North Central London Integrated Care System

Enfield Scrutiny Panel

NCL Mental Health Transformation and Childrens & Young Persons Mental Health Crisis Response Update

April 2024

North London Mental Health Partnership

NHS Barnet, Enfield and Haringey Mental Health NHS Trust

Camden and Islington NHS Foundation Trust

ENFIELD Council

Content

North Central London Integrated Care System

North London Mental Health Partnership

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

ENFIELD Council

Executive summary

North Central London Integrated Care System

Context

- The Core Offer programmes for Mental Health services across North Central London (NCL) was established to address the baseline reviews of the service, completed in 2021 with NCL system partners and stakeholders. These established a compelling case for change based on the level of inequity and need against access to services and historic levels of funding. To respond to the case for change**, a core offer was co-produced and agreed which specifies what services should be available to everyone in NCL**.
- The Core Offer programmes will drive improvement in our population health outcomes associated with mental health services. We have developed a **Community and Mental Health Outcomes Framework**, aligned to **NCL's Population Health and Integrated Care Strategy** to track benefits and enable us to target where additional focus is required. NCL ICSs Population health and integrated Care strategy **aligns with Enfield's Health and Wellbeing Strategy**.
- The expected impact on residents' experience of care have been set out. Some of the major areas of transformation is in **improved community mental health services**, where there is increased collaborative working between GPs, community groups and adult social care. This includes increased support for **children transitioning to adult services** and older people, linking together physical health and social drivers with mental health. Another important service launched was the section 136 hub which went live in October 2023 which is delivering the **much needed improvements for people who experience mental health crisis in London**.
- There are **still some challenges** to be addressed, including **tackling autism and ADHD- Attention-Deficit/Hyperactivity Disorder diagnostic waits**, but Mental Health core offer programmes are improving population health through advancing **early intervention and prevention**, improving **coordinating functions**, **integrating physical and mental health** and reducing pressure on acute services so that **more people can be cared for outside of acute hospital settings**.

Purpose of this Scrutiny Panel Paper

1. **Provide an overview and update on the progress of the mental health service reviews to date;**
2. **Outline the benefits that the core offer has brought for Enfield residents in 23/24;**
3. **Set CYP- Children and Young People Crisis responses and transformation**
4. **Highlight some important successes and challenges**
5. **Set out the next steps for mental health core offer implementation in 24/25 and beyond.**

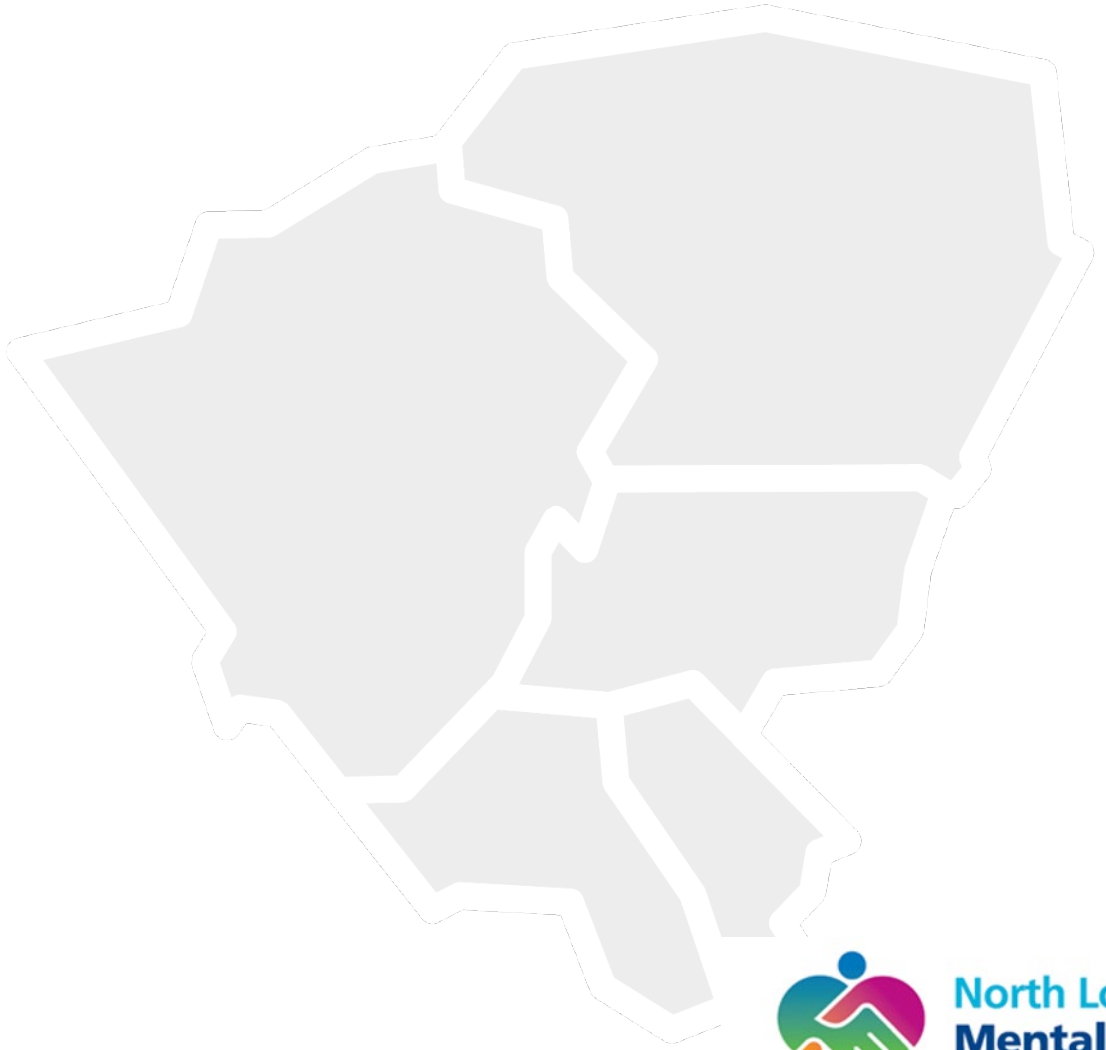
North London Partnership engagement

North Central London Integrated Care System

Follow the video link to watch

Community Transformation Programme Animation (youtube.com)

North Central London Integrated Care System



Recap and overview of the programme

North London Mental Health Partnership

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

ENFIELD Council

There is a strong case for changing community health and mental health services

A case for change for mental health and community services across NCL was developed in March 2021. The case for change centred around inequalities, provision, access, spend and resident feedback. Below, are examples from 2021 that illustrate these issues.

Inequalities

There are stark inequalities in health needs and outcomes across NCL

Compared to the London averages, Enfield has higher proportions of residents who are unemployed, living in temporary accommodation, or have low educational outcomes. Enfield has a 6.9 percentage points gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate for 2022/23 (Public Health Outcomes Framework).
18% of people on the NCL mental health services caseload are Black/Black British, however, Black/Black British people accounted for 27% of NCL mental health inpatient admissions in 2019/20.

Provision

There is significant inequity, variation and gaps in service provision depending on where you live, and this is not aligned to need

20% of children referred to mental health services in Islington wait over 18 weeks from referral to their first contact with services, compared to 1.2% of children in Barnet and 1.6% of children in Camden

Access

The way you access services and how long you wait is also dependent on where you live

Much of our mental health services are geared to a crisis response rather than prevention.

Spend

Different amounts are spent per head in different boroughs, and this does not correlate with need

When compared with the level of need in each borough, we can see that current community health spend does not correlate with need. Enfield has the highest level of need but one of the lowest unweighted spend per capita for community services across NCL.

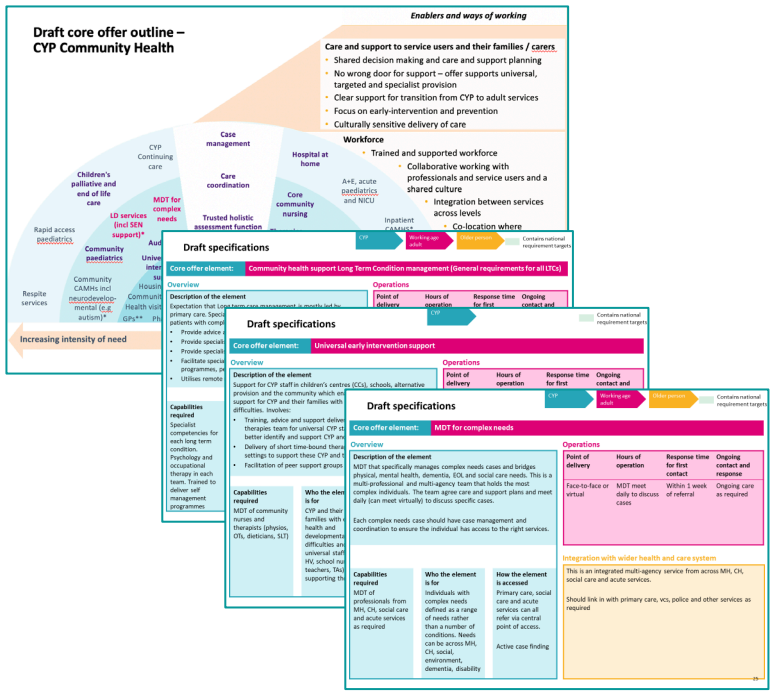
Service user/resident feedback

Services are difficult to navigate, and require servicer users to repeat their stories

Feedback from residents via our Resident Reference Group notes the distress caused by constant repetition of histories and stressed the need for shared records.

To respond to the case for change a core offer was agreed which specifies what services should be available to everyone in NCL

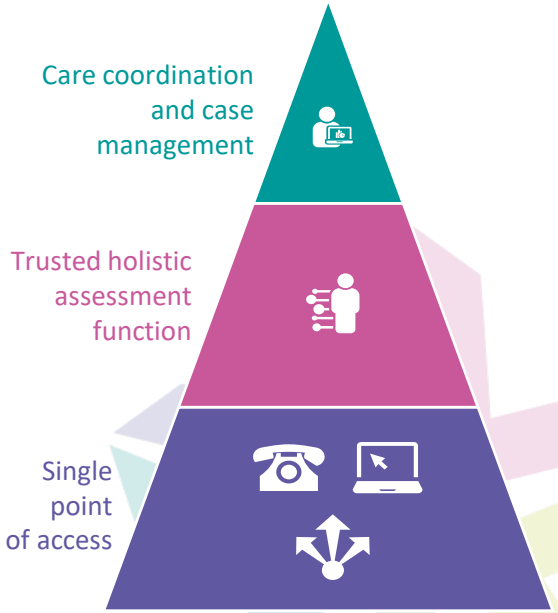
The purpose of the core offer is to address the inconsistency of service provision across NCL by setting out a commitment to the NCL residents of the support they can expect to have access to regardless of their borough of residence.



Each core offer outline provides a description of the care function for the services and lays out access criteria, hours of operation, capabilities required, where the care function should be delivered, waiting times and how the care function should link in with the wider health and care system.

- Operating hours and out of hours provision
- Integration between the care function and other services and agencies
- Access to the care function and criteria
- Response time for first contact and ongoing contacts (in line with national guidance)
- Method of delivery (e.g.. in person, virtual)
- Workforce capabilities required
- Description of the service, including requirements to meet best practice guidance

Each outline also contains a set of coordinating functions which links service providers, ensuring effective communication, preventing duplication of services, identifying gaps in care, and assuring better health outcomes.



Delivering the core offer is a key part of NCL's Population Health and Integrated Care Strategy.

North Central London Integrated Care System

NCL Population Health and Integrated Care Strategy describes our vision for an **integrated** system focused on **prevention, early intervention** and **proactive care**.

We have developed a **Community and Mental Health Outcomes Framework,** aligned to the strategy. This allows us to track outcomes at both an NCL and borough level to measure the impact of implementing the core offer, to understand if we are meeting population needs and to ensure that we are improving equity across North Central London.

How will delivery of the core offer contribute to improving population health for NCL residents?

Population Health and Integrated Care Principle	Equity An environment in which everyone has a fair opportunity to thrive, regardless of who they are.	Population Health Improving the physical and mental health and wellbeing of people within and across a defined population, while reducing health inequalities.	Integrated care Joining up the health and care services required by individuals, to deliver care that meets their needs in a personalised way.	Aligning resources to need Focusing our resources and delivery capabilities in proportion to the degree of need.
Core Offer Deliverable	**Improve access to services and reduce inequalities of access**	**Improve population health outcomes related to Community and MH services**	**Increase integrated working at a system and local level to ensure integrated delivery**	**Establishing a sustainable model of funding**
Description of core offer work	• Work with system partners (local authority, primary care, Trusts and VCSE) to understand gaps • Target resources to the highest areas of need • Develop robust implementation plans	• Develop a core set of metrics for how services contribute to improvement in our NCL population health outcomes (Start Well, Live Well and Age Well) • Embed data collection & review processes • Report outcomes at key governance forums	• System partners are represented at key programme governance forums • Anticipatory care and community mental health teams are delivered in place through multiple agencies working together	• Community investment reduces overall system cost and relieves pressure on our acute hospitals. Providers are also focusing on productivity improvement initiatives • Ensure the Mental Health Investment Standards funding is deployed effectively to increasing the capacity and quality of mental health services to treat more people amidst rising need.

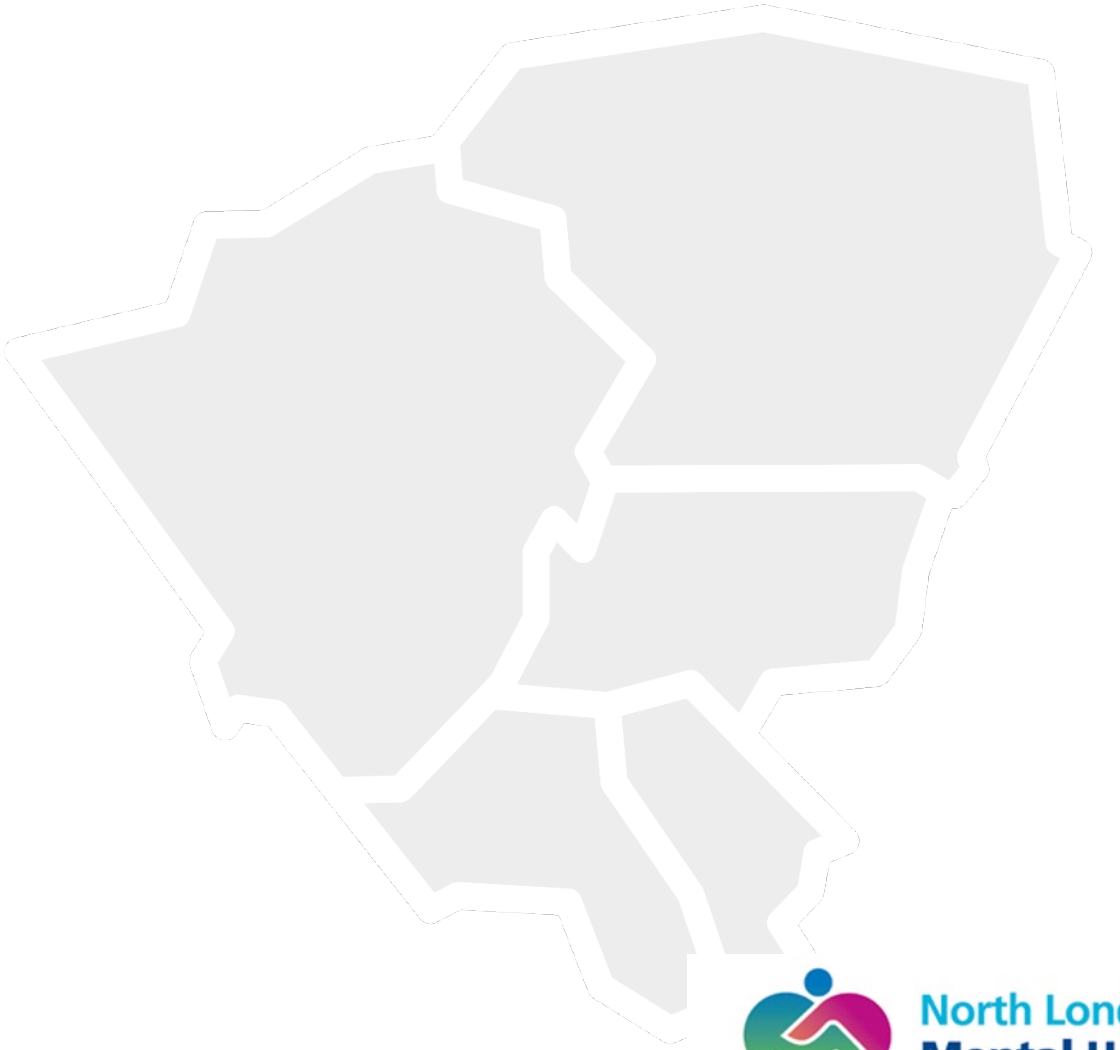
Significant new investment into Mental Health Services has been made since 22/23 via the MHIS- Mental Health Investment Standard and SDF- Service Development Funding

North Central London Integrated Care System

	Programme ambition	22/23	23/24
Mental Health	**In addition to the £c.400m baseline expenditure in 21/22, further planned recurrent investment of £28m has been invested since 22/23 in line with the national MHIS target and SDF allocation for targeted improvement.**	• *CYP recurrent investment* **: £2.6m** • *Adult recurrent investment* : **£8.5m**	• *CYP recurrent investment : **£5.7m*** • *Adult recurrent investment : **£11.1m***
		Recruitment: NHS Mental Health workforce in NCL increased by **+6.4%** in 22/23	*Recruitment*: If all 219 planned net additional posts are recruited to by year end, there will be a further **+4%** increase in the MH workforce this year.

MHIS - Mental Health Investment Standard
SDF - System Development Funding

North Central London Integrated Care System



Transformation in Enfield

- **Public Health**: Mental Health in Enfield summary
- **London Borough of Enfield**: Transformation of Prevention and Wellbeing Services
- **North London Mental Health Partnership:**
  - Children and Young People Mental Health
  - Adult Mental Health

North London Mental Health Partnership

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

ENFIELD Council

Mental Health Public Health in Enfield summary

Mental health conditions can develop due to various reasons. Some of the risk factors to consider include, but are not limited to, employment, poverty, housing, substance misuse, discrimination, access to services, treatment services etc.
(A detailed list can be found in the appendices.)

- Enfield's data shows that the highest number of referrals to mental health services are from the youngest residents: 'under 18s' and '18-24', followed by '65+'.
- We found that most referrals were due to the resident being "in crisis" and this was the top reason for referral across all age groups.

Education and qualifications:
- 47.8% of Enfield pupils (1,850) achieved grades 5 or above in English and Maths GCSE in 2022-23.
- This is below the London average of 50.6%. (source: Explore education statistics)
- Enfield's adults (aged 16+) are more likely than average to hold no formal qualifications. Over one fifth, 22.5% or 57,813 people, are in this group: a higher percentage than in London (16%) and in England (18%) on average. (Source: Census 2021 data.)

Employment
- Enfield's unemployment rate (6.3%) is higher than the London average (4.8%).
- Around 9,500 people aged 16 and over in Enfield were unemployed in the year ending September 2023.

Income and poverty:
- There are 40,780 low-income households in Enfield with 37,917 children. (source: LIFT dashboard, Feb 24)
- 11,366 of these households are living in relative poverty, which impacts 8,571 children.

Housing:
- In February 2024, Enfield had 3,216 households and 3,956 children living in temporary accommodation. (Source: Pentana)
- The lack of secure housing can impact job opportunities and education.

Sexual orientation and gender identity:
- In the 2021 Enfield Census, 5,621 residents declared their sexual orientation to be other than Straight or Heterosexual, representing 2.2% of people aged 16 years and above. This was 1.78% (1,503) for people from minority ethnic groups and 2.39% (4,118) for those not from minority ethnic groups.
- The data also informed us that in Enfield, 2,800 people aged 16 and over declared a gender identity different from the sex they were registered with at birth - representing 1.1% of the total population. This is a higher rate than in London (0.9%) and the national average (0.6%). (Source: Census 2021 data)

Mental health and suicide rates:
- Between 2020 to 2022, the Enfield annual rate of suicides was 4.9 per 100,000 residents.
- This is below the London rate of 6.9 and the England rate of 10.3. (Source: the ONS, Table 2: Number of deaths and age-standardised suicide rates per 100,000 population for local authorities).

Enfield Family Hub provision

North Central London Integrated Care System

- **One-to-one perinatal mental health appointments** are now being offered by the NHS Specialist Perinatal Mental Health Service at both FHs (Family Hub).
- **Start for Life web pages & printed Start for Life brochure have been published.** Mental Health service navigation training for FH staff. Pilot sessions run for Family Hubs staff & partners by the NHS Enfield Talking Therapies. These covered - *Navigating the Enfield NHS Mental Health Services* and one *Supporting Service Users. Spotting signs & symptoms and support in a crisis*. Training will continue as part of team meetings.
- **Parenting programmes** have been run and will continue to be run through the Family Hubs that focus on or contain content around perinatal mental health, mental health, emotional development of children.
- From 1st March we have launched in partnership with the **Solihull Approach** free on-line courses for parents / carers – these are aimed at improving emotional health and wellbeing in parents, children, teenagers, carers, adults and grandparents. Information on the Enfield website at **New development courses for parents and healthcare professionals | Enfield Council**
- The above is complemented by free on-line courses for professional (that contribute to CPD) - **Enfield PRF | Online courses for professionals - Solihull Approach | Parenting (solihullapproachparenting.com)**

London Borough of Enfield transformation of Prevention and Wellbeing services.

North Central London Integrated Care System

Enfield's VCSE - Voluntary , community and Social Enterprise Sector has a diverse and well established Voluntary and Community Sector, accommodating over 650 voluntary organisations, community groups, faith groups, sports clubs, and uniformed groups across the borough. The Council recognises the unique position of local voluntary and community groups in supporting residents, and the value of this sector in contributing to the capacity and cohesion of the community.
In 2017/8 the Health Housing and Adult Social Care (HHASC) Service Development Team commissioned a programme of preventative support in Enfield. This was a central part of Council's response to the Care Act 2014 and the commitment to improve preventative and early intervention services and ensure the changing needs of the Enfield population are met.

Six Outcome contracts were procured to support the Prevention and Early Intervention priorities of ASC (Adult Social Care), which are due to expire 30 November 2024.

Outcome 1- Enfield Carers Centre for the delivery of the contract *Helping People Continue Caring Service* -
Outcome 2 - Age UK Enfield for the delivery of the contract *Supporting vulnerable adults to remain living healthily and independently in the community including avoiding crises*
Outcome 3 – Enfield Voluntary Action for the delivery of the contract *Supporting people to improve their health and well-being and improving self-management.*
Outcome 4 - Enfield Disability Action. (EDA) for the delivery of the contract *Helping Vulnerable Adults to Have a Voice*
Outcome 5 - Alpha Care Ltd for the delivery of contract *People recover from illness, safe and appropriate discharge from hospital*
Outcome 6 - Community Barnet for the delivery of the contract *Increased and improved information provision*

Through the future commissioning of Prevention & Early Intervention Services for 24/25 , the Council aims to facilitate positive outcomes, consistent with the Adult Social Care (ASC) Supporting Independence Strategy and the White Paper (People at the Heart of Care). Engagement events have taken place; including briefings to and feedback from all the Care Partnership Boards. People living in the borough of Enfield will continue to have choice, control, and receive support to live independent and healthy lives.

London Borough of Enfield Transformation of employment services

North Central London Integrated Care System

Individual Placement Support (IPS)

IPS offers intensive, individually tailored support to help people to choose and find the right job, with ongoing support for the employer and employee to help ensure the person keeps their job.

Using a personalised and strength-based approach to support people to find a job of their choosing. IPS aims to help people find paid jobs within just weeks of being referred to the service, then it continues to work with both employer and employee to sustain the job placement for as long as possible, or to help the client into a different job.

Four years of joint funding from Council, BEH-MHT (Barnet, Enfield and Haringey NHS Mental Health Trust), MHEP (Mental Health and Employment Partnership) and ICB- Integrated Care Board ended on the 31st March 2024. Performance data for the contract is shown below:

Enfield IPS	Total for contract
Referrals	707
Engagements	442
Number of people entering work	171
Number of paid employment outcomes (Multiple job starts for one person)	204
13 weeks sustained employment	116

From 01/04/2024 the ICB and Council will support each other to deliver a further years contract, allowing time for the ICB to formalise an NCL approach to MH IPS funding.

Enfield is separately working with Haringey to deliver an IPS Primary Care model which includes supporting MH clients in preparation for future changes to the Government's Universal Offer approach.

North Central London Integrated Care System

Children and Young Peoples Mental Health Services Overview

CYPMHS Transformation is driven by a commitment to improve access, responsiveness, and quality of care for children and young people facing mental health challenges.

Through innovative service models and collaborative partnerships, we ensure young people receive the support they need to thrive.

In times of crisis, we ensure timely and effective interventions to reduce harm and promote recovery timely

These crisis services are seamlessly integrated within our broader transformation, contributing to a holistic approach to mental health care for children and young people.

Overview of the 23/24 Core Offer Priorities and Impact: *Children and Young People Mental Health*

The priority investment areas for the 23/24 Children and Young People Mental Health Core Offer are outlined in the table below. Investment in mental health services, as a result of the core offer, has improved the health and experience of residents in 23/24.

**Hypothetical resident case study*

Freya* is 14-years-old. She appears withdrawn and tired in class. She has stopped playing in the band she was formerly a member of. She lives in cramped accommodation with not much money at home, her parents are separating, and she is being bullied at school. They are grateful to be referred to the Early Years team who offer them strategies and home visits.

Freya's school has a mental health support team (MHST) with a range of individual, group and parent education offers on subjects including bullying and family issues, designed to encourage resilience in CYP and parents. Freya's teachers access advice from the team about how they might help given the challenges. Freya's parents each joined one of the MHST parent wellbeing coffee mornings. A referral to the central point of access facilitated access to suitable local offers for Freya and her parents based on their need at the time. Freya is able to access digital, voluntary sector and local authority offers designed to help her navigate her challenges and family circumstances. If her emotional wellbeing is impacted further, Freya can be assessed within a few weeks for a more specialist community CYP MH intervention, and if accepted receive evidence based professional counselling or a CBT based individual or group offer.

If Freya experiences a mental health crisis, professionals e.g. school staff, her GP team, and her parents understand what crisis support is available, including 111 press 2. If the need arises, Freya can be referred for intensive support from the Home Treatment Team as a preference to inpatient admission, to enable a faster recovery with better outcomes.

CORE OFFER	IMPACT OF INVESTMENT	WHAT THIS MEANS FOR PEOPLE LIKE FREYA
Home Treatment Team	Significant reduction in the need for mental health inpatient admissions	Hospital at home support avoids unnecessary disruption of life, education and relationships
School Support Teams	Prevention and early support for mild to moderate mental health that takes a whole school approach	Understand their emotions, resilience in the face of hardships, and empowered to ask for help
Community Transformation	Increased access, reduced waits, and reduced variation in CAMHS provision	Improved access, experience and outcomes for CYP and families across all NCL boroughs
Central point of access	Integrated front door identifies need and facilitates effective social, emotional and mental health (SEMH) response(s)	Advice, signposting and triage of need across the full range of social, emotional and mental health support
Early years	Multi-agency CYP/family assessments for children aged 0-5 years and co-developed intervention plans	Parents / young children receive wrap around support from the right agencies at the right time

Transformation Updates

North Central London Integrated Care System

Single Point of Access: Team has been established where all referrals are received with brief interventions offered within the team where appropriate with the aim to see 85% of CYP referred within 4 weeks.

24/7 Crisis Response: Children and young People have access to 24/7 crisis service through our crisis telephone line, Crisis hubs and A&E liaison services.

Home Treatment Team has been established to work with community team, young people and families to prevent hospital admissions. They also work closely with young people admitted with the aim of reducing the length of stay in hospitals

Day Hospital : A day hospital has been established which provides an alternative to admissions and works closely with the home treatment team

Transformation Updates

North Central London Integrated Care System

Mental health Support in Schools deliver three core functions: (1) Evidence-based interventions for mild to moderate mental health and emotional wellbeing concerns (e.g. anxiety and low mood) (2) Support to senior mental health leads in schools to develop a whole-school approach to mental health and wellbeing (3) Timely advice and signposting to schools, to ensure children and young people receive the right support at the right time, and to support effective collaboration between education, specialist CAMHS, and other agencies. Currently delivering in 67 out of 97 schools with an expansion to all schools by 2026

Increasing Access: We are working with underserved communities who do not access services due to stigma to destigmatise mental health/promote access. We are starting a project with Enfield Jubilee church in May 24 to do seminars to debunk mental health myths in the Afro Caribbean congregation. From May 2024, walk-in clinics are opening in Enfield to allow young people and their families to self-refer to Children's & Young Peoples Mental Health Services.

0-5 years services: Multi-agency 0-5 years CYP/family assessments and co-developed intervention plans, combined with the establishment of links across Family Hubs, all of which is aligned with the early years offer.

Involving young people and families in their care and service development, with the Enfield Co-production work being Highly Commended at HSJ awards. A youth board has been established and is supporting the re-design of the crisis pathway redesign, as well as developing the group programme for the 18-25 transitions pathway.

CYPMHS Journey

North Central London Integrated Care System

Young Person In Mental Health Crisis

Young Person struggling with mental health but not in Crisis

Presents at A&E
If CYP needs medical treatment, Liaison clinicians available to CYP for assessments

Calls Crisis Line
CYP call crisis line and if medical emergency advice to go to A&E. If non medical emergency signpost to other Crisis Services

Crisis HUB
CYP seen by CAMHS clinician

GP
CYP goes to see GP who may refer to Single point of Access for an assessment

Mental Health Support in Schools

Walk in Clinic
CYP walk in to a clinic and seen by clinician

Beacon Centre Inpatient Ward admission for further assessment and treatment

Home Treatment Team
CYP receives intensive support at home

Day Hospital
Alternative to inpatient admission

Single Point Of Access
Triages all referrals. Signpost as appropriate, offer advice, offer initial assessment and brief intervention up to 6 sessions . If CYP needs further intervention and specialist treatment they are transferred to the core teams

Neurodevelopmental Assessments e.g ASD/ADHD

Family Therapy, Psychotherapy, Psychology

CORE Teams
Clinical Pathways
Choice of Face to Face or Virtual

Psychiatry Review

Groups and psychoeducation

DISCHARGE

North London Mental Health Partnership

THRIVE: Getting Advice
BEH SPA 'No Wrong Front Door'

Barnet, Enfield and Haringey Mental Health NHS Trust

Camden and Islington NHS Foundation Trust

Barnet Borough	Enfield Borough	Haringey Borough
Integrated Front Door 24/25	Integrated Front Door 24/25	Integrated front door 24/25

THRIVE: Getting Advice
BEH SPA ' No Wrong Front Door'

24/7 functionality SPA linked to Crisis Line and NHS 111.
Triage, Intake, clinical assessment undertaken quickly to identify needs early to include 1st assessment, Extended assessment up to 3 sessions and brief intervention. Specialist ND triage.
Advice, guidance and support for CYP, their families and other professionals working with CYP.
On line referral form, integrated with EMIS and with IA technology to support streaming.
Signposting to service according to Thrive needs based grouping. Outcomes scores and clear SOP's to inform decision making.

Getting Help	Getting more Help	Getting Risk Support/	Urgent and Emergency Care	Tri Borough/NCL wide
Pathways in all 3 divisions	Pathways in all 3 divisions	Enhanced Care	In patient	ND Assessment pathway

What is new ?
Single point of access for all divisions with one contact number aligned to crisis number. Digital referral form, CAMHS Triage team carrying out assessments/ Triage/signposting supporting referrers and self referral. Principal of no wrong front door. Patient facing service delivering assessment and brief intervention. Centralised collation of outcome measures and scoring used to determine pathways in conjunction with Shared Decision Making. New walk in clinics. Choose and Book.

North London Mental Health Partnership

Barnet, Enfield and Haringey Mental Health NHS Trust

Camden and Islington NHS Foundation Trust

THE YOUTH BOARD

The youth board, was formed in December 2023 and comprises 16–25-year-olds with lived experience.

MEMBERS

The board has nine members from across Barnet, Enfield and Haringey who have lived experience

ROLE OF MEMBERS ON THE BOARD

Providing feedback to CYP services based on personal experiences
Sharing reflections and priorities for mental health services
Advocating for the voices of young people in meetings, giving feedback on new initiatives,
Co-designing services with NHS professionals, participating in research initiatives.

CURRENT COPRODUCTION ACTIVITIES

Enfield 18-25 Pathway Focus groups to review the pathway
Co creating welcome packs for new staff members at the Beacon centre
Working with NCL to review and redesign the crisis pathway
Working with BEH in co designing The NDS pathway
Barnet coproduction research and focus groups
Co designing and delivering search training for staff at the Beacon Centre

Children and Young People's Mental Health Services: Next Steps, 24/25 Priorities

North Central London Integrated Care System

Addressing health Inequalities

There are stark inequalities in health needs and outcomes across NCL

Implementing targeted interventions and work with underserved communities to increase access and provide early interventions.

Neurodevelopmental Service Pathway

There is significant inequity, variation and gaps in service provision depending on where you live, and this is not aligned to need

Work with partner's in the NCL to develop a single pathway. Expand Staff expertise and improve access to assessments and family support

Increasing Access

The way you access services and how long you wait is also dependent on where you live

Establishing additional access points via walk in clinics in libraries, community centres and GP surgeries. Increasing Digital offer and extended hours for appointments

Reducing Waiting Times

Different amounts are spent per head in different boroughs, and this does not correlate with need

Through the single point of access, implement a streamlined effective triage systems to meet the new national 4 week wait standard. Increase workforce with new Investment to offer more appointments including out of hours and weekends.

Overview of the 23/24 Core Offer Priorities and Impact: *Adult Mental Health*

The priority investment areas for the 23/24 Adult Mental Health Core Offer are outlined in the table below. Investment in mental health services, as a result of the core offer, has improved the health and experience of residents in 23/24.

**Hypothetical resident case study*

Mel* is a 55-year-old and lives in North London. She lost both of her parents to Covid-19 in quick succession. She has been through periods where she feels extremely anxious and has flashback. Mel's mental health is impacting her ability to work and means she sometimes needs to get urgent help.

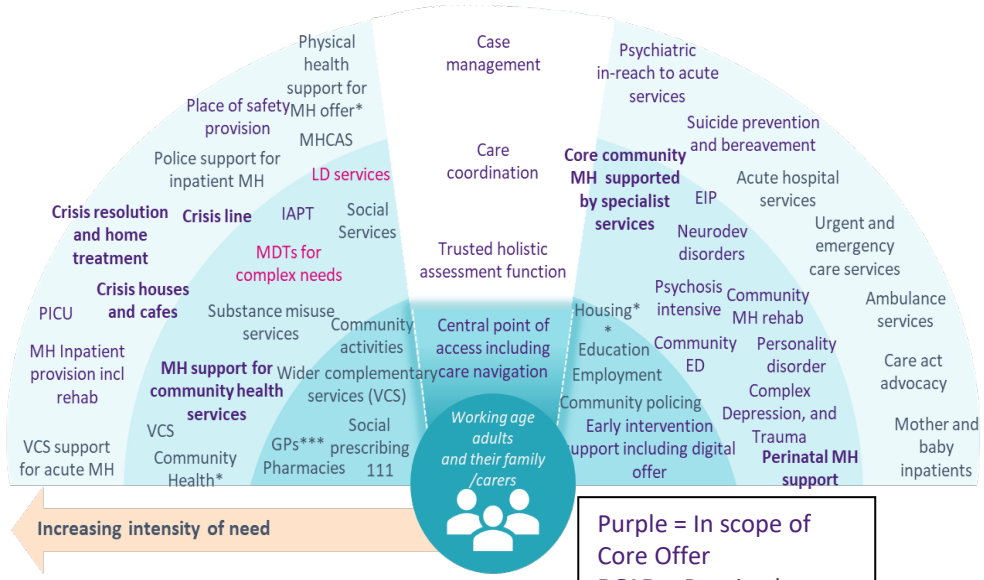
Due to new investment, there is more wrap-around support when she feels she is at breaking point and needs urgent help. She can walk into her local crisis café, which is now open for longer hours, and be provided with a safe, supportive space to manage the crisis. If appropriate for her needs, she can also be admitted to a crisis house which will provide therapeutic support and 24-hour intensive support in a residential setting. In future, with the new Think111*2, her partner will also be able to call and be signposted to support, to make sure Mel has access to the urgent support she needs.

CORE OFFER	IMPACT OF INVESTMENT	WHAT THIS MEANS FOR PEOPLE LIKE MEL
Community Transformation	Reduction in waiting times for community mental health services	Access to timely treatment closer to where people live that is joined up with adult social care and the voluntary and community sector, providing people with holistic support
THINK 111 and Crisis Lines	All age crisis hub will respond to all 111 (2) mental health calls for the 5 Boroughs in the NCL Partnership	Easier and quicker for people of all ages, their families and carers to receive urgent mental health support
Perinatal	Expansion of specialist service - new staff recruited into the service and additional clinical and group space secured	Pregnant and post-natal people with moderate to severe mental health needs can access the specialist input for an extended period of pre-conception to 24 months after birth
Crisis	Increased investment in all crisis cafes across NCL so they can open for longer and see more peoples	Access to immediate help that is a safe alternative to emergency departments in a time of crisis. Accessible to people outside of core working hours including weekends
Length of stay in hospital	The number of days people need to spend in hospital is reducing	Recovery time is quicker with the right support when in hospital. Fewer people will need to go out of area for a hospital admission

How Paul's access and experience of care is different because of the new MH Core Community Teams

North Central London Integrated Care System

**Hypothetical resident case study*



Purple = In scope of Core Offer
BOLD = Received investment in 23/24

Paul* is a 28-year-old male who had been referred to the Early Intervention Service when he was just 19 years old. He has a serious mental illness and has been in and out of services for the last 8 years including several spells in an acute mental health hospital. Paul left school with no qualifications and has very few friendships, he has been estranged from his family and is very isolated.

Due to new investment and the development of the Core Community teams Paul has been able to address some of the social issues which have kept him in poor mental health. While being cared for clinically by his psychiatrist and care coordinator he has also engaged with the voluntary sector element of the service and has joined a few social activities including a gardening club. Paul's self-confidence has grown, and he feels ready to think about work. He is now in contact with the employment support worker in the Core team who is helping him to develop his skills and find paid employment.

For the first time in many years Paul is adhering to his medication and has not had a hospital admission for over 12 months. His support worker his helping him to re-connect with his family

Enfield Adult Mental Health:
Stepped care approach and how we integrate Enfield Services

North Central London Integrated Care System

SINGLE POINT OF ACCESS

Getting Advice

Those who need signposting

Mind in Enfield - IAPT-Enable -Carer Centre
IPS Employment/DWP -Recovery College
Age Concern- Wellbeing Connect – Precious Moments
BAME advocacy – Council commissioned VCSE – CAB – GP Social Prescribers – Cost of Living Advice Hub – LBE Access Pathway – MyLife Enfield Self Management Health and Care website

Wellbeing & Prevention

Those who need solution focused support

IPS/Employment, Mind in Enfield, BEH-Step 2 IAPT, Crisis Café, Enable, BEH Step & Thrive, Carer Centre, Recovery College; ARRS - Advanced Clinical Practitioner Primary Care/GP Practices;- Emotional and wellbeing Support workers / Peer support workers - MH Housing Advisors - IAPT Step 2 &3 (BEH-Mind)

Getting more help

Those who need more extensive support and specialist interventions

BEH – ADHD - BEH- Personality Disorder- VCS – BEH- Complex Emotional Needs -BEH-EIP –BEH Community rehabilitation -BEH -Older Person community teams. BAME complex Care Rehabilitation advocacy / IMHA – NCL ICB and LBE Providers Framework for joint packages of care - Penrose Community Rehabilitation supported accommodation provider – Dual diagnosis– Inpatient Complex care pathway

Getting help

Those who need to be in contact with CORE teams interventions

SMI QOF register; Federation SMI health check core offer - BEH Wellbeing team – IPS for SMI.BEH Integrated Core Teams – MH IDTs for P1 MH enablement , P2 Intermediate Care beds.– Saheli – Nasfiyat – Alpha Care – DAAT

ENFIELD COMMUNITY INTEGRATED FRONT DOOR

North Central London Integrated Care System

New Referral
Core I Pathway Referrals
via GP/IAPT/LD

SPA Team
Single Point of Access

DIALOG+

Existing Referral
Core Psychological Pathway Referrals
via NHS Talking Therapies/MDT/ACUTE

STEP 1
Getting Advice & Prevention
Those who need advice and signposting

Triage

SIGNPOST

Community Engagement Team
Universal offer
Education & Awareness
Wellbeing Workshops

1st & 2nd Target Contacts
Inc Groups; Webinars

STEP 2
Wellbeing & & Prevention
Those who need solution focused support

Step & Thrive Mild-Moderate
Step & Thrive Intensive Offer
VCS, IPS, other partners

DIALOG+

Community Engagement Team
Community Group Programme
MH & physical interventions
Co-produced Groups

Target Contacts
Inc Groups1:1,
TEL VIDEO,
Webinars

STEP 3
Getting Help
Those who need to be in contact with CORE Teams interventions

ARRS Primary Care interventions
Core Teams

DIALOG+

North & South
CORE Teams &
Psychological Pathways

Target Contacts
Inc TEL VIDEO

STEP 4
Getting More Help
Those who need more extensive support and specialist interventions

Core Teams
Other Intensive specialist interventions

PATHWAYS

CAD | 18-25 | Psychosis | Systemic | C-PTSD | PD

Target Contacts
Inc TEL VIDEO

Enfield Community Mental Health Integrated Pathways

Referrals
4 weeks wait from referral to "needs-base intervention

Incoming professional and outside agencies

Enfield Front Door Services

Multidisciplinary teams

- Empowering service users and carers experience and involvement (co-production).
- Minimising waiting times & waiting lists in the specialist services.
- Focusing on the care and prevention of deteriorating patient
- Reducing A&E and hospital admissions
- Focusing on prevention and self-care.
- Promoting engagement , inclusion and participation.

Single Point of Access integrated to LBE

North Central London Integrated Care System

Doctors | Nurse | Social Worker

Enfield Community Engagement Team - [NEW SERVICE]: VCSE, IPS, STEP & THRIVE

Nurse | Voluntary Community Service: Peer Workers Community Support workers | Psychologist | Graduate Mental Health Workers | Assistant Psychologist | Occupational Therapist | Individual Placement & Support Employment

Enfield Community Mental Health Core Teams - North and South Localities
EIS- Early Intervention Service, CRT Community rehabilitation teams

VCSE -Voluntary Community Service Peer workers & Community Engagement workers | Nurse | Psychology and therapists | Social Worker | Pharmacists | Individual Placement & Support Employment | Doctor

ARRS – Additional Role Reimbursement Scheme - Integrated to Primary Care

Nurse
Non-medical nurse prescribers

ACP – Mental Health Advanced Clinical Practitioners

Enfield Community Mental Health & Wellbeing Forum

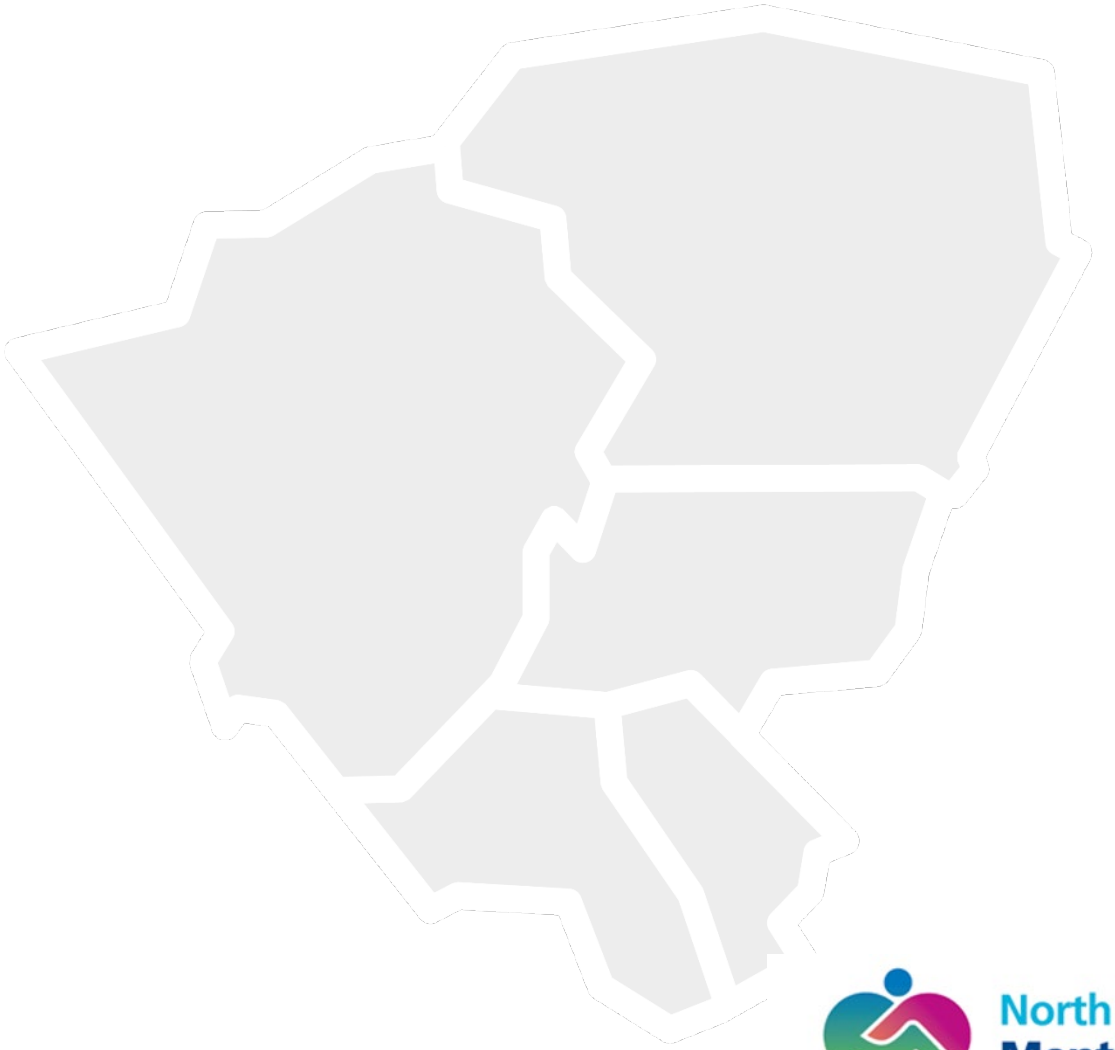
22nd February 2024 at Green Towers - Edmonton- Enfield

- **12** open invite co-production meetings over 3 months
- **35** Enfield Community Teams & Organisations took part
- **331** people attended the event
- **14** workshops delivered; **168** people took part
- **70** Physical health checks
- **14** EBE's - Experts by Experience expressed interest in
- joining the Partnership Involvement Register

To find out more about the event and read quotes from Service Users, Carers, our VCSE Manager, and watch short videos from some of the organisations who were there on the day, please visit our website@

https://t.ly/4sRRc'

North Central London Integrated Care System



2024/25 Vision

North London Mental Health Partnership

NHS Barnet, Enfield and Haringey Mental Health NHS Trust

Camden and Islington NHS Foundation Trust

ENFIELD Council

NCL Vision for Mental Health Services, including key priorities in 24/25

There are opportunities to integrate tiers of service delivery, including within CAMHS, and strengthen integration with physical health/social care

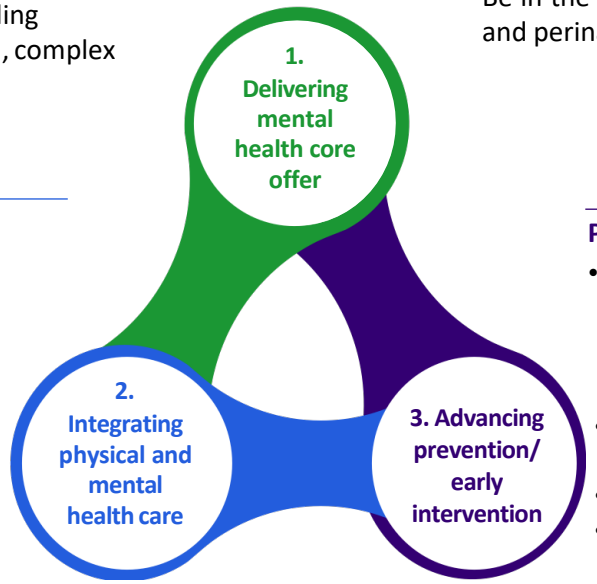
1. DELIVERING MENTAL HEALTH CORE OFFER

Inpatient Mental Health Services

- **New MH inpatient commissioning framework**
- **Reviewing configuration of inpatient services** to optimise length of stay, flow and sustainable staffing levels for rising demand for inpatient care, and deliver the Strathdee Review recommendations while accommodating impact of further policy initiatives (RCRP)
- Shared focus with partners on **reducing long lengths of stay** (including improving suitable alternative services to meet people's needs, e.g., complex rehab and intensive supported accommodation)

Community-based service access, wait times and quality improvement

- **Streamlining and simplifying pathways** for improved **CYP** access, services/system navigation, clinical effectiveness.
- **Improvement in waiting times**; new standards in development for Urgent and Emergency Care and all age community mental health;
- Be in the top quartile nationally for **improved outcomes recording** for CYP, community and perinatal mental health services.



2. INTEGRATING PHYSICAL AND MENTAL HEALTH CARE

Longer Lives

- **Optimise through local implementation of NCL 'Longer Lives' at place**: Improving life expectancy, reducing ill-health and advancing equalities for adults with severe mental illness, including through annual health checks

Population segmentation and risk stratification across both physical and mental health

- Exploring common mental illness or severe mental illness (SMI) as entry conditions to LTC LCS*
- Including a mental health component in NCL's population segmentation

Mental Health Core Offer for homeless people

- Developing our NCL **Core Offer for homeless people** on basis of NICE guidelines and building on the learnings from the pilot in Camden - providing integrated health and social care services for people experiencing homelessness

3. ADVANCING PREVENTION AND EARLY INTERVENTION

Prevention Concordat for Better Mental Health

- Committing to the **Prevention Concordat for Better Mental Health** to promote evidence-based planning and commissioning, and for advancing mental health equalities

Promote public awareness

- Developing a **delivery plan** for enhancing and implementing the early prevention and intervention offer for working age adults and older adults
- Increase public understanding of NCL direct access MH services
- Creating **public comms resources** to increase mental health literacy, support self-help and self-referral to direct access services

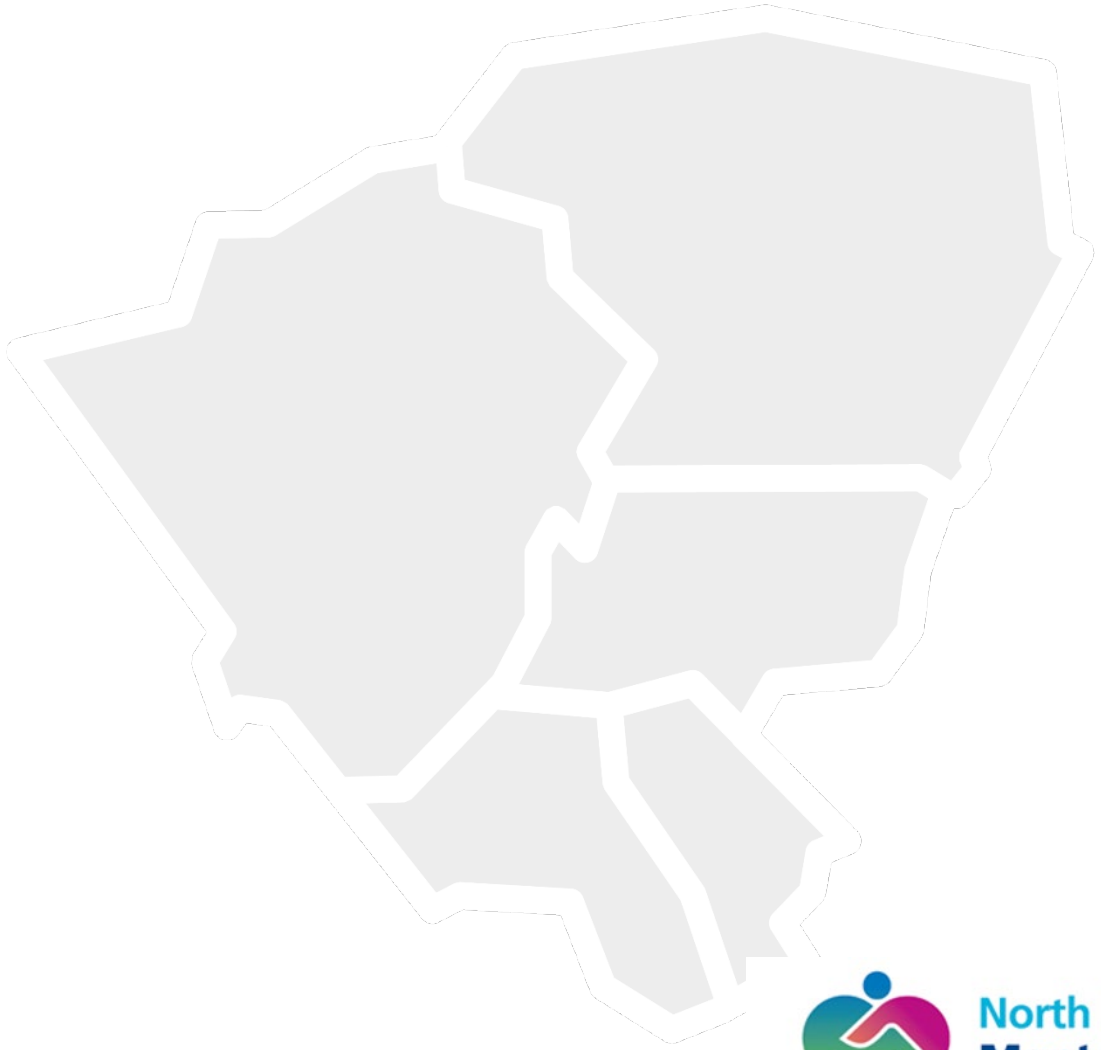
Suicide prevention

- Reducing deaths by suicide through **applying (at scale) best and good practice**[+] and finding different and unique solutions where necessary

**Long Term Conditions Locally Commissioned Service*

[+]NCISH (National Confidential Enquiry into Suicide and Safety in Mental Health) and IMV (Integrated Motivational – Volitional) model for suicidal behaviour

North Central London Integrated Care System



Appendix

North London Mental Health Partnership

NHS Barnet, Enfield and Haringey Mental Health NHS Trust

Camden and Islington NHS Foundation Trust

ENFIELD Council

Section 136 Hub (1/2)

North Central London Integrated Care System

The s136 hub has been developed to strengthen our NCL Crisis pathway. It is already demonstrating a positive impact on residents, as a result of partners across the system (police and healthcare staff) working more closely together to support people in a mental health crisis.

Section 136

Section 136 is part of the Mental Health Act that gives police emergency powers. Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. At the place of safety, the person's mental health will be assessed, and care will be provided. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern.

Section 136 Hub Context & Aims

In 2017, a single phone line was established for the Metropolitan Police Service (MPS) to receive mental health advice and connect with the nearest Health Based Place of Safety (HBPoS). However, this solution did not always function as intended.

1. HBPoS staff did not always answer calls in a timely manner
2. Mental Health professionals were not always available to give advice
3. Many patients were conveyed by officers to a place of safety (whether ED or HBPoS) which many not have been the most appropriate setting.
4. Both patients and officers experienced lengthy waiting times at various stages of the pathway
5. While waiting, some patients were detained in MPS vehicle

All of the above led to a poor experience for the individuals with thousands of frontline policing hours lost.

New Section 136 Model

On the 30th October, a north and south s136 hub was launched serving the whole population of London. The north hub is based at St Annes hospital staffed by a team of clinicians operating 24/7. It supports officers from all of London's principal police forces in managing individuals who are detained or at risk of being detained under section 136 of the Mental Health Act. The developed service is tasked to:

1. Execute a comprehensive triage and assessment drawing on all accessible records.
2. Ascertain the nearest accessible Health Based Place of Safety (HBPoS) for those already under detention.
3. Direct individuals to an appropriate service after clinical assessment, which could be the nearest HBPoS or, if suitable, an alternative care setting.

The objective is to facilitate prompt, specialised evaluation and care, thus reducing the impact on A&E (Accident & Emergency) departments and advancing outcomes for patients.

So far, the programme has improved communication with officers by issuing Post Event Messages, and by providing access to more robust service performance data to inform service and quality improvement initiatives.

Section 136 Hub (2/2)

North Central London Integrated Care System

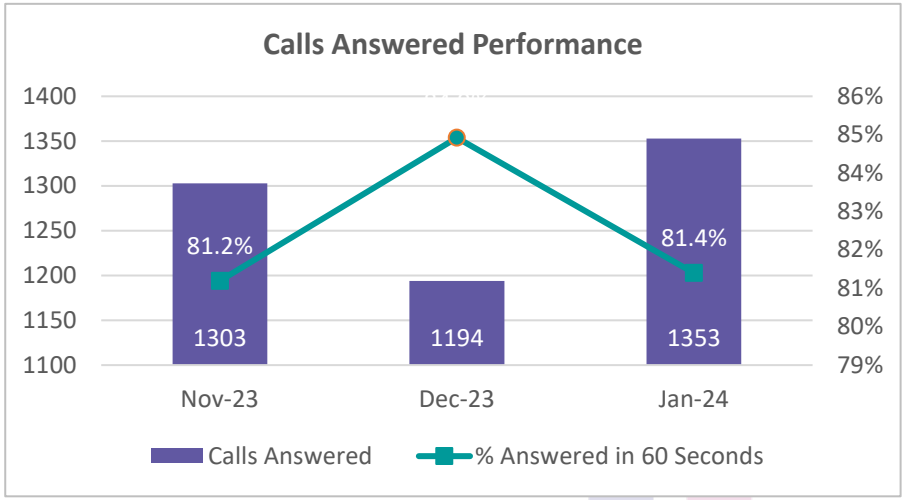
The Impact

Implementation of the hub has led to optimised utilisation; **expedited patient access to appropriate care;** a significant **decrease in the time police spend with patients**, resulting in an **enhanced experience** for those most vulnerable.

Early data is showing that this service is delivering the much-needed improvements for people who experience mental health crisis in London

The following data covers the period 30th October 23 – 31st January 2024 across London. The baseline is the weekly average from the previous 3 months, 31st July 2023 to 29th October 2023 (random dates to capture full weeks).

296 total average calls made weekly to the pan-London s.136 Hub	A **28% reduction** in the total number of patients detained under section (pan-London)
A **101% increase** above the forecasted 147 calls to the service each week	An average of **62%** of patients who were not under section prior to hub contact were referred to alternative pathways
Police contact the service for an average of **139 unique individuals** per week	**56% reduction** in the number of patients presenting at the Emergency Department
59% of individuals the hub was contacted about were already placed on a section by the calling officer	An average **37% reduction** in time spent by police managing patients at risk of detention under section (7 vs. 11 hrs)



The Next Phase

The next phase of this programme will see **increased work with police colleagues** to ensure officers are contacting the centralised hub before application of a section to further **reduce the numbers of individuals detained.** The month-by-month data is showing that police officers are increasingly calling the hub before a s136 is applied.

Risk factors for Mental Health

North Central London Integrated Care System

- The state of a person's mental health is heavily influenced by social determinants, which are the conditions in which people are born, grow, live, work, and age.
- In the table to the right, we have split these into 3 groups: individual characteristics, social circumstances and environmental factors.
- These factors, such as household income, education, employment, housing, social support, culture, discrimination, and access to basic services, all play a role in people's mental health.
- Social determinants can either promote or hinder mental health, depending on whether they provide people with opportunities, resources, and protection, or expose them to stress, adversity, and marginalisation.

	Adverse Factors	Protective Factors
Individual characteristics	Low self esteem	Self esteem/ confidence
	Cognitive/ emotional immaturity	
	Difficulties in communicating	Communication skills
	Illness	Good health
	Disability / lack of independence	Independence
	Substance misuse/ addiction	Good wellbeing
Social circumstances	Social isolation	Social support
	Adverse childhood experiences/ neglect/ family conflict	Positive family interaction
	Homelessness	Security in housing
	Poverty	Economic security
	Low educational attainment	Educational achievement
	Unemployment/ underemployment	Good quality employment
Environmental factors	Access to basic services	Equality of access
	Discrimination	Fair social treatment
	Inequality	Social/ gender equality
	Lack of safety	Physical security & safety

LIST OF ACRONYMS

North Central London Integrated Care System

ACRONYMS	Description
ASC	**Adult Social Care**
A&E	**Accident and Emergency**
ADHD	**Attention-Deficit/Hyperactivity Disorder**
BEH	**Barnet, Enfield and Haringey Mental Health NHS Trust**
CYP	**Children and Young People**
CYPMHS	**Children and Young People's Mental Health Service**
EDA	**Enfield Disability Action**
FH	**Family Hub**
HBPoS	**Health Based Place of Safety**
HHAS	**Health, Housing and Adult Social Care**
HTT	**Home Treatment Team**

ACRONYMS	Description
ICB	**Integrated Care Board**
IPS	**Individual Placement Support**
LA	**Local Authority**
LBE	**London Borough of Enfield**
LCS	**Locally Commissioned Service**
LTC	**Long Term Condition**
MH	**Mental Health**
MHEP	**Mental Health and Employment Partnership**
MHIS	**Mental Health Investment Standard**
NCL	**North Central London**
PTSD	**Post Traumatic Stress Disorder**

ACRONYMS	Description
Q (1,2,3,4)	**Year Financial Quarter**
SDF	**Service Development Funding**
VCSE	**Voluntary, Community and Social Enterprise Sector**
WIC	**Walk in Clinic**