North London Mental Health Partnership

NHS
Barnet, Enfield and Haringey Mental Health NHS Trust
Camden and Islington NHS Foundation Trust

# Better Mental Health
# Better Lives
# Better Communities

North London Mental Health Partnership

## Clinical Strategy supporting document

2024 - 2029

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## Contents

## Version Control

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## Definitions

| | |
|---|---|
| ADHD | attention deficit hyperactivity disorder |
| ADL | activities for daily living |
| AMHE | advancing mental health equalities |
| ASIST | applied suicide intervention skills training |
| BEH | Barnet, Enfield & Haringey |
| BOWS | benzodiazepine and opiate withdrawal service |
| BSL | British sign language |
| C&I | Camden & Islington |
| CAMHS | children and adolescent mental health services |
| CBT | cognitive behavioural therapy |
| CHRTT | crisis resolution and home treatment teams |
| CNWL | Central North West London Foundation Trust |
| COPD | chronic obstructive pulmonary disease |
| CPA | care programme approach |
| CQC | care quality commission |
| CxIOs | Chief Experience and Innovation Officers |
| CYPMH | children and young people mental health |
| DIALOG | a scale of 11 questions. People rate their satisfaction with eight life domains and three treatment aspects on a 7-point scale. DIALOG provides a score for subjective quality of life and a score for treatment satisfaction. The scale is part of the DIALOG+ intervention but can also be used on its own |
| DIALOG+ | a full therapeutic intervention. It incorporates the DIALOG scale but goes far beyond administering a scale |
| DMS | discharge medicine service |
| EDI | diversity, and inclusion |
| ELFT | East London Foundation Trust |
| ePMA | electronic prescribing and medicines administration |
| EPR | electronic patient record |
| EPS | implement electronic prescribing system |

| | |
|---|---|
| FP10 | FP10 are prescriptions that are purchased by NHS organisations including Hospital Trusts, and are distributed free of charge to medical and non-medical prescribers, NHS dentists and other organisations as required. |
| GDPR | general data protection regulation |
| GP | general practitioner |
| Heal-D | healthy eating & active lifestyles for diabetes in African and Caribbean communities |
| HealtheIntent | a data and insights platform |
| HEE | health education England |
| ICB | integrated care board |
| ICS | integrated care systems |
| IoMH | institute of mental health |
| IPS | individual placement support |
| KPI | key performance indicator |
| LAS | London Ambulance Service |
| LGBTQ | lesbian, gay, bisexual, transgender and queer |
| LISA | London Inclusion Sports Academy |
| LoS | length of stay |
| MDT | multi disciplinary team |
| MECC | making every contact count |
| MHCAS | mental health crisis assessment service |
| MHCAS | mental health crisis assessment service |
| NELFT | North East London Foundation Trust |
| NICE | National Institute for Health and Care Excellence |
| NIHR | National Institute for Health and Care Research |
| NLFC | North London Forensic Provider Collaborative |
| NLFS | North London Forensic Service |
| NLMHP | North London Mental Health Partnership |
| NMP | non-medical prescribing |
| NRT | nicotine replacement therapy |
| OBD | occupied bed days |
| PCREF | patient carer race equality framework |

| | |
|---|---|
| PFA | psychological first aid |
| PPIE | patient and public involvement and engagement |
| PSED | public sector equality duty |
| PTSD | post-traumatic stress disorder |
| QDiabetes | a risk prediction algorithm which calculates an individual's risk of type 2 diabetes taking account of their individual risk factors such as age, sex, ethnicity, clinical values and diagnoses |
| QI | quality improvement |
| QOF | quality outcomes framework |
| QRISK3 | a clinical risk assessment tool used in the UK to estimate a person's risk of developing cardiovascular disease (CVD) over a specific time period, typically 10 years |
| R&D | research & development |
| RCRP | right care, right person |
| RiO | an electronic patient record system |
| SMI | serious mental illness |
| SMS | substance misuse services |
| STAMP | supporting treatment and appropriate medication in paediatrics |
| STOMP | stopping the over-medication of children and young People with a learning disability, autism or both |
| TIO | trauma informed organisation |
| TT | talking therapies |
| UCL | University College London |
| UCLP | University College London Partners |
| VCSE | voluntary, community and social enterprise |
| WLHT | West London Health Trust |
| WRES | workforce race and equality standards |

## 1. Introduction

This is the Clinical Strategy for the North London Mental Health Partnership which will deliver the clinical aims and objectives of the **Partnership Strategy** over the next five years. The Partnership Strategy outlines our ambition to offer cutting-edge, local, high quality mental health and wellbeing support to our service users and communities. We are committed to working with service users, carers and partners to improve the mental health of everyone in North London. This will mean supporting people to be resilient and have good mental health. We will offer early intervention for those with mental health problems to prevent these problems worsening. We will also promote and support what people and communities can do to underpin their own wellbeing, reducing harm and promoting healing.

We are committed to being a trauma-informed organisation, recognising that adverse childhood events and previous experiences in adulthood can contribute to mental and physical health problems and our approaches and actions must always be mindful not to further traumatise people.

Each of our 15 clinical areas developed their strategies in order to achieve greater consistency across North Central London so that residents will have equitable access to and quality of care. Each of these were reviewed by the co-production group, our recovery lead, and the Equality Diversity and Inclusion team. The views of our trauma-informed experts were also sought. These clinical areas are:

- Children & Young People
- Forensics and Prisons
- Adult inpatient
- Crisis & Emergency
- Adult community
- NHS Talking Therapies
- Older Adults
- Rehabilitation
- Substance Misuse
- Learning Disabilities & Neurodevelopmental
- Perinatal and Maternal Mental Health
- Specialist Eating Disorders
- Veterans
- Transitions

This strategy has been co-produced with service users, carers, experts by experience, and staff. It has been informed by our wider workforce and our partner organisations' ambitions, including our Integrated Care Board, Local Authorities, Voluntary Sector, Metropolitan Police, and London Ambulance Service.

## 2. Our five-year Partnership Strategy

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In the NLMHP we will create a new, shared culture and set of values, aimed at providing care that is co-produced, trauma-informed, preventative, compassionate, personalised and strengths-based.

We will work with partners to identify people's holistic needs and support them with their housing, employment, education, social and economic needs, which all impact on their mental health and drive health inequalities.

We will accelerate our approaches to co-producing the design and development of our services with service users, carers, experts by experience and peer support workers.

We will improve our understanding of and connections with the communities we serve, building on the use of data, and putting in place a framework for action in order to address health inequalities. Each community mental health team will have clear aims to reduce inequalities and deliver equitable outcomes, and how they achieve these will be co-produced with local people and service users.

We understand that our service users and carers want services to be more responsive, accessible and tailored to individual needs with a focus on overall wellbeing.

Our proposed population health model requires investment to grow our core community mental health teams embedded in primary care that are multi-agency, multi-disciplinary, and accessible to local communities. This model includes borough-wide intensive teams to work with people with very complex needs. These services will focus on prevention and recovery, and care which is delivered closer to home.

We will ensure that our service users and carers are less dependent on inpatient services, receiving earlier interventions at home or in the community. Evidence based interventions will be offered by skilled mental health professionals who are representative of their community. There will be continuity of care from clinicians and teams that service users and carers get to know. We will integrate our services with partner organisations so that people's mental, physical and social health are managed holistically.

An outcome of this strategy is for our two organisations to become a new, single organisation which will present further opportunity to develop innovative clinical pathways that span NCL.

North London Mental Health Partnership Five Year Strategy

## 3. Building on Past Foundations
### Our previous clinical strategies and what we have achieved

We are not starting from ground zero. We have had clinical strategies in place that are the result of co-production, consultation and engagement with service users, carers, staff and partner organisations. This work is not lost. This new strategy builds on that work and extends it into a single clinical strategy for the NLMHP. Circumstances have changed as a result of the pandemic and a new organisation of mental health services.

The impact of the COVID-19 pandemic was recognised in the strategies that were launched at the start of the pandemic. Many of the ambitions in the strategies were severely hampered during and following the pandemic by increased demand for mental health services; severe difficulties recruiting and retaining staff; the move to working from home; and the financial pressures in the wider NHS system.

The pandemic shone a light on health inequalities. Addressing these were an ambition in the clinical strategies. Lots of work has been happening to reach out to local communities to learn from them what will make our services accessible and relevant. The data we collect are improving which enables more targeted initiatives to promote equality, diversity and inclusion.

The strategies said that services must be trauma informed. The new Partnership Strategy has committed us to becoming a trauma-informed organisation. We now have a well-established trauma-informed collaborative that is extending to include all services and we will adopt an existing trauma-informed strategy for the NLMHP.

Our services are applying the principles of a recover-orientated approach which fosters hope, therapeutic optimism, shared decision making and aims to reduce stigma. We are much better at co-producing services and individual care plans. Dialog+ has been introduced for most adult and older adult community services and will be extended to cover more services. This is now our main tool for creating co-produced care plans; it is also a patient rated outcome and experience measure. As these data develop, we will know whether our services are delivering what matters to people in terms of their mental wellbeing.

Evidence-based interventions have been a fundamental part of the previous strategies. There is more we need to do in areas such as advanced care planning and addressing drug and alcohol problems. We are doing a lot more to support people with their physical health problems as part of our quest to reduce the mortality gap for people with serious mental illness (SMI).

Our most important opportunity for prevention and early intervention is in our services for children and young people. There is enormous demand for these services, and access and waiting times are serious problems. These services have been brought together under a single division and the clinical and operational model is being clarified. A patient tracking list is in place, so we know where and how long children and young people are waiting and this enables us to understand where we need to employ resources more effectively.

In line with the strategies, we have been developing our community services with a focus on place-based care using the principles of population health management. We now have core community mental health teams across all five boroughs. This has been an enormous undertaking and the model is evolving as we learn. Through our integrated working with primary care and the voluntary sector we are increasingly in a better position to intervene early and prevent mental health problems escalating, and to support people with their physical and social health. We now have data platforms in place that link data from our systems, primary care, acute and community providers which facilitate integrated care and, also, population health management.

We have been working on our crisis and emergency pathways. Soon we will have a single crisis line for North London that will also receive ‘NHS111 press 2’ calls made locally. The Mental Health Crisis Assessment Service (MHCAS) is now a resource for residents in all five boroughs. More work is being done to develop a crisis and emergency model that is consistent across North London. A priority in the clinical strategies was ensuring people admitted to hospital are discharged as soon as their needs can be met in the community. As a result of this work the

necessity to admit people to out of area, private hospitals has reduced and our ambition remains to eliminate this completely.

Our specialist services that include forensics, prisons and eating disorders have developed according to ambitions in the clinical strategies and continued to offer excellent care.

The newly formed NLMHP provides us with an exciting opportunity to build upon past foundations and achieve greater improvements in our mental health services.

BEH Clinical Strategy 2021-2026

C&I Clinical Strategy 2020-25

## 4. How and whom we have consulted

The development of the NLMHP Clinical Strategy has been a collaborative endeavour, embracing the diverse perspectives and expertise of service users, carers, staff, partner providers, and voluntary sector organisations. This approach is essential because a clinical strategy must address current and upcoming challenges and this complexity requires the expertise of those receiving and delivering services across our wonderfully diverse population so that we truly meet the needs of our communities.

At the start of developing this strategy, we set up a co-production group comprising service users, carers, and staff. The remit of the group was to review and provide feedback for the clinical strategies of the 15 clinical areas. Each of these 15 strategies indicated where they were on the co-production ladder, i.e., whether they were co-produced, involved engagement or consultation with service users and carers. They ranged from good co-production to an ambition for future co-production.

The co-production group shaped the final text that went into the NLMHP Clinical Strategy document. We held 15 co-production group meetings where there was open and constructive discussion about our clinical services drawing upon the invaluable insights and diverse experiences of people who have first-hand experience of our services.

We held three engagement workshops that brought together service users, staff and stakeholders from the ICB, Local Authority and Voluntary Sector providers. We held two dedicated sessions with our Governors. We hosted two online webinars for our staff.

We have also drawn on the ideas generated in the extensive consultation that took place for the NLMHP Partnership Strategy.

We are immensely grateful to our co-production group and everyone who attended the various engagement events. Their active involvement has been instrumental in shaping this strategy, ensuring it is responsive, inclusive, and aligned with the needs and aspirations of our communities living in North London.

## 5. What we heard from service users & carers

We continue to work within the spirit of 'National Voices' and 'Think Local Act Personal' aspirations as outlined in their 'No Assumptions' (2014) document, which sets out a number of 'I' statements from people with lived experience of mental illness.
We remember what our service users and carers previously told us is important to them.

***Who I am:***

1) *I want to be defined as an individual*
2) *I want my cultural identity to be recognised and understood*
3) *I want to be seen as a person not a diagnosis or illness*

***How I wish to be supported:***

- *I want to be seen by a skilled person as soon as possible who listens to me and treats me with respect*
- *I want staff to have more conversations with me to get to know me and understand me better so that my plan is about me not just my illness*
- *I want my mental and physical health needs to be recognised and addressed*
- *I value peer support both on the wards and in the community as well as professional and clinical support*
- *I want services and support to be designed in partnership with people with lived experience of mental health services*
- *I want to be offered talking therapy, not just medication. Medication might be the quickest way to stop a crisis but not the best way to address the cause*
- *I want better links to community activities such as the arts, music, theatre, libraries, social groups*
- *Keep me in touch with my community and my culture*

***What's important to me:***

- *I want clear simple pathways into and through my care and support, that I can see and understand*
- *I want clear information about what I can expect and to know the faces of people I might see*
- *I want different services to know about each other to ensure they can give me the care I need when I need it*
- *I want to know what I need to do if I am in a crisis and to receive a quick response*
- *As a carer I want to be better informed and supported but understand this sometimes needs to be balanced with the views and needs of the person I am caring for*
- *If I am not seen in my own home, I want the environment to be welcoming and comfortable and automatically take into account any sensory needs I might have*
- *Not having to repeat my story more than once*

***How People behave with me:***

- *I want services and professionals to listen to me, respect me and not make assumptions about me*
- *I want the staff I meet to be trained to understand mental health and physical health needs and able to help me as a whole person*
- *I want staff to talk to me about what and who is important to me in my life*
- *I want all the professionals working with me to meet together with me and my family or carer regularly*
- *Any Advance Decisions I made need respecting in a crisis*
- *Listen before judging me*

### 5.1. What we heard in addition from our service users and carers in 2023

**Trauma-informed approach**

- All care must be provided in a trauma-informed way

**Person-centred care**

- Tailor care based on individual needs.
- Recognise the overlap of physical and mental health.
- Address psychological, social and environmental issues and recognise employment can have a negative or positive impact on mental health.

**Co-production and Patient Engagement**

- Establish guidelines for involving service users in decision-making.
- Create an online patient engagement platform in order to make it easy for people to know what is being done and to get involved.
- Collect patient and carer feedback and act on it.

**Carers**

- Consider the wellbeing of carers.
- Involve carers in care planning.
- Involve carers in the co-production of services.

**Access and Care Delivery**

- Intervene early and prevent mental health problems escalating.
- Addressing challenges in navigating services.
- Address challenges faced by disadvantaged groups in accessing care.
- Inpatient beds and treatment options must be near usual social networks.
- Provide people in hospital with meaningful patient activities.
- Processes to reduce admission time and readmissions must be efficient.
- Discharge from hospital must be properly planning bearing in mind home may feel a lonely place after a busy ward.
- Training on self-harm and suicide prevention must be available to staff and carers.
- Provide people with day services as an alternative or step down from hospital.

**Substance Misuse and Dual Diagnosis**

- See substance misuse as a condition to address and not as a mischief.
- Offer age-specific education on substance misuse, targeting young people aged 13-18.
- Recognise substance misuse early and offer timely access to treatment.
- Train staff and monitor for and respond to new harmful, illicit drugs.

**Staff Wellbeing**

- Address staff wellbeing to prevent burnout.

**Community engagement and partnerships**

- Strengthen partnerships with community organisations.
- Collaborate with other service providers and share best practices.

**Environment**

- Addressing issues such as noisy wards and limited space.

## 6. What we heard from our Staff and Governors

**Stakeholder engagement**

- Service users and carers must be involved in co-production and decision-making.
- Include voluntary and community organisations.
- Engage with children and young people.

**Clinical approaches**

- All services to adopt a trauma-informed approach.
- Clarify what is meant by a 'recovery-orientated' approach.
- Focus on prevention and early intervention.
- Ensure interventions are evidence-based and clinical care is high-quality.
- Facilitate communication and information sharing, e.g., easy availability of language BSL (British Sign Language) interpreters and more translated resources.
- There must be a clear approach to addressing substance misuses problems.

**Service access**

- Understand and address access to our services by people who are reluctant to seek help from GPs.
- The must be a well-coordinated interface with other service providers, e.g., police.
- Services must be easily accessible.
- Address waiting times and resource challenges.
- Consider programmes of prevention, outreach, and support in education settings, e.g., schools, colleges, universities.

**Service delivery**

- Integrate mental and physical health services.
- Ensure continuity of care.
- Care must be place-based.
- Improve crisis and emergency services (access as well as safety).

- Eliminate inappropriate out of area placements.
- Use and report clinical outcome measures.
- Value feedback from service users and carers about the quality of care.

**Suicide Prevention**

- Ensure there is a continuous focus on suicide prevention and reduction in self harm.
- Monitor and analyse data of deaths by suicide according to ethnicity and inequalities.

**Social determinants of ill health**

- Recognise housing as a significant issue, especially the limited availability of supporting housing.
- Recognise and contribute to addressing social determinants of health.
- Remember other environments, e.g., prisons, where people may have mental health problems.
- Organise outreach to area of high deprivation.
- Pay attention to the diversity and cultural competence of the workforce.

**Research and Quality Improvement**

- Sharing learning across the partnership.
- Provide access to data and research teams.
- Support qualitative and quantitative research.
- Encourage research into supporting independence and innovation.

**Workforce**

- Workforce recruitment, retention, and staff wellbeing and career development.
- Pay attention to diversity in the workforce, including experts by experience.
- Provide training so that staff feel confident in their skills (focus on NHS training instead of outsourcing).

**Data and Digital systems**

- Different clinical digital systems must be interoperable.
- Collect and analyse data about demand for services.
- Correlate data relating to mental health disorders and spend.
- Ensure we have training and skills for data production, analysis and presentation.

**Realise the benefits of the NLMHP**

- Offer services across NCL that are consistent in quality.
- Consolidate small, fragile services to make them sustainable.
- Represent and champion mental health services in NCL.
- Engage effectively with the Integrated Care Boards (ICBs) and other providers.

**Strategy implementation and evaluation**

- Give attention to the effective dissemination and communication of the NLMHP Clinical Strategy.
- Ensure the strategy is understood and implemented across all services.
- Use the strategy to standardise processes and clinical models.
- Monitor and evaluate improvements made as a result of the strategy.

## 7. What we heard from local partner organisations

### 7.1. NCL Population Health Strategy

This is a response by the NCL Integrated Care Board (ICB) to the escalating health needs of our population and the growing evidence of widening inequalities. The strategy describes a vision for a more prevention-oriented, proactive, integrated, holistic and person-centred approach to care. The ambition, as an integrated care partnership of health, care and voluntary sector services, is to work with residents of all ages in North Central London so they can have the best start in life; live more years in good physical and mental health in a sustainable environment; to age within a connected and supportive community; and to have a dignified death. This document describes how care will be integrated and the approach to population health improvement for the next five years.

A series of population health outcomes are identified that will serve as a collective focus. These are divided into 'start well', 'live well' and 'age well' and include a number of specific mental health outcomes:

- Improved mental health and reduced inequalities in perinatal outcomes.
- All young people and their families have a good experience of their transition to adult services.
- Reduced racial and social inequalities in mental health outcomes.
- Improved physical health in people with serious mental health conditions.
- Reduced deaths by suicide.
- People are supported to stay in jobs, including mental health services.
- Earlier preventions, detection and management of long term condition, including dementia.

NCL-PH-IC-strategy

### 7.2. NCL Core Mental Health Offer

The Core Offer describes the mental health care functions and services that should be available across NCL for different age segments of the population and how these care functions integrate with the wider health and care system. It provides a brief specification for each care function and service. A digital element is integrated throughout the specifications.

This is an innovative approach that will ensure consistency across NCL and it reflects population need. Built in are co-ordination functions to facilitate access to services and better joined up services, i.e. a central point of access, a trusted holistic assessment function and care coordination and case management. The level of support relates to the degree of complexity of need. This will help to reduce health inequalities and deliver more proactive, integrated care.

There is a shared outcomes framework and key performance indicator (KPI) dashboard which will be used to track equitable outcomes improvement.
NCL MHS Core Offer Report

### 7.3. Primary Care

Our local GP leaders have raised issues regarding the limited availability of assessment, treatment and ongoing management resources for people with neurodevelopmental disorders and eating disorders. Much of this then falls upon GPs to manage. There are also concerns about the lack of interface agreements required for some psychiatric medications, especially for children and young people for whom medication prescription is often 'off-label'.

The Fuller Stocktake report highlighted the following key messages:

- **Challenges in Primary Care:** one reason is the inadequate access to urgent appointments causing patient dissatisfaction and low staff morale, leading to concerns about the sustainability of the current primary care model.
- **Integrated neighbourhood teams:** the vision for integrated primary care revolves around creating integrated neighbourhood teams that bring together various healthcare professionals and organisations to deliver a holistic model of care. Leadership and cultural shifts are required to foster this approach. These teams should align primary care, secondary care, and community resources while involving the community itself. Personalised care people with complex needs can be supported by good data, clinical leadership, and community involvement. The ultimate goals are to prevent ill health, enhance patient satisfaction and tackle health inequalities.
- **Same-day access and continuity of care:** These are two interconnected issues. By establishing a robust infrastructure for same-day urgent care, space is created for improved continuity of care. Urgent care should offer a variety of options, including online advice, community pharmacies, general practice, urgent treatment centres, and more; this will require extensive collaboration between various providers. Patient preferences vary with some needing immediate attention and others valuing continuity.
- **Data**: The success of integrated neighbourhood teams hinges upon effective data sharing to facilitate personalised care coordination, service planning, and research. A shift is required towards using data for improvement, not just monitoring. Systems must establish clear data sharing plans, involving providers and patients to enable population health management.
  Fuller Report

### 7.4. Local Authorities

Each of our five Local Authorities has a Health and Wellbeing strategy and below are some common themes relating to mental health and wellbeing.

Wellbeing support:

- Promote a whole system response to supporting individual and community resilience to improve mental health and wellbeing across all age groups.
- Encourage social prescribing to involve lonely, isolated individuals and those with mild mental health issues in community activities.
- Encourage physical activity, healthy eating, and smoke-free living for improved emotional wellbeing.
- Broaden digital wellbeing support.

Access to early help and support:

- Recognise the link between mental and physical health and promote parity of access to mental and physical health services.
- Focus on effective interventions and treatments for all ages.
- Increase access to psychological support, including to NHS Talking Therapies.
- Diagnose dementia early.
- Address mental health crises.
- Increase alcohol screening and access to support for problematic alcohol use.

Support for children, young people, and families:

- Improve access to mental health support for children and young people, in particular to those with long term conditions.
- Support children aged 0-5 and their families for a healthy start.
- Provide mental and physical health support to schools.

Suicide prevention and bereavement support:

- Develop and promote suicide prevention strategies.
- Implement bereavement support services for those affected by suicide.

Addressing inequalities:

- Address the wide employment gap between people with Serious Mental Illness (SMI) and the general population.
- Attend to the impact of COVID-19 on mental health, particularly among specific groups like younger people; those with pre-existing mental health conditions; socially isolated individuals; and people from minority ethnic communities.

Training:

- Promote mental health literacy among residents and the workforce.
- Provide training programmes like Making Every Contact Count (MECC) and Mental Health Awareness and First Aid (MHFA) to increase knowledge and support.

Barnet Joint Health and Wellbeing Strategy 2021-2025
Camden Health and Wellbeing Strategy 2022-30
Enfield Joint Health and Wellbeing Strategy 2020-2023
Haringey Mental Health and Wellbeing Framework
Islington Refresh Joint Health and Wellbeing Strategy

### 7.5. Metropolitan Police

When people are in mental health crisis, they need timely access to support that is compassionate and meets their needs. While there will always be cases where the police need to be involved in responding to someone in mental health crisis (for example, where there is a real and immediate risk to life or serious harm, or where a crime or potential crime is involved), police are increasingly involved when they are not the most appropriate agency to respond, and they are not able to handover care to a more appropriate professional in a timely manner. This impacts on the ability of the police to carry out their other duties effectively, and importantly, can result in people with mental health needs experiencing greater distress and having poorer experiences of the mental health care pathway.

The strategic approach described in 'Right Care, Right Person' (RCRP) provides a framework for assisting police with decision-making about when they should be involved in responding to reported incidents involving people with mental health needs.

To adopt the approach successfully, strong partnerships need to be formed between police forces, health bodies and local authorities to identify how to implement this approach in a way that best meets the needs of the local population and the shared aims of the agencies involved. To supplement the strategic approach set out by the Department of Health & Social Care, the National Police Chiefs' Council, College of Policing, and NHS England are producing detailed guidance to support local areas with the operational delivery of RCRP.
National Partnership Agreement: Right Care, Right Person (RCRP) - GOV.UK (www.gov.uk)

### 7.6. London Ambulance Service (LAS)

Each year, over two million Londoners encounter challenges with their mental health. The LAS mental health team, consisting of specially trained clinicians, delivers expert and compassionate care and advice to address the approximately 14,000 monthly calls related to mental ill-health that they receive.

During a mental health crisis, the Accident and Emergency (A&E) departments may not be the most suitable place for people and can be a source of added stress or trauma. the LAS aims to reduce the number of people with mental health problems that they take to A&E, as their needs

can often be met equally well, if not more effectively, in their own homes, within the community, or through alternative services.

To facilitate this, LAS have enhanced the mental health training provided to their staff and introduced mental health nurses to the clinical hub in their control room. They play a crucial role in assessing patients and directing them to the most appropriate point of care or service within their local community. These nurses also serve as expert advisors for ambulance crews and 999 call-takers.

In November 2018, LAS launched a new approach to responding to patients experiencing a mental health crisis by pairing a paramedic with a mental health nurse in mental health joint response vehicles (MHJRV). This joint working supports people at home or in the community and often avoids the need to convey someone to hospital.

### 7.7. Provider collaboratives

**North London Forensic Collaborative**

The North London Forensic Consortium is comprised of the five NHS providers of secure mental health services in North London; Barnet, Enfield and Haringey Mental Health NHS Trust (BEH) – lead provider, West London Health Trust (WLHT), East London Foundation Trust (ELFT), Central North West London Foundation Trust (CNWL) and North East London Foundation Trust (NELFT).

BEHMHT, ELFT and WLHT forensic services are all rated OUTSTANDING by the CQC with CNWL and NELFT rated GOOD. This provides NLFC with a solid foundation on which to further develop quality, pathways and collaborative working. Since mobilising the New Care Model Pilot in April 2018, NLFC have been striving to meet the aspirations within the Five Year Forward View for Mental Health (2016) and NHS Long Term Plan (2019) for fewer external placements, reduced length of stay (LoS), investment in new community services and care closer to home. To date NLFC have met this challenge and surpassed the success criteria set within their original business.

**North London Adult Eating Disorders Collaborative**

The North London Adult Eating Disorders Provider Collaborative went live in October 2021. CNWL Foundation NHS Trust is the lead provider for this Collaborative, with BEH and NELFT Foundation Trust being the other providers. The key functions of this Collaborative have been to adopt a systems-based approach to inpatient, day programme and outpatient/community services.

**Children and Adolescent Mental Health Services (CAMHS)**

a) Generic CAMHS

In 2021, an NCL review of community services and mental health services, for all ages, identified inconsistencies in service offer, access and outcomes for the NCL population.

NCL ICB aims to achieve its transformation vision by working in partnership with service users, wider cohorts of the young adults population and an extensive range of stakeholders to co-produce a NCL young adult programme which will achieve better outcomes and more positive experiences for 16-25 years accessing mental health services across the footprint. BEH, The Tavistock & Portman NHS Foundation Trust Whittington Health NHS Trust, Royal Free London NHS Foundation Trust, University College London Hospitals NHS Foundation Trust and Great Ormond Street Hospital NHS Foundation Trust have begun to move towards a Provider Collaborative model to deliver the following key priorities including; primary prevention, digital innovation, standardisation of the clinical model, developing the workforce model, expanding and establishing services to increase capacity, and further developing the research and evidence base.

b) Tier 4 CAMHS

The North Central East London CAMHS Provider Collaborative went live in October 2020. East London NHS Foundation Trust is the lead provider and BEH, NELFT and Royal Free Hospital are partners. The Collaborative oversees Tier 4 inpatient services across the collaborative. Maintaining quality, safety and patient flow are key objectives.

### 7.8. London's all-age Mental Health Crisis Care Concordat

This all-age crisis care concordat, which seeks to build on the 2014 crisis care concordat. It is a partnership agreement between the NHS and other organisations as a London. It covers everyone in London with a mental health need, including those with a co-existing diagnosis of Autism, ADHD, learning disabilities, and those with drug or alcohol co-morbidities. The vision is that all Londoners experiencing a mental health crisis, their families & carers, have access to timely and equitable support that is best suited to their needs, leading to an improved patient experience & outcome. The offer will be trauma-informed, and co-produced from design to delivery with those who access care and support.

There are four principles underpinning the concordat with the key underpinning principle being to tackle inequalities in access, experience, and outcomes:

1) **Prevention:** The focus will be on supporting individuals to live well in their communities and addressing inequities in access and outcomes, particularly for Black men.
2) **Local access:** provide appropriate care closer to home and offering alternative services thereby reducing avoidable Emergency Department attendances. Front-line staff will have access to advice to ensure the most suitable intervention for individuals potentially subject to detention under section 136.
3) **Timely and proportionate Support:** people presenting at Emergency Departments during a mental health crisis will receive timely and effective support, including alternatives to admission.
4) **Purposeful inpatient care:** when inpatient care is necessary it will be purposeful, close to home, and with a clear plan for discharge upon admission.
   London's All Age Crisis Care Concordat

## 8. What we have learnt from national documents

### 8.1. The Community Mental Health Services Framework for Adults and Older Adults

The Community Services Framework calls for a radical re-balancing of mental healthcare in favour of integrated community services. Different models of mental healthcare over the past 30 years have led to the fragmentation of services. Services must re-establish the original principles of community-based care: services that are patient--centred; accessible at any point in the care pathway ('no wrong door'); integrated within the local community; and comprehensive in their scope.

All health, Local Authority and voluntary sector services working with people with mental health problems should come together as multiagency, multidisciplinary services in a truly integrated way to support co-produced, patient-centred care. They will be responsible for the holistic care for all people with mental health problems, from less serious to complex needs, in a Primary Care Network population of 30,000-50,000 people. The boundary between primary and secondary care falls away because people are working in a team, sharing information, allocating interventions to people with the right skills and a strong emphasis on linking people into their local community resources.

This removes the problem of people not having the right diagnosis or complexity to access services because services will be responsible for a population and not a caseload. It avoids people having to reach a crisis point to get a service and be at risk of admission to hospital. It aims to end the two-tier system where people are currently either 'on CPA' or 'off CPA' (Care Programmed Approach).
Specialist borough-wide or multiple borough-wide services are required for people with very complex needs or to provide specialist interventions.

The benefits to the workforce are a wider pool of people to share the workload; fewer assessments because information is shared; no complex referral forms between agencies; and reduced administration. NHS-funded care needs to be co-ordinated seamlessly with Local Authority services, and the voluntary, community and social enterprise (VCSE) sector.

### 8.2. NHS Long Term Plan

The NHS Long Term Plan, published in January 2019 by NHS England, will shape NHS services for the next decade. A ring fenced fund worth £2.3 billion a year in real terms by 2023/24 will ensure that the NHS provides high quality, evidence-based mental health services to an additional 2 million people. The ambition is to tackle health inequalities, promote self-care, tackle workforce shortages and deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.

The following are the key deliverables:

- Further expansion of perinatal services, including access to specialist community care from pre-conception to 24 months after birth, increased availability of evidence-based psychological therapies, access for partners and Maternity Outreach Clinics.
- Further expansion of services to children and young people, including 24/7 crisis services; referral to treatment time standards for eating disorders; and a comprehensive offer for 0-25 year olds.
- Further expansion of NHS Talking Therapies.
- Integrated community models for adults with serious mental illness (SMI), including eating disorders, personality disorders, and rehabilitation. Also increased numbers of physical health checks, greater access to Individual Placement and Support (IPS) to help find and retain employment; and services standards for first episode psychosis.
- 24/7 crisis resolution and home treatment services meeting best practice; alternative crisis services; and more mental health liaison services in general hospitals meeting 'core 24' standards.
- An improved therapeutic offer for inpatients; a reduced length of stay in acute mental health inpatient settings; and an end to acute out-of-area placements for mental health patients by 2021.
- Suicide prevention programmes and suicide bereavement support services.
- Targeted funding for rough sleepers and gamblers.
- NHS-led collaboratives for specialist mental health services, learning disability and autism services.
- Required levels of digitisation and achieve data quality maturity.

### 8.3. Adult Crisis and Acute Care

The Mental Health Adult Crisis and Acute Care GIRFT Programme National Speciality Report was published in April 2021. Timely access to mental health care is vital; in many cases the more time that passes before treatment is accessed, the greater the likelihood that a condition will become more chronic and difficult to treat; requiring admission; and the greater the risk of secondary or tertiary disabilities. Stepping up and stepping down the intensity of care when appropriate, as well as ensuring that access to care operates on an easy-in, easy-out basis, means that fewer people will be stranded in the wrong part of the pathway (or outside of services) at any given time. Key domains are demand, capacity, flow and outcomes. Overarching all four of these areas is gathering, reporting and using data.

The report makes the following recommendations:

- Understands the needs of the local community and the demand for mental health services.
- Be clear which needs IAPT services have been commissioned to meet locally.
- Understand and mitigate increased demand on SMI services related to COVID-19.
- Ensure that the aims of the NHS LTP Mental Health Implementation Plan and LTP transformation funding are met locally.

- Work with local partners and national bodies to establish and train sufficient numbers of professionally qualified staff to meet the patient need for SMI services. Reduce vacancy rates and the reliance on agency and locum staff.
- Consider of opportunities to improve the skill mix and evaluate the impact of any changes or innovations, e.g., increasing the numbers of peer support workers, physician or nurse associates, develop new roles (both professionally and non-professionally qualified) and models of care delivery.
- Use existing staff capacity efficiently and clinician time to best effect; look at staff wellbeing and support.
- Ensure that systems are not routinely running at or very near maximum capacity in order to reduce staff burnout and risk of errors; give sufficient flexibility to deal with surges in demand; and allow time for system thinking and review.
- Routinely collect data to explore unexplained variation in reception and acceptance of referrals.
- Engage with patients and carers to identify and reduce avoidable barriers to patient access to SMI services.
- Monitor, analyse and report on step-up in intensity of services to ensure that step-up is essential, timely and equitable.
- Ensure that person-centred care and co-production of care plans is standard. For people who lack capacity, care planning should follow the principles and rules set out in the Mental Capacity Act.
- Record robust, publicly available outcome and intervention data.
- Trusts need to capture and analyse the impact of all interventions to assess risks and benefits as part of evidence-based practice.
- **I**ncrease awareness of whether variation is warranted or unwarranted.
- Develop and report robust ways for capturing interventions and outcomes for services that are heavily linked into partnership working.
- Reduce litigation costs by application of the GIRFT programme's five-point plan.

Timely access to mental health care is vital; in many cases the more time that passes before treatment is accessed, the greater the likelihood that a condition will become more chronic and difficult to treat; requiring admission; and the greater the risk of secondary or tertiary disabilities. Stepping up and stepping down the intensity of care when appropriate, as well as ensuring that access to care operates on an easy-in, easy-out basis, means that fewer people will be stranded in the wrong part of the pathway (or outside of services) at any given time.

Key domains are demand, capacity, flow and outcomes. Overarching all four of these areas is gathering, reporting and using data.

### 8.4. Rehabilitation services:

NICE guidance was published in August 2022 for people who have complex psychosis and would benefit from rehabilitation. The NHS Long Term Plan incorporates community rehabilitation as a core part of the Community Mental Health Framework, with significant funds assigned.

There is great unwarranted variation between trusts for rehabilitation services including: out of area placements (0 to 114); the amount spent per 100,000 population (£141,000 to £5.2m); the mean lengths of stay in inpatient high dependency rehabilitation units (50 to 1,567 days).

The Mental Health Rehabilitation GIRFT Programme National Specialty Report was published in April 2022. Based on the evidence, best practice, and findings from the deep dive meetings with trusts and key stakeholders, the recommendations fall into five broad themes:

- Improving the use of data to drive services, patient pathways, community rehabilitation and supported housing.
- Developing NHS-led provider collaboratives and integrated rehabilitation systems.
- Data-driven continuous quality improvement (QI).
- Standardisation of local procurement processes and protocols.
- Ensuring the right workforce with the right training, and hence skill set, can support improved patient care, treatment, and outcomes.

Working in collaboration can transform services and bring people closer to home. Using the existing evidence base and best practice from around the country and internationally, it is clear that a whole system approach to rehabilitation, and specifically local rehabilitation, provides the best chance of getting it right for this population.

## 9. What we know about our local population & population health management

### Our approach

We will use a population health management approach that concentrates on subgroups and segments within our population, defined by a shared need. Good intelligence through linked data helps us better understand current and future health needs of our local population and with this our clinical strategy will deliver services which are more proactive, preventative and better prioritised through effective allocation of capacity, addressing demand and delivering more cost-effective patient outcomes and productivity. A key priority is to address health inequalities.

We will develop our population health data set and analysis and use those data to match our resources according to local need. There is a lot of data that is not collected which adds complexity to this ambition.

## Our population

NCL has a **relatively young resident population** of circa **1.79m resident and 1.76m GP registered** people in 2022 according to GP data. There may be differences due to over-counting in GP practice registers, under-counting in population estimates, as well as variation in definitions of who counts as 'resident' in the country. The census data approximated 1.4m for 2021 based on persons on the electoral register (it undercounts by at least 3%).

Pre-COVID **NCL's resident population was expected to incerase by 5% by 2030, with the largest increase of 32% in 65+ year olds** (ranging from a 27% increase in Enfield to 39% in Camden).

NCL is the **second most deprived of the five London integrated care systems with areas of deprivation across all 5 boroughs**, often in close proximity to areas of affluence. More than 1 in 5 people in NCL live in the 20% most deprived areas nationally, while almost 1 in 3 live in the second most deprived 20% areas. There are particular concentrations of deprivation towards the east of NCL, with Enfield, Haringey and Islington having on average higher levels of deprivation. This is further reflected in the Poverty Profile across the partnership.

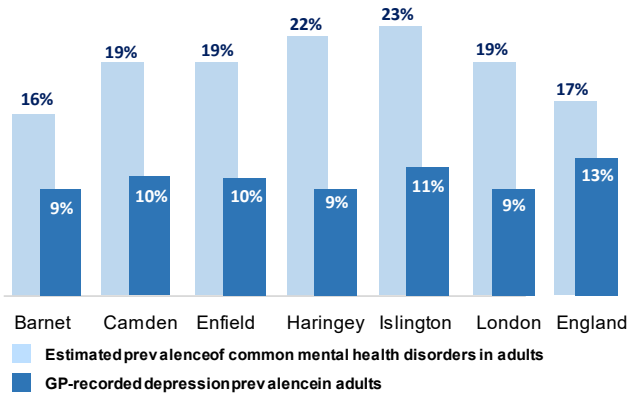
The **severe and enduring mental illness** (SMI) prevalence average for England is 0.95%, The average for London is 1.11%. Only Blackpool (1) and Hackney (2) rank higher than Camden and Islington for the prevalence of SMI mental health conditions in England. The incidence of SMI is relatively stable except in Islington where there is a small reduction.

An estimated 233,000 adults have some form of **common mental health disorder** in NCL. Across NCL the prevalence of depression is increasing.

# Mental Health

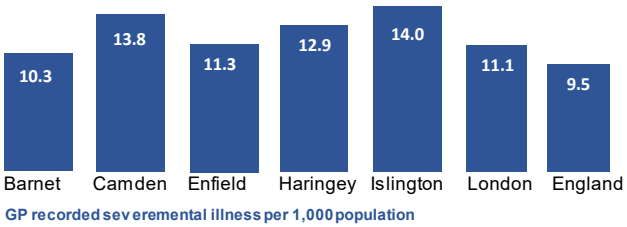
## 233,427 adults with common mental health disorders

In 2021/22 an estimated 233,310 adults had some form of common mental health disorder in the five boroughs.




## 19,649 adults with severe mental illness

In 2021/22, 19,649 people in the five boroughs were recorded by their GPs as having severe mental illness ("SMI" - bipolar disorder, schizophrenia, or other psychosis).




Sources:
- Royal Free Hospital Annual Report 2023
- Fingertips

Better Mental Health Better Lives Better Communities.

### Diversity

**Our population is ethnically diverse**. Although more than half of NCL residents are White, around 20% are of an Asian background and 20% of Black ethnicity. Barnet and Camden have larger Asian communities, whereas Haringey and Enfield have larger Black communities.

**Different communities have very different age structures**. There are higher proportions and numbers of children and young people in Mixed (39%), Bangladeshi (30%), and Black African (28%) communities compared to the NCL average (21%). There are proportionately more people aged over 65 in White Irish (29%), White British (20%), Black Caribbean (19%) and Indian (18%) communities compared to the NCL average (13%).

**Across North Central London there is a high level of population health need and inequalities**. Improvements in life expectancy across NCL have stalled in recent years and life expectancy and healthy life expectancy have declined following the pandemic. **Residents in all our boroughs are living on average 20 years in poor health**.

## Poverty Profile

| | | Barnet | Camden | Enfield | Haringey | Islington | London Ave |
|---|---|---|---|---|---|---|---|
| Living Standards | Child poverty rate (AHC) | 28% | 32% | 34% | 37% | 38% | 35% |
| | Income deprivation (relative to London overall) | 0.77 | 1.18 | 1.49 | 1.43 | 1.58 | 1 |
| | Pay Inequality (80:20 ratio of earnings) | 2.63 | 2.69 | 2.69 | 2.45 | 2.61 | 2.64 |
| | Poverty rate | 25% | 34% | 34% | 35% | 22% | 27% |
| People | Infant mortality rate per 1,000 live births | 2.8 | 3.6 | 3.5 | 3 | 3.1 | 3.4 |
| | Premature mortality :Deaths of <75 year olds per 100,000 | 250 | 279 | 315 | 330 | 364 | 316 |
| | Qualifications at 19:19 year olds without level 3 qualifications | 23.40% | 29.60% | 35.80% | 32.50% | 31.90% | 24.40% |
| work | Out-of-work benefits | 11.30% | 10.70% | 15.90% | 16.60% | 13.20% | 12.20% |
| | Low Pay: Proportion of borough residents' jobs that are low paid | 19.60% | No data | 28.70% | 26.10% | 13.50% | 20.20% |
| | Unemployment rate | 5.90% | 3.90% | 6.50% | 5.20% | 4% | 5.30% |
| | Unemployment rate 3 year change | 1.2pts | -1pts | 0.9pts | -0.1pts | -0.5pts | 0.2pts |
| Housing | Eviction: Repossessions per 1,000 households | 2.09 | 0.89 | 3.53 | 3.91 | 1.95 | 2.42 |
| | Main homelessness duty owed per 1,000 households | 0.62 | 0.34 | 0.68 | 0.53 | 0.78 | 0.74 |
| | Housing affordability: Median rent as a percentage of median pay | 43.40% | 58.60% | 38.70% | 47.20% | 54% | 46.30% |
| | Housing delivery: Average net affordable, social and discounted housing completions | 140 | 140 | 100 | 140 | 120 | 132 |
| | Rough sleeping: People seen sleeping rough by outreach | 173 | 666 | 183 | 268 | 238 | 214 |
| | Temporary accommodation: Households in temporary accommodation per 1,000 | 13.7 | 4.7 | 25 | 24.5 | 7.8 | 16.4 |
| Shared Opportunity | GCSE attainment: Percentage of pupils who achieved grade 4 | 84% | 75.30% | 71.10% | 72.60% | 72.90% | 75.60% |
| | No qualifications:Proportionwith no qualifications | 6.9 | 6.1 | 4.4 | 3.6 | 6.7 | 6.7 |

**Life expectancy and healthy life expectancy varies within and across our boroughs**. Whilst residents in Barnet and Camden have higher life expectancy than the London average, Islington residents and men in Haringey have lower life expectancies. During the five years preceding the COVID-19 pandemic, life expectancy for men living in Upper Edmonton West in Enfield was around 15 years lower than for men living in Frognall and Hampstead Town (in Camden). There is nearly 20 years variation in healthy life expectancy between the most and least affluent areas in NCL. For people experiencing homelessness, the average life expectancy is 30 years shorter than the general population, largely from preventable conditions.

### Children and young people

The NCL 0-18 population is expected to increase by over 6000 between 2020 and 2030; the 12-17 age group is expected to grow by over 11%. In 19/20, children and young people mental health service providers in NCL saw a 12% increase in referrals. In NCL 30% of children are growing up in poverty. Islington and Haringey are in the top 20% most deprived areas UK wide.

### The Boroughs – key highlights

***Barnet*:** Is the second largest London borough by population and has an estimated population of 389,400 (2021 census). There is a significant older population with 6.8% of the population aged 75 years and over. A significantly higher percentage of older people are living alone. The SMI prevalence in adults (QOF 21/22) is 1.03%.

***Camden*:** Has an estimated population of 330,500 (2021 census) with a large proportion aged between 20 and 39 due to the large number of educational institutions and employment opportunities. The prevalence of depression in adults is 6% compared to the NCL average of 4%. The SMI prevalence in adults (QOF 21/22) is 1.38%.

***Enfield*:** Is the seventh largest London borough and has an estimated population of 330,500 (2021 census). Of year 6 pupils, 42% are overweight or obese and there are significantly high levels of GP diagnosed diabetes (8.4%) compared to the London average (6.8%). The SMI prevalence in adults (QOF 21/22) is 1.13%.

***Haringey*:** Has an estimated population of 264,100 (2021 census) with a large proportion aged between 25 and 44. The SMI prevalence in adults (QOF 21/22) is 1.29%.

***Islington*:** Has an estimated population of 216,100 (2021 census) with a large proportion aged between 20 and 39. Of the adult population, 7% are diagnosed with depression compared to the NCL average of 4%. The residents report the highest levels of disability across NCL. The SMI prevalence in adults (QOF 21/22) is 1.38%.
Barnet's population | Camden's population | Enfield's population | Haringey's population | Islington's population

## 10. What does national benchmarking tell us

The NHS National Benchmarking published in October 2022 gives us a good view of where our services stand with regard to performance and resources compared to other NHS mental health trusts. It takes into account that different populations have different levels of mental illness burden and weighs the data accordingly. In this latest Benchmarking report (October 2022) the data for Barnet Enfield and Haringey (BEH) are reported separately to Camden and Islington (C&I).

As in all London mental health trusts people from black, asian and minority ethnic communities make up a much higher proportion of our inpatient and community caseloads than the rest of the country. In NLMHP 48-54% of all admissions and 50-56% of people detained are from black, asian and minority ethnic communities.

**Adult inpatients**
The NLMHP have more adult acute beds than the national average. More people are admitted and bed occupancy in BEH is the highest in the country. Our length of stay is equal to the national mean in BEH and in the top quartile in C&I. Of those people who are admitted, about 75% are detained under the Mental Health Act, which is well above the national average of 47%. The national average length of stay for people detained under the Mental Health Act is 42 days; in BEH it is 37 days and C&I 47 days. In all the mental health trusts in London, the highest percentage of occupied bed days (OBD) are for people who have a psychotic illness; the national average is 65% and in NLMHP it is about 85%, the highest in the country.

In C&I 42% of Occupied Bed Days (OBD) are consumed by people discharged with a length of stay of 90 days or longer; in BEH this is 24% which is equal to the national average. The 30-day readmission rate is comparable to the national average.

In the NLMHP about 26% of people admitted are not previously known to services compared to the national average of 16.8%. More people have no fixed abode. BEH performs well in 72 hours follow up post discharge. Our use of restraint is well below the national average, although prone restraint is above the national average.

Our Psychiatric Intensive Care Unit's length of stay is well below the national average and the lowest in London. Prone restraint is above the national average and in C&I the highest in London.

We have fewer nurses and consultants working on our adult wards than the national average.

**Rehabilitation, Eating disorders & Forensics**

High dependency rehabilitation bed occupancy is high and in BEH the length of stay is below the national average and the lowest in London. In C&I the length of stay is well above the national average. Our Eating disorders ward's length of stay is well below the national average and the lowest in London. Low and medium secure bed occupancy is high, and length of stay is long.

**Older adults**

Compared to the national average we have more beds, higher bed occupancy rates and low lengths of stay. We have few delayed transfers of care. Our readmission rates are low. We have fewer inpatient consultants and nurses than the national average in BEH. The community caseload is very low in BEH and high in C&I, this difference is due to the different memory service models. Community contacts are well below the national average.

**Adult community & crisis teams**

Our community caseload varies greatly. In BEH it is 79% above the national average and in C&I 37% below. In BEH 100% of service users had a face-to-face contact in the 3 months prior to 31 March 2022, the highest in the country; in C&I this was about the national average. Community contacts are well below the national average in C&I and above in BEH. We have substantially more people with psychotic illnesses on our community caseloads. The number of community staff per $10^5$ weighted population in NLMHP is 60.1 which is well below the national average of 88.5.

The early intervention services vary in the NLMHP. In BEH the caseload is below the national average; the referral acceptance rate is low; and the contacts per patient is high. In C&I the caseload is well above the national average; the referral acceptance rate is 100%; and the contacts per patients is low. Staffing levels are below the national average.

Our Crisis Teams perform well above the national average for face-to-face contacts. We conduct many more section 136 assessments than the national average.

**Balance of activity**
48-55% of our investment and 45-60% of our staff are in hospital care, but this accounts for only 11-19% of our activity.

**What conclusions can we draw**
Issue of equality, diversity and inclusion must be central to our thinking because over half of our service users are from black, Asian and ethnic minority communities.

The overwhelming majority of adults who are admitted in the NLMHP have a psychotic illness and are detained under the Mental Health Act; both these factors usually result in longer lengths of stay. However, some of our wards can match the national average length of stay, therefore it should be possible to achieve this in all our wards. We need to pay particular attention to people who end up staying in hospital 90 days or longer. Generally, our wards for older people, and eating disorders compare well to the national average. Some of our rehabilitation and forensic wards need to address their long lengths of stay. We are heavily invested in hospital care despite it being a relatively small part of our activity.

Our community services have fewer staff than the national average, but caseloads and contacts vary a lot suggesting different practices and processes. It is possible that our crisis teams are seeing more people because our community teams have limited capacity. The difference in community caseloads for older people can be explained by some memory services following up people with dementia throughout the course of the illness.
Adult and Older People's Mental Health Benchmarking 2021/22 MH044 (BEH)
Adult and Older People's Mental Health Benchmarking 2021/22 MH011 (C&I)

## 11. What are the problems we need to solve

The NHS has faced unprecedented challenges in recent years with mental health services facing an overall increase in demand due to:

- The impact of Covid-19 and the cost-of-living crisis on people's mental health and wellbeing.
- Deteriorating children and young people's mental health, often made worse by social media.
- An increasingly fractured society, resulting in greater levels of loneliness and social isolation.
- An ageing population, with increasingly complex care needs, including mental health needs from conditions including dementia.

- A growing population.

These challenges have been intensified by:

- Health and social care staffing shortages due to staff leaving and limited numbers in training, resulting in competition for staff across the country.
- Financial pressures resulting from the cost of responding to Covid-19 and the wider economic situation nationally.

**As an organisation, we recognise the following problems:**

- There is a growing demand for mental health services in our population, which has a high prevalence of mental illness.
- Many of our services have long waiting times.
- There is an overreliance on acute services instead of a focus on prevention and early intervention.
- We have long lengths stay on many of our wards.
- We need to realise our ambitions in equality, diversity, and inclusion.
- Key clinical and service performance data is not consistently analysed and fed back to clinical teams for service improvement.
- We require better digital infrastructure to enhance our efficiency and effectiveness.
- Our clinical workforce spends too much time on administrative tasks.
- Some of our estate is outdated and often unsuitable for their intended purposes.

## 12. What are our must-dos and constraints

The Care Quality Commission (CQC) is the statutory regulator for the quality of health and social care in England. It is responsible for registering and monitoring compliance of NHS and social care providers with the essential standards of quality and safety. Registration with the CQC is a national requirement. There is greater rigour in and expectations from the CQC. Although this robust approach is welcomed, it does add much higher demand on services in delivering these standards and preparing for inspections.

Whilst both organisations making up the NLMHP are rated 'good' by the CQC, our most recent CQC inspection reports published in March 2018, January 2020, January 2023 for C&I and March 2016, January 2018, September 2019, July 2021, February 2022, and October 2023 for BEH have issued regulatory breaches in the following areas:

- We must improve our performance in the workforce race and equality standards (WRES).
- Our staff must be up to date with their mandatory training.
- All our wards must accommodate patients in bedrooms that are designed to support their privacy and dignity. The location of one of our seclusions rooms poses a particular problem.

- Physical health checks must be completed and recorded whenever rapid tranquilisation is used.
- We must address the high rates of unfilled staff shifts on some of our acute and PICU wards.
- Some of our older adult wards require improved governance processes to assess, monitor and improve the quality and safety of services. All staff must be aware of any safety incidents and learn from them.
- People requiring an assessment under the Mental Health Act, must be assessed promptly to ensure their safety and that of others and our crisis teams must meet their targets times for face-to-face assessments.
- We must stop holding patients in the health-based place of safety beyond the 24-hour Section 136 detention period with no legal framework for holding them beyond that.
- All facilities used by patients in the health-based place of safety must be safe, with an appropriate standard of fixtures and fittings.
- Some of our crisis services must ensure that governance processes for medicines management are reviewed and embedded to ensure the safe administration, recording and storage of medicines.
- Some of our teams have excessive caseloads.

**Access targets**

There are national access and waiting time targets for NHS Talking Therapies, Early Intervention in Psychosis, Hospital Liaison, and Dementia services -- we are required to meet these targets. There is the new target for people referred to community mental health services to be started in treatment within four weeks of receipt of a referral.

**Finances**

The NLMHP is accountable to the North Central London (NCL) Integrated Care Board. There is enormous pressure on all local NHS providers to contribute higher than normal levels of efficiency savings to achieve financial sustainability in NCL. We must demonstrate that any new investment into mental health services provides clinical and efficiency improvements to the overall health economy. We have set ourselves a standing aim of achieving an annual small surplus to be a financially sustainable organisation.

**NHS Long Term Plan**

The NHS Long Term plan comes with service developments that we must deliver.

## 13. What we cannot do and why

We provide evidence-based interventions for people who have mental health conditions. Like the rest of the NHS, we have limited financial resources and rising demand. We have a duty to

make the best use of resources to improve the mental health of the population we serve. We cannot provide services beyond what we are commissioned and funded to provide.

We need to have the capacity to take on people who are acutely ill and help them recover. Service users and carers are managing their own mental health on a day-to-day basis, and we need to empower them to do this, including linking them into the wide range of support in the community provided by, amongst others, the Local Authority and the voluntary sector. If people feel supported in their communities, then they will have less need for long term support within mental health services thereby freeing up services to see other people. There is a relatively small number of people with very complex needs who will require specialist mental health support for most of their lives and we will offer this to them.

All our services will be as clear as possible on the period a service will be offered. This will be a co-produced decision with the service user and their carer and consider evidence and national guidelines.

If at the end of a period of treatment a service user has achieved their recovery goals and they no longer require the input of the mental health service, then they will continue their recovery journey with the help of community and social resources. Their care plan will include a clear and easy pathway back to getting specialist help should they need this. We understand and expect that recovery is different for individuals and that returning to use our services for periods of time will be necessary for some people. This does not mean a failure on behalf of the service user or services, but that the journey to recovery needs input from a variety of sources at different points.

If a person's current primary struggle is to do with housing and/or benefits, then we recommend support is first sought directly from the appropriate agencies. We cannot meet the expectation that because these issues may cause distress, that they are something for mental health services to resolve. However, we do work with colleagues in those agencies offering advice and a general understanding of mental health to support how they engage with people who may be experiencing mental distress.

Often, we are asked to see people with problem behaviours that are not primarily due to a mental illness or people with behaviours related to drug and alcohol use and/or antisocial personality traits or disorders who show little insight or willingness to engage in meaningful change. Whilst we can provide expert advice to other services, we cannot provide a direct service ourselves. Our substance misuse services work with people with some, however minor, willingness to engage. We understand that for some people with drug and alcohol problems initially engaging with services can be challenging and part of their recovery journey and we will support them to take this first step.

We are not commissioned to provide services for people with brain injury, for example due to trauma or alcohol, which can result in behaviour and other neuropsychiatric problems. We will continue to provide services to people who have a pre-existing mental illness and then sustain a brain injury.

With the high prevalence rates of mental illness, we know that many people using all public services will have mental health problems and we cannot take on every person. The NCL Integrated Care System (ICS) provides a good opportunity for all services to work together to provide support to people with mental health problems. Working collaboratively, we will be able to share expertise, tasks and responsibilities with all our partner organisations including Housing, Police, Prisons, Probation and other Local Authority services.

## 14. What will stop us succeeding and why

There are number of service-user, workforce and organisational factors that we will need to keep in mind if we are to make this plan succeed.

### 14.1. Our Service Users

**Losing the support of service users:** We are doing all we can to engage our service users and carers in the development of this strategy and will continue to do so. However, as we develop our actions and things that are familiar begin to change, service users and carers may start to have doubts that the changes will improve things for them. To mitigate this, it is essential that we involve them in the design, implementation and review of all service changes and developments.

**Change of treatment and support:** Many of our service users and carers have been receiving care and support for many years, some continuous and some as and when needed. Some of the changes we plan will change the way they access that treatment and support and what happens when they feel better. We want to enable people to return to being full members of their community as much as possible. This starts with assessment and care planning, ensuring recovery and well-being goals are included. Our services are just one part of an individual's circle of support.

### 14.2. Our workforce

**Losing the support of our staff:** Many of our staff have worked in NLMHP for a long time and will have seen many changes, not always for the better; we must ensure that we all understand and are fully engaged in any changes. Change fatigue, low morale and burnout would impede our success.

We must minimise the risk of staff feeling de-skilled by ensuring well in advance that training is in place to support any new ways of working. We want every member of staff, whatever their role and contribution, to feel that they are a part of delivering this strategy.

**Skills in the workforce:** To deliver this strategy our workforce needs the right set of values, skills and knowledge. To succeed we need new, innovative and flexible ways for our workforce to gain the required skills. The skills to use digital technology effectively are essential because

improved efficiency in the use of time and resources are likely to be contingent upon greater adoption of technology.

**Recruitment and retention of staff:** There is a national shortage of nurses. It is increasingly difficult to recruit doctors into psychiatry. The ongoing industrial action by doctors is having a negative on morale. The NHS is no longer seen as a beneficial place to work with staff attracted to better pay and conditions in the private sector or oversees.

Some services, like Talking Therapies, have a higher turnover of some of their staff because they tend to attract psychology graduates who may stay a relatively short period before entering a psychology training programme.

Our reputation for high quality training, as a centre of research and delivering innovative care attracts people to apply to work in the MLMHP. Our workforce, organisational development, staff wellbeing, and equality, diversity and inclusion strategies all support our ambition for all staff members to feel valued and respected, to have equal opportunities and to be part of the success of the organisation. Our ability to recruit and retain will be better if we have a happy and engaged workforce.

### 14.3. Organisational factors

**Finances:** We operate in an ICS that is financially challenged and there is great pressure to use all resources to close the system deficit. To mitigate this, we will work with our commissioners and partner organisations and make the case that investment in mental health benefits the entire health and care system.

**Increasing demand:** We will see a significant increase in demand for our services, not just from our local population, but also from new people coming into the areas we serve. We will continue to work to understand the impact of this rising demand and the best way to respond within the resources available.

**Sharing information within integrated teams:** Our ambition for our services to be integrated with those of other providers relies on our ability to share information both ways with our partner organisations. Currently, the ability of our different electronic record keeping systems to communicate with each other is improving through information sharing platforms like the London Care Record, but systems are not interoperable. Even within the NLMHP we have two separate instances of an electronic patient record; we have plans to remedy this.

**Constraints on partner organisations:** Reduced public spending has impacted our Local Authority and voluntary sector, which form the bedrock of support in the community. Without these resources in our communities, people with mental health problems may find it harder to manage their own mental health and may rely more than usual on specialist services. We will work with our service users, carers, staff and partners to design a model of integrated services

that brings together and funds a wide range of community options thereby utilising resources more effectively.

**Alignment with partner organisations:** Integrated working is a key driver for the NLMHP and all our partners. However, other demands and expectations governing each organisation can sometimes get in the way of effective partnership working. To mitigate this, we will continue to work with our partners to ensure that the needs of our population always come first and that we work together with service users and carers to manage competing demands.

**Access and other national targets:** Access, waiting time and other national targets can shift the focus of our priorities. Through our governance processes we will ensure that we remain focussed on delivering our clinical strategy, whilst also meeting the external demands placed upon us by our regulators.

## 15. How will we know that we are succeeding

We will know that we are succeeding as we progress the delivery of the strategic objectives as laid out in the Partnership Strategy:

**We provide consistently high-quality care, closer to home**

- We will provide high quality inpatient care in facilities in North London to any service user who needs it.
- We will be responsive, co-producing care with all our service users and carers, and ensuring all service users have ease of access to the care and support they need.
- We will lead the improvement of children and young people's mental health care with partners across North London.
- We will have buildings and estate that provide the most therapeutic environments for care and treatment of service users and for staff to work in.

**With our partners in North London and each Borough we will ensure equity of outcome for all**

- We will extend our work with local communities and voluntary groups to address health inequalities and improve population health.
- We will improve outcomes for everyone who uses our services, reducing unwarranted variation and ensuring consistency in the delivery of care.
- We will reduce disparities in care delivery, such as the overrepresentation of some ethnicities in the use of the Mental Health Act and other restrictive practices.

**We create great places to work, providing staff with a supportive environment to deliver outstanding care**

- We will create a culture where staff are able to bring their authentic self to work and feel truly supported with learning and career development opportunities.

- As a local anchor institution, we will work with partners, such as educational providers, and our communities to facilitate routes into jobs with us for local people.
- We will make demonstrable progress towards having leadership and management teams that represent the communities we serve.

**We will be more effective as an organisation by pioneering research, Quality Improvement and technology**

- We will create a learning culture, empowering our teams to undertake research and QI projects and convert these into the delivery of best practice, developing innovative services, and enabling local patients' access to the latest treatment options.
- We will transform the delivery, efficiency and effectiveness of our organisation through the use of data, technology and implementation of best practice.

## 16. What we have chosen to act on and why

Based on what we have heard and learnt we have chosen our clinical approach, our priorities for all our services and how we will improve and innovate.

### 16.1.Our clinical approaches

Our approach to clinical care will be:

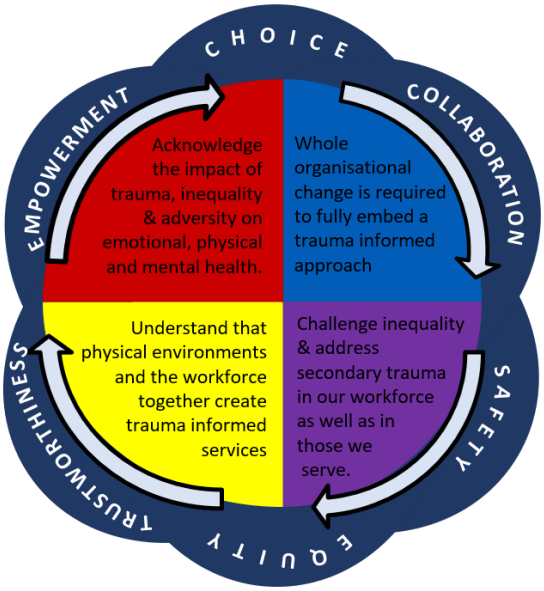
- Trauma-informed.
- Recovery-orientated.
- Evidence-based.

#### 17.1.1 Trauma-Informed

We are committed to being a Trauma Informed Organisation (TIO). A TIO recognises the impact of trauma and adverse childhood events in people's lives. It does not assume everyone has or should be treated for Post-Traumatic Stress Disorder (PTSD). Rather, it incorporates knowledge about trauma in all aspects of the organisation and aims to provide environments where people feel safe enough to disclose what has happened to them, where they can expect staff to listen with compassion and respect, and where staff have the skills to validate and 'bear witness' to these events and show understanding in their responses.

A trauma-informed approach can be defined as being 'grounded and directed by a complete understanding of how trauma exposure affects services users' neurological, biological, psychological and social development' (Paterson, 2014). A high percentage of people who use mental health services have experienced trauma. The design and delivery of our services must reflect this trauma awareness and the prevalence of traumatic events as well as the different ways that this can affect people.

Trauma- informed approaches are defined by the domains of Safety, Empowerment, Collaboration, Choice and Trustworthiness (Fallot and Harris, 2001). Our model also includes the domain of 'equity' to reflect the growing understanding of trauma as a result of inequality (McNicholas S, Greenfield P, Rose A).




Being trauma informed is a duty of care for the whole organisation and requires a whole cultural perspective in how we operate. To succeed, these domains must be embraced in all aspects; in direct therapeutic interventions and integrated into leadership, estates, human resources, research and strategic priorities.

People who work in public services can be traumatised by the experiences they hear, witness and are exposed to at work, or come with their own history of adversity, trauma and abuse. A TIO must ensure that policies, procedures and support structures available recognise this potential for trauma in our staff and carers, as well as those who use our services. This approach enables staff to look after themselves and in doing so, model a trauma informed approach in their own work or caring roles.

Being a TIO aligns with our commitment to see and act on any reports or seen acts of sexual violence, harassment or abuse within our services. This is clarified in our policy for preventing and responding to sexual violence, harassment and abuse.

**How**

- We will develop and implement our trauma-informed framework and collaboratives across the partnership and provide training and support to staff in delivering trauma informed care.

**Outcome**

- All our services will recognise and acknowledge that adversity and trauma in childhood and adult life causes or contributes to the development of a range of mental health problems.
- Our policies and practises will reflect this trauma awareness.
- We will have conditions and environments that reduce harm and promote healing, especially for individuals who have already experienced trauma.

### 17.1.2 Recovery-orientated

**"Recovery isn't about getting back to how you were before; it's about building something new." "Recovery is something you achieve for yourself. It is not something that someone else does for you, but others may be able to help if you want them to."** (www.Rethink.org 2015)

Recovery means different things to different people. In January 2016 a group of our service users and staff composed the following definition of Recovery:

> "The process of recovery is different for each person and needs to be defined by them and seen in the context within which they live.
>
> It involves the person learning to cope with features of their condition and moving towards increased wellness and meaningful activity.
>
> This process is under-pinned by caring relationships with others and can involve empowerment, increased confidence, hope and independence, together with active challenge to stigma.
>
> It is an ongoing process, and each individual will have their own pace of change.
>
> It is important that our service listens carefully to each person we work with and acknowledges differing views when these arise."

Service users told us they want staff to talk to them about what and who is important to them. They want to be treated as a whole person, bearing in mind their culture and community. They want their care plan to be about them, their strengths and not just their illness.

Staff said care plans should empower service users, encourage autonomy, hope and independence, and be sensitive to their journey of recovery. Everyone told us how important it is for a care plan to be co-produced with the service user and their carer so that they are meaningful to them. Care plans should help people self-manage and identify meaningful social goals. For some of our services users, for example those with dementia, their goals may be about maintaining independence and personal care. Involving carers and relatives in care planning, where appropriate, is vital particularly so for those who are irreversibly losing their capacity to make decisions.

The recovery-orientated approach aligns with collaboration with local charities and third sector organisations and the strength-based approach of our Local Authority partners.

**How**

Our recovery strategy will focus on:

- Developing service user co-production; identifying levels of involvement and working together to achieve our collective ambitions.

- Building relationships with our service users; we will use DIALOG+ as both a patient reported outcome measure and a care planning tool to facilitate staff having meaningful conversations with service users to help create excellent quality care plans.
- Embedding co-production through Recovery College courses produced, delivered and attended jointly by service users, carers and staff.
- Building Partnerships through linking with other organisations to map out opportunities for service users, e.g., supporting people into employment through Individual Placement Support (IPS); becoming a peer support worker; participating in research.

**Outcome**

Our service users will:

- have meaningful and useful care plans.
- feel connected to their social network.
- have a sense of hope and optimism.
- feel their identity has been respected.
- feel a sense of meaning and purpose in their lives.
- be empowered to manage their mental health problems, including having information clearly presented about options that are appropriate to them.

### 17.1.3 Evidence-based

There is a lot of high-quality research providing evidence of interventions that are effective in treating mental health conditions. These include psychological therapies, medication, social interventions, occupational therapy interventions.

Service users and carers told us they want to be seen by a skilled person and offered a range of therapies. Staff said they want to be equipped with expert knowledge and skills, especially in talking therapies. They want services to be professional.

Interventions that have an evidence base are approved by NICE and described in the NICE guidelines. The success of any interventions is dependent on the power of strong therapeutic alliances between service users and their clinicians.

**How**

- Through our People and Organisation Development strategy we will ensure that staff have the skills, attributes and capability to deliver evidenced-based interventions.
- We will evaluate our services against NICE guidelines.
- We will use outcome measures to measure the effectiveness of our services.
- We will rapidly apply research into practice.

**Outcome**

- Our service users will achieve their recovery goals more effectively.
- Our staff will feel they have the skills to deliver high quality, clinical care.

### 17.2 Our service priorities

Our service priorities are:

- Co-production.
- Personalised care.
- Equality Diversity and Inclusion.
- Addressing the physical health of people with serious mental illness.
- Integrating mental health, physical health and social care.
- Addressing drug and alcohol problems.
- Early intervention and prevention.
- Internal interfaces.

### 17.2.1 Co-production

Co-production is the bringing together of lived experience, our service users and carers, as well as learnt experience, our staff and those responsible for services; to work together to improve services. It is essential for individuals to work together, respecting the experiences of one another and how each are integral to the design, development, and delivery of high-quality care. (See the Ladder of co-production, www.thinklocalactpersonal.org.uk).

People who use and work in services are best placed to be creative and propose better ways of working. Research shows us that services designed through co-production are more likely to be cost effective, responsive, have high satisfaction rates and good health outcomes (Working Well Together, National Collaborating Centre for Mental Health Outcomes, 2019).

Our service-users and carers feel it is essential that they have equal opportunities to become involved in the business of the partnership, to understand the governance arrangements in place to support them, and to be recognised and rewarded for their contributions.

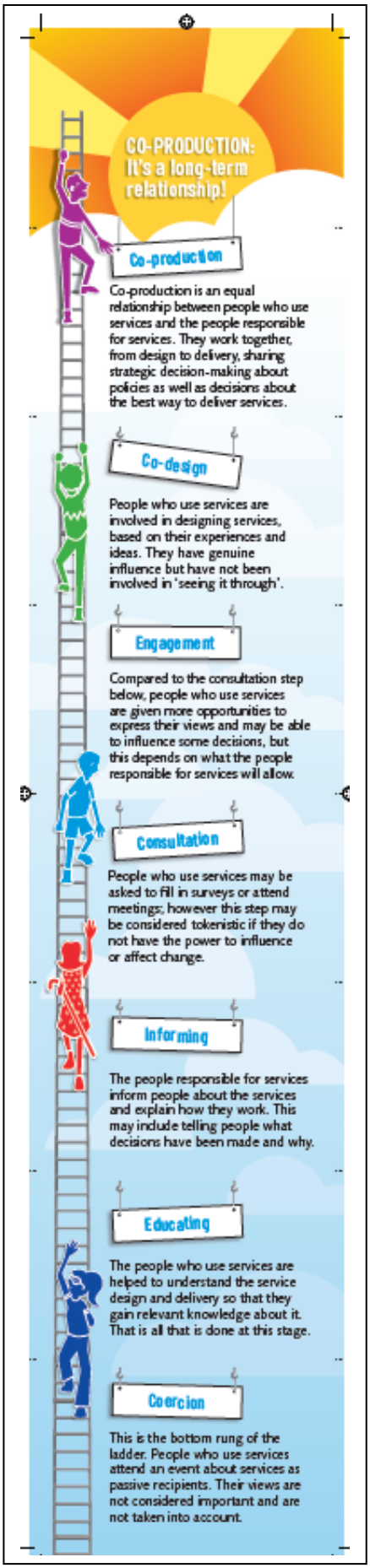
Involvement opportunities build our capacity to coproduce and include sitting on interview panels for Trust staff; attending or co-facilitating workshops or training; representing service user and carer voices within board meetings, committees, and groups; joining a service planning group; and being an elected governor. Having strong service user and carer involvement and working to progress up the co-production ladder when it comes to the design, development, and delivery of our services is essential for developing high quality recovery-orientated services.

**How**

- We will develop our service user involvement strategy around the principles laid out in Working Well Together from the National Collaborating Centre for Mental Health.

**Outcome**

- Service users and carers will know the range of opportunities available.
- Service users and carers will feel valued and that they have an equal voice.
- Staff will feel empowered to coproduce with service users and carers in designing and improving their services.



### 17.2.2 Personalised Care

Personalised Care will benefit up to 2.5 million people in England by 2024, giving them the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life. A one-size-fits-all health and care system simply cannot meet the increasing complexity of people's needs and expectations. Personalised care is based on 'what matters' to people and their individual strengths and needs.

There are six components to personalised care:

- **Patient choice:** people are permitted and enabled to select where they receive healthcare services. This choice, enshrined in the NHS Constitution, offers the right to make informed decisions about NHS services. People may choose a GP or the location of their first outpatient appointment. These choices are guided by local agencies and legal rights, including those under Section 117 of the Mental Health Act.
- **Personalised care and support planning:** structured conversations help develop comprehensive care plans, empowering people to take control of their health and well-being. This streamlines the integration of health and social care resulting in a single, personalised care and support plan, aligned with the person's unique needs, values, and preferences.
- **Supported self-management:** peoples' skills, knowledge, and confidence in managing their health are enhanced. This encompasses interventions such as peer support and health coaching. The goal is to foster informed health choices and active participation in your own care.
- **Shared decision-making:** through a collaborative process clinicians and patients make treatment decisions together, which align the person's preferences and the clinician's expertise.
- **Social prescribing:** people are connected to community resources to address practical, social, and emotional needs. NHS England have been promoting the integration of social prescribing into primary care networks, as part of holistic care and support.
- **Personal Health Budgets (PHBs):** PHBs offer flexibility and choice for managing health needs, ongoing care, specific goals, and support for children and young people with education and care plans. These budgets can be used individually or pooled for collective goals. People subject to Section 117 of the Mental Health Act; NHS Continuing Healthcare; continuing care for children and young people; and NHS wheelchair provision all have a legal right to PHBs. Healthcare professionals and organisations can access information and support regarding PHBs through the Personalised Care Collaborative Network.
  NHS England » Personalised care

### 17.2.3 Equality Diversity and Inclusion

Public Sector Organisations are subject to legal duties to give due regard or regard to addressing health inequalities and advancing equality of opportunity.

These separate duties are the Public Sector Equality Duty (PSED), section 149 (1) of the Equality Act 2010 and the Health Inequalities Duties set out as section 13G of the National Health Service Act 2006 as amended.

The NHS defines health inequalities as:
*"…preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs."*

It is well documented that "the life expectancy of people with severe mental health problems can be up to 20 years less than the general population. This combined with the events of 2020, have shone a light on the inequality that persists in our society. The COVID-19 pandemic, which has disproportionately impacted specific groups. The NHS Long Term Plan commits that people with severe mental health problems will have their physical health needs met." Within this context the national NHS England's 'Advancing Mental Health Equalities Strategy (AMHE)' identifies groups with the most pervasive mental health inequalities in England, in the access; experience; outcomes of mental health services as: age, ethnicity, sexual orientation, gender, disability & deprivation.

**85% of older people** with **depression** receive **no NHS support** (Burns, 2015).

**Black adults** are the **least likely** ethnic group to report being in receipt of **medication** for mental health, or **counselling**, or **therapy** (Cabinet Office, 2018).

Black People
Are **eight times more likely** than White British people to be given a community treatment order after being treated in hospital under the Mental Health Act (NHS Digital, 2019).

People who identify as **LGBT+** have **higher rates** of common **mental health problems** and **lower wellbeing** than heterosexual people, and the gap is **greater for older adults** (over 55 years) and those **under 35** than during middle age (Semlyen et al, 2016)

**Women are ten times as likely** as men to have experienced extensive **physical and sexual abuse** during their lives: of those who have, **36%** have **attempted suicide**, **22%** have **self-harmed** and **21%** have **been homeless** (Scott and McManus, 2016)

Children from the **poorest 20%** of households are **four times** as likely to have **serious mental health difficulties** by the age of 11 as those from the wealthiest 20% (Morrison Gutman et al, 2015)

In addition, the national AMHE strategy aims at making care fairer for all. Its sets out three domains to achieve this:

1. Supporting local health systems.
2. Collecting and using data and information to inform decision-making.
3. Creating a diverse and representative workforce which is equipped with the capabilities to achieve change.

Promoting equality and addressing health inequalities are at the heart of the NLMHP Strategy. A fundamental and distinct aspect of the NLMHP is the diverse communities we serve across our 5 Boroughs of Camden, Islington, Barnet Enfield and Haringey and our diverse workforce. We value and celebrate this diversity which adds to the wealth of the organisation and brings enormous benefits in terms of creativity, innovation, and prosperity. However, we also acknowledge there much more we still need to do to improve disparities in access, experience, and outcomes.

The Partnership's ambitions around Equality, Diversity, and Inclusion (EDI) and Health inequalities are reflected in our EDI Strategy 2022-25 and the 5 EDI Priority areas:

- Improve service user access and experience.
- Better health outcomes.
- Representative and supported workforce.
- Inclusive leadership.
- Culture change and mainstreaming EDI.

Our EDI ambitions are aligned with our Partnership 5-year Strategy, our forthcoming People and Organisational Development Strategy and this Clinical Strategy. Throughout the development of the clinical strategy, including the associated suite strategies related to the services we provide, we have:

- Given due regard to the need to eliminate discrimination, harassment, and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it.
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.
- Produced the State of Health Inequalities report, which identifies health inequalities across our Partnership.
- Set up a Service User workstream to ensure the voice of our diverse communities feed into our work including the Patient Carer Race Equality Framework (PCREF)
- Meeting our reporting requirements and identifying action around the Workforce Race Equality Standards (including Bank and Medical WRES). Workforce Disability Equality Standard, Pay Gaps, and the new NHS EDI Improvement Plan.

We will continue our journey to ensure EDI and addressing Health inequalities to maximise the impact of our endeavours to improve health outcomes for all. We will report progress via our annual Public Sector Equality Reports.

### 17.2.4 Addressing the physical health of people with serious mental illness

**Longer Lives – the role of the NLMHP**

Improving the physical health of people with severe mental illness (SMI) has been a priority for over two decades, targeted both in global research and national policy initiatives. Despite these ongoing efforts, little progress has been made to date in reducing the premature mortality that this population faces, with evidence suggesting that the gap is widening. In North Central

London (NCL), which has the highest prevalence of SMI among integrated Care Systems (ICS) in England, men with SMI are dying over 18 years earlier than the general population, and women over 14 years earlier; and largely from preventable conditions. This represents huge inequality and inequity and demands large scale solutions involving all parts of our health and care system if we are to make a change.

**Longer Lives** is NCL's five-year strategic delivery plan for transforming care for this population. Longer Lives was formed with the support of UCL Partners and a steering group of experts by experience, using a combination of national and local data analysis, scoping of a wide range of existing provision and strategic work within NCL, scoping of good practice nationally and locally, interviews with clinical experts and system leaders within NCL, and extensive engagement with people with lived professional and personal experience of mental illness.

The Longer Lives strategic delivery plan has three pillars:
(i) The **Five Focus Areas** for action.
(ii) The **Four Guiding Principles** for working with people with SMI.
(iii) The **Annual Physical Health Check: making it count.**
*Please see the Longer Lives document for more detail on each of these pillars.*

The 'Five Focus Areas for action' include aims, commitments, and measures for five areas of practice, spanning primary care, secondary care, VCS, and the wider system. They are as follows:

1. Living well in NCL
2. Cardiometabolic disease: diabetes, weight management, blood pressure and cholesterol
3. Lung disease and tobacco dependence
4. Cancer screening and treatment
5. Proactive, personalised outreach for the most marginalised 20%

A number of the commitments within each of these five areas are best delivered or co-delivered by North London Mental Health Partnership. These are outlined in the links.
UCLP NCL ICS Longer Lives SMI Report

### 17.2.5 Integrating mental health, physical health and social care

Service users told us they want to be helped as a whole person and that they want staff to be trained to understand both their mental and physical health needs. Our social connections, living environment, income and physical health are all fundamental to our mental wellbeing. Integrated care will allow us to improve people's outcomes and experiences by bringing services together around people and communities. This will involve addressing the fragmentation of services and lack of coordination people often experience by providing person-centred, joined-up care. The services that will need to come together to work in a multi-disciplinary, multi-agency way include mental health services, primary care, Local Authorities, community physical health services, acute hospitals and the Voluntary, Community and Social Enterprise (VCSE) sector.

The drive properly to integrate mental health, physical health and social care is clearly outlined in the NHS Long Term Plan and the Community Mental Health Services Framework.

This way of working is essential in the delivery of the Longer Lives ambition of closing the mortality gap experienced by people with serious mental illness.

**How**

- With our service users, carers, staff and our partner organisations we will continue co-producing our model for our community services. We must understand people's experiences of how services work together as well as how they experience individual services.
- Building on our Core Teams, we will work in an integrated way with key partners including GPs, Adult Social Care, voluntary sector and community physical health providers to strengthen prevention and early intervention and join up people's care close to where they live.
- We will work with GPs and other partners to ensure that we have a joined-up approach for identifying physical and mental health needs across the population.
- With partners we will implement the universal delivery of preventative interventions in primary and secondary care services that will lead to measurable improvements in mental and physical health outcomes and experience of care.
- We will ensure that our staff are trained to deliver interventions, such as UCLP Primrose, which use an integrated approach to mental and physical health and support people to improve both.
- We will continue to support the NCL digital strategy that enables sharing of clinical information to deliver care in an integrated way with partner organisations and within the rules of GDPR.
- We will use data and other information to identify specific population needs and provide proactive, preventative interventions.
- Our People and Organisation Development strategy will ensure that our workforce has the knowledge and skills to work in an integrated way.

**Outcome**

- Our service users will feel that their mental health, physical health and social needs are being considered in a coordinated and holistic way and they will have better outcomes including feeling more connected to their local community.
- Our staff will feel connected to staff working in other organisations and will have a shared sense of responsibility for supporting the population of a specified geographical area.
- Our staff will feel empowered to focus on what matters most to people.
- Our service users will feel that staff really know their local area and they will be able to access support close to home.
- We will be able to demonstrate that in partnership with other organisations we are developing services that meet the needs of local populations.

### 17.2.6 Drug and alcohol problems

Many of our service users have co-existing problems with drugs and alcohol alongside their mental health problems. We have high prevalence rates of drug use and alcohol dependence across the lifespan in the North London Mental Health Partnership (NLMHP), particularly heroin and cocaine.

The demographics of service users and the nature of substances used, including prescription drugs and new psychoactive substances (NPS), are changing. Locally and nationally, there is great concern about the number of people dying from accidental drug overdoses and physical health problems as a consequence of drug and alcohol use.

Drug and alcohol problems are so prevalent that we cannot consider that people with a dual diagnosis are a separate group needing different services and workers, but rather the nature of the presentation requires all staff to have effective clinical skills and knowledge to support services users.

Staff working in all settings, including in-patient, community and outreach must be trained and equipped to work with co-existing substance use and mental health problems. Practitioners within mental health and substance misuse services with specific skills to work with co-existing problems can provide support to enable mainstream mental health services to care for service users with these complex needs.

We acknowledge that drugs and alcohol are often a part of someone's mental health problem and a way of coping. Although it is important for people to be sober at the time of appointments in order to be able to derive benefit, we support what service users and carers have told us - that we should not expect people to have long-term abstinence from drugs and alcohol in order to access mental health services.

Even though we have substance misuse services that deliver specialist services, this theme is about what we expect from all our services, and an integrated prevention and treatment programmes at this time is essential.

**How**

- Our workforce strategy will ensure that all our clinical staff have the evidence-based skills to assess and have supportive conversations with people about their drug and alcohol use. This will enable better understanding and training for clinical staff working with service users to identifying and address substance use disorders as a core part of mental health treatment intervention.
- Our substance misuse and dual diagnosis services will support the necessary training and supervision.

- Each service will have an individual plan that will address this within their operational policy.

**Outcome**

- Our staff will feel confident to speak to service users about drug and alcohol problems.
- Service users' feelings about their drug and alcohol use will be routinely evaluated with appropriate screening tools. Care planning, including DIALOG+, will address the needs of drug and alcohol use alongside the mental and physical health needs of service users.
- More practitioners will feel confident about working in partnership with drug and alcohol services instead of requiring service users with co-existing problems with drugs and alcohol alongside their mental health problems to complete their work with one service before working with another.
- Fewer service users will feel excluded form mental health teams because of their drug and alcohol use.
- More service users will feel enabled to address their drug and alcohol problems.

### 17.2.7 Early intervention and prevention

Our services for children and young people have a particular role to play in detecting and treating mental health problems early in course of an illness thus preventing many children and young people going on to have a chronic life-long struggle with their mental health.

Service users and carers told us they want to be seen by a skilled person as soon as possible. Easy and efficient access to mental health services allows people to be seen early in the course of their illness and evidence-based interventions can prevent symptoms deteriorating and recurring.

We heard many stories from service users and carers about having to wait until their mental health has deteriorated to a point of crisis before they are able to attract the attention of services. Often carers are ignored when they report early signs of someone breaking down. It can be difficult to get into services. Many of our services have no mechanism for self-referral and waiting for a GP appointment adds long delays to getting help.

Mental health services help shoulder the responsibility of preventing physical illness by having discussions with service users; providing them with information; ensuring they have physical examinations and blood testing; and helping them access physical health care. Particular topics to address with service users include diet, exercise, alcohol, smoking and dental care.

**How**

- Our clinical models for children and young people, adult and older adult community mental health services will make it easier for people to access help faster and earlier in the course of their illness.
- Through co-produced care plans and using a trauma-informed, recovery-orientated approach we will support people to manage their mental health, physical health and social needs.

**Outcome**

- Our service users will have better mental health, physical health and social outcomes.
- There will be a reduction in the need for people to be admitted to a psychiatric or physical health hospitals.

### 17.2.8 Internal interfaces

The interfaces between our teams and services have been identified as often being a significant obstacle to seamless and good quality patient care.

We do not always operate as a single organisation; sometimes teams may operate as silos putting up barriers to people getting on or off their caseloads. This is driven by the unparalleled demand for mental health services and teams trying to limit work to a manageable level in order to provide good care and risk management to those people on their caseload. This may then leave people who would benefit from that team's care unable to do so. Energy and resources are taken up passing information and referrals between teams. This may manifest in service users being on a waiting list with no support because, if they are on a team's caseload, then other teams may be reluctant also to have them on their caseload.

GPs get very frustrated when one of our teams asks them to make a referral to another of our teams. GPs feel that we know our services better than they do and we should not be asking them to do our administrative tasks.

**How**

- Referral processes between our teams must be an easy and smooth process.
- The core community mental health services hold responsibility for the management of mental health problems within a neighbourhood or primary care network (PCN) population. These services may refer people to intensive teams but continue supporting them whilst they wait to access the intensive service. Whilst under an intensive team, they could still access support offered by the core community mental health services, e.g., peer support, links to community resources.
- People cannot be excluded from services according to rigid criteria, for example, if they have substance misuse problems – their needs and ability to engage with services must be assessed in order to provide holistic, person-centred care.
- Whenever any of our teams in the NLMHP assess that a person would benefit from another of our services, the responsible worker will make that referral and not ask the GP to make that referral.
- There is an efficient process for timely escalation of unresolved decisions around patients being accepted on to team caseloads.

**Outcome**

- Referrals between our teams will be a straightforward process.
- Service users will not be on waiting lists with no support unless it has been assessed as clinically appropriate.
- We will not ask GPs to refer people from one of our teams to another.

### 17.3 How we improve and innovate

Our two main vehicles for improving and innovating are through using quality improvement methodology and research.

#### 17.3.1 Using Quality Improvement methodology


QI
NORTH LONDON MENTAL HEALTH

How do we achieve our Vision?

Use Quality Improvement as the methodology.

Quality Improvement is not only positioned in Aim 4 but will also support teams to achieve the other 3 aims.

## Key National and Partnership Drivers

The Care Quality Commission's (CQC) examination of how NHS trusts rated as outstanding have embedded quality improvement (QI) across their organisations highlights the importance of building the right skills and culture among staff*.

QI, as a key element of the Partnership Strategy aligns with the NHS Delivery & Continuous Improvement Review** All NHS providers, working with Integrated Care Boards (ICBs) will embed a QI method aligned with the improvement approach.

**Quality Improvement**

The Partnership plans to drive QI at scale and pace. Embedding QI in the culture of the organisation will help configure our services more effectively, to improve the quality of care.
We plan to investigate having a QI Strategic Partner

A QI Academy is being developed which, is planned to be located in the Institute of Mental Health on the St Pancras site.
A training programme will continue to expand with different levels of training.

References:

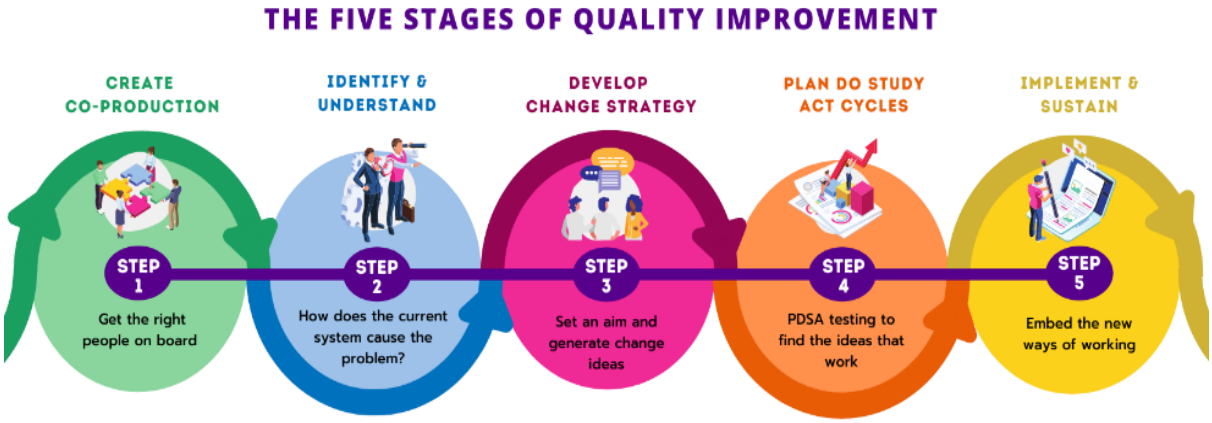

* The improvement journey - The Health Foundation

**NHS delivery and continuous improvement review: findings and recommendations

Our Partnership QI Strategy outlines how we will build on the progress and strengths of the two original QI Programmes across the NLMHP to deliver on our partnership and the national strategic aims.

Our vision is to create a culture of continuous improvement at scale and pace across the NLMHP, embed QI as core to achieving our strategic aims, and become a centre of QI excellence across the system.

We are using the Model for Improvement as the template for our improvement work. Our QI team have developed our own Five Stage approach with an emphasis on co-production with our Service Users and Carers.




**How can QI support Teams?**

The QI team can provide advice and support for QI work and a key part of this is helping staff to use data to make improvements.

QI methodology can be used to answer the following questions to improve quality of care, efficiencies, and productivity:

| |
|---|
| ➢ What is the data showing us? |
| ➢ Where are the gaps in our practice that indicate a need for change? |
| ➢ What changes do we need to make to improve our service? |
| ➢ Do we know/understand where variation exists in our team/organisation? |
| ➢ How do we know any changes have made a difference? |

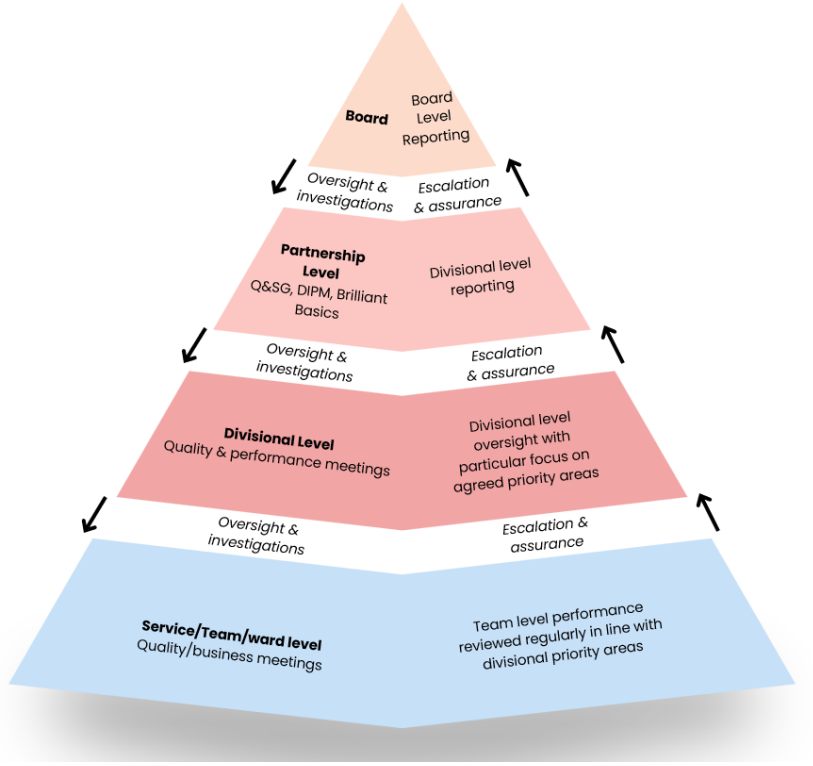
Achieving our QI vision cannot be delivered alone, and we work with a range of partners across North Central London in the mental health sector and more broadly. We want to be QI leaders across the system, supporting our partners to develop QI capability so we can collaborate effectively and achieve our shared goals.

## Quality Management System


A Quality Management System is a systematic and coordinated approach to managing quality, that aligns our quality objectives with the information and data we view, and our processes for managing quality and continuous improvement.

The coordinated approach involves a cycle of quality planning to understand what matters and setting clear quality priorities and measures; quality control and assurance where required information is easily accessible and monitored, identifying areas for further investigation or action; quality improvement by using a systematic approach to improvement and feedback, where progress is reviewed, and learning is shared across the system.

This single framework of quality can improve the flow of information from floor to board and ensures standardised ways of analysing information at all levels, therefore reducing duplication and enhancing the way we use data meaningfully and efficiently. The quality management system empowers staff to be clear about what's expected of them, how they maintain oversight of quality and identify what they need to improve. Engaging people with data and outcomes in this way is a mechanism for creating a positive culture and high performing teams.



### 17.3.2 Research

**Summary of the 2023-2029 Joint Research Strategy**

Research is fundamental to the Partnership's pursuit of excellence in healthcare. Research, innovation and continuous improvement are the cornerstones for building better mental health services for our population.

It has been known for some time that organisations involved in research have better patient outcomes; even service users who are not directly involved in the studies themselves benefit from being in research-active Trusts. Organisations with a strong research culture also have better recruitment and retention of staff. One of the CQCs characteristics of a 'Well-Led' organisation, now looks more closely at research as a priority for improving patient care, assessing support for opportunities for patients to join cutting-edge research projects and clinical trials. With this in mind, the R&D strategy guides us towards the transformational changes that will enhance the well-being of our service users, carers and the communities we serve and enhance the effectiveness of our care.

The vision of the strategy coupled with the development of the IoMH at the Trusts St Pancras site, in the heart of the Knowledge Quarter seeks to provide a step change in the way we approach mental health care. It embodies the spirit of collaboration, inviting all stakeholders to contribute their expertise, ideas, and enthusiasm and lays out our strategic priorities and objectives framed around 8 pillars.

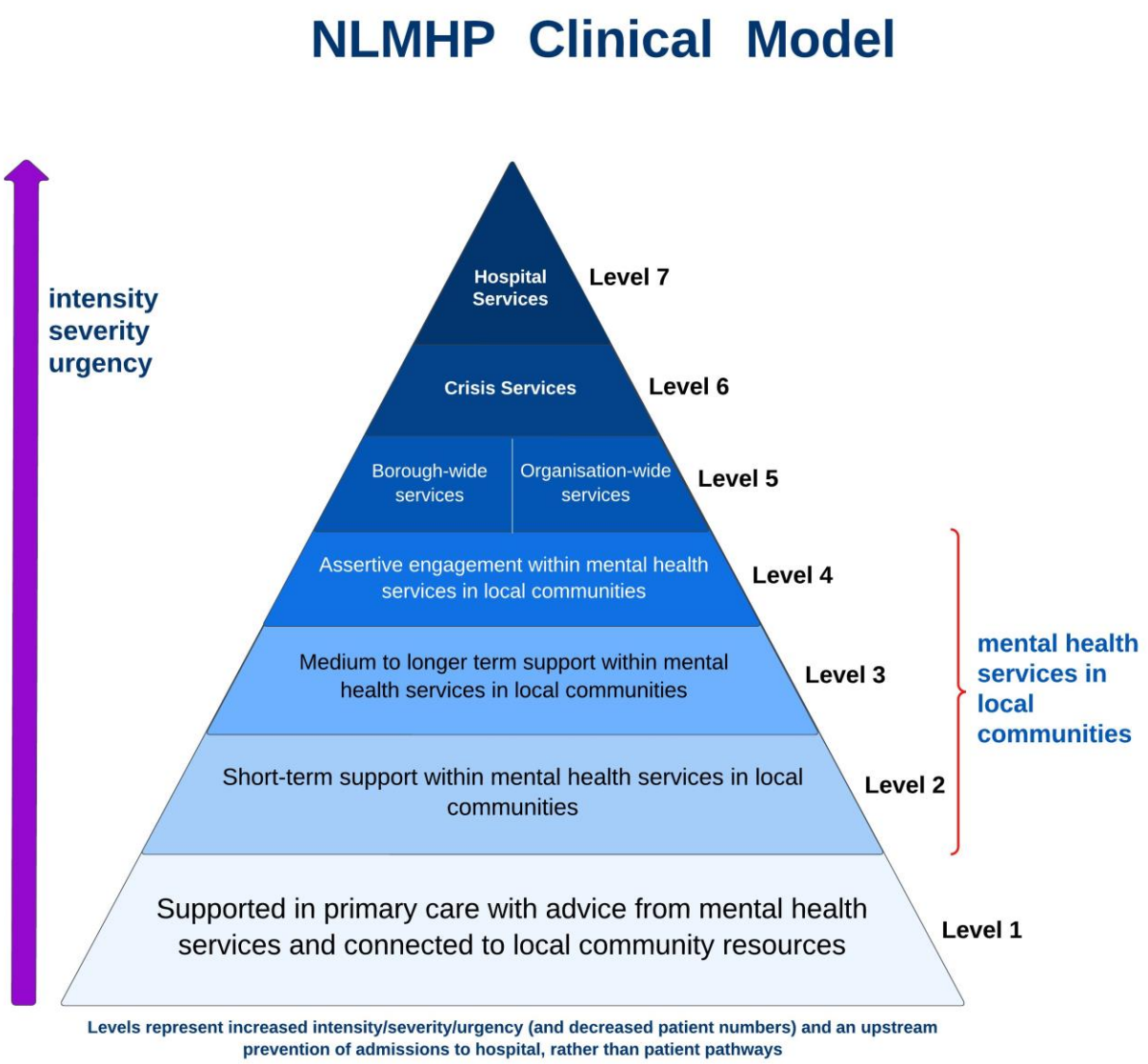
1. **Realising the benefits of the NLMHP clinical partnership**
   The NLMHP provides an opportunity to extend research and its impact to a much wider population. Expertise that is already present can work across the footprint of the two Trusts, while new areas of research can be developed.
2. **Developing the Partnerships capacity and capability**
   For research to flourish in the NLMHP it is essential that we build capacity and capability in our current staff and ensure structures and systems are in place to develop the future workforce so they can fully engage with the research agenda.
3. **Tackling health inequalities**
   The NLMHP serves an incredibly diverse population with significant health challenges, so there is a moral imperative to ensure that the research we do is inclusive and reflects the population we serve.
4. **Raising the visibility and profile of research**
   It is important that patients, their carers and staff are aware of the opportunities research brings, of the achievements of our clinical academics, and of the potential benefits of research participation.
5. **Increasing service user involvement in research**

The active participation of patients, carers and the public in research is something to be encouraged, ensuring that the research developed meets their needs.

6. **Adopting research and innovation into clinical practice**
   Research sitting on a shelf has no value. It is not enough, therefore, for the NLMHP to lead on trials and effective recruitment of service users into trials, while driving innovation, the partnership must also lead on the adoption and implementation of new ideas into clinical practice.
7. **Strengthening the range of research partnerships**
   There is a strong history of academic-clinical collaboration in clinical research, and the next five years will see the NLMHP build on this. The partnership will work closely not only with the UCL-IoMH but will extend and strengthen partnerships with other academic organisations that reflects our multidisciplinary workforce as well as other key stakeholders such as the local authority and our primary care colleagues.
8. **Building a robust clinical R&D support infrastructure**
   The NLMHP recognises that to have a thriving research culture, the right infrastructure needs to be in place to support the research endeavour.

The R&D strategy is not just a plan; it is a pledge and a commitment to the relentless pursuit of excellence in mental health care - a shared vision for a brighter, healthier future.

## 17. Our clinical model




Our clinical model is based on a population pyramid.

**Level 1: Prevention and Recovery.** Everyone with mental health problems will be supported in primary care and their community, sometimes with support from mental health services in the form of advice to professionals or direct treatment and support from mental health services. This level also includes people who are not registered with a GP service which makes their route into mental health services more complex. Our services will work in partnership with GPs and community organisations to develop prevention and resilience strategies in their local population, based on local knowledge, population health data and a joined-up approach to community assets & resources.

**Levels 2-4: Early Intervention, Recovery and Outreach.** Core community mental health teams will build relationships with their local community and other services in order to prevent or intervene early when people are at risk or already developing mental health problems. They will

have the capacity to offer support and treatment in the short or longer term and, also, to engage assertively when people have very complex needs. The support and treatment offered will be holistic and person-centred, with a focus on prevention and recovery. Our aim is to help people to recover and thrive.

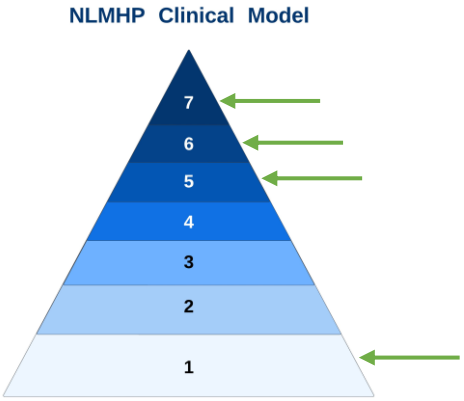
**Level 5:** These are the intensive services that operate on a borough or organisation-wide geography offering specialist interventions that are usually time limited.

**Level 6:** These services offer a range of options for people to get help if they are experiencing an acute mental crisis.

**Level 7:** We will always offer a hospital admission to anyone who requires it when other less restrictive options have been considered.

## 18. Our clinical areas

### 18.1. Children & Young People




Research during and after the COVID-19 pandemic revealed significant impacts on the mental health of children and young people. Rates of mental health problems increased, notably among girls, older youth, disadvantaged children, and those with special needs. In our services we are experiencing this increased demand for help with mental health problems.

The Children and Young People Mental Health (CYPMH) pathway will deliver safe, effective, needs-led and coproduced care for children and young people. Partnerships will be established with all stakeholders, including children, young people, families, social care, and voluntary sector providers. By working together timely, comprehensive care will be provided to children and young people living in the boroughs of Barnet, Enfield, and Haringey.

The partnership extends beyond local stakeholders to include other NHS care providers across North Central London (NCL), working together to enhance the mental health and resilience for all children and young people in NCL.

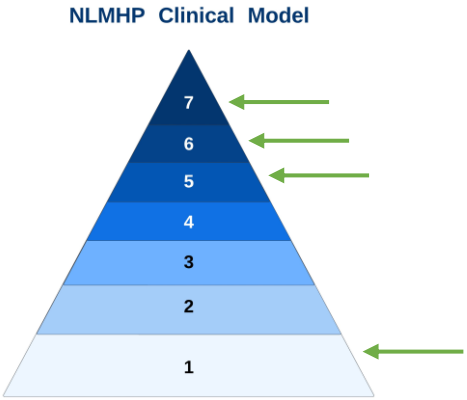
The level of care provided in the community will enable children and young people to thrive within their local environments, thereby avoiding mental health crises developing and the need for A&E attendances and hospital admissions.

Quality improvement principles play a pivotal role in service improvements. Pilot projects will be initiated and tested, with successful ones being scaled up across our CYPMH services. We will engage the expertise of our academic and research colleagues to evaluate new ideas and ensure that what we do is evidence-based.

Whilst striving for excellence, there are internal and external challenges to overcome. Factors to address include increasing efficiency, extending operating hours, staff recruitment and retention. To improve the working lives of our staff, we will review work environments, ensure career development opportunities, and provide support especially during service changes.

Services for children and young people are fragmented across NCL with some wide variation due to previous commissioning decisions. A mapping exercise for NCL is necessary to ensure that all children and young people in NCL receive and equitable, high-quality service.
Children and Young People clinical strategy 2023

### 18.2. Forensics & Prisons




North London Forensic Service (NLFS) is a part of the North London Forensic Provider Collaborative (NLFC), the latter oversees the delivery and commissioning of inpatient and community adult secure services across North and East London. The NLFS is our tertiary service offering comprehensive criminal justice and forensic services in North London. We provide specialist assessment and treatment in hospital and the community for people posing a serious risk to others, including those in the Criminal Justice System. We deliver mental health services in prisons, custody suites and in other specialised units in partnership with law enforcement agencies.

In the NLFS we are committed to continuous improvement in patient outcomes and experience. Our care is trauma-informed, person-centred, holistic and evidence-based and our care plans

are co-produced with our service users. Our clinical model aligns with best practices in mental health forensic services and positive risk taking and least restriction are key guiding principles.

We uphold the principles of The Human Rights Act 1998, ensuring inclusivity for everyone irrespective of their background or physical ability. Our CHOICES Community Hubs Social are important in fostering inclusion and addressing stigma thereby helping people integrate into the community.

Our services are integrated, and we actively manage our pathways so that people are in the least restrictive environments that can meet their needs. We invest in out-of-hospital initiatives to support people transitioning to less restrictive, community-based care.

Our relationships with partner organisations have to be robust because we are working with people who may pose a high risk to others; these include the police and others in the criminal justice system, the local authority and the voluntary sector.

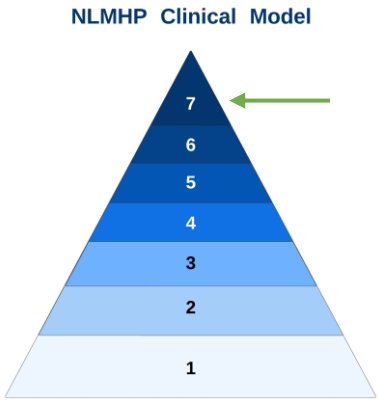
As part of this strategy, we will do the following:

- We will develop and implement a trauma-informed strategy.
- We will involve service users and carers and coproduce our services with them.
- We will enhance patient flow to reduce out-of-area placements.
- We will focus on health inequalities.
- We will continue to develop our community services.
- We will undertake projects to optimise the use of medication.

The challenges we face include difficulty moving people through the pathway efficiently because of blocks in the wider system. Complex mental health comorbidity can impact on service user's pathway progression through hospital into community living. As in the rest of the NHS, staff recruitment and retention are a big challenge. The quality of some of our estates is poor. Addressing these challenges is essential to us achieving this strategy.
Forensic clinical strategy 2023

## 18.3. General Adult Pathway

### 18.3.1. Adult Inpatients




The Adult Inpatient Clinical Strategy supports delivery of the Partnership Strategy by clarifying the clinical model for adult inpatient services. Meeting needs locally requires the service to accommodate the evolving requirements of the local population, including recommendations for older adults and people who need rehabilitation services. We aim consistently to achieve a bed occupancy rate of 85-90% and a length of stay target of 32 days or the same length of stay as the best performing comparable ICS. This will be achieved by offering timely, high-quality alternatives to admission, ensuring that people stay in hospital only for as long as is clinically necessary and that we provide the right support to prevent people from being re-admitted. This approach will eliminate out-of-area placements and reduce unnecessary waits for admission in Emergency Departments, Places of Safety and the Mental Health Crisis Assessment Service.

We will improve the use of data by providing weekly metrics at ward level, ensuring clear and accessible data visualisation, and leveraging the Electronic Patient Record (EPR) system for reporting on process measures without additional recording on other systems. We will minimise the reporting burden. We will use the single bed management tool to support coordinated patient flow across all our inpatient services.

In order to secure and grow the workforce we will improve staff retention through supervision, reflective practice, and, after incidents of violence and aggression, support from appropriately qualified staff. We will have a workforce plan for the next 5-10 years. We actively collaborate with academic institutions and professional training schemes to provide high-quality training and placements that leads to the recruitment of locally trained staff, with a focus on recruiting people who live in local communities. We will grow our lived experience workforce, including peer support workers, coaches and volunteers.

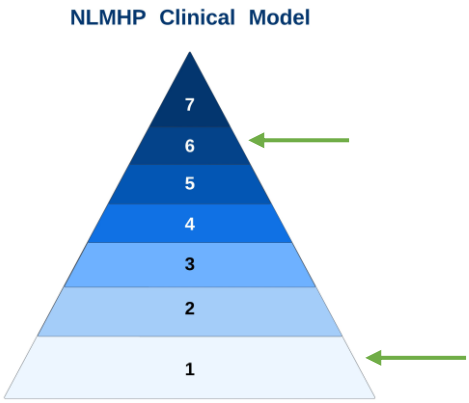
We will reduce the reliance on agency and bank staff. We will develop new roles and extended roles such as multi-professional approved clinicians, independent prescribers, nurse and physician associates, and clinical associate psychologists.
We will embrace digital solutions to aid transforming care and reducing the administration burden on staff so that they have more time for clinical care. Our patients will have access to

digital devices whenever possible to stay connected to their social networks and actively participate in their care.

We will actively promote research, innovation and quality improvement. We will utilise the expertise of leading academic experts within the North London to inform our strategy and models of care.

We acknowledge our challenges which include addressing the demand and demographic changes posed by the growing and ageing population in a sustainable manner. Recruitment and retention of our workforce requires a local response of creating high performing teams and a partnership wide strategy of making NLMHP a great place to work. Some of our estates are old and do not provide a good environment for our patients and staff and they take additional effort to provide safe services.
Adult Inpatient clinical strategy 2023

### 18.3.2. Crisis & Emergency Care




We know that even with the best community mental health teams, at times there will be need for emergency and crisis services in mental health. If and when that crisis arises, we provide an open access seamless service to support people wherever possible within our mental health services and not relying on our acute hospital colleagues to deliver this care.

Our crisis and emergency services will operate as a single, integrated system with the crisis line being the main point of access. We will offer an array of options and settings in order to offer patient choice and least restriction. On some of our sites we will bring together crisis services to strengthen and facilitate integration.

Our clinical approach is trauma informed. We offer holistic assessments that recognise the impact of traumatic events in people's lives. We aim to support people in the least restrictive way possible and in an environment that enables and supports them to feel safe. We constantly seek to adapt, improve and be early adopters of new models of care. We will embed co-production and Quality Improvement (QI) methodology in service design and change.

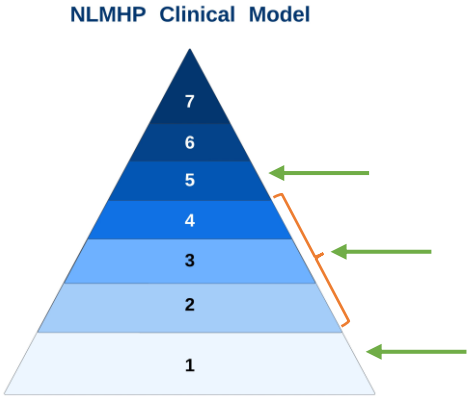
Aligned with our broader clinical strategy, we will shift the focus from crisis care to prevention and early intervention within the community. We will empower people to manage their own wellbeing and prevent deterioration of their mental health.
Our crisis telephone line is staffed by trained mental health professionals and is available 24/7. It serves as the primary point of contact. After an initial assessment over the phone, people are linked into suitable services based on their needs. This may include attending the Mental Health Crisis Assessment Service (MHCAS) or being seen in the community by a crisis response and home treatment team (CRHTT). Our MHCAS acts as a mental health emergency department accepting direct conveyance from EDs, London Ambulance Service and the Metropolitan Police Service, as well as people self-presenting.

Other parts of the integrated offer include:
Crisis Houses: offering short (up to two weeks) crisis admissions.
Crisis Cafés: located in each of the five NCL boroughs and offering flexible support.
Hospital Liaison Teams: offering specialist assessment and advice in Acute hospitals.
Place of Safety: accepts people detained under section 136 of the Mental Health Act.

By having a range of options for people experiencing a mental health crisis, we can often offer appropriate community support, and using hospitalisation only as a last resort.

There is an increasing demand for crisis services. Our population is growing, especially older age groups. There are challenges with recruitment of staff. Since we operate across a wide geography and with multiple partner organisations, we face the challenge of a lack of interoperability of service user records.
Crisis clinical strategy 2023

### 18.3.3. Community Transformation




This comprehensive strategy will deliver community mental health services for young people, working age adults and older adults, integrated at a local community level with partner organisations and the voluntary sector. Our core community mental health services will be responsible for the mental health care of a local population that maps onto Primary Care

Networks and Local Authority Neighbourhoods facilitating a population health approach, bridging the conventional division between primary and secondary care.

The clinical approach will be person-centred, trauma-informed, and recovery-orientated. Through collaboration with partners, people will be supported with their physical health needs and the social determinants that may be impacting their health. Using DIALOG+ as a care planning tool we will embed co-produced care plans as normal practice. Peer workers will play an essential role in this strengths-based approach.

Core community mental health services will consist of multi-agency, multidisciplinary teams with generic and specialist functions in order to address the breadth of clinical presentations and needs, with no diagnostic exclusions. It will be easier and quicker to access support. Services will have a good understanding of their local community and its assets and will support people to access local health and wellbeing resources.

Core community mental health services will be augmented with intensive services that will offer specialist interventions for people with very complex needs. The collaborative interface between core and intensive services will enable people to access care based on their needs, irrespective of which team caseload they are on. This strategy recognises the importance of specialist knowledge and skills required when working with distinct groups, such as young or older adults, and the need for seamless continuity of care to prevent gaps during transitions between services.

A key component of this strategy is the redesign of services for people with psychosis. There will be a pathway spanning support within primary care services; different levels of support within core mental health services; and intensive support in the community rehabilitation and early intervention services. We will promote secondary prevention; support people in avoiding relapses, crises, and hospital admissions; and tackle social and physical health inequalities associated with psychosis. We will support people to achieve their hopes and aspirations.

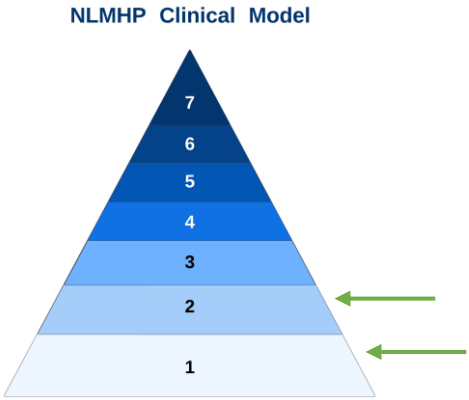
There will be clear pathways and interfaces with intensive teams for people with mood and anxiety, personality and eating disorders.

Digital tools will support the population health management approach, e.g., MaST (management and supervision tool), HealtheIntent. Through population data we will align our resources to match the needs of the local populations, which will assist in reducing inequalities and unwarranted variation. We will deliver preventative interventions to improve long term health outcomes.

We will continue to engage our workforce in the delivery of this strategy so that everyone is clear on the aims. Recruitment and retention is a serious challenge to its success. The growing

population and increased demand for services has required a new approach which this strategy articulates. A barrier and burden on the workforce is the existence of multiple digital systems that do not interface with each other amongst the various partner organisations; our digital strategy will propose solutions to this.
Community clinical strategy 2023

### 18.3.4. NHS Talking Therapies




The Talking Therapies Clinical Strategy for the NLMHP outlines the aims, objectives, and clinical priorities for the next five years. The services in Barnet, Enfield, Camden and Islington are under the Partnership; the strategy has had input from the Haringey service, which is under the Whittington NHS Trust. We will offer a range of goal-focused, evidence-based, psychological interventions to people with common mental health problems, using a stepped care model where the most effective, but least intrusive treatments, are offered, based on problem severity. We will offer accessible, high quality, interventions that are effective (as demonstrated by at least 50% of our patient's reaching recovery on standard outcome measures) and delivered by an appropriately trained, qualified and accredited workforce.

Services will be delivered in a trauma informed way through compassionate engagement with our service users, and co-produced treatment decisions. Staff training, supervision, and support will follow trauma-informed care principles.

The aims, objectives and priorities of the services across three key areas are:

1. **Service Delivery**
   - Ensuring equity of access and outcomes for all, using a data driven approach to identify underrepresented groups accessing the service, increase outreach efforts in partnership with community organisations, and develop specific roles to lead outreach into communities.
   - Improving waiting times and reducing internal waits, with service users informed about waiting times from the outset.

- Digital approaches will be embedded throughout the patient pathway to improve service quality. We will ensure equity of access and outcome for people who experience digital exclusion.
- Enhancing access for people with long term health conditions and comorbid anxiety and depression.
- Priority access for perinatal clients.

**2. Our workforce**

- We will develop a high performing workforce through training and career progression opportunities.
- Staff wellbeing will be promoted through supervision, protected time for reflection and flexible working arrangements.
- We will increase diversity within our workforce and improve diversity in senior roles.
- We will promote NHS Talking Therapies in our local communities both as a resource for treatment, and potential career opportunities.
- We will use demand and capacity modelling to predict staffing needs.
- We will embed QI approaches and research to plan and monitor improvements.

**3. Partnerships and Co-production**

- We will coproduce service changes with our service users.
- We will use service user feedback to improve, including patient experience questionnaires, advisory groups, and involvement in recruitment.
- We will collaborate with our Local Authorities and Public Health colleagues to develop NCL-wide approaches to community engagement and to support population health management.

Talking Therapies clinical strategy 2023

**Student mental health**

There are high numbers of students living and studying in NCL and our services have made adaptations to address their particular mental health needs, including the challenges of students moving frequently (e.g., during holiday periods). This includes offering a range of digital options for treatment.

In our NHS Talking Therapies (TT) services there are specific staff members linked to the student GP practices in South Camden who have expertise in working with students. There are good links with university counselling services and guidelines for TT staff have been developed around assessment, managing risk and linking in with a range of local support services.

TT services offer a range of workshops for students at many local colleges and universities regarding specific issues, such as coping with exam stress. They also participate in university

induction days to tell students about how they can access psychological help if needed at any point.

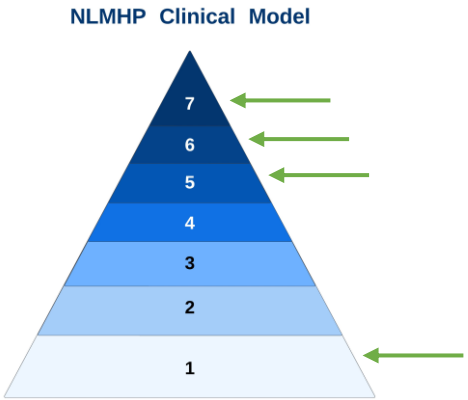
There are particularly good links with UCL – the largest university in the area. In 2021 the University Clinic was established in a collaboration between UCL and NHS services, including NLMHP. It had 3 main objectives:

1. To establish a programme of research in young people's mental health, in particular student mental health.
2. To develop novel psychological interventions.
3. To provide clinical and research placements for post graduate mental health professionals.

The common mental disorders clinic, which runs as part of the university clinic, is provided in collaboration with NLMHP. This includes specific programmes for treating Body Dysmorphic Disorder, Virtual Reality Programmes for Depression (an NIHR funded study), and a number of new digital interventions for common mental disorders.

An example of an effective UCL/NLMHP link was the response to the impact of the Ukraine war on students. A programme was set up to offer Psychological First Aid (PFA) to students impacted by the war. A number of Psychological Wellbeing Practitioners from TT services were trained to deliver this intervention as part of the programme.

### 18.4. Older Adults




Currently the over 65 population make up 16% of the population of NCL, varying from 19 % in the outer boroughs with a larger proportion of older adults living in care homes, to 10% in the inner-city areas. The current predictions are that this proportion will rise in all boroughs, in the case of Camden by 60%.

We are future proofing our services to provide an integrated offer of support to help older people with mental health problems live comfortable, dignified and fulfilling lives, with optimised overall health and independence.

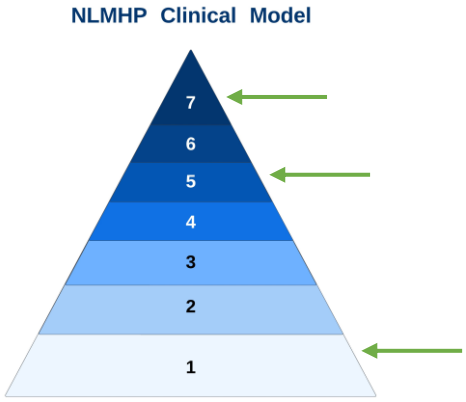
All older adults with mental health needs associated with ageing and frailty will have easy access to local, specialist, high quality care delivered by compassionate staff working holistically with partner agencies. Engagement, assessment and care delivery will be personalised to reflect the unique and complex interplay of relevant contributory psychiatric, cognitive, psychological, behavioural, functional and physical health factors. Care will be available in a variety of settings to alleviate suffering, optimise quality of life, and support with life adjustments and ageing well.

Services will be flexible to changing needs, placing patients, families and carers at the centre of decision-making which is underpinned by statutory and ethical principles of good care. We value the diversity of the communities we serve, and we will improve opportunities for co-production and tackling stigma, ageism, social isolation and recognising health and social inequalities that impact mental health and wellbeing.

Our model of care will span the duration of need for people who have progressive and deteriorating conditions. We will adopt universal, needs-led eligibility criteria. We will provide a service that is equitable for everyone living in NCL, e.g., access to specialist home treatment teams and day recovery services. We will work together with our older adult bed-base to reduce admission waiting times; always admitting people as close to home as possible. We will develop a consistent memory services model to meet the increasing demand. We will advocate for the needs of older adults within community transformation work, building interfaces with core and intensive mental health teams. Our services will have peer support workers.

Our challenges ahead include the rise in the ageing population, particularly those aged 80 and older, which along with areas of high deprivation, lead to health inequalities. Meeting evolving needs efficiently will require careful consideration of how we use our resources. Workforce recruitment and retention are difficult making staff wellbeing even more important than ever before. As new treatments arise for dementia, a different approach to services may be required.
Older Adults clinical strategy 2023

### 18.5. Rehabilitation



Over the next five years we will enhance our rehabilitation services in order to offer equitable access across our five boroughs with local rehabilitation pathways tailored to cater to the needs of local populations. We will work with commissioning colleagues to return people from out of area placements, along with the accompanying resources, to provide services locally.

Our person-centred, trauma-informed, recovery-orientated approach will optimise patient outcomes and experiences. Through strong therapeutic relationships, we will help people with severe and debilitating psychotic illnesses break the cycle of repeated, long hospital stays and to achieve independence, a sense of hope and wellbeing, and their own aspirations.

We will align treatment and support in our inpatient and community rehabilitation services to the evidence-based interventions outlined in NICE guidelines. Continuous professional development through quarterly training sessions will ensure our staff have the skills and competencies required.

Carers play a pivotal role in people's rehabilitation journeys and to support carers we will facilitate regular support groups in all rehabilitation services. We will facilitate regular carer assessments so that carers' needs are assessed and addressed. We will establish service user and carer forums to gather valuable feedback, address concerns, and collaboratively develop quality improvement plans.

We have a strong track record in research, and we will continue this because people who engage in research have better outcomes; research attracts staff to work in the field; and it ensures our services remain informed by the latest advances in the field.

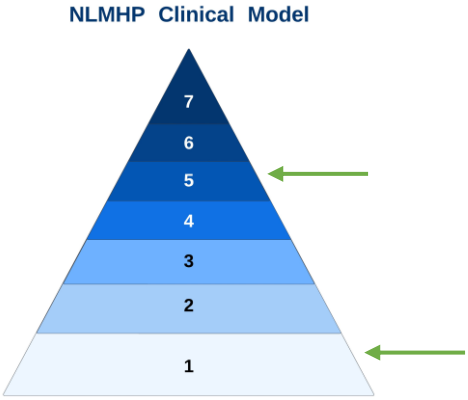
We will make data-driven decisions. Routine outcome measures, along with diversity data, will be collected and integrated into our reports and dashboards. This comprehensive system will track referrals, lengths of stay, processes, and outcomes, in order to drive efficient and equitable access to rehabilitation services.

All our inpatient rehabilitation services and community rehabilitation teams will participate in the Royal College of Psychiatrists peer accreditation quality improvement network and achieve accreditation.

Our main challenge is the high demand for rehabilitation bearing in mind we have the highest prevalence of psychotic illnesses nationally. This creates problems of people waiting long periods on acute wards for places in rehabilitation services. This necessitates strategic management of bed usage and patient flow. Some boroughs lack inpatient rehabilitation facilities and we do not have a unit for women who require a high dependency long term unit. This leads to out-of-area treatment with concerns about care quality and resource efficiency. There is a general shortage of supported housing units.

Staff recruitment and retentions is an ongoing challenge.
[Rehabilitation clinical strategy 2023]

### 18.6. Substance Misuse




The Substance Misuse Services (SMS) are driven by an unwavering commitment to co-production, forging impactful partnerships with service users and carers. While we have already established commendable practices like the trauma-informed hub, a significant cultural shift is imperative. Over the next year, SMS will review its treatment system, engaging with service users and carers to reshape services, priorities and operations, facilitated by a dedicated co-production group.

SMS tackles clinical complexities as a core task. Many service users face co-morbidities, impeding access to physical and mental healthcare. To address this, SMS will expand Buvidal and Naloxone availability, offering peer-to-peer training. Enhancing physical health care pathways, including the Chronic Obstructive Pulmonary Disease (COPD) clinic, remains pivotal. Engaging prison leavers in treatment aims to break the cycle of crime and substance misuse. Evidence-based paths for non-opiate and alcohol users are a priority, extending to collaborative efforts with hostels and alignment with Core teams and Mental Health Crisis Assessment Service (MHCAS).

Effective data use is crucial for progress. While gathering service user data for national reporting, SMS aims to harness it for service development and individual care planning. Collaboration between service users, managers, teams, and QI coaches will drive strategic data application. Integration of local population and service data will address under-represented populations. IT partners will optimise electronic patient record (EPR) systems, complemented by an online presence through social media and a dedicated website for North London Mental Health Partnership (NLMHP), offering recovery tools.

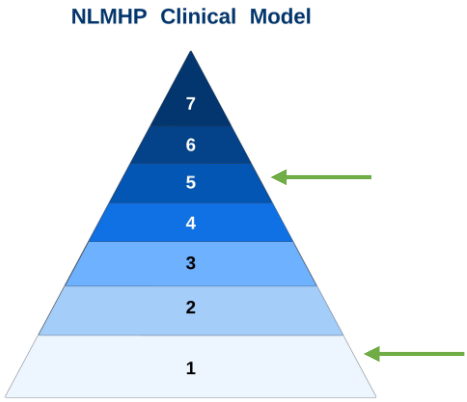
Productivity is paramount. SMS seeks to bolster number of individuals in effective treatment among non-opiate and alcohol users, and those under forty. Completion of treatment, harm mitigation, and reducing adverse behaviours linked to misuse are key objectives.

Research, innovation, and quality improvement are embedded in our ethos. Collaborations with institutions like UCL and initiatives like the club drug service, Benzodiazepine and Opiate Withdrawal Service (BOWS), and the COPD clinic exemplify this commitment.

Challenges emerge, including uncertainty with contract extensions for Enfield, Haringey and Islington, where potential re-procurements in the next two years pose disruptions. Competition against national organizations supported by dedicated teams presents bid writing challenges. Recruitment and retention difficulties persist, exacerbated by re-procurement. Diverse borough populations necessitate inclusive services, achieved through partnerships with public health entities and evolving information systems like the HealtheIntent Registry.

In conclusion, SMS's resolute commitment to co-production, clinical excellence, data-driven insights, productivity, and innovation carries us towards an inclusive, resilient future with improved outcomes.
SMS clinical strategy 2023

### 18.7. Learning Disabilities & Neurodevelopmental Disorders




#### 18.7.1. Learning Disabilities

Our holistic whole person, whole-family approach, multi-professional collaboration and co-production will positively impact on a learning disability population with significant disability in terms of physical, mental health co-morbidity, neurodiversity and socio-economic isolation. We strive to ensure NCL to be a place where people with learning disabilities are enabled to live healthy and happy lives, in their own homes, with the people they love and as active members of their local communities. We want people to have the best health and wellbeing possible, with the opportunities to do things that matter to them. We are committed to providing reasonable adjustments to ensure equitable access to all our health services that improve the health outcomes and experience of people with a learning disability.

The NLMHP contributes to the delivery of Specialist Integrated Learning Disability Community Services within NCL for Barnet, Camden, Enfield, Haringey, Islington, and also forensic

community and inpatient services through the NLFS. Each service is hosted by the respective Local Authority and provides health and social care support to adults with learning disabilities in their homes as well as a variety of community and hospital settings, aiming to be responsive to the needs of their local populations. In partnerships between the five local authorities and relevant local NHS Trusts, each service provides a single point of access for all adults with a learning disability living within that borough supporting in total approximately 7300 individuals and their families across NCL recorded as having a learning disability on GP registers. The North London Forensic Service provides inpatient medium and low secure care, as well as community learning disability caseload management across the five boroughs.

Service Users and Carers are an integral part of all our services. In each borough service users, their families, care providers and advocates are included in Learning Disability Partnership Boards and subgroups, Health and Wellbeing Boards, service specific co-design and co-production work and policy and service development.

Our services work to a number of National, Legislative and Local drivers and ensure compliance with the NHS Improvement Standards for Learning Disabilities and their associated performance outcomes.

Each borough-based learning disability service provides a clinical model in line with the relevant NHSE guidance - Building the Right Support, NHSE 2015.

Community learning disabilities services, adhere to the diagnostic criteria in line with International Classification of Diseases 11th Revision (ICD-11) i.e., a significant impairment of intellectual functioning (IQ less than 70 or equivalent measurable through academic performance) and concurrent impairment of adaptive functioning, both of which have an onset in the early developmental stage (significantly before adulthood with a lasting effect on development).

Learning disability services will undertake audits in line with NICE guidelines, NHS Benchmarking Standards and the Green Light Toolkit.
Learning Disabilities clinical strategy 2023

### 18.7.2. Neurodevelopmental Disorders

Adults of any age in NCL with neurodevelopmental needs related to ADHD and Autism will have access to timely, person-centred, trauma-informed, co-produced, high-quality care that helps to enhance their mental health, and wellbeing. We will work collaboratively with GPs, core community mental health teams, social care, housing, specialist mental health services, and voluntary care partners to deliver holistic care. We will prioritise lessening the impact of disabilities and impairments. We will improve the understanding of neurodevelopmental issues, including neurodiversity and neurodivergence, in the wider population. We will focus on addressing inequality drivers related to race and socio-economic status.

Our service is clinic base. In addition to direct work with service users, consultation and support are also provided to other professionals.

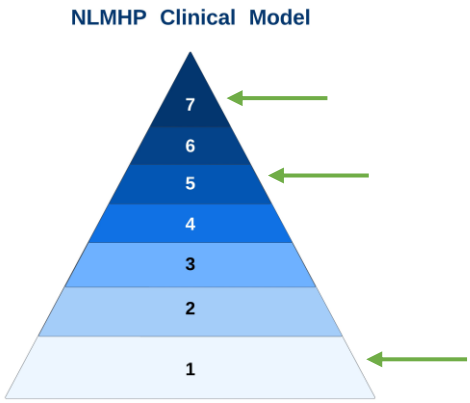
Referrals for ADHD are triaged to assess eligibility and clinical complexity. Specialist clinicians conduct assessments and treatment options may include medication and psychological interventions. Ongoing reviews will be offered to patients as required.

Referrals for Autism are screened and, if appropriate, assessments are offered following which feedback is provided and people are signposted as necessary.

Our main priority is to reduce waiting times for new referrals to less than 12 months within the next five years, ideally to 6 months or less. We will do this by greater use of non-medical prescribers, peer workers and stronger partnership working particularly with GPs and the voluntary sector. We will explore innovative ways to manage the waiting list more effectively. We will build our capacity to offer training to increase knowledge and skills in primary care and other mental health teams in supporting people with neurodiversity. We will continue our involvement in research so that we contribute to developing our understanding of neurodiversity.

Our main challenge is inadequate resources to meet the demand for our services leading to delayed assessments and limiting our ability to offer a more comprehensive service. There is heightened public awareness of neurodiversity, and this is driving the demand for assessments. We need better discharge pathways to make the services sustainable. Our digital infrastructure is challenged. The high demand and excessive administrative tasks are contributing to staff burnout and problems with staff retention.
NDD clinical strategy 2023

### 18.8. Perinatal & Maternal Mental Health




The Perinatal Mental Health Service will deliver high-quality, comprehensive care to support the mental well-being of expectant and new mothers, their partners, and children. The service seeks to enhance accessibility, especially for vulnerable groups like minority ethnic backgrounds and socially disadvantaged individuals. The service will collaborate with various stakeholders

through joint clinics, consultation sessions, and targeted training to improve referrals and care quality. Perinatal champions, equipped with specialised training, will offer support and training within the team and extend services to self-referrals.

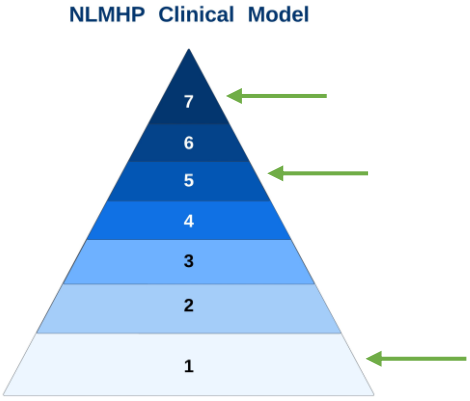
Additional funding will strengthen the workforce, enabling the service to reach its access goals and offer a wider range of interventions. Psychological input, including case formulations, will aid in progressing complex cases. Peer workers will play a pivotal role in patient engagement and building social connections, promoting mental health equity for perinatal women. The service will intensify outreach efforts, partnering with community organisations to engage marginalised and vulnerable groups, and connect with community ventures, such as children's centres, places of worship, and community hubs.
The service will enhance its presence in maternity settings, collaborating with perinatal midwives and obstetric clinics. Flexibility in appointment and a sensitive approach will improve the patient experience. The service is committed to supporting partners, including biological fathers, stepfathers, same-sex partners, birthing partners, and carers, by assessing their mental health needs and providing appropriate support. They will be inclusive and supportive of gender diversity and trans individuals on their parenthood journey.

To accommodate more service users, a Brief Intervention Stream (BIS) will be introduced, providing streamlined care for individual cases.

Challenges remain particularly in expanding evidence-based care for those with moderate to severe perinatal mental health difficulties. Balancing increased numbers of new assessments whilst maintaining care quality is a key challenge. The service manages the complexities of higher-risk cases and interagency collaboration. New interventions and changes need time to establish, and stakeholder communication is vital for effective care pathways. Finding suitable spaces for the South sub-team is a priority, as is providing adequate support and supervision for perinatal peer support workers, who face unique challenges.

Overall, the Perinatal Mental Health Service will improve accessibility, collaboration, and care quality for perinatal mental health, while addressing challenges through innovative approaches and dedicated support for both patients and staff.
Perinatal clinical strategy 2023

## 18.9. Specialist Eating Disorders




The St Ann's Eating Disorder Service delivers comprehensive care for adults on the path to recovery from eating disorders. We provide compassionate, evidence-based treatment that addresses the psychological, physical, and emotional dimensions of the illness. We co-produce our service and individual care plans with our service users. Our clinical approach is trauma informed.

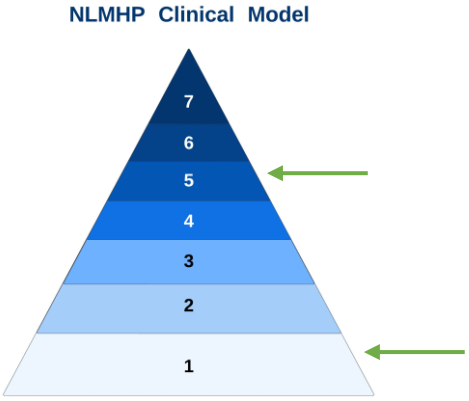
Operating across several boroughs, our service is one of the largest in the country. Our multi-disciplinary team offers inpatient and outpatient treatment for adults with moderate to severe eating disorders. We receive over 1000 referrals annually, with around 600-700 service users on our caseload at any given time.

Treatment options vary according to the disorder. We offer a range of psychological therapies as well as pharmacotherapy, dietetic support, occupational therapy, art therapy, and family therapy.

Our objectives include making access easier and equitable and tackling waiting times. We will build on our partnerships with other organisations and NLMHP services in order to broaden and smooth clinical pathways. We will engage with our stakeholders and provide training for referrers. We will invest in our workforce development. We will use data to track clinical outcomes and performance indicator.

Our main challenges are workforce recruitment and retention, and funding uncertainties. The potential loss of funding for interventions and team training poses risks to the success of this strategy. Other challenges include addressing unwarranted variations in clinical care and engaging other services in working jointly with people with coexisting mental health conditions.
Eating Disorders clinical strategy 2023

## 18.10. Veterans




This strategy addresses the unique needs and challenges faced by veterans and ensures equitable access to effective and tailored treatments.

Our clinical approach is veteran and trauma informed. We recognise the prevalence of trauma among veterans. Our assessments will be comprehensive, our engagement compassionate, and our treatment decisions will be coproduced with veterans and their partners.

We will offer equitable access to all veterans requiring treatment for mental health problems. We will increase efforts to reach more veterans by expanding our partnerships with veterans' organisations and community groups. We will develop roles within our team to lead on outreach, working closely with local statutory and non-statutory organisations, to develop tailored approaches for veterans from different communities.

We will manage waiting times and reduce delays in accessing care. We will utilise external services to meet rising demand and use innovative approaches such as digital interventions for less complex cases. Veterans will be informed about waiting times, and efforts will be made to minimise internal waits for ‘step 3’ interventions.

We will use digital interventions, as an adjunct to therapy, and for post-discharge support. We will ensure equity of access and outcome for people who experience digital exclusion.

We will collaborate with other healthcare providers and organisations to ensure that care is holistic and person-centred so that veterans with coexisting physical health conditions, substance misuse, debt related issues, occupational issues, etc, receive effective and coordinated care.

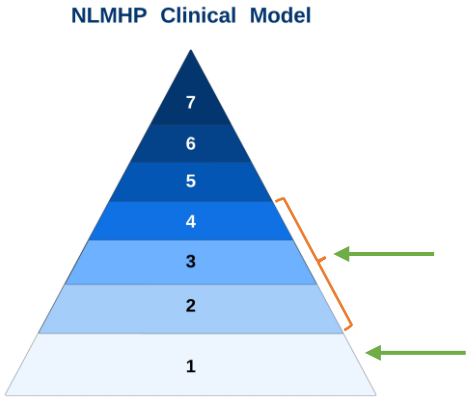
We will develop a high performing workforce through training and career progression opportunities with an emphasis on retaining experienced professionals. We will increase diversity within our workforce and improve diversity in senior roles.

Veterans and their partners' involvement thorough co-production will be central to service development and improvement. We will work with our established service user advisory group to involve veterans in recruitment panels and use their feedback to enhance service delivery.

We will use research and service evaluations to improve the quality of services and treatment outcomes for veterans. We will collaborate with academic institutions and research organisations to inform evidence-based practice and develop innovative approaches.

There are challenges in meeting the unique needs of veterans, including the complexity of the clinical work; external services that have primary clinical responsibility being under pressure, and workforce recruitment and retention.
Veterans clinical strategy 2023

### 18.11. Transitions




We will provide comprehensive support to young adults transitioning from children and young people's mental health services to adult mental health services as they approach their 18th birthday. In line with the NHS Long-Term Plan, we will establish transition plans for all young people who need them thereby enhancing the transition experience for young people and their families. We will also identify young people who have high risk often due to complex needs.

Our approach is trauma-informed recognising the impact of adverse childhood events and trauma on mental and physical health. Our guiding principles include co-production, evidence-based interventions, and person-centred holistic care through multi-agency collaboration.

Young Adults and their families have said that a service designed to help provide clarity and efficiency in their transition from young people to adult mental health services is vital in reducing the stress and anxiety caused by historical approaches to managing transitions, for example, having to meet lots of different people, telling your story multiple times, having referrals refused. This all creates more uncertainty at an already uncertain and challenging time in their lives.

Supporting young people through the transition involves five phases:

1. Pre-transition discussions are initiated before the young person reaches 17½ years of age.
2. If it is agreed that support with transition is needed, then the Transitions team is contacted.
3. A transition plan is then developed in a multi-agency transition meeting which the young person's referring worker is invited to. This plan is shared with the young person and will only become the formalised plan if the young person agrees with the recommendations.
4. The transitions plan is then actioned usually at the age of 18 or an agreed alternative time.
5. The effectiveness of the plan is evaluated and reviewed based on feedback.

Along with offering transition meetings, we are embedded in core community mental health services within a wider offer to young people. We offer a clinical service to young people who either do not meet eligibility criteria for adult mental health services or have lost confidence with more traditional ways of being supported.

Although our service provision varies across the five boroughs based on geographical variation, our priority is to create an equitable service across NCL, creating co-produced pathways aligned with local needs.

Our challenges include securing sufficient investment; recruitment and retention of staff; navigating the complexity of cross-system working; garnering professional cooperation; addressing rigid age cut-off points; and maintaining visibility to senior leaders for ongoing support and development.
Transitions clinical strategy 2023

## 19. Our approach to reducing suicide

Our approach to reducing suicide is underpinned by a comprehensive Partnership Suicide Prevention strategy, launched in February 2022. This strategy aligns with the NCL-wide suicide prevention initiative and involves collaboration with multiple agencies. Strong governance is being established aligned with the introduction of the *Patient Safety Incident Review Framework* within the Partnership to facilitate learning within a trauma-informed approach. This includes awareness of the impact of suicide on people, including staff. To drive this initiative, an action group comprising clinicians, partner agencies, and individuals with lived experience of the impact of suicide has been formed, and includes a focus on supporting and engaging carers.

Thus far, the Partnership made significant progress in various areas:

- **Meaningful Involvement**: Carers with lived expertise have played a vital role in shaping and implementing the strategy. Their valuable contributions have enriched the development and delivery of our suicide prevention initiatives.
- **Bespoke Training**: In November 2022, we commissioned external specialist suicide prevention training (Applied Suicide Intervention Skills - ASIST) to continue training a range of clinicians. We have conducted a series of successful learning events open to all clinicians within the Partnership and have further sessions planned three times a year. In 2023-24 we are focusing on the development of bespoke localised training sessions via our clinical lead and champion network and will continue the implementation of the Dialog+ person-centred care planning tool.
- **Collaborative Partnerships**: We have fostered strong partnerships with voluntary and statutory providers dedicated to preventing suicide and supporting individuals at risk of suicide and those close to them. These collaborations have enhanced our ability to provide comprehensive care and support across our services and systems.
- **Clinical Lead and Champion Roles**: To drive the implementation of our Suicide Prevention strategy, we have established Clinical Lead and Champion roles within the Partnership. These individuals, including 60 Suicide Prevention Champions, undergo intensive training and actively participate in a Community of Practice, ensuring a high level of expertise and knowledge in suicide prevention that can be provided at a local team level. The Partnership is committed to growing and strengthening these roles, and ensuring they have capacity to fulfil these roles.
- **NCL Support After Suicide Service**: Partnership service users, carers and staff have access to this service providing support services to those impacted by a death by suicide. The service is currently provided by a Third Sector provider with close collaboration with the Partnership.

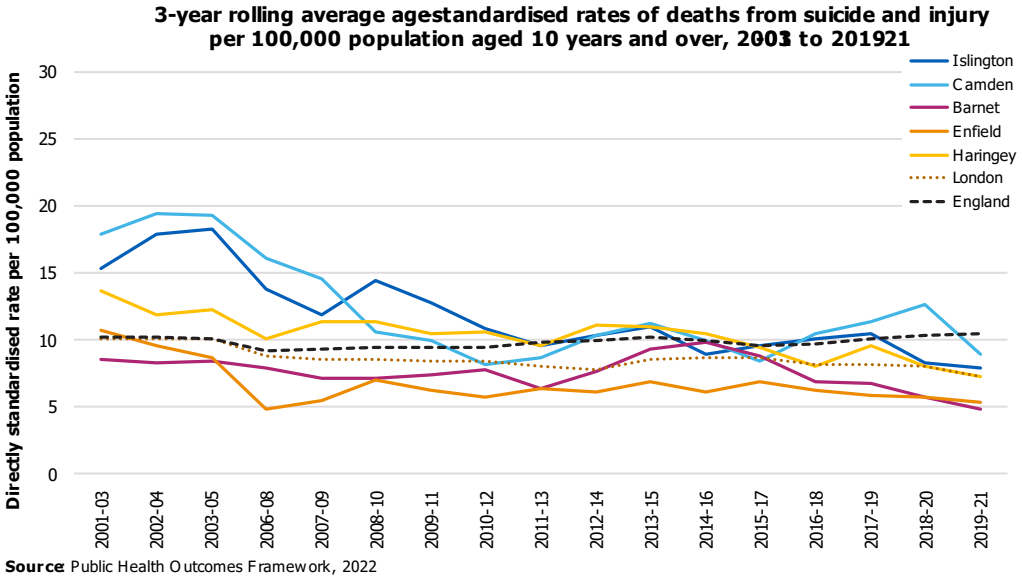
The Partnership will introduce changes to the new Electronic Patient Record (EPR) system (RiO) to implement safety care plans and improve documentation around risk history.

Further funding has been granted to continue the NCL wide Suicide Prevention Project involving a broad range of Third Sector and Statutory Services, with strong engagement of the North London Mental Health Partnership.

As part of our commitment to continuous improvement, we actively collaborate with other partners in NCL to sustain key aspects of the NCL-funded work. For example, the Data and Insights Group, chaired by Barnet Public Health, will continue its valuable work, providing essential data-driven insights and guidance.

By incorporating these strategies and initiatives into our Clinical Strategy, we aim to create an environment that prioritises suicide prevention, actively engages carers, and delivers high-quality care and support to individuals at risk of suicide and their families.

ONS data 2001-2003 to 2019 -21: suicide rates across NCL




**Source**: Public Health Outcomes Framework, 2022



## 20.How we will work with people who access our services

We will not know that the services we are providing are meeting the needs of those we serve unless we champion their views and feedback. We share the view of the NHS constitution which states that ”the patient will be at the heart of everything the NHS does”; we remain committed to its principles and the pledges it sets out recognising the importance of a coordinated and co-produced approach.

Those who use our services have told us that they want better communication and to feel as if they are partners in the NLMHP. They want to influence; co-produce goals; and create a shared vision where we work collaboratively to design, develop, deliver, and improve services. They have highlighted the need for the feedback loop to be closed, i.e., when feedback is collected, it is acted upon and the outcome fed back. It is imperative that the organisation is transparent and continues to aspire to co-production and always commits to consultation and collaboration. Those that give their time to participate in involvement activity want to be informed of the impact of their contribution; whilst also being recognised and rewarded appropriately in a way that works for them.

We will involve people actively who use our services right through from co-creating individual care plans to coproducing existing and new services to enhance overall experience and outcomes.

**How**

- **Involvement Registers**: we have involvement registers that give people the opportunity to participate in shaping and improving our services, whether this be through sharing their lived experience; being the voice of lived experience in groups and committees; or supporting staff to ensure that the service user voice is embedded throughout service design, development, and delivery. People can also receive regular information about the work of the NLMHP. We will publicise these opportunities widely.
- **Service User Groups and Forums:** we have some well-established service user groups and will continue to support them to grow, amplify and champion the voices of those using services. We are committed to ensuring there is clear governance around these groups so that we can be held to account. We will share learning, good practice, training, and resources to build on this across the NLMHP.
- **A strategy about experience and involvement:** we will co-produce a partnership strategy that will set out how we will improve the experience of service users and carers and how we will involve them in the business of the NLMHP.
- **Training:** we will build on the existing training provision for those people who get involved offering development opportunities to gain new skills and knowledge and even progress into our lived experience workforce. We will train staff so that they are well equipped to support those who get involved.
- **You said, we did:** we will co-produce with those who use our services the best ways to communicate our actions. Building on options like the 'you said, we did' notice boards.

**Outcome**

- Those who access our services will feel listened to and act as equal partners in their care.
- People will feel informed about their own care and the work of the NLMHP.
- People will know how to get involved, how to give their feedback and how we've acted on this feedback.
- Feedback received from service users and carers will have clear and consistent pathways to action at both an organisational and service level.
- People will feel able to get involved and have the appropriate knowledge and skills for meaningful and effective participation.
- People will be rewarded and recognised for their contributions in a way that works for them.
- Staff will be trained in how to involve people in a way that is supportive and meaningful.

## 21. How we will work with carers

A carer is anyone who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid.

Carers have told us they want better communication and transparency both in relation to the person who is cared for, their caring role and the wider NLMHP commitment to carers. They would like their contribution and value to be recognised, and to be included as active partners within the care team. That means their expertise is utilised, where appropriate, to make care decisions and plans. Despite the pressures of caring having a negative impact on the health of carers, we know they are not always given the correct support, advice and information; or opportunities that will empower and enable them to advocate better for the person for whom they are caring.

In the NLMHP we recognise the invaluable role of carers and are committed to actively involving them in our services to enhance overall experience and outcomes.

**How**

- **Involvement Register**: we have involvement registers that give carers the opportunity to participate in shaping and improving our services, whether this be through sharing their carer lived experience, being the voice of carers in groups and committees, or supporting staff to ensure the carer voice is embedded throughout service design, development, and delivery. Carers can also receive regular information about the work of the NLMHP.
- **Carers Groups:** we have some well-established carer support groups and continue to share learning and good practice to build on this across NLMHP. We will support and grow the presence of carers groups locally.
- **Carer Peer Support Coach roles:** we are commencing a pilot project with carer peer roles in two boroughs to see how lived experience roles can facilitate good practice in inpatient and community settings.
- **Community of Practice:** we are in the process of developing a community of practice to bring together people with a shared passion for supporting carers to learn from each other and share best practice.
- **Carers Strategy:** we have pledged to co-produce a Partnership Carers Strategy with carers, to plan, clearly define and set out how we work together going forward.
- **Training:** we will ensure that staff have carers awareness training and create or signpost carers to training to empower them in their roles. We will also foster training opportunities for carers to learn skills for wellbeing and advocacy.
- **Triangle of care:** we are committed to the principles of Triangle of Care, and it's recommended standards.

**Outcome**

- Carers feel included as valued active partners within the care team.
- As active partners in care, Carers have access to support and skills development that helps them do so effectively.
- Carers feel well supported, with improvements to their health and wellbeing.

- Staff are ‘Carer aware’ trained, identifying, involving and supporting carers.

Our clinical strategy highlights the importance of working collaboratively with carers. Through proactive engagement, clear communication, provision of information, advice, and guidance; and the establishment of support structures, we will create an inclusive environment where carers are recognised and valued as crucial partners in the shaping and improvement of our services. We understand that the engagement and collaboration with carers is not a one-time effort but a continuous process and therefore we are committed to the ongoing involvement of carers in service design, development, and delivery.

## 22. How we will assure clinical quality and safety

Quality Governance establishes a framework for the organisation and individuals to ensure the delivery of safe, effective, and high-quality care and treatment. At NLMHP, our governance structures and processes for continuous learning and improvement ensure that there are effective quality governance arrangements in place from 'Floor to Board'. Review, monitoring and oversight of these arrangements takes place through scheduled reporting to the following:

- Trust Board.
- Quality and Safety Committee.
- Quality and Safety Group.
- Divisional Quality and Workforce Meetings.
- Weekly Trust Safety Huddle.

Our quality governance structures and processes provide a means for effective monitoring of key quality and performance indicators and learning from patient safety incidents, audits, service reviews, and service user feedback.

Through our quality governance systems, the Board is provided with assurances on the quality of our services and patient safety. We produce comprehensive organisation and divisional quality dashboards (incorporating safety, experience, and effectiveness); we have an active national and local clinical audit programme; we monitor themes and trends in service user experience and complaints; we monitor the standards of our inpatient wards and a number of community teams through the Tendable audit application, through executive-led safety walk-arounds and scheduled Quality Reviews of service, and we have a robust risk management and escalation framework in place.

Our Clinical Fridays programme, an initiative that sees senior nurses across the organisation doing walkabouts every Friday on inpatient and community sites, gives staff the opportunity to talk openly and honestly with nurse leaders about quality and safety.

We continue to work with our Experts by Experience (EbEs) to ensure our quality governance arrangements embed high-quality care and services for all of our service users. Our involvement register of EbEs continues to grow with more EbEs getting involved in several programmes of work to improve the quality of services.

We recognise that having a strong culture that is fair and inclusive helps create the conditions necessary for safe and effective service user care and experience, and staff wellbeing.

### 22.1. The Complex Case Panel

Complex Case Panels offers clinical and ethical guidance in addressing intricate and challenging clinical scenarios. These complexities encompass substantial associated risks, obstacles in discharging patients from inpatient services, managing issues related to poor engagement or difficult family dynamics, navigating through recovery progression obstacles, and evaluating complex diagnoses. The paramount objective is to provide a comprehensive and holistic formulation of underlying dynamics and accurate diagnoses. Additionally, the panel is dedicated to recommending effective pathways forward, tailored to each individual case's unique requirements.

Referrals to the Complex Case Panel are open to all clinical teams within the NLMHP, fostering a collaborative and multidisciplinary approach. The panel comprises five members, including three consultant psychiatrists, one consultant medical psychotherapist, and one consultant psychologist. It meets monthly devoting focused attention to one case at a time, ensuring thorough consideration and informed decision-making.

The Complex Case Panel is committed to the welfare of our patients and the professional development of our clinicians. By maintaining a supportive and informative space, we continue to empower our clinical teams to enhance patient outcomes and provide the highest standard of care in complex and challenging situations.

**As part of our clinical strategy, we will establish more of these specialist panels to advise on complex cases.**

## 23. How we will deliver our delegated Local Authority duties

**The Care Act 2014** is the main legislation that governs adult social care in England. It aims to make care and support clearer, fairer, and more person-centred. It also promotes the wellbeing, prevention and integration of care and support with other services, such as health and housing. The Act details the rights and responsibilities to service users, carers, local authorities, and their partners.

The NLMHP works closely with our five Local Authority Adult Social Care Departments. In the Boroughs of Camden, Islington, and Enfield we have been delegated some of the local authority functions under Section 75 partnership agreements. This means that we can conduct some of the local authority's health-related functions, such as providing social care services or public health interventions. This can help to improve integration, efficiency, and outcomes for service users. In Barnet and Haringey, we work through an informal agreement (called a Memorandum of Understanding) with our Local Authority Partners which aspires to similar principles.

We are committed to delivering our delegated functions in line with the Care Act 2014 and its vision for social care. We will do this by:

- **Working in partnership** with local authorities, health services, and other relevant organisations, to ensure that people receive seamless care and support that meets their needs. We share information, coordinate assessments and plans, align budgets and resources, and provide joint services or teams where appropriate. We participate in Safeguarding Adults Boards and other local forums that promote cooperation and integration.
- **Providing person-centred care and support**. We involve people in the assessment, planning and review of their care and support, and ensure that they have choice and control over how their needs are met. We provide personal budgets, direct payments, or individual service funds where appropriate, and offer independent advocacy if needed.
- **Promoting wellbeing and prevention.** We provide or arrange services that prevent or delay the development of or reduce care and support needs. This can include providing information and advice, universal services, community support, or targeted interventions.
- **Applying a consistent eligibility threshold for care and support**. We assess the needs of people who may require care and support, and determine whether they are eligible for services, based on a consistent set of national criteria based on the impact of the person's needs on their wellbeing, and their ability to achieve certain outcomes.
- **Supporting carers**. We recognise the valuable contribution of carers to society and provide them with the same rights to assessment and support as people who need care. We assess the needs of carers who may require support, and determine whether they are eligible for services, based on a consistent set of national based on the impact of the carer's needs on their wellbeing, and their ability to achieve certain outcomes.
- **Safeguarding adults at risk of abuse or neglect**. We make enquiries, or cause others to do so, when we have reasonable cause to suspect that an adult in our area is experiencing, or is at risk of, abuse or neglect, and has care and support needs that make them unable to protect themselves. We will work with partners to agree on a course of action that protects the adult and promotes their wellbeing. We will report any suspected crimes to the police and cooperate with investigations. We regularly attend **Safeguarding Adults Boards.**

The Care Act 2014 has been updated several times since it came into force, to reflect the changing needs and expectations of people who use care and support services. Some of the key changes include:

- **Clarifying the role of advocacy in the assessment, planning and review processes**: local authorities must provide or arrange independent advocacy for people who have **substantial difficulty** in being involved in these processes, and who have **no appropriate person** to support them. This is to ensure that people's views, wishes and feelings are taken into account, and that they can understand and exercise their rights.
- **Strengthening the links between the Care Act and the Mental Capacity Act 2005:Local authorities must presume that people have capacity to make their own decisions, unless proven otherwise;** that they must support people to make their own decisions, as far as possible; that they must respect people's right to make unwise decisions, as long as they understand the consequences; and that they must act in people's best interests, when they lack capacity.
- **Prevent abuse and exploitation of known vulnerable groups**, **as well as assist new groups of people, who may be at risk and require safeguarding**: This means that we protect the **right to live in safety, free from abuse and neglect**, of people who have care and support needs that make them unable to protect themselves. We do this by following the **six principles of safeguarding**: empowerment, prevention, proportionality, protection, partnership, and accountability. We also identify and support new groups of people who may be vulnerable due to factors such as age, disability, mental health, social isolation, poverty, or discrimination.
- **Strengthen partnerships and cooperate with other organisations to protect vulnerable individuals and communities and provide effective responses to safeguarding concerns.**

We recognise the vital role of social workers in implementing the Care Act 2014 and our responsibilities as a formal partner and its vision for social care. Social workers are essential for supporting people with mental health issues, as they can provide diagnosis, treatment, therapy, and connection to resources. They also work with the whole person, their family, and their community, and protect those who are vulnerable while respecting their human rights. The Human Rights Act provides a legal framework that guides and supports rights-respecting decisions about the support provided. We value and support the core skills and values of social workers, and also recognise that people who use our services have rights and entitlements, as well as a responsibility to become active citizens within their community.

## 24. Creating Great Places to Work: Our People & Organisational Development Strategy

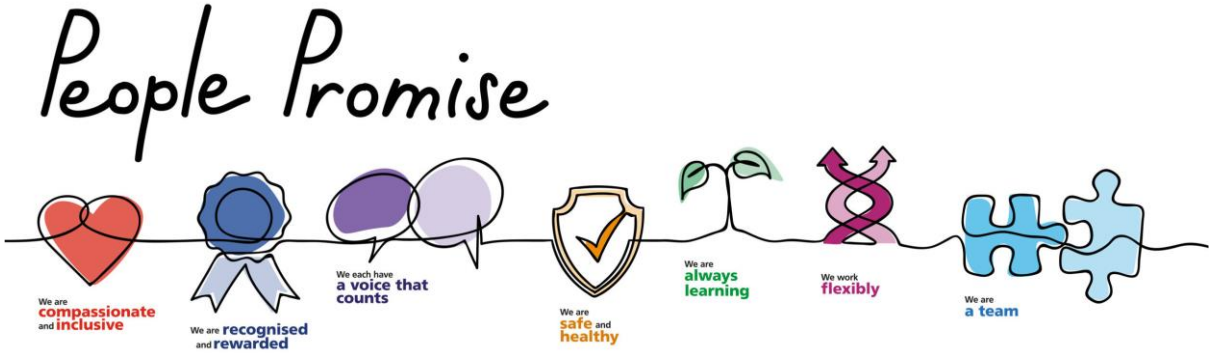
The purpose of this Strategy is to set the direction and describe our plans for how we will develop our workforce and provide great places to work. This is needed to enable us to achieve

our ambition, to offer cutting-edge, local, preventative, co-produced, person-centred mental health and wellbeing support to our service users and our communities.

Nationally, The NHS People Plan creates specific commitments to:

- Looking after our people – with quality health and wellbeing support for everyone.
- Belonging in the NHS – with a particular focus on tackling the discrimination that some staff face.
- New ways of working and delivering care – making effective use of the full range of our people's skills and experience.
- Growing for the future – how we recruit and keep our people, and welcome back colleagues who want to return.

This is supported by the national NHS People Promise:




As the major mental health service provider for North London, we are an important part of North Central London (NCL) Integrated Care System (ICS). NCL ICS has described a vision for the system approach to workforce, enabling organisations to:

- Be excellent employers, developing and supporting the wellbeing of existing staff and attracting new people to live and work in North London.
- Plan their workforce and development needs to deliver new care models in new settings, including in integrated care systems.

Be socially responsible organisations, using our influence and decision making to best serve the interests of our communities and reduce inequalities.

Our Partnership Strategy recognises these requirements and the role they play in the delivery of our ambitions. The intended impact of this is to create conditions where staff like the culture at work, feel they have a consistent team around them and have opportunities to develop their career.

The Partnership Strategy identifies two key workforce priorities:

**Transformation of our workforce** by working together to address the external challenges facing the mental health workforce and the evolving needs of our staff. This covers the whole employee life cycle from supporting local routes into employment to creating clear opportunities across career pathways for new and existing staff to support retention. We will also embed leadership and management development opportunities to create a workforce that is empowered to innovate and improve the health outcomes of our service users. Additionally, we will create a flexible working environment for our staff.

**Creating a just, fair, inclusive and compassionate culture across the partnership.** We will create a learning culture free from blame, in which staff will be encouraged to speak up. We will seek to understand why things go wrong, and work in partnership to continuously develop. We will champion the diversity in our workforce, treating everyone fairly and compassionately, whatever their background or circumstances.

Our engagement with staff across the Partnership and the national staff survey has highlighted five areas for priority focus to help us achieve the conditions that will make this possible.

- **Addressing the basics** to give staff the tools and support they need to deliver good care.
- Creating our **future workforce**, through the development and retention of our staff and recruitment of additional people.
- Developing a **shared fair and inclusive culture.**
- Delivering on our commitment to **equality**, celebrating our **diversity.**
- Keeping our people **safe and well.**

People and Organisational Development Strategy

## 25. The role of our Allied Health Professions

To meet the evolving and often complex needs of people with mental illness, autism and learning disabilities, we believe that a clinical strategy should articulate a compelling, courageous, and creative forward-view, which challenges traditional boundaries and promotes new integrated roles and ways of working and is underpinned by a strong culture of continuous improvement.

Seven of the 14 Allied Health Professions (AHP) are represented across the Partnership:

- Art Therapists.
- Dieticians.
- Drama Therapists.
- Music Therapists.
- Occupational Therapists.
- Physiotherapists.
- Speech and Language Therapists.

The NHS Long Term Plan describes AHPs as playing a central role in the delivery of person-centred care to help meet the growing demands and pressures the NHS is facing. The Mental Health Workforce Plan for England' (2017) also highlights the vital and varied role of AHPs as first responders, in diagnosis, rehabilitation and recovery of everyday life, and self-management.

AHPs are key in realising the vision set out in the clinical strategy, providing a real opportunity for advancing practice development and transformation to enhance the care we offer to service users, their families, and our communities across North London and beyond.

AHPs provide diverse yet tailored interventions across the lifespan. They are instrumental in improving access and flow, increasing capacity to enable fairer and faster access to the right care. For example, evidence suggests that two sessions with a primary care occupational therapist for a person with a mental health condition can lead to a 66% increase in confidence and a 50% reduction in GP appointments (AHPs in Mental Health Toolkit, HEE, 2022). AHPs enable people to avoid admission and remain in the community and can facilitate early, high-quality, and sustainable discharge from hospital demonstrated by reduced length of stay (https://improvement.nhs.uk/resources/allied-health-professions-ahps-supporting-patient-flow/ referenced in the NHS Long Term Plan, Section 4.2)

AHPs bring efficiency and expertise by:

- Bringing connectivity of mental and physical health interventions (they are often dual trained with specialist skills in physical as well as mental health) to tackle health inequalities.
- Delivering specialist preventative, early and longer-term mental health intervention with users of services, their families, and carers.
- Developing and enabling integrated pathways to provide a strategic overview and for services users to have all their needs addressed.
- Helping maintain healthy lifestyles in individuals and at population health level through preventative, health promoting, intervention.

Working at the top of their competencies and skills, AHPs can lead teams to new ways of working. We want to ensure that AHPs are in the right place, at the right time, with the right skills to deliver the first point of contact and advanced pathways of rehabilitation and recovery across sectors and age groups in mental health, learning disability, and autism services. To this effect this clinical strategy supports a multi-professional and integrated service approach spanning traditional boundaries. This requires clear leadership and management and must be accompanied by a comprehensive workforce plan, including the development of advanced clinical practice (ACP) and multi professional approved clinician roles. These roles, undertaken by experienced AHPs, as well as colleagues from other professional groups, working in a multidisciplinary manner, will enable us to meet people's needs and will facilitate improved quality of care, for example by addressing key points of transition.

## 26.What we need from our medicines optimisation strategy

**Provide quality care through expert medicines optimisation**

- Single NLMHP DTC (Drugs and Therapeutics Committee) to provide robust and consistent clinical governance across NLMHP, including development, implementation and monitoring of single medicines formulary, policies and guidelines which are evidence based and ensure efficient use of resources.

- Deliver patient focused pharmaceutical care plans during hospital admission and following discharge, that are based on accurate medication histories and service user involvement to minimise length of stay and reduce readmission.
- Deliver structured medication reviews in community-based services, to ensure effective and safe ongoing treatment and support deprescribing and reducing polypharmacy. This includes the Learning Disabilities and Autism STOMP/STAMP (STopping Over Medication of People with a learning disability, autism or both/Supporting Treatment and Appropriate Medication in Paediatrics) programmes.
- Deliver joint interface guidelines and pathways with GP practices to optimise pharmaceutical care, ensuring necessary infrastructure and expertise in place to support the delivery.
- Use population health data to identify unacceptable variations in medication treatment and target plans to eliminate variation.

**Develop and maintain a high-level workforce**

- Increase the number of HEE (Health Education England) commissioned trainee pharmacist and pharmacy technician apprenticeship posts, including cross-sector posts in primary care, to improve recruitment & retention of pharmacy staff to deliver the medicines optimisation programme.
- Develop and implement a non-medical prescribing (NMP) strategy to embed NMP within service models across all divisions, ensuring robust clinical governance processes are in place.
- Develop multi-disciplinary career pathways and opportunities across services and interfaces to facilitate career progression, that incorporate medicine optimisation responsibilities.

**Digital Transformation**

- Implement electronic prescribing and medicines administration (ePMA) across all inpatient and relevant community teams.
- Implement electronic prescribing system (EPS) in outpatient services to enable FP10 prescriptions to be sent directly to community pharmacies.
- Optimise discharge medicine service (DMS) with community pharmacy to support effective transfer of care.
- Implement digital medicine cabinets (Omnicell) across inpatient units to support safe administration and efficient stock management of medicines.

## 27. What we need from our digital strategy

### Technology at work must work.

Our Partnership Digital Strategy is still being developed, but at the heart of its development is the commitment to delivering the best possible experience of digital technologies and services to all staff and patients.

We will embrace the concept of "digital brilliant basics" and move away from a one size fits all approach to technology. We will ensure staff have the right tools for their role. Our staff need technology that makes their core task – to care for patients – effective and efficient. We will only implement digital solutions that we are sure give back to our nurses, doctors, psychologists and AHPs "**time to care**" for our patients.

Computers will always be available at the point of care, they will work at speed, and they will reliably and quickly connect to our networks. All essential software systems will be readily loaded, and then carefully monitored, so that we know we are delivering robust levels of availability and minimising time lost to "tech stress" and poor staff experience of our technology systems. We will improve our digital and data training capacity to ensure that staff have the right skills and ongoing support to make best use of new technology and improved ways of working. We will build a 21st century technical infrastructure that provides robust cyber security, resilience, and reliable and fast connectivity to essential systems.

We will innovate, building on best practice elsewhere, new technology, and ideas from our staff that identify how we can use technology to delivery continuous Quality Improvement.

**Our clinical systems** will be consistent across the partnership. We will work towards operating from one instance of one EPR acknowledging the massive productivity loss that is inbuilt into any clinical pathway operating across more than one core clinical system. We will continuously invest in the optimisation of our primary EPR and ensure that all other clinical systems – whether pathology or prescribing or bed management software - are fully integrated with it. Our EPR will be configured with staff needs in mind. Every new form and function will be designed and configured to maximise efficiency and productivity at the front line, and we will ruthlessly test this before launching into live. "*We shape our digital systems, and they then shape us"* to misquote Churchill – in other words – we will focus on adaptive change as much as on the technology itself.

Our data. We believe that our systems should keep patients safe, and provide consistent, high quality, evidence-based treatments that enable our patients to achieve the outcomes and quality of life they want in their communities. We will invest in our Analytics function and data platforms to enable automation and reduce the data burden on staff and enable us to feedback near real-time data to clinical teams so they can monitor and improve the clinical care they offer.

We will work with our partners across **NCL Integrated Care Board** – to support information sharing, population health management and insights, and engagement with our local population via a patient held record.

We want to become a Centre of Excellence for Data Analytics, to allow us to attract, **recruit and retain** clinicians into the digital space and provide training and career opportunities for aspiring CxIOs as well as technologists and data scientists and data engineers.

And finally, a word about **our culture and leadership** in digital.

**We are** highly skilled. We are collaborative. We are relentlessly patient focused. We are inclusive. We are open to ideas, feedback and constructive criticism. We are driven by the desire to enable delivery of the highest quality care and the best possible outcomes for our local population.
#digital #NLMHP

## 28. What we need from our estates strategy

Service users and carers told us it is important to them to be seen in environments that are welcoming, comfortable, and safe. They also prefer to be seen in or near their own homes.

Accessing services and working in well designed, inspirational environments help to make us feel valued. Safety and wellbeing are therefore essential features in the design of modern psychiatric facilities. Our clinical services are enhanced by our workforce being able to interact, share ideas and make connections and the way we design our estates can enhance this networking. Although we have some modern, well-designed buildings, including Blossom Court, Highgate East, Lowther Road, we also operate from some old and often outdated buildings that need additional resources to improve the quality and effectiveness of these environments. With modern, well-designed buildings we will have a reduced impact on the environment.

Some of the inpatient facilities at the Dennis Scott Unit and Chase Farm are not designed to meet modern needs. We have four inpatient sites; our estates strategy should plan to replace the older stock with new purpose-built wards, potentially consolidating inpatient services on fewer sites. We require all our hospital facilities to be fully accessible and provide warm, welcoming and therapeutic environments. Having our inpatient facilities consolidated would give economies of scale to facilitate clinical and managerial cover and flexibility. It will also enable more joined up work with physical healthcare services.

Our hospital estate must deliver:

- A wide range of therapy spaces, including spaces for physical activities and for developing activities for daily living (ADL).

- Adherence to current guidelines and standards, e.g., ensuite bathrooms in all bedrooms and rooms that meet or exceed the nationally set room sizes.
- Spaces for supporting family and carers, including a faith room and high-quality tribunal facilities.
- Accessibility of the whole facility by wheelchair and navigable to people with sight and hearing impairments.
- Direct access to outdoor space from all wards.
- Landscaped public realm and spaces, such as a café, that help to reduce stigma.
- Flexible ward layouts that allow changes to be made in line with changes in demand.

We will carry out a review of the suitability of all the estate inhabited by our community services and will make plans to replace or adapt facilities that do not support the clinical strategy. Our clinical strategy requires integrated community mental health centres which act as centres for delivering clinical care, bases for our community teams and spaces for collaboration with our local partners.

Designs for the community buildings must deliver:

- A light, open and modern design to create a comfortable feel.
- An open and welcoming reception area.
- Accessibility to people with disabilities and other protected characteristics.
- A high number of clinical rooms that are flexible as local needs and services change.
- Desks, meeting pods and quiet spaces to allow our teams to work in agile ways within the buildings and between sites.
- Social spaces for our staff to improve wellbeing and relations between teams.
- A number of group rooms (including ADL kitchens) and meeting rooms for our services, and open to community groups when not in use.
- Facilities for partner organisations to improve collaboration and delivery of our clinical strategy.
- Where economies of scale allow, an accessible café open to all stakeholders to help reduce stigma, preferably as a social enterprise to offer service users an environment to develop skills for employment.

In addition, our estates strategy needs to include developing a network of consulting rooms across the communities we serve where we can see people near to where they live, e.g., GP surgeries, Local Authority buildings, community services buildings.

In all our buildings we require a user-friendly room booking system that will provide clinicians, researchers and service user/carer groups the ability to plan ahead and secure space for their intended activities.

Our flagship building on the St Pancras site must provide interactive opportunities to our local community that will attract people to come and learn about mental health and wellbeing. This is the right site to provide clinical services aimed at our immediate local communities in Camden as well as some other services that operate across a wider geographical footprint. Being close to large transports hubs also makes this the right place to situate our clinical services that cover the whole of NCL and/or further afield. We need quality, extensive, flexible teaching spaces for our own teaching and training programmes, including our recovery college and QI academy, as well as space for UCL to deliver some of their mental health related teaching programmes. In the round this will foster an environment where service users, carers, clinicians, academics and the public interact and collaborate producing fresh and innovative ideas as well as supporting training and development of our current and future workforce.

## 29. Organisational Effectiveness

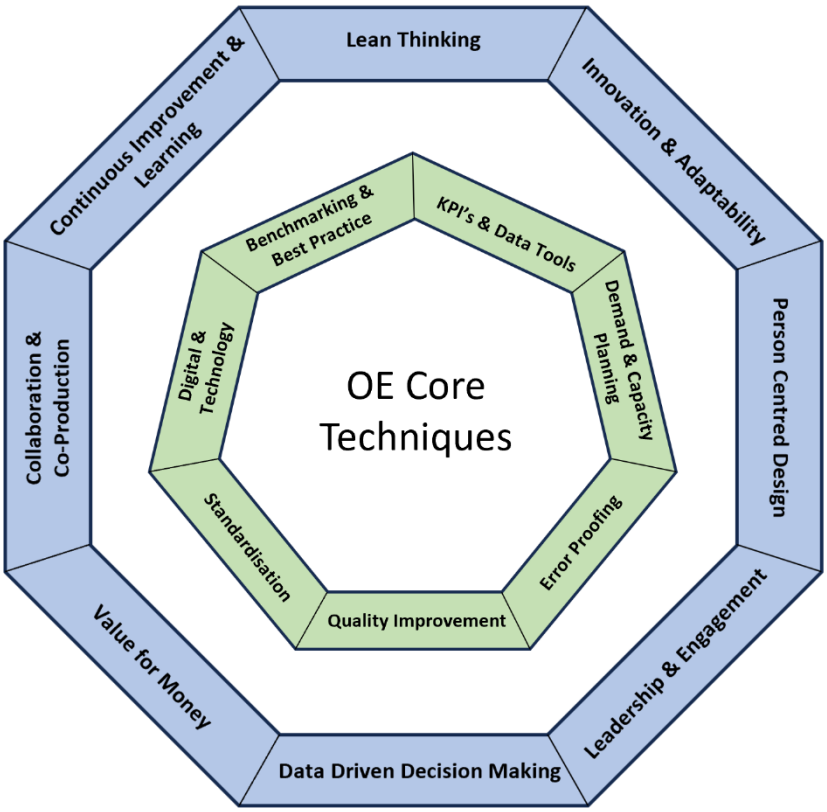
As part of our clinical strategy and in response to the growing needs across the population we serve, there is a recognition that as a Partnership, we need to find ways to maximise the use of our collective clinical and operational resources and deliver the greatest value for the 'public pound'.

Organisational Effectiveness refers to the extent that the Partnership is successful in achieving its goals and objectives and encompasses areas such as clinical effectiveness, performance, efficiency and adaptability to the environment we operate in.

We embrace an Organisational Effectiveness (OE) approach that supports reducing unwarranted clinical variation, improving outcomes and increasing our productivity and the efficient and effective use of our resources.

Our OE approach is built on a set of **eight OE principles** that are intended to help guide our thinking and behaviours alongside **seven core OE techniques** that help define and drive our day-to-day actions:

## Organisational Effectiveness (OE) Principles




Some of these principles and techniques will be more familiar than others and the following explanations will give further insight. Both our principles and the core techniques will start to become more widely understood and used as we continue our improvement journey.

Corporate support functions such as the Performance Improvement Team and the Quality Improvement Team will be able to provide advice and guidance and will apply an Organisational Effectiveness lens to improvement activity.

# OE Principles

**Lean Thinking**
Apply lean principles to eliminate waste, streamline processes, and enhance the efficiency of delivery.

**Data Driven Decision Making**
Use data and analytics to inform planning and decision making, improve outcomes, and optimise resource allocation.

# Core OE Techniques

**Quality Improvement**
Implement the Partnerships Quality Improvement methodology to systematically improve any aspect of service delivery.

**KPI's & Data Tools**
Use relevant KPI's to understand quality and performance and data tools to visualise and analyse relevant metrics for decision making and improvement.

**Continuous Improvement & Learning**
Cultivate a culture of continuous learning and improvement, encouraging healthcare professionals to regularly evaluate and improve processes.

**Innovation & Adaptability**
Embrace innovation and adaptability to respond effectively to evolving healthcare challenges and technological advancements.

**Person Centred Design**
Prioritise service user / patient needs and experiences aligning service delivery to meet those needs.

**Collaboration & Co-production**
Promote collaboration between teams and functions, breaking down silos to provide integrated and comprehensive care that makes sense to the person.

**Value For Money**
Identify and prioritise the aspects of services that add value from the patient's perspective, eliminating waste and inefficiency to maximise the impact of available resources on outcomes.

**Leadership & Engagement**
Provide strong and visionary leadership that promotes a positive, inclusive and healthy workplace that recognises and values colleagues' crucial role in achieving the Partnerships goals.

**Benchmarking & Best Practice**
Compare performance metrics internally and externally to understand where there are opportunities for improvement and harness best practices to enhance organisational effectiveness.

**Error Proofing**
Design and improve systems and processes to eliminate or reduce the likelihood of errors being made. Errors can impact directly on service user / patient care or be a cause of additional work for colleagues.

**Standardisation**
Design and improve systems and process that are documented, agreed and used consistently by everyone doing that type of work across the Partnership.

**Demand & Capacity Planning**
Forecasting future demand for services and aligning resources to meet that demand, understanding where there are constraints and bottlenecks so that adjustments and optimisation can occur to balance demand and capacity.

**Digital & Technology**
Identifying and making the case for digital and technology solutions to simplify or eliminate tasks or support with effective decision making and delivery of care and support.

## 30. What clinical leadership model do we need to deliver this strategy

Clinical leadership is a task for all multidisciplinary professionals. As an organisation providing clinical services, we require sufficient and highly skilled clinical leadership in order to provide safe, high quality services. The NLMHP has invested in clinical leadership that spans across all professions.

There is a tension between place-based clinical leadership and clinical pathway leadership. Placed-based clinical leadership supports the strategic ambition of population health management that is built on strong relationships with local communities and partner organisations. Pathway clinical leadership supports the development of equitable services across NCL and drives out unwarranted variation. We have to find a way to provide both of these functions in our future clinical leadership model.

For some of our services the pathway model of clinical leadership is already in place including for CYPMHS, Forensics & Prisons, Talking Therapies, Perinatal, and Veterans services. For Adult Inpatient, Crisis & Emergency, Older Adult, Substance Misuse, Eating Disorders and Neurodevelopmental services this is partially in place. Place-based clinical leadership is in place for Community, Rehabilitation, Transitions and Learning Disability services.

We will develop this hybrid model of place-based and pathway clinical leadership by extending existing pathway clinical leadership roles across the five boroughs and current place-based clinical leadership roles will be assigned responsibility for pathways that are not currently covered by pathway clinical leadership.

# 31. Appendices

## 31.1. Appendix (1):

**"Longer Lives" commitments for delivery by North London Mental Health Partnership.**

### 31.1.1. Living well in NCL

*Bringing together all our learning from our patient and public involvement and engagement (PPIE) work to understand: what does "health" mean for people with SMI? What are their priorities? What kind of support do they want, where and who from?*

NCL Secondary Care Commitments:

2.1.1 Our annual health check for people with SMI will reliably prompt physical health care planning and interventions.

2.1.2 We will provide, from the point of the health check, care planning which is holistic and uses a coaching approach, with longer appointments and peer work involvement as appropriate. As part of this we will aim to roll out UCLP-Primrose across NCL.

2.1.3 We will offer regular (at least annual) psychiatric medications reviews for all SMI patients by a professional suitably experienced in mental health, with a holistic focus. Consideration of weight gain will be a top priority for clinicians.

2.1.4 As an ICS, we will ensure that there is tailored information for our service users with SMI. All our services will provide information for issues such as side effects and specific health conditions, co-produced with people with lived experience. "Tailored" will mean adjusted for SMI/taking psychotropic medicines, ethnicity, culture, socioeconomic status, literacy, language etc. We will start with information tailored to particularly high-risk communities. See Heal-D (Healthy Eating & Active Lifestyles for Diabetes in African and Caribbean communities) as an example.

2.1.6 As an ICS, we will offer regular health and wellbeing groups and access to free exercise in a range of settings for people with SMI, whether they are under specialist care or not. The focus will be enjoyable activities, groups and peer support, with strong links with VCS and community groups to enable this. See Inclusion Sports, run by LISA (London Inclusion ports Academy), as one example.

### 31.1.2. Cardiometabolic disease:

**Diabetes, weight management, blood pressure and cholesterol**

*How do we prevent, treat, and manage heart disease and diabetes more effectively; how do we intervene earlier and more effectively for problematic weight gain?*

NCL Secondary Care Commitments:

2.2.2 All patients who need treatment for hypertension and/or hypercholesterolemia (as identified in their physical health check) will receive it.

2.2.3 We will consistently assess cardiovascular and diabetes risk across our services, for example by embedding use of the QRISK3 and QDIABETES tools in primary and secondary care settings.

2.2.4 All SMI patients who need them (including those outside the SMI cohort but on mood stabilisers or antipsychotics) will have a 12-lead ECG at least annually.

2.2.5 All patients will be offered high impact, holistic support and peer work to improve cardiovascular health. As part of this, we will aim to roll out UCLP-Primrose across all our boroughs.

2.2.6 We will support GPs and psychiatrists in refreshing or gaining competencies in medical management of metabolic syndrome.

2.2.7 We will include diabetes control within the mental health risk assessment for people with comorbid diabetes and SMI, to manage the risk that deteriorating mental state poses for self-management of diabetes and to prompt additional support.

2.2.8 All mental health staff supporting patients with or at risk of diabetes will receive training on diabetes prevention and care as per the 10 point Inpatient and Community Mental Health Workers free diabetes training.

2.2.9 Mental health staff who frequently support patients with or at risk of diabetes will be supported to deliver diabetes courses for patients. See DESMOND, the nationally recognised training programme for people at risk or with diabetes, as one example.

2.2.12 We will review the availability of specialist diabetes medical and nursing input for mental health inpatient services. See the HIN improving diabetes care report.

2.2.13 We will review diabetes service specifications, with a particular focus on: (i) mental health provision, including psychiatry, and (ii) support available for more complex patients with additional access needs. Psychiatric expertise could be included via a fully integrated psychiatrist, or via in-reach, for example by allowing referrals to psychiatric liaison teams from outpatient clinics.

2.2.14 We will establish referral criteria and bidirectional pathways between diabetes services and (i) mental health services and (ii) substance misuse services. All relevant clinicians should be able to make the referral. Mental health clinicians supporting patients with SMI will be invited to patients' diabetes appointments to support attendance. Virtual access to appointments and MDTs may help facilitate this work.

### 31.1.3. Lung disease and tobacco dependence

*How do we increase early and accurate diagnosis and treatment for a range of respiratory conditions, including tobacco dependence?*

NCL Secondary Care Commitments:

2.3.1 All relevant NCL staff will be offered treating tobacco dependence training. NICE recommends the National Centre for Smoking Cessation and Training (or similar) training modules be used to provide staff with the necessary skills to support service users to quit. Motivational interviewing skills will be part of this training, with regular top ups.

2.3.2 As an ICS, we will implement a genuine smoke-free policy in all hospitals. By effectively treating nicotine withdrawal and cravings, we will both improve patients' health and enable a cultural change so that the norm is no longer that patients expect to smoke on escorted leave, or when outside on hospital grounds. Smoking materials brought into the wards will be kept and returned at discharge. Staff time will be freed up and diverted towards ward groups and activities.

2.3.3 NCL inpatients will be offered NICE guideline recommended treatments, including the full range of choices of NRT and other medications as appropriate. Pharmacotherapy with

long acting NRT (patches) will be offered to patients within 30 minutes of admission to prevent nicotine withdrawal.

### 31.1.4. Cancer screening and treatment

*How can we increase uptake of cancer screening and treatment?*

NCL Secondary Care Commitments:

2.4.1 We will include cancer screening reminders and support in the annual physical health check for people with SMI, including specific actions and alerts for people who miss screening appointments.

2.4.4 As an ICS, we will review, improve and standardise the current support offer for patients with SMI at the point of cancer diagnosis e.g., care navigation, peer support, or specialist mental healthcare (depending on need).

2.4.5 Our cancer services will provide information and training on screening and signs and symptoms to services supporting patients with SMI, for example to supported housing providers, third sector organisations, and to mental health services.

### 31.1.5. Proactive, personalised outreach for the most marginalised 20%

*Who are the 20% of people with SMI who don't have any of their annual health check and are not currently accessing any health support except in times of crisis? How do we reach this 'seldom heard from' group?*

NCL Secondary Care Commitments:

2.5.2 We will establish clearer, robust links and pathways between secondary care mental health services and VCSE or grassroots community services. This will include details on how best to share information and jointly manage risk.

2.5.5 We will explore and develop the role of HealtheIntent (or similar) as a way to identify people with SMI or in health inclusion groups who are not engaged with care, so that additional engagement resource (such as outreach) can be deployed, and to flag such patients to the wider system as having an ongoing unmet health need.

2.5.6 We will develop the role of core community mental health teams as a route for escalation of patients who require additional or enhanced physical health support including people with SMI who have missed health checks, cancer screening and 2 week wait appointments or other key interventions. This will result in a personalised engagement plan involving those with the most appropriate skills to reach the individual.