear pain management pathway." Haringey

"Increasing demand on children's services - growth in autism needs and identification, more focus on prevention - obesity etc. in children" Islington

A lower proportion of diabetics in Enfield receive all the NICE recommended health checks and attend education programmes to help them self-manage their condition

Proportion of patients receiving all 8 care processes*, 2019



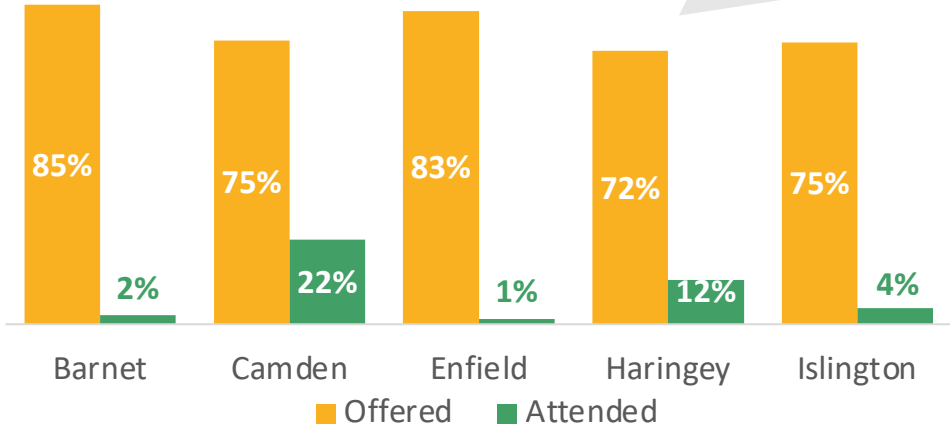
The 8 care processes are:

1. Cholesterol check: CVD risk
2. Serum Creatinine blood test: kidney function
3. Smoking status
4. BMI
5. Foot examination: risk of diabetic foot problem
6. Blood pressure: CVD risk
7. HbA1c blood sugar: high levels increase risk of diabetic complications

*Source: National Diabetes Audit, CF analysis, NICE

% of patients newly diagnosed with Type 2 diabetes offered or attended Structured Education within 12 months of diagnosis, 2019

There may be multiple factors affecting attendance rates, which could include service capacity, and these may differ by borough.

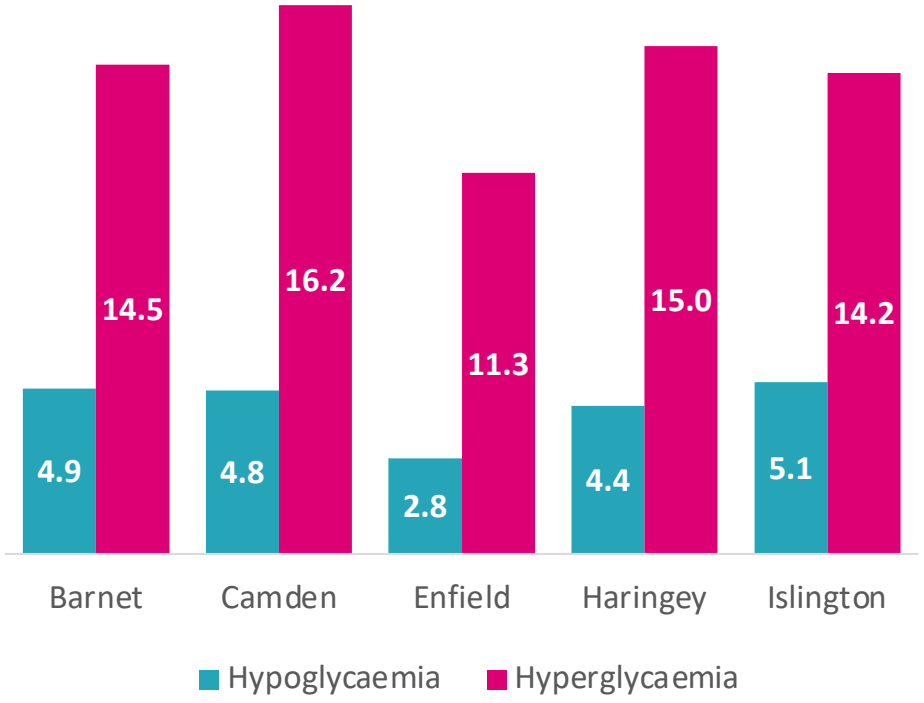


Structured education programmes can help adults with Type 2 diabetes to improve their knowledge and skills. The programmes encourage patients to take self-manage their condition effectively.

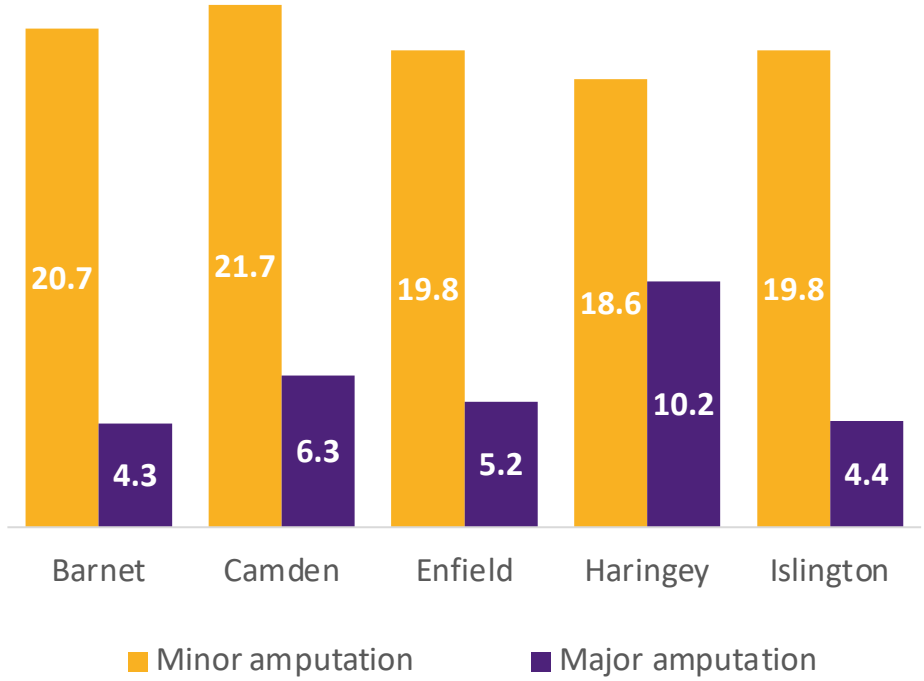
*Note: Diabetes care processes are mostly delivered in primary care and so completion is related to primary care capacity - Enfield has the lowest number of GPs per head. This is nevertheless relevant for community health services due to interdependencies between primary and community care. People who do not receive the right checks may go on to require increased support from community health services.

There is variation in outcomes for patients with diabetes across NCL; investment alone does not deliver better outcomes

Hospital admissions for hypoglycaemia and hyperglycaemia, admissions per 1,000 registered population with diabetes by CCG, 2019/20



Number of minor and major diabetic lower-limb amputation procedures, rate per 10,000 registered population with diabetes by CCG, 2015-2017. The rate of amputation procedures is directly age and ethnicity standardised by CCG.

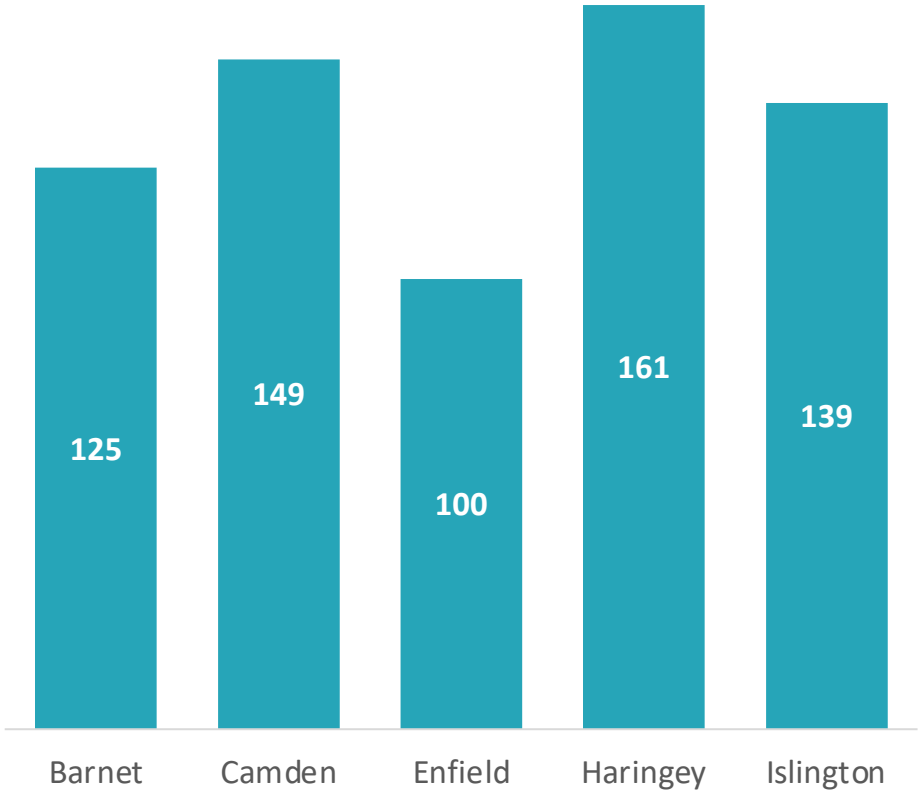


This analysis shows two possible measures of outcomes for patients with diabetes. Further investigation is needed to understand what is driving these outcomes. The scope of this work covers community health services and there would be other spend that is not captured here.

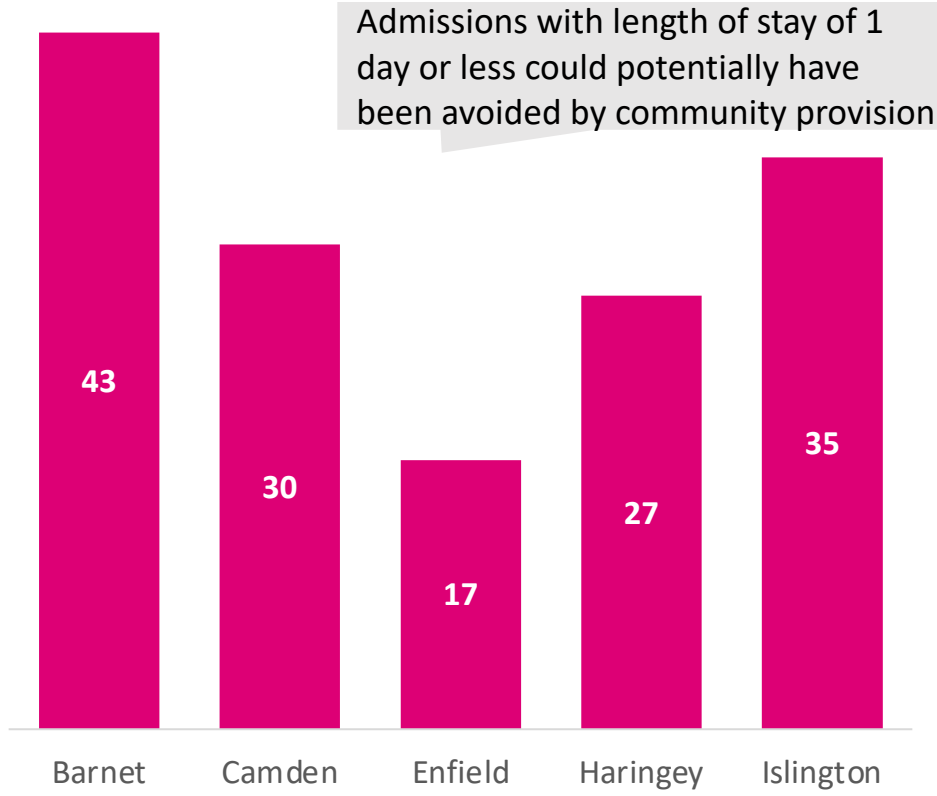
Source: HES, QOF 2019/20, NHS Fingertips, CF analysis

We also see this in outcomes from community COPD provision. Enfield has lower levels of admissions despite lower level of community respiratory resource

Rate of admissions to hospital for COPD, total admissions per 1000 population with COPD, 2019/20



Rate of admissions to hospital for COPD lasting one day or less, total admissions per 1000 population with COPD, 2019/20



This analysis shows a possible measure of outcomes for patients with COPD in terms of hospitalisation. Further investigation is needed to understand what is driving these outcomes. The scope of this work covers community health services and there would be other spend that is not captured here.

Source: HES, QOF CCG population registered with COPD 2019/20, CF analysis

Interviewees reflected themes that are supported by the baseline analysis

Variation and lack of clarity of provision

- Universal agreement that community health offer varies considerably across NCL in terms of service models, criteria and levels of access
- Many expressed there is confusion among professionals and residents about what services are available

"Hospitals don't know what you will get when discharge; no clear set of common services"

Inequity and inequality of access to care

- A post-code lottery was commonly described with level of provision not matched to need, but instead to investment
- Primary care struggles to access community care provision with long waiting lists and high thresholds

"You sit as a GP in Camden- where you can refer looks very different to in Enfield"

"We are not meeting the needs of more deprived communities"

Variation in historic funding

- There was universal recognition of the variation in community health funding across boroughs
- Many expressed that that funding was not linked to levels of need
- There's a general sense that investment in community services has a positive impact on overall system performance, and that this is lacking in some places, in particular Enfield and Haringey.

"In Enfield and bordering Haringey we have some of the highest levels of need and yet the least funding…this feels wrong"

Fragmentation of provision

- Some expressed the view that there are too many community providers in NCL and this was contributing to the variation in provision
- Others felt that the number of providers wasn't in itself a problem, but the lack of integration across services and teams is the problem

"The issue isn't multiple providers, but how we have been commissioned"

"Multiple providers create fragmentation and variation in provision"

Workforce challenges

- Particular concerns expressed linking service fragility to the fragility of workforce, in particular in smaller services and smaller community providers
- Some described the relative inflexibility of workforce to move between services and adapt to need with this being compounded by high vacancy rates and recruitment challenges (including competition with PCNs)

"Retaining staff particularly post Covid with an ageing staff population will be challenging"

Attendees at the baseline workshop reflected there is a clear case for change to tackle health inequalities, optimise use of resources and develop system working

Address health inequalities	• Attendees recognised there are significant health inequalities and inequities across NCL, in terms of the community service offer and access to services • There is unwarranted variation as people living in different areas do not receive the same offer • There is a gap between need and provision, which is driven by historic funding inequities • This leads to inequity in outcomes for patients
Optimise use of resources	• Resources (finance and workforce) are not distributed equitably across NCL, which contributes to health inequalities • There is a need to consider how to redistribute and direct resources most effectively to support those with the greatest levels of need and ensure that this is in line with the CCG's published financial strategy to target resources to reduce inequalities across the ICP • System expenditure is not optimised and needs to be considered in the round to deliver best practice care, sustainability and value for money
Further develop relationships and integrated working	• Attendees reflected that historically there have not always been good relationships between organisations, and a lack of trust. This has been partly due to competition and lack of resources • Recently, during Covid, this has improved through regular conversation and more collaborative working including sharing of risk and responsibility – Covid has driven different ways of working which now need to be embedded as ongoing ways of working • There is currently fragmentation of provision with a lack of integration of services along patient pathways • Good relationships and integration are key to delivering both transformation and the best care and outcomes
Organisational form should follow function	• Many expressed the view that the design of the core offer should be agnostic of organistional form; the core offer should combine best practice models of care as well as support delivery of national standards to improve quality and meet the needs of different population groups, taking a population health management approach • Organisational form was raised as a potential barrier or enabler to service delivery, which means it needs to be considered once the core offer has been designed

Contents

During the interviews, stakeholders described their desired outcomes from review

Development of a core equitable offer

- Broad consensus that a care model should be designed around the needs of different population groups with a more standardised offer for each group
- Common view that community health services should act as the "glue" between primary care, acute and social care services
- However views differ about how granular the core offer should be. Some believe there should be a common service specification; others believe it should be a minimum service offer for local systems to build on; others argue it should be a set of outcomes leaving for local systems to design services.

"Need to have a more standardised care offer focused on population needs; but standardisation doesn't mean identical offers"

"A core offer shouldn't mean everyone is offered the same care…we have very varied population needs across NCL"

Local integrated care for patients with LTCs

- Many expressed that care for patients with long term conditions should be provided where possible at a neighbourhood or PCN level, delivered by integrated primary care, community health, LA and wider partners

"Keen to see a model as preventative and upstream as possible, not just focused on urgent care pathway"

Equitable funding as key enabler

- Shared view that there needs to be more equity in funding but differing views on how this should be achieved
- Some believe that this should involve additional investment in historically underfunded boroughs i.e. Enfield and Haringey to meet underlying needs; Others believed it is not affordable to increase all funding to Camden and Islington levels and a degree of redistribution of funding is required

"Clearly an argument for redistribution of money to tackle inequalities"

"This review cannot result in levelling down of funding… there needs to be additional funding for under resourced areas"

Role of clinical leadership

- Many expressed the importance of clinical leadership in driving forward a needs focused approach to community provision
- Others described the centrality of visible clinical leadership in supporting a multi-disciplinary working at a local level

"Providers need to come together and make best use of available money to meet the needs of patients""

"Visible clinical leadership makes a big difference"

During the interviews, stakeholders also reflected on where they saw opportunities for development and improvement in community health services

Learning from Covid

- Shared view that Covid was a trigger for driving positive change in community health services. Specifically the push to support rapid discharge and reduce readmissions.

"Need to maintain momentum of increased community provider collaboration during Covid"

Integration

- Pockets of good integration with primary care and effective community step up and step down (Camden rapid response and Islington virtual ward) models that need to be shared.
- Some suggested that we need to build on the neighbourhood models, which are developing in a number of boroughs; the neighbourhood model should involve wider services than are currently involved in primary care networks.
- Big opportunities for reducing duplication with Local Authority services.

"Camden GPs view the Camden rapid response team as being a joint team with them rather than separate to them"

"Lots of overlap between work of district nurses, OTs and social workers"

Specific community services

- Frequently quoted examples of good practice included community pulse oximetry, community outreach into care homes and the Islington MSK service
- Many spoke of the desire to innovate and for NCL to be a centre of innovation

"We have developed very successful care home in-reach models and shown these reduce hospital admissions"

Organisational form

- Many talked of benefits of vertical integration model at Whittington Health with benefits of joined up accountability for delivery of acute and community services, closer team working and resultant better acute outcomes and system financial savings.
- Others described the benefits of large specialist community providers having increased expertise and bringing the benefits of scale and reduction in costs. Some cited successful integration between large community provider with local authority and acute, arguing that it is relationships rather than organisational form that enable integration
- Some noted that organisational change was a distraction

"The Whittington model means that community and acute teams have shared accountability for supporting patients to remain at home"

"Specialist community providers bring expertise and economies of scale"

During the baseline workshop, attendees reflected on their vision for how the core offer should deliver transformation to address the case for change

Patient engagement and satisfaction

- Put community and patient engagement at the heart of design
- Deliver patient / resident satisfaction
- Deliver person centred care
- Design an offer tailored to need, not around organisations or form

Core offer development

- Best practice, innovative, pathways to equitably meet the needs of different population groups
- Build on existing work and success
- Develop a model that joins up care
- Identify pathways which efficiently deliver high quality outcomes
- Standardisation of access and offer (eg. hours, workforce, competencies, responsiveness etc)
- Delivery of nationally mandated standards and targets

Ways of working together

- Establish the vision for relationships between community providers and between community and other providers
- Set a framework for integrated and collaborative working
- Be sustainable from a workforce perspective
- Engage staff with the design
- Determine how autonomy will function at place/ICP level

Outcomes

- Address health inequalities
- Better measurable clinical outcomes for the population, with a shared outcomes framework
- Set a road map for how we will achieve these outcomes

Sustainability

- Be affordable
- Optimise use of system resources
- Understand services that could be optimised by an NCL-wide approach
- Be flexible to changing requirements over time in different parts of NCL

Contents

Next steps

This report will be the basis of the case for change around which the NCL system is aligned in order to develop a new 'core offer' for community health services and to implement transformation.

The next phase of this review will co-develop a shared outcomes framework and KPI dashboard which will be used to track performance going forwards.

Clinical and operational stakeholders from across NCL organisations will come together through a series of workshops and deep-dive sessions to co-design a new core offer for community health services in NCL which will deliver the desired outcomes.

Finally, a transition plan will be developed to set out how the core offer will be implemented in the medium to long term.

Contents

Service mapping

Mapping of community health services across NCL (adult services)

Community service	Barnet	Camden	Enfield	Haringey	Islington
Unplanned care services					
Rapid Response	CLCH	CNWL	BEH	WH (and virtual ward)	WH (and virtual ward)
Walk-in centre	CLCH	No service	No service	No service	No service
Support to care homes	CLCH	Camden GPs	BEH	WH, BEH, LA	WH, LA
Planned care services					
Integrated discharge team	CLCH	CNWL	BEH	WH (supported discharge team)	WH (supported discharge team)
Discharge to Assess	CLCH (incl. enhanced nursing support)	CNWL	BEH	WH	WH, LA
Early supported stroke discharge	CLCH	CNWL	No service	WH	WH
Communtiy stroke rehabilitation services	CLCH (incl. volunteer run stroke support service)	CNWL (Camden Neurological and Stroke Service)	BEH BEH (outpatient offer - community physiotherapy), Acquired Brain Injury – Headway East London	WH (ICTT)	WH (ICRT)
Community neurological rehabilitation services	RFH				
Community rehabilitation / intermediate care services	CLCH	CNWL	BEH	WH (ICTT)	WH (REACH)
Bedded rehabilitation	CLCH	CNWL	BEH	No longer provided	WH
Bedded neuro-rehabilitation	RFH (NRC)	RFH (NRC)	RFH (NRC)	RFH (NRC)	RFH (NRC)
District nursing	CLCH	CNWL	BEH	WH	WH
Falls services	CLCH and RFH	CNWL	BEH and Age UK	WH (ICTT)	WH (REACH)
Bone health and fracture liaison	No service	No service	BEH	No service	No service
Community matrons	CLCH	No service	BEH	WH	WH
Palliative and End of Life Care	North London Hospice	CNWL and RFH	North London Hospice, BEH	NMUH	CNWL and St Joseph's
Specialist					
Diabetes	CLCH	RFH (lead provider)	BEH, GP Federation	WH	WH
Respiratory	CLCH	CNWL	BEH	WH	WH
Spirometry	CLCH	CNWL	Not identified	WH	Not identified
Heart Failure Service	CLCH	CNWL	BEH	WH	WH
Continence Services	CLCH (incl. stoma)	CNWL	BEH	WH	WH
Pain Management	No service	UCLH	BEH (part of MSK service)	WH, part of MSK, unfunded	WH
Lymphoedema Service	BEH	St John's Hospice / UCLH	BEH	WH	WH
Tissue Viability	CLCH (specialist service)	CNWL	BEH	WH (TV and DNs), Accelerate (complex)	WH
Parkinson's Service	CLCH	CNWL	BEH	WH (acute)	WH (acute)
Sickle Cell and Thalassaemia	No service	WH (acute)	NMUH	NMUH	WH (acute)
Self management services (expert patient group education)	Not identified	Not identified	Not identified	WH	WH

Key

- BEH
- CLCH
- CNWL
- WH
- Other
- X Not identified or not provided

Mapping of community health services across NCL (adult services)

Community service	Barnet	Camden	Enfield	Haringey	Islington
Specialist					
Anticipatory care service for older people	Not identified	Not identified	Not identified	WH / GP federation	WH / GP federation
Phlebotomy	CLCH	CNWL	NMUH	WH and NMUH	WH
Learning disabilities	CLCH, LA	T&P, CIFT WH	BEH LA	WH LA	WH
Vision services	No service	RNIB	AQP (multiple providers)	Moorfields, AQP	Moorfields, optometrists
Community ENT	No service	No service	UCLH	Non-NHS contract	UCLH
Community Gynaecology	RFH and GPs	No service	Enfield Health Partnership	Islington GP Federation	No service
Community Urology	No service	No service	BMI	No service	No service
Adult therapies					
MSK Physiotherapy	CLCH	UCLH (lead provider)	WH BEH (MSK + community physio)	WH	WH
ICMSK (consultant led service)	CLCH	No service	BEH	No service	No service
Speech and Language Therapy	CLCH	CNWL - not stand-alone	BEH	WH	WH
Nutrition and Dietetics	CLCH (incl. home enteral feeding)	CNWL	BEH (incl. home enteral feeding)	WH (incl. home enteral feeding)	WH (incl. home enteral feeding)
Podiatry	CLCH	CNWL	BEH	WH	WH
Podiatric surgery	CLCH	No service	No service	No service	No service
Orthotics	CLCH	CNWL (in podiatry)	BEH (in podiatry)	WH (in podiatry)	WH (in podiatry)
Equipment and technology					
Wheelchair Services	AJM Healthcare	CNWL	LA	WH	CNWL
Community equipment	Millbrook	Medequip	LA	Medequip, LA	Medequip, LA
Assistive technology	Millbrook	LA	LA	LA	LA
Care coordination					
Care coordination	LA CLCH	CNWL	BEH - community matrons	WH	WH
CHC	CCG	CNWL	CCG	WH	WH

Key

- BEH
- CLCH
- CNWL
- WH
- Other
- X Not identified or not provided

Notes:

- CLCH Rapid Response and D2A services are integrated
- CLCH intermediate care service provides multidisciplinary rehab to patients at home. Team comprises PT, OT, rehabilitation assistants/ support workers, consultant support, SaLT.
- CLCH care home support has been provided during Covid but is not a commissioned service
- CNWL Camden integrated primary care service comprises district and community nurses, OT, PT, psychologists and SaLT. Service offer includes complex wound care/tissue viability, continence care, End-of-life, falls services, case management, medicines administration, CHC, home-based rehabilitation
- CNWL Carelink integrates complex care for 6 weeks, Stroke ESD, Community rapid response, CCR complex, hospital rapid response, palliative care, overnight sit in, out of hours referrals, D2A)
- WH Integrated Community Therapy Team (Haringey) comprises OT, PT, SaLT, rehabilitation practitioners. Provides Adult rehab (MSK, orthopaedic, respiratory, neuro, stroke), falls prevention, admission prevention.
- WH REACH Intermediate care team (Islington) comprises dietician, consultants, nurse, OT, psychologists, PT, rehabilitation assistants, and SaLT. Rehabilitation support to prevent hospital admission, facilitate discharge, promote independence, falls service, goal-oriented rehabilitation.
- WH Islington Community Neuro-Rehab Team provides specialist adult neuro-rehab for Islington.
- WH anticipatory care service for older people (Haringey): Integrated service to prevent deterioration in the frail elderly. Team comprises community matron, GP, pharmacist, OT, PT, social worker, care navigator, mental health professional, manager
- WH anticipatory care service for older people (Islington) in development. Will bring together Integrated Care Ageing Team (consultant geriatrician, GP w. si, nurse, pharmacist, OT, PT) Preventing Ageing Well Team, Community matrons, MDT coordination.

Mapping of community health services across NCL (children's services)

Children's community service	Barnet	Camden	Enfield	Haringey	Islington
Health visiting (LA funded)	CLCH	CNWL	NMUH	WH	WH
School nursing (LA funded)	CLCH	CNWL	BEH	WH	WH
Oral health promotion (LA funded, public health nursing)		WH	BEH	WH	WH
Special school nursing (NHS funded)	CLCH	RFH	BEH	WH	WH
Family Nurse Partnership (LA)	Decommissioned	Decommissioned	Decommissioned	Decommissioned	WH
Healthy Start Programme (LA)	CLCH LA	CNWL LA	LA	LA WH	WH
Children's community nursing					
Generalist function	CLCH	RFH	BEH	NMUH WH	WH
Long Term Conditions and Specialist Care	CLCH	RFH	BEH	NMUH WH	WH
Epilepsy	RFH	RFH	BEH	Hospital based	WH
Children's sickle cell and thalassaemia	No service	WH	BEH	Hospital based	WH
Community allergy / Atopy services	No service	RFH	BEH	NMUH WH	WH
Children's continuing care assessment service	CLCH	WH	BEH	WH	WH
Children's continuing care provision	Agency spot purchase	WH	BEH	Agency spot purchase	WH
Hospital at home	No service	No service	No service	No service	WH
Children's primary care nurses	No service	No service	No service	No service	WH
Children's palliative care	Agency spot purchase	WH – Life Force	BEH	WH – Life Force	WH
Community paediatrics	RFH	RFH	BEH	WH	WH
Child development team	RFH	CNWL, CICS	BEH	WH	WH
Looked after children's health team / child protection / safeguarding	CLCH	CNWL	BEH	WH	WH
Sleep service	No service	CICS	BEH	WH	WH
Down's syndrome pathway	RFH	CICS	BEH		WH
Autism diagnostic pathway	RFH	CNWL, CICS	BEH	WH 0-11 TP 12-17	WH
Further services					
Children's bladder and bowel service	No service	CNWL	RFH	School nurse enuresis clinic	WH
Community orthoptics	CLCH	No service	NMUH	NMUH	WH
Vision screening reception	CLCH	CNWL	NMUH	NMUH	LA
Audiology	WH	WH	WH	WH	WH
Therapies: SLT	NELFT	WH, CICS	BEH	WH	WH
Therapies: OT	NELFT	RFH, CICS	BEH	WH	WH
Therapies: Physio	NELFT	RFH, CICS	BEH	WH	WH
MSK	CLCH	RFH, CICS	BEH	WH	WH
Dietetics (infants feeding, children's healthy weight)	CLCH	CNWL, CICS	BEH	WH, small service	WH
Weight management (Tier 3)	CLCH	Brandon Centre	BEH	No service Health visiting	Brandon Centre
Wheelchair Services (all ages)	AJM Healthcare	CNWL	BEH	WH	CNWL

Key

- BEH
- CLCH
- CNWL
- WH
- Other
- X Not identified or no service
- TBC

Stakeholder engagement

Appendix – stakeholder engagement full list(s): Interviews (1/3)

Name	Role	Organisation
Jane Betts	Officer Lead	LMC
Craig Seymour	GP Federation Lead / Primary Care Network Lead)	Islington GP Federation
Nufar Wetterhahn	Primary Care Network Lead - Network 3	Barnet
Primary care		3
Mo Abedi	Clinical director	BEH
David Cheesman	Director of strategy	BEH
Jinjer Kandola	Chief Executive / ICS Lead for Mental Health	BEH
Amanda Pithouse	Director of Nursing	BEH
Mike Fox	Chief Finance Officer	CLCH
Anne Whateley	Director of Partnerships and Integration	CLCH
Graeme Caul	Managing Director - Goodhall Division	CNWL
Hannah Witty	Chief Finance Officer	CNWL
Kevin Curnow	Chief Finance Officer	WH
Clare Dollery	Medical Director	WH
Siobhan Harrington	Chief Executive / ICS Lead for Community	WH
Michelle Johnson	Director of Nursing	WH
Community provider		12
Sarah Hayes	Chief Nurse	NMUH
Andy Heeps	Chief Operating Officer	NMUH
Maria Kane	Chief Executive	NMUH
Rachel Anticoni	Chief Operating Officer	RFH
Caroline Clarke	Chief Finance Officer	RFH
David Grantham	ICS Lead HR & Workforce	RFH
Kate Slemeck	Chief Executive / ICS Lead for Urgent Care	RFH
Acute provider		7

Appendix – stakeholder engagement full list(s): Interviews (2/3)

Name	Role	Organisation
John Hooton	Chief Exec	Barnet Council
Brigitte Jordaan	Director of Children's Services	Barnet Council
James Mass	Director of Adult Social Services	Barnet Council
Dawn Wakeling	Exec Director Adults and Health	Barnet Council
Richard Lewin,	Deputy CEO	Camden Council
Jess McGregor	Director of Adult Services	Camden Council
Martin Pratt	Director of Child Services	Camden Council
Jenny Rowlands	Chief Exec	Camden Council
Piers Simey	Director of Public Health	Camden Council
Dudu Sher Amani	Public Health Consultant	Enfield Council
Bindi Nagra	Director of Health and Adult Social Care	Enfield Council
Anne Stokes	AD Children's services	Enfield Council
Doug Wilson	Director of Strategy and People	Enfield Council
Zina Etheridge	Chief Executive	Haringey Council
Will Maimaris	Director of Public Health	Haringey Council
Charlotte Pomery	Director of Commissioning	Haringey Council
Beverley Tarka	Director of Adult Social Services	Haringey Council
Carmel Littleton	Director of Children's Services	Islington Council
Lindsey Roberts-Egan	Chief Exec	Islington Council
Stephen Taylor	Director of Adult Social Services	Islington Council
Nurrullah Turan	Cabinet Member for Adults and Health	Islington Council
Local authority		21

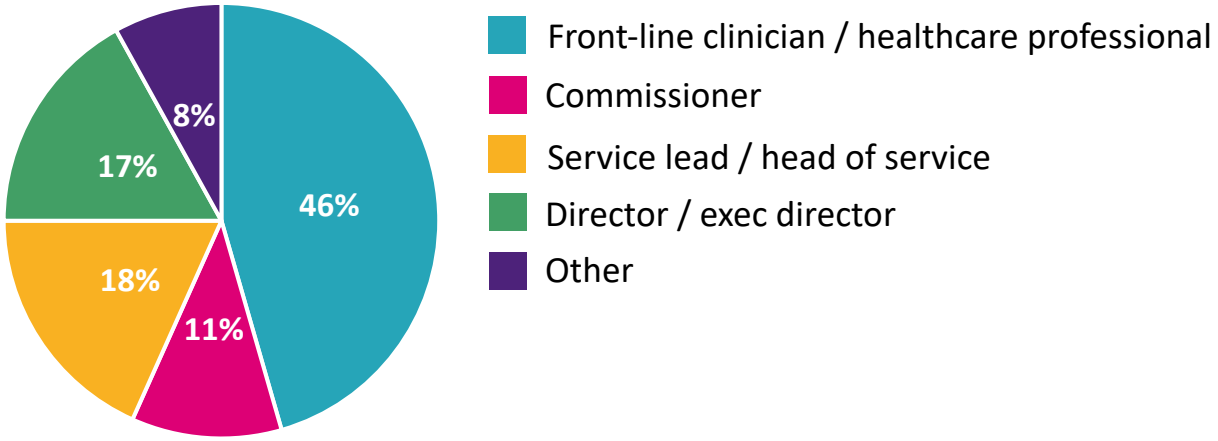
Appendix – stakeholder engagement full list(s): Interviews (3/3)

Name	Role	Organisation
Ian Bretman	Chair NCL Engagement and advisory board	NCL CCG
Chris Caldwell	ICS Lead Nurse	NCL CCG
Katie Coleman	NCL Clinical lead for LTCs, personalisation and ageing well	NCL CCG
Simon Goodwin	Chief Finance Officer	NCL CCG
Neel Gupta	Clinical Representative - Camden	NCL CCG
Will Huxter	Executive Director of Strategy	NCL CCG
Sarah Mansuralli	Executive Director of Strategic Commissioning	NCL CCG
Sarah McDonnell-Davies	Executive Director of Borough Partnerships	NCL CCG
Frances O'Callaghan	Accountable Officer	NCL CCG
Jo Sauvage	Chair and Clinical Representative - Islington/ ICS Lead for Primary Care	NCL CCG
Commissioner		10
Mike Cooke	ICS chair	NCL CCG
Dominic Dodd	Chair of NCL provider allliance	
Rob Hurd	ICS System Lead	RNOH
Other		3
Total interviewees		**56**

Appendix – stakeholder engagement full list(s): Survey

Organisation	Responses
Primary care	63
Community provider	91
Local authority	39
Acute provider	14
Commissioner	42
Other	14
Total respondents	**228** *(respondents can work across multiple organisations)*

Roles of survey respondents



Source: NCL Community Services survey responses, CF analysis

Appendix – stakeholder engagement full list(s): Community Baseline workshop attendees

Attendee	Role	Organisation
Alexander Smith	Director of Transformation	NCL CCG
Alexis Ingram	Primary Care Network Lead - Network 3 / GP Federation Leads	Primary care
Alice Tertois	Contract Lead	NCL CCG
Alison Kett	Deputy Director for Nursing and Patient Experience	WH
Andy Heeps	Chief Operating Officer	NMUH
Anne Whateley	Director of Partnerships and Integration	CLCH
Azom Mortuza	Divisional Director of Operations, Community Services	NMUH
Chitra Sankaran	Enfield GP Lead	NCL CCG
Chris Caldwell	ICS Lead Nurse	NCL CCG
Christina Keating	Designated Nurse for Safeguarding Children	NCL CCG
Clare Dollery	Medical Director	WH
Craig Seymour	GP Federation Leads / Primary Care Network Lead - North	Primary care
Dan Windross	Assistant Director, Integration	NCL CCG
Daniel Morgan	Interim Director of Strategic Commissioning	NCL CCG
David Grantham	ICS Lead HR & Workforce	RFH
Dennis Enright	Chief Operating Officer	CLCH
Frances O'Callaghan	Accountable Officer	NCL CCG
Graeme Caul	Managing Director - Goodhall Division	CNWL
Hannah Witty	Chief Finance Officer	CNWL
Helen Mehra	Head of Nursing - Enfield Community Services	BEH
Jane Betts	Officer Lead	LMC
Jinjer Kandola	Chief Executive / ICS Lead for Mental Health	BEH
Jo Murfitt	NCL Community and Mental Health Strategic Reviews Programme Director	NCL CCG
Jo Sauvage	Chair and Clinical Representative - Islington/ ICS Lead for Primary Care	NCL CCG
Katherine Gerrans	Director of Primary Care Nursing	NCL Training hub

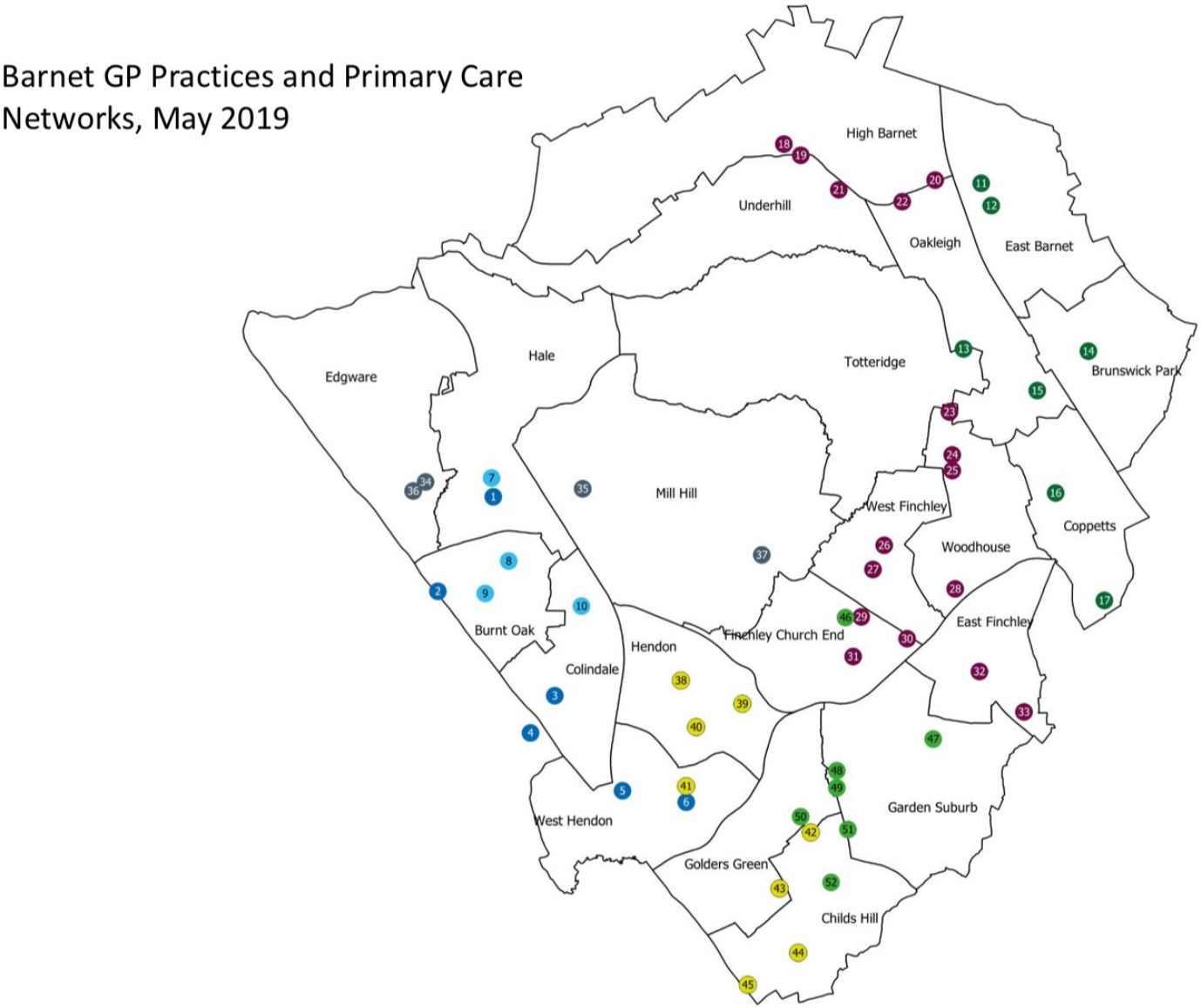
Appendix – stakeholder engagement full list(s): Community Baseline workshop attendees

Attendee	Role	Organisation
Katie Coleman	NCL Clinical lead for LTCs, personalisation and ageing well	NCL CCG
Katy Millard	Community Services Director	CNWL
Kevin Curnow	Chief Finance Officer	WH
Manpareet Dhaliwal	Associate Director of Finace	CNWL
Mark Eaton	Interim Director of Strategic Projects	NCL CCG
Martin Pratt	Director of Children's Services	Camden Council
Michelle Johnson	Director of Nursing	WH
Mike Fox	Chief Finance Officer	CLCH
Mo Abedi	Clinical Director	BEH
Natalie Fox	Chief Operating Officer	BEH
Nitika Silhi	Enfield GP Lead	NCL CCG
Nurrullah Turan	Cabinet Member for Adults and Health	Islington Council
Parmjit Rai	Managing Director - Enfield Community Services	BEH
Rachel Anticoni	Chief Operating Officer	RFH
Robyn Doran	Chief Operating Officer	CNWL
Sally Dootson	Director of Operations	RFH
Sarah Mansuralli	Executive Director of Strategic Commissioning	NCL CCG
Sarah McDonnell-Davies	Executive Director of Borough Partnerships	NCL CCG
Simon Goodwin	Chief Finance Officer	NCL CCG
Siobhan Harrington	Chief Executive / ICS Lead for Community	WH
Sita Chitambo	Divisional Director of Nursing, Community Services	NMUH
Steve Ebert	Communications and Engagement	NCL CCG
Tamara Djuretic	Director of Public Health	Barnet Council
Vicky Weeks	Medical Director London	Primary care

PCN locations

NCL PCN locations (Barnet)

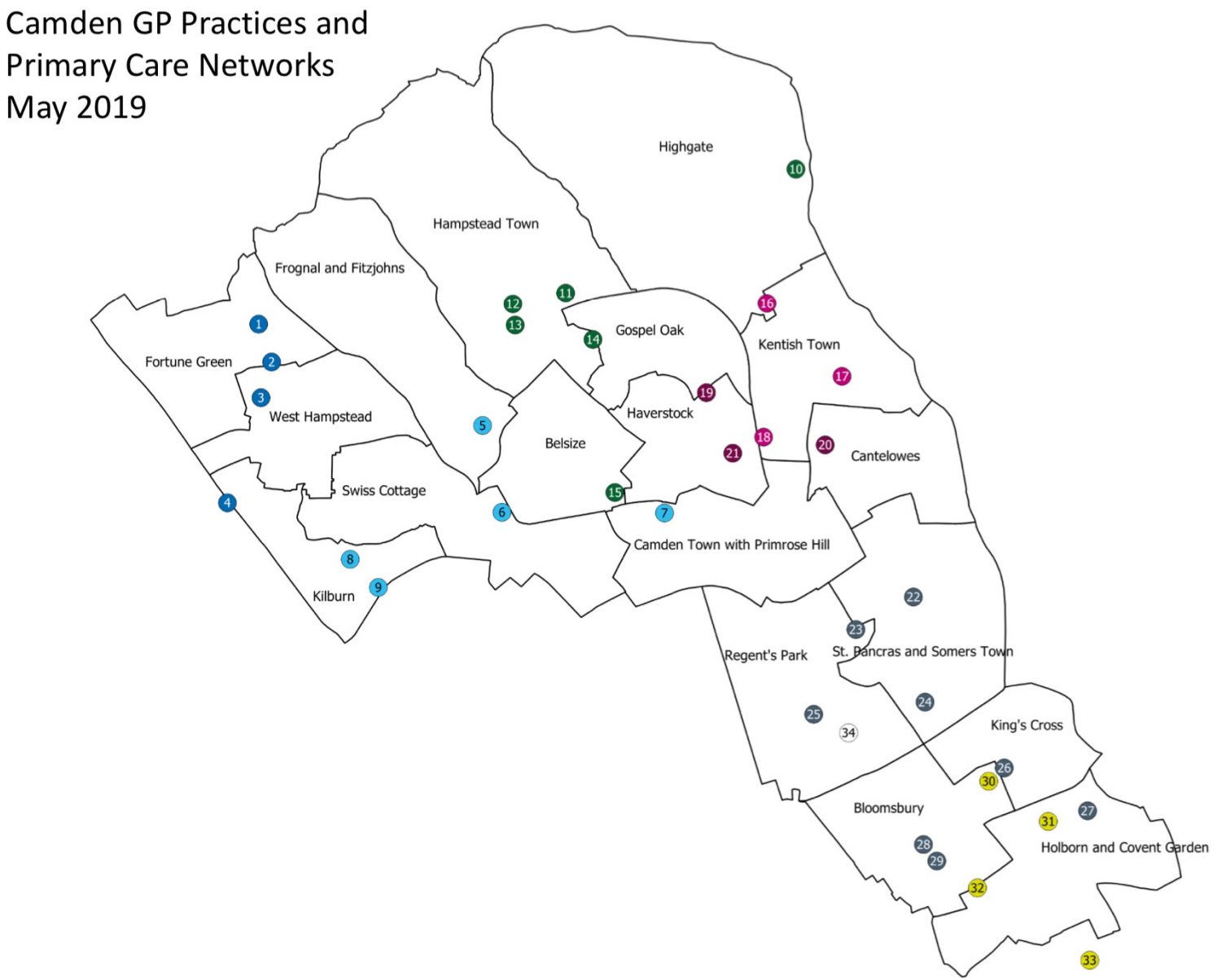
- PCN 1D
- PCN 1W
- PCN 2
- PCN 3
- PCN 4
- PCN 5
- PCN 6



Source: NCL CCG website https://www.northlondonpartners.org.uk/news/north-central-londons-primary-care-networks-showcased-as-best-practice.htm

NCL PCN locations (Camden)

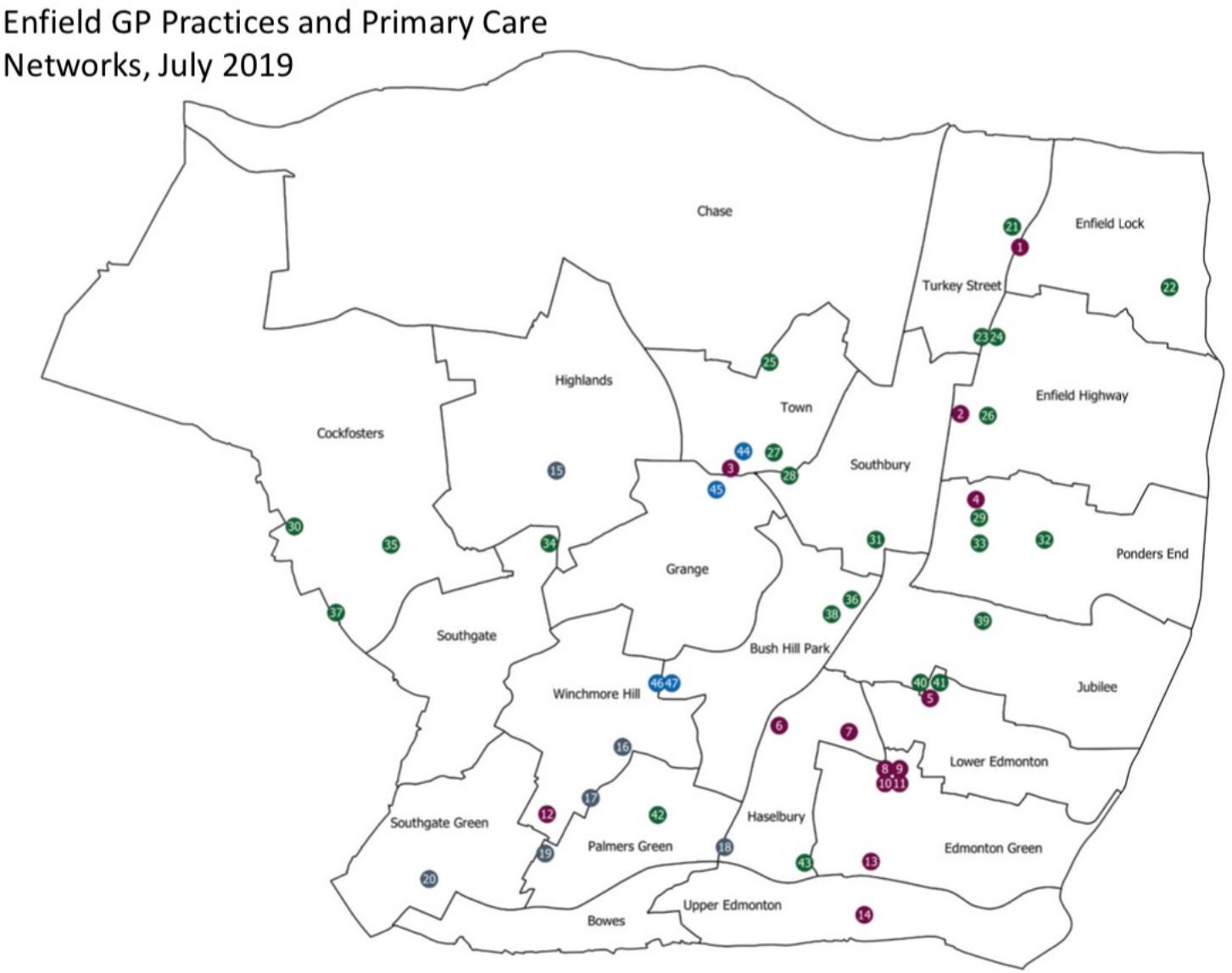
- Central Hampstead PCN
- West Camden PCN
- North Camden PCN
- Kentish Town Central PCN
- Kentish Town South PCN
- Central Camden PCN
- South Camden PCN



Source: NCL CCG website https://www.northlondonpartners.org.uk/news/north-central-londons-primary-care-networks-showcased-as-best-practice.htm

NCL PCN locations (Enfield)

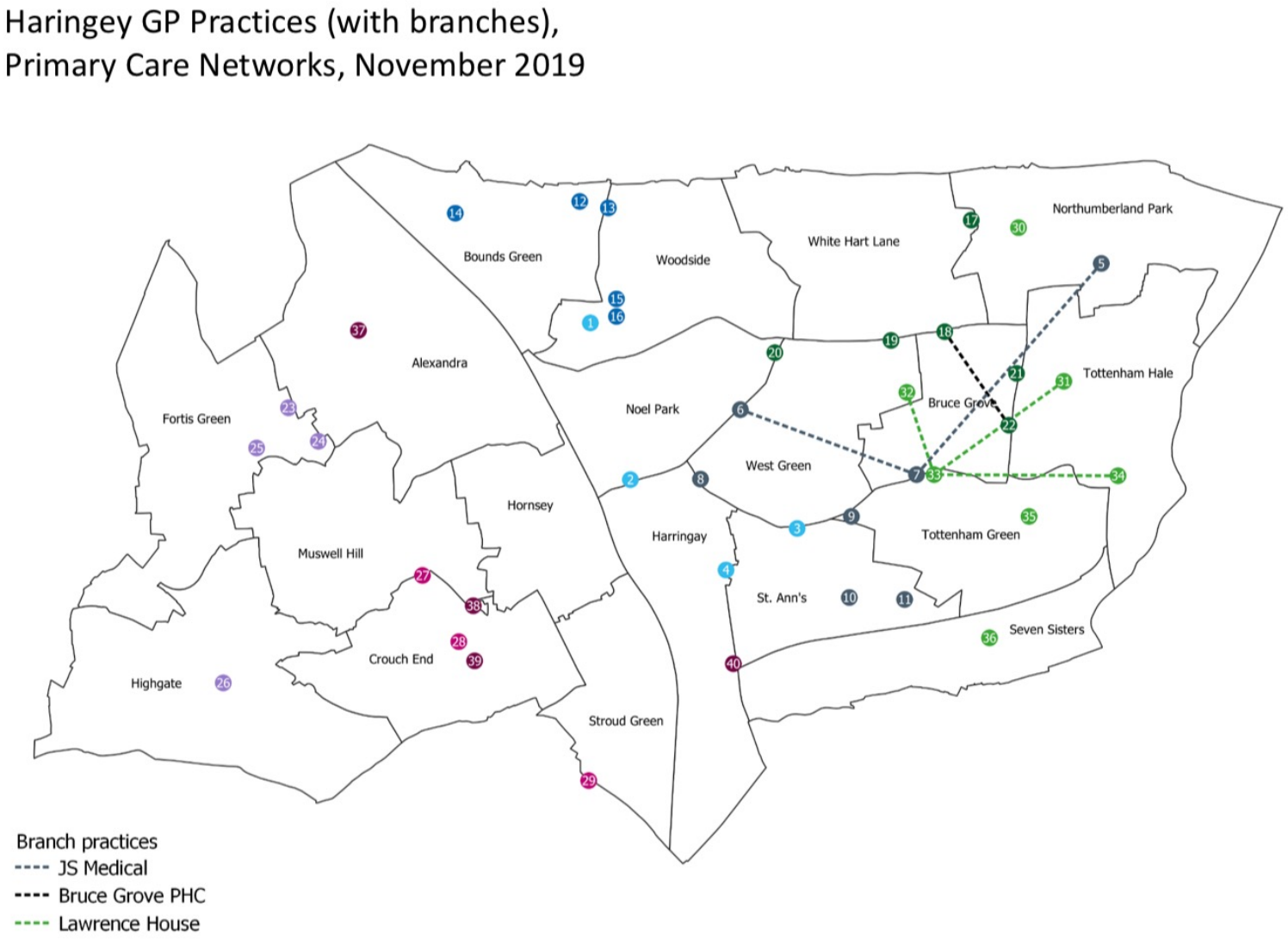
- Enfield South West PCN
- West Enfield Collaborative PCN
- Enfield Unity PCN
- Enfield Care Network PCN



Source: NCL CCG website https://www.northlondonpartners.org.uk/news/north-central-londons-primary-care-networks-showcased-as-best-practice.htm

NCL PCN locations (Haringey)

- North West PCN
- South West PCN
- West Central PCN
- East Central PCN
- North Central PCN
- N15/South East PCN
- North East PCN
- Welbourne PCN

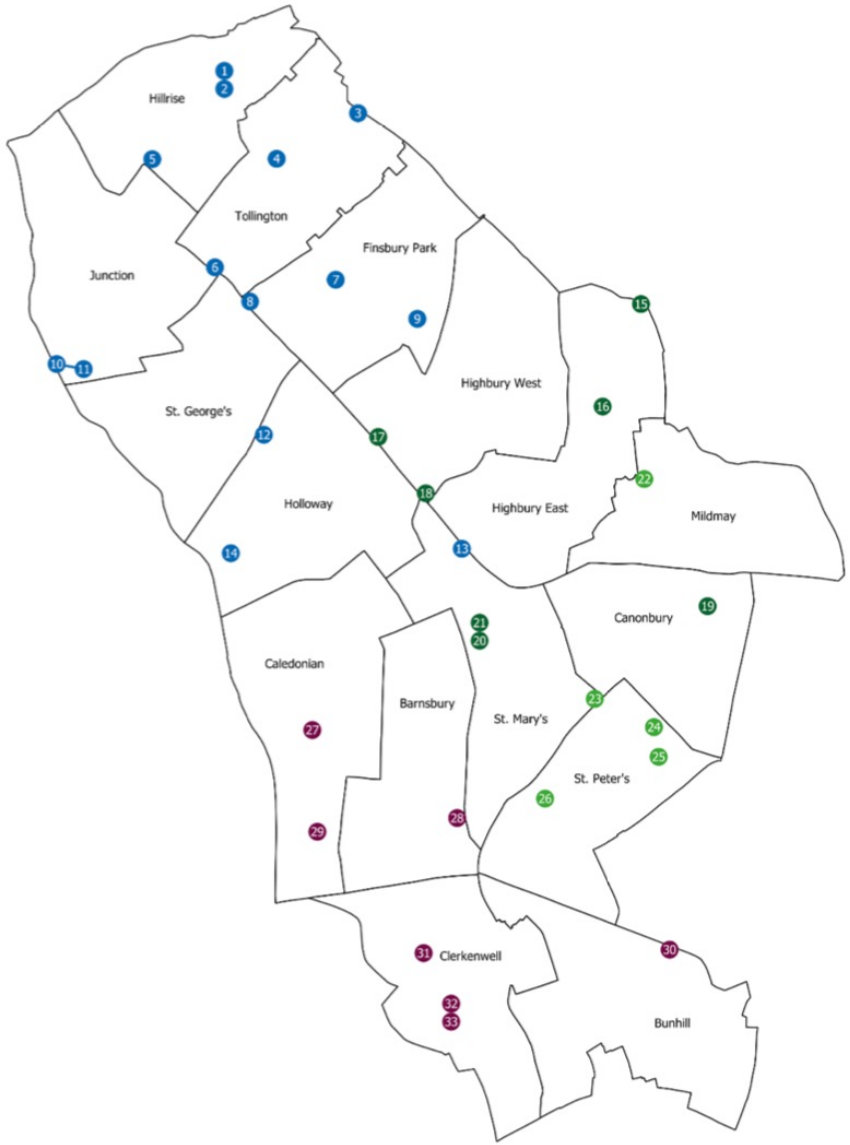


Source: NCL CCG website https://www.northlondonpartners.org.uk/news/north-central-londons-primary-care-networks-showcased-as-best-practice.htm

NCL PCN locations (Islington)

- North PCN
- Central 1 PCN
- Central 2 PCN
- South PCN

Islington GP Practices,
Primary Care Networks,
May 2019

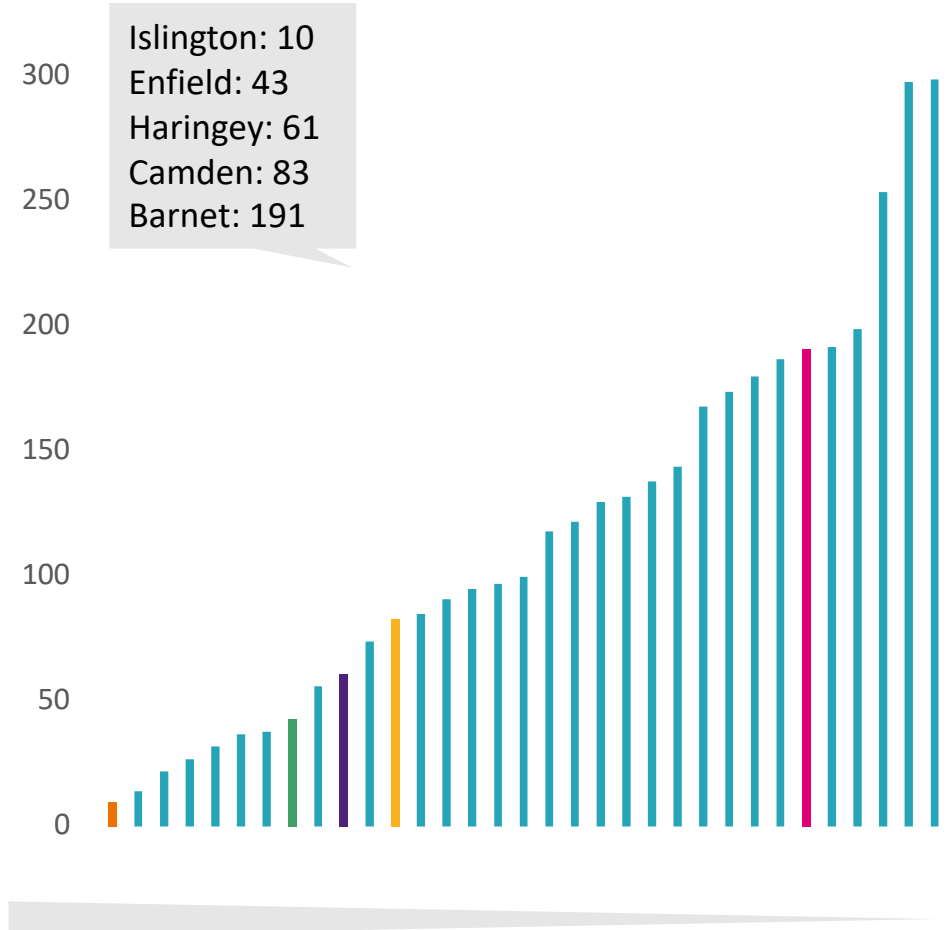


Source: NCL CCG website https://www.northlondonpartners.org.uk/news/north-central-londons-primary-care-networks-showcased-as-best-practice.htm

Income deprivation affecting children and older people

29% of LSOAs in Islington are in the most deprived 10% nationally for income deprivation affecting children

Income deprivation affecting children, rank of average national score, London Local Authority Districts shown, 2019

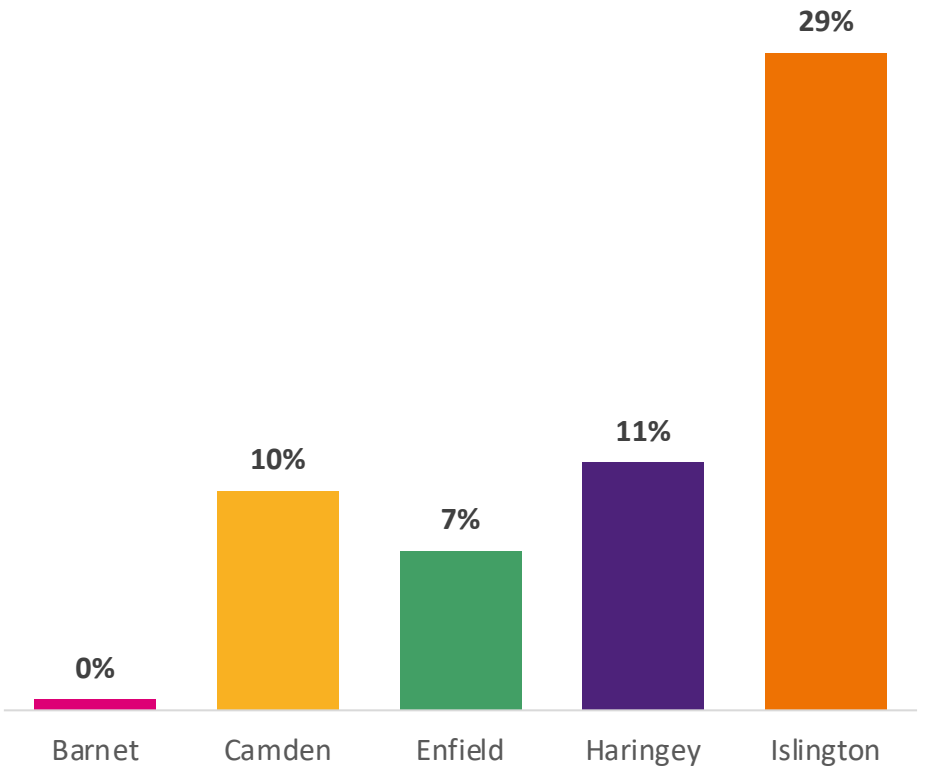


(National rank 1)
Most deprived

(National rank 317)
Least deprived

Source: IMD 2019

Income deprivation affecting children, % of LSOAs in most deprived 10% nationally, NCL boroughs, 2019

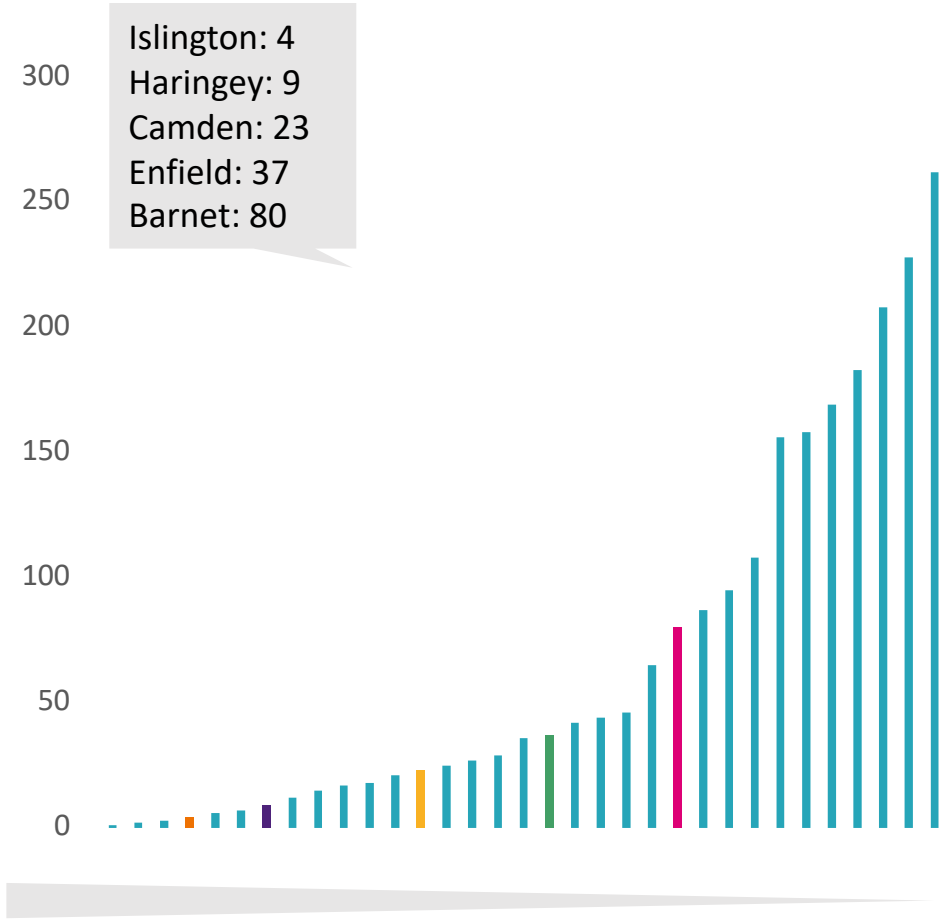


The Income Deprivation Affecting Children Index (IDACI) measures the proportion of all children aged 0 to 15 living in income deprived families

Barnet
Camden
Enfield
Haringey
Islington

44% and 50% of LSOAs in Haringey and Islington respectively are in the most deprived 10% nationally for income deprivation affecting older people

Income deprivation affecting older people, rank of average national score, London Local Authority Districts shown, 2019

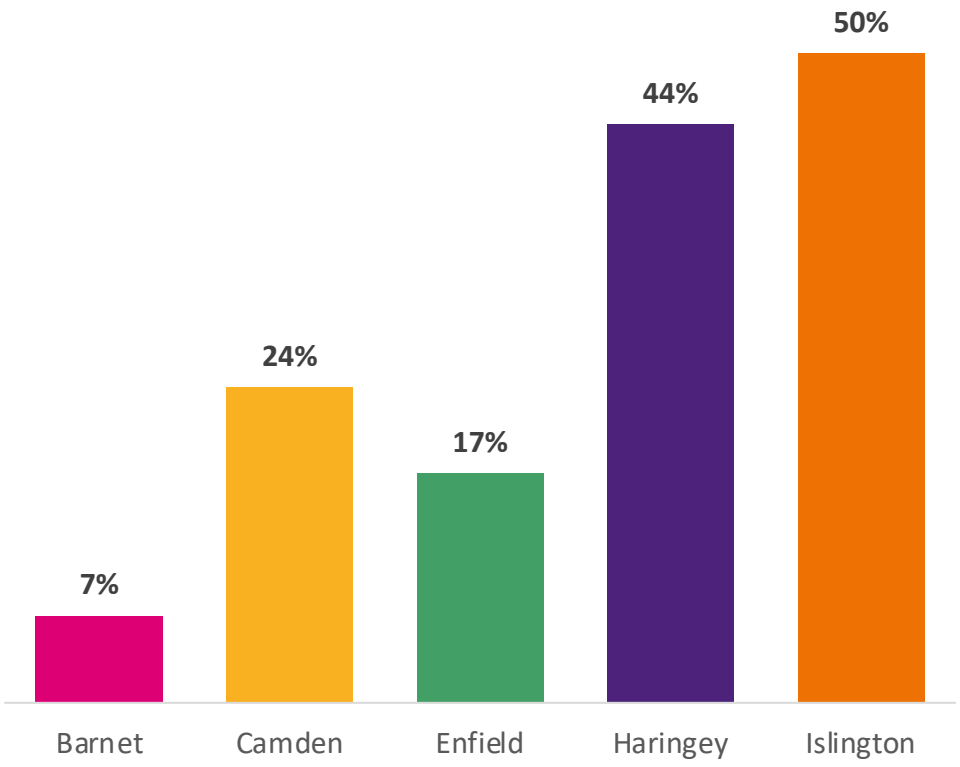


(National rank 1)
Most deprived

(National rank 317)
Least deprived

Source: IMD 2019

Income deprivation affecting older people, % of LSOAs in most deprived 10% nationally, NCL boroughs, 2019



The Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of all those aged 60 or over who experience income deprivation

Barnet
Camden
Enfield
Haringey
Islington