

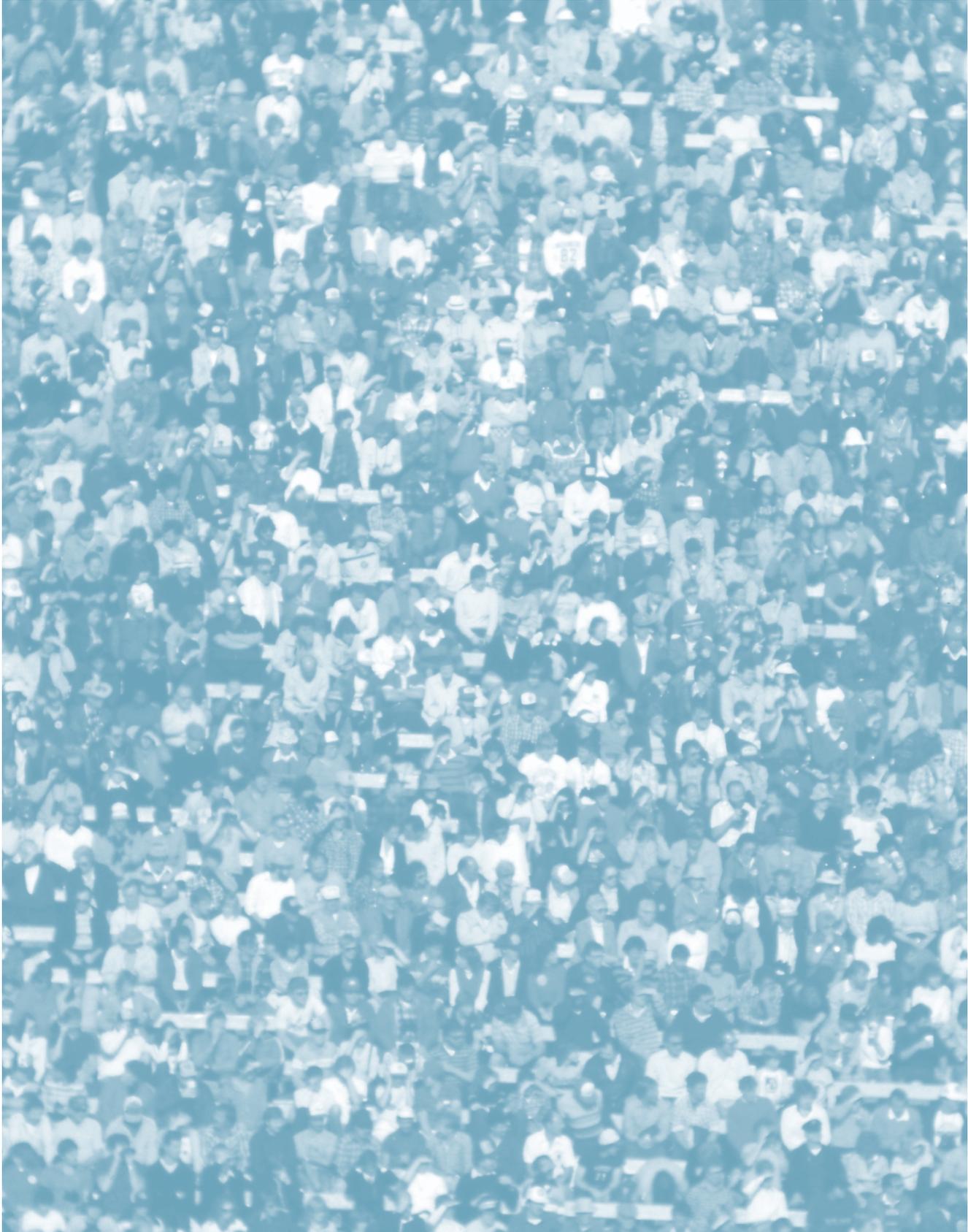


# Enfield Joint Adult Mental Health Strategy 2014-2019

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[www.enfieldccg.nhs.uk](http://www.enfieldccg.nhs.uk)

  
Enfield  
Clinical Commissioning Group

**ENFIELD**  
Council 



**Figure 1: Our Vision for Adult Mental Health Services in Enfield**

## **Our Vision for the Mental Health and Wellbeing of Adults in Enfield**

### ***What will be Different over the Next 5 years?***

There will be a strong focus on service quality, recovery and outcomes delivered through effective partnerships

There will be improved access to:

- Support to maintain mental health and wellbeing for all
- Early diagnosis and intervention
- Information about services and support
- Evidence based assessment, treatment and support
- Housing with flexible support
- Support by GPs and in community settings
- Good quality support for people during acute phases of illness
- Support to find meaningful occupation or employment and to maintain income
- Support to develop meaningful relationships and participation in community activities
- Support to address both mental health and physical needs
- Support for carers

There will be more:

- Control and choice in care planning
- Effectively co-ordinated care
- Of a community presence for adults with mental health issues
- Involvement of service users in decisions about services and support
- Effective use of resources in secondary care, with care targeted at those who need access to specialist services the most
- Attention to the mental health and wellbeing of carers
- Attention to faith and cultural beliefs

There will be less:

- Stigma and discrimination associated with mental health issues
- Inequity in mental and physical health and wellbeing
- Avoidable harm and injury
- Time spent away from their homes by adults with mental health issues

And fewer:

- Avoidable crises and admissions to hospital
- Adults with mental health issues who feel alone and unsupported
- Adults with mental health issues who are excluded from the communities in which they live

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## Foreword

We consulted on the Joint Enfield Adult Mental Health Strategy 2014-2019 from 21 November 2013 to 24 February 2014. A range of Enfield organisations and residents participated. Having reviewed our priorities and objectives in light of the feedback given, we are pleased to introduce the full strategy to you. We believe it now better reflects the needs and views of the Enfield population.

The strategy sets out our strategic goals:

- 1: To improve the mental health and wellbeing of the population**
- 2: To improve recovery from mental health issues**
- 3: To develop the Mental Health Care system**

It describes our vision (See Figure 1), our priorities and the action we have agreed to take over the next 3 to 5 years to achieve it.

Partnership has been shown to be at the heart of excellent mental health care and key to ensuring the mental health and wellbeing of individuals and communities. Collectively, participants in the consultation gave the strongest support to the objective relating to the development of a partnership with service users and carers. This is at the heart of our approach. We will act on our commitment to build a strong partnership with service users and carers as a matter of urgency. In addition, we will work with local communities, staff and the voluntary and independent sectors to deliver the intended improvements to the mental health and wellbeing of residents in Enfield.

Signatures: and designations

**Dr Mohammed Abedi**  
Chair, Enfield Clinical Commissioning Group

**Councillor Donald McGowan**  
Chair of the Health & Wellbeing Board and  
Cabinet Member of Health and Adult Social  
Care

# Executive Summary

- The Government has put good mental health and resilience at the heart of the country and individuals' economic and social wellbeing. Mental health is therefore identified as being “everybody's business” and mental and physical health and wellbeing are to be given equal status. The Government requires individuals, communities and the organisations within them to take responsibility for improving their own mental health and wellbeing and/or that of other people. The Government also suggests that individuals and communities have a responsibility to challenge “the blight of stigma and discrimination<sup>1</sup>”. Local authorities and the NHS are in the driving seat of the action needed to improve mental health and wellbeing<sup>2</sup>.
- Improving the mental health and wellbeing of adults living in Enfield has therefore been prioritised by Enfield Council (the Council) and Enfield Clinical Commissioning Group (the CCG). The Council and the CCG are committed to working together to improve the quality and efficiency of mental health services and therefore mental health outcomes for Enfield residents. This includes ensuring that there is a strong focus on mental health promotion and prevention, early intervention, addressing the wider determinants of mental health and wellbeing, building community resilience and ensuring that equal status and priority is given to mental and physical health and wellbeing. The Council and the CCG are also committed to ensuring that there is full scrutiny and accountability across the mental health care system.
- In line with **No Health Without Mental Health<sup>3</sup>**, the national mental health strategy, the Council and the CCG have agreed 2 strategic goals:

**1. To improve the mental health and wellbeing of the population.**

**2. To improve recovery for adults with mental health issues.**

The overall aim of the strategy is to improve the quality of services – safety, effectiveness and patient experience – and to make the best use of the financial and other resources available. The effectiveness of implementation of the strategy will be measured by improvement in overall outcomes for both service users and carers; Tools for measurement will be embedded into the commissioning process.

- 6 key outcomes are identified in the national mental health strategy:
  - More people will have good mental health.
  - More people with mental health issues will recover.
  - More people with mental health issues will have good physical health.
  - More people will have a positive experience of care and support.
  - Fewer people will suffer avoidable harm.
  - Fewer people will experience stigma and discrimination.

These provide the framework for improvement. Initial work has been undertaken to develop more robust outcome measures. This work includes starting to adopt a values based approach to commissioning. Commissioners will work with all stakeholders to develop these outcome measures over the life of the strategy.

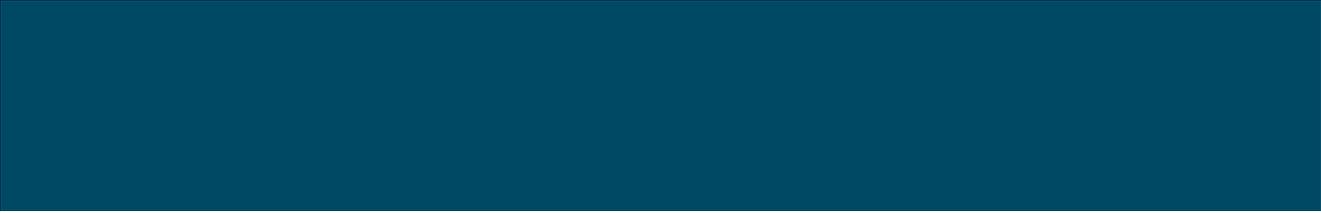
- The strategy addresses the needs of adults with mental health issues aged 18 years or over. This includes transition to and from these services. It also addresses the needs of adults with a learning

<sup>1</sup> No health without mental health: a cross government mental health outcomes strategy for people of all ages, DH, 2011

<sup>2</sup> No health without mental health: a cross government mental health outcomes strategy for people of all ages, DH, 2011

<sup>3</sup> No health without mental health: a cross government mental health outcomes strategy for people of all ages, DH, 2011

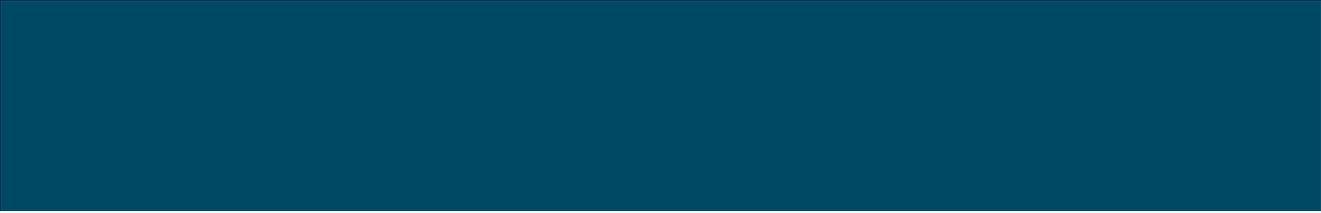
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disability and/or autism and adults who abuse drugs and/or alcohol who also have a mental health problem. The Council recognises the contribution made by carers and the need to support them effectively if they are to continue in their caring roles. Therefore the mental health and wellbeing of all carers and support for carers of adults with mental health issues is included in the strategy.

- In line with the national strategy, a life course approach to service delivery will be adopted, with pathways and services organised and accessible by need rather than age. Care will be better co-ordinated and seamless. The transition from child and adolescent mental health services (CAMHS) to adult services and for adults with a functional mental health problem to services for older people who are physically frail, with depression and anxiety that starts in later life and/or have an organic illness including dementia, will be improved. The needs of families where there is an adult with a mental health problem will also be addressed.
- It is estimated that there are 37,294 adults aged 18-65 years living in Enfield with a neurotic disorder e.g. depression, anxiety, obsessive compulsive disorder. Estimates of the prevalence of serious mental illness e.g. schizophrenia, bipolar disorder and other psychoses vary. Application of the rates gives a range of 1,000-5,000 adults living with serious mental illness in Enfield. The number is likely to rise by 3 percent by 2020 as a result of the projected growth in the adult population.
- The strategy addresses the following key areas of concern in Enfield:
  - Deprivation is a risk factor and proxy indicator of mental health issues in a community. As there are significant areas of deprivation in Enfield with 10 wards being in the top 20 percent most deprived wards in the country and 3 wards being in the top 10 percent most deprived wards nationally, a substantial number of people in Enfield are at significant risk of developing mental health issues. This is evidenced by the fact that the standardised mortality rate for adults with serious mental illness aged 18 to 75 years in the borough is the third highest in all the London boroughs.
  - The need to ensure that the mental health needs of the significant numbers of people from black and minority ethnic (BME) communities are identified and appropriate support is offered; it is estimated that between 39 and 55% of the Enfield population is from a BME community.
  - Supporting the significant numbers of adults in touch with secondary care mental health services who are unemployed to find meaningful occupation or employment; only 4 percent of this group is in work. Evidently this rate is extremely low and must therefore be addressed. However, it should be noted that the average rate of employment for this group nationally is only 6 percent.
  - Giving equal priority to mental and physical health care; as in many other areas nationally, Enfield investment in mental health services in Enfield is significantly lower than for physical health care services when compared per head of population.
  - Ensuring a stronger focus on supporting adults with mental health issues to recover; this is a challenge faced by most mental health care economies national; significant action is needed to achieve the joint vision and enable adults with mental health issues to maximise their potential to:
    - ◆ Live independently with flexible support when, and if, it is needed.
    - ◆ Develop meaningful relationships and participate in the communities in which they live and work.
    - ◆ Live in secure, settled accommodation with a job or meaningful occupation and support to maximise their income.

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In order to achieve the shift to a recovery focussed service, a significant shift in the way services are delivered is needed. This strategy will drive the cultural shift and service redesign that is required.

- A number of other improvements are necessary if the vision for improved mental health is to be achieved. In Enfield, the greatest improvement is needed in the following areas:
  - Addressing (mental) health inequalities, in particular those experienced by black minority and ethnic (BME) communities and those from lesbian, bisexual, gay and transgender individuals (LGBTi).
  - Acute mental health care; inpatient and community based and including support in a crisis, inpatient rehabilitation and psychiatric liaison services.
  - Developing the community mental health services infrastructure; support and training for primary care to manage mental health issues; housing and flexible support; support to find meaningful occupation including employment; maximising income.
  - Ensuring early intervention, including access to psychological therapies for those with common mental health issues and support in crisis.
  - Challenging stigma and discrimination.
  - Delivering accessible services for all.
  - Improving the mental health and wellbeing of the population.
  - Ensuring that care is well co-ordinated and integrated.
  - Ensuring that transition from child and adolescent to adult mental health services is effective and seamless.
  - Ensuring that the needs of older adults with non-organic mental health issues are addressed effectively (including transition).
  - Supporting carers of adults with mental health issues and ensuring the mental health and wellbeing of all carers.

The action that will be taken to achieve these improvements is detailed in Sections 5 and 6.

- In order to support more adults with mental health issues in the communities in which they live and work, the relationship and interface between primary and secondary care will be developed, building on the strengths of the existing model of community support in the context of the emerging GP locality network model. Effective working relationships between GPs and the voluntary sector will be established as part of this. Support and training will be provided to GPs and other staff in primary care. The potential to transfer resources from secondary to primary care to enable the development of the new model will be assessed.
- The strategy incorporates the commissioning priorities identified in the mental health commissioning strategy 2013-15 for the boroughs of Barnet, Enfield and Haringey.
- The CCG is currently working with commissioners in Barnet and Haringey and the current tri-borough Mental Health Service Provider to develop a mental health services investment plan as part of its strategic planning processes taking into account of the financial challenges faced by the health and social care system. It addresses the significant increase in mental health admissions experienced during 2013-14 and seeks to improve productivity and ensure that performance is in line with national benchmarks for the performance of mental health services.
- Achieving financial balance across the health and social care economy is a major concern and challenge to many. Work has still to be done to develop and appraise options for future service

delivery and the scope for re-investment. Key stakeholders will be involved in identifying priorities as it will not be possible to address all the identified gaps in the next 5 years. In fact, as it is likely that it will be necessary to reduce investment, it will be necessary to deliver most improvements through improved productivity and efficiency. It appears that there is potential to achieve improvement through the following:

- Transferring resources from secondary to primary care based mental health services.
- Review all placements in and out of the borough.
- Improving the patient journey e.g. by reducing duplication, improving communication between teams and organisations.

Any proposal for re-modelling and/or development will be subject to consultation by the Board of each organisation. Commissioners will bid for national funding where appropriate and will support the voluntary sector to bid for national charitable and government funds to develop preventative, recovery and outcome focused community services.

- The CCG and the Council have agreed 8 strategic objectives. (See Table 1.) These were developed from the initial objectives considered during the 14 week consultation held from 21 November 2013 to 24 February 2014. 202 people were involved in this process.
- The strategy will be delivered by the Mental Health Partnership Board and the Mental Health Strategy Implementation Group working in partnership. An initial 2 year work plan will be agreed to support delivery of the strategic goals and objectives contained in Section 5, Table 2. The 2 groups will work together to monitor implementation and revise the strategy as appropriate.

**Table 1: Enfield Joint Adult Mental Health Strategy: Strategic Objectives 2014-2019**

<b>A.</b>	<b>To improve the mental health and wellbeing of the population.</b>
1.	To promote mental health and wellbeing and prevent mental illness.
2.	To reduce inequalities in mental health.
3.	To improve access to mental health assessment, treatment and support.
4.	To improve the mental health and wellbeing of all carers and improve support for carers of adults with mental health issues.
<b>B.</b>	<b>To improve recovery for adults with mental health issues.</b>
5.	To ensure that mental health care is provided as close to home as possible, is personalised, recovery orientated and focussed on outcomes.
6.	To improve the quality* and efficiency and therefore outcomes from secondary care mental health services. <i>*safety, effectiveness, patient experience</i>
<b>C.</b>	<b>To develop the mental health care system.</b>
7.	To develop strong partnerships between mental health services, commissioners and providers and ensure that communities, service users and carers are fully involved in service improvement and planning.
8.	To improve the commissioning of mental health services.

## SECTION 1

# Introduction

### What are Mental Health Issues?

There are many definitions of mental health, but it is generally considered to consist of a set of outwardly observable skills, attributes and behaviours such as the ability to live productively, adjust to change and to maintain satisfying relationships with others and establish a set of personal emotions and thoughts such as enjoyment of life, a sense of self-worth and empathy.

The term mental health problem is used in this document to describe the full spectrum of mental health issues, from common mental health issues such as moderate depression or anxiety that are more prevalent in the population, to serious mental illness such as schizophrenia and bipolar disorder which is less prevalent. It also includes personality disorder which describes an enduring pattern of inner experience and behaviours that differ significantly from the expectations of the culture in which the individual lives. Personality disorder starts in adolescence or early adulthood. It is pervasive, inflexible, stable over time and leads to significant distress and impairment.

Mental health issues can be divided into 2 main groups:

- **Organic:** caused by identifiable brain malfunction, such as dementia.
- **Functional:** not caused by structural abnormalities of the brain (i.e. they are not organic). The term “functional” refers to the likely impaired functioning, ranging from minor to substantial, that the disorder can lead to in terms of day-to-day life. There are 2 main groupings:
  - **Neurosis:** severe forms of normal experiences such as low mood and anxiety e.g. depression.
  - **Psychosis:** severe distortion of a person's perception of reality e.g. schizophrenia.

Recently, in work to develop a mental health tariff, a system of clustering mental health issues has been adopted. The care clusters are based on a combination of the diagnosis and severity of needs arising from that diagnosis. (See Figure 2)

**Figure 2: The 3 Main Grouping of Care Clusters under Mental Health Payment by Results**

Functional MH Issues		Organic MH Issues
<b>Common mental disorders [non psychotic] Clusters 1-8</b> Depression/anxiety Personality difficulties Eating disorders OCD Age related difficulties	<b>Psychotic [severe/enduring illness] Clusters 10-17</b> Schizophrenia Bipolar disorders Severe depression	<b>Cognitive impairment Clusters 18-21</b> Alzheimer's Vascular dementia

Care for adults in clusters 1-3 to 4 i.e. with common mental health issues, is generally provided in primary care and is managed by GPs with support from secondary care mental health services. Psychological interventions, including counselling and cognitive behavioural therapy, commissioned from voluntary sector or independent providers or mental health trusts are also provided for adults in these clusters. Care for adults in cluster 18 is also provided mostly in primary care by GPs with support from secondary care services. Diagnosis and initial assessment and treatment is provided by secondary care mental health services.

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Care for adults with severe non-psychotic disorders – cluster 4 and the psychotic disorders in clusters 5 to 17 is provided by mental health trusts (secondary care). Mental health trusts bring together health and social care practitioners to deliver integrated care. Very specialised treatments for people with very severe illness are provided by tertiary care services.

Having mental health issues can be distressing for individuals and often has a significant impact on their lives. It also affects, and can have a significant impact on, their families and friends and the communities in which they live. Adults with mental health issues often<sup>4</sup>, have lower incomes<sup>5</sup>, find it harder to both obtain and stay in work<sup>6</sup>, are more likely to be homeless<sup>7</sup> or insecurely housed, and are more likely to live in areas of high social deprivation<sup>8</sup>.

## The Scope of the Strategy

This strategy covers the services commissioned by either the Council or by the CCG and the primary care services commissioned by the NHS England for adults with mental health issues. It excludes the specialised, tertiary services commissioned by the NHS Specialised Commissioning Group, although the pathway to and from these services, along with the investment, which is considerable, in these services are included. It includes adults with a learning disability and/or autism who also have a mental health problem as well as adults who have a mental health problem who also abuse alcohol and/or drugs. There is a separate framework for services for adults with autism<sup>9</sup>.

The strategy addresses the needs of carers – both the mental health and wellbeing of all carers, and the specific needs of carers of adults with mental health issues.

A life course approach to meeting need is adopted. The strategy addresses transition from child and adolescent mental health services (CAMHS) to adult services and transition from adult services to services for older adults who are physically frail and/or those with organic illness. Adopting a life course approach requires the extension of the pathway for adults with a functional mental health problem to end of life; there will be a choice for people as they get older to remain in contact with services provided along the functional pathway or to make the transition to services for older people. Those likely to choose to change include those adults who are physically frail who need access to the wider range of health and social care services provided for older people or those who have dementia<sup>10</sup>. There is a separate strategy for people with dementia and their carers in Enfield<sup>11</sup>. The need to ensure that the needs of older adults with functional mental health issues is addressed within this strategy.

## How the Strategy was developed

A multi-agency steering group was convened to oversee the development and ensure implementation of the strategy. A wide range of stakeholders has been involved in the development of the strategy. The Joint Commissioning Manager (Mental Health) held interviews and meetings with approximately

4 Chevalier A and Feinstein L (2006) *Sheepskin or Prozac: The causal effect of education on mental health*. Discussion paper. London: Centre for Research on the Economics of Education, London School of Economics, available at: <http://cee.lse.ac.uk/cee%20dps/ceedp71.pdf>

5 Meltzer H, Bebbington P, Brugha T et al. (2010) Job insecurity, socio-economic circumstances and depression. *Psychological Medicine* 40(8):1401-1407.

6 McManus S, Meltzer H, Brugha T et al. (2009) Adult psychiatric morbidity in England 2007. Results of a household survey. Health and Social Care Information Centre, Social Care Statistics

7 Government Office for Science (2008) *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century – Final Project Report*, available at <http://tinyurl.com/ForesightReportMentalCapital>

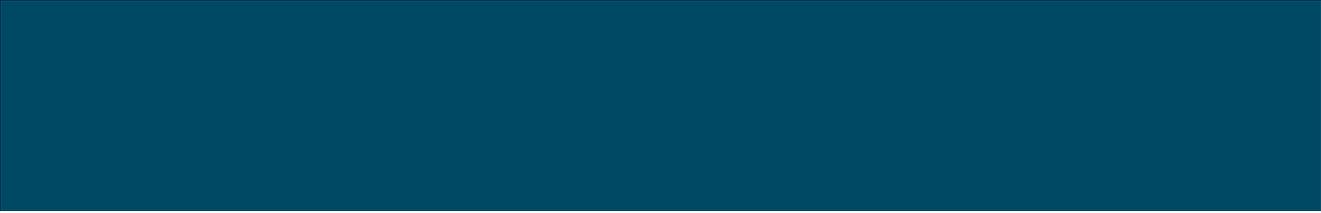
8 Health and Safety Executive (2009) *How to tackle Work-related Stress: A guide for employers on making the Management Standards work*, available at: [www.hse.gov.uk/pubns/indg430.pdf](http://www.hse.gov.uk/pubns/indg430.pdf)

9 Enfield Joint Autism Framework, 2013, London Borough of Enfield and The CCG

10 The needs of this group have not been addressed strategically in Enfield. The need to address this will be identified within this strategy

11 Enfield Joint Dementia Strategy, 2011, London Borough of Enfield and The CCG

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70 individuals in 1:1 or group settings. Interviews and group discussions involving 37 people were held to gather views and information by an independent researcher as part of the mental health needs assessment. A review of national and local health and social care mental health strategy, policy and the evidence base was also completed. Work previously completed by local commissioners, providers, service users and carers to improve mental health services was reviewed and the performance of services was assessed.

A 14 week public consultation was held from 21 November 2013 to 24 February 2014. Three methods were used to secure feedback during the consultation period:

- 1:** A survey questionnaire hosted on the Council, the CCG and the Current Mental Health Service Provider websites.
- 2:** Two half day public consultation events on 7 and 21 January 2014 with a focus on:
  - Employment
  - Accommodation
  - Community based mental health services

The topics were set in the wider context of the overall strategy. The aim was to seek people's views on the issues and potential solutions. The information gathered has been integrated into the final draft of the strategy.

- 3:** Fifteen meetings with groups and individuals

The feedback received during this process has been summarised into the Enfield Joint Adult Mental Health Strategy 2014-2019: Consultation: November 2013 to February 2014: Summary of Submissions: March 2014.

A strategy is only as good as its implementation and its ongoing relevance in terms of its potential to enable and drive the required change and improvement. Therefore, the strategy, and the goals and objectives contained in it, will be kept under review for relevance and their potential to enable the required improvement. It will be adapted and developed as appropriate.

## SECTION 2

# National and Local Policy Context

### **Mental Health Strategy and the Cost of Mental Health Issues**

In 2010, the social and economic cost of mental illness was estimated to be £105 billion per annum in England<sup>12</sup>. Approximately £28 billion of the cost is the cost to UK employers alone<sup>13</sup>. In addition, the cost of crime by adults who had conduct problems during adolescence was estimated to be £60 billion per annum<sup>14</sup>. In stark contrast to these figures, only £11 billion of the annual NHS budget was spent on NHS mental health care in 2010/11. It is anticipated that the annual cost of mental health issues will have doubled by 2026. Most of the need is in the community, but a significant proportion of overall expenditure on mental health services is spent on beds in secure and high dependency and acute inpatient services.

The importance of mental health and wellbeing for individuals and the country's social and economic status has been increasingly recognised over the last 15 years. In 1999, The National Service Framework for Mental Health Services<sup>15</sup> (NSF) specified the approach to delivery and the range of services that should be commissioned to ensure that both adults with common mental health issues and adults with serious mental illness are able to access the assessment, treatment and support they need. Almost 10 years later, New Horizons: A shared vision for mental health services<sup>16</sup>, laid out a multi-stakeholder vision for mental health services. It adopted a broad view of the action needed to promote the mental health and wellbeing of the nation as a whole. In 2011, the public health strategy, No health without mental health<sup>17</sup>, reinforced this message. It specified the action needed to ensure improvement in mental health care, as well as the role of wider public health and community infrastructures in promoting mental health and wellbeing.

In the new national mental health strategy published in the same year<sup>18</sup>, the Government demonstrated its commitment to improving mental health and wellbeing, and described how it intended to achieve the changes necessary. The strategy emphasised the importance of mental wellbeing for individuals and the country's social and economic status, identifying good mental health and resilience as "fundamental to our physical health, our relationships, our education, our training, our work and achieving our potential"<sup>19</sup> and stating that "our objectives for employment, education, for training, for safety and crime reduction, for reducing drug and alcohol dependence and homelessness cannot be achieved without improvements in mental health. (Mental health and wellbeing are) of critical importance to individuals as well as bringing wider social and economic benefits"<sup>20</sup>.

The strategy states that everyone must "to take action and will be supported by the Government to do so." In addition, "we all need to take responsibility for caring for our own mental health and that of others and to challenge the blight of stigma and discrimination"<sup>21</sup>. The aim is to improve:

- The mental health and wellbeing of the whole population and to keep people well.
- Outcomes for people with mental health issues through high quality services that are equally accessible to all.

In the strategy, the Government makes the well-established link between mental ill health and deprivation and between limiting long term physical illness, deprivation and the risk of mental illness.

12 Community Mental Health Profiles 2010: DH, 2010

13 NICE, 2009

14 Sainsbury Centre for Mental Health, 2009

15 The National Services Framework for Mental Health Services in England, DH, 1999

16 New Horizons: A shared vision for mental health services, DH, 2009

17 No Health without Mental Health: a mental health outcomes strategy, DH, 2011

18 No health without mental health: a cross government mental health outcomes strategy for people of all ages, DH, 2011

19 No health without mental health: a cross government mental health outcomes strategy for people of all ages, DH, 2011

20 No health without mental health: a cross government mental health outcomes strategy for people of all ages, DH, 2011

21 No health without mental health: a cross government mental health outcomes strategy for people of all ages, DH, 2011

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## Quality and Outcomes in Mental Health Care

6 key outcomes are identified in the strategy:

- More people will have good mental health.
- More people with mental health issues will recover.
- More people with mental health issues will have good physical health.
- More people will have a positive experience of care and support.
- Fewer people will suffer avoidable harm.
- Fewer people will experience stigma and discrimination.

These outcomes are relevant whatever our age and wherever we live. The Government has therefore recommended an integrated, “lifecourse” approach to improving mental wellbeing and supporting people with mental health issues to recover from mental health issues. A “needs-led”, personalised approach that ensures the development and delivery of age appropriate services without inflexible boundaries in the way that services are organised so that they are organised solely on the basis of individual need and preference is essential.

Early diagnosis and intervention are key to the improvement of the overall mental health and wellbeing of the population, reducing both the severity of symptomology and the duration of illness. Action is therefore being taken to ensure early diagnosis and intervention in all areas of mental health. However, national policy prioritises early intervention in psychosis and dementia and for people with depression and anxiety.

As for all care groups, personalisation – empowering individuals and ensuring that they have choice and control over treatment and care – underpins the improvement of mental health services. However, there is still much work to do to implement this effectively for adults with mental health issues.

The concept of recovery from mental health issues has developed over recent years. Recovery can be defined as:

*“The process through which people find ways of living meaningful lives with or without ongoing symptoms of their condition.”<sup>22</sup>*

People who use mental health services have identified 3 key principles:

- The continuing presence of hope that it is possible to pursue one’s personal goals and ambitions.
- The need to maintain a sense of control over one’s life and one’s symptoms.
- The importance of having opportunities to build a life ‘beyond illness’.<sup>23</sup>

Recovery colleges have been established by many mental health trusts as part of their drive to ensure that care is focussed on recovery and achieving positive outcomes for people with mental health issues. The colleges deliver training and education on mental health diagnoses, assessment, treatment and support, mental and physical wellbeing and a range of other subjects related to mental health. Training is delivered to practitioners, service users and carers. The courses are delivered by trained staff members with peer recovery trainers. The aim is to:

- Offer support for people who use services and enable them to become experts in their own (self) care.
- Enable family, friends, carers and practitioners to better understand mental health conditions and support people in their personal recovery journeys.

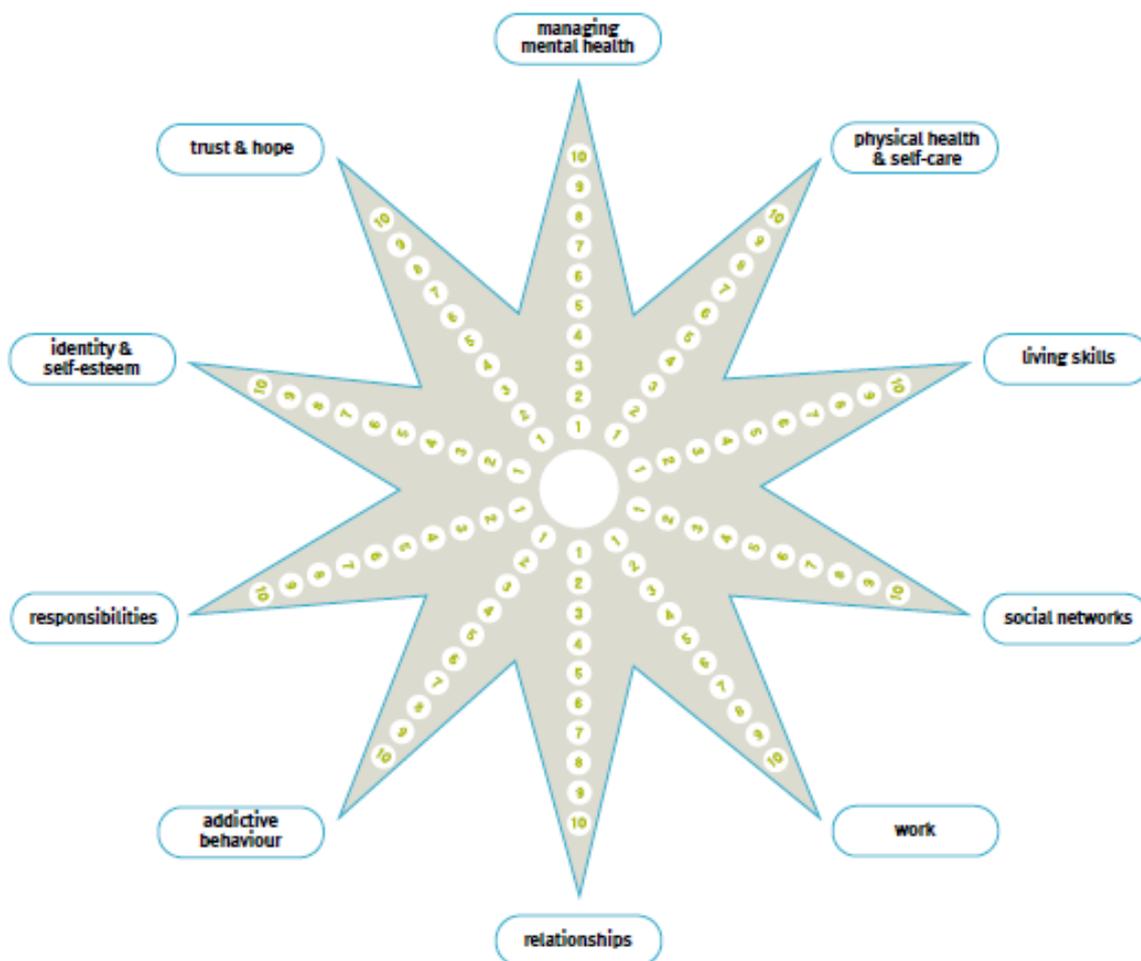
<sup>22</sup> Supporting Recovery in Mental Health, Mental Health Network, NHS Confederation, Briefing Issue 244, June 2012

<sup>23</sup> Supporting Recovery in Mental Health, Mental Health Network, NHS Confederation, Briefing Issue 244, June 2012

The recovery college can also be used to enable the change in organisational culture and the way care is delivered that is needed to deliver recovery and outcome focused assessment, treatment and support.

Recovery is the outcome required from mental health care. Measuring recovery is difficult, partly because it is unique to each individual and partly because it is hard to measure some of the dimensions of recovery scientifically or precisely. However, there is some commonality in the characteristics of recovery amongst individuals. These have been identified as part of the work to develop effective outcome measures undertaken nationally; service users and staff involved in mental health services have developed a tool – the recovery star – that helps service users and those working with them to monitor and measure progress with recovery. Albeit that application of the tool as a measurement tool is not always popular, the star clearly defines what is important to service users carers identifying the desired outcomes from care and support. It therefore specifies the primary focus for intervention and support. (See Figure 3. below).

**Figure 3:** The Recovery Outcomes Star



Increasing priority is being given to ensuring that health and social care services are delivering value for money and real improvement – outcomes – for patients and clients. National outcome measures are being developed for all health care services:

- The Friends and Families Test.
- Patient Reported Outcome Measures (PROMS).
- Clinician Reported Outcome Measures (CROMS)
- Patient Reported Experience Measures (PREMS).

The Health of the Nation Outcome Score (HoNOS), a clinical tool has been in use as by mental health trusts for a significant period.

The recent focus on ensuring outcomes focussed care and support and the approach to developing outcome measures is now being embedded within the framework of values based commissioning. Values based commissioning builds on the principles of values based practice. By giving equal weight to 3 “pillars”:

- Patient and carer perspectives and values.
- Clinical knowledge and expertise.
- Knowledge derived from scientific or other systematic approaches (evidence).

It makes decision making relating to care more explicit through the exploration and inclusion of the values underpinning those decisions. By including values in the first place, it also gives greater weight to values. It aims to give equal power and influence to clinicians, managers, commissioners, patients/ service users, carers, communities, providers – non-statutory and statutory – in decision-making at all levels. The intention is to co-produce services. It aims to use service user/patient and carer assets rather than simply seeing them as individuals with needs that have to be met. Involvement and engagement are intended to lead to increased empowerment that leads to the delivery of more service user/ patient focussed services, potential for improved cost-effectiveness and achievement of key outcome measures. It aims to deliver greater ownership of decisions.

Improving the quality of services is a key priority for health and social care services nationally. There are many definitions of quality varying from definitions that include ensuring that all service components operate optimally to specific definitions of what quality means in practice and in terms of outcomes. For the purposes of this strategy, quality is defined using the definition adopted locally by the CCG and that of Lord Berwick in his review of safety in the NHS in England:

- **Safe services:**
  - The right staff, correctly trained and learning from experience<sup>24</sup>.
  - Avoiding harm from care that is intended to help<sup>25</sup>.
- **Effective services:**
  - Evidence based, right care, right place, first time<sup>26</sup>.
  - Aligning care with science and ensuring efficiency<sup>27</sup>.
- **Good experience of services:**
  - Service users feel valued and cared for<sup>28</sup>.
  - Patient centred, timely, equitable<sup>29</sup>.

<sup>24</sup> Commissioning for Health 2013-16, Draft 8.0, CCG, 2013

<sup>25</sup> A promise to learn – a commitment to act, Improving the Safety of Patients in England, National Advisory Group on the Safety of Patients in England, 2013

<sup>26</sup> Commissioning for Health 2013-16, Draft 8.0, CCG, 2013

<sup>27</sup> A promise to learn – a commitment to act, Improving the Safety of Patients in England, National Advisory Group on the Safety of Patients in England, 2013

<sup>28</sup> Commissioning for Health 2013-16, Draft 8.0, CCG, 2013

<sup>29</sup> A promise to learn – a commitment to act, Improving the Safety of Patients in England, National Advisory Group on the Safety of Patients in England, 2013

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## **The Mental Health of Older Adults**

Addressing the mental health needs of older adults has also been an increasing priority for the Government. Improving the mental health of older adults is Standard Seven of the Older People's National Service Framework<sup>30</sup>. Later publications such as Forget Me Not<sup>31</sup> Securing Better Mental Health for Older Adults<sup>32</sup>, Everybody's Business<sup>33</sup> and Raising the Standard<sup>34</sup> specifically addressed the mental health needs of older adults. These documents were followed by Clinical Guideline 42: Dementia, supporting people with dementia and their carers in health and social care<sup>35</sup>. This publication identified addressing discrimination, training, ensuring valid consent for treatment, improving carer assessment and support, co-ordination and integration of health and social care as priorities for improvement of dementia care as critically important. The National Dementia Strategy<sup>36</sup> was published in 2009. There are 17 key objectives. The aim is to improve the quality of care for people with dementia and their carers.

The current national social and economic climate has put pressure on resources for both health and social care services. The NHS is focussed on improving the efficiency and effectiveness of services. Saving and re-investing £20 billion (approximately 20 percent) of the budget for health care between 2010 and 2015. Councils have experienced a reduction of 27 percent in their budgets over the past 3 years and are subject to further reductions. As part of the drive to improve efficiency, a mental health tariff is being implemented for mental health services. The tariff is based on the mental health care clusters.

## **The Mental Health of Carers and Support for Carers of Adults with Mental Health Issues**

The Government recognises that people spend much more time being looked after by or caring for a loved one than they spend with health professionals. It has therefore increasingly recognised the contribution of carers and the need to support them in their caring role if they are to be able to continue caring and to maintain their quality of life. The Government also understands that they need to be involved in planning the support and care of those for whom they care.

The Health and Social Care Act 2012 enacts the Government's intention to make it easier for carers to access support and to be more involved in the care and support of the person they are caring for. The key priorities are:

- Helping people with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset in designing local care provision and in planning individual care packages.
- Enabling those with caring responsibilities to fulfil their educational and employment potential.
- Providing personalised support for both carers and those they support and enabling them to have a family and community life.
- Supporting carers to stay mentally and physically well.

30 Older People's National Service Framework DH, 2001, London

31 "Forget Me Not", Audit Commission, 2000, 2002, London

32 "Securing Better Mental Health for Older Adults", DH, 2005, London

33 "Everybody's Business", CSIP, 2005, London

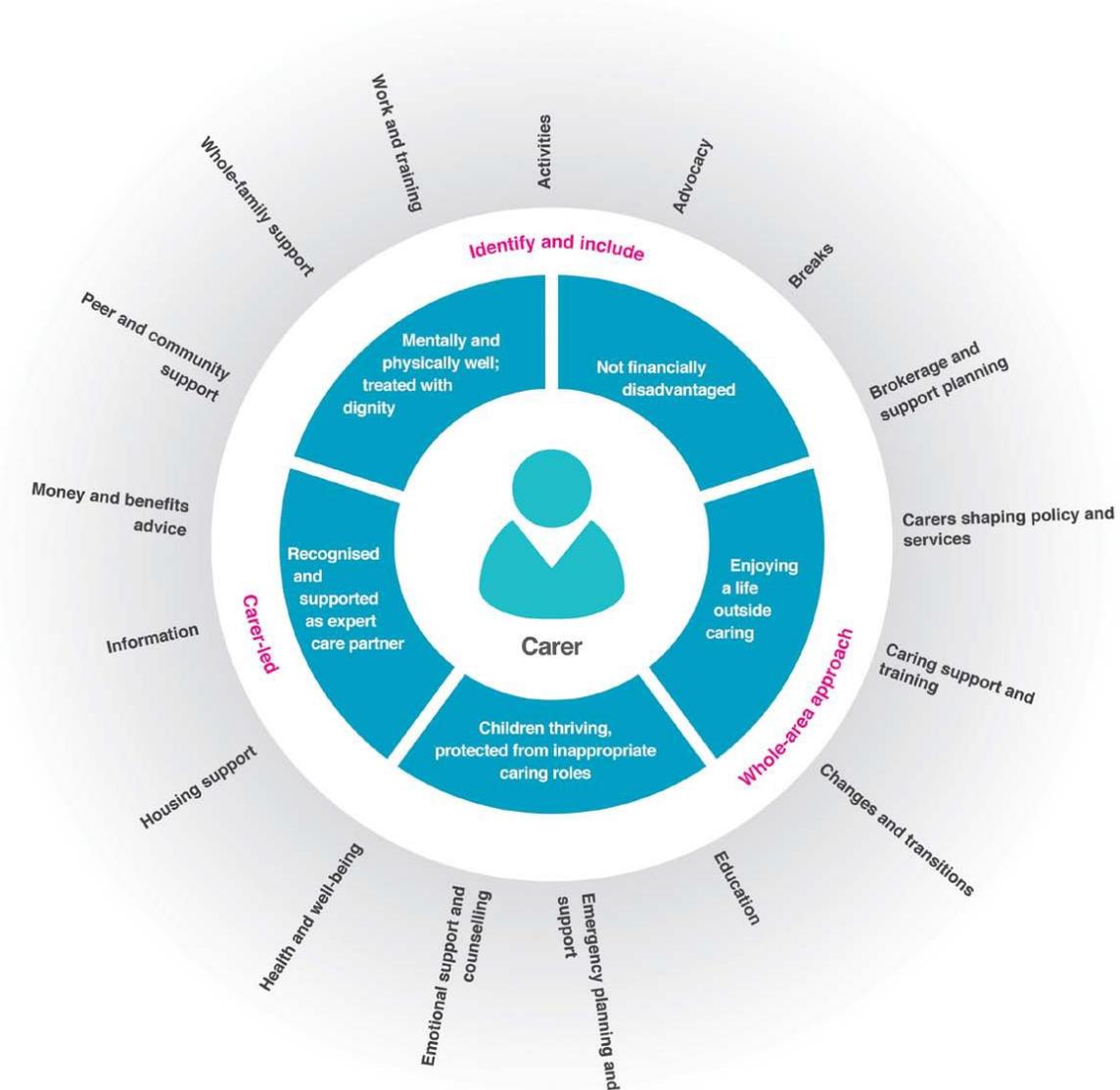
34 "Raising the Standard" Royal College of Psychiatrists, 2006, London

35 Clinical Guideline 42: Dementia: supporting people with dementia and their carers in health and social care, NICE/SCIE, 2006

36 Living well with dementia: A National Dementia Strategy, DH, 2009

The implications of the above for both health and social care are twofold. Firstly, they have a responsibility to commission and provide services that identify carers of people with mental health issues early and to involve them in the care of the person they care for. They also have a responsibility to assess carers' needs in their own right and to put processes in place to provide the necessary support. Secondly, health and social care services must address the mental health needs of all carers and to promote their mental and physical health and wellbeing. A model of comprehensive support for carers has been developed by the Government working with the Carers' Trust. (See Figure 4 below.)

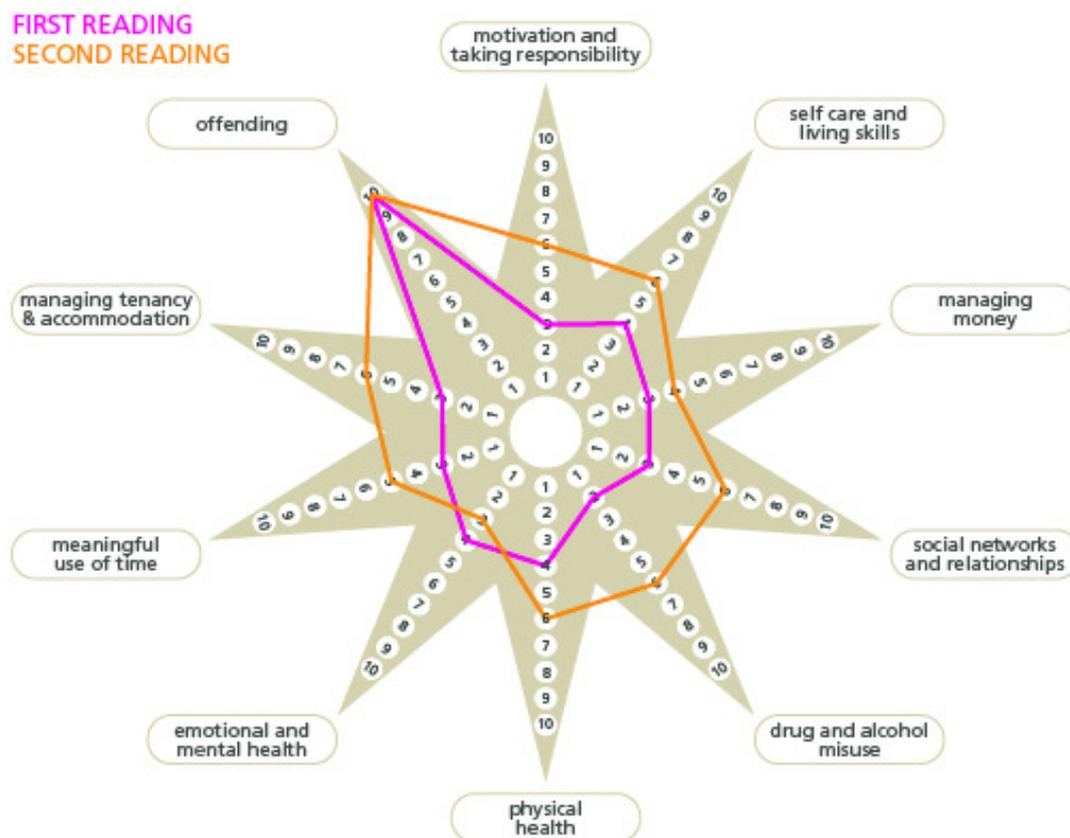
**Figure 4: Model of Support for Carers**



Carers of adults with mental health issues often struggle to cope. Part of the problem is created by the difficulty they experience in getting information about the needs and support being offered to the person they are caring for. This is often because the individual does not recognise their contribution or want their involvement. This creates difficulty for staff. A tool to address this has been developed by the Carers' Trust – The Triangle of Care. It describes an approach to addressing the issue and provides training tools for staff. Initially developed to address the issue in inpatient settings, it has been developed so that it can be applied to community mental health services.

In addition to the Triangle of Care, carers and staff involved in the delivery of mental health services, have worked together to develop a tool that enables the monitoring and measurement of outcomes – the aspects of the person's life that needs to be managed effectively based on the service users' recovery star. (See Figure 5 below.)

**Figure 5: Carers' Recovery Outcomes Star**



All of the above will be delivered in the context of the Health and Social Care Act and the Care Act 2014 that is currently before Parliament. The Care Bill codifies and reforms social care laws in response to the white paper, *Caring for our future*<sup>37</sup>. This legislation puts a number of duties on both the Council and the CCG. Duties under the Health and Social Care Act 2012 include the duty to:

- Commission in such a manner as to promote integration across health providers and health and social care where this will improve the quality of services, reduce inequalities in relation to accessing services or reduce inequalities in relation to outcomes.

<sup>37</sup> *Caring for our future: reforming care and support – white paper, DH, 2012*

- Develop strategies for meeting the needs of the local population; these must consider the extent to which local needs can be met more effectively by partnering arrangements between CCGs and Councils.
- Establish a health and wellbeing board. This must work in an integrated manner and provide advice, assistance and other support to encourage partnership working between CCGs and Councils under Section 75 of the NHS Act 2006. It must undertake a joint strategic needs assessment and develop a joint strategy to prioritise and address need.

The Act also:

- Emphasises the importance of joint working between CCGs and between CCGs and Councils. This can include encouragement to pool funds and to enter into partnership arrangements.
- Makes partnership a preferred approach to commissioning rather than just one approach of many.

The Care Act 2014 aims to:

- Fundamentally reform the operation of law giving priority to people's wellbeing, needs and goals. Wellbeing includes physical, mental and emotional wellbeing, personal dignity and protection from abuse and neglect.
- End the postcode lottery for care and support by establishing national eligibility criteria for Council support. This makes the process of securing funding more transparent. The Bill also puts a cap on the costs people will have to pay for care in their lifetime.
- Enact some of the Government's response to the Mid-Staffordshire Inquiry, progressing actions to address the "unacceptable" failings in care. Key among them is action to improve the safeguarding of adults and ensuring that transition to adult services at the age of 18 is more effective.

## Local Policy Context

### CCG

The CCG was established on 1 April 2013. It has identified 5 strategic goals. These form the basis of its commissioning plan<sup>38</sup> which aims to:

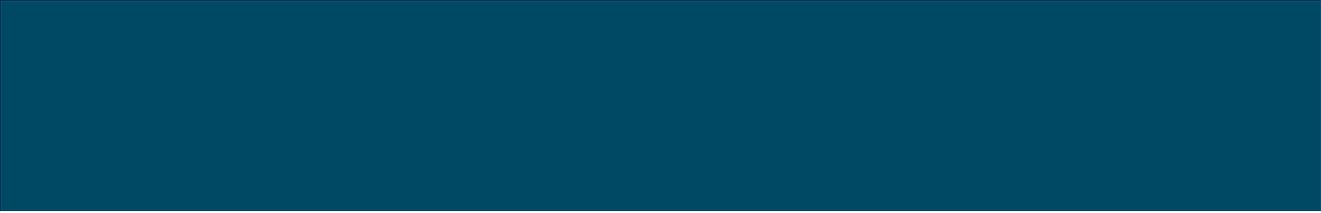
- Enable the people of Enfield to lead longer, fuller lives by tackling the significant inequalities that exist between communities.
- Provide children with the best start in life.
- Ensure the right care in the right place, first time.
- Deliver the greatest value for every NHS pound spent.
- Commission care in a way that delivers integration between health, primary, community and secondary care and social care services.

3 principles underpin the work programmes:

- Clinically effective and safe services.
- Patient centred: a good patient experience.
- Most effective use of NHS resources.

<sup>38</sup> NHS Enfield Clinical Commissioning Group: Commissioning for Health 2013-16, Enfield Clinical Commissioning Group, 2013

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The CCG's aim is to ensure the greatest value from every pound invested. Therefore there will be a focus on the relationship between the quality of the patient's outcome in relation to the cost of delivering that outcome. This is a move away from the previous approach which concentrated on activity and process measures. Improvement will be delivered through further work to develop effective care pathways.

The CCG recognises that access to, and the quality of primary care services in Enfield is variable. This has an impact on both the care received by patients directly through primary care and on the use of acute hospital and mental health services, driving up spend on hospital care and reducing the ability to invest in local and community based services. Identifying primary care as being at the heart of delivering modern, high quality and safe services for patients, the CCG has identified the improvement of the quality of primary care services as a key priority. It aims to improve the integration of care, to improve the use of planned care and to ensure that care is provided closer to home with better access to primary care. This will:

- Improve access to primary care.
- Reduce variation in quality and patient experience.
- Reduce attendances at urgent and emergency care services in hours.
- Improve the integration of care for individuals with long term conditions, reducing reliance on unplanned care and secondary care admission.
- Ensure better care for children and families.

In order to deliver the required improvement, 4 GP locality networks have been established. A network is a group of practices working together to provide strong, local clinical leadership for the primary care transformation programme. It will enable a bottom-up approach to planning, commissioning and service delivery based on local knowledge. Practices in networks will be able to join together to offer services that would otherwise need to be delivered in a hospital setting. There will be strong engagement and partnership with the voluntary sector and local communities. A key objective is to improve the integration of care.

Mental health is one of 6 programmes of work developed by the CCG to support achievement of its strategic goals. The aim is to understand the needs of the population and to commission effective and efficient services for people with mental health needs with the focus being on recovery and rehabilitation. The joint strategy articulates its vision for services for adults with mental health issues over the next 5 years. Implementation of the strategy will deliver the improvement needed.

### **Enfield Council<sup>39</sup>**

The Council is ambitious in its aspirations for Enfield. It aims to be outward-facing, reaching out to residents and businesses, providing a clear voice for the borough with the Government and investors. It aims to provide strong community leadership and a clear and consistent message to its residents. With resources under severe pressure, and tough decisions about spending, services and investment to be made, this is particularly important. The Council aims to:

- Bring energy and focus to its work in order to accelerate the pace of change in the most deprived communities, being ambitious and creative, tackling inequality and improving quality of life for all.
- Protect the most vulnerable in our society, including children and young people, older people and those with disabilities.
- Listen to what local people say and to provide strong community leadership to address the issues that matter.

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<sup>39</sup> Fairness for All: Enfield Council's Self-Assessment against the Excellent Level of the Equality Framework for Local Government, 2011

- Tackle financial challenges with determination, retaining the focus on quality and value-for-money and targeting investment where it is most needed.
- Work in partnership with neighbouring councils, the voluntary sector, other agencies and the community as part of a team working towards a shared vision.

The Council is committed to 3 strategic aims:

- **Fairness for all:** To serve the whole borough fairly, tackling inequality through the provision of excellent services for all, targeted to meet the needs of each area, listening to and understanding the needs of every community.
- **Growth and sustainability:** To help Enfield reach its full economic potential, and harness the potential that exists in the borough to build a strong and sustainable future for residents, the environment and the economy. This includes supporting local businesses and forging a new relationship with employers, attracting investment to increase jobs and business growth and supporting and empowering the voluntary and community sector.
- **Strong communities:** To listen to the voices and needs of Enfield's diverse communities and to create meaningful opportunities for residents to lead local improvement, and be involved in decision-making, including decisions about devolved budgets. The Council aims to be open and accountable, to communicate more effectively and to show community leadership in championing the needs of Enfield.

Through the Regeneration, Leisure and Culture Department, the Council has identified a number of objectives which aim to bring the Council and organisations and communities across Enfield together to deliver cross-cutting agendas related to business and skills development, regeneration, transport, leisure, culture housing and the development of sustainable communities. A key objective is to improve the life chances of the most deprived communities by developing and supporting the capacity of people to fully realise their potential and by recognising the unique opportunity that arises from Enfield's diversity.

Improving mental health and wellbeing in Enfield is a priority for the Council. The joint strategy articulates its vision for services for adults with mental health issues over the next 5 years. Implementation of the strategy will deliver the improvement needed.

### ***Enfield Health and Wellbeing Strategy***

The Council and the CCG have worked with partners to develop a Joint Enfield Health and Wellbeing Strategy. The aim is to improve the health and wellbeing of the population and to reduce inequalities. This will be achieved by addressing the population's health and social care needs through an holistic approach and by ensuring that organisations work together in an integrated way to meet identified need. 5 priorities have been agreed:

- Create stronger communities.
- Narrowing the gap in life expectancy.
- Best start in life.
- Healthy lifestyles, healthy choices.
- Support people to be independent, safe and well.

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Child and adolescent and adult mental health are both a priority for both organisations and are therefore priorities in the Health and Wellbeing Strategy. The Health and Wellbeing Board has identified key milestones for adult mental health services under the last priority. It will be monitoring progress over the 5 life of the strategy.

### ***Commissioning Strategy for Adult and Older People’s Mental Health Services in Barnet, Enfield and Haringey 2013-15***

A mental health commissioning strategy for the period from 2013-15 has been developed for the boroughs of Barnet, Enfield and Haringey. The strategy provides a framework for the continuing modernisation of mental health services and responds to a broad range of mental health and social needs. Its focus is the improvement of secondary and primary care based mental health services. It includes the health and social care services that deliver an integrated response to the need for assessment, treatment and support for adults with serious mental health issues in the 3 boroughs. The strategy is located in the wider context of health and social care services in the boroughs but does not address the need for improvement and development of these services.

The aim of the strategy is to:

- Support people in maintaining and developing good mental health and wellbeing.
- Give people the maximum support to live full, positive lives when they are dealing with their mental health issues.
- Help people to recover as quickly as possible from mental illness.

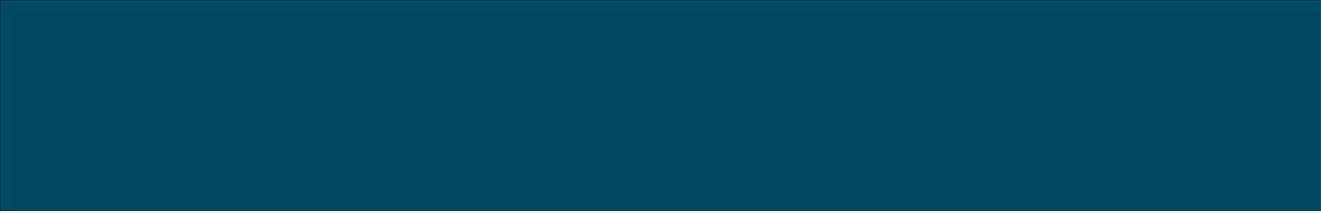
The strategy proposes a “transformation model of care”. This will give an increased focus on the stepped care recovery model, integrated care, effective team working and the aspirations set out in the national strategy<sup>40</sup>.

It identifies the following commissioning priorities:

- The need to further extend capacity in primary care to support people with mental health issues to stabilise in the community and wherever possible maintain or move back into paid work.
- Promote the use of individualised budgets.
- Prepare integration of all counselling and therapy services through the development of Increasing Access to Psychological Therapy services (IAPT).
- The delivery of effective alternatives to hospital admission.
- Wherever possible, deliver services as close to where people live as possible. This will involve reviewing clients currently placed out of district to ensure we are supporting people effectively to move on.
- Encourage the involvement of services users and carers in strategic planning, service review and development. Commissioners will work actively with the Mental Health Partnership Boards.
- Emphasise recovery, valuing lived experience and fostering peer leadership.
- Develop a stepped care recovery model to support individuals in the community and reduce the numbers entering secondary care mental health services.
- Ensure the recommendations from the Francis Report are recognised locally and form the cornerstone of commissioning priorities.

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<sup>40</sup> No health without mental health: a cross government mental health outcomes strategy for people of all ages, DH, 2011

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- Central emphasis on the recovery model and the promotion of mental health and wellbeing, whilst supporting people in the community; the tenet of recovery and therefore the ethos of the strategy is that it is not determined by cure of ‘clinical recovery’. Instead, it emphasises the unique journey of the individual living with mental health issues to build a life for themselves beyond illness. A person can recover their life without necessarily ‘recovering’ from their illness. Therefore there is an expectation that all services support the individual in maximizing their potential and supporting them in mainstream society, thus re-defining recovery to incorporate quality of life, a job, a decent place to live, friends and a social life.

The following services for adults with mental health issues are prioritised for improvement 2013-15:

- Primary care services.
- Psychiatric liaison services.
- Services for people with attention deficit and hyperactivity disorder.
- Access to psychological therapies.
- Improvement of mental health services provision for adults with a learning disability and/or autism.

The main provider of secondary care mental health services in Enfield is BEHMHT. The Trust also provides psychological therapies commissioned under the IAPT initiative. It provides services to the neighbouring borough of Haringey. It has developed its own strategy for improvement from 2013-18<sup>41</sup>. The current Mental Health Service Provider has been involved in the development of the Strategy and key elements of the organisations strategy for improvement have been incorporated into the Enfield Strategy.

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<sup>41</sup> Trust Clinical Strategy, Barnet, Enfield and Haringey Mental Health NHS Trust, 2013-18

## SECTION 3

# Current and Future Demand

Current and future demand for services for adults with mental health issues and their carers has been estimated by completing a mental health needs assessment. This is based on a balance of national and local data and consists of demographic data, the incidence and prevalence of mental health issues and information about local services and service use (activity).

### The Prevalence of Mental Health Issues

It is known that:

- At least 1 in 4 adults will experience a mental health problem at some point in their lives and that 1 in 6 adults is likely to be experiencing a mental health problem at any one time<sup>42</sup>.
- Almost half of all adults will experience at least one episode of depression during their lifetime<sup>43</sup>.
- 1 in 10 new mothers experience post natal depression<sup>44</sup>.
- 60 percent of adults living in hostels have a personality disorder<sup>45</sup>.
- 90 percent of all prisoners are estimated to have a diagnosable mental health problem (including personality disorder) and/or a substance misuse problem.
- The incidence of mental health issues can increase in times of economic uncertainty, as can the rate of suicide.
- The number of older people in our population is increasing, with a corresponding increase in the number of those at risk of dementia and depression<sup>46</sup>.
- 23 percent of the burden of disease in the UK lies with mental health issues.
- Only 26 percent of adults with mental illness receive care.
- On average, people with schizophrenia die 15-25 years earlier than other people.
- Depression is associated with 50 percent increased mortality from all disease.
- Mental health issues are estimated to be the commonest cause of premature death.
- The presence of mental health issues in people with a physical illness is associated with a 45-75 percent increase in service costs per patient after controlling for severity of physical illness<sup>47</sup>.
- 12-18 percent of all expenditure on long term physical conditions is linked to poor mental health and wellbeing – at least £1 in every £8 is spent on long term conditions.

Deprivation is a risk factor for poor mental health. It can be used as a proxy for identifying likely high rates and incidence of mental health issues in a community, helping to identify communities where there is likely to be a need for targeted interventions and increased levels of activity to ensure positive mental health and wellbeing. Ensuring that deprivation is addressed positively for individuals and communities is therefore key to maintaining mental health and wellbeing and facilitating recovery from mental health issues. It is therefore a key plank of the national mental health strategy. It also means that action across all council and clinical commissioning group functions is needed and will help to improve the mental health and wellbeing of the population.

Social capital is the level of cohesion and trust in a community and the level of participation in the community in which an individual lives. It helps to promote mental wellbeing and to prevent mental health issues. Interaction, social networks and community engagement indicate the presence or otherwise of factors which lead to positive mental health and wellbeing. Improvements in these areas

42 McManus S, Meltzer H, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey*. Leeds: NHS Information Centre for Health and Social Care.

43 Andrews G, Poulton R and Skoog I (2005) Lifetime risk of depression: restricted to a minority or waiting for most? *British Journal of Psychiatry* 187: 495-496

44 Gavin N, Gaynes B, Lohr K et al. (2005) Perinatal depression: a systematic review of prevalence and incidence. *Obstetrics and Gynaecology* 106: 1071-1083

45 Rees S (2009) *Mental Ill Health in the Adult Single Homeless Population: A review of the literature*. London: Crisis and Public Health Resource Unit.

46 McCrone P, Dhanasiri S, Patel A et al. (2008) *Paying the Price: The cost of mental health care in England*. London: King's Fund, 220-226

47 Mental Health Deep Dive, Strategic Clinical Network, NHS England, 2013

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improve the quality of life of everyone and help people with mental health issues feel that they belong to their communities enabling them to recover from mental health issues more easily.

In addition to the social determinants of poor mental health, poor physical health can lead to the development of mental health problem. It may also be a consequence of poor mental health and wellbeing. People with long term mental health conditions are known to be more likely to experience mental health issues. The presence of mental health issues is also known to slow down the rate of recovery from a physical illness. People with long term conditions are likely to be at increased risk of mental health issues.

## **Local Needs Assessment**

This section is drawn from the Enfield Joint Strategic Needs Assessment and the mental health needs assessment completed in October 2013.

### ***Population Profile and the Estimated Number of Adults with Mental Health Issues in Enfield***

The number of people in the Enfield population is growing. It increased from 273,559 to 312,466 (15%) between 2001 and 2011. In 2012, 317,287 people were living in Enfield. This number is projected to increase to 330,000 (4%) by 2022 and to 340,000 (7%) by 2032. The growth in adults over age 65 years is likely to be greatest. The number of adults aged 18-64 years will increase by 3.6 percent over the 7 years to 2020. The number of people with mental health issues is determined by the incidence of the various disorders in the population. Therefore, the number of adults with a mental health problem in Enfield is likely to increase. It is possible that a greater increase than that resulting from the projected growth in population will occur because the incidence of mental health issues is known to increase in times of significant economic pressure. There is evidence – nationally and locally – that the rate, and therefore the numbers, are increasing now.

In 2012/13, it was estimated that in Enfield there were:

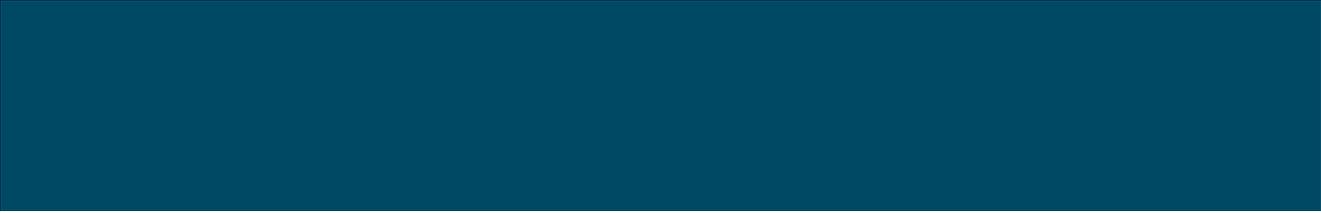
- 37,294 adults with a neurotic disorder. This is likely to increase of 1,273 to 38,567 by 2020.
- 4,003-8,006 adults living with a serious mental illness. This is likely to increase by between 143-285 to 4,146-8,291 by 2020.
- 13,813 adults have a personality disorder. This is likely to increase to 14,436 by 2020.
- 62 adults with early onset dementia i.e. under 65 years, with a likely increase of 4 to 66 by 2020. (This compares with an estimated increase in the number of adults aged 65 years and over of 424 from 2,871 to 3,295 (15%)).
- 247 new mothers each year suffering from post natal depression with a further 247 not being identified. Each year, it is likely that 5 new mothers will suffer from puerperal psychosis.

There are significant areas of deprivation in Enfield with 10 wards being in the top 20 percent most deprived wards in the country. 3 wards are in the top 10 percent most deprived wards nationally. The rate and number of adults with mental health issues in these wards is likely to be high.

Approximately 19 people, 75 percent of whom are men, in Enfield commit suicide each year.

During 2011-12, 1,128 drug users in Enfield were in contact with specialist services. It is likely that 846 (75%) of these people have a need for some form of mental health treatment. 10 percent of these people (85) are likely to need treatment by secondary mental health services. However, many drug users do not access specialist drug treatment services. In 2011-12 only half were known to treatment services. Therefore it is likely that the number of people with a dual diagnosis is significantly higher.

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Between 39 and 55 percent of the population of Enfield is from a BME community; The 2001 Census figure for those residents who classified themselves as non-white British was 38.8 percent. However, the latest projections put this figure at 54.9 percent. The largest ethnic minority group in Enfield is made up of Cypriots (both Greek and Turkish), who make up 8.7 percent of the total population. Enfield and Haringey, a neighbouring borough has the largest Turkish and Greek Cypriot population in the country. In 2001, 25 percent of Enfield's population were born outside the UK. The number of Somali, Kurdish and Turkish residents has increased significantly over the last decade. These figures put Enfield on a par with many boroughs where the non-white UK proportion of the population is actually in the majority.

The most common faith or belief of Enfield residents is Christian. The 2001 Census figures calculate this at 63.2 percent. However, the second most popular faith or belief stated in Census returns was those people who say they have no faith or religious belief – 12.3 percent. The third most common faith was defined as Muslim at 9 percent. However, market research and the school census data on ethnicity both indicate that the Muslim proportion will have increased substantially since 2001.

Latest estimates suggest that around 1,825 asylum seekers came to Enfield in the five years to mid-2009. Home Office statistics show that at least 420 asylum seekers were believed to be resident in Enfield at the end of 2009. It is estimated that up to 2,000 illegal immigrants may also be resident in the borough. In addition, the latest annual National Insurance figure for registered migrant workers stands at 7,120. Between April 2004 and September 2010, the total number of National Insurance registrations from all foreign nationals was 39,550, many of whom were Polish.

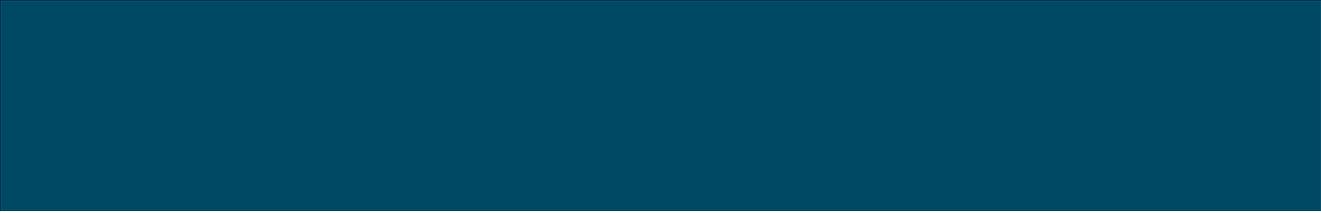
It has always been difficult to gather firm figures for members of the lesbian, gay, bisexual and transgender (LGBTi) community because of the stigma felt by some to be attached to defining oneself as belonging to that community. In addition, the question has not been asked directly in the Census. However, lifestyle surveys in the past have suggested that 6.3 percent of men and 5.7 percent of women have had partners of the same sex at some time in their lives. Other estimates put the figure at around 10 percent. A recent survey of 250,000 people by the Office for National Statistics puts the national figure at between 1 percent and 2 percent of the population. This means that around 4,300 people in Enfield could belong to the LGB community. It is also estimated that the figure of transgender people nationally stands at around 2,000.

The latest projections estimate that 16 percent of Enfield's population have a disability or long-term illness that limits their daily activities. This is equivalent to 1 in every 6 or 7 people. However, experts believe that this is likely to be an underestimate as many people do not like to classify themselves as disabled. The number of 'entitled cases' for Disability Living Allowance has risen in Enfield over the last 4 years from 10,270 to 11,730. In the same period, the number of people entitled to Attendance Allowance rose from 6,460 to 6,830, and Carer's Allowance from 1,840 to 2,480.

### ***Inequalities in Mental Health and Wellbeing in Enfield***

In 2012/11, the excess mortality ratio for adults with a serious mental illness aged under 75 years in Enfield was the 3<sup>rd</sup> highest rate amongst people with a serious mental illness in London, although the rate was lower than the England rate. While the general population mortality rate amongst under 75s was 316 per 100,000 in 2010/11, mortality amongst adults with serious mental illnesses was 1,200 per 100,000 for the same period. This gives an excess mortality amongst adults with mental illness of 884 per 100,000.

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People with mental health issues frequently live in deprived areas. They often have difficulty securing a job and therefore having enough money to live on and finding settled accommodation. Accommodation, employment and enough money to live on are core to the mental and physical wellbeing of us all. 29 percent of adults in Enfield who are in touch with secondary care mental health services are not in settled accommodation. Only 4 percent are in employment.

There are significant inequalities in physical and mental health between communities and age groups in Enfield. The status varies according to the ethnicity and age of the population and because of other one-off events in Enfield.

There is a significant difference between the use of inpatient assessment beds by adults from BME communities in comparison with use by adults from white British or white Irish communities. Further analysis is needed to understand the reasons for and implications of this.

### **Understanding Mental Health Need in Enfield: Consultation with Stakeholders**

As part of the work to complete the mental health needs assessment in July 2013, 37 people with an interest in services for adults with mental health issues were consulted. All the key stakeholder groups were involved in this process. The following issues were identified:

- Accessibility of services and awareness amongst service users.
- Availability of services.
- Quality of local services.
- Safety of local services.
- Support for people who have been discharged into the community.
- Integration of services between different organisations in Enfield.
- Changes in need amongst service users.
- Cultural factors.
- Other Areas (personal budgets and housing).

## SECTION 4

# Market Analysis

A market analysis has been undertaken in order to identify the strengths and weaknesses of current service provision and therefore to identify gaps. These gaps are addressed in the service design, strategic objectives and commissioning intentions described in Section 5.

### Service Provision

The main provider of mental health services in Enfield is the Barnet, Enfield and Haringey Mental Health NHS Trust (BEHMHT) (the current Mental Health Service Provider).

Care for adults with common mental health issues is provided in primary care managed by GPs with support from the current Mental Health Service Provider. Psychological interventions including counselling and cognitive behavioural therapy are also commissioned from the current Mental Health Service Provider the IAPT initiative.

An integrated health and social care service for adults aged 18 to 64 years of age with serious mental illness and their carers is also commissioned from the current Mental Health Service Provider. The services provided are as follows:

- A triage service to enable timely access to the service best placed to meet the needs of the individual.
- Early intervention in psychosis services for adults aged between 14-35 years experiencing their first episode of psychosis, or those who are in the first 3 years of psychotic illness.
- 2 community support and recovery teams (East and West Enfield), offering assessment, treatment and support to adults with serious mental illness.
- A community rehabilitation team for people living in 24 hour supported housing.
- A recovery house jointly provided with Rethink, providing short-stay accommodation and support for up to 14 days for adults in crisis (12 beds).
- A complex care team for adults with complex mental health needs.
- Acute assessment and treatment services – an inpatient service (51 beds), including psychiatric intensive care service, 136 suite, a day therapy service and a home treatment team.
- A psychiatric liaison service.
- A community eating disorder service.
- A forensic outreach service and forensic friends and family support group.
- A personality disorder service.
- A health psychology service for people who have physical health issues, long term medical conditions or those who have had a difficult medical experience.
- A service for adults with organic mental illness including dementia.

The current Mental Health Service Provider, supported by the Council, provides an integrated health and social care service for adults aged 65 years and over with functional and/or organic mental health issues, the latter as part of Enfield's dementia pathway. Transition from adult mental health services is at around the age of 65, although the point of transition is tailored to individuals' needs and preferences. The service provides acute and community assessment, treatment and support in inpatient and community settings including the service user's home. The Council provides information and support to people in Enfield over the age of 55 with a diagnosis of dementia who do not have health needs.

Specialised treatments for people with very serious illness are provided in community teams or tertiary care inpatient services commissioned by specialised services commissioners. Services include the following:

- Inpatient rehabilitation service.
- Low secure service.
- Medium secure service.
- High secure.
- Forensic outreach service.
- High secure services are provided by a handful of providers nationally.

The majority of low and medium secure services for adults living in Enfield are provided by the North London Forensic Service.

Specialised accommodation with varying levels of support is purchased by the Council for adults with mental health issues from a range of providers. In addition, floating support is commissioned by the Council to help people maintain their independence in their own homes.

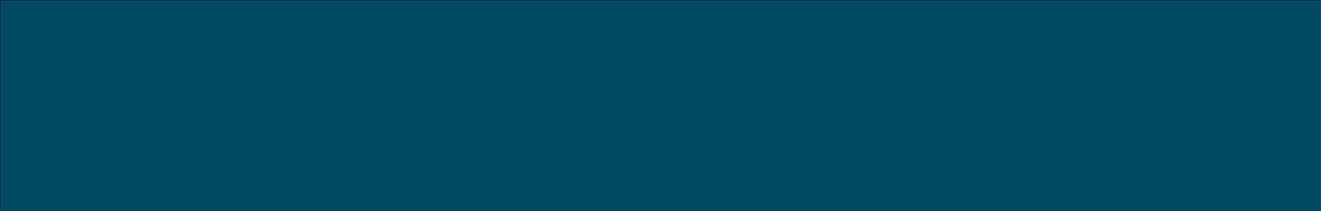
Enfield Council and the independent sector (commissioned by Enfield Council), provide a reablement service, domiciliary care, residential and nursing home care along with care packages at home or in nursing homes to support those with dementia. People with dementia and their carers also access a wide range of services provided by the third sector, including respite care, day opportunities and information and advice.

The mental health enablement service at Park Avenue in Bush Hill Park, provides support to promote independent living, healthy lifestyles, community participation, choice and control for those assessed as eligible. All adults with mental health needs who have been assessed as vulnerable under the borough's Fairer Access to Care Services (FACS) criteria and who are not already receiving bought social care support packages are eligible for support from the enablement service. Short-term (3-6 months) personalised interventions are offered to assist people to achieve the identified outcomes. A self-referring drop-in service is available, although service users are mostly recommended by consultants, care co-ordinators and GPs. The service aims to prevent admission to hospital and reduce delayed discharge from hospital.

A number of voluntary agencies offer activities specifically targeted at adults with mental health issues in Enfield:

- Enfield Mental Health Users Group (EMU) an independent user group that represents users' views on mental health issues. It offers group advocacy, support groups and information.
- Mind in Enfield provides a range of services to meet the needs of mental health service users and to challenge the stigma and isolation experienced by people who have mental health issues.
- The Hanlon Centre provides leisure and sports facilities and job search assistance and receives around 90 visits per week from those with mental health conditions.
- The Richmond Fellowship support adults into employment providing specialist employment information, advice and guidance to support and enable clients to develop core work skills.
- The Ebony People Association provides services and support to BME communities living in Enfield.
- Enfield Saheli offers support and advice to women in Enfield and neighbouring boroughs. The charity is run by women for women, with special emphasis on support for Asian women of all ethnicity.
- The Enfield Clubhouse is based on the international Clubhouse model of work-based rehabilitation. It aims to help people who have experienced mental health issues to rebuild their lives.

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There are numerous community organisations and charities that offer support and activities to adults of any ethnicity and from a range of backgrounds. Many of these are willing and able to work with adults with mental health issues. The Council has prioritised the development of voluntary and community services<sup>48</sup>.

Enfield Carers' Centre provides support for all carers in Enfield through advocacy, training, respite and a be-friending service. A monthly support group for carers of adults with mental health issues meets there.

## **Service Performance**

This section provides information on what we know about the performance of current services. Services are defined as performing well or poorly if the indicator is rated as a positive or negative outlier in performance against that of England as a whole. Performance that is average is determined by indicators that are neither significantly better nor significantly worse than the performance of England as a whole. However, this is only a comparative measure which is useful in terms of identifying priorities. More in-depth work is needed to understand quality e.g. patient experience.

Performance in adult mental health services in Enfield is good in the following areas:

- Rate of emergency hospital admissions for self-harm.
- Hospital admissions caused by unintentional and deliberate injuries.
- Timeliness of social care assessments.
- Admission to permanent residential care.
- Social care clients receiving a review of their care.

average in the following areas:

- Rate of hospital admission for unipolar depressive disorders.
- Percentage of people entering treatment psychological therapies for treatment.
- Rate of recovery following psychological therapy.
- Self-directed support.
- People in touch with secondary care services in paid employment.

and poor in the following areas:

- Identification by GPs (the number of adults with depression and schizophrenia, schizotypal and delusional disorders registered on GP registers is low).
- Use of inpatient beds for schizophrenia, schizotypal and delusional disorders (admission rates and bed use are high).
- Provision of settled accommodation (the number and percentage of adults in settled accommodation is low).
- Use of self-directed support (the number and percentage of adults receiving a direct payment is low).

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48 Voluntary and Community Sector Strategic Commissioning Framework 2013-16, London Borough of Enfield, 2013

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Some performance is assessed as being higher or lower than England i.e. performance is not assessed as being good or bad. This approach is used where there are a number of possible reasons for the rating. The indicators do not differentiate between services for people with a functional illness and dementia. Further work is needed to understand how services are performing prior to initiating action.

Performance in Enfield is assessed as being high in the following areas:

- The number of people using mental health services.
- The number of contacts with mental health services as a whole.
- The number of people on CPA.
- The number of contacts with a CPN.
- The number of bed days.

High performance could be caused either by inappropriate service use, or success in identifying people with mental health issues. However, the latter is unlikely due to the relatively low numbers of people registered as having a mental health problem on the GP registers.

The current Mental Health Service Provider currently provides 22 acute inpatient beds per 100,000 adult population across the 3 boroughs it serves. The figure for Enfield is 21.5 per 100,000. This is below the national median. As a London provider serving a population with higher than average deprivation, this appears to represent a comparatively efficient utilisation of in-patient resources. However, at the same time there is significant expenditure – current estimates are around £1.0 million – on out of area treatments by The current Mental Health Service Provider. The majority of this is on acute inpatient care or inpatient rehabilitation. Further analysis is needed to understand the cost and reason for the expenditure. During 2013/14 there has been increasing pressure on inpatient services in Enfield.

## **Service Gaps**

The most significant gap in commissioned services was the provision of a psychiatric liaison service. An effective psychiatric liaison service is the key to a cost effective health and social care and mental health services system and model. It ensures that a robust specialist mental health assessment is completed as an individual accesses acute general hospital services, usually when in crisis. It also supports staff in acute general hospital settings to work effectively with adults with mental health issues. The psychiatric liaison service has been shown to ensure that better use of beds is made in acute general hospitals by ensuring that only those who need to be admitted for treatment of a physical health problem are admitted. Those who need treatment for an acute phase of a mental health problem are diverted to acute mental health services for assessment and treatment in the community or an inpatient bed. These services have also been shown to deliver better outcomes for patients by ensuring timely assessment of their physical and mental health status, and more timely access to the service that can best meet their needs. The CCG provided funding to set up a psychiatric liaison service during 2013/14. It is continuing to fund it during 2014/15 but will be working with providers to pick-up the cost based on savings that should follow its establishment.

In addition, there is currently no service for new mothers with post natal depression. It is likely that there are 548 women who will need this service per annum. Half of these are currently identified and in touch with their GPs. A few are referred to mental health services. A business case has been developed by the Enfield Parent Infant Mental Health Services (PIMHS). Investment of between £81,625 to £144,250 depending on the capacity and model to be adopted is needed to establish this service. Work is currently underway to improve patient experience and outcomes through the development of improved

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care pathways and improved co-ordination of the services that are already commissioned and provided across the health and social care economy.

There is also a need for improvement in the range and/or capacity and quality of the following:

- Mental health promotion and prevention activities.
- Culturally and faith sensitive assessment, treatment and support services.
- Primary care based mental health assessment, treatment and support.
- Capacity to meet the need for psychological therapies for adults with common mental health issues:
  - The CCG has increased capacity to 10 percent of the prevalence of depression and anxiety in the adult population. The national target is 15 percent. The effectiveness of the service currently commissioned will be monitored during 2014/15 with a decision being made about the quality of the service and the total capacity needed in the longer term. Provide psychological interventions of adults with Long Term Conditions.
  - Provide psychological interventions for older adults.
  - Provide support into employment for adults accessing psychological therapies (This is a core component of IAPT services and supports and helps to maintain recovery.)
- Support to find meaningful occupation and/or employment or training.
- Settled accommodation and flexible support.
- Voluntary sector and community based activities.
- Peer support.
- Access to secondary care mental health services.
- Improved access to information, advice and guidance.
- Acute care including home treatment, inpatient care, effective crisis response and effective psychiatric liaison.
- Inpatient rehabilitation.
- Early onset dementia.
- Effectively co-ordinated care and joined up, integrated services.

Ensuring that transition from child and adolescent to adult mental health services and from adult to older adult or dementia service is effective is a key concern.

## **Market Development**

The Council and the CCG will stimulate the market and encourage the development of new services to provide the new approaches needed to service delivery. The Council has agreed a market development strategy to help to achieve this<sup>49</sup>.

## **Finance and Investment**

### ***Future Resourcing***

It is clear that the economic climate and the increasing pressure on health and social care services that arise from both the projected overall increase in the population, the aging population, developments in medical science and technological advances that increase the range of treatments that are possible and increasing public expectations, means that it is unlikely that there will be an increase in the financial resources available to either the CCG or the Council. In fact, a reduction is much more likely. It is

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<sup>49</sup> Market Statement: working with Enfield Adult Social Care Market to deliver change

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therefore imperative that resources are targeted effectively and the productivity is maximised. This is the premise on which the triborough and local adult mental health strategies are based. Therefore any service improvement and development will only be achieved if significant improvement in productivity is achieved.

The current Mental Health Service Provider has faced a significant increase in adult acute admissions and there continue to be more beds in the system than the number commissioned. This has had an impact on the investment plan for 2014/15 with the following additional investment being required:

1. £790,000 additional acute inpatient activity
2. £645,000 psychiatric liaison
3. £512,000 increasing access to psychological therapies

The CCG is currently working with commissioners in Barnet and Haringey and the The current Mental Health Service Provider to develop an investment plan for mental health as part of its strategic planning processes and which take account of the financial challenges faced by the health and social care system. The aim is to improve service quality and outcomes and to develop a mental health services investment plan. This plan will address the significant increase in mental health admissions experienced during 2013-14. It will seek to improve productivity and ensure that performance is in line with national benchmarks for mental health trust performance.

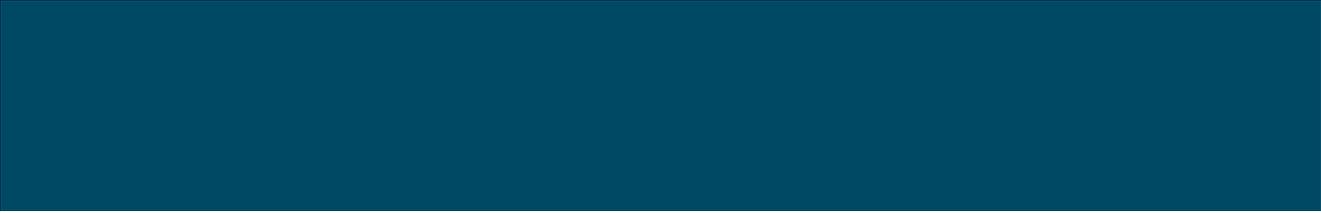
Along with all other Councils in England, Enfield Council has been subject to a reduction of £59 million in its allocation over the past 3 years. Pressure on resources will continue with a further £60 to £65 million reduction being required.

Most developments that need significant resourcing in the strategy are schemes that have already been identified by either the Council or the CCG, although detailed business cases and costings are still needed prior to final agreement being given to proceed:

- The Council
  - The capital cost of developing a mental health and wellbeing centre/re-providing Park Avenue mental health resource centre (capital resources identified in principle, revenue consequences may not be fully covered.)
  - Increasing the number of units of settled accommodation by approximately 25 units. (Capital cost and source of funding to be determined.)
- or the CCG
  - Inpatient rehabilitation assessment and treatment service – tri-borough service. (Capital and revenue cost to be determined. To be funded through service re-design/re-configuration including bringing people in out of area placements back to Enfield.

However, new investment may be required to meet the needs identified in the strategy as follows:

- The Council:
  - Social care support/activities for adults living in community settings.
  - Increased floating support.
  - Holding an anti-stigma/anti-discrimination campaign – £20-40k (bid to National Time for Change monies submitted September 2013).
  - Holding a mental health awareness campaign – £20-£30k.

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- Mental health promotion initiatives.
  - Delivering mental health first aid training for all frontline staff.
  - Enhancing health promotion initiatives to include mental health.
  - Support for carers of adults with mental health issues.
- The CCG:
    - IAPT: funding to meet up to 15 percent of the prevalence of the disorder to meet national target 2014/15 if deemed necessary to meet demand or need. (Currently funded at 10 percent.)
    - Primary care mental health service (full/partial funding from the transfer of resources that may follow clients from secondary to primary care under work to develop care pathways.)
    - Improving peri-natal mental health services.
    - Psychiatric liaison service (currently pump priming provided by the CCG; acute general/mental health provider responsibility).
  - Joint Council/CCG:
    - Assessment, treatment and support the mental health needs of BME communities and other groups with protected characteristics (cost to be identified following mental health needs assessment for this group).
    - Initiatives to increase the employment of adults with mental health issues by the Council, the CCG and The current Mental Health Service Provider.

Where costs are known, these are indicated. In all other cases, the cost is to be determined. Therefore initial discussion with relevant services, directorates and the Council DMT and Cabinet, the CCG Executive Team and Board to determine which of the schemes will be prioritised. As service development will be undertaken in the context of ongoing and significant pressure on resources, in advance of these discussions, work is needed to gain an increased understanding of the potential to resource these schemes through improvements in productivity and service redesign. All stakeholders will be invited to be involved in this process as the creativity and ideas of everyone as to what needs to be improved, what the priorities for improvement are and how that improvement could be achieved is needed.

As the strategy is implemented, business cases will be developed for each proposal and submitted to the relevant Board for approval. Where proposals for change are significant, there will be full public consultation or consultation with those directly affected by the proposal, along with public bodies such as Healthwatch and the Council Health Scrutiny Committee in accordance with best practice and statutory and legal requirements.

## SECTION 5

# Gap Analysis and Design of Future Provision

This section sets out the CCG and the Councils' joint vision, key strategic goals and objectives and associated commissioning intentions. This is the core of the strategy and describes what the 2 organisations intend to do to improve the mental health and wellbeing of Enfield residents and to improve recovery for adults with mental health issues and their carers between 2014 and 2019. The objectives are aligned with the aims and objectives in the national mental health strategy<sup>50</sup> and are underpinned by a robust evidence base which includes the research, needs assessment and market analysis described in the preceding sections.

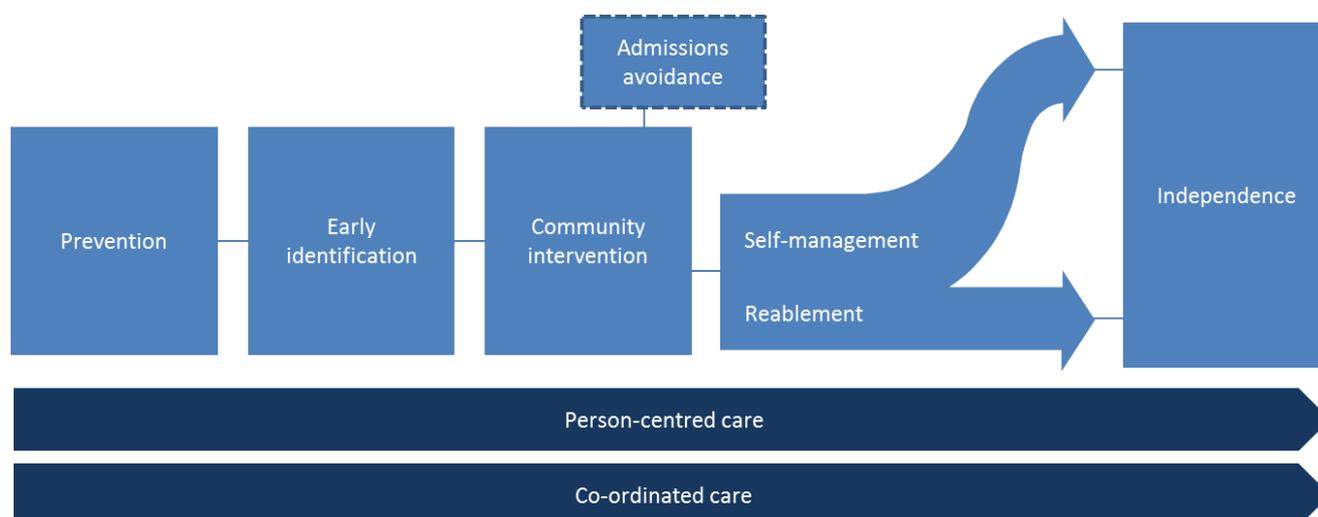
A vision for the mental health and wellbeing for adults in Enfield has been agreed. (See Figure 1.) In line with national strategy, 2 strategic goals have been agreed:

1. To improve the mental health and wellbeing of the population.
2. To improve recovery for people with mental health issues.

Within this, priority is given to recognising the role and contribution of carers and the need to support them effectively if they are to continue in their caring roles. The overall aim of the Enfield Joint Adult Mental Health Strategy is to improve quality – safety, effectiveness and patient/client experience, efficiency and therefore outcomes for Enfield residents.

The enhancement of the current community based mental health service is a key priority. Work to develop an improved model of integrated and effectively co-ordinated care has started and will continue through the life of the strategy. (See Figure 6 below).

**Figure 6: Enfield Model for Integrated Health and Social Care Across all Areas**



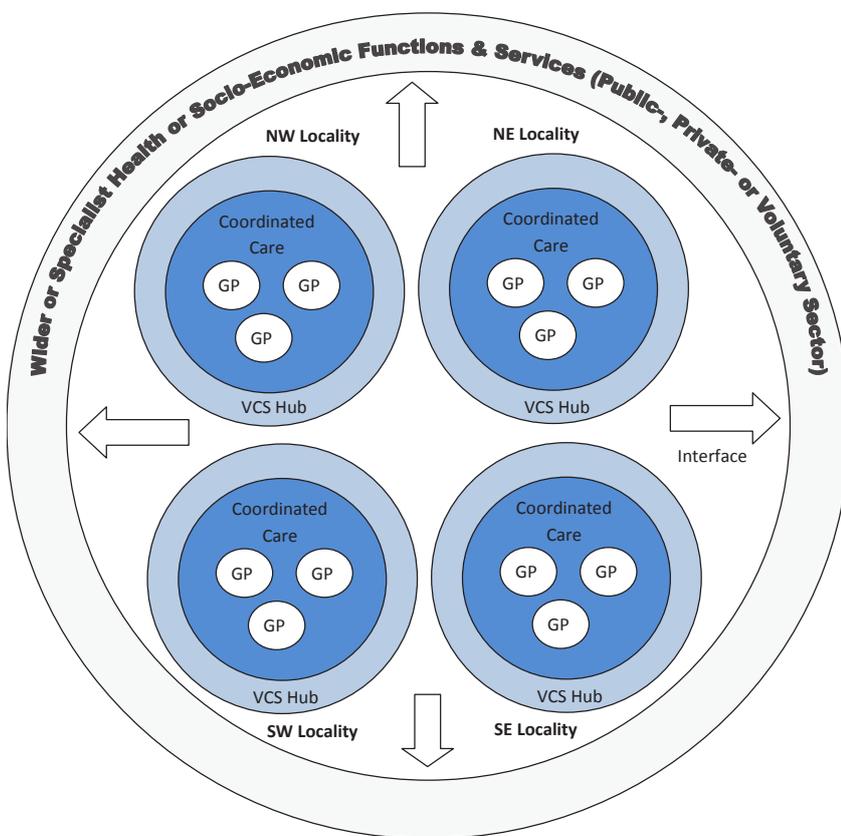
<sup>50</sup> No health without mental health: a cross-government mental health outcomes strategy for people of all ages: Implementation plan, DH, 2012

The aim is to improve the quality, efficiency and outcomes for people with health and social care needs who are resident in Enfield. The following principles underpin the model:

- Effectively co-ordinated, joined up and integrated care.
- Needs-led, personalised person-centred care.
- Flexible, multi-agency and multi-disciplinary working
- Prevention and early identification.
- Community based care.
- Care provided as close to home as possible.
- Following up health and social care interventions with an emphasis on reablement and self-management.
- Maximising independence.
- Enabling people, especially those with long term health conditions, to manage their conditions.
- Interventions based on Values Based Practice.

Alongside this, a locality model in primary care has been developed and is being piloted. (See Figure 7 below):

**Figure 7: The Pilot Enfield Locality Model**



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It is likely that the integrated model of health and social care and the locality model will be developed and adapted for adults with mental health issues as well as for other client groups. The model for adult mental health care will include:

- A stepped model of care tier 0-4.
- A stepped model of care for psychological therapies for adults with common mental health issues.
- A primary/secondary care care pathway.
- A system of risk stratification and management in primary care.
- A shared care protocol between primary and secondary care.
- Integrated assessment, treatment and support for mental and physical health and health and social care needs.
- A training programme for GPs, other primary care practitioners and other frontline workers across health and social care and other local government services.

The strategic objectives proposed in the consultation draft of the strategy have been revised in light of the CCG and the Council's learning about the current status of services and the feedback received. These are shown in Table 2 below. The objectives include relevant objectives from the Strategy for Mental Health Services for Adults and Older People in Barnet, Enfield and Haringey. The strategy will be delivered in partnership with service users and carers, statutory and non-statutory providers, the voluntary sector, local communities, service users and carers. It will be underpinned by values based commissioning and focussed on achieving positive mental (and physical) health care outcomes for the population of Enfield.

**Table 2: Enfield Joint Adult Mental Health Strategy: Strategic Goals and Strategic Objectives**

Task	Products	Outcomes	Responsibility Lead Organisation	Timescale Years (1-5)
<b>A. TO IMPROVE THE MENTAL HEALTH AND WELLBEING OF THE ENFIELD POPULATION</b>				
<b>1. To promote mental health and wellbeing and prevent mental illness</b>				
<b>1.1 Develop a programme of effective mental health promotion and prevention intervention.</b>	<ul style="list-style-type: none"> <li>i) 2-5 mental health promotion and prevention approaches agreed as evidence-based and to be implemented across or in targeted areas within the Borough</li> <li>ii) The evidence base for ‘Ecotherapy’<sup>51</sup> or ‘social therapeutic horticulture’ as a mode for improving both mental and physical health concurrently established and the benefit and potential of using Council owned land to develop a sustainable ‘Market Gardening’ project evaluated.</li> <li>iii) Mental health awareness campaigns developed with local communities established Borough-wide.</li> <li>iv) Mental health awareness campaigns targeting priority groups developed with relevant communities.</li> <li>v) ‘The Big White Wall’ project piloted and evaluated across Enfield following: <ul style="list-style-type: none"> <li>• Incidental contact with a GP or medical practitioner i.e. an appointment for a different ailment.</li> <li>• Following delivery of a physical Health Check.</li> <li>• Following contact with IAPT services to address a ‘common mental disorder’.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>i) Improvement in EMWB scores in defined groups: <ul style="list-style-type: none"> <li>• Targeted areas of deprivation.</li> <li>• BME communities.</li> <li>• LGBTI communities.</li> <li>• Adults on primary care registers.</li> <li>• Adults on secondary care caseloads.</li> </ul> </li> <li>ii) Improved physical health of participants as measured by a reduction in risk scores as defined by a Health Check or improvement in existing chronic health conditions;</li> <li>iii) Progress towards achieving parity of esteem for mental and physical health and wellbeing made.</li> </ul>	LBE	1-5
<b>1.2 Improve mental health awareness and the knowledge of all frontline health, social care and Council workers.</b>	<ul style="list-style-type: none"> <li>i) Appropriately tailored mental health awareness/first aid courses and online courses delivered to all frontline health, social care and Council workers: <ul style="list-style-type: none"> <li>• Primary care.</li> <li>• Health and social care practitioners in community services.</li> <li>• Staff supporting the Council Customer Pathway.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>i) Increased knowledge and awareness of mental health issues (Post course evaluation).</li> <li>ii) Adults with mental health issues and their carers reporting increased awareness and knowledge of mental health issues.</li> <li>iii) Health and social care practitioners reporting that they “make every contact count”... and evidence of this.</li> </ul>	LBE	2-5

<sup>51</sup> Ecotherapy is exposure to nature and the outdoors as a form or component of psychotherapy. To improve both mental and physical wellbeing. This type of therapy is based on the premises of ecopsychology, which explores the relationships between mental, environmental, and spiritual health

Task	Products	Outcomes	Responsibility Lead Organisation	Timescale Years (1-5)
<b>1.3 Improve mental health awareness and knowledge of targeted groups of frontline workers beyond health, social care and the Council.</b>	i) Appropriately tailored mental health awareness/first aid courses and online courses delivered to: <ul style="list-style-type: none"> <li>• The police.</li> <li>• Job Centre Plus.</li> <li>• Other groups identified as needing training.</li> </ul> ii) Other priority groups identified and Mental health first aid courses delivered to 2-5 groups.	i) Increased knowledge and awareness of mental health issues and services of relevant workers. (Post course evaluation). ii) Adults with mental health issues and their carers reporting increased awareness and knowledge of mental health issues.	LBE	2-5
<b>1.4 Establish a programme of preventative work with families with an adult who has a mental health problem.</b>	i) Effective interventions for working with families agreed by CAMHS and adult mental health services practitioners. ii) A programme in place to prioritise working with families with an adult who has a mental health problem.	i) Reduction in the number of children with a preventable mental health problem.	LBE	1-5
<b>1.5 Establish a programme to challenge stigma and discrimination.</b>	i) A programme of events to challenge stigma and discrimination established.	i) Increased knowledge and awareness of mental health issues and services in the population of Enfield. ii) Adults with mental health issues and their carers reporting increased awareness and knowledge of mental health issues.	LBE	1-5
<b>1.6 Establish a suicide awareness and prevention programme.</b>	i) Suicide awareness and prevention included in mental health awareness and promotion training for the frontline workers listed above. ii) A suicide prevention strategy developed with relevant stakeholders. iii) Work undertaken with GPs.	i) A reduction in the number of suicides of Enfield residents over 5 years. ii) A reduction in the number of suicides of residents in other Boroughs over 5 years.	LBE	2-5
<b>1.7 Establish a programme to promote awareness of mental health issues in the workplace amongst employers.</b>	i) A mental health and employment Programme implemented across Enfield following a pilot in Edmonton: <ul style="list-style-type: none"> <li>• Mental health training programme (Jobcentre Plus, Work Programme, Volunteer involving organisations)</li> <li>• Mental health and employment pathways</li> <li>• IAPT employability group</li> <li>• Enhanced jobs brokerage support</li> <li>• Engagement with employers to support staff and employees to improve chances of job retention.</li> </ul>	i) Impact: <ul style="list-style-type: none"> <li>• Improved employment outcomes for people with mental health issues or at risk of developing them</li> <li>• Improved mental health and wellbeing of people with identified mental health issues who are also unemployed</li> <li>• Improved mental health and wellbeing of all people who are unemployed.</li> <li>• Early intervention/prevention of mental ill health in workplace.</li> </ul>	LBE	1-5

Task	Products	Outcomes	Responsibility Lead Organisation	Timescale Years (1-5)
	Delivering: <ul style="list-style-type: none"> <li>Improved pathways between services so that the journey of being out of work and having mental health needs is clearer and empowers the user.</li> <li>Mainstream employment services equipped to understand and deal with mental health issues.</li> <li>Increased awareness about mental health among employers and practical support offered.</li> <li>Identification of evidence-based interventions/approaches.</li> </ul>			
<b>1.8 Work with communities to identify and address the things that enhance mental health and wellbeing.</b>	i) 2-5 projects to improve mental health and wellbeing underway with local communities. ii) Mental health commissioning, Council housing department and housing associations working together to improve capacity and quality of housing. iii) A programme of conferences and 1-2 day seminars to build and promote culturally relevant wellbeing and resilience models established.	i) Improvement in EMWB scores* in defined groups: <ul style="list-style-type: none"> <li>Targeted areas of deprivation.</li> <li>BME communities.</li> <li>LGBTi communities.</li> <li>Adults on primary care registers.</li> <li>Adults on secondary care caseloads.</li> </ul> ii) Improvement in community resilience. iii) Mental health and wellbeing initiatives integrated into: <ul style="list-style-type: none"> <li>Enfield Strategic Partnership</li> <li>3x Local Area Partnerships</li> <li>Edmonton Project</li> <li>Other initiatives across Enfield</li> </ul>	LBE	1-5
<b>2. To reduce inequalities in mental health*</b> <i>* Includes addressing the physical health care needs of adults with serious mental health issues</i>				
<b>2.1 Work with faith and community leaders, voluntary sector organisations and local communities to understand and address the mental health needs of BME communities.</b>	i) Needs assessment for BME communities completed. ii) 2-5 projects with local communities underway. iii) Service/s to meet prioritised needs commissioned.	i) Improvement in EMWB scores* or alternative tool in defined groups: <ul style="list-style-type: none"> <li>Targeted areas of deprivation.</li> <li>BME communities.</li> <li>LGBTi communities.</li> <li>Adults on primary care registers.</li> <li>Adults on secondary care caseloads.</li> </ul>	LBE	1-5

Task	Products	Outcomes	Responsibility Lead Organisation	Timescale Years (1-5)
<b>2.2 Work with LBGTi individuals and groups and relevant organisations to understand and address the mental health needs in these communities.</b>	<ul style="list-style-type: none"> <li>i) LBGTi needs assessment completed.</li> <li>ii) 2-5 projects with local communities underway.</li> <li>iii) Service/s to meet prioritised needs commissioned.</li> </ul>	<ul style="list-style-type: none"> <li>i) Improvement in EMWB scores* or alternative tool in defined groups: <ul style="list-style-type: none"> <li>• Targeted areas of deprivation.</li> <li>• BME communities.</li> <li>• LBGTi communities.</li> <li>• Adults on primary care registers.</li> <li>• Adults on secondary care caseloads.</li> </ul> </li> <li>ii) Improvement in: <ul style="list-style-type: none"> <li>• The rate of access</li> <li>• Outcomes from community and acute mental health interventions.</li> </ul> </li> </ul>	LBE	1-5
<b>2.3 Ensure that the physical health care needs of adults with mental health issues are addressed effectively by primary and secondary care mental health services.</b>	<ul style="list-style-type: none"> <li>i) Physical health (cardio metabolic) screening for everyone with a serious mental illness carried out for all in line with national CQUIN and guidelines: <ul style="list-style-type: none"> <li>• Smoking status.</li> <li>• Lifestyle (inc. exercise, diet, alcohol and drugs).</li> <li>• Body Mass Index.</li> <li>• Blood pressure.</li> <li>• Glucose regulation.</li> <li>• Blood lipids.</li> <li>• Hepatitis C.</li> </ul> </li> <li>ii) Smoking cessation programme for adults with serious mental illness in place.</li> <li>iii) Support to manage weight offered and promoted for adults with serious mental illness in in-patient care.</li> <li>iv) Protocols to support achievement of the standards (CQUIN) for communication between primary and secondary care for adults with serious mental illness on CPA: <ul style="list-style-type: none"> <li>• An up-to-date care plan has been shared with the GP, including the holistic components set out in the CPA guidance: <ul style="list-style-type: none"> <li>– ICD codes for all primary and secondary mental and physical health diagnoses.</li> <li>– Medications prescribed and monitoring and adherence support plans.</li> <li>– Physical health condition(s) and ongoing monitoring and treatment needs.</li> <li>– Recovery interventions including lifestyle, social, employment and accommodation plans where necessary for physical health improvement.</li> </ul> </li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>i) Reduction in the difference in expected length of life of people with serious mental illness and those who do not have a serious mental illness (standardised mortality ratio).</li> <li>ii) Physical health (cardio metabolic) screening for physical health care meets the national standard (CQUIN) (90% adults with serious mental illness on CPA).</li> <li>iii) National targets met for smoking cessation in adults with serious mental illness on CPA.</li> <li>iv) National target met for screening of adults in inpatient settings supported to manage their weight.</li> <li>v) Communication between primary and secondary care meets the national standard (CQUIN) (90% adults with serious mental illness on CPA).</li> <li>vi) The target for the % of patients with schizophrenia and bipolar affective disorder and other psychoses with a review recorded in the previous 15 months is achieved (includes the requirement for evidence that the patient has participated in routine health promotion and prevention advice appropriate to their age and health status).</li> <li>vii) Comparison of QOF indicators at 0 and 12 months to measure improvement following implementation.</li> </ul>	CCG	1-2

Task	Products	Outcomes	Responsibility Lead Organisation	Timescale Years (1-5)
<b>3. To improve access to mental health assessment, treatment and support.</b>				
<b>3.1 Ensure that there is a clearly defined pathway to services and clearly defined care pathways for each condition.</b>	<ul style="list-style-type: none"> <li>i) Community/Primary/secondary care care pathway.</li> <li>ii) Community/acute secondary care care pathway.</li> <li>iii) Care pathways for each condition.</li> </ul>	<ul style="list-style-type: none"> <li>i) Reduction in mental health symptoms (through earlier intervention).</li> <li>ii) Reduction in duration of mental health issues.</li> <li>iii) Reduction in mental health crises.</li> </ul>	CCG	1-2
<b>3.2 Improve access to information, advice and signposting.</b>	<ul style="list-style-type: none"> <li>i) Online mental health services directory developed.</li> <li>ii) Decision re: the potential benefit of establishing a (mental) health and wellbeing centre.</li> <li>iii) Decision re: establishing (mental) health and wellbeing centre enacted.</li> </ul>	<ul style="list-style-type: none"> <li>i) Reduction in mental health symptoms (through earlier intervention).</li> <li>ii) Reduction in duration of mental health issues.</li> <li>iii) Reduction in mental health crises.</li> <li>iv) Increase in self-management, choice and control.</li> </ul>	LBE	1-5
<b>4. To improve the mental health and wellbeing of all carers and improve support for carers of adults with mental health issues</b>				
<b>4.1 Ensure that the mental health needs of carers of people with all needs are identified and addressed.</b>	<ul style="list-style-type: none"> <li>i) Adults in caring roles are identified on primary care registers.</li> <li>ii) Adults in caring roles identified on primary care registers are offered an assessment of their mental and physical health needs and access to psychological therapies where indicated.</li> </ul>	<ul style="list-style-type: none"> <li>i) Increase in no. and % carers of adults identified on primary care registers.</li> <li>ii) Increase in no. and % carers of adults on primary care registers offered an assessment of their mental and physical health needs.</li> <li>iii) Increase in no. and % carers of adults on primary care registers accessing psychological services.</li> </ul>	LBE	1-5
<b>4.2 Ensure that carers of adults with mental health issues are identified and that their mental health needs are addressed.</b>	<ul style="list-style-type: none"> <li>i) Carers of adults in touch with secondary care mental health services are identified, offered an assessment of their mental and physical health needs and access to psychological therapies where indicated.</li> </ul>	<ul style="list-style-type: none"> <li>i) Increase in no. and % carers of adults in touch with secondary care mental health services offered an assessment of their mental and physical health needs.</li> <li>ii) Increase in no. and % carers of adults in touch with secondary care mental health services accessing psychological services.</li> </ul>	LBE	1-5
<b>4.3 Improve support for carers of adults with mental health issues.</b>	<ul style="list-style-type: none"> <li>i) An action plan to improve support for carers of adults with mental health issues is developed and progressed jointly with local carers.</li> </ul>	<ul style="list-style-type: none"> <li>i) Increase in the no. and % carers of adults in touch with secondary care services who say that they feel supported in their caring role.</li> </ul>	LBE	1-5
<b>4.5 Ensure that the contribution and needs of carers are taken into account in care planning for adults with mental health issues.</b>	<ul style="list-style-type: none"> <li>i) Care Triangle implemented by mental health providers.</li> </ul>	<ul style="list-style-type: none"> <li>i) Increase in the no. and % carers of adults in touch with secondary care services who say that they feel supported in their caring role.</li> <li>ii) Increase in the no. and % carers of adults in touch with secondary care services who say that they feel that they have been appropriately involved in designing the care and support of the person for whom they care.</li> </ul>	LBE/CCG	1-5

Task	Products	Outcomes	Responsibility Lead Organisation	Timescale Years (1-5)
<b>B. TO IMPROVE THE RECOVERY OF ADULTS WITH MENTAL HEALTH PROBLEMS</b>				
<b>5. To ensure that mental health care is provided as close to home as possible, is personalised, recovery orientated and focussed on outcomes.</b>				
<b>5.1 Work with all stakeholders to improve the capacity and effectiveness of the current model of community based care for adults with common mental health issues and adults with serious mental illness.</b>	i) A model of community based assessment, treatment and support established based on the current mental health services infrastructure, the emerging model of GP local networks and associated partnerships with the voluntary sector and local communities established. This will include: <ul style="list-style-type: none"> <li>• A stepped model of care for psychological therapies.</li> <li>• A primary/secondary care pathway.</li> <li>• A system of risk stratification.</li> <li>• A shared care protocol - primary and secondary care.</li> <li>• Co-ordinated care for mental and physical health issues and health and social care needs.</li> <li>• A training programme for GPs established.</li> <li>• A training programme for other primary care practitioners established:               <ul style="list-style-type: none"> <li>– Reception staff.</li> <li>– Community nurses.</li> <li>– Health Visitors.</li> <li>– Community therapists.</li> </ul> </li> </ul>	i) An increase in no. and % service users supported by GPs solely and/or under shared care protocols. ii) An increase in knowledge and skills of GPs in managing mental health issues. iii) An increase in knowledge and skills of reception staff, community nurses, health visitors and community therapists staff in identifying and managing mental health issues.	CCG/LBE	1-5
<b>5.2 Drive and support a shift in the culture of mental health services delivery across the health and social care economy in Enfield.</b>	i) Outcome measures for recovery that are meaningful to service users agreed and being monitored based on national guidance and local service user and carer views. ii) Care is increasingly personalised with the use of self-directed support and personal budgets.	i) Data on outcomes monitored. ii) Improvement in outcomes evidenced over time. iii) An increase in the no. and /or % adults in touch with secondary care mental health services receiving a direct payment or using self-directed support.	CCG/LBE	1-5

Task	Products	Outcomes	Responsibility Lead Organisation	Timescale Years (1-5)
<b>5.3 Prioritise addressing the risk factors for mental ill health for all adults with mental health issues.</b>	<ul style="list-style-type: none"> <li>i) GPs and providers prioritise meeting the need for:               <ul style="list-style-type: none"> <li>• Physical health care needs.</li> <li>• Settled accommodation.</li> <li>• Employment or meaningful occupation.</li> <li>• Support to maximise income. in assessment, treatment and care planning.</li> </ul> </li> <li>ii) An increase in the number of units of settled accommodation with flexible support.</li> <li>iii) An increase in the capacity of services to support retaining/ gaining employment for adults with:               <ul style="list-style-type: none"> <li>• Common mental health issues.</li> <li>• Serious mental illness.</li> </ul> </li> <li>iv) People accessing IAPT services have access to support to retain/ gain employment.</li> <li>v) Mental health embedded in Borough-wide initiatives to support Enfield residents into employment.</li> <li>vi) An effective partnership/joint working established with Job Centre Plus.</li> </ul>	<ul style="list-style-type: none"> <li>i) Reduction in the difference in expected length of life of people with serious mental illness and those who do not have a serious mental illness (standardised mortality ratio).</li> <li>ii) Physical health (cardio metabolic) screening for physical health care meets the national standard (CQUIN) (90% adults with serious mental illness on CPA) .</li> <li>iii) National targets met for smoking cessation in adults with serious mental illness on CPA.</li> <li>iv) National target met for screening of adults in inpatient settings supported to manage their weight.</li> <li>v) Communication between primary and secondary care meets the national standard (CQUIN) (90% adults with serious mental illness on CPA).</li> <li>vi) Reduction in inpatient admissions and other emergencies due to lack of housing/breakdown in housing and /or support systems.</li> <li>vii) Reduction in delayed transfers of care from inpatient services.</li> <li>viii)Reduction in the no. and/% adults in touch with secondary care mental health services placed in temporary accommodation.</li> <li>ix) No. adults in touch with secondary care mental health services in settled accommodation increased from 70% to 80%.</li> <li>x) Number of adults in touch with secondary care mental health services in employment increased from 4% to 15%.</li> <li>xi) Adults in touch with secondary mental health services have at least one activity which they are fully engaged per week.</li> <li>xii) An increase in the number and % adults in touch with secondary care mental health services signposted to employment services, training and education.</li> <li>xiii) All adults in touch with secondary care mental health services who have problems with income or debt signposted to appropriate advice.</li> </ul>		

Task	Products	Outcomes	Responsibility Lead Organisation	Timescale Years (1-5)
<b>5.4 Provide care as close to home as possible.</b>	<ul style="list-style-type: none"> <li>i) A reduction in the use of 24-hr residential accommodation in and out of area.</li> <li>ii) Improved access to home treatment for mental health crises.</li> <li>iii) A pathway to access assessment agreed for those who identify themselves or the person they care for as having deteriorating mental health.</li> <li>iii) Earlier diagnosis and intervention preventing escalation of mental ill health.</li> <li>iv) Improve access to psychological therapies for people with common mental health issues (includes IAPT and other psychological interventions e.g. counselling.)</li> </ul>	<ul style="list-style-type: none"> <li>i) A reduction in the no. and/or % adults in out of area residential placements.</li> <li>ii) A decrease in the no. and/or % of adults admitted to inpatient care without assessment by the Home Treatment Team.</li> <li>iii) A reduction in the incidence of mental health crises.</li> <li>iv) An increase in the number of people recorded with: <ul style="list-style-type: none"> <li>• Common mental health issues</li> <li>• Serious mental illness</li> </ul> on GP registers.</li> <li>v) Improved access to psychological therapies.</li> <li>vi) Adults with mental health issues and carers reporting: <ul style="list-style-type: none"> <li>• Improved responsiveness from services when the mental health of individuals with a mental health diagnosis is identified in primary or secondary care as deteriorating by either themselves and/or a friend or family carer.</li> <li>• Improved responsiveness from: <ul style="list-style-type: none"> <li>– Primary care</li> <li>– Secondary care services when a possible deterioration in the mental health of an individual is identified for the first time.</li> </ul> </li> </ul> </li> </ul>	CCG/LBE	1-5
<b>6. To improve the quality* and efficiency and therefore outcomes from secondary care mental health services</b> <i>*safety, effectiveness, patient experience</i>				
<b>6.1 Ensure that the secondary care mental health services system is accessible, effective and efficient.</b>	<ul style="list-style-type: none"> <li>i) An effective single point of access.</li> <li>ii) Clearly defined care pathways based on the mental health care clusters and NICE guidelines for each care cluster or condition developed, implemented and evaluated.</li> <li>iii) A lifecourse approach to mental health services delivery in Enfield adopted.</li> </ul>	<ul style="list-style-type: none"> <li>i) A reduction in inappropriate admissions to acute general hospital care.</li> <li>ii) An increase in adults being given effective support on presentation at accident and emergency departments.</li> <li>iii) Adults with mental health issues in touch with secondary care mental health services and carers have access to prioritised evidence based treatments (including psychological therapies in inpatient and community settings.</li> <li>iv) Reduction in average length of stay on community caseloads as services are recovery focussed and therapeutic.</li> <li>v) Improvement in service users and carers' views of services. (Patient and carer surveys.)</li> </ul>	CCG	1-5

Task	Products	Outcomes	Responsibility Lead Organisation	Timescale Years (1-5)
<b>6.2 Improve the response to mental health crises.</b>	<ul style="list-style-type: none"> <li>i) Establish a psychiatric liaison service.</li> <li>ii) Improve the response of acute and community secondary care services.</li> </ul>	<ul style="list-style-type: none"> <li>i) Reduction in suicides.</li> <li>ii) Reduction in serious untoward incidents.</li> <li>iii) Reduction in mental health symptoms.</li> <li>iv) Improved mental health outcomes.</li> <li>v) Improved experience of mental health services.</li> <li>vi) Appropriate use of inpatient beds.</li> <li>vii) Care provided closer to home.</li> </ul>	CCG	1-5
<b>6.3 Ensure that the mental health needs of young people and young adults (14-25 years) are met effectively.</b>	<ul style="list-style-type: none"> <li>i) A CAMHS strategy produced and being implemented.</li> <li>ii) Protocols and pathways for transition from CAMHS to adult mental health services agreed and in place.</li> <li>iii) Consideration given, and the outcome enacted, regarding the option to establish a young people/adult mental health pathway starting from age 14 to 25 years.</li> </ul>	<ul style="list-style-type: none"> <li>i) Young people do not experience avoidable relapse when reaching: <ul style="list-style-type: none"> <li>• Early adulthood.</li> <li>• Adulthood.</li> </ul> </li> <li>ii) Improved experience for young people when reaching: <ul style="list-style-type: none"> <li>• Early adulthood.</li> <li>• Adulthood.</li> </ul> </li> </ul>	CCG	1-5
<b>6.4 Improve perinatal mental health services.</b>	<ul style="list-style-type: none"> <li>i) Develop high level care pathway: North Central London.</li> <li>ii) Develop local care pathway: Enfield.</li> <li>iii) Develop service model: Enfield.</li> </ul>	<ul style="list-style-type: none"> <li>i) Improved short and long-term mental health outcomes for women, their families and babies.</li> <li>ii) Women and their partners expressing increased satisfaction with the quality of maternity and early-years assessment, treatment and support.</li> </ul>	CCG	1-5
<b>6.5 Improve outcomes for older adults with non-organic mental health issues.</b>	<ul style="list-style-type: none"> <li>i) Address the needs of older adults with non-organic mental health issues clearly in the council and CCG joint strategies.</li> <li>ii) Protocols and pathways for transition from adult to older adult mental health services agreed and in place.</li> </ul>	<ul style="list-style-type: none"> <li>i) Improved outcomes for older adults with non-organic mental health issues</li> <li>ii) Improved experience for those transferring from adult to older mental health services.</li> </ul>	CCG	1-5
<b>6.6 Ensure that the need for mental health assessment and treatment of people with additional needs are addressed effectively.</b>	<ul style="list-style-type: none"> <li>i) Address the mental health needs of adults with: <ul style="list-style-type: none"> <li>• Autism</li> <li>• A learning disability.</li> <li>• Who abuse drugs and alcohol.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>i) Adults with mental health issues with: <ul style="list-style-type: none"> <li>• Autism</li> <li>• A learning disability.</li> <li>• Who abuse drugs and alcohol and state that they are able to access to mental health assessment, treatment and support in: <ul style="list-style-type: none"> <li>– Community settings.</li> <li>– Inpatient services as easily as adults without these problems.</li> </ul> </li> </ul> </li> </ul>	CCG	1-5

Task	Products	Outcomes	Responsibility Lead Organisation	Timescale Years (1-5)
<b>C. TO DEVELOP THE MENTAL HEALTH AND SOCIAL CARE SYSTEM</b>				
<b>7. To develop strong partnerships between mental health services, commissioners and providers and ensure that communities, service users and carers are fully involved in service improvement and planning.</b>				
<b>7.1 Increase the involvement of adults who access mental health services and their carers and all stakeholders in the implementation and development of the joint adult mental health strategy.</b>	<ul style="list-style-type: none"> <li>i) Values based commissioning established.</li> </ul>	<ul style="list-style-type: none"> <li>i) Service users and carers involved at all stages of the commissioning cycle.</li> <li>ii) Service users and carers involved in the delivery of services.</li> <li>iii) All stakeholder groups involved at all stages of the commissioning cycle.</li> <li>iv) All stakeholder groups involved in the delivery of services.</li> </ul>	CCG/LBE	1-5
<b>7.2 Increase the capacity of service user groups to engage with people with mental health issues in primary and secondary care settings.</b>	<ul style="list-style-type: none"> <li>i) Capacity in service user groups increased.</li> <li>ii) An increase in the number of peer supporters and trainers in Enfield.</li> <li>iii) An increase in the number of service users supported by other service users.</li> </ul>	<ul style="list-style-type: none"> <li>i) An increase in the % adults with mental health issues supported solely in primary care or under shared protocols.</li> <li>ii) An increase care in the % adults in touch with secondary mental health issues with the skills to seek employment.</li> <li>iii) The % adults in touch with secondary mental health issues decreasing.</li> </ul>	CCG/LBE	1-5
<b>8. To improve the commissioning of mental health services</b>				
<b>8.1 Establish an effective structure for implementation of the Adult MH Strategy.</b>	<ul style="list-style-type: none"> <li>i) MH Programme Board with TOR.</li> <li>ii) Service users and carer in involvement in the MH Programme Board.</li> <li>iii) Other stakeholders from the statutory, non-statutory, and voluntary sectors involved in the MH Programme Board.</li> </ul>	<ul style="list-style-type: none"> <li>i) Improved mental health experience and outcomes.</li> </ul>	CCG/LBE	1-5
<b>8.2 Develop the mental health care market.</b>	<ul style="list-style-type: none"> <li>i) Accommodation provider market developed.</li> <li>ii) Voluntary care sector market developed.</li> </ul>	<ul style="list-style-type: none"> <li>i) Improved mental health experience and outcomes.</li> </ul>	LBE	1-5

Task	Products	Outcomes	Responsibility Lead Organisation	Timescale Years (1-5)
<b>8.3 Improve the commissioning process.</b>	<ul style="list-style-type: none"> <li>i) Full mental health needs assessment completed including assessment of needs of BME and other disadvantaged or excluded groups.</li> <li>ii) Effective strategic development including needs assessment, reviewing current services, gap analysis and prioritisation.</li> <li>iii) Effective procurement and contracting; service design, market development, capacity planning</li> <li>iv) Effective monitoring and evaluation; performance monitoring, seeking patient/service user/carer views; involvement of service users, carers, public in mental health services development</li> <li>v) Effective joint commissioning (health and social care)</li> <li>vi) Increased accountability for the quality of mental health services.</li> </ul>	<ul style="list-style-type: none"> <li>i) Service users, carers and other stakeholders involved in all stages of the commissioning process.</li> <li>ii) Increased understanding of mental health needs including the needs arising from race, ethnicity, faith, gender and sexual orientation.</li> <li>iii) Improved responsiveness to mental health needs arising from race, ethnicity, faith, gender and sexual orientation.</li> <li>iv) Detailed mental health needs assessment for BME communities.</li> <li>v) Effective arrangements for joint commissioning in place.</li> <li>vi) Improved responsiveness to complaints.</li> </ul>	CCG/LBE	1-5
<b>8.4 Develop meaningful measures of mental health outcomes.</b>	<ul style="list-style-type: none"> <li>i) A values based approach to commissioning adopted.</li> <li>ii) Friends and families test implemented.</li> </ul>	<ul style="list-style-type: none"> <li>i) Improved reporting and monitoring of outcomes.</li> <li>ii) Improved satisfaction with mental health services in patient and carer surveys.</li> <li>iii) Improved Friends and Family test scores.</li> </ul>	CCG/LBE	1-5

## SECTION 6

# Implementation and Monitoring Arrangements

### **Implementation and Monitoring**

The strategy will be delivered by the Mental Health Partnership Board and the Mental Health Strategy Implementation Group working in partnership. An initial 2 year work plan will be agreed to support delivery of the strategic goals and objectives contained in Section 5, Table 2. The 2 groups will work together to monitor implementation and revise the strategy as appropriate.

### **Future Funding and Investment**

The strategy identifies a number of gaps in services. Many of the proposed improvements will be achieved through improvements in productivity and re-investment of resources released through any efficiencies achieved by service redesign:

- Transfer resources from secondary to primary care based mental health services.
- Bring people back to Enfield from out of area placements.
- Improving the patient journey e.g. by reducing duplication, improving communication between teams.

Work has still to be done to re-model and appraise options for future service delivery. Key stakeholders will be involved in identifying priorities beyond those identified in as it will not be possible to address all the identified gaps in the next 5 years. Commissioners will support the voluntary sector and other organisations to bid for national charitable and government funds to develop community services.

### **Outcomes**

Implementation of the strategy will be actively monitored and work will be undertaken with all stakeholders to ensure that meaningful measures of improvement, quality and outcomes are in place. Service users and carers will be in the driving seat for improvement.

Initial work to develop outcome measures and indicators has been undertaken as a starting point for this work. This will be combined with developing values based commissioning. These measures are likely to include an Enfield-wide mental health and social care performance dashboard as well as work to develop of outcome measures that are meaningful to Enfield residents.

## Glossary

<b>ASC</b>	Adult Social Care
<b>BEH</b>	Barnet, Enfield and Haringey
<b>BEHMHT</b>	Barnet, Enfield and Haringey Mental Health Trust (the current Mental Health Service Provider)
<b>BME</b>	Black and Minority Ethnic Communities
<b>CPA</b>	Care Programme Approach
<b>CCG</b>	Clinical Commissioning Group
<b>CLOMS</b>	Clinician Reported Outcome Score
<b>CROMS</b>	Client Reported Outcome Score
<b>CCG</b>	Clinical Commissioning Group
<b>EMU</b>	Enfield Mental Health User Network
<b>EMWB</b>	Edinburgh Mental Wellbeing Scale
<b>FACS</b>	Fairer Access to Care Services
<b>HHSAC</b>	Health, Housing and Adult Social Care
<b>HoNOS</b>	Health of the Nation Outcomes Score
<b>LBE</b>	London Borough of Enfield/Enfield Council
<b>LBGTi</b>	Lesbian, Bisexual, Gay, Transgender individuals
<b>NCB</b>	National Commissioning Board
<b>NHS</b>	National Health Service
<b>PbR</b>	Payment by Results
<b>PIMHS</b>	Parent Infant Mental Health Services
<b>PREMS</b>	Patient Reported Experience Score
<b>PROMS</b>	Patient Reported Outcome Score
<b>QOF</b>	Quality and Outcomes Framework (GP contract)

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**Adult Social Care Commissioning Team**  
**Health, Housing and Adult Social Care**

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