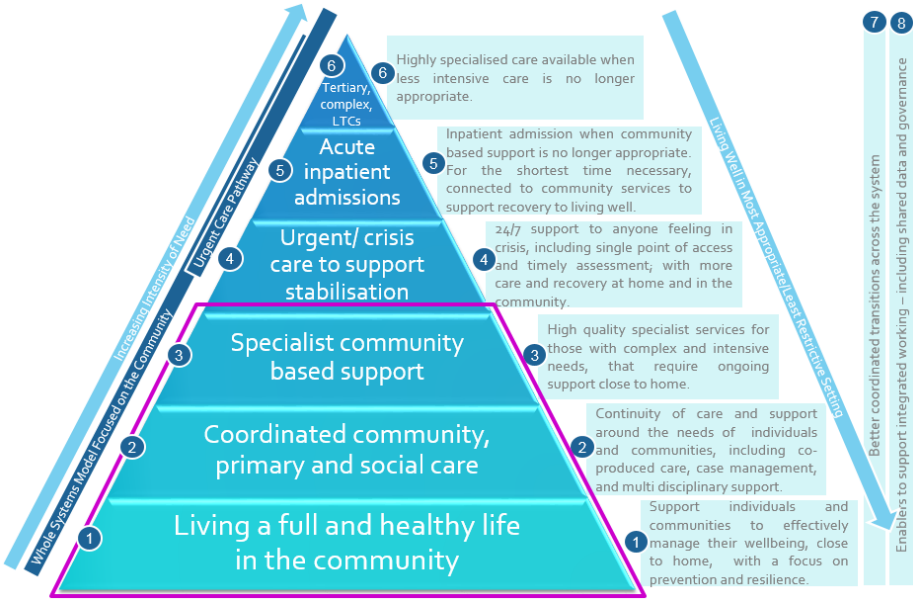
Improving outcomes will be the crucial measure of success of the care closer to home model. Using national and international evidence, we have estimated that some of the outcomes that our health and care closer to home model could potentially deliver are:

- 70% of people at the end of their life will have a care plan to support them to die in their place of choice
- 4% decrease in unplanned pregnancies
- a reduction in alcohol consumption with 10% fewer alcohol-related hospital admissions
- up to 150,000 fewer emergency department attendances
- 63,000 fewer non-elective admissions
- 35,000 fewer outpatient attendances
- 10% reduction in falls-related hospital admissions
- a halving of the numbers of late HIV diagnoses
- 50,000 weight management referrals leading to a reduction in excess weight
- 66% of people with high blood pressure have it diagnosed and controlled
- 55% of people with atrial fibrillation are receiving anti-coagulants
- 69% of people with diabetes have controlled blood glucose.

6.2.3 Mental health

We will develop a 'stepped' model of care (see exhibit 6) supporting people with mental ill health to live well, enabling them to receive care in the least restrictive setting for their needs.[34] We recognise the key role and accountabilities of social care for people with long-standing mental ill health and drawing on this will be central to the success of the stepped model.

Exhibit 6: The mental health 'stepped' model of care



[34] As identified in the Mental Health Taskforce Report

We aim to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds. This will improve overall mental health outcomes across NCL, reduce inequalities for those with mental ill health, enable more people to live well and receive services closer to home and ensure that we are treating both physical and mental ill health equally. We will achieve the key mental health access standards:

- more than 50% of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within 2 weeks of referral
- 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within 6 weeks of referral, with 95% treated within 18 weeks.

Maisie suffers from dementia, and is cared for by her husband Albert. Previously, after falling at home, Maisie was admitted to hospital. Due to the accident and change of surroundings, Maisie was agitated and more confused than normal. In future, the hospital will have Core 24 liasion psychiatry meaning that the liaison team will be able to help the hospital support both Maisie's physical and mental health needs. As Maisie will receive holistic care it will mean that she is ready to be discharged sooner than if only her physical health needs were supported. Maisie's husband Albert will also be supported by the dementia service, allowing him to continue to care for Maisie at home.

Initiatives will cover mental health support for all age groups and include:

- **Improving community resilience:** both for the general population, and those at risk of developing mental ill health or of it becoming more severe. For the general population this includes a promotional drive aimed at increasing basic mental health awareness including self-awareness, normalising mental health needs and reducing stigma. For the at risk population focus will be given to improving access and support through training of non-mental health specialists to recognise mental ill health symptoms, improving service navigation, development of open resources, and provision of individual and group therapies; employment support to help people to maintain and get back into work including through Individual Placement Support[35]; and suicide prevention work to strengthen referral pathways for those in crisis, linked to the local multiagency suicide prevention strategies.[36] This will be delivered in conjunction with other regional and national schemes such as the London digital wellbeing platform. We will continue to build upon current work; for example Barnet CCG and local authority are already working towards a dementia friendly borough by providing lunch clubs, reminiscent therapy and engaging with local shops to raise awareness.
- **Increasing access to primary care mental health services:** ensuring more accessible mental health support is delivered locally within primary care services, developed as part of the CHINs; enabling both physical health and mental health needs to be

[35] Five Year Forward View - 29,000 more people living with mental ill health should be supported to find or stay in work (~725 within NCL)
[36] Five Year Forward View - Reduce suicide by 10%

supported together[37]. We will offer support directly to patients and support to GPs and other professionals; enabling more people to access evidenced based mental health services[38], and more care to be offered through CHINs rather than requiring referral to secondary care mental health services. Services will include increasing the IAPT offer to reach 25% of need.[39]

- **Improving the acute mental health pathway:** building community capacity to enable people to stay well and reduce acute presentations. This includes developing alternatives to admission by strengthening crisis and home treatment teams; reviewing Health Based Place of Safety (HBPoS) provision with the view to reduce the number of units and to have a sector wide provision that meets all requirements; and investing in longer term supported living arrangements to ensure effective discharge, enabling more people to live well in the community.
- **Developing a Female Psychiatric Intensive Care Unit (PICU):** we will ensure local provision of inpatient services to female patients requiring psychiatric intensive care, where currently there is none. This will enable patients to remain close to their communities, with a more streamlined and effective pathway ensuring a focus on recovery.[40]
- **Investing in mental health liaison services:** scaling up 24/7 all-age comprehensive liaison to more wards and Emergency Departments, ensuring that more people in Emergency Departments and on inpatient wards with physical health problems have their mental health needs assessed and supported.
- **CAMHS and perinatal:** initiatives as set out in section 6.2.1.
- **Investing in a dementia friendly NCL:** looking at prevention and early intervention, supporting people to remain at home longer and supporting carers to ensure that we meet national standards around dementia, including a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

An important enabler of a number our initiatives is the redevelopment of both the Barnet, Enfield and Haringey Mental Health Trust St Ann's site and the Camden and Islington Foundation Trust St Pancras site (in conjunction with the proposed relocation of Moorfields Eye Hospital Foundation Trust to the St Pancras site).

The proposed developments of the St Ann's and St Pancras sites would:

- transform the current inadequate acute mental health inpatient environments on both sites
- provide more therapeutic and recovery focussed surroundings for patients and staff
- improve clinical efficiency and greater integration of physical and mental health care
- release estate across the trusts, to enable development of community-based integrated physical and mental health facilities
- develop world class research facilities for mental health and ophthalmology enabling practice to reflect the best evidence

[37] FYFV – at least 280,000 people with severe mental ill health have their physical health needs met (~7,000 within NCL)
[38] Five Year Forward View - more adults with anxiety and depression have access to evidence based psychological therapies (~15,000 within NCL)
[39] Five Year Forward View
[40] Five Year Forward View - inappropriate out of area treatments for acute mental health care should be eliminated in all areas by 2020/21.

- provide land for both private and affordable housing, as well as supported housing for service users and housing for key workers.

6.2.4 Urgent and emergency care[41]

Over the next five years, we will deliver urgent and emergency care (UEC) services that are reliable, work well together and are easily understood. Our services will be consistent and inspire confidence in patients and professionals; supported by the use of an integrated digital care record that can be accessed across organisations. The first 2 years will focus on reducing variation in our services and the latter years will focus on transformation of the urgent and emergency care system, aligning closely with the care closer to home model.

Mary is 83 years old and lives at home with her husband. Mary had a fall at home and injured her ankle. Her husband was unable to help her get up so he called 999 for an ambulance. Mary was taken to the nearest A&E and admitted to hospital, where she is diagnosed with a urinary tract infection (UTI). She was reviewed by the consultant: a plan was put in place for treatment of her UTI and physiotherapy was recommended for her ankle. Over the weekend, Mary's UTI improved, but there was no consultant to review her condition or physiotherapist to provide her care, so Mary was unable to go home. When going to the toilet in the night, Mary fell again and stayed in hospital for a further 2 weeks. Mary became increasingly less mobile and more frail and dependent.

In future when Mary falls, her husband will dial 999, and a paramedic will be dispatched. When the clinical assessment does not suggest any fractures, the crew will access the local directory of services whilst on scene and electronically refer Mary to the Acute Care at Home service with request for a 12 hour response. Mary will then be visited at home by the falls team the next day who will design a package of care for Mary including reablement, allowing Mary to stay at home. The falls team will be able to detect if there is anything unusual about Mary's behaviour, and make a rapid appointment with her GP if they suspect a UTI. Mary will then get the antibiotics she needs to resolve this at an early stage.

Our aims are to:

- **Create a consistent UEC service across NCL:** all UEC services in NCL will meet National and London-wide quality standards[42] which will promote consistency in clinical assessment and the adoption of best practice. Patients will be seen by the most appropriate professional for their needs, which may include directing them to an alternative emergency or urgent care service.
- **Develop and implement a high quality integrated UEC service:** all urgent care services across NCL (including NHS 111, GP out of hours, Urgent Care Centres) will work together to offer consistent care. These services will be renamed 'Integrated

[41] This workstream includes all aspects of Urgent and Emergency Care provision delivered in the acute setting, including support for people to leave hospital. Also in scope is the development of a high quality, integrated urgent care system.
[42] As defined by the NHS E UEC designation process