FIT FOR THE FUTURE

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Enfield Council Health & Adult Social Care Scrutiny Panel

Transformation
What is the Impact on Enfield residents?

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Josephine Carroll - Managing Director, BEH- Enfield Mental Health Division
Parmjit Rai - Managing Director, BEH-CAMHS Division

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• Community Transformation Outcomes ➢ Outcome 1: More people receiving support ➢ Outcome 2: See people quickly ➢ Outcome 3: Higher quality care
Young People Mental Health Transformation

Context

The aim of the Community Transformation programme is to deliver mental and physical health support to more people in the community with SMI by ensuring all parts of the primary and secondary health and social care system, including VCSE organisations, work together.

An integrated care model will bring all the agencies that support people with different mental health needs closer to develop new services which help keep people safe and able to contribute and participate in their local communities to create or fulfil hopes and aspirations in line with individual wishes. This is part of delivering Person-centred approaches that have an evidence-base in improving whole-life outcomes for people.

The Trust has designed our new service model and care pathways through co-production and co-design with stakeholders, partners and service users and carers. Enfield Council officers are a key partner and members of the programme. The investment is enabling the Trust to increase the size and skill mix of the workforce whilst providing training to help them to work differently. One example is the introduction of Dialog+ to create co-produced personalised care plans which focus on holistic health and social needs for all service users. The ICB and ICS has invested in joint commissioning arrangements with the Council.

The goals for the Community Transformation are to realise the following outcomes:

- Outcome 1: More people receiving support
- Outcome 2: See people more quickly
- Outcome 3: Provide higher quality care

Partnership working with Enfield Council and Integration

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In Enfield, we have strong and long standing Partnership Arrangements and ways of working in an integrated way that benefit our residents. A few examples of these are below.

The Enfield Mental Health Community Transformation and core offer delivery is being implemented under the auspices of Enfield Partnership Board Mental health sub-group with updates provided to the HWBBs Mental Health Partnership Board, Joint Health and Social Care Commissioning Board and other health, care and support system stakeholder forums.

The Enfield Partnership Board and its sub-groups are co-chaired and / or well attended by key Members of the Council, such as, the Director of Adult Social Care (DASS), Director of PH services, Service development leads, commissioners and contract leads within the Council.

ICB and BEHMHT have worked with Enfield council to deliver a broad range of mental health services under the transformation programme through joint commissioning arrangements. E.g.: Joint contracting of the Working Well Trust specialist Employment services for people with MH needs, the Autism Hub provided by a VCSE Enfield one-2-one.

The Enfield Crisis Café was established under a system steering group and the crisis case finder is employed by the Council via Section 75 arrangements, s.256 MH Prevention funding of £360k via Section the Partnership Agreement held between NCL ICB and Enfield Council.

BEHMHT and Enfield Council hold a Section 75 Partnership Agreement to ensure the delivery of integrated teams across health, care and support system and models. Integrated services have a proven evidence base in providing positive outcomes for people with Mental health needs as this approach ensures person centred care and support is delivered.

Enfield Borough Place based Partnership Governance structure July 2022

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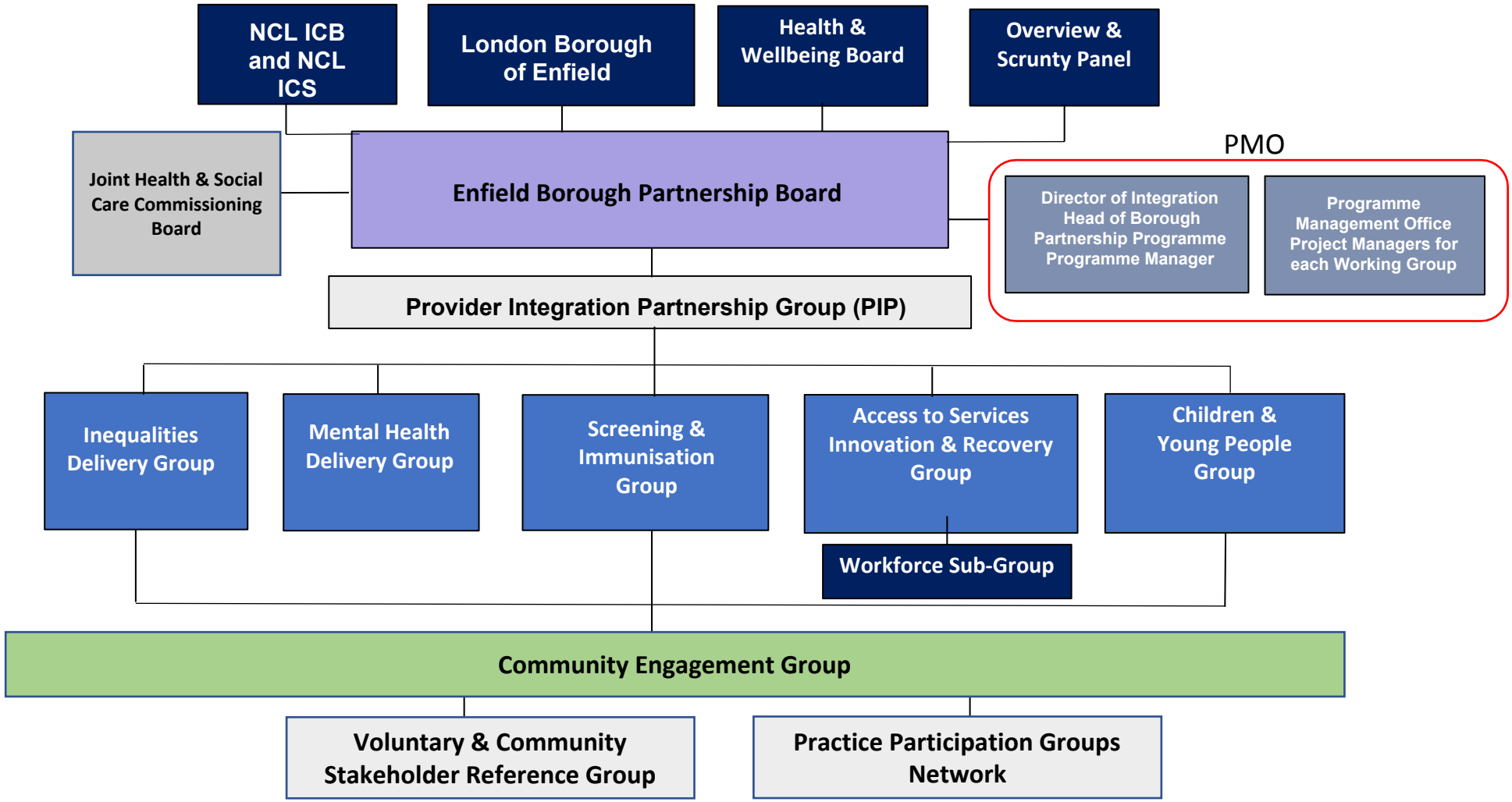

Community Transformation Engagement Event
30th Sept 2022

Programme Workstreams

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Deliverables by 2023/24

- An integrated model of primary and community mental health working alongside VCS and Social Care
- Additional clinicians to reduce number of admissions and keep more people with SMI in their communities
- Case-finding to address inequalities in accessing mental health support
- Rapid access to MH services providing treatment within 4 weeks
- Holistic personalised care plans for all service users
- Physical health support for people with SM

Trust Strategic Aims

Excellence for service users *(Patient experience care in areas that matter most to them)*	Empowerment for Staff *(Staff are valued and developed.)*
Partnership with others *(Least intensive and clinically appropriate care closer to home)*	Innovation in Services *(Support more people with SMI in our communities)*

Community Transformation Outcomes

Key changes and areas to measure quality impact and outcomes

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1	**More people receiving support**	Additional workforce to keep more people with SMI in their communities	Intensive pathways directly linked to core community teams (PD, ED, Comm Rehab, IPS, EIP)	Reducing inequalities by reaching out to community and voluntary networks (case-finding)
2	**See people more quickly**	Allocating a key worker to all service users to enable safe, consistent care	Re-organising core community teams and pathways around PCNs	Rapid access to treatment within 4 weeks by March 2023
3	**Higher quality care**	Holistic Dialog+ personalised care plans for mental, physical and social needs	Fully integrated MDT with Primary Care, Social Care and VCS with simplified points of access	Using MaST to help predict and prevent crisis and support community discharges

Outcome 1

More people receiving support: Intensive pathways

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Older Adults
- Increasing capacity through specialist education to support to core teams.
- Strengthened Intensive Support Teams with Psychology groups commenced (Saheli Womens', wellbeing group)

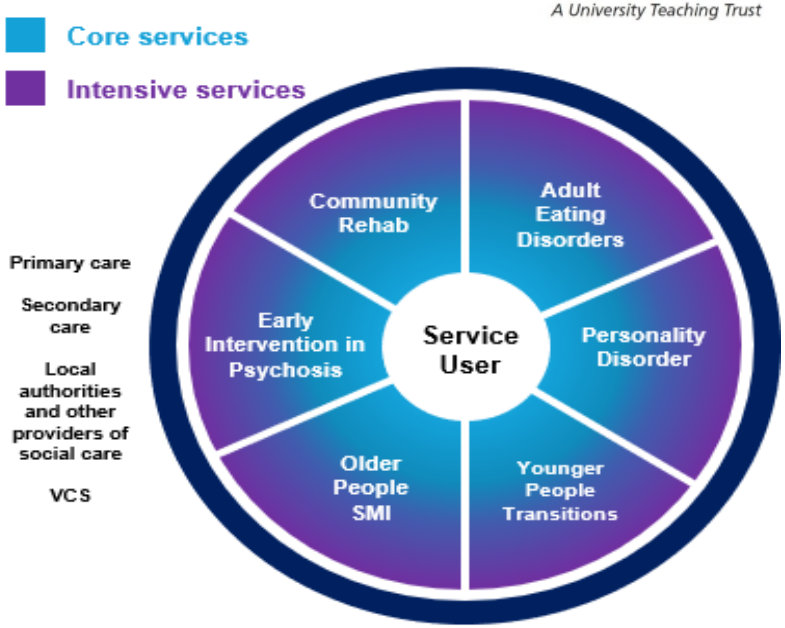
Early Intervention in Psychosis
- Enfield now **achieving Level 3** standard
- Enfield achieved nearly **100%** for Physical Health

Community Mental Health Rehabilitation
- Reduce reliance on inpatient provision and as part of the wider new model, Council partners are fully involved
- Four workstreams have been formed across NCL with multi partner collaborations

Physical Health
- Pilot new delivery models relating to physical and MH care especially for BAME service users
- Supporting uptake of Annual Health Checks

Personality Disorders
- Continue to deliver against the 60% waiting time standard and improve links to the core offer

Eating Disorders
- Aligned to core model, embed Experts by Experience, No barriers to access e.g. BMI or weight thresholds, offering early intervention model

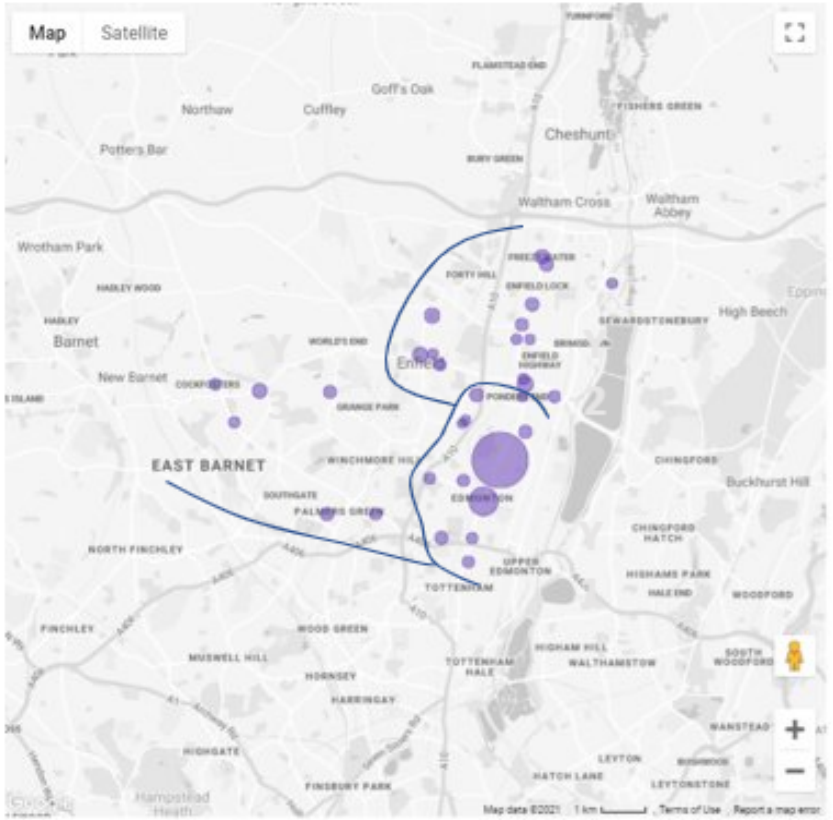


Key actions
- Community Transformation investment, including a range of new roles, is supporting multi-disciplinary core community teams integrated with PCNs, Social Care, Employment staff, and the VCS sector
- With Yr1 and Yr2 investment plans are to increase the workforce by 68wte new roles.
- Investment in Peer Support and Community Engagement roles directly employed by Voluntary and Care sector organisations
- 50% match funding with Primary Care Networks to introduce GP three Advanced MH Practitioner roles in GP Surgeries.

Outcome 2
See people quickly

- Community Mental Health teams are now aligned around Primary Care Networks (PCN's)
- Enfield have engaging with the Primary Care Networks resulting in clustering around PCN neighbourhoods/GP practices (47 practices in total) – **see map example**
- Capacity in Multi-disciplinary teams has increased with clinical and non-clinical staff, including **new roles, VCS and GP-based MH practitioners**, to work closely with psychological therapy, and intensive support pathways

Re-organisation of Enfield Teams around Neighbourhood Clusters (PCN sub-level)



N.B. Size of circle reflects % of SMI on list combined by GP group practices

Improving access to treatment – first episode Psychosis

Key data and findings

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- ✓ 42% of clients are black or black British, an increase from 26% the previous year
- ✓ 57% of clients male, and 43% are female
- ✓ 2 week wait for commenced treatment met 100%
- ✓ High levels of service user/carer satisfaction
- ✓ 15% of clients transferred to longer term mental health teams
- ✓ 85% of patients discharged back to their GP
- ✓ 100% clients on the caseload are within 3 years of treatment
- ✓ 68% of the clients have had annual physical health checks.
- ✓ 92% referral to treatment rate met

Outcome 3

Higher quality care: Holistic Dialog+ personalised care plan

Status

- Dialog+ is an outcomes-based intervention using a questionnaire to assess a Service Users quality of life and experience of care received, in a structured way, and enabling a personalised holistic care plan to be created
- Initial reporting is looking at # of users trained, # of users active, # of DIALOG assessment completed.
- Organisational Development Plan includes DIALOG+ for teams

Key next steps

- Continuing our journey to shift away from CPA and manage this transition through a phased approach:
- The trajectory for teams using Dialog+ is expected to reach **78%** by end of Mar 23

Outcome 3

Higher quality care: Personalised holistic care plan

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Dialog + Service User and Community Team Feedback

"Using DIALOG+ was brilliant, it helped me to identify, for the first time, the specific areas of my life where I was stuck and needed help. By breaking my challenges into manageable parts, I was able to identify actions and potential solutions. It has changed my life for the better."
Service user

''A young non-engaging female has been with me since last November, I using Dialog+ regularly. She went from being as low as one can be, less than 9 months later she is now a volunteer and applying for a university to study mental health! She has blossomed into a rose right before my eyes."
Community team member

"In my appointment, I talked about my challenging areas, I identified small actions to take before the next meeting…I agreed to contact a local recruitment agency who could help me update my CV and prepare for job interviews. This opened new doors."
Service user

Outcome 3

Higher quality care: PCN/GP Surgery based clinicians

Enfield's Advanced Clinical Practitioner feedback

Feedback from Evelair Piper, Enfield Advanced Clinical Practitioner

"I am based at Forest Road Group Practice Tue-Thur and provide face to face, video and telephone consultations to service users with complex MH problems, who often also have several physical health conditions.

I also serve as a point of access for direct consultation and advice, as well as training and support for other practitioners on issues around mental health/illness.

ACPs manage clinical care in partnership with individuals, families and carers and other care providers, by analysing and processing complex health and social problems and work with the service user to find innovative solutions to enhance their experience and improve outcomes.

The ACP role is pivotal in that it supports the aims and vision of the Trust. Another aspect of my role include attending and contributing to collaborative Primary Care Network Multi-Disciplinary Team and Trust meetings, work closely with senior management and partners to promote and influence positive changes in policy across the service.

I'm looking forward to bringing the skills and knowledge I have developed during my career, to this exciting new role that will make real and positive change to people's lives''

Outcome 3

Higher quality care: Voluntary and Care Sector support

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- A 59 year old client had been under locality team for several years. The client accessed our Service presenting with anxiety and severe depressive episodes, EUPD and alcohol dependence. He was experiencing social withdrawn, self neglect, and missing medical appointment appointments. The multiple conditions he was experiencing led the client to aggravate his presenting condition and accessing crisis support services on a regular basis.

- The VCS staff member supported client to prioritise and attend GP and other medical appointments and to re-engage with alcohol management support. They identified other social needs e.g. new furniture with items within the house, and helped the client to secure those via the Enablement Team. Client reported bad eating and self care habits, so they were referred to courses on Healthy Eating and supported to go Grocery shopping to start building positive habits.

- VCS applied for Freedom Pass to enable the client to attend community activities, and they use this to regularly attend groups including Hearing Voices and LGBT specialist support groups and counselling. Client has not reported a crisis for over a year.

"I just wanted my thanks and appreciation noted. My son has had mental health problems for many years. Since VCS support worker has been appointed key worker, there has been a positive impact on my sons mental health. He understands, and for the first time my son relates to his worker. He has started to venture out with some confidence and looks forward to seeing him. Coming from despair, for the first time in many years hope has been given to us. He has insight and a buoyant personality which is improving my sons self-worth and motivation. This has not happened in many years."
Community Engagement Practitioner

"I love being able to use my own personal experience to support somebody else and see them going through positive change. It is challenging but when somebody starts to make changes and feel better it makes it worthwhile."
Peer Engagement Practitioner

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CAMHS Transformation Update

Parmjit Rai

Managing Director

November 2022

CHILDREN AND YOUNG PEOPLE MENTAL HEALTH – LTP Priorities for Enfield			
Priority	**Description of LTP Priority**	**Deliverables in 22/23**	**Outcomes**
1. LTP 24/7 CYPMH Crisis Response	• Provision of 24/7 Crisis Services to CYP across NCL	• 24/7 Crisis Line for all ages with CYP specialists • A&E diversion Hub with Enfield available from 09:00 -24:00 hrs • Crisis Liaison service mobilised into North Middlesex Hospital A&E and Paediatric Department..	• Enfield CYP access to 24/7 Crisis Services.
2. Community CYP MH services, early intervention and prevention offers and pathways	• Reduce Waits • Increase school based services • Removing unwarranted MH treatment access gaps for in-borough Looked after children (LAC*) • Address inconsistency and gaps in community based universal and early intervention offers. • Develop integrated delivery models and partnership working in the core offer delivery not just clinical pathway/model.	• Appropriate allocation of SDF funding to community CAMHS to manage waits and local variation in capacity and service gaps, including achievement of planned access and wait times trajectories. £700K to Enfield Division for 21/23 and 22/23 • Additional MHSTS in Enfield	• Reduction in waiting times • Increase in school based services
3. LTP Eating Disorders targets and Disordered Eating and ARFID support pathway	• Increase capacity in Eating Disorders pathway to achieve and maintain LTP targets for urgent and routine waits • Mobilise pilot Community Disordered Eating and ARFID support and pathways • Strengthen community CAMHS and ASD links to support multi-agency planning for co-morbidities e.g.. ASD, self-harm.	• Uplift into specialist Eating Disorder Services in NCL • Mobilisation of Community Disordered eating disorder service in Enfield • LD/ ASD Keyworker project roll out in Enfield for 23/24	• Disordered eating service clinician embedded in Enfield CAMHS. • LD/ASD Keyworker project implementation in 22/23.

CHILDREN AND YOUNG PEOPLE MENTAL HEALTH : LTP Priorities for Enfield			
Priority	**Description of LTP Priority**	**Deliverables in 22/23**	**Outcome**
4. MH Support Teams in Schools	• Increase number of schools accessing Mental Health Support Teams aligned to national trajectory	• Waves 7 and 9 MH Support Teams in Schools bring the total teams to 14 in NCL (45% coverage for NCL)	• Enfield has 50/96 schools with provision. Further wave 9 investment will extend to all schools in the Borough.
6. Central Point of Access	• Implement NCL wide Thrive model including integrated front doors with system partners.	• Planning for integration of front doors	• Deliver multi-agency models in 23/24
7. Crisis Services and Adolescent assessment and interventions including psychosis	• Extend provision of 24/7 Crisis Provision in line with National guidance for CYP.	• 24/7 Crisis Line implemented • Crisis Liaison Service at NMUH for Enfield CYP • A&E Diversion hub set up with key worker in Enfield to respond to 4hr response time • DBT service to mobilise in Jan 23 • Home Treatment Team mobilise in March 23	• CYP have access to 24/7 crisis support.
8. CYP LD, autism and ADHD	• Achieve ambitions of Transforming Care agenda to offer better care closer to home and improved assessment and treatment pathways.	• Implement 22/23 ASD/ADHD waiting list recovery plan – 40 CYP in Enfield being offered assessments via NCL with a further 60 offered via digital provider. • LD/ ASD keyworker pilot implemented in 22/23. •	• Reductions in assessment waits anticipated byQ4 23/24

YOUNG ADULTS (18-25) – LTP Priorities for Enfield			
Priority	**Description of LTP Priority**	**Deliverables in 22/23**	**Outcomes**
1. Student and young adult wellbeing support	• Increase support for students and young adult wellbeing support.	NCL residents will benefit from increased capacity and new models of care for YA, inc; • proactively reach out into community settings and partner providers incl. Local Authority Services (YOS and LAC and the VCS , bridging young people into services as required. Focus on vulnerable groups specifically BAME, care leavers (incl. people seeking asylum) and young offenders • offer developmentally appropriate pan-diagnostic assessment, formulation intervention and be a resource, supporting colleagues to do the same • develop and roll out training for Adult MH staff in specialist services on adolescence and transitioning, including trauma impact on developmental delay. • Transition champions will work across age and intensive team boundaries, proactively identifying CAMHS users requiring AMHS. Offering highly specialist psychological and systemic assessment, formulation and care planning as appropriate for young adults and families, and bridge YA into the most appropriate AMHS service. Offer leadership, consultation, training, supervision within AMHS • Transition workers (primarily Expert by Experience) will help YA access signposted services and support care planning activities. They will offer containment and coordination, build a therapeutic relationship using a person-centered recovery approach and provide psychologically informed interventions. • Enhanced delivery to reach YP at risk of serious youth violence	• Phase one transition teams embedded in core teams in Enfield and working across Adult and CYP services.
2. Adolescent and Young Adult Mental Health Service	• Improve provision for YA accessing services by providing flexible and integrated care with focus on CYP who are accessing services for the first time and vulnerable groups such as Care Leavers and UASC.		
3. Transition MDT (case discussion) and transitions champions	• Ensure that all young people have transition plans and access to a transition service that is NICE Compliant and in which they feel their care is improved,.		

New Investment & Impact

Enfield secured £224k in 21/22 and recurrently in 22/23 of the overall North Central London Mental Health investment into Community CAMHs provision (32% of £700k), delivering the following impact:

The additional investment increased the generic Community CAMHs workforce by 10.2wte posts across a range of disciplines and introduction of new skilled workforce

Introduction of a new Crisis Liaison team at North Middlesex Hospital - 184 CYP seen in 6 months
Continuation of 24/7 Crisis Line and Crisis Hub to CYP and families in Enfield
Disordered Eating Service implemented across NCL with clinician based in Enfield

Enfield Transition team embedded in core adult team to support 18–25
NCL wide DBT service to go live in Jan 23
Enfield CYP to access Home Treatment Team service March 23

New Investment & Impact

Mental Health Support Team invest in Enfield since 2019 to support the roll out of delivering emotional support within school settings

Mental Health Support Team MYME
Investment in 2019/20 and 21/22 to extend school-based offer in Enfield (50 schools out 96)
Further investment in wave 9 (23/24) will extend the coverage to nearly all schools in the borough

MHSTs deliver three core functions:
Evidence-based interventions for mild to moderate mental health and emotional wellbeing concerns (e.g. anxiety and low mood)
Support to senior mental health leads in schools to develop a whole-school approach to mental health and wellbeing
Timely advice and signposting to schools, to ensure children and young people receive the right support at the right time, and to support effective collaboration between education, specialist CAMHS, and other agencies.

Waiting List Improvements

Following the additional investment into community CAMHS, improvements in the following areas:

Waits for 1st appointment decreased from 235 in August to 196 in September and no cases waiting over 41 weeks for 1st appointment or contact

Group sessions offered to support timely access to services

Offering a digital platform for both supported and unsupported guided help for anxiety and CBT

Weekend clinics commenced in May 22 with additional staffing capacity to offer appointments to patients waited the longest for specialist assessments

Welfare checks embedded within the service, to keep in touch with families on waiting lists

Digital platform offer for both supported and unsupported guided help for anxiety and CBT

Enfield division achieved significant reduction in waiting times and waiting lists

There has been a 44.5% reduction of children and young people wating for specialist assessment and treatment from 1357 in September 2021 to 747 in October 2022

Targeted work to improve triage, discharges resulting in reduced number of waits

Key Challenges and Next Steps

Key Challenges	• Longest waits for Neurodevelopmental pathway - waits of over 52 weeks. • Further development with system Partners , Thrive model in the borough of Enfield to strengthen VCS offer.
Next Steps	• Opportunities to support and collaborate with Enfield Council with the developments and the Family Hub • Strengthened, collaboration with borough partners to support priority commissioning • Further recovery in the NDS pathway • Developing a sustainable workforce strategy • Maintaining local staff wellbeing initiatives • Strengthening QI within the service to improve flow and patient experience • Evaluating the impact and success of new roles developed • Building on the Co-Production work in Enfield