8. Coordinated Mental Health services and improved outcomes for our population

We have been working together to consider what the requirements set out in the NHS Long Term Plan mean for our residents, staff and health and care partner organisations across North Central London (NCL). We have a collective commitment to deliver changes that will improve the health and wellbeing of residents and have listened to what residents and communities have told us is important to them.

This draft plan builds on existing plans and work already underway across NCL and sets out how we will deliver the commitments in the Long Term Plan. It has been developed by, and with the insights from, representatives working in NCL, including staff working in health and social care, and clinical leaders and managers, patients and residents, and our partner organisations from across the NHS, social care, voluntary sector and beyond. Local leaders across our partner organisations, including NHS trusts, general practice, commissioners and local authorities have been closely involved in shaping and overseeing the development of these plans. We are continuing to work closely with all of these groups as we refine the plans and move into delivery and implementation of the commitments.

If you would like to feedback or contribute to this work as we further develop our plans and implementation, please see the 'Listening to residents and communities' section for more details on how to get involved.

Our Vision and Principles for All-Age Mental Health Care and Support in North Central London

Our vision for mental health care and support in North Central London (NCL) is based on the mental health needs of our population, and aligns with the NHS Long Term Plan (LTP) ambitions for children and young people, adults and older adults, aligning to the Community Mental Health Framework and best practice across the country.

Our principles are that a network of local services will:

- Organise care around our communities.
- Take a life course approach ensuring service offers meet the needs of infants, children, young people (including the collective system approach 0-25), adults and older adults.
- Co-ordinate integrated services between primary and secondary care, and between health care, social care and Voluntary and Community Sector (VCS) services.
- Step up and step down care for people with increasing complexity and more specialist needs.
- Know our communities, including understanding and addressing inequalities.
- Be proactive, flexible and responsive to needs.
- Understand and take a proactive partnership approach to addressing the social determinants of serious mental ill health.
- Make use of community assets and resources, including online resources and personal contacts.

In order to meet the needs of the increasing population of people with mental health conditions we will prioritise care delivered in the community. The original mental health plan by North London Partners in Health and Care, published in 2016, was informed by a mental health needs analysis and full pathway evaluation, and the overarching STP vision remains that: “We will work with individuals and communities to build a model of care and support that enables our population to live well”, with the guiding principle of shifting more mental health care from being delivered in an acute setting to an integrated community setting where patients can have their mental, physical and social needs met in a coherent and coordinated way. The NHS Benchmarking Network analysis of London’s Mental Health services in February 2019 identified a requirement for additional community investment of circa £60 million annually, for 740 WTE staff to treat 14,000 additional patients, to bring caseloads in line with the national average.

Through integrated care systems and partnerships we will deliver closer integrated working between Primary Care Networks (PCNs) and NHS Mental Health Providers supporting neighbourhood localities and VCS partners to manage mental ill health, providing a holistic approach to address the wider determinants of health. We will support patients to benefit from these integrated services by providing multi-disciplinary, multi-agency approaches addressing both physical and mental health. Our vision is to increase prevention by using population measures and to work with our public health colleagues to increase awareness and self-management of mental health and to embed ‘making every contact count’ as a principle across our NHS workforce. We will manage mild to moderate mental health conditions such as stress, anxiety and depression in the community through our strengthened PCNs, our developed VCS services, social prescribing, IAPT services and peer support workers. We will focus on the STP wide Mental Health in Schools trailblazer programme for children and young people. We will enable specialist services to manage the increasing complexity of mental and physical health needs and crisis care.

In line with this vision and to support the development of new integrated community models for adults and older adults with severe mental illness (SMI) and children and young people (CYP) in crisis, our priority areas for investment are:

1) Stabilisation, expansion and development of core community services for people with complex needs due to serious mental illness (psychosis, personality disorder and severe mood and anxiety disorders), in partnership with expanded primary care mental health and VCS services;
2) Achieve the ambition of 100% coverage of 24/7 children and young people crisis services; and
3) Delivery of Early Intervention in Psychosis (EIP) services in line with national standards.

Delivery of the new framework for community mental health services, by stabilising, expanding and developing core community teams, is our highest priority, and a priority for investment, as they will have the greatest impact on the lives of people with mental health conditions and on the wider system. Our long-term vision will see these teams transformed to embrace a population health approach, aligned with PCNs and integrated care systems. Across our Child and Adolescent Mental Health Service (CAMHS) partners there is agreement to develop and deliver services for CYP in line with the THRIVE principles. Delivering EIP services and CYP crisis in line with national standards will prevent and reduce more acute and complex mental health presentations. Increasing core community services will lead to acute admission avoidance, a reduction in avoidable primary care usage and London Ambulance Service (LAS) demand, reduced social impact due to costs of lost

employment and career breakdown, lower lifelong health system utilisation, improved quality of life and ultimately a reduction in the mental health mortality gap.

Our vision for mental health support is based on the principles established by our Expert by Experience (EbyE) Board which has been a key partner in the design and delivery of service transformation. The EbyE priorities set out below have informed the work to respond to the NHS LTP ambitions and the continued development of the local care and support offer;

Improved access to care and support

- Better access to care and support, embedding a "no wrong door" approach.
- Address the significant areas of unmet need, and where people are on waiting lists for complex care treatment, provide support in the interim.
- Better coordination of access to specialist support once patients are discharged from secondary care, including fast track access to specialist mental health teams in a crisis.

Service provision and development

- Similar support services will be available irrespective of their borough.
- A greater community support offer, specifically out of hours services such as Crisis Cafes. Stronger support and funding for the Voluntary and Community Sector to act as a care provider subject to the same outcome measures as statutory services.
- Transparency in how gaps in service provision will be addressed and how support will be provided to people who require "complex care/the level above IAPT but below crisis intervention".
- Support mental health workforce expansion, particularly valued peer support roles.
- Care will be provided closer to home where ever possible prioritising the care of our children and young people's mental health services (CAMHS).

Outcomes and monitoring

- Increased focus on patient-centred goals like patient recovery outcomes, housing, employment and access to education.
- Patient and public participation in evaluation and monitoring of services.

We recognise that workforce transformation is critical in the successful delivery of the LTP, and a significant programme of work within the STP will include a focus on: developing and retaining our existing staff; increasing the skill mix and capacity of the integrated physical and mental health workforce in the wider healthcare system, e.g. through mental health specific training via PCNs and VCSs; recruiting new mental health clinical staff; and developing existing models of peer support workers and other new roles e.g. nurse associates, physician associates, children wellbeing or education wellbeing practitioners. We will expand the training and education programme for peer support workers and their managers, including coaching and on the job learning. This will enable mental health patients to be offered the support of a peer mentor: in community teams; at times of crisis, including in psychiatric liaison services; on inpatient wards; and to every person post discharge from a psychiatric ward.

In line with national guidance, North London Partners in health and care will ensure that resources, including both uplifts in CCG baselines (as per the Mental Health Investment Standard) and national transformation funding, earmarked to deliver the targets in the LTP for mental health, are committed in full to deliver these objectives. Our submission to NHS England and Improvement in response to the LTP has been put together on this basis.

We are working together as a system, to ensure that our plans for the implementation of LTP commitments are being developed in ways which maximise the impact in terms of improved outcomes for mental health service users. We are clear that these developments will also help relieve service and financial pressure on acute hospitals and other parts of the system. Mental Health providers are fully committed to supporting the delivery of the STP's Medium Term Financial Strategy. Further work is underway to confirm more detailed allocation of these resources. It is recognised that not all resources will flow to NHS mental health providers but partners are committed to full transparency on how resources are spent on services that will directly address mental health needs as outlined in the LTP, and joint planning to ensure resources are invested to have maximum impact.

The funding provided through the LTP for mental health services will enable our system to move towards providing a more equitable mental health response across the STP geography for children and young people, adults and older adults. This will be supported by the Strategic Alliance agreed in June 2019 between Barnet, Enfield & Haringey Mental Health NHS Trust (BEH) and Camden & Islington NHS Foundation Trust (C&I), as well as close working between mental health and acute hospital trusts. The Alliance seeks to emulate the success of the South London Partnership of mental health trusts in realising a range of benefits, including the standardisation of care across a wider geography, more effective integration of mental health care with other services, improved patient outcomes by bringing care closer to home and increased career support for staff to improve recruitment and retention. As well as the CAMHS New Care Model Collaboration across North Central and North East London, the ambition is to learn from each other's and national best practice to raise quality across the sector. Our LTP response acknowledges and builds on the work already undertaken to define and develop mental health programmes based on local mental health population need, taking into consideration future population projections and funding trajectories set by NHS England and Improvement. It is intended therefore that the provision outlined in the LTP response will evolve to become increasingly standardised across NCL in future years, whilst recognising that we serve a diverse population across our system and the need to ensure borough services are responsive to those local needs and contexts.

To do this providers will work together through provider collaboratives

There are currently three NHS Provider Collaboratives in development in North London that are progressing to take responsibility for the NHS England Specialised Commissioning budgets. All three collaboratives will be engaging with our five local authorities and CCGs as well as the NCL Transforming Care Partnership (TC). North London Partners in health and care will be represented in the mobilisation groups as well as the on-going governance structures.

The main objectives for these collaboratives are to ensure:

- care closer to home through the elimination of out of area placements;
- incentives for community care and not inpatient services;
- opportunity to join up pathways with secondary/primary care; and
- providers in North London working as a system not in competition.

Provider Collaborative	Scope	Lead Provider & Membership

North London Forensic Consortium	All North London inpatient and community forensic services, including Transforming Care.	BEHMHT (lead), and CNWL, WLHT, ELFT and NELFT
NCEL CAMHS Provider Collaborative	Working with NEL STP to develop a collaborative model for Tier 4 services and on course for the fast track funding for April 2020.	ELFT (lead), and BEHMHT, NEFLT, Whittington Health, Tavistock and Portman NHS FT, GOSH
North London Eating Disorder collaborative	All North London	CNWL (lead) and BEHMHT

North London Forensic Consortium will be a wave 2 pilot site for the new specialist community forensic team model, which will be rolled out over a 2-3 year period, initially covering Barnet, Enfield and Haringey and expanding to Camden and Islington from 2022/23. The service will support the development of accommodation pathways by co-commissioning housing providers, which will enable the reduction of length of stay for forensic inpatients, improve housing pathways and increase community resources.

We are working in collaboration with NEL STP to develop a **CAMHS Provider Collaborative** model for Tier 4 services. The shared geography, larger footprint and bed base will enable development of a robust pathway linked to community services to ensure young people are able to receive care close to their families and communities and only stay in hospital for as long as they absolutely need to. It is expected that from April 2020, the collaborative will oversee and manage the 94 CAMHS Tier 4 beds across NE and NC London, and will work towards bringing Children and Young People currently placed in out of area and out of NHS placements back into more suitable clinical settings.

The Year 1 implementation plans include:

- Establishing the Commissioning Hub based in ELFT
- Setting up the NCEL integrated Bed Management system
- Undertaking a clinical review of Tier 2 and Tier 3 pathways across NCEL and identifying commissioning priorities
- Delivering improved standardised clinical pathways that address variance in length of stay, re-admission rates, out of area placements and occupancy
- Improving the quality of services through shared learning and by supporting all services to transition to Outstanding CQC ratings

The contractual commitment with NHS England and Improvement to enable the commencement of the operation of the collaborative from April 2020 includes agreeing and setting up a systematic governance structure to oversee and assure process quality. This structure includes a board, steering committee, clinical quality, finance and performance committees, and central involvement of experts by experience.

Specialist Eating Disorder (ED) and Personality Disorder (PD) services are provided by BEH. The ED Service provides specialist ED assessment and treatment to adults, including a community service, day programme and 20 bedded inpatient unit. The key elements of the service are:

- The moderate to severe eating disorder community service which is comprised of psychiatrists, psychologists, liaison nurse, a family therapist and a dietitian (18 WTE).
- The service is NICE guidance compliant providing front line treatments for anorexia nervosa, CBT-E based group therapy for bulimia nervosa and binge eating disorder and Nutritional Insights group.
- Family therapy is provided, Carers' Skills Training, Carers' Support Group as well as a weekly Peer Support Group is facilitated by two Peer Support Workers.

Future service and staffing expansion ambitions include: developing the model to ensure more ED and PD patients are able to receive appropriate care in integrated primary and community mental health settings; providing treatment to those with mild ED; providing individual therapy to those with bulimia nervosa in line with the NICE guidelines; providing physical health monitoring of the high risk patients; and embedding First episode and Rapid Early intervention for Eating Disorders (FREED) in the service.

Stabilising and Expanding Community Teams

New integrated community models for adults with SMI (including care for people with eating disorders, mental health rehabilitation needs and a 'personality disorder' diagnosis) spanning both core community provision and also dedicated services will ensure at least 370,000 adults and older adults per year have greater choice and control over their care, and are supported to live well in their communities (FIXED).

As articulated in our vision, we recognise that significant resources are required to stabilise, expand and develop core community services for people with complex needs due to serious mental illness, and to deliver Early Intervention in Psychosis (EIP) services in line with national standards. They are two of the top priorities for investment in North Central London, due to the high impact on the lives of people with mental health conditions and the wider system benefits. Central to the development of a joint clinical strategy by our Mental Health trusts will be the development of new integrated community mental health models which will bring together the mental health support and treatment currently provided in primary care, secondary care, and by voluntary and community sector (VCS) services. The development of these models will represent a radical change in the approach towards the delivery of community mental health care, ensuring that care is more responsive and less fragmented, adopting a no wrong door approach, with more streamlined links with specialist mental health services that may be delivered within Primary Care Networks (PCNs) and the wider community.

This transformation and closer partnerships with PCNs supporting neighbourhood localities and VCS partners will mean that all patients benefit from integrated services providing multi-disciplinary, multi-agency approaches addressing physical and mental health and substance misuse holistically. High users of health resources will be supported by a high intensity and community support model, based on needs and complexity. It is anticipated there will be a direct correlation between a greater number of people benefitting from the new integrated community models and less reliance on specialist and crisis mental health services. This will support patient's mental health rehabilitation via the work of the community mental health framework where they will be able to access borough level specialist support based on an individuals' complex care needs.

We will focus on using enablement and recovery approaches, extending care to 'hard to reach' groups currently under represented, and ensuring care is closer to home through the elimination of out of area placements. Developments in community provision will continue through transformation funding, the mental health investment standard, utilisation of devolved specialised commissioning budgets and the expansion of Primary Care Mental Health services. Investment in Community Mental Health Teams (CMHTs) using baseline funding in 2019/20 and 2020/21 will move services to standard caseloads, and then expand services in line with the community framework. Expanding access to specialist services where needed will help to bridge the gap between primary and secondary care. We will also build on Primary Care Mental Health teams in 2020/21 to meet the needs of patients with SMI and PD, to improve access and enable a four week community response time for people with a SMI.

Maintain 95% CYP Eating Disorder referral to treatment time standards

We are committed to delivering high quality care which is close to home and enables young people to receive treatment as early as possible. This includes a commitment to improving young people's access to eating disorder (ED) services in order for all young people to receive treatment within 28 days or sooner depending on need.

The Royal Free Eating Disorder Service for Children and Young People (RFHED-CYP) provides community treatment for ED in all five boroughs. The service performs well against the access and waiting time standards, achieving 98% for routine referrals seen within 4 weeks, and 91% for urgent referrals seen within one week in 2018/19. The RFHED-CYP is also commissioned to provide an intensive service for young people with severe ED (15 slots) to remain at home with their family, avoiding hospital admission.

Within the context of increased demand we will increase investment in workforce to allow for recruitment in line with the Royal College of Psychiatry guidance to support early intervention and allowing young people to remain at home as well as sustaining performance against the access and waiting time standards. Workforce priorities for the service are speciality doctors (psychiatry) and eating disorder therapists. Developing a specialist paediatrician will improve training and support for paediatric nurses, and there is also the need to increase the capacity of home treatment specialists and dieticians.

RFHED-CYP has piloted a NICE compliant new model of care anorexia-nervosa-focused family therapy for CYP (FT-AN). The model focuses on supporting and upskilling families and carers to help their child recover from the ED and streamlines service delivery, reducing internal waiting lists within the service. The year-long pilot of FT-AN reported a 77% increase in average weight gain over the first three months of treatment. In 2019/20 HEE funding for Stepping Forward is being used for staff training to mainstream the FT-AN service. This will also allow for staff training to introduce bulimia-nervosa-focused family therapy [FT-BN] to CYP with bulimia nervosa in line with NICE guidance.

With increased capacity, the service will provide training to the wider, interdependent workforce such as school staff (including school nurses) and GPs to improve identification through understanding of early signs of the development of an ED and increasing local service capabilities through skills training to support young people with ED. The service expansion will ensure CYP are able to access ED services directly via self-referrals. An action plan will be developed to continue the work to support improved transitions for young people with ED to appropriate adult support. This work is being considered with the context of providing needs based support for young people aged 16-25 years old.

Improving support for young people with an ED requiring crisis intervention is included in our priorities. Building on the support offered by the Eating disorder intensive service (EDIS),

there is an ambition to develop an emergency, rapid treatment service to support CYP who are acutely unwell on the paediatric ward or who have co-morbid psychiatric difficulties. The service will work with the New Care Model provider collaborative to develop pathways for step up and step down support for young people requiring an inpatient bed; these pathways will ensure that young people receive timely, high quality support and support reduced length of stay.

A total of 390,000 people with SMI will receive a physical health check

Expansion of the primary care mental health workforce and further upskilling, including links to specialist support from mental health trusts, will enable the expansion of health checks and improvements in clinical outcomes. The Primrose trial led by UCL (published in the Lancet Psychiatry) is being piloted in one borough including new peer support worker roles. We will look to build on these pilot outcomes through community mental health partnerships with primary care throughout to deliver evidence-based interventions which will improve the overall health outcomes of this population group.

The implementation of a new digital system (Health Information Exchange, HIE) will include a specific registry for Physical Health Checks for Adults with SMI. This digital system will automate the current process for identifying GP practices with low completion rates of health checks for this cohort, greatly improving the support available for these practices and their patients through existing QUIST initiatives. The longer term vision is to use HIE to embed Making Every Contact Count principles to ensure every SMI patient is offered physical health checks wherever they come into contact with an appropriately trained member of staff.

Current delivery approaches include incentivising primary care to uptake annual health checks for people on the SMI register, commissioning new specialist primary care mental health teams and seconded community matrons from the mental health trust to GP federations, for example the C&I Integrated Practice Unit (IPU). Our current reported performance of 29.5% of the SMI population receiving the full health check is significantly below national expectations, and our ambition is to increase the number of physical health checks through developing integrated care networks and primary care networks to ensure at least 60% through 2023/24.

Individual Placement Support

Individual Placement and Support (IPS) services are available following close working between health and social care in all boroughs, with an expansion through Wave 2 funding to extend the access through primary and secondary care. Funding to sustain IPS services will continue with the ambition to meet the national model of IPS fidelity due to significant evidence base for system wide impact including fewer mental health admissions, lower CMHT activity, lower social care spend and improved community and personal well-being.

The 60% Early Intervention in Psychosis access standard will be maintained and 95% of services will achieve Level 3 NICE concordance

While all EIP services are meeting the 60% access standard, the RCPsych CCQI survey in early 2019 showed they are currently at NICE guidance level 2, as they do not offer the full range of recommended interventions to provide the best outcomes for people. At Risk Mental States (ARMS) 2016 standards said that all teams need to be open to patients up to age 65. Our EIP services already accept over 35s, and C&I were the first London Trust to do this in 2011. The 2016 standards said EIP services should provide treatment for people with ARMS. These are service users who have not yet developed psychosis, but are showing signs that they are progressing to psychosis. We do not currently have dedicated teams for ARMS, but are looking at models of care from OASIS in SLaM and Tower Hamlets as best

practice. Caseloads across north London are higher than recommended, with some teams having caseloads almost double those in guidelines, limiting contact with service users. Delivery of high fidelity EIP services in line with national standards requires significant additional resources to increase capacity, and due to the long term impact on mental health patients and wider system benefits, is therefore a top priority for investment.

Maintain ambition to eliminate all inappropriate adult acute out of area placements

We recognise the significant impact inpatient services have on the whole mental health system and patient care and are committed to ensuring appropriate provision of inpatient beds, which, together with increasing community capacity, is critical to reducing the current pressures on inpatient services. Benchmarking data indicates that while C&I is at the London average for numbers of adult acute inpatient beds (but below the London average if beds for overseas visitors are accounted for), BEH currently has significantly below the London average numbers of inpatient beds for its weighted population. Alongside the detailed mental health needs analysis carried out in 2016, BEH have commissioned an Urgent Care Pathway review looking at how it best responds to the increasing demand for inpatient admissions and increasing acuity of admissions. A key objective of the Urgent Care Review is to support the elimination of inappropriate Out of Area Placements (OAPs). The conclusions of the Urgent Care Review will be published in late 2019 and will help shape priorities for future investment between additional inpatient beds as well as additional alternatives to admission. We are committed to ensuring sufficient capacity in both community and inpatient settings to meet the needs of the population, improve individual patient care and eliminate inappropriate OAPs. A business case is being developed to support the proposed increase in inpatient beds in the short - medium term, while further alternatives to admission are developed and the community teams are transformed.

Both C&I and BEH are focussing on reducing the number of 50 day+ patients and also reducing complex patients' length of stay and patients with three or more admissions over the last three years. Reducing length of stay will impact bed occupancy and PICU bed usage, supporting the elimination of inappropriate OAP and meeting care closer to home ambitions

The therapeutic offer from inpatient mental health services will be improved by increased investment in interventions and activities, resulting in better patient outcomes and experience in hospital. This will contribute to a reduction in length of stay for all services to the current national average of 32 days (or fewer) in adult acute inpatient mental health settings

We recognise there are different challenges for inpatient services across NCL, and reducing length of stay will lead to reductions in four hour and 12 hour breaches for mental health patients in acute trusts as well as S136 breaches, which will enable us to meet the mental health compact ambitions. Importantly, all these improvements will enhance patient and staff experience and lead to safer wards.

All partners are committed to reviewing mental health inpatient demand and capacity as part of work looking at bed optimisation through the Medium Term Financial Strategy. We will review the therapeutic offer in inpatient services, including staffing, in line with best practice, recognising the impact on patient care and length of stay. Trusts review staffing levels reported via the safer staffing tool. Currently there are activity co-ordinators, OTs and peer workers working in inpatient settings providing a range of therapeutic activities on wards. Workforce plans are in place to support recruitment and retention challenges, a skills mix review of future ward staffing requirements is underway through the workforce strategy,

trusts are developing plans to rebrand and develop HCAs roles creating a career pathway into increased levels of Nursing Associates and then into nurse training. Staffing levels will increase in line with funding, to have the greatest impact on the patient's recovery journey and optimise safe care. BEH have identified a capital improvement bid to convert their current shared bedrooms into single bedrooms across the Trust's estate (capital cost approximately £500k).

Delivery of initiatives via Additional Fair Share Funding

Annual Activity trajectory: 345,000 additional CYP aged 0-25 accessing NHS funded services by 2023/24 (in addition to the FYFVMH commitment to have 70,000 additional CYP accessing NHS Services by 2020/21)

We had met the FYFV target, which includes access to support via school or college based Mental Health Support Teams (MHSTs), by the end of 2018/19, and so are now focussing on the expanded target.

Our CAMHS partners have agreed to adopt the THRIVE Principles to frame development, integration and expansion of our mental health services for CYP with support to be available through services aimed at 'thriving', 'getting advice', 'getting help', 'getting more help' and 'risk support'. We will deliver increased access through expanding services for 0-5 year olds, student populations through MHST, and those young adults approaching age 18 and beyond who require support for mental health needs, including access to IAPT, and using service models like Minding The Gap.

With the exception of an approved extension for Camden, all our CCGs have recently submitted their Local Transformation Plan updates which demonstrate progress against planned deliverables and in line with the 2019/20 KLOEs and NCL's needs based commissioning, differentiated local level plans, and partnership working across a range of local service footprints. All plans reflect our collaborative working against core priorities to deliver more joined up services, share good practice and undertake peer assurance functions, overseen by our CAMHS Programme Board.

Work has recently being undertaken across each borough to align the approach to 0-18 year old activity targets to ensure there is a consistent approach to growth targets across the STP which demonstrate year on year growth, are locally achievable and meet requirements set out in the NHS LTP. These trajectories are based on the 2018/19 actual performance, which outperformed original access targets set out in local operational plans. Work between the Commissioning Support Unit (CSU) and CCGs to review and realign local commitments with our system LTP approach will now be undertaken. Prevalence rates will remain unchanged until revised numbers are published nationally as it had been advised by NHSE/I that this is an iterative process, which will not be finalised prior to this submission. Our CSU are working with business intelligence partners to determine a strategy for how to capture activity across expanded service offers 0-25 year olds to ensure performance requirements from 2020/21 are fulfilled.

<u>Improving access and wait time performance - funding update</u>

We have received £259K transformational funding for the following initiatives to be undertaken throughout 2019 and 2020, which will contribute to improved service access and performance reporting:

- Undertake system-wide demand and capacity modelling to understand service demand, and whether the right capacity and skills exist in the right settings to provide equitable and accessible care locally across NCL.
- Audit of reporting capacity, capability and process factors into the Mental Health Service Dataset (MHSDS) to develop improvements to the quality and flow of outcomes data reported into the MHSDS and NHSE digital platform, by all providers, including voluntary, community and social enterprise (VCSE) sectors.
- Develop a consistent, shared NCL wide approach for a CAMHS care planning, which will be shared across NHS providers through Health Information Exchange digital information sharing solution, due to go live from April 2020.
- Build on previous local work to pilot a solution for crisis care plans, with options for service users to access on hand held devices and share with VSCE providers.

Service offer for 0-5 year olds

The service offer for 0-5 year olds is currently varied across the five boroughs however there is commitment between CAMHS commissioners and providers to develop these services in line with the THRIVE principles and through embedded partnerships with broader sectors, e.g. community children's centres which include formal partnerships under section 75 agreements, universal services for the early years delivered by the LA and health visiting service, as well as a range of services integrated with parental mental health and family support services, perinatal and infant mental health and behavioral and developmental assessment services.

To inform development of our 0-5 service offer, partners will map need and current provision to identify and address gaps, including working with PCNs to ensure appropriate supply to fill children's centres. This will help ensure there is a consistent and comprehensive service offer across all boroughs, and with mental health support provided through all stages of childhood, pre-birth, infancy, pre-school, through school and into further education and early adulthood. Our overarching approach will be developed up as part of the 0-25 service expansion work.

At a strategic and planning level local authorities' co-ordinate delivery of the national Healthy Child Programme (0-5 year old and 5-19 year old). These evidence-based public health programmes require partnership working particularly with children's centres and other early years' providers, schools and the voluntary sector and focus prevention and early intervention. All boroughs have partnership working arrangements in place to identify local priorities, improve service delivery by all partners and improve care pathways for children and families. In addition, the 2-2 ½ year old integrated review which takes place across NCL is an opportunity for parents to discuss their child's development with a health professional and/or early years setting provider which is a key opportunity to ensure children are on track to be 'school ready' at 4 years of age.

Expanding the 16-25 support offer

We are committed to developing additional services that ensure that CYP in the 16-25 age range will receive appropriate services. This will be achieved in the following ways:

- Expanding the Mental Health Schools Provision to college and university populations through local colleges and universities. A universities working group is currently evaluating best practice across the STP.
- Expanding Minding the Gap (MTG)* like prevention and early intervention services (developed by Camden) across the STP which is a prevention and early intervention service for young people aged 16 to 24, supporting their transition from children's into adult's services, and helping prevent problems from escalating, reducing unplanned presentations at crisis. Islington are developing a similar model to the HIVE programme component of MTG, a model of targeted intervention which is a holistic, integrated and wide-ranging health and wellbeing offer to CYP under just one roof.
- Member of the partnership collaborative for crisis and community CAMHS including work with adult mental health services to ensure smooth transition as the new pathways embed.
- Outcomes from the CAMHS new care model work with NE London that aims to have a bed management system up and running within the next three months combined with the bed base analysis across NCL adult providers, will allow work to improve step up and down care for young people with the aim of keeping their care local.
- Targeted model for Special educational needs and disability (SEND) provision extending into the 18 plus range is in the process of rolling out across NCL.
- A streamlined pathway for young adults with appropriate referral into EIP services in line with national standards will prevent and reduce more acute and complex mental health presentations. Refer to EIP section.
- Strengthening provision of IAPT services for 16-25 year old population through group workshop provision for more outreach and increased access.

*MTG was developed in 2015 by Camden CCG and Camden Council, in partnership with young people and with NHS and VCS organisations: Catch 22, Camden & Islington NHS Foundation Trust (C&I), the Brandon Centre, the Tavistock & Portman NHS Trust, Anna Freud and The Winch. It comprises of three key elements:

- a mental health transitions team at C&I;
- a counselling and psychotherapy service provided by the Brandon Centre; and
- The Hive, a state-of-the-art youth hub operated by Catch 22, which hosts a team of mental health workers providing individual and group support, as well as wider health and wellbeing services, such as sexual health, substance misuse, employment, personal development support as well as social activities.

The impact of rolling out MTG-like services may shift some demand from the clinical workforce through upskilling a more generic and voluntary sector workforce who can help 18-25 year olds navigate and manage broader life challenges of transitioning to adulthood. The work to determine the model of care for 0-25 year olds will ensure there is a clear understanding of where the gaps are in terms of achieving an appropriate mix and size of workforce to meet local variations in need across the system. Ongoing workforce planning continues, including better understanding opportunities for peer support workers and training needs across adult and CYP mental health services.

<u>Planning for expanded services for those aged 0-25</u>

A first meeting of NCL CYP and adult services commissioners and providers was held in October 2019 focusing on developing shared understanding of the national ask, building shared local expectations around challenges and principles for delivery, and giving early consideration of necessary governance and engagement approaches for the local system

and service development. Participation included balanced representation across the CAMHS and adult commissioning and provider spaces, all five boroughs and regional representatives from Healthy London Partnership, but future work will incorporate the VCSE sectors, primary care and service users.

Workshop discussions were informed by the 'Meeting the needs of young adults within models of mental healthcare' paper, and inform our next steps for the programme of work which are summarised below:

- Expectation that the size of unmet need will be bigger than we may think, and therefore baselining activity and demand is a priority piece of work.
- System discussion around the overarching guiding principles to service development and delivery may be, such as a consistent framework, i.e. based on THRIVE principles; no wrong door; and co-production with CYP.
- Locally led service and pathway mapping and data collection.
- Different strategies for service development could include a 'big bang' brand based model such as Headspace (Australia), treatment/disorder specific pathways, or defined age-brackets. What is important is that people receive person-centred and age appropriate care.
- Our approach to governance for service development and mobilisation will build on locally driven initiatives and strengths, and link in with regional and national approaches and guidance as appropriate.
- Determining appropriate engagement and collaboration mechanisms, recognising the breadth of partners with a role to play in ensuring our young people receive person centred, age appropriate care. For example, this will include NHS Specialised Commissioning, Local Authorities, VCS, health & Justice, primary care, education, training and employment services.
- Identifying opportunities for engaging young people to ensure co-design mechanisms are prominent.

Expansion of access to specialist community perinatal mental health services

A specialist community perinatal mental health service, providing care for women with severe or complex mental health needs in the perinatal period, built on the existing small provision and went live with new staff in July 2017 to cover the whole of NCL. The service is funded from CCG baselines, and our successful Transformation Funding application will increase staffing levels in 2019/20 to support the national target of 4.5% of the live births. Given the access expansion required this is the prime focus of work in the initial years, however evidence-based care pathways operate locally for specialist community perinatal services, and the service will improve these too in the service transformation.

The perinatal service was recently independently reviewed demonstrating strong service user satisfaction and compliance with key good practice guidelines. In addition there are examples of initiatives that contribute to the health and well-being of a wider cohort of women, including:

- Haringey is a national site for Mums and Babies in Mind project hosted by Mental Health Foundation.
- IAPT Perinatal Leads operate in each borough and Perinatal Champions, raising awareness and promoting openness around perinatal mental health. The IAPT perinatal leads in our local services already receive supervision from the specialist community perinatal service in 3 of the 5 boroughs, this will be expanded to all 5 in 2020/21.

Planned improvements and next steps:

- Plans are in place to increase access to the service in line with national standards through a significant increase in staffing levels. We anticipate for example that staffing in 2020/21 will almost double in size from the staffing establishment in 2019/20.
- The service is developing clear plans for this extension including the necessary estate required for delivery, how teams need to be re-organised to deliver such a large expansion, IT requirements etc.
- Recognising some women are under-represented in the service at present, we will focus on developing approaches to engage people who find help harder to access such as teenagers and mothers from some BAME groups, and those for whom English is not their first language. This will be informed by the Patient and Public Involvement work that the Maternity Transformation Early Adopter has gathered, about what women want from services. Referrals are accepted from any professional involved in their care.
- The current service will expand its remit to ensure it offers care to women from pre-conception up to 24 months post-delivery.
- Similarly expanding the offer to fathers and partners of women will start to take place from 2020/21 when the first Family Therapist will join the team, as well as nursery nurses who can also help with this. The new service will gain wider support for partners/fathers including evidence-based assessment and signposting.
- The psychological element of the service will expand in 2020/21 with more psychologists joining the team and a family therapist, this will expand incrementally as the target access rate grows over the next four years, expanding the post diagnosis and post birth interventions to provide a range of treatment interventions. We are also working with key stakeholders from community perinatal mental health service, maternity services, health visiting, adult social care, GPs, children's services, and other local services that exist in some boroughs to deliver psychological care to new parents to ensure that the pathway is seamless and not duplicated.

Maternity Outreach Clinics in all STPs/ICS by 2023/24

As a Maternity Transformation Programme Early Adopter, initiatives are being developed to deliver more personalised care for women and babies, improving outcomes and reducing inequalities. Our Local Maternity System (LMS) works collaboratively across networks to ensure strong engagement with specialist perinatal mental health commissioners and providers. Mental health pathways and the training in antenatal and postnatal care is being reviewed to ensure that services are identifying and supporting women's mental health, including onward referral to more specialist services such as IAPT.

Cochrane evidence associates continuity of carer with significant improvements in the safety, personalisation and experience of maternity care. This has particular significance when applied to vulnerable women. The LMS is working with Maternity Voice Partnerships to gather insight from local stakeholders, including groups that face health inequalities, to co-design perinatal mental health continuity of carer pathways to provide targeted care during the antenatal, intrapartum and postnatal period. A key focus is on the development of Postnatal Improvement Plans, including postnatal perinatal mental health pathways. NCL LMS is keen to become a Maternity Outreach Clinic early implementer in 2020/21, and will continue to expand Maternity Outreach Clinics throughout the ICS in the following 3 years on the LTP.

24/7 adult crisis resolution and home treatment teams (CRHTT)

There is 100% coverage of CRHTT services which operate on a 24/7 basis and include Crisis Single Point of Access (C-SPA) functions in addition to Home Treatment and Assessment teams. C&I also have a specialised Older Adults Home Treatment Team.

CRHTT provision in 2018/19 comprised 1 qualified staff member per approximately 12k adult population. Robust assessment of additional capacity needed, and revising the model to meet the local mental health need has led to the increasing the workforce in 2019/20 and 2020/21 in line with guidance and expanding the MDT to include OTs, social workers, psychologists, link workers. Using the transformation funding investment in this way, means CRHTT provision will now be able to deliver a high-fidelity service by 2021, and then maintaining high-fidelity coverage. There is a current evaluation commitment to review Crisis Pathways in BEH and continued commitment as pathways develop. Strengthening CRHTTs and providing care closer to home in the community will be critical to: managing the increasing pressures on inpatient beds and to reducing out of area placements, particularly in BEH; reducing acute and MH admissions; reducing reliance on primary care and LAS; reducing length of stay; and improving patient safety and quality of care.

Recruitment is underway to increase staffing to 1 qualified member of staff per 7-8k adult population in C&I and 1 qualified member of staff per 9k adult population for BEH from 2019/20 onwards reflecting the high prevalence of (national guidance states that services should employ 1 qualified staff member per 9-12k population, depending on need). This enhanced staffing will ensure better management of current demand and response times, reduce pressure on the service by improving gatekeeping, triage and early discharges and enhance access especially at night. A 24/7 Crisis response is available via 111 (Hub during the day, and a centralised Night Team) in BEH but requires improvement. There is a 24/7 C-SPA in C&I but requires improvements in warm transfers from 111. Consideration will be given to moving to one NCL NHS 111 SPA for all ages.

Development of local mental health crisis pathways (alternative crisis service provision)

Current alternative crisis service provision is varied due to historic funding differences. Therefore, alternative crisis service provision transformation funding is targeted within the north of NCL to focus on crisis café provision and peer coaching. Alternative crisis services will evolve to become increasingly uniform and equitable across the STP to all age groups for people, and their carers by 2023/24.

Our vision is to follow the planned approach to preventing crisis, every borough will adopt a multi-dimensional approach to preventing crisis across the whole system including a range of alternative crisis services and approaches. NHS-led crisis care alternatives include: Crisis Houses, a Recovery House, an Acute Day Unit, 24/7 Liaison Teams, and the VCS in partnership with the NHS provide a range of integrated alternative services provision according to local need. A new dedicated Health Based Place of Safety (HBOS) for adults is scheduled to open in December 2019 at the Highgate Mental Health Centre.

Initiatives via Additional Funding Allocations Made To Individual Systems in Consultation with NHS England/Improvement Regions

Improving Access to Psychological Therapy (IAPT) Services

IAPT access rates were met in Q4 2018/19 equivalent to an annual rate of over 19%. IAPT services are commissioned to meet the expected growth in targets, with funding committed to support each service to expand their workforce in line with the existing access trajectory (22%); mid-year performance highlighted some areas of risk. IAPT trainee numbers have

been agreed, with contract variations in place to provide salary support in line with regional funding requirements.

Recovery rate targets have been consistently met for the past year in all services, demonstrating the sustained quality of service provision. Remedial action continues to address challenges in referral to treatment and hidden waits in some areas. Services are employing a range of strategies to reduce waiting times for patients and ensure targets are met.

The majority of IAPT activity is co-located in primary care, and most VCS activity is delivered in community settings. By co-locating staff in Primary Care, the IAPT clinicians will be accessible to patients with the appropriate level of need and be able to support the physical health and mental health together. IAPT Long Term Conditions (LTC) services were established in two boroughs as part of Wave 2 regional funding and have been sustainably funded with expansion into new clinical areas. The evaluation of these services has not demonstrated the previously expected system impact to enable reallocation of resources, but it has informed the continued development of LTC provision across NCL. We have integrated IAPT physical health pathways in line with the IAPT guidance manual and have plans for further roll out to more LTCs. Further progress is expected with development of the VCS offer, and further expansion of therapists co-located in primary care following successful deployment in all boroughs.

The recent updates in the prevalence of anxiety and depression places new challenges on our services to meet the access targets. There will be a phased achievement of the target based on expanding services and attracting new workforce whilst not de-stabilising services. We will be using a variety of interventions in order to be able to offer a diverse and effective range of IAPT offers including: IAPT for people with an SMI, increasing our digital developments; more group treatments and workshops; increasing development and support to VCS services; and developing an outreach arm of service delivery. We will look to grow the IAPT offer for older people as part of Ageing Well and also younger people to prevent longer term mental ill health.

IAPT services are already working with our 16-25 population through colleges and universities and in the community. For example, in Camden in Q1 2019/20 there were 503 referrals from 18-25 year olds, which equates to 30% of the total referrals. We are looking to strengthen and build on work with this age group through facilitating group workshop provision to provide more outreach and increase access. Principles for increasing access for this age group will be addressed in the wider system approach to developing a comprehensive service offer for 0-25 year olds.

CYP Mental Health Support Teams

All five boroughs had successful bids to be trailblazer sites for Mental Health Support Teams (MHST) in schools. Camden and Haringey were in Wave 1, including as pilot sites for the four week wait standard, and went live in late 2018. Islington, Barnet and Enfield are in Wave 2. Enfield went live in September 2019, with Islington and Barnet to follow in January 2020. All teams will offer the nationally prescribed core functions, and the phased mobilisation of MHSTs across each borough, will include:

- Each trailblazer has two MHSTs planned for phased mobilisation, with consideration for expansion to follow evaluation of the trailblazers.
- All boroughs will exceed the ambition for 20-25% coverage.
- Target resources to local need, for example evidenced by, Barnet's focus on areas with the most populous and deprived wards, substance misuse, the most early help referrals, and highest GP referral numbers for specialist CAMHS. Undertaking audits and

engagement to map local needs and current service provision across primary, secondary and special need schools; share an activity data base with MHSTs and wider partnership to demonstrate targeted needs led interventions and approaches for each school; or take a whole borough based approach with flexibility built into specific deliverables from the menu at school based level which is also informed by JSNA.

- Joint local assessments of need in educational settings carried out with school/college leadership with planned MHST work in line with training and resources. For example, work of MHSTs are informed by joint assessment and review working of JSNA, public health and SEND JSNA; joint meetings of MHSTs linking with educational psychologists and mental health leads in schools, SENCO and CAMHS clinicians, as well as wider borough network of LA and VCSE services accessible by CYP; school based audits and review meetings.
- Integration with NHS specialist CYP mental health services through existing screening and referral processes with CAHMS clinicians in schools and local pathway mapping with MHST and existing CAMHS providers, including step up/step down pathways with early help and prevention services.

This extended provision will ensure improved access to community services and from 2021 we will extend access to mental health support teams to colleges and universities in order to ensure the 16-25 age range have access to this provision.

NCL also recently established a MHST Trailblazer Programme Group to help information sharing and collaboration between the MHST pilots. It held its first meeting in November 2019, includes representation from health, care and education, and will feed back to the NCL CAMHS Programme Board. The group's purpose is to consider how:

- Learning and good practice from the 5 Trailblazer Programmes (Wave 1 & 2) will maximise the success of all 5 initiatives.
- To utilise good practice that has delivered strong outcomes in distinct areas, to take a whole system approach to delivering MHSTs, increasing equity of access and support.
- Learning from Trailblazers may influence the commissioning of a range of effective and high quality services that impact positively on outcomes for children's social and emotional mental health.
- To support the necessary growth of the CWP (Children Wellbeing Practitioner) or education wellbeing practitioners aligned to MHST.

Targeted Funding For Range of Smaller Initiatives and Pilots

Mental Health Liaison Services

All five acute hospital sites in NCL with an A&E department deliver Mental Health Liaison Services (MHLS) 24/7 and report their performance against Core 24 access targets. Our MHLS are supporting adults and older adults presenting in mental health crisis at the Emergency Department to have timely access to inpatient care based on a mental health assessment and care plan within 4 hours of arriving, as well as responding within 24 hours following ward referral. There is local commitment to the consolidation and expansion of MHLS, and all partners have adopted a joint MHLS Collaborative Agreement and Core 24 service specification with associated KPIs.

Due to the increasing attendances in acute trusts by people with mental health conditions and subsequent pressure on MHLS, we are currently performing 'near core 24' standards. We are committed to sustaining current levels of staffing for MHLS, and will use Wave 2

MHLS transformation funding to enhance provision at all sites in 2020/21, through a further 16.8 WTE staff members. The Multi-disciplinary Team includes Consultant Psychiatrists, Doctors, Psychologists, Service and Team Managers, Social Worker / AMHP, Occupational Therapist, Nurses, Drug and Alcohol nurses, Assistant Practitioners and Peer Support Workers, as well as working alongside the Local Authority Substance Misuse Services who provide in-reach at every hospital site. This service expansion to 111.25 WTE costing nearly £8M will enable all hospitals to meet Core 24 Standards for adults and older adults by 2021, with a commitment to maintain fidelity and sustain staffing levels from 2021/22 onwards.

CYP mental crisis services - 100% coverage of 24/7 age appropriate mental health crisis care for CYP that combines crisis assessment, brief response and intensive home treatment functions

Improved provision of CYP crisis services is one of our three priorities for delivering the LTP and the most pertinent priority for our CAMHS Programme Board. Whilst there are differing levels of resources, providers and capacity across NCL, the ambition is to align our provision to meet population needs. We will achieve 100% 24 hour crisis coverage by 2024, through a consistent offering for crisis response which includes:

- An NCL crisis line / single point of access for crisis support for all ages
- Embedding the Out of Hours Crisis Service in 2019/20
- Improved pathways in and out of community CAMHS and the extension of the Crisis teams into intensive home treatment modalities. This will be also replicated for our Special Education and Needs Disability (SEND) population through the development of the home treatment programme - Transforming Care Prevention and Support (TCaPS).
- Additional crisis training and development across CAMHS
- A crisis roadmap of services
- Standardising crisis safety and coping plans across providers, including through the access and wait time funding to develop crisis care plans (see 2.6.3).
- Identification of an appropriate CYP Health Based Place of Safety, which is an area of significant need for NCL CYP.

Improved crisis pathways: Our ambition is to develop a local integrated pathway for 0-25 year olds with higher tier mental health needs, which includes rapid community-based and out-of-hours responses to crisis. There will be investment in expanding the crisis workforce and training for the crisis response teams, which will draw on a number of evidence-based models such as on Dialectical Behaviour Therapy (DBT) for emergent personality disorders.

The New Models of Care (NMOC) programme for CAMHS Tier 4 Services in NCL is a provider collaborative with North East London. This work will develop a range of approaches to crisis which is expected to result in admission prevention, warranted reduction in length of stay, safe discharge into the community, and a reduction of admission to acute paediatric beds. The reprofiling of inpatient expenditure into community based care, and savings from local commissioning will be reinvested into Home Treatment offers that further reduce the need for inpatient admissions. We will also work closely with Specialised Commissioning and jointly with Health and Justice Commissioners to develop local integrated pathways including transitioning in or out of acute, specialist and secure settings. The development of the acute care pathway will occur in phases as additional LTP investment becomes available and savings are realised through the provider collaborative.

Other relevant initiatives currently being undertaken include:

- Data collections to scope programmes of work such as the Crisis workstream, Paediatric Liaison subgroup and workforce implications.

- Seeking CYP / families' views to support development of strategies to improve experience of the crisis pathway as it develops.
- Improving access to information online about CAMHS including local and digital mental health offers.
- Using our population health tool, HealtheIntent, to develop a single list of CYP presenting with self-harm/ suicidal behaviours and a registry with presence of crisis management plan (CMP) and follow up review. This work will takes data from across the health and social care system to support clinical practice and help reduce unwarranted variation.
- Workforce and estates implications will be determined based on outcomes of the NMOC work and how the crisis and out of hours and psychiatry rotas will develop. The use of beds and locations for crisis support for CYP with ASD/LD needs as an alternative to A&E is also expected to be better understood once the NMOC work progresses.

Areas identified which the STP recognise also need addressing include:

- A further focus on a suitable Health Based Place(s) of Safety for CYP in crisis, or subject to the power of section 136 of the Mental Health Act. This is currently a system gap in terms of dedicated provision across the STP which requires attention. It has been identified as an area for future capital investment. Consistent policy, communication of local arrangements, police training, cross-agency sharing of process and contact details and the development of street triage for CYP with police all remain ambitions for the STP.
- Shared training opportunities and learning across different areas including blue light services. There is close working with blue light services through the Crisis Care Concordat meetings in the sector. As well-established multi-agency groups these groups have a range of key stakeholders from CYP and adults services, blue light services, local authority, public health, and VCS with senior representation from our NHS mental health providers. The membership includes a focus on crisis care for young people and adults and will also support the intentions around the local offer for 0-25s.

Out of Hours: A pilot CAMHS out of hour's crisis service has been partially operational since July 2019. The intention for the pilot is to deliver emergency (4hr) and urgent (24hr) crisis response to CYP presenting in crisis across the five acute hospital sites with A&E and paediatric wards between 15:00 hours to midnight on weekdays and midday to midnight on weekends. There is support for this service from the on-call consultant rotas.

Local community CAMHS provide a seven-day follow up, including a review of safety and coping plans, as required for CYP beyond their crisis presentation. For 18-25s, there will continue to be CRHT, and MHLS based at all five acute hospitals (see CRHT and MHLS sections).

We will develop CYP crisis services in line with LTP ambitions and the London CYPMH Workforce Strategy to ensure an equitable crisis response is available where and when it is needed. An expansion plan (including staff training and alternatives to A&E) based on local needs assessment, will be developed following the evaluation of the Out of Hours Crisis Service pilot, and finalisation of plans for the New Models of Care re-profiling of inpatient savings to crisis and home treatment and DBT is clarified in early 2020.

Mental Health Liaison Services (MHLS): Extending MHLS for CYP is a key deliverable and reflects the priority within the FYFV and LTP to ensure that 'good quality mental health liaison services will be available more widely across the country'. The development of the CYP crisis care pathway has highlighted significant variation in availability of and access to CAMHS liaison psychiatry. The current model based on outdated, historical arrangements is

unsustainable due to reliance on high numbers of trainees, and does not provide a consistent all-age offer. Care on acute paediatric wards and use of agency RMNs varies across different locations and is dependent not only on liaison arrangements but also the staffing model of nursing, health care assistants and other key roles, which has resulted in a lack of parity across the system. The LTP investment in CAMHS nursing will link to the nurse-led Out of Hours service to ensure a clear pathway that meets CYP needs. A task and finish group has been looking at these different models and working with commissioning support unit colleagues to review this provision and develop improved models and treatment.

We will pilot a model of mental health teams directly employed by the hospital to work with children admitted in crisis to paediatric wards who will work with liaison and community teams to ensure the most effective care during assessment and discharge. The proposed team would incorporate a skill mix with capabilities to address different levels of need and support children with ASD and LD. This model also intends to provide flexibility across the STP footprint for staff to provide cover between locations to meet shifting capacity needs. This model is preferred by providers and commissioners to avoid repeated use of different agency staff who may not have a CAMHS specialism and it would also enhance the CAMHS skills base and resource across the acute paediatric sites.

Mental health professionals working in ambulance control rooms, Integrated Urgent Care services, and providing on-the-scene response in line with clinical quality indicators

Part of the Mental Health Compact implementation will be a review of mental health urgent care pathways and models to ensure patients in mental health crisis receive the appropriate care in the right environment. The basis of this will be an analysis of the acuity of patients and the existing pathways that will inform our future service model.

Our Integrated Urgent Care (IUC) service has NHS 111 'warm transfers' in place to transfer patients to the mental health SPA and this service will be evaluated alongside other models to inform the future IUC Clinical Assessment Service model to support patients in mental health crisis. C&I have a dedicated phone line for blue light services and we are developing an 'Appropriate Care Pathway' (ACP) to enable London Ambulance Service (LAS) staff, both on scene and in the LAS Clinical Hub, to appropriately refer into the mental health SPA and reduce inappropriate conveyances to ED. Our UEC End of Life Care Programme is supporting care homes to use Co-ordinate My Care to record a person's Advanced Care Plan to ensure people's end of life care wishes are respected if they do not wish to be transferred to hospital.

In London the evaluation of pilots of the Mental Health Car as an Ambulance Pioneer Service and Street Triage are informing recommendations about future models and pathways. We await the work underway at a national level to develop clinical quality indicators for mental health response from ambulance services, key performance indicators and data collection expectations for mental health.

Our vision is for integrated mental health services supporting Urgent Care pathways and for appropriately qualified, skilled and trained emergency response staff to support patients in mental health crisis calling 111 and 999, with support from mental health specialist staff where clinically relevant. Plans will be developed with LAS and wider system partners, including for mental health transport vehicles, training for ambulance staff and the introduction of nurses and other mental health professionals in Integrated Urgent Care Clinical Assessment Services through our borough level Crisis Care Concordat partnerships where joint planning, governance and delivery of crisis pathway are discussed and developed. The size of the development will be proportionate to investment and in line with

the access and waiting time standards for urgent and emergency mental health care that will be tested by NHS England during 2019/20, with trajectories for expansion set thereafter.

Model for problem gambling from 2019/20

NCL were not successful in securing the problem gambling 2019/20 funding. Due to the established existing services and ability to expand the model, this is not a priority.

Enhanced suicide prevention initiatives and bereavement support services

According to ONS figures (2017), there were 568 suicides in London of which 109 (19.2%) were in NCL. Our vision for suicide prevention is closely aligned to the focus on the wider determinants of health and poverty reduction.

There are system-wide multi-agency suicide prevention and awareness strategies in place, with derived action plans the basis for work between partners. Mental health services, suicide prevention group and associated partners have also surveyed their current provision against the 10 ways to improve safety. The Trusts strategies are reviewed by their Quality and Safety Committees, and in line with London Health and Care Vision we will refresh our commitments to further reduce the suicide rate and support bereaved individuals.

Delivering suicide prevention initiatives;

- Suicide prevention is core to current risk assessment approach within mental health services, and utilises existing local health and voluntary sector partners for referrals.
- 'Reducing Access to Medication as a Means of suicide' programme (includes the joint working with community clinicians and primary care staff).
- Existing work on reducing out of area placements, reducing staff turnover and ward safety plans will contribute to plans for inpatient services.

Delivering bereavement support services

Our Directors of Public Health are committed to developing a postvention suicide bereavement support service, providing timely and appropriate support to families and staff. We successfully bid for additional funding from Public Health England with a view to piloting a postvention service starting in Q4 2019/20. Part of the mobilisation will be to establish an approach to identification and referral for families and next of kin who may have been bereaved by suicide. Delivery will include a commitment to continually review through the existing local suicide prevention action plans to ensure its sustainability. The pilot evaluation will inform the long-term provision of postvention services which include:

- Postvention leaflet development and dissemination through the Met Police.
- Digital Information Sharing Hub facilitating secure data sharing amongst multiple agencies (Thrive LDN).
- Suicide prevention education programme (16+ years, in education and university).
- Citywide suicide awareness campaign.
- Training, policy and practice review in mental health trusts.

These initiatives will be supported by increased crisis resolution and rapid response resources, and by work underway with partners to expand the population approach to deliver better awareness and training around trauma, distress, self-harm and suicidality.

Mental health services to support rough sleepers

Haringey has been selected as a national pilot site for rough sleeping mental health services. The rough sleepers needs assessment including mental health galvanised strong support between CCGs, MH Trust, LA and VCS organisations, supported by joint commissioning to be able to move at pace to deliver mental health services to support rough sleepers.

An integrated multi-disciplinary approach was adopted to co-produce services for rough sleepers, the service will integrate existing homelessness services, a co-located outreach team including Homes for Haringey, employment support, financial/debt advice, Violence Against Women and Girls, VCSE partners, social care provision for rough sleepers, the team will further integrate GPs, Psychiatrists and Psychologists, occupational therapists, outreach workers, nurses, peer support workers via trauma-informed approaches, working in parallel with integrated substance use treatment pathways to ensure effective holistically support. The outreach team regularly link with hostels, day-centres, street outreach teams, hospitals and primary or secondary care.

Recognising the prevalence of rough sleeping in Camden and Islington, a MDT led by public health have developed a funding proposal, recently unsuccessful, but identified as a system wide priority based on need.

CYP mental health plans align with those for children and young people with learning disability, autism, special educational needs and disability (SEND), children and young people's services, and health and justice [from 2022/23]

We have a well-established Learning Disability and Autism Partnership Group for CYP which is a sub group of the NCL Learning Disability and Autism Programme Board, and is chaired by the Commissioning lead for NCL CAMHS Programme Board. This provides a robust interface to ensure consideration of the mental health needs of CYP with Special Educational Needs and Disability (SEND). We recognise the importance of whole system working, particularly with education and social care colleague's when working to meet the needs of this cohort.

Our ambition focuses on improving outcomes for CYP, including those with SEND/LD/ASD, through early identification of need and timely evidence-based interventions.

<u>Early Identification of Need</u>

The Transforming Care Prevention and Support (TCaPS) service is an NHS England Accelerator site initiative, with 12 months pilot funding. Using a keyworker model the service provides flexible early intervention and crisis prevention support for young people and their families rated green and/or amber on the At Risk of Admission registers. Building on the evaluation of this keyworker model, which has shown benefits using Personal Health Budgets (PHBs) in supporting needs of people with autism and no learning disability, and impacts of early identification an early intervention preventing escalation through the system, we plan to extend the keyworker model into supporting young people in inpatient mental health units as set out in the LTP.

<u>Evidenced Based Interventions</u>

All areas have a CAMHS pathway for young people who present with a diagnosed learning disability and co morbid mental health need, although there is some variation in delivery. This includes support to young people who are also in local special schools. Locally there is more work to do with education partners to consider how young people are identified and assessed to have a learning disability in the first instance.

Our programme ambition is to ensure delivery of an equitable and effective service model and that CAMHS providers are able to deliver evidenced based interventions to this specific cohort of CYP with diagnosed LD/ASD presenting with mental health difficulties.

Our children's commissioners are planning further market development work with providers and support workers being available to support those young people with autism and mental health, linking with each area's SEND plans. There is some provision of dedicated Positive Behaviour Support (PBS) Teams for CYP but there is variation in availability and service models which we need to review. This will build on NCL workforce upskilling work such as PBS which has been extensively delivered across CYP as well as adult services, helping to support local STOMP/STAMP initiatives.

Developing crisis support

A business case to create better community crisis and intensive support provision is in development to explore options for a building-based respite and crisis 'crash pad' facility, to reduce CYP admissions into Tier 4 services. The service will provide planned short breaks which will sit alongside key worker roles to reduce family breakdown at home which can result in unplanned admission and children and young people being taken into care. Discussions have started with NHS England to enable targeted capital investment 2020/21 for the development of this innovative service.

Care Education and Treatment Review (CETR) processes are well established with a shared protocol in place to ensure a consistent approach in line with NHS England guidance. A number of the children and young people who are part of the Transforming Care cohort will be accessing support through an Education, Health and Care Plan (EHCP) and/or social care support services and our Admission Avoidance Register meetings and CETRs help join up provision for individuals.

All areas have dedicated mental health provision provided into youth offending services and the Liaison and Diversion Model is also established across NCL. Typically for Youth Offending Services providers are commissioned to in reach to services to support and encourage engagement. While tailored to the needs of the local population, we increasingly want to ensure a consistent and equitable approach to meeting the mental health needs of young people in or on the edge of criminal justice pathways and learn from models that have had success in engagement of young people and impact on health outcomes.

The development of the CAMHS Forensic Team across NC and NEL, provided by the Tavistock and Portman, has been well received and local professionals across all areas have made use of the service and started to develop good working links. The model has also supported capacity building locally to consider the needs of this specific group of young people that present with significant challenges. As the service continues to establish itself and work alongside our local CAMHS providers knowledge skills and confidence in working with YP who present with significant challenge and risk will increase.

Older adults and Dementia

There is a commitment amongst system partners to support people to age well. The ambition is to go further in improving the care we provide to older people, taking a holistic approach to addressing frailty, including physical and mental co-morbidities, supporting older adults by providing care closer to home, keeping older adults well in the community and preventing unwarranted hospital admissions through our Integrated Care Systems and delivery partners. The health and social care borough partnership plans focus on older

people and ensure the specific mental health needs of our elderly populations will be addressed with a particular emphasis on dementia and delirium.

North London Partners in Health and Care has the highest dementia diagnosis rate (82.0%), and Enfield, Camden and Islington are the top three boroughs in England. We are one of only three areas working with the national dementia policy team to capture and share our examples of best practice in dementia care, such as Enfield's Care Home Assessment Team (CHAT, see below). We have adopted the London referral to diagnosis ambition of 95% of people receiving post diagnostic support within 6 weeks of referral. An example of integrated physical and mental health services for older people is the integration of dementia specialists working with and through the PCNs. There are integrated older people's specialist community teams based on frailty and physical health care for patients with dementia and co-morbidities, working with social care and integrated local authority teams to keep people well in their own homes by providing holistic support services. These teams prevent crisis and manage crisis in the community, and where needed provide appropriate and personalised care in care homes, supporting all patients with dementia to have an advanced care plan to manage the patient's physical and mental health needs and respect their wishes in management of their conditions and long term care needs.

Older People's Mental Health

C&I have a specialist OPMH division called Services for Ageing and Mental Health (SAMH) which has inpatient and community services and staff with a wide range of specialist skills to support older people, including Psychiatrists, Mental Health Nurses, Social Workers, Psychologists, Occupational Therapists, and Support Worker. SAMH support patients to manage their co-morbid mental and physical health needs. C&I provide a specialist older people's CRHT and have older people IAPT specific workers that provide both group and individual sessions. They have 2 memory services for the identification, diagnosis and provision of post diagnostic support for patient with dementia and their carers. All our Mental Health Liaison Services provide fully integrated adult and older peoples liaison services, therefore this population will benefit proportionally. They offer a number of evidence-based treatments, integrated with physical health services where appropriate, including talking therapies from the team psychologists, medication management, setting up home care, home visits, assisting patients with day to day tasks and referrals where needed, providing advice and guidance to patients, families and carers, helping with social and housing needs and advice on benefits.

In BEH there are dedicated OPMH community services including Community Mental Health teams, a Day Hospital which provides step up and down support to acute trusts, 3 Memory Services for the identification, diagnosis and provision of post diagnostic support for patient with dementia and their carers. BEH provide psychology for older people across the Trust to support older people with SMI. Older people can also access the generic trust wide CRHT team 24/7 service. BEH are currently exploring the potential benefits and impact of a dedicated OPMH community crisis service which all neighbouring trusts have implemented, in light of the impact of quality of care for people with dementia and on acute hospital activity. Older People with functional ill-health have equitable access to IAPT. BEH have dedicated OPMH services for people with a functional diagnosis and dementia and work closely with community health colleagues to provide support for our OPMH inpatients around specific physical health care needs such as Diabetes, SLT and Tissue Viability. There is regular Geriatrician input to the OPMH inpatient wards.

The interface between OPMH and Ageing Well/frailty services are addressed through Integrated Care Network, Primary Care Networks, Frailty network and Acute frailty network,

adults integrated care partnership, Social Prescribing Link Worker roles, borough complex care MDTs, Frailty Hotlines, Advanced Care Plans are uploaded on CMC including preferred place of death. Through the Integrated Care Network OPMH workforce is flexibly organised around local communities and built around clusters of GP practices who address mental health, physical health and social care needs holistically, care can be stepped up where or when more specialist care is required, and stepped down, in a flexible manner without the need for cumbersome referrals and repeated assessments.

We have multiple examples of integrated care and optimally utilising our OPMH workforce. An example of best practice for innovative integrated physical and mental health services for care homes is the Enfield Care Home Assessment Team (CHAT) who provide physical and mental health support to care homes in Enfield and are sharing best practice across NCL. The CHAT model saw a 35% reduction in unwarranted A&E attendance and admission to acute hospital beds. The service also helps to facilitate the timely discharge from acute hospital beds via a Trusted Assessor function, provides holistic support and training to care homes and facilitates end of life care support.

Adult Neurological Development Disorders (NDD) of Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD)

There are currently long waits, often in excess of 12 months, for adult patients accessing diagnosis and treatment for ADHD and ASD that has not being diagnosed in childhood. As knowledge and awareness of these NDD conditions has grown in recent years, our existing commissioned services are not sufficient to meet local demand and can result in some patients travelling long distances. These undiagnosed and untreated conditions often exacerbate co-morbid mental health conditions and lead to poor experiences and engagement with other health and social care systems and community engagement; leading to poor quality of life and increased use of other health care services such as crisis and GP services. We are re-commissioning this provision to establish a single service to meet local need for adult NDD, to improve quality, efficiency and deliver care closer to home integrated with local health and care systems, this will be a radical change in the delivery of this service that is more responsive and less fragmented.

100% of CCGs will achieve the Mental Health Investment Standard from 2019/20

NCL CCGs have consistently met the Mental Health Investment Standard across the Five Year Forward View period and have a continued commitment to meet in subsequent years.

Digitally enabled Mental Health Care

Demonstrate progress against assessments of digital maturity (e.g. Digital Maturity Assessment).

• 100% of mental health providers meet required levels of digitisation (FLEXIBLE)

• Local systems offer a range of self-management apps, digital consultations and digitally-enabled models of therapy (FLEXIBLE)

• Systems are utilising digital clinical decision-making tools (FLEXIBLE)

Mental Health partners are supporting the Health Information Exchange development in NCL which will create a health analytical database and allow record sharing. Mental Health Trusts

recognise that continual development and upgrading of EPR systems are needed to support the digital developments. Mental Health providers each have a digital strategy which aligns to the LTP vision of integrated physical and mental health supported by innovative technology. Our longer term vision is to explore the opportunities presented by digitally enabled decision making, online consultations, standardising electronic prescribing and benefitting from streamlining ways of working such as the Section 12 doctor app. In addition, for CYP the ambition is for CYP digitally enabled care plans and to work on improved digital solutions for 0-25 year olds. Mental health services recognise the need to move towards agile working and providing care closer to home, supporting staff in the community to work remotely can better service the patient populations such as updating care plans during or after home visits and conducting remote ward rounds with secondary care colleagues.

Improving the quality of mental health data

All providers, including third & independent sector providers, are committed to submit comprehensive data to the Mental Health Services Data Set (MHSDS) and IAPT dataset.

- BEH and C&I are fully committed to the submission of MHMDS and IAPT Datasets. This is done on a monthly basis at the trust.

100% of providers to be compliant with MHSDS v4.0 ISN in 2019/20

- BEH, C&I and The Tavistock and Portman NHSFT are compliant with MHMDS v4.

100% of mental health providers to achieve and maintain a score of 95%, or above, in the MHSDS Data Quality Maturity Index from 2020/21

- The Tavistock and Portman NHSFT is 95% complaint. Both BEH and C&I are committed to achieving the score of 95% and over. BEH is on an upward trajectory to deliver the 95% target by 2020/21, C&I will be compliant by Q4 2019/20.

100% of providers to be SNOMED CT compliant from 2020/21

- BEH clinical systems are SNOMED CT compliant. SNOMED CT is used in ED services in the Trust, and work is underway to extend the use of SNOMED CT codes in line with the 2019/20 CQUIN.
- C&I are working with our EPR suppliers to ensure SNOMED CT compliance from 2020/21.
- The Tavistock and Portman NHSFT submit outcome measures and modalities, their supplier is developing further SNOMED functionalities delivered in 2020/21.

100% of NHS mental health providers to submit patient-level costing information by 2020/21

- C&I and The Tavistock and Portman NHSFT are submitting patient level costing and will continue to submit.
- BEH has recently upgraded their costing system to enable the production of patient level costs and will be compliant in 2020/21, in line with the national timetable.

All STPs must set out how they will reduce health inequalities by 2023/24.

People with severe and enduring mental illness are at greater risk of poor physical health and reduced life expectancy compared to the general population. People living with SMI and PD experience some of the worst inequalities, with a life expectancy of up to 20 years less than the general population. People with an SMI are twice as likely to have at least one other diagnosed long term condition as people who don't have an SMI. In NCL, nearly half of people on Employment Support Allowance is due to a mental illness. Almost half of people with an SMI are smokers and twice as likely to be obese than the general population, and self-reported physical activity is lower amongst people with a SMI.

Ethnicity data shows us that Black and Mixed ethnic groups have the highest prevalence of SMI. Within this Black Caribbean and Mixed (White and Black Caribbean) ethnic groups have the highest prevalence of SMI. Young Black males are more likely to present in crisis, be sectioned under the Mental Health Act and more likely to experience poor outcomes from treatment.

Through the Community Mental Health Framework for Adults and Older Adults our ambition is for all patients to have easy access to services, reduced waiting times, no fragmented services and no wrong door approach, with services that are easier to navigate. We are working with Public Health and the wider sector around people who experience multiple disadvantage to develop a more targeted approach for this cohort and reduce health and social care inequalities.