North Central London Integrated Care Partnership

Tuesday 11 July 2023; 15:00-17:00

Committee Rooms 1 and 2, Islington Town Hall, Upper Street, Islington, London N1 2UD

	Item	Page	Time	Lead
1.	**Welcome and Introductions**	Oral	15:00	Chair
2.	**Minutes and Actions**	Page 2	15:10	Chair
3.	**NCL Inequalities Fund – Evaluation**	Page 12 *Also see Appendix A and Appendix B*	15:15	Sarah D'Souza
4.	**Mental Health** • **CAMHS Deep Dive** • **Adult Mental Health Emergency Pathway**	Page 15	15:50	Sarah Mansuralli
5.	**Discussion on future NCL workshop on the delivery of the Population Health and Integrated Care Strategy**	Oral	16:30	Chair
6.	**AOB**	Oral	16:50	Chair

North Central London
Integrated Care Partnership
11 July 2023 - Action Log

On Agenda	
Needs Urgent Update	
In Progress	
Completed	

Meeting Date	Action Number	Action	Lead	Deadline	Update
18 April 2023	1	**Childhood Immunisations – Test and Learn Paragraph 2.1.8** To provide a summary of the immunisations work to the ICB Board.	Dan Glasgow	August 2023	It is planned to take a summary to the Editorial Board in August 2023.
18 April 2023	2	**Discussion – challenges and opportunities for 2023/24 Paragraph 3.3.2** To bring a paper on the position with regards to the development of place based working and Borough Partnerships (opportunities and challenges) to a future meeting.	Sarah McDonnell-Davies/ Dawn Wakeling	October 2023	The Leadership Centre report for NCL is now available. London work on the relationship between system and place led by PPL is progressing and draft findings are being developed. Within NCL, reflections on opportunities and challenges are being gathered from Borough Partnership leads to inform a paper for October 2023.

18 April 2023	3	**Population Health and Integrated Care Strategy Paragraph 4.1.3** To facilitate a discussion on the Population Health and Integrated Care Strategy delivery plan, timescales and milestones.	Sarah Mansuralli/ Will Maimaris	September 2023	A workshop for system partners to discuss the priorities and delivery of the Strategy is being planned and due to be held by September 2023.

North Central London Integrated Care System

Draft Minutes

Meeting of North Central London Integrated Care Partnership

18 April 2023 between 12pm and 2pm
Arlington Room, Laycock Centre, 28 Laycock St, London, N1 1SW

Present:	
Cllr Kaya Comer-Schwartz	Leader, Islington Council (Chair)
Cllr Peray Ahmet	Leader, Haringey Council
Cllr Barry Rawling	Leader, Barnet Council
Cllr Anna Wright	Camden Council
Cllr Nesil Caliskan	Leader, Enfield Council
John Hooton	Chief Executive, Barnet Council
Linzi Roberts-Egan	Chief Executive, Islington Council
Frances O'Callaghan	Chief Executive Officer, NCL Integrated Care Board
Jon Abbey	Corporate Director, Children's Services, Islington Council
Nnenna Osuji	Chief Executive, NMUH
Dr Chris Caldwell	Chief Nursing Officer, NCL Integrated Care Board
Sara Sutton	Assistant Director for Place-based Commissioning and Partnerships, Haringey Council
Will Maimaris	Director of Public Health, Haringey
Alpesh Patel	Chair, GP Provider Alliance
Doug Wilson	Statutory Director of Health and Adult Social Care, Enfield Council
Phil Wells	Chief Finance Officer, NCL Integrated Care Board
Darren Summers	Deputy Chief Executive, Camden and Islington NHS Foundation Trust
Kirsten Watters	Director of Public Health, Camden Council
Dr Jo Sauvage	Chief Medical Officer, NCL Integrated Care Board
In attendance	
Sarah Mansuralli	Chief Development and Population Health Officer, NCL Integrated Care Board
Sarah McDonnell-Davies	Executive Director of Place, NCL Integrated Care Board
Dawn Wakeling	Executive Director Communities, Adults and Health, Barnet Council
Dan Sheaff	ICS Policy Lead, North London Councils

* Standing Participant

Amy Bowen	Director of System Improvement, NCL Integrated Care Board
Jose Acuyo	Head of Population Health Commissioning, NCL Integrated Care Board
Dan Glasgow	Director of Vaccination Transformation, NCL Integrated Care Board
Apologies	
Mike Cooke	Chair, NCL Integrated Care Board
Martin Pratt	Deputy Chief Executive and Executive Director of Supporting People, Camden Council
Beverley Tarka	Director of Adults, Health and Communities, Haringey Council
Jinjer Kandola	Chief Executive Officer, Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health NHS Trust
Dominic Dodd	Chair, UCL Health Alliance
Cllr Georgia Gould	Leader, Camden Council
Baroness Julia Neuberger	Chair, UCLH and Whittington Health
Minutes	
Steve Beeho	Senior Board Secretary, NCL Integrated Care Board

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1	The Chair welcomed attendees to the Meeting. Apologies had been received from Mike Cooke, Caroline Clarke, Jinjer Kandola, Beverley Tarka, Dominic Dodd, Cllr Georgia Gould, Martin Pratt and Baroness Julia Neuberger.
1.1.2	Jon Abbey and Kirsten Watters were attending on behalf of Martin Pratt (Jon as Directors of Children's Services deputy and Kirsten as Camden Council deputy). Sara Sutton was attending on behalf of Beverley Tarka and Darren Summers was attending on behalf of Jinjer Kandola.
2.	**Childhood Immunisations – Test and Learn**
2.1.1	Dr Chris Caldwell and Kirsten Watters, Joint SROs of the Childhood Immunisations programme, introduced the paper. It was noted that this area of work had been identified as a priority for collective action at the previous meeting. Discussions have taken place around how to accelerate work on this at the Borough level, building on system learning from delivering Covid vaccines to address the high level of variation and poor uptake in certain communities. There is an over-arching goal for all children in NCL to be fully vaccinated by the time they start school. Good progress been made on this but it is not evenly spread, so there is a focus on accelerating this to make a difference across NCL.
2.1.2	It was noted that the decline in immunisation uptake figures pre-dated the pandemic. The decline in London was steeper than other areas, and this was also leading to a widening of health inequalities. Work is taking place to engage communities across London. NCL is at the forefront of a lot of this work, particularly with regards to faith forums and its hyper-local approach. There have been welcome increases in take-up of MMR1 and MMR2, which reflects excellent work at a system level and in borough, especially in identifying where children are coming forward late for vaccinations.

2.1.3	It is clear that there are inequalities across every immunisation programme and with respect to ethnicity, age and deprivation and these inequalities widen as children get older. There is an urgency to focus on the under-fives, while also recognising the importance of the adult programmes as these have a significant impact on health system resilience. Robust, equitable and high immunisation uptake is at the cornerstone of population health systems, so the work that is now taking place to build trust and demand for vaccines, will provide a strong platform for implementing future population health strategies.
2.1.4	Each Borough has a delivery structure in place, including leadership via an Immunisations and Vaccinations Steering Group. This is facilitating work locally and supporting a hyper-local approach to delivering immunisation programmes. The paper contained examples of key actions working with local communities and how this is being shared to support the principle of 'once for NCL' where this will optimise impact. It is important to ensure that robust systems are in place to maintain data quality and that the NCL workforce - especially in public health, primary care, community, health visiting and maternity services - is utilised effectively as part of a whole system approach. There is targeted communications and engagement, building on the learning from the pandemic. Community outreach is being used to provide added value across other Population Health challenges, such as screening and health promotion.
2.1.5	It was noted that although the Vaccination programme is currently regionally commissioned, the excellent work taking place on delivery will put NCL in a strong position in the future when it is able to have more local control over meeting the needs of its communities as part of the anticipated Section 7(a) delegation in 2024/25.
2.1.6	ICP members then discussed the paper, making the following comments: • The importance of children being 'school ready' was acknowledged. Health visitors have an important role to play pre-school and it will be important to engage with them, along with midwives, maternity teams and school nurses so that they can be supported to have the right conversations. • The forthcoming changes to Section 7a of the Children's Act will enable a more consistent approach to vaccinations in schools • Two recent child deaths in one Borough from a disease that children can be immunised against, underlined the potential consequences of not being vaccinated • Childhood Immunisations is embedded in the main GP contract, with separate commissioning by NHS England for school-age service provision. • Community pharmacy became a key site for delivery during the pandemic, , but there is no mechanism to support them to deliver Childhood Immunisations ongoing. The recent Phase 1 Polio campaign demonstrated that there is untapped potential • Digital infrastructure (for example around 'Call and Recall') isa barrier within the neighbourhood model and the ICS needs to consider what can be done to address this • It was highlighted that Camden Council have gathered a large amount of data on pre-school children to help them understand whether local children are fully immunised, a healthy weight and have speech and communication needs etc. This is being used to engage families who may be more receptive to advice during the transition to school period • The lack of a regional population health management system to track immunisations makes it important to use opportunities such as attendance at A&E, to 'make every contact count' and gather data locally. • Concern was expressed about signs of vaccination fatigue in the community and the apparent lack of a joined-up approach in Haringey around recent polio vaccinations • Spring Covid boosters will only be offered to vulnerable populations, including children. Paediatricians and nurses in hospitals will be key in driving this message, but it is recognised that they are often under considerable pressure, so innovative thinking will be needed to support them in making every contact count • There was general agreement that it would be helpful to set some targets and associated timelines but these would need to be agreed collectively. • It was noted that the first step was to refresh workplans identifying what can be implemented quickly in each Borough with predicted impact.

	• The ICP is keen to support 'big ideas' and the report demonstrates the value of an ICP providing the authority to work together on common goals • It was agreed that Dan Glasgow would provide a summary of this for the ICB Board.
2.1.7	The NCL ICP **NOTED** the progress, next steps and key challenges.
2.1.8	Action: Dan Glasgow to provide a summary of the immunisations work to the ICB Board.
3	**Our Borough Partnerships - delivery and development**
3.1	**Updates on local priorities and progress**
3.1.1	Sara Sutton provided an update on work in Haringey, which included the following: • Haringey Borough Partnership have selected Community Mental Health as its *Test and Learn* area. Approximately 9% of the population have a recognised diagnosis of depression and the percentage diagnosed with severe mental illness (1.4%) is higher than the average across London (1.1%). • Work has been taking place to build the foundations for delegated decision making within the Borough Partnership through the development of Outcome Improvement Priorities and improving oversight and understanding, particularly around mental health investment and transformation activities. • An external review of Council-commissioned mental health service provision has also been commissioned • Alongside the above, a Section 75 Review will take place over the next six months. This will help the ICB and Council identify transformation priorities for services in the scope of the S75. It should also help partners consider and articulate how shared decisions might be taken together and via the Borough Partnership.
3.1.2	Kirsten Watters provided an update on work in Camden, which included the following: • A Section 75 review is taking place to look at the extent to which this reflects the Borough Partnership priorities while also seeking to identify opportunities for efficiency and improved outcomes. • The review will also look at how Public Health Grant priorities are aligned with Section 75 and Borough Partnership priorities • There is local work on alignment across partners key strategies and plans. Population health approaches are being woven through the Borough Partnership plan, on to the Health and Wellbeing Strategy and through to the Population Health and Integrated Care Strategy.
3.1.3	Dawn Wakeling provided an update on work in Barnet, which included the following: • The Autism pathway and the commissioning of the care market have been identified as *Test and Learns*. • A multi-disciplinary model is now in place for frailty and dementia across all Primary Care Networks (PCNs) and an integrated paediatric MDT model is currently in development in four out of seven PCNs • A community mapping exercise has been carried out to identify the resources available at PCN level for adult services and voluntary and community initiatives. • The Borough Partnership's Joint Dementia Strategy is due to be agreed • The Barnet Innovation Fund has to date awarded £820,000 to 47 voluntary and community sector projects. • Following a recent tender, external analysis will shortly be carried out on the Barnet 'Health and Care Pound', looking at what is spent in Barnet across the system.
3.1.4	Linzi Roberts-Egan provided an update on work in Islington, which included the following: • An Integrated Front Door is being developed between health and social care to provide a single place for joint triaging of caseloads

	• In order to reduce hospital admissions, the Recovery Service is addressing thorny issues through multidisciplinary working and short-term interventions which often require the involvement of more than one agency • There are now three physically and virtually co-located Integrated Community Teams working across the Borough, building on the learning from an earlier pilot. • The mental health framework is being embedded to improve the effectiveness of the response to patients in the community and this is now bearing fruit.
3.1.5	Doug Wilson provided an update on work in Enfield, which included the following: • The Enfield Borough Partnership has new Co-Chairs - Nnenna Osuji and Alpesh Patel have been appointed to these posts. • There is a strong focus on early intervention and prevention under the CORE20PLUS5 model, with a particular focus on obesity, smoking cessation and improved self-management of long term conditions • Community hubs have been set up and are working well. • Partners are looking at the S75 and at areas which the Partnership could take a more integrated approach to with more decisions taken via the borough partnership, such as voluntary sector contracts.
3.2	**Update on London-wide and NCL work**
3.2.1	Dawn Wakeling and Sarah McDonnell-Davies provided an overview of London-wide and NCL work taking place: • The Place Decision Framework – a document which outlines our approach to working together at place in NCL, continues to be developed. It is owned by the Place Editorial Board, an externally facilitated space which brings leads together to consider how we drive maturation of these arrangements and ensure an effective and complimentary relationship between system and place. • Test and Learn projects will provide valuable learning about what it takes for the Borough Partnerships to mature and take on a leadership role in the system. • The Leadership Centre, which has been facilitating some of this work, are providing a final report to inform our next steps and ongoing development. • Work is also ongoing on a 'roadmap' which describes an 'end state' and the key enablers needed to create truly impactful Borough Partnership arrangements where partners work together to take and optimise their decisions and impact. • As agreed at the last meeting, a piece of work to look across London at arrangements in each ICS regarding the relationship between system and place has commenced. PPL have been commissioned by the London office of ICB Chief Executives to undertake this work and have drafted an initial outline of what this will entail. • This report will cover a range of areas , including looking at the different visions for Borough Partnerships, the way that authority / decision making and infrastructure is working across the systems, and understanding how history, context and relationships influence the approaches being taken • Learning will be gathered from each system. It is anticipated that an initial draft report will be available in Autumn.
3.3	**Discussion – challenges and opportunities for 2023/24**
3.3.1	ICP members then discussed, making the following comments: • The system has undergone numerous reorganisations as we work towards integration and develop a population health approach to tackling inequalities. • It is essential that the borough partnerships take this forward by committing to delivering genuine change through a focus on early intervention and prevention and building more integrated workforce models • It is important to ensure that the Borough Partnerships have sufficient resource and capability to drive real change on the ground. • It is recognised that local partners coming together to take decisions in the collective best interest will be challenging.

	• Building on the reflections from the Leadership Centre, it might be helpful at the next meeting to consider what we are sponsoring as system leaders and what tone we are setting to drive the types of decisions that allow for integration • It was suggested that further thought needs to be given to how the ICP might come to understand the sheer breadth and depth of the work underway under each of the Borough Partnerships. Although the verbal updates are helpful, they inevitably only scratch the surface of the work taking place. Although it would also be helpful to identify the 2-3 key things each borough needs to deliver locally • School readiness is a major area for integrated working. Schools are having to contend with an increasing number of Tier 1 mental health challenges and we know the whole issue of 'school readiness' links back to having a good home environment. A holistic approach is needed across the system that gives young people the best start in life, with the right resource in place • The system needs to strike a balance between tailoring local solutions and an NCL framework with an evidence base in order to offer equitable solutions to the entire NCL population • Significant sharing and learning is taking place both within Borough Partnerships and across them via the Editorial Board. It would be helpful to collectively share where we have struggled to date, and what the Leadership Centre said about where we should be going in the medium term. It was agreed that Sarah McDonnell-Davies and Dawn Wakeling would bring a short reflective paper on this theme to a future meeting for discussion.
3.3.2	Action: Sarah McDonnell-Davies and Dawn Wakeling to bring a paper on the position with regards to the development of place based working and Borough Partnerships (opportunities and challenges) to a future meeting.
4.	**Population Health and Integrated Care Strategy**
4.1.1	Dr Will Maimaris and Sarah Mansuralli introduced the paper, making the following points: • The draft strategy has been further revised in light of feedback at the last meeting • It has now been presented to the five Health and Wellbeing Boards, all of whom were supportive • The main changes in the document relate to the key delivery areas • The strategy identifies a series of levers that could shape how we work as a system, including aggregating resources • The ICB Board has identified the need to reach a level of granularity within the delivery plans so that plans are in place for each key delivery area and the levers for change. • Some of these will be much more system-oriented while others will need to be driven via Borough Partnerships. • It is important that these delivery plans are aggregated and a discussion takes place regarding the outcomes frameworks and metrics we set ourselves • The transition to delivery will be based on three key horizons – 0-18 months, 18-36 months and longer than 36 months. It is recognised that the first phase is both a foundational and transitional period, where we need time to create the system infrastructure and architecture to monitor and deliver. • It is important that the strategy is socialised within, owned and recognised by every organisation in the system. • The significant cultural change needed to deliver this strategy will come about by creating an awareness of what we are trying to achieve while also enabling and empowering teams to work differently by thinking more holistically about wider determinants and root causes • The prevention/early intervention approach set out in the strategy is key to the future sustainability of public sector services. • Partners will need to champion people change within their respective organisations and there is a standing offer for Sarah Mansuralli and Will Maimaris to come to speak to leadership teams about what this means for their organisations • Conversations to date at Borough Partnership level have been highly positive, with a lot of alignment and willingness to deliver PHIS priorities.
4.1.2	ICP members then discussed the paper, making the following comments:

	• It is important to think about population health in both the here and now, as well as looking ahead 18 months. • Although the system has responded well to mitigate the impact of the recent industrial action, it is impossible to quantify at this stage how many people were not booked in for operations or significant appointments as a result of the strikes. When patients have a hospital appointment booked they are already some way down the pathway in terms of prevention. There is already a concern among the public that they will have to wait a considerable length of time for hospital treatment and the industrial action has exacerbated this perception. These factors underline the need for an even greater emphasis on keeping well and an increased focus on prevention. • The recent Kings Fund report, *The rise and decline of the NHS in England 2000–20*, talks about shifting funding from hospitals into the community, but notes there has been a reduction in the proportion of NHS funding being spent on primary care. However, when the NHS is in a planning round and hospitals have deficits, its extremely challenging to divert funding elsewhere. Investing outside hospitals will require collective courage and will be difficult. • Getting frontline staff to think more about preventative healthcare and do things differently when they are already extremely pressurised will inevitably be challenging. To address this, leaders should think about how best to ask people to do a limited number of different things • It is important to view the current situation in the context of declining health outcomes in the aftermath of Covid and the cost of living crisis, as well as health and care system pressures. The system therefore needs to focus on health promotion as well as its hyper-local 'offer' for those people who are yet to become unwell • Although an increased emphasis on making every contact count would bolster secondary prevention, there is clearly room for improvement in health literacy in the general population. Some of the recent regional work around access, suggests that this educational work hasn't been done as well lately as it has been in the past, as it has not been systemic or far-reaching enough • Partners should use this difficult time to encourage the public to take responsibility for their health and promote greater self-reliance • The experience of colleagues feeling re-inspired after being moved from hospital work to deliver Covid vaccinations in the community, shows how really thinking about local communities and populations can provide an opportunity to re-energise staff • It was acknowledged that NHS financing can make long-term planning more challenging compared to the greater freedom that local authorities have in this area. The system needs to get better at economic analysis to identify and demonstrate how investment can deliver financial savings further down the line. • There are terrific resources in NCL, such as UCL, cancer charities and the Crick Institute which we need to leverage • It was further noted that financial planning will be critical to create the headroom to invest in population health improvement approaches. The strategy offers a lever to align resources to need, building on the recommendations in the recent Hewitt Review about investing in early interventions in primary and secondary care • Although the strategy is welcome, there is a risk that if the short-term challenges are not rapidly addressed, any efforts around the long term will be dissipated and there will be a general decline. Although the challenges facing the system are not new, there has been a noticeable change in public attitudes towards the NHS. This is exemplified by a growing belief that it is not worth phoning for an ambulance and the increasing number of residents going private because of concerns around access to primary care • It is also recognised that it is important to have service users and residents involved in the development of local delivery plans as part of a commitment to co-production • It was agreed that Sarah Mansuralli and Will Maimaris would facilitate a discussion on the delivery plan, timescales and milestones • It was also noted that it has been suggested that the Strategy should be discussed at an ICB Board Seminar, looking at access, workforce and sequencing/prioritisation.
4.1.3	The NCL ICB **ENDORSED** the Population Health and Integrated Care Strategy.

4.1.4	Sarah Mansuralli and Will Maimaris to facilitate a discussion on the Population Health and Integrated Care Strategy delivery plan, timescales and milestones.
5.	**Actions and next meeting**
5.1	There was no other business. The Chair thanked members for their contributions.
5.2	The next meeting would be held on 4 July 2023. This was subsequently rescheduled to 11 July 2023.

Inequalities Fund – Evaluation Update

North Central London Integrated Care System

- Purpose of NCL Inequalities Fund was to develop innovative and collaborative solutions to entrenched health inequalities, driven by lived experience and co-produced by local communities. The funding was predominantly allocated (70%) in proportion to deprivation with remainder on non-geographically based need.
- Developed in line with evidence including Fenton (*Beyond the Data*) and Michael Marmot, and flagged at outset that we would be measuring impact using both traditional and new / different methodologies, in line with evidence
- Robust monitoring framework implemented, which took into account individual scheme metrics and wider reach and ripple across the system. In addition, Middx University were commissioned to review the levels of co-production with schemes and the effectiveness of this
- The paper describes high performing schemes to give a flavour of what success looks like, whilst also highlighting broader positive changes and ways in which we can apply lessons to the wider system
- High performing scheme examples
    i. Severe and multiple disadvantage in Haringey – linking housing, mental health, VCSE together for proactive response – reduced A%E attendances by 800, can assume admissions by 80 (cohort of 120)
    ii. Barnet CVD peer support – 50% showed blood pressure reduction
    iii. Black Health Improvement Programme – overwhelming positive feedback from practices

Inequalities Fund – wider lessons learnt

North Central London Integrated Care System

Broader positive changes

- Kick started innovation at borough level through delegation of funding
- Successful example of system / borough working, with system determining need based on agreed comparative data (deprivation) but boroughs driving innovative using local insight and intelligence
- Local community empowerment schemes built trust and relationships with underserved communities – demonstrating the importance of time spent identifying higher risk communities and developing connections

Challenges

- Timescales – addressing entrenched issues requires commitment and time. There were challenges in recruiting staff from underserved communities, and demonstrating impact will take longer – but evidence shows the importance on focusing on prevention, not just avoiding crisis
- Measurement – we are keen to ensure measurement that reflects what's important to specific communities, but are mindful that this limits at scale measurement. Key themes have been identified – e.g. building trust etc, to demonstrate progress made.

System wide learning

- The Population Health Improvement Strategy makes a commitment to align resources to need.
- The Inequalities Fund shows the impact that can be made through allocating resource at a system level to areas of greatest need. To ensure this flows through all workstreams, we propose collecting / reporting the right data to ensure we understand where our greatest needs are – e.g. ethnicity, deprivation, age and gender in all services – and that **resource is aligned to these needs**
- Demonstrating impact over short time scales is challenging. Augmenting this by measuring performance in all our standards through an **equity lens** – would ensure we are identifying high need segment of our population and **demonstrate progress**

Questions for ICP

North Central London Integrated Care System

- The Population Health and Integration Strategy makes a partnership commitment to **align resources to needs**. The Inequalities Fund is an example of this. **What other actions should we take as a partnership to develop this approach?**

- Measuring the impact of the Inequalities Fund has been challenging and has involved us thinking more broadly about how we do this. **What approaches should we use to demonstrate improvement in equity for our population at system, borough partnership and organisational level?**

- **Co-production** with communities most impacted by health inequalities is at the heart of the Inequalities Fund schemes. **How can we take the learning from this work and apply this more broadly to our system transformation work?**

- **How should we build on the Inequalities Fund work as a system in the future?**

North Central London Integrated Care System

Integrated Care Partnership

CAMHS ‘deep dive’

Adult Mental Health Emergency Pathway

North Central London Integrated Care System

CAMHS ‘deep dive’

Executive Summary

North Central London Integrated Care System

- North Central London has made **significant progress in achieving the vision set out in the NHS Long Term Plan,** which was **supplemented by the NCL core offer** for Mental Health to further target variation in offer across our system.
- However, even since the LTP and core offer, mental health need among children and young people has increased **locally and nationally**, with rates of probable mental health conditions increasing to 1 in 6 for 7–16-year-olds and 1 in 4 for 17-19.
- We know that supporting children and young people with mental problems **requires system-wide collaboration** and the NHS cannot do it alone. Community assets and other public services are crucial in the support we offer to children and young people.
- In supporting children and young people, **we have identified 5 key challenges for our system**, which are:
    1. We have **fragmentation** in our offer based on geography and historic investment and service provision;
    2. One aspect of variation in service provision is that our providers utilise **different EPR systems**, meaning local people cannot easily move between services across our ICS footprint without telling their story more than once;
    3. **Spend per head varies significantly by Borough** and further work is required to relate investment to mental health need;
    4. **Performance and waiting times** post-Pandemic remains challenged in most areas across NCL;
    5. **Investment and collaboration must prioritise addressing access, experience and outcomes**. Effective collaboration between providers and system partners will be required to address these challenges and ensure the planned impact for the CYP population of NCL.

North Central London has made significant progress in achieving the vision set out in the NHS Long Term Plan

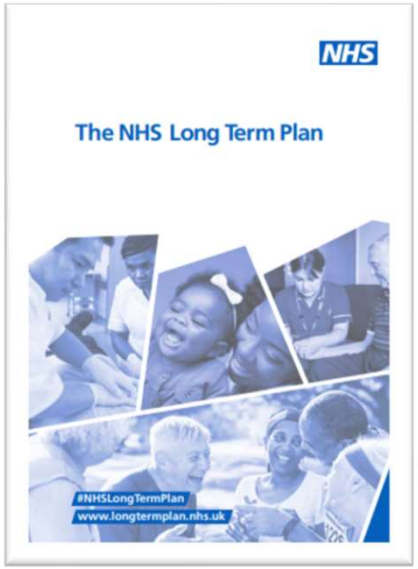
North Central London Integrated Care System

Access: LTP ambition for NCL 0-25s accessing support from NHS funded mental health services is 25,478 for 2023/24, contributing to the national (345,000) target

MHSTs: Mental Health Support Teams in schools and colleges. Prevention, early intervention and whole school approach planned for 20-25% of the country. In NCL there are 16 MHSTs covering *45% of the ICS.

**NHSE calculation of coverage – 8,000 CYP population per team*

Waiting time pilots: NCL boroughs (Camden and Haringey) were part of the national 4 week wait pilot. Waiting time target performance is a core NHSE and ICS priority



Eating disorders investment: Boost funding in to Eating Disorders and Eating difficulties services to recover and sustain waiting time targets and enhance pathways and intensive support. NCL invested £711k at RFL and £366k at T&P in CYP ED services from 2022/23

Crisis: By 2023-24 NCL will have achieved 100% coverage of 24/7 age-appropriate crisis provision for CYP, combining crisis assessment, brief response and intensive home treatment functions (including via the all-age crisis helpline developments brought forward during the pandemic, and NHS 111)

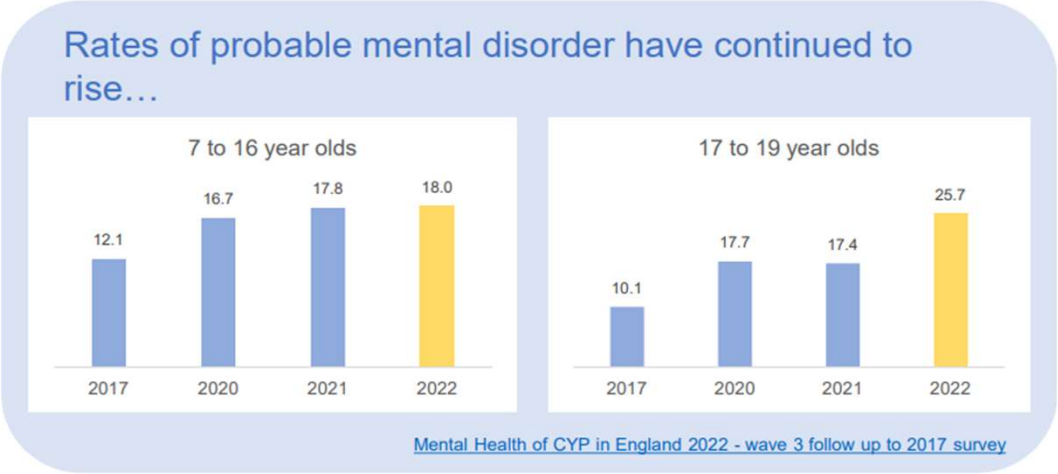
Local needs-based inpatient provision: NCL CAMHS providers are part of the NCEL CAMHs Provider Collaborative (Tier 4/inpatient). Savings from reduced out of area placements and lengths of stay have been invested in NCL

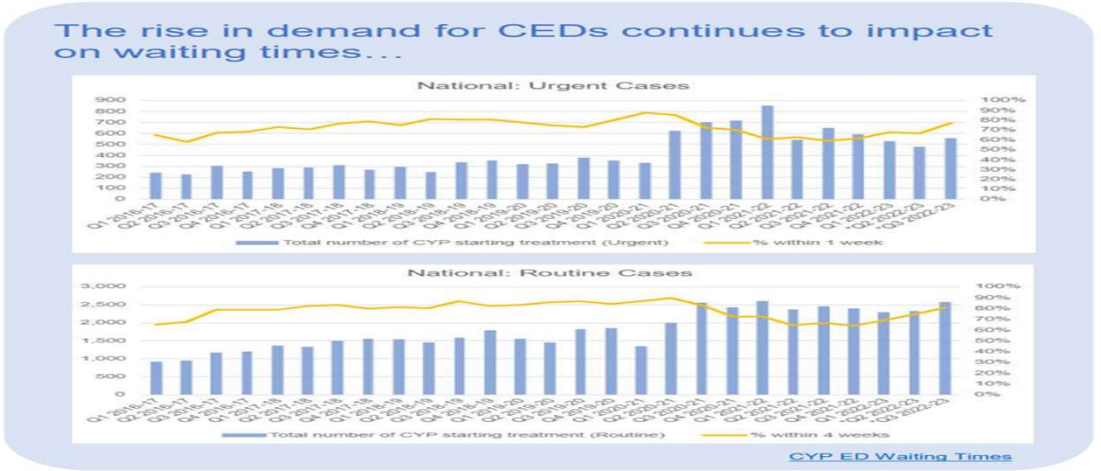
Mental health need among children and young people has increased locally and nationally

North Central London Integrated Care System

The national picture tells us that even since the LTP and core offer that needs continues to increase. We know that:

- **Rates of probable mental health conditions have increased** in 7 to 19 year olds in England. It was estimated to be 1 in 9 or 10 in 2017. Now it's 1 in 6 for 7 to 16 year olds – five in every classroom, and 1 in 4 for 17 to 19 year olds.[ii]
- "Intentional self-harm; and event of undetermined intent" (suicide) was the **leading cause of death** for both males and females aged **5-19** (and 20-34) in England and Wales in 2021.[iii]
- 1,145 children and young people (aged under 18) in the UK died by suicide in (the eleven years) 2010-20.[iv] A yearly average of 104 deaths. One child or young person every three days. **80% of the children and young people who died by suicide had no contact with local NHS** mental health services / CAMHS.
- These non-demographic factors will be **exaggerated by demographic growth for CYP in NCL**, with the population of under 18s across NCL is expected to increase by 1.8% (over 6000 CYP) between 2020 and 2030, with the largest increase expected in Islington. The largest increase by age group is expected among the 12-17 age group (+11.5%).





Overview and 5 key challenges for the system

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- North Central London ICB spends £54m on Community CYP MH services, £49m of which is with our main CYP MH providers (BEH, C&I, RFL, T&P and Whitt). The remainder being in the VCS sector, either through MHSTs or the Early Help and Prevention offer at borough level.
- In May 22, as a system, we **agreed that BEH MH Trust would become the lead organisation for CYP MH services** across NCL, including the **implementation of a CYP MH Core Offer**. In July 22, ICB and Local Authority leaders met to shape the proposal for a lead organisation.
- The lead organisation has been a consensus-based approach to bring about **greater consistency, mutual aid and collaborative working**. This approach has brought more capacity to the leadership of the CYP MH system, it has built on the positive partnership working shown through the pandemic response.

Challenges to collectively address in community CYP Mental Health

1 **Variation in offer**	Despite BEH being the lead organisation for CYP MH services, there is still a complex provider landscape and **significant variation** in the CYP MH offer across NCL. The extent of fragmentation remains concerning (Barnet have a North and South service), with children and young people needing to be referred between providers for different types of care, which has a negative impact on waiting times.
2 **EPR systems**	This fragmentation of provision impacts operational teams who are having to navigate between **multiple EPR systems**. Multiple EPR systems meaning communication and integration is challenging operationally for our staff.
3 **Finance**	**Spend per head on both NHS and non-NHS services varies significantly by Borough** is not aligned to caseload per 1000 population. Spend per head varies significantly by Borough and further work is required to relate investment to mental health need.
4 **Performance**	Whilst workforce numbers have increased as a result of significant additional investment (CYP MH has had the highest rate growth in investment from the MHIS), **performance remains challenged with access**, eating disorders waiting times and long waits for community CYP MH services.
5 **Prioritising impact**	**Investment and collaboration must prioritise addressing access, experience and outcomes**. Effective collaboration between providers and system partners will be required to address these challenges and ensure the planned impact for the CYP population of NCL.

Questions for discussion

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For discussion

What can partners do differently to address the issues of fragmentation and variation of services, siloed patient information, alignment of resource to need to improve CYP mental health support in NCL?

NCL ICB are convening CEOs of CAMHS provision to explore options to address the challenges outlined on the previous slide. Are there any crucial issues missing that the NHS needs to address together?

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Adult Mental Health Emergency Pathway

Objectives of update and context on the challenge of out of area placements (OAPs) and long length of stay (LoS)

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Objective of update

To demonstrate some of the progress that we have made with regard to reducing out of area patients, length of stay but also highlight the challenge/risk of the Right Care, Right Person initiative on this area and the work we need to do with Met Police and others to address this.

Eliminating OAPs for acute inpatient MH care is a key target for NCL. They are not the best for patients and significantly more expensive than placing within NCL. They are the **result of unoptimized utilisation of the MH bed-base** in NCL.

Optimising utilisation is driven by addressing 3 key areas:

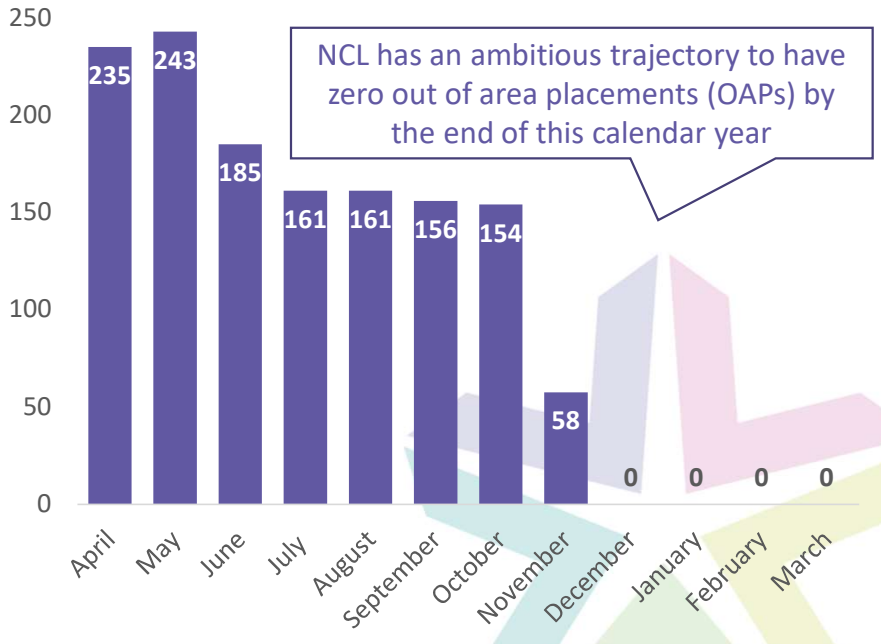
1. **Admission prevention through improved pre-admission**
2. **Improving flow within the hospital**
3. **Expediting discharge to a lower acuity care settings**

The NLMHP is delivering the 10 high impact actions to support reducing both admissions to and LoS in acute inpatient MH care.

Mitigating actions around Right Care Right Person are being implemented to address risks around wider provision of emergency MH support, which will be to ensure that improvement trajectories for OAPs and LoS are met.

Projected inappropriate OAP bed days for NCL in 23/24

Number of Out of Area Placement Occupied Bed Days



Initiatives to reduce admissions and LoS by creating OOH crisis options and improving flow and discharge

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The NLMHP is delivering 10 actions for discharge programme and partnership QI programmes for pre-admission, inpatients and post discharge care. This is being supported by expanded provision of out of hospital emergency care settings in the Community in Line with Core Offer and LTP developments.

1. Admission prevention through improved pre-admission

Efforts to reduce unnecessary admissions by creating OOH crisis options:

- **24/7 MH crisis line**, to switch to 111*2 (self-referral)
- **S136 Hub** for north London (see slide 12)
- **Crisis alternatives**: Cafes and Houses (self-referral)
- **Crisis Resolution and Home Treatment service** (for those people who are clinically assessed as being acutely unwell)
- **MH Liaison service** in every Acute hospital, providing support across departments
- Health-based **Place of Safety** (5 across NCL, excluding Emergency Departments)

2. Improving flow within the hospital

Strategic actions and operational improvements

- Implement RiO Flow Operations tool for increased system support and flow management
- Care formulation / planning in 72 hours
- Daily review e.g., Red2Green
- Identify common reasons / solutions to delay. Start reviewing those who are Clinically Ready For Discharge and those with Length of Stay > 60/90 days
- Review and regular partnership Multi Agency Discharge Events LoS > 60 days for complex discharges - reducing long stay patients and has artificially increased average LoS but this is creating greater flow across the Partnership
- Identifying barriers to discharge early with partners and action to address
- All parities given 48 hours-notice of discharge
- Forensic pathway improvements (Ministry of Justice) and developed escalation process for Psychiatric Intensive Care Unit
- MH system engagement from LA Housing, Social Care and ICB Complex Care

3. Expediting discharge to a lower acuity care settings.

There have been improvements in acute inpatient flow across the Partnership with a reduction in OAPs

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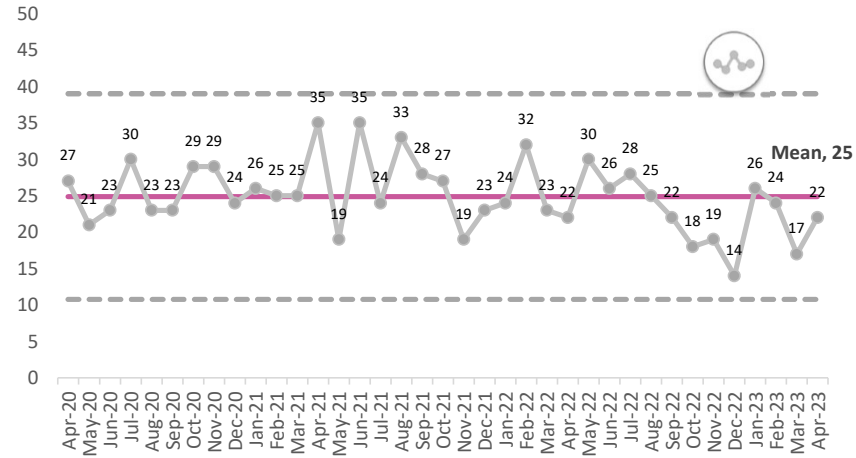
- Long Lengths of Stay (over 60 days) have increased across both sides of the Partnership over the last three years While 60% of admissions are under 30 days - 80% of total OBD capacity is consumed by the other 40% of admission numbers
- Significant progress has been made in recent months to reduce average LoS to the 32 days necessary to operate within NCL core bed base (296 beds)

- There has been a recent decrease in Out of Area OBDs, following a peak in December 2022, due to the ongoing concerted effort from the operational teams, improving delays and programme to improve discharge and flow
- Performance: 259 OAP OBDs per month for May 2023 - 60% lower than last three years average. OAPs costs totalled £382k for the first two months, this is £75K high than trajectory. Year-to-date costs are however 50% lower than the monthly average in 22/23

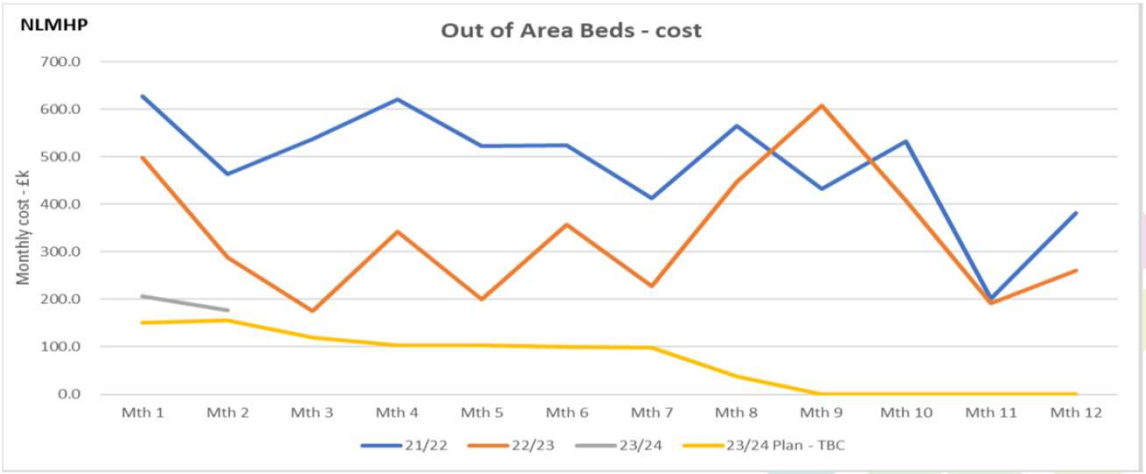
Over 60 days length of stay on discharge in BEH

Number of discharges staying over 60 days



NCL OAP costs, actuals and trajectory

OAP costs by month



Risks and mitigations in light of Right Care Right Place approach

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The NLMHP is delivering 10 actions for discharge programme and partnership QI programmes for pre-admission, inpatients and post discharge care. This is being supported by expanded provision of out of hospital emergency care settings in the Community in Line with Core Offer and LTP developments.

Risk and challenge	Proposed mitigating actions
Increase in Section 136 Reduction in Transport Handover delays	• NHSE will confirm funding of c. £1m to trial the centralised s136 Hub for 12 months from Sep 23 • NLMHP will host the s136 Hub for north London (and SLP for the south) • NLMHP's centralised s136 Hub mobilisation is linked to their start-up of 111*2 for NCL during Sep 23 • All partners have committed to work to reduce disproportionate S136 detentions of Black men
Patients who go AWOL from MH & Acute sites. Increase in CTOs. Increase in LOS due to being risk adverse and not giving as much leave (£)	NLMHP-wide & London-wide Policy on AWOL for MH and Acute Sites and need to work a MISPER policy with the police. There is pan-London work in progress, such as on the Mental Health Crisis Care Concordat – and we are also keen to focus on what we can do in partnership locally to meet the needs of the public.
Section 135 and Police may not be in attendance	Risk Assessment being clear only to request police when required Security might need to be mobilised – Costing for this being assessed

The ICB is bringing some of our most senior people in North Central London public services together for a roundtable discussion focused on ensuring that vulnerable local residents, including people with serious mental health issues, get the right support as quickly as possible, with particular attention on the interface between the police and health services.

Questions for discussion

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For discussion

What more can be done together to support people to stay well in community setting and minimise time in hospital and recover?

What can be done together to better support residents in vulnerable situations in the context of 'right care right place'?

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Appendix A

CAMHS ‘deep dive’: System Challenges

1. Variation in offer across NCL

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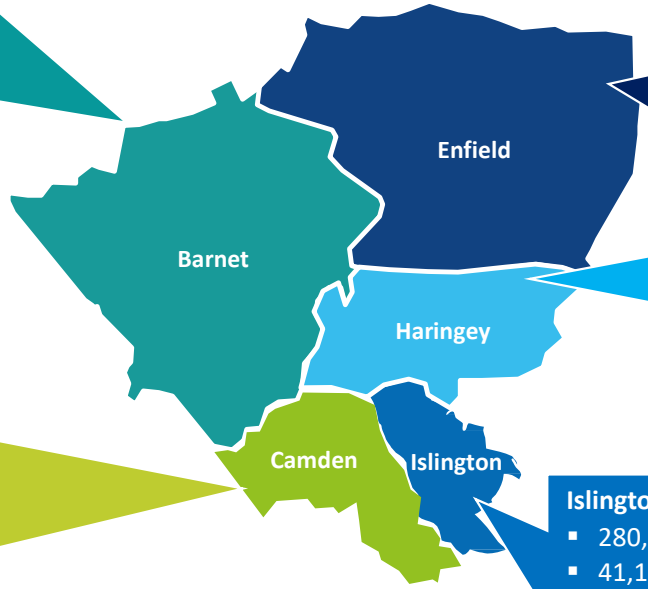
North Central London (Barnet, Camden, Enfield, Haringey and Islington) has a population of approximately 1.7 million residents, of which 323,000 are under 18. There are multiple providers for CYP MH in each borough (excl T4)

Barnet
- 437,371 total registered population
- 94,898 under 18s
- **NHS Provider(s): BEH, RFL & T&P**
- Non NHS Provider(s): Mental Health Support Teams, Health & Justice liaison and diversion, CYP MH in schools, Children and Young People's Wellbeing Practitioner (CWP) services, Xenzone – online counselling, Barnet Integrated Clinical Services (BICS, KOOTH

Camden
- 284,807 total registered population
- 40,549 under 18s
- **NHS Provider(s): RFL, T&P**
- Non NHS Provider(s): Brandon centre – counselling and psychotherapy and parenting (jointly funded with London Borough of Camden), Strength and Learning through Horses (LB Camden), Coram Creative therapies (LB Camden), Fitzrovia Youth in Action – peer support, Manor gardens – parental peer support (LB Camden funded) , Depaul Camden Kaleidoscope (supported housing), Catch 22 (Adolescent Mental Health), KOOTH



Enfield
- 354,822 total registered population
- 83,683 under 18s
- **NHS Provider(s): BEH, T&P**
- Non NHS Provider(s): Brandon Centre, KOOTH, DAZU educational activities

Haringey
- 331,754 total registered population
- 62,540 under 18s
- **NHS Provider(s): Whitt, T&P, BEH**
- Non NHS Provider(s): Brandon Centre, Open Door, Haringey Mind, Haringey Shed, Deep Black, KOOTH

Islington
- 280,828 total registered population
- 41,126 under 18s
- **NHS Provider(s): Whitt, T&P**
- Non NHS Provider(s): KOOTH, Barnardos – Third sector counselling and therapeutic service, Isledon – Emotional Wellbeing workers, Brandon Centre – young people counselling and psychotherapy, Islington Council - TYS counselling

2. Multiple EPR systems meaning communication and integration is challenging operationally for our staff

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		Camden	Islington	Barnet	Enfield	Haringey
Early help and prevention	NCL wide	VCSE – Non NHS EPR				
	Borough VCS	Multiple EPR systems, differ per provider				
Community CYP MH	Core	T&P	Whitt	T&P / RFH / BEH	BEH	
	DBT	Whitt				
	NDD – Assessment	Whitt				
	NDD – Assessment	T&P	Whitt	T&P	BEH	
	NDD – Treatment	T&P	Whitt	BEH	BEH	
	Home Treatment Teams	BEH				
	Avoidant Restrictive Food Intake Disorder	T&P				
	Crisis Hubs	Whitt			BEH	
Inpatient CYP MH		BEH / Whitt				
Secondary care Eating Disorders		RFH				

EPR	Various	Care Notes	RiO	Cerner

- The use of multiple EPRs across NCL makes communication a challenge operationally.
- For example, in Barnet the community CYP MH offer is provided by three providers, each have their own EPR. In addition, there is a different EPR used by the local authority schools teams, the RFL out of hours team, liaison and VCS early help offer providers.

3. Spend per head varies significantly by Borough and further work is required to relate investment to mental health need

- **Overall CYP MH expenditure equates to £54m,** non NHS spend equate to £5m. NCL have prioritised CYP MH spend throughout the period of the LTP with only Adult Community receiving more funding annually.
- **£5.6m invested based on need and based on gaps in core offer in 23-24**, noting limited investment in Enfield VCS/ borough spend and requirement to deliver core offer universally across NCL (HTT roll out and increase in liaison offer in the North).
- **Spend on Non-NHS services varies significantly between boroughs**. Enfield have the lowest proportion of spend on Early Help and Prevention. *
- In addition, the **spend per head of population differs by Borough**. BEH have higher caseload numbers and lower average spend per head. When comparing caseload size to investment BEH has the largest caseload and least investment (61% of the caseload for 49% of the investment). Further work is required to **understand why this is, whether demand/ need driven, operational or a mix of both.**

M12 2022-23 Trust led expenditure

MHIS	Total	BEH	CIFT	TAVI	RF	WH	Non NHS
	£'000	£0	£0	£0	£0	£0	£0
Children & Young People's Mental Health (excluding LD)	42,565	17,317	0	9,738	2,401	9,688	3,421
Children & Young People's Eating Disorders	2,491	0	0	0	2,491		0
Total MHIS	**45,056**	**17,317**	**0**	**9,738**	**4,892**	**9,688**	**3,421**
SDF	**£'000**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**
Children & Young People's Mental Health (excluding LD)	2,485	1,851		306		328	
Children & Young People's Eating Disorders	511				511		
Perinatal Mental Health (Community)	389		389				
MHST	5,617	2,108		1,056	0	755	1,698
Total SDF	**9,002**	**3,959**	**389**	**1,362**	**511**	**1,083**	**1,698**
Grand Total	54,058	21,276	389	11,100	5,403	10,771	5,119

*Note though that LAs will also invest in VCS services, therefore a borough based comparison would need to consider all investment, not solely NHS.

4. CYP MH performance remain significantly challenged (1/3)

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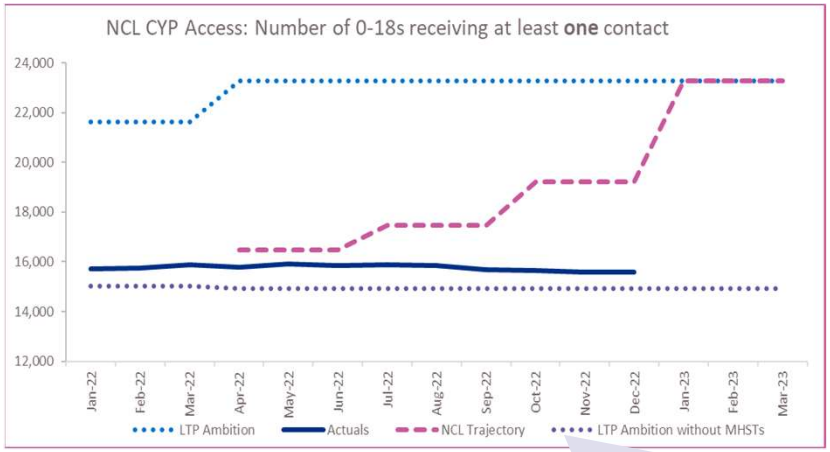
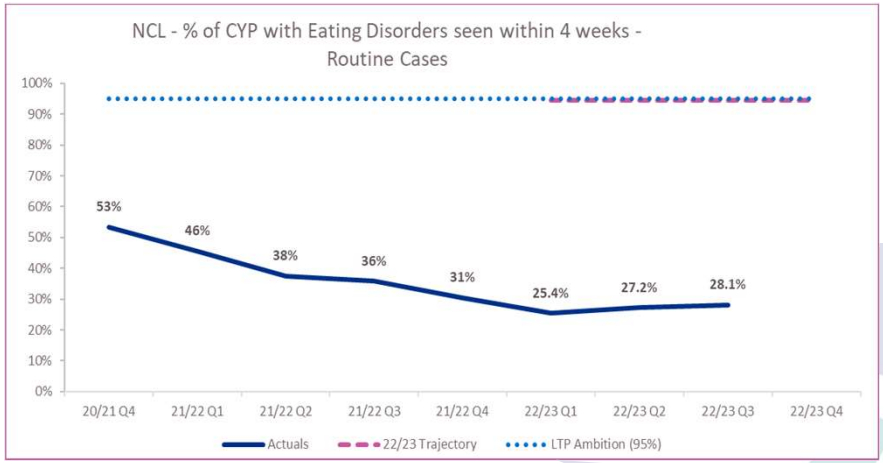
Performance summary

- As of July 2022, BEH caseload is currently at 5851, T&P at 1748 and Whittington at 1958. **Caseload numbers have been consistent over 2021/22**. **Waiting times over the financial year 2021/22 have fallen for both assessment and treatment**. 79 CYP were waiting for over a year for assessment in Apr 21 compared to 66 in Mar 22.
- **However, NCL access targets of 23,291 CYP as part of the LTP are currently not being met** and with the latest data period (Apr 21 to Jun 22) showing on average 15,690 CYP accessed MH services. For 2021/22, **DNA rates average at 9.1%** with cancellation rates by patient averaging at 5.2%.
- The Eating disorders service provided by Royal Free FT**, neither routine or urgent cases are being seen within target timeframe.**
- The number of **CYP having their outcomes measured** at least twice is above the target for T&P but **below target for BEH**.
- **Crisis referrals have had significant variation** across the year in 2021/22, ranging from 45 to 111 a month. The monthly average number of A&E attendances in Q1-Q3 22/23 is the same as Q1-Q3 21/22.

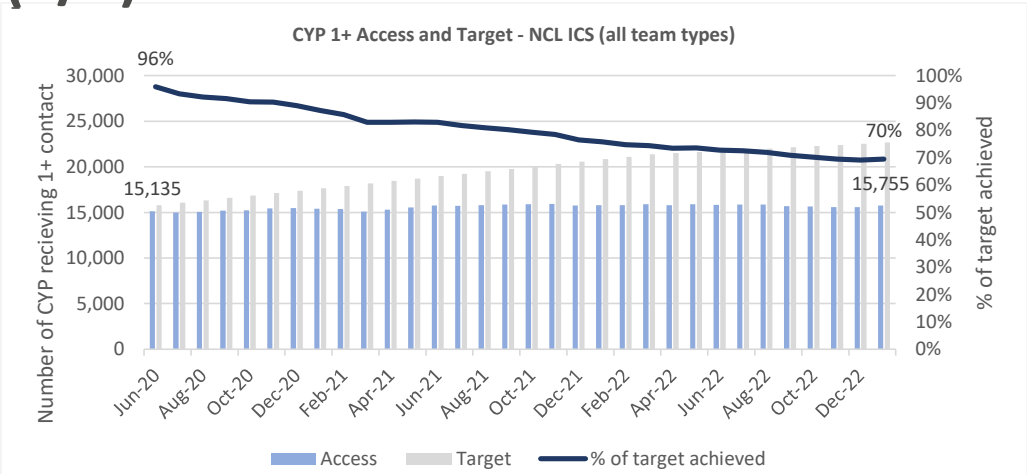


NCL do not currently meet the access target. The target is made up of MHST activity, which is significantly below target, due in part to data capture issues



Additional investment has seen the average wait time for Routine Referrals reduce by 2 weeks from 6.8 to 4.6 wks. However, the Trust Acute EPR system has created challenges in reporting accurate waits

4. CYP MH performance remain significantly challenged (2/3)



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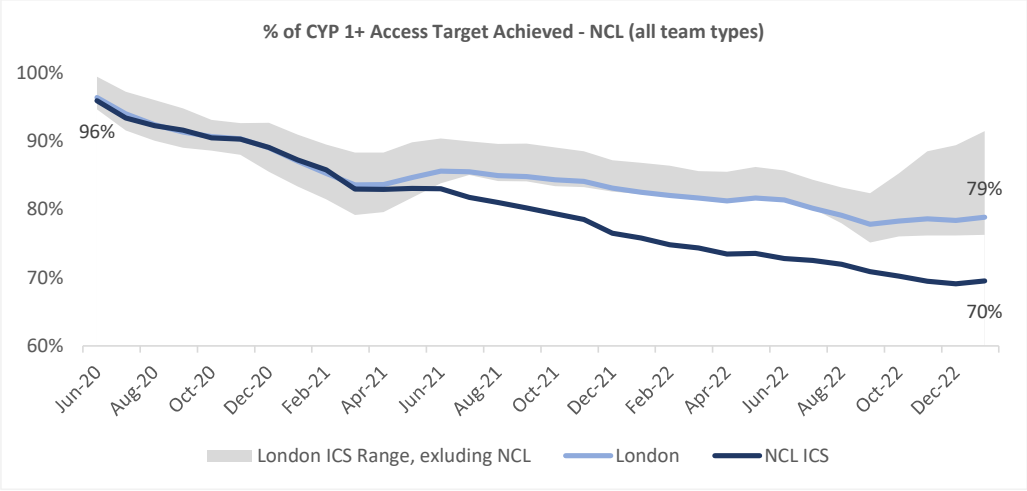
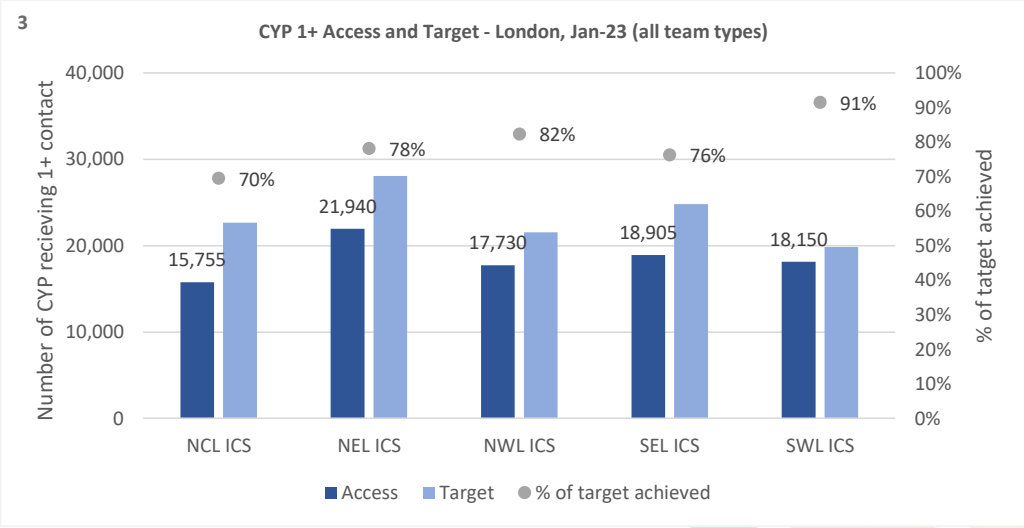


- NCL delivered services to 15,755 CYP in the year leading up to Jan-23, achieving 70% of it's 22,666 target (including MHSTs) (Graph 1)
- **The 12 month rolling CYP 1+ contact access has remained broadly the same from 15,135 in Jun-2020, while the target has increased from 15,789 to 22,666. This has caused the % of the target achieved to steadily decrease from 96% to 70% (Graph 1)**
- **NCL has been the lowest performing London ICS against the access target since Jun-2021 (Graph 2)**
- However, % target achieved has decreased in London as a whole, from 96% in Jun-2020 to 79% in Jan-23 (Graph 2)
- **SEL and NEL are achieving 76% and 78% of their access target respectively (as of Jan-23), while SWL is achieving 91% (Graph 3)**

3



Source: MH CDP

Access and targets are rolling 12 months

4. CYP MH performance remain significantly challenged (3/3)

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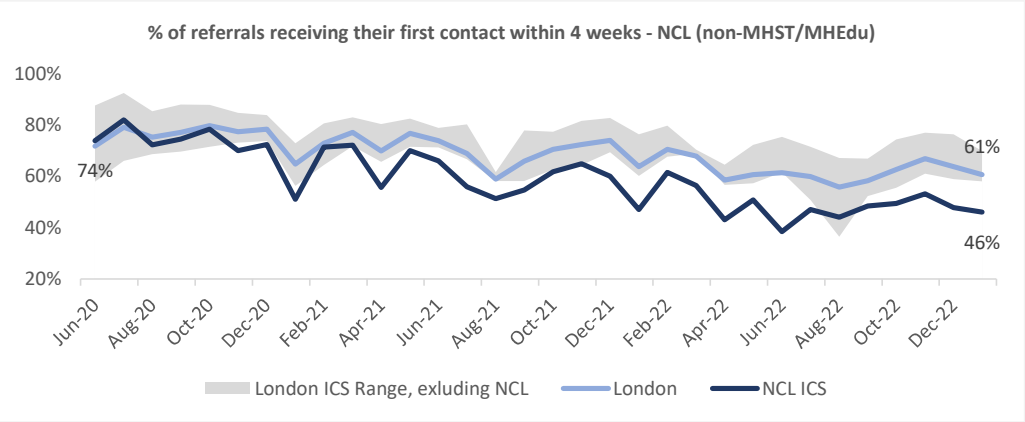
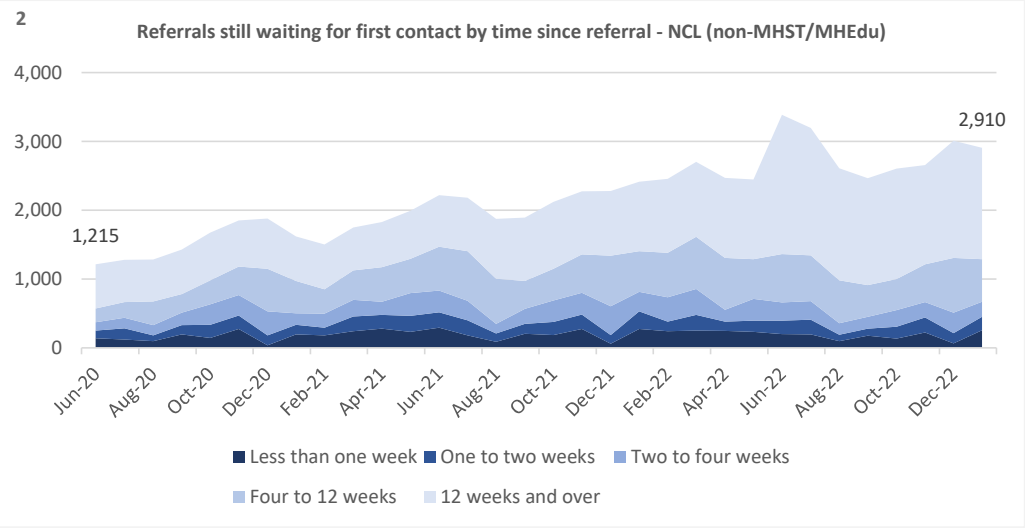


- The % of CYP receiving their first contact within 4 weeks of referral to a non-MHST/MHEdu team in NCL has decreased from 74% in Jun-20 to 46% in Jan-23. This is below the current London average of 61% (Graph 1)
- **NCL has the lowest % of CYP seen within 4 weeks of the London-ICSs (Graph 1)**
- There are currently 2,910 CYP waiting for a contact with a non-MHST service in NCL – an increase from 1,215 in Jun-20 (Graph 2)
- **1,620 of the CYP currently waiting for a contact with a non-MHST/MHEdu team in NCL have been waiting longer than 12 weeks, while a further 620 have been waiting four to 12 weeks (Graph 3)**
- NCL currently has the smallest waiting list of the ICSs (Graph 3)

2



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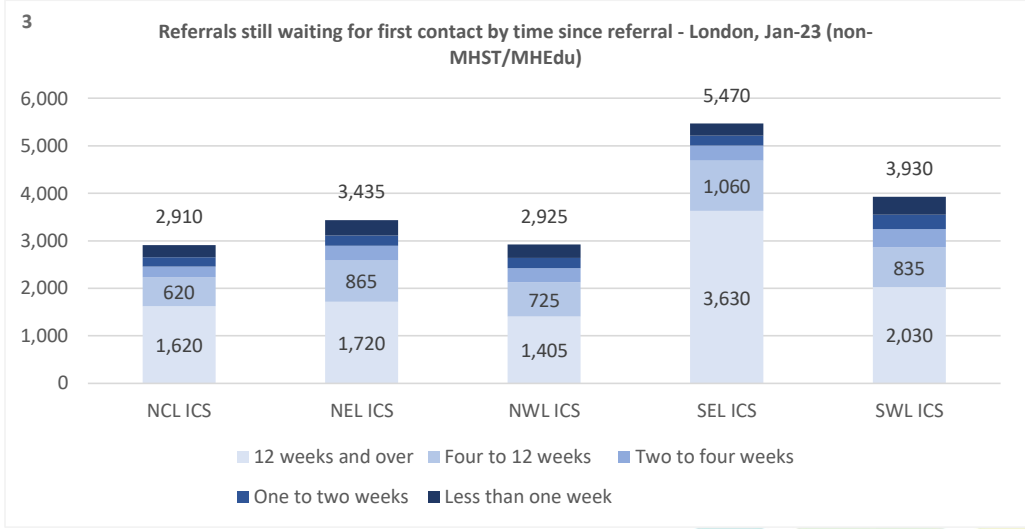

Source: CYP MH Dashboard. All team types, excluding Mental Health Support Teams/Mental Health in Education Services

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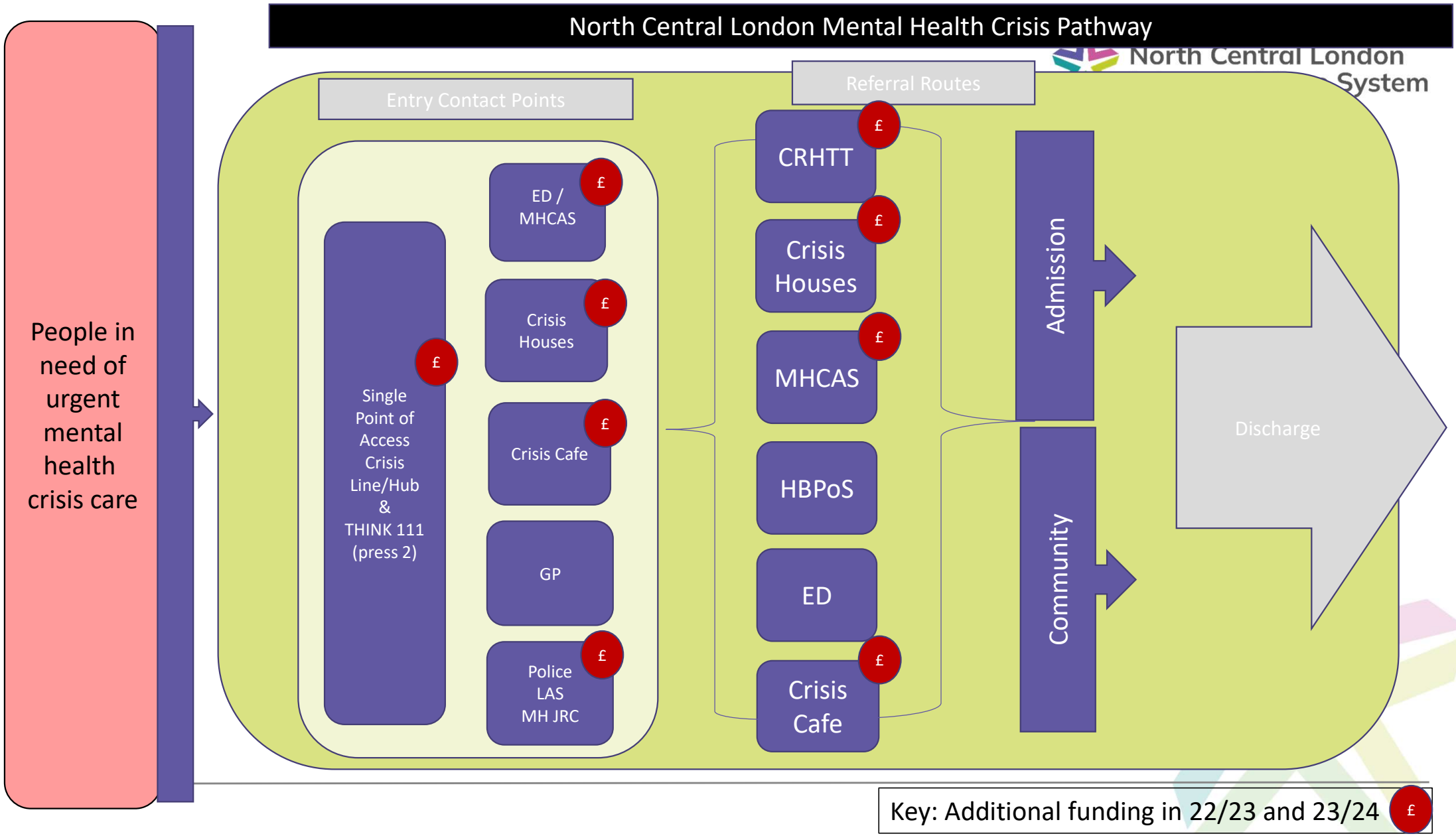
Appendix B

MH Adult Emergency Care Pathway: Pathway Overview, High Impact Actions and Right Care Right Place

North Central London Mental Health Crisis Pathway



NCL High Impact Actions to Improve Patient Flow

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High Impact Actions

Examples: High Impact actions being undertaken to improve patient flow

Transformation of Community MH services. 15k patients received evidence-based trauma informed psychological therapies via our new transformed services, wrapped around primary care and integrated with social care and VCS.

Focus on reducing LoS and clinical variation - More NCL residents are receiving inpatient care closer to home, there has been a reduction of 15 since Jan 23 in the number of patients being placed outside of NCL, Avg. of 7/day in May 23. **Expediting the discharge** of the top 3 long LoSs and focus on HIUs 60+ / 90 days+ via Complex Discharges Panel.

Crisis Resolution Home Treatment Teams – **NEW Haringey Pilot Rapid Response Team, strengthened CRHTs** which provide a rapid response to patient in crisis either online or F2F and gatekeeping.

Improved PICU LOS – Forensic pathway improvements (MOJ) and developed escalation process.

Complex rehab repatriation and rehab pathway focus within Q2&3

MH CAS redevelopment **increasing equity of access across NCL.**

As we further develop as an integrated care system, we need to **maximise the opportunities in reducing DTOCs, especially for our 60+ and 90+ Clinically Ready for Discharge (CRfD)** patients via supported accommodation pathways.

London MH Crisis Care Concordat measures

NCL are embedding the refreshed MH Crisis Care Concordat.

1. **Reduction of average Length of Stay (LoS) to national target of 32 days (excl. leave).**
   NCL agreed ambition: Reducing LoS from 42.5 days (22/23) to 32 days to operate within NCL core bed base (296 beds). Enhanced psychology and OT for even more therapeutic value.
2. **Downward trend in percentage of beds occupied by people who are Clinically Ready for Discharge (CRFD)**
   High Impact actions and NHSE 10 Discharge Actions being undertaken to reduce LoS to 32 days. MADE and Super MADE events continue. New Trust CRFD form embedded in operating system.
3. **Reduction in 60+ and 90+ long length of stay**
   MH system engagement from LA Housing, Social Care and ICB CIC. (Currently 28 people, total ~8,000 days.)
4. **Bed occupancy operating at 85% (Royal College of Psychiatry)**
   Preliminary analysis assumes a 95% occupancy level due to current demand.
5. **Reduction in OAPs to support achievement of LTP plan ambition to eliminate inappropriate out of area bed usage**
   Target 0 - OAPs by the end of 23/24.
6. **Embed local measures, e.g., patient experience and therapeutic benefit.**
   The NCL MH Core Offer Outcomes Dashboard will measure '% patient experience during admission', re-admission and wider recovery outcome metrics.

Right Care Right Place Approach for Mental Health

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- A national scheme that aims to address challenges in the current system of mental health care by ensuring that people who need urgent care are directed to the most appropriate service for their needs.
- Key features include a triage system that assesses the level of risk and urgency of each call, alternative places of safety such as crisis cafes, crisis houses, and specialised mental health ambulances, a national partnership agreement based on the Right Care Right Person model followed in Humberside, and a person-centred, collaborative, preventive, and recovery-oriented approach.

Main Benefits

- Improved outcomes and experiences for people with mental health issues, who can receive timely, appropriate, and less restrictive care in their own community.
- Reduced demand and pressure on A&E departments and police services, who can focus on their core roles of providing emergency medical care and crime.
- Increased efficiency and effectiveness of mental health services, who can avoid unnecessary hospital admissions and provide more integrated and coordinated care.
- Enhanced collaboration and partnership between different agencies and professionals involved in mental health care, who can share information, resources, and expertise.

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References

References

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iii) Office for National Statistics (ONS), released 1 July 2022, Deaths registered in England and Wales: 2021. Section six 'Leading causes of death'. [Available at ONS Registered deaths 2021]

iv) National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report 2023: UK patient and general population data 2010-2020. 2023. University of Manchester. [NCISH Annual Report 2023]