ADULT & OLDER PEOPLE MENTAL HEALTH SERVICES IN BARNET, ENFIELD & HARINGEY

COMMISSIONING STRATEGY 2013/15

Contents

1. EXECUTIVE SUMMARY

The Adult and Older People Mental Health Commissioning Strategy considers the delivery of mental health services in Barnet, Enfield and Haringey for the period of 2013-15. The strategy takes the mental health modernisation process forward by laying out a number of key messages and commissioning priorities that will direct the delivery of services in the future.

The three local authorities and CCGs have a joint responsibility for ensure that Mental Health services are commissioned for the population of BEH. Enfield CCG is designated as the lead CCG for taking forward Mental Health Commission on behalf of Barnet and Haringey.

The Strategy covers three very diverse boroughs in North/Outer London with unique population mix and unique challenges relating to Mental Health and wider health concerns in the community. However the challenges across the Boroughs have a number of common factors which are detailed in section 10 of this strategy.

The Strategy provides a framework for the continuing modernisation of mental health services and responds to a broad range of health and social needs. The shared vision is to improve the mental health and wellbeing of people living in Barnet, Enfield and Haringey and we will do this by ensuring we commission comprehensive, integrated and personalised services.

In particular these services will:

- 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 problems.
- Help people to recover as quickly as possible from mental illness.

In terms of wider commissioning activity, there will be a need to engage with Providers through market testing, to manage the process for shifting the emphasis to more community based support and interventions, which will mean moving activity from secondary mental health services back into primary care within an integrated, innovative stepped care model, closer to people's homes, based on cost effective evidence-based interventions.

2. COMMISSIONING PRIORITIES

- The need to further extend capacity in primary care to support people with mental health problems 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 IAPT.
- The delivery of effective alternatives to hospital admission.
- Wherever possible deliver services as close to people 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 service users and carers at strategic planning, service review and development. Commissioners will actively work with the Mental Health Partnership Boards
- Emphasis on 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 from

the cornerstone of commissioning priorities.

- 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 this Strategy is that it is not determined by cure or "clinical recovery". Instead it emphasises the unique journey of the individual living with mental health problems 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, redefining recovery to incorporate quality of life a job, a decent place to live, friends and a social life.

3. THE NATIONAL AND LOCAL CONTEXT

There are a range of National Policy drivers which support and provide a context for this strategy, for example:

- NSF Five Years On – 2005
- Mental Health and Social exclusion report – 2004
- Choosing Health White Paper – 2004
- Our Health, our Care, our Say – 2006
- A new deal for Welfare – 2006
- Transforming Social Care – 2008
- Local Health and Well-being Strategies
- CCG Operating Plans
- Local Corporate Health and Social Care Objectives

However, the main driver for change in the National Mental Health Strategy "No Health without Mental Health" published in 2011, the key factors are detailed as follows:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have positive experience of evidence based timely interventions
- Fewer people will suffer avoidable harm and have confidence that services are safe
- Fewer will experience stigma and discrimination

In addition, there is the recent commitment from the Secretary of State, to move towards greater integrated health and social care in order to deliver better outcomes and efficiencies, so as to meet the current and future demographic challenges and relevant NICE guidelines.

4. THE STRATEGY

The Strategy describes mental health provision in terms of a planned, stepped pathway approach. It is recognised that improved effectiveness of early support and intervention in primary and community settings will reduce the dependency on secondary services.

The Commissioning Strategy considers 4 tiers reflecting the standards in the National Service Framework:

Tier One: Promotion and Prevention
Tier Two: Primary Care and Community Care
Tier Three: Secondary Mental Health Care

Tier Four: Tertiary services e.g. , Forensic Mental Health, Mother and Baby, Female Psychiatric Intensive Care

5. THE NATIONAL PICTURE OF MENTAL HEALTH AND WELLBEING

- Mental Health problems can affect anyone. Common mental health Problems are as frequent and common as physical disorders. Poor mental health significantly affects life choices and health outcomes.
- One in six of the population has a common mental health problem at any one time.
- WHO predict that depression will be the leading cause of disability internationally by 2020?
- Suicide is the most common cause of death in men under 35.
- Nationally, 900,000 people on incapacity benefit are off work because of mental health problems.
- The cost of mental health has been estimated at £77 billion per annum. People with mental illness are more likely to die prematurely than those without mental illness due to suicide but also death from respiratory and other illnesses.
- There is a well-documented correlation between poor mental and Physical ill health as well as a clear link to homelessness, substance misuse and dangers of a chaotic lifestyle. **Appendix 1** details the wider health challenges across the 3 Boroughs

6. FINANCIAL RESOURCES

The Department of Health publishes the outcome of the financial mapping exercise for adult and older people based on LIT self-assessment financial mapping returns. The overall spend by CCG on Adults and Older peoples Mental Health Services is as follows:

Investment		Weighted Population	Weighted Investment per head
Barnet	£47,223	277,61	£331.4
Haringey	£64,012	280,842	£619.2
Enfield	£50,657	256,909	426.8

Source 2011/12 DOH Financial Mapping Returns

By 2015/16 it is likely that Payment by Results will be applicable for the mental health services, and its introduction will completely change the way mental health services are funded. There will be national tariffs for treatments, currencies for treatments according to resource use and diagnosis and activity based funding. This will be a complex process and current information and activity data available is highly variable. However once the system has been introduced a key benefit is that there will be less need to negotiate the price of a service and more room for negotiation on quality and how best the service can meet the needs of the local population.

The above indicate the quantum of financial resource dedicated to the mental health services from health and social care. There have been a number of benchmarking exercises which have tried to establish whether this level of resource is adequate to meet local needs. However, it is difficult to establish whether such exercises take into account all available data and they tend to be utilised selectively, with Commissioners highlighting reports which seem to show a favorable level of investment and Providers highlighting reports showing the opposite and it is not always clear that data sources are comparable to enable an accurate analysis or comparison.

Therefore, given the relatively short period covered by the Strategy, along with the current economic circumstances and lack of clarity about the full introduction of payment by results for mental health, the assumption is that the level of resource will only show marginal change and it is therefore imperative that source resources are targeted effectively in this climate.

The services currently commissioned across the three Boroughs are detailed in Appendix 3

There has been significant debate over the balance of community and in- patient services related to appropriate balance and costs.

There has been significant improvement in the utilisation of both adult and older peoples' in-patient services in the recent past as the tables below demonstrate:

	April 2008	April 2009	April 2010	April 2011	April 2012
Barnet	114	63	59	48	36
Enfield	109	62	59	62	35
Haringey	109	71	70	55	43

Adult acute average length of stays (days)

These figures illustrate the overall reduction in in-patient activity and lengths of stay on the adult wards as a result of improved efficiency, productivity and reduced the number of emergency re-admissions and developed new alternatives to hospital admissions. The number of adult admissions has remained fairly consistent over the last four years, but lengths of stay and occupied bed days has reduced significantly. The opening of the 3 Recovery Houses and development of more service bases in the community will reduce the number of admissions and further reduce the lengths of stay.

In addition the absence of a local inpatient Rehabilitation Service as facilitated the gradual reduction in lengths of stay and improved bed utilisation.

The provision of adult acute mental health inpatient beds vary across the NHS from 15 per 100,000 population to 53 beds per 100,000 population. The median position nationally is 23 beds per 100,000 population.

BEH currently have 22 beds per 100,000 which is below the national median. As a London provider serving a population with higher than average deprivation this represents a comparatively efficient utilisation of in-patient resources.

The breakdown by Borough is a follows:

- Barnet **14** (amongst lowest nationally)
- Enfield **21.5**
- Haringey **32.5**

In terms of older people's acute in-patient mental health services, the occupied bed days have reduced by 58% in the last five years, as detailed below:

2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
22,000	20,000	17,000	14,500	9,200	9,227

Acute older adults occupied bed days

There may be some scope for further reduction going forward but it is equally appropriate to

look at service efficiencies from community and complex care service lines

Additionally, it will be necessary to further understand the bed utilisation by CCGs as local provision does not mean local use given the movements of patients.

Commissioners and local authorities have also indicated that they wish to maintain a bed base in each borough which reduces but does not eliminate the possibility of savings by the reconfiguration of services. In particular, Barnet do not wish to see their residents disadvantaged by the further centralisation of services on sites in Enfield and Haringey.

7. LOCAL COMMISSIONING CONTEXT

The three CCGs have responsibility for commissioning health services whilst the local authorities commission social care services. In order to ensure that commissioning is integrated each Borough has a local Strategic Partnership Board tasked with taking forward the common agendas. The Partnership Boards include a wide range of local stakeholders including Councils, PCTs, service users, carers and voluntary organisations.

Services for people with mental health problems represent just a part of the wide range of services commissioned by Local Authorities and CCGs. Our strategy for mental health needs to be seen in the context of our wider aspirations to improve all the services that are commissioned. Each of the organisations has established clear goals and aspirations summarised below:

- Affordable and decent housing.
- People to be supported in taking responsibility for their own health.
- Good access to high quality health services.
- Supporting families and individuals who need it – promoting independence, learning and wellbeing.
- Improving the satisfaction of residents and businesses within the Borough as a place to live, work and study.
- Targeting health and social care at the most vulnerable, specifically people with mental health needs and disabilities.
- Increase the choice and control in decision making over their individual services for service users, patients and carers.
- Increase the individual and collective influence of service users, patients and carers in shaping future services.
- To focus services to maximise and maintain peoples' health, independence and inclusion.
- To develop and maintain accessible services including fully accessible premises and homes.
- To develop integrated community pathways and services by working in partnership and co-ordinating development and investment.
- To ensure a workforce that is trained, reliable and efficient and to work with the independent sector to ensure the same is true of their workforce.
- To focus on the quality of service provided to service users, carers and patients.
- Implement recommendations from the Francis Report.

Service Model for the Future

We wish to see a transformation model of care so there is increased focus on the Stepped Care Recovery Model, integrated care, effective Multidisciplinary Team Working and the aspirations sent out in the National Strategy. At the moment, mental health services are too

narrowly focused, not joined up and not addressing the needs of individuals.

Delivering an integrated model of care will be challenging but the range of services described below cover a range of mental health needs – health promotion and prevention, primary and community care, secondary mental health services and specialist mental health services.

a. Health Promotion and Prevention

- Campaigns to reduce stigma and promote inclusion
- Employment opportunities and training
- Promotion of good mental health in all environments
- Information on health and wellbeing
- Improved housing facilities
- Support at difficult times e.g. bereavement
- Support for Carers

b. Primary Care and Community care

- Skilled primary health care workers
- Access to GPs and support
- Advice on finding the right services
- Housing, benefits and employment advice
- Access to psychological therapy support
- Early Intervention in Psychosis Teams
- Integrated Community Mental Health Teams
- Crisis and Home Treatment Teams
- Adult ADHD Services
- Eating Disorder Services
- Personality Disorder Services
- Dementia Services

c. Secondary mental health services

- Access to hospital services for people in crisis
- Range of supported accommodation
- Day opportunities
- Care co-ordination

d. Tertiary Services

- Forensic inpatient services
- Mother and baby Services
- Eating Disorder Services

9. KEY PRIORITIES FOR CHANGE

Detailed below are the key cross Borough priorities for change in the delivery of mental health services that Commissioners will take forward up to 2015.

a. Primary Care

Continue the shift towards primary care provision, supporting the transfer of patients and interventions from secondary to primary care through the development of integrated and enhanced primary care provision and liaison services.

This will mean a continues shift in resources and manpower over a strategic period from secondary to primary care so the majority of Mental Health interventions take place in primary and community settings regardless of who is delivering them. These services will provide high

levels of intervention in community settings and further reduce reliance on inpatient services. This network of services could be subject to market testing should Commissioners wish to pursue such an option.

Improved support and access to primary care services

- **Stepped Care and Recovery Approach**: There should be appropriate resources to diagnose and treat mental health patients in primary care when clinically appropriate. Only when further input is required will patients be referred into secondary and/or specialist services.
- **Timely Access**: Patients will have prompt access to assessment, treatment and support. GPs will have access to prompt information, advice and management support.
- **Support increased Confidence**: The service will improve the confidence of GPs to provide care and treatment for people within a primary care setting by providing timely, robust assessments and recommendations.
- **Improved communication** between primary and secondary care; for example through liaison arrangements and agreed standards and protocols.
- **Improved trust** in the service provided by BEH by having experienced staff available to give advice, make decisions and smooth care pathways.
- **Ensure efficient throughput** by providing effective clinical assessments that give clear recommendations and support stepping down patients from secondary to primary care.

b. Improve Care Pathways

- Develop plansfrom the Maudsley International Review of In-patient services. This may include cross Borough whole system initiatives looking at care pathways, focusing on more effective accommodation pathways which will yield benefits to all partners.
- Ensure that service users do not experience difficulties in the transition between services e.g., CAMHS to adults and adults to older people services. Providers will focus on these transition points to ensure there are clear pathways which include specific support allowing people to manage the transition effectively.
- Ensure that care pathways are in place to meet the needs of people with co-morbid conditions such as autism and learning disabilities. Services should be accessible and adapted to meet the needs of those requiring specialist support.

c. Service users more in control of the service they receive

- Significant increase in the number of service users who are directly influencing their care through the use of personalised care budgets.
- Ensure packages of care are increasingly influenced by service users.
- Informed information to service users on what services are available and how they can be accessed.
- Ensure that service users are at the centre of service re-design and have a "clear journey" through services which are easily navigated.
- Recognition that the "expert patient model" approach and that service users are experts in mental health care by means of

their experiences in the mental healthcare system.

- Introduction of peer support arrangements in secondary mental healthcare to help bridge the gap between the mental health professional and service user.
- Enhances availability of information on mental health awareness and description of services available locally and how they are accessed.
- Support to carers and availability of family therapy services where appropriate to help service users to be supported and maintained in the community.
- Recognition of the role the third sector services can offer service users in terms of community maintenance and less stigmatising interventions.
- Recognition of the critical contribution carers make to the support and treatment of people with mental health problems. Preventative work with carers can reduce re-admissions and relapses as well as enhancing the effectiveness and efficiency of mental health services generally.

d. Improved support for people with physical and mental health problems

- Improving access to physical health services will mean regular health check-ups and an integrated approach between secondary and primary care services.
- Address the needs of people presenting with undiagnosed conditions by improving better access to psychological therapies.
- Emphasis on the overall wellbeing of the service users taking into account physical healthcare and a balance between medication and talking therapies.

e. CCG Quality and Safety Initiatives

- Work collaboratively to improve service line financial and activity data reporting.
- Work collaboratively to prepare for the introduction of payment by results.
- Work collaboratively on an agreed Service Quality Improvement agenda going forward, particularly in relation to the following:
  - Timely complaint investigations
  - Timely reporting of serious incidents
  - Timely investigation of serious incidents
  - Demonstrable organisational learning from serious incidents recommendations
    - Thematic reviews
    - National reports
    - Analysis of “near misses”
  - CQUIN targets achieved
  - Robust safe-guarding adults and children procedures
  - Action plans relating to CQC Alerts
  - Standardised access and timely interventions across all care pathways
  - Francis Recommendations

- Exploit the expertise of service users and secondary care staff in delivering mental healthcare to provide training opportunities for the diverse range of non-specialist mental

health staff associated in the delivery of effective mental health services.

- GPs and other Primary Care staff
- A&E staff
- Ambulance staff
- Primary Care reception and admin staff
- Police and Emergency services

f. Service Developments

Develop a Stepped Care Recovery Model which will involve a network of GPs, Primary Care Mental Health Workers IAPT, Crisis and Triage Teams working collaboratively to screen and assess people to maintain as many individuals as possible in Primary Care with the emphasis on reablement. The following two diagrams describe this approach.

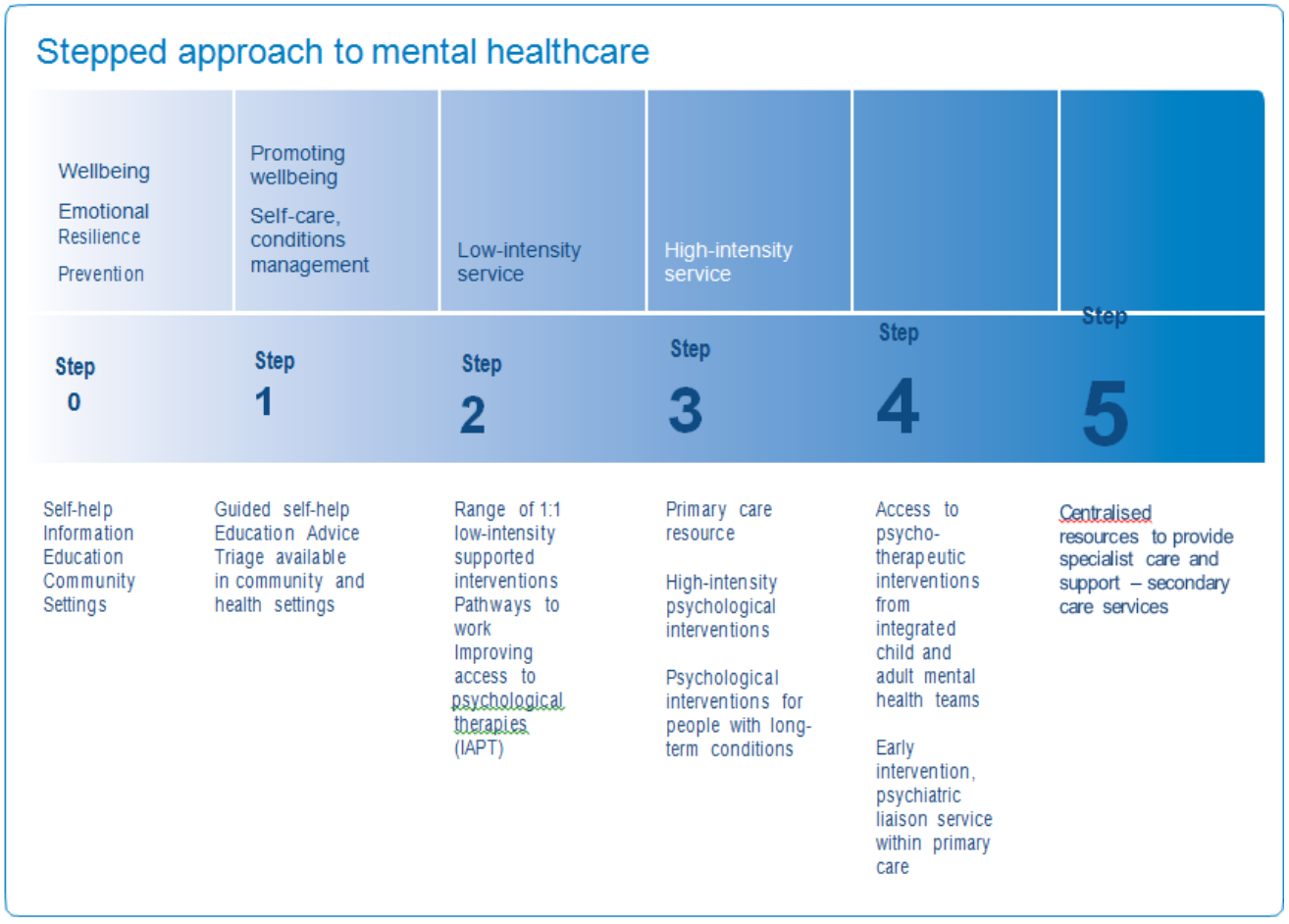
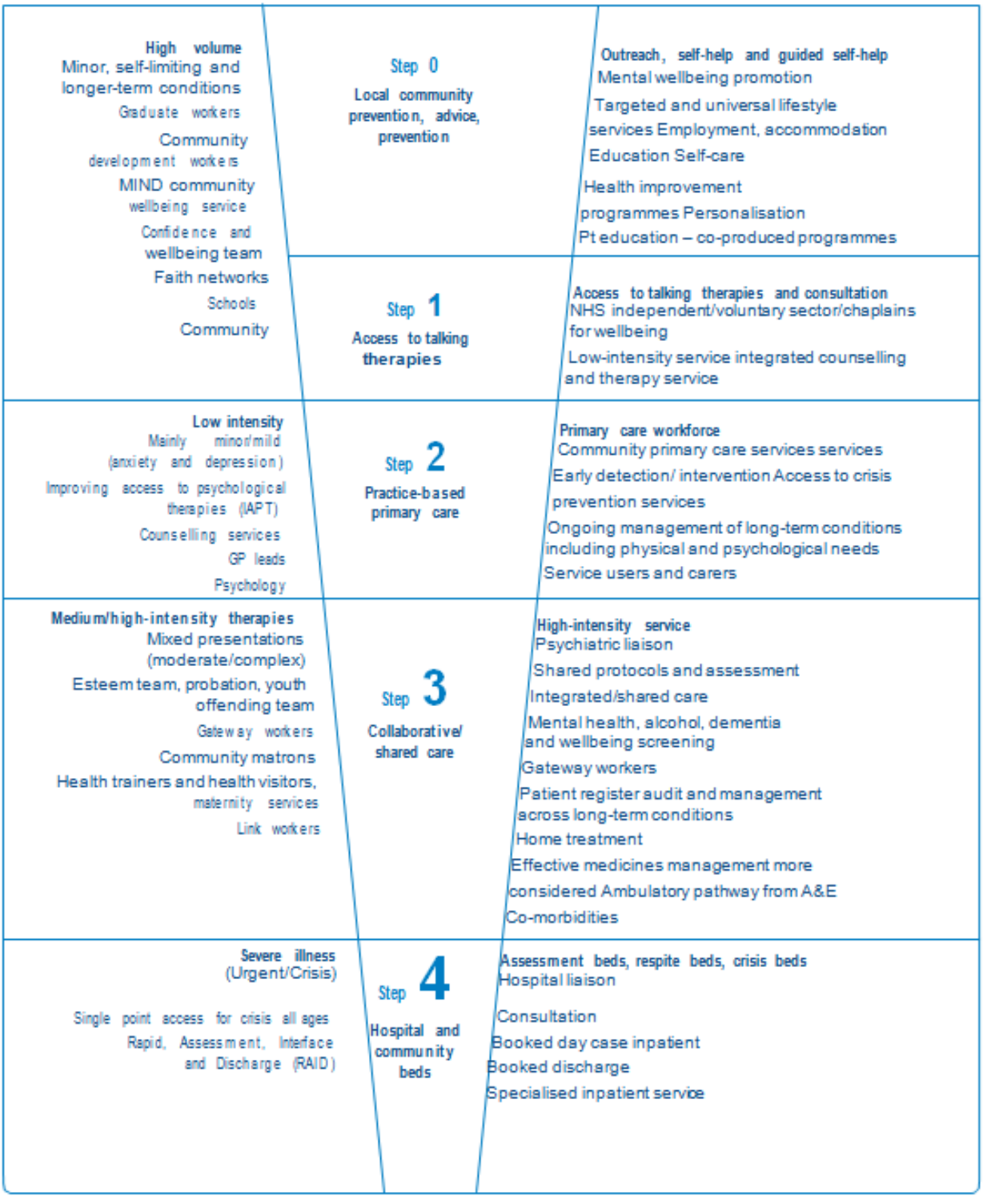


Figure 2: Integrated primary care and wellbeing model

This diagram depicts the I primary care mental health and wellbeing model. Within the model, people can step up or step down according to need.

Wellbeing is a theme at all levels through the model and access to programmes incorporating wellbeing and positive psychology is offered in a range of settings including faith, schools, children and family centres, health and community venues.



Key features would include:

- Improved access to mental health assessments for primary care referrals including extended / out of hour's services.

- Improved patient experience by working closely with service user advisory groups to design and develop better services with a more skill workforce.

- Home Treatment teams would work more closely with community assessment to keep people in primary care where possible.

- Improving the quality of the assessment by reviewing the skill mix of the assessment teams. Most experienced staff would be deployed in the assessment and triage function to formulate best treatment approach and ensure patients are seen in the most appropriate setting for their needs.

- Working closely with the Local Authorities to provide a stronger re-ablement function to facilitate, where appropriate, the management of those patients with social care needs in primary care.

- Benefits would include earlier assessment and improved signposting of patients into the most appropriate services to meet their needs with care managed in primary or community settings wherever possible. As well as improving patient experience and service quality, it would reduce the number of unnecessary admissions to hospital

- Assessment of all referrals from primary care and other referral sources (including police and other statutory services, emergency services and in-patient wards) of people who are not known to secondary care services. Referrals will be screened and in discussion with referrers, some will be signposted to alternative sources.

- Face to face assessment of referrals from primary care and other referral sources, with signposting or onward referral to other sources of treatment and support including IAPT.

- Extended hours to provide urgent assessment in primary care settings outside of traditional office hours.

- Linked working with Re-ablement services in the Local Authority to facilitate, where appropriate, the management of people with social care needs in primary care. Once this enhanced primary care service is in place consideration will be given to transferring all patients in clusters one to three from secondary to primary care. This will have an activity impact on secondary services and the expectation is that this will provide a Commissioner QIPP in 2014/15.

    - Reinstate the cross Borough adult ADHD services to previous activity levels and agree how this service is to be further developed.
    - Further expansion of IAPT provision and access to psychological therapies generally.
    - Continue to work towards the separation of functional and organic in-patient services for older people including the re- organisation of the Oaks unit and Ken Porter unit to ensure they are clinically sound and fit for purpose and work towards the development of a dementia care pathway.

- Continued Commissioner support for the redevelopment of the St Ann's site to provide high quality fit for purpose in-patient facilities.
- Develop a rehabilitation model locally for individuals requiring a more prolonged in-patient admission (12-18 months), this service is currently provided out of Borough which makes care co-ordination and family support problematic.

  In the meantime, the current Complex Care Panel will continue with revised Terms of Reference, focusing on 3 patient COHORTS. The expectation is that this provides financial benefits to Commissioners and Providers in 2013/14 and 2015/16 although it is accepted that the level of savings will taper as patients are placed in accommodation which is clinically and financially appropriate for their needs.
  Changes to the current configuration of services to enable the provision of a Personality Disorder Service across the 3 Boroughs
  The development of a local autism diagnostic service which will support other Community Teams and Primary care through training and consultation to better support people in the community

  Work collaboratively across health and social care to remodel the Day Hospitals for Older People
  Ensure improved access for people with a Learning disability or Autism to local Crisis or Home Treatment services including Acute beds as appropriate in order to provide care closer to home and reduce reliance on out of area placements

- Lead a formal consultation exercise to deliver a more appropriate service model for long term continuing care services. The new service will make support for older people more community based by developing services outside Hospital to support people who need long term care either in their own homes or Independent Sector provision. A smaller number of dementia treatment and assessment beds will be commissioned with a specific focus on intensive work with older people with challenging behavior or severe mood disorders to ensure they can continue to live at home with the support of appropriate community services. The expectation is that this provides a Commissioner QIPP in 2015/16.
- Implementation of the Barnet Dementia Action Plan with clearly defined pathways including early dementia detection and Memory services. A Dementia Hub will be developed comprising of multi-agency interventions and support for people with dementia and family and Carers. This will be a key service development and will provide some or all of the following

  - Memory Clinic service
  - Advice and support at the point of diagnosis
  - Alzheimer's services for people with high needs
  - Dementia Café
  - Carers Training
  - Support Groups
  - Tele-care/Tele-health

In partnership with Acute Commissioners lead the development of a Rapid Assessment Intervention and Discharge Service (RAID) at Barnet and Chase Farm, North Middlesex and Royal Free Hospital. This service will improve the quality of care, drive down lengths of stay and reduce admission rates across the whole spectrum of mental health co-morbidity in the acute hospitals including dementia, self-harm and substance misuse. There are two key components as follows:

- Direct assessment and treatment of patients presenting with overt mental health problems, allowing the acute Trust care

  Pathways to function smoothly and reduce unnecessary delays, similar assessment and treatment of patients who present with co-morbid health problems such as dementia.
- High quality education and support of Acute staff through both formal teaching and informal techniques, to rapidly train up Acute Trust staff in identification of patients who might benefit from liaison psychiatry input and improve their own care of such patients.

10. INDIVIDUAL BOROUGH PLANS

Individual Borough plans derived from local needs assessment, Commissioning Strategies and Partnership Board priorities display many similarities, the main themes of such plans are detailed below

10.1 Health Promotion and Prevention

Smoking cessation initiatives
Self directed support including the use of personal budgets Suicide prevention initiatives
Early intervention through health promotion work in schools and with families

10.2 Primary Care and Community care

Greater provision of integrated community treatment in Primary care

Training and support to GPs Improved access to IAPT
Improved support to individuals and carers in times of crisis

- Improving the interface between primary and secondary mental health care.
- Improving crisis response services
- Improve Memory Clinics, care at home and in Care Homes for patients with dementia, spanning early diagnosis and end of life care
- Ensure effective Care Pathways for people with co-morbid conditions eg Learning disabilities, Autism, Attention Deficit Disorder and Personality Disorder
- Development of enhanced Community based Dementia Services to address lower than expected ratio of recorded to expected levels of Dementia

10.3 Secondary Mental Health Services

- In partnership with Primary and Community Care Services develop admission avoidance schemes to address the high rate of hospital admissions for depressive and delusional disorders and schizophrenia
- Ensure an appropriate balance between inpatient and community Mental Health services.

10.4 Tertiary Services

- Develop a local rehabilitation model for patients requiring a prolonged period of hospital admission to reduce the current reliance on out of area placements
- Ensure there is a well-defined and effective Care Pathway between general mental health services and Specialist Forensic services

11. IMPLEMENTATION PLAN AND FINANCIAL OUTLOOK

It has been agreed to establish a Mental Health Transformation Board with representation from BEH, the CCGs and other Stakeholders. The Board will be chaired by the CCG Accountable Officer with the Lead for Mental Health working across the CCGs and the Mental Health Trust. The purpose of the Board will be to ensure the implementation of the Commissioning Strategy and other dependent initiatives such as the Trusts Clinical Strategy and Quality and Safety Review.

The first task of the Board will be to agree an implementation plan within three months of signing off the three Borough Strategy, the timescale for the delivery of the strategy is anticipated to between 18/24 months.

The Board will work to a PMO methodology, utilising a number of key workstreams reflecting local priorities to ensure the following:

- Oversee and monitor the delivery of the Reports as agreed by the Board.
- Oversee projects, activities and outputs in line with the Project Plans and deliverables, through the use of support and advice as required for each of the projects and highlight reports.
- Ensure Projects being taken forward align with the locally agreed strategies.
- Review risks through the use of a risk assurance framework ensuring that :
- robust clinical risk assessment and management is in place
- handover of documentation at the close of any programmed activity.

The Transformation Board will establish 4 sub-groups mapped to the key themes of this Commissioning Strategy as follows:

- Prevention and Health Promotion – Local Authority lead
- Primary Care and Community Services – GP lead
- Secondary Care –CCG lead
- Tertiary Service –BEH lead

As a consequence of the challenging financial position going forward all Stakeholders are likely to be identifying potential savings or efficiencies for reinvestment from the health economy with decommissioning and potential staff redundancies during service re-design.

At the outset therefore BEH and Commissioners need to agree the baseline for all service lines including indirect and overhead costs.

It is anticipated that every decommissioning decision will release some savings, though for small reductions these may be marginal. However, if the reduction is a substantial amount more significant savings, perhaps not all immediate should be released to Commissioners. This will apply to direct costs, indirect costs and organisational overheads.

The Transformation Board will have to ensure at the outset that potential savings required are not being double counted. BEH will have its own Cash Releasing Efficiency Savings and the CCGs their own QIPP targets and the initiatives to achieve both needs to be transparent. In line with the Francis recommendations the Board will need to assure itself that the QIPP/CIP plans have been through a rigorous Quality Impact Assessment to ensure that there is no adverse impact on quality and safety issues as detailed in the CCG Operating Framework.

CRES clearly relates to the ability of BEH to provide the same (or higher) level of activity for less income and the decommissioning of services is fairly clear. The grey area relates to provider led CRES, service re-design initiatives and Commissioner led re-design initiatives which may overlap with both parties anticipating the financial benefits realised.

It is therefore essential for the Transformation Board that CCGs and BEH are transparent in declaring their savings intentions and agreeing into which category each of these will fall and therefore where the savings will be attributed.

12. Next Steps

The Governance and Financial framework for the implementation of this Strategy needs to be established as soon as possible. The key milestones to doing so are as follows

Agree Terms of Reference for the Transformation Board **30/7/2013**.
Agree Commissioner QIPP and Provider CIPs **17/7/2013**

Joint meeting with BEH and CCG Executives and Senior Clinicians to agree the ground rules for working together going forward and the appropriate structures for doing so **30/7/2013**

In terms of the key service developments the milestones are as follows:

a) Primary Care Services

This strategy is intended to drive the majority of Mental Health interventions and support from secondary care into community based recovery settings in line with the Stepped Care Recovery Model outlined earlier.

This is a significant and crucial piece of work which will require detailed planning, consultation and careful implementation. This is therefore a major piece of work to be remitted to the Primary Care Sub group of the Transformation Board to be established in **September 2013**. It should be possible following due consultation and detailed planning to establish the new service by **June 2014**

b) RAID

Two Business Cases are required to develop this service which will need to dovetail together, one by the Provider and one by Commissioners- the latter with an emphasis on cost and potential financial and quality benefits going forward, offset against any upfront pump priming funding that may be required. These are to be completed by the end of **July 2013** and implementation remitted to the Secondary Care Sub Group with an expectation that the service is in place by **December 2013**

c) ADHD

The Clinic has now been re-established in line with the Commissioning Strategy and work has begun on how the service is to be further developed in light of local financial constraints of financial constraints. Activity and cost information is currently being analysed and this development should be remitted to the Primary and Community Services Sub group to be established in **September 2013**. It is anticipated that the expanded local service will be in place by **October 2013**

d) Older Persons Services Re-Configuration

Concern over quality issues on the Oaks unit has led to discussions already taking place about a new model of service which involves the separation of functional and organic inpatient services. A Steering group with Commissioner involvement is to be established to take this initiative forward, and this work needs to be completed by **October 2013**, given the concerns expressed. Monitoring of the impact of implementation should be remitted to the Primary and Community Services Sub Group to be established in **September 2013**.

e) Continuing Care Services re-configuration

This is primarily an Enfield issue, but not exclusively as any changes will impact on the other two Boroughs who do use the Oaks unit and also have a small number of patients on the associated Continuing Care Wards. The next step is a Paper to the Enfield CCG Transformation Board in **July 2013**, outlining the issues and suggesting options for taking forward this sensitive piece of work.

A full Business Case will need to written by **November 2013** to allow for a due period of formal consultation so that the new service can be in place by **October 2014** when the Contract with the current Provider comes to an end. This process is to be overseen by the Specialist Services Sub Group which is to be established in **September 2013.**

f) IAPT

Both Barnet and Enfield CCGs are undertaking work to determine how their IAPT services will meet the national targets by 2015. This may include additional investment and/or market testing.Both CCGs will be discussing this matter further in **July 2013** and the Primary and Community Services Sub Group to be established in **September 2013** will oversee the implementation of recommendations going forward.

g) Development of a Local Rehabilitation Service

This is a significant and complex piece of work which is in its infancy, external Clinical and Commissioning expertise may be required to further develop this initiative. The oversight of this work should be remitted to the Secondary care sub group to be established in **September 2013**. The first task is to produce a Proposal for a local model of service by **January 2014** for discussion and onward consultation with a view to establishing the local service by **October 2014**.

h) Development of Dementia Services

This piece of work is already well developed in Barnet and BEH have been asked by Commissioners to ensure that any changes to their older peoples services is complementary to and enhances the changes that are anticipated in Barnet. It would seem sensible therefore to bring those these two pieces of work together under the aegis of the Primary and Community Services Sub Group to be established in **September 2013** with a view to implementing the Barnet specific proposals by **April 2013** and assessing whether such service developments could be of benefit in the other two Boroughs

i) Autism and Learning Disability Developments

This piece of work is currently at an early stage and should be remitted to the Secondary Care Sub Group to develop these initiatives to ensure the new service model is established by **April 2014**

j) Day Hospital Remodelling

Again this work is in its early stages but could have significant implications across the 3 Boroughs and needs to be fully integrated and complementary to developments in Social Care Services. This piece of work needs to be led by the Primary and Community Services Sub Group, with an anticipated implementation date of **April 2014** following an inclusive Consultation Process

April 2013 – Updated 20 June 2013
Further updated 26th June 2013
Further updated 8th July 2013
Further updated 17th July 2013

Community Mental Health Profile 2013 for Barnet

Key

Regional average

Not significantly different to England

Significance Not Tested

England Average

Where percieved polarity:

Significantly worse than England

Significantly better than England

Where no percieved polarity:

Significantly lower than England

Significantly higher than England

	Wider Determinants of Health	Local value	Eng. Ave.	Eng. Worst*	England Range	Eng. Best*
1	**Percentage of 16-18 year olds not in employment, education or training, 2011**	4.1	6.2	11.9		1.9
2	**Episodes of violent crime, rate per 1,000 population, 2010/11**	12.7	14.6	34.5		6.3
3	**Percentage of the relevant population living in the 20% most deprived areas in England, 2010**	5.8	19.8	83.0		0.3
4	**Working age adults who are unemployed, rate per 1,000 population, 2010/11**	64.2	59.4	106.2		8.3
5	**Rate of hospital admissions for alcohol attributable conditions, per 1,000 population, 2011/12**	18.9	23.0	38.6		11.4
6	**Numbers of people (aged 18-75) in drug treatment, rate per 1,000 population, 2011/12**	2.8	5.2	0.8		18.4
	Risk Factors					
7	**Statutory homeless households, rate per 1,000 households, all ages, 2010/11**	1.83	2.03	10.36		0.13
8	**Percentage of the population with a limiting long term illness, 2001**	13.5	16.9	24.4		10.2
9	**First time entrants into the youth justice system 10 to 17 year olds,**	587	876	2,436		343

	2001 to 2011					
10	**Percentage of adults (16+) participating in recommended level of physical activity, 2009/10 to 2011/12**	8.5	11.2	5.7		17.3
Levels of Mental Health and Illness						
11	**Percentage of adults (18+) with dementia, 2011/12**	0.61	0.53	0.95		0.21
12	**Ratio of recorded to expected prevalence of dementia, 2010/11**	0.54	0.42	0.27		0.69
13	**Percentage of adults (18+) with depression, 2011/12**	8.46	11.68	20.29		4.75
14	**Percentage of adults (18+) with learning disabilities, 2011/12**	0.35	0.45	0.21		0.77

Treatment		**Local value**	**Eng. Ave.**	**Eng. Worst***	**England Range**	**Eng. Best***
15	**Directly standardised rate for hospital admissions for mental health, 2009/10 to 2011/12**	216	243	1,257		99
16	**Directly standardised rate for hospital admissions for unipolar depressive disorders, 2009/10 to 2011/12**	30.5	32.1	84.8		4.7
17	**Directly standardised rate for hospital admissions for Alzheimer's and other related dementia, 2009/10 to 2011/12**	53	80	226		5
18	**Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders, 2009/10 to 2011/12**	96	57	233		5
19	**Allocated average spend for mental health per head, 2011/12**	179	183	147		257

20	**Numbers of people using adult & elderly NHS secondary mental health services, rate per 1000 population, 2010/11**	2.5	2.5	0.0		9.6
21	**Percentage of referrals entering treatment from Improving Access to Psychological Therapies, 2011/12**	35.2	60.1	28.9		99.7
22	**Numbers of people on a Care Programme Approach, rate per 1,000 population, 2010/11**	7.7	6.4	0.3		17.1
23	**In-year bed days for mental health, rate per 1,000 population, 2010/11**	191	193	72		489
24	**Number of contacts with Community Psychiatric Nurse, rate per 1,000 population, 2010/11**	150	169	3		584
25	**Number of total contacts with mental health services, rate per 1,000 population, 2010/11**	330	313	31		823
Outcomes						
26	**People with mental illness and or disability in settled accommodation, 2011/12**	65.9	66.8	1.3		92.8
27	**Directly standardised rate for emergency hospital admissions for self harm, 2011/12**	121	207	543		52
28	**Indirectly standardised mortality rate for suicide and undetermined injury, 2010/11**	104	100	174		29
29	**Hospital admissions caused by unintentional and deliberate injuries in <18s, 2009/10**	79	123	217		68
30	**Improving Access to Psychological Therapies - Recovery Rate, 2011/12**	51.0	43.8	9.9		65.3

31	**Excess under 75 mortality rate in adults with serious mental illness, 2010/11**	596	921	1,863		210

* - For indicators 6, 20, and 22-25, there is no perceived polarity, so "lowest" and "highest" replace "worst" and "best"

Community Mental Health Profile 2013 for Enfield

Key

Regional average

Not significantly different to England

Significance Not Tested

England Average

Where percieved polarity:

Significantly worse than England

Significantly better than England

Where no percieved polarity:

Significantly lower than England

Significantly higher than England

Wider Determinants of Health		**Local value**	**Eng. Ave.**	**Eng. Worst***	**England Range**	**Eng. Best***
1	**Percentage of 16-18 year olds not in employment, education or training, 2011**	**4.2**	**6.2**	**11.9**		**1.9**
2	**Episodes of violent crime, rate per 1,000 population, 2010/11**	**15.0**	**14.6**	**34.5**		**6.3**
3	**Percentage of the relevant population living in the 20% most deprived areas in England, 2010**	**27.0**	**19.8**	**83.0**		**0.3**
4	**Working age adults who are unemployed, rate per 1,000 population, 2010/11**	**74.8**	**59.4**	**106.2**		**8.3**
5	**Rate of hospital admissions for alcohol attributable conditions, per 1,000 population, 2011/12**	**20.0**	**23.0**	**38.6**		**11.4**
6	**Numbers of people (aged 18-75) in drug treatment, rate per 1,000 population, 2011/12**	**5.2**	**5.2**	**0.8**		**18.4**
Risk Factors						
7	**Statutory homeless households, rate per 1,000 households, all ages, 2010/11**	**1.70**	**2.03**	**10.36**		**0.13**

8	Percentage of the population with a limiting long term illness, 2001	15.2	16.9	24.4		10.2
9	First time entrants into the youth justice system 10 to 17 year olds, 2001 to 2011	1,343	876	2,436		343
10	Percentage of adults (16+) participating in recommended level of physical activity, 2009/10 to 2011/12	9.3	11.2	5.7		17.3

Levels of Mental Health and Illness

11	Percentage of adults (18+) with dementia, 2011/12	0.41	0.53	0.95		0.21
12	Ratio of recorded to expected prevalence of dementia, 2010/11	0.36	0.42	0.27		0.69
13	Percentage of adults (18+) with depression, 2011/12	7.99	11.68	20.29		4.75
14	Percentage of adults (18+) with learning disabilities, 2011/12	0.38	0.45	0.21		0.77

Treatment		Local value	Eng. Ave.	Eng. Worst*	England Range	Eng. Best*
15	Directly standardised rate for hospital admissions for mental health, 2009/10 to 2011/12	259	243	1,257		99
16	Directly standardised rate for hospital admissions for unipolar depressive disorders, 2009/10 to 2011/12	30.9	32.1	84.8		4.7
17	Directly standardised rate for hospital admissions for Alzheimer's and other related dementia, 2009/10 to 2011/12	123	80	226		5
18	Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders, 2009/10 to	113	57	233		5

	2011/12					
19	**Allocated average spend for mental health per head, 2011/12**	**190**	**183**	**147**		**257**
20	**Numbers of people using adult & elderly NHS secondary mental health services, rate per 1000 population, 2010/11**	**2.8**	**2.5**	**0.0**		**9.6**
21	**Percentage of referrals entering treatment from Improving Access to Psychological Therapies, 2011/12**	**51.3**	**60.1**	**28.9**		**99.7**
22	**Numbers of people on a Care Programme Approach, rate per 1,000 population, 2010/11**	**10.1**	**6.4**	**0.3**		**17.1**
23	**In-year bed days for mental health, rate per 1,000 population, 2010/11**	**327**	**193**	**72**		**489**
24	**Number of contacts with Community Psychiatric Nurse, rate per 1,000 population, 2010/11**	**189**	**169**	**3**		**584**
25	**Number of total contacts with mental health services, rate per 1,000 population, 2010/11**	**432**	**313**	**31**		**823**
Outcomes						
26	**People with mental illness and or disability in settled accommodation, 2011/12**	**61.5**	**66.8**	**1.3**		**92.8**
27	**Directly standardised rate for emergency hospital admissions for self harm, 2011/12**	**84**	**207**	**543**		**52**
28	**Indirectly standardised mortality rate for suicide and undetermined injury, 2010/11**	**78**	**100**	**174**		**29**
29	**Hospital admissions caused by unintentional and deliberate**	**96**	**123**	**217**		**68**

	injuries in <18s, 2009/10					
30	Improving Access to Psychological Therapies - Recovery Rate, 2011/12	49.4	43.8	9.9		65.3
31	Excess under 75 mortality rate in adults with serious mental illness, 2010/11	884	921	1,863		210

* - For indicators 6, 20, and 22-25, there is no perceived polarity, so "lowest" and "highest" replace "worst" and "best"

Community Mental Health Profile 2013 for Haringey

Key


Regional average


Not significantly different to England


Significance Not Tested

England Average

Where percieved polarity:


Significantly worse than England

Significantly better than England

Where no percieved polarity:


Significantly lower than England


Significantly higher than England

Wider Determinants of Health		Local value	Eng. Ave.	Eng. Worst*	England Range	Eng. Best*
1	Percentage of 16-18 year olds not in employment, education or training, 2011	4.2	6.2	11.9		1.9
2	Episodes of violent crime, rate per 1,000 population, 2010/11	21.8	14.6	34.5		6.3
3	Percentage of the relevant population living in the 20% most deprived areas in England, 2010	55.9	19.8	83.0		0.3
4	Working age adults who are unemployed, rate per 1,000 population, 2010/11	85.1	59.4	106.2		8.3

5	**Rate of hospital admissions for alcohol attributable conditions, per 1,000 population, 2011/12**	**19.0**	**23.0**	**38.6**		**11.4**
6	**Numbers of people (aged 18-75) in drug treatment, rate per 1,000 population, 2011/12**	**6.6**	**5.2**	**0.8**		**18.4**
Risk Factors						
7	**Statutory homeless households, rate per 1,000 households, all ages, 2010/11**	**5.04**	**2.03**	**10.36**		**0.13**
8	**Percentage of the population with a limiting long term illness, 2001**	**14.7**	**16.9**	**24.4**		**10.2**
9	**First time entrants into the youth justice system 10 to 17 year olds, 2001 to 2011**	**1,488**	**876**	**2,436**		**343**
10	**Percentage of adults (16+) participating in recommended level of physical activity, 2009/10 to 2011/12**	**10.4**	**11.2**	**5.7**		**17.3**
Levels of Mental Health and Illness						
11	**Percentage of adults (18+) with dementia, 2011/12**	**0.25**	**0.53**	**0.95**		**0.21**
12	**Ratio of recorded to expected prevalence of dementia,**	**0.45**	**0.42**	**0.27**		**0.69**

	2010/11					
13	Percentage of adults (18+) with depression, 2011/12	7.41	11.68	20.29		4.75
14	Percentage of adults (18+) with learning disabilities, 2011/12	0.35	0.45	0.21		0.77

Treatment		Local value	Eng. Ave.	Eng. Worst*	England Range	Eng. Best*
15	Directly standardised rate for hospital admissions for mental health, 2009/10 to 2011/12	345	243	1,257		99
16	Directly standardised rate for hospital admissions for unipolar depressive disorders, 2009/10 to 2011/12	41.0	32.1	84.8		4.7
17	Directly standardised rate for hospital admissions for Alzheimer's and other related dementia, 2009/10 to 2011/12	73	80	226		5
18	Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders, 2009/10 to 2011/12	160	57	233		5
19	Allocated average spend for mental health per head,	209	183	147		257

	2011/12					
20	**Numbers of people using adult & elderly NHS secondary mental health services, rate per 1000 population, 2010/11**	**3.9**	**2.5**	**0.0**		**9.6**
21	**Percentage of referrals entering treatment from Improving Access to Psychological Therapies, 2011/12**	**55.2**	**60.1**	**28.9**		**99.7**
22	**Numbers of people on a Care Programme Approach, rate per 1,000 population, 2010/11**	**11.4**	**6.4**	**0.3**		**17.1**
23	**In-year bed days for mental health, rate per 1,000 population, 2010/11**	**366**	**193**	**72**		**489**
24	**Number of contacts with Community Psychiatric Nurse, rate per 1,000 population, 2010/11**	**232**	**169**	**3**		**584**
25	**Number of total contacts with mental health services, rate per 1,000 population, 2010/11**	**527**	**313**	**31**		**823**
Outcomes						
26	**People with mental illness and or disability in settled accommodation, 2011/12**	**60.4**	**66.8**	**1.3**		**92.8**

27	**Directly standardised rate for emergency hospital admissions for self harm, 2011/12**	**103**	**207**	**543**		**52**
28	**Indirectly standardised mortality rate for suicide and undetermined injury, 2010/11**	**123**	**100**	**174**		**29**
29	**Hospital admissions caused by unintentional and deliberate injuries in <18s, 2009/10**	**101**	**123**	**217**		**68**
30	**Improving Access to Psychological Therapies - Recovery Rate, 2011/12**	**44.8**	**43.8**	**9.9**		**65.3**
31	**Excess under 75 mortality rate in adults with serious mental illness, 2010/11**	**534**	**921**	**1,863**		**210**

*** - For indicators 6, 20, and 22-25, there is no perceived polarity, so "lowest" and "highest" replace "worst" and "best"**

LIT Comparative Report Adult Services LIT = Barnet

	LIT Investment by Direct Provider Type			
Direct Service Group	**£000's**	**NHS**	**Non Statutory**	**Social Services**
Access & Crisis Services	**£3,434**	£3,363	£0	£71
Accommodation	**£4,969**	£6	£4,963	£0
Carers' Services	**£154**	£0	£154	£0
Clinical Services	**£7,319**	£7,050	£269	£0
CMHTs	**£5,488**	£4,160	£0	£1,329
Continuing Care	**£2,359**	£957	£1,402	£0
Employment/Day/Resource Centres	**£1,034**	£0	£607	£428
Direct Payments	**£262**	£0	£262	£0
Home Support Services	**£958**	£0	£958	£0
Mental Health Promotion	**£0**	£0	£0	£0
Other Community & Hospital	**£977**	£977	£0	£0
Personality Disorder Services	**£41**	£41	£0	£0
Psychological Therapy Services (IAPT)	**£1,297**	£1,297	£0	£0
Psychological Therapy Services (NIAPT)	**£1,361**	£1,041	£319	£0
Secure & High Dependency	**£4,653**	£4,165	£487	£0
Services for MDO's	**£3**	£3	£0	£0
Support Services	**£527**	£0	£527	£0
Total Direct Services in £000's	**£34,835**	£23,060	£9,948	£1,828
Direct Costs	**£34,835**			
Indirect Costs / Overheads	**£3,524**			
Capital Charges	**£1,016**			
Total adult investment in £000's	**£39,376**			

LIT Comparative Report Older People LIT = Barnet

	LIT Investment by Direct Provider Type			
Direct Service Group	**£000's**	**NHS**	**Non Statutory**	**Social Services**
Care and repair - OPMH	**£0**	£0	£0	£0
Care for People in General Hospital	**£1**	£1	£0	£0
Carer's Services - OPMH	**£27**	£0	£27	£0
Emergency Services - OPMH	**£0**	£0	£0	£0
Intermediate Care - OPMH	**£0**	£0	£0	£0
Other Specialist MH Services - OPMH	**£4,588**	£4,290	£0	£297
Primary and Community Care				
- Day Services	**£633**	£322	£311	£0
- Homecare	**£0**	£0	£0	£0
- PCS	**£0**	£0	£0	£0
- Residential	**£1,524**	£0	£1,524	£0
- Specialist Housing	**£0**	£0	£0	£0
Special Groups - OPMH	**£5**	£5	£0	£0
Support Services - OPMH	**£0**	£0	£0	£0
Total Direct Services in £'000s	**£6,777**	£4,618	£1,861	£297
Direct Costs	**£6,777**			
Indirect Costs/Overheads	**£837**			
Capital Charges	**£234**			
Total OPMH investments in £'000s	**£7848**			

LIT Comparative Report Adult Services LIT = Haringey

	LIT Investment by Direct Provider Type			
Direct Service Group	**£000's**	**NHS**	**Non Statutory**	**Social Services**
Access & Crisis Services	**£4,457**	£3,581	£0	£876
Accommodation	**£11,462**	£0	£11,462	£0
Carers' Services	**£299**	£0	£269	£31
Clinical Services	**£6,600**	£6,600	£0	£0
CMHTs	**£5,580**	£4,284	£0	£1,297
Continuing Care	**£82**	£14	£68	£0
Employment / Day / Resource Centres	**£1,500**	£0	£498	£1,003
Direct Payments	**£195**	£0	£195	£0
Home Support Services	**£159**	£0	£159	£0
Mental Health Promotion	**£0**	£0	£0	£0
Other Community & Hospital	**£42**	£8	£34	£0
Personality Disorder Services	**£815**	£815	£0	£0
Psychological Therapy Services (IAPT)	**£959**	£283	£676	£0
Psychological Therapy Services (NIAPT)	**£1,306**	£1,246	£60	£0
Secure & High Dependency	**£10,382**	£10,382	£0	£0
Services of MDOs	**£295**	£295	£0	£0
Support Services	**£562**	£0	£562	£0
Total Direct Services in £'000s and %	**£44,697**	£27,509	£13,981	£3,206
Direct Costs	**£44,697**			
Indirect Costs / Overheads	**£3,654**			
Capital Charges	**£1,743**			
Total adult investment in £'000s	**£50,093**			

LIT Comparative Report Older People LIT = Haringey

	LIT Investment by Direct Provider Type			
Direct Service Group	**£000's**	**NHS**	**Non Statutory**	**Social Services**
Care and repair - OPMH	**£0**	£0	£0	£0
Care for People in General Hospital	**£0**	£1	£0	£0
Carer's Services - OPMH	**£0**	£0	£0	£0
Emergency Services - OPMH	**£17**	£17	£0	£0
Intermediate Care - OPMH	**£0**	£0	£0	£0
Other Specialist MH Services - OPMH	**£8,353**	£3,434	£4,920	
Primary and Community Care				
- Day Services	**£509**	£186	£315	£8
- Homecare	**£151**	£0	£151	£0
- PCS	**£287**	£0	£0	£287
- Residential	**£3,500**	£0	£3,390	£110
- Specialist Housing	**£222**	£0	£222	£0
Special Groups - OPMH	**£0**	£0	£0	£0
Support Services - OPMH	**£0**	£0	£0	£0
Total Direct Services in £'000s	**£13,040**	£3,637	£8,998	£405
Direct Costs	**£13,040**			
Indirect Costs/Overheads	**£710**			
Capital Charges	**£277**			
Total OPMH investments in £'000s	**£14,027**			

LIT Comparative Report Adult Services LIT = Enfield

	LIT Investment by Direct Provider Type			
Direct Service Group	**£000's**	**NHS**	**Non Statutory**	**Social Services**
Access & Crisis Services	**£3,996**	£3,258	£0	£738
Accommodation	**£2,245**	£0	£0	£2,245
Carers' Services	**£132**	£0	£80	£52
Clinical Services	**£7,836**	£6,119	£1,717	£0
CMHTs	**£4,726**	£3,423	£0	£1,303
Continuing Care	**£3,539**	£0	£3,539	£0
Employment / Day / Resource Centres	**£371**	£0	£0	£371
Direct Payments	**£46**	£0	£0	£46
Home Support Services	**£1,975**	£0	£36	£1,939
Mental Health Promotion	**£0**	£0	£0	£0
Other Community & Hospital	**£650**	£95	£0	£555
Personality Disorder Services	**£47**	£47	£0	£0
Psychological Therapy Services (IAPT)	**£1,453**	£543	£910	£0
Psychological Therapy Services (NIAPT)	**£1,272**	£824	£448	£0
Secure & High Dependency	**£6,446**	£6,210	£0	£236
Services of MDOs	**£159**	£159	£0	£0
Support Services	**£416**	£0	£347	£69
Total Direct Services in £'000s and %	**£35,309**	£20,678	£7,077	£7,554
Direct Costs	**£35,309**			
Indirect Costs / Overheads	**£3,491**			
Capital Charges	**£1,180**			
Total adult investment in £'000s	**£39,980**			

LIT Comparative Report Older People LIT = Enfield

	LIT Investment by Direct Provider Type			
Direct Service Group	**£000's**	**NHS**	**Non Statutory**	**Social Services**
Care and repair - OPMH	**£0**	£0	£0	£0
Care for People in General Hospital	**£0**	£0	£0	£0
Carer's Services - OPMH	**£0**	£0	£0	£0
Emergency Services - OPMH	**£0**	£0	£0	£0
Intermediate Care - OPMH	**£0**	£0	£0	£0
Other Specialist MH Services - OPMH	**£7,527**	£7,362	£0	£165
Primary and Community Care				
- Day Services	**£888**	£888	£0	£0
- Homecare	**£0**	£0	£0	£0
- PCS	**£0**	£0	£0	£0
- Residential	**£0**	£0	£0	£0
- Specialist Housing	**£0**	£0	£0	£0
Special Groups - OPMH	**£0**	£0	£0	£0
Support Services - OPMH	**£0**	£0	£0	£0
Total Direct Services in £'000s	**£8,415**	£8,250	£0	£165
Direct Costs	**£8,415**			
Indirect Costs/Overheads	**£1,616**			
Capital Charges	**£646**			
Total OPMH investments in £'000s	**£10,677**			

The services currently commissioned across the three Boroughs are detailed in Appendix 3 as

Barnet

Acute Care Beds **41**	Primary Care Mental Health Team
Psychiatric Intensive Care Beds **16**(3 Borough service)	CMHT **x 2** for older people
Functional Complex Continuing Care Beds **27**	Memory clinic / Day Hospital
Recovery Beds **12**	Complex Care Team **x 1**
Acute Assessment Centre	ADHD
Drug and alcohol Service	Community Rehab Team
IAPT	Wellbeing Clinic
Home Treatment Team	
Early Intervention Team	
Community Support & Recovery Teams **x 2**	

Accommodation Support

- Approximately 130 people in registered care homes, 140 places in dedicated accommodation and over 1,000 units with floating support. There is also a specialist recovery team to assist people in moving from registered homes to more independent living

Day Services

5 Centres

Other Support

- Advocacy support from MIND and Barnet Voice
- Carer support workers and support groups

Enfield

Acute Care Beds **51**	Primary Care Mental Health Team
Dementia Complex Continuing Care Beds **71**	136 Suite
Older Adults**24** (3 Borough)	CMHTs **x 2** for older people
Recovery Beds **12**	Memory Clinic / Day Hospital
Acute Assessment Centre	ADHD
Primary Care Mental Health Team	Community Rehab Team
IAPT	Wellbeing Clinic
Home Treatment Team	Complex Care Team
Community Support & Recovery Teams x 2	

Accommodation Support

- 30 Local Authority and residential care homes
- 22 homes providing supported housing
- Home support services

Day Services

- 4 Centres

Other Support

- Advocacy services e.g., from Ebony People's Association
- Information and advice services

Haringey

Acute Care Beds **50**	Early Invention Team
Specialist Beds **20** (Eating Disorder)	Community Support & Recovery Team
Recovery Beds**7**	Memory Clinic
Drug Advisory Service	CMHT **x 2** for older people
Intake Team (3 Borough Service)	ADHD
Acute Assessment Centre	Community Rehab Team
Primary Care Mental Health Team	Wellbeing Clinic
IAPT (Whittington)	Complex Care Team
Home Treatment Team	

Accommodation Support

- A range of accommodation and housing support services from the third sector and a range of supported housing schemes

Day Services

- 2 Centres

Other Support

- Advocacy services through MIND and Rethink plus Carers support provided by the Mental Health Carers Association
- Range of counselling services covering ethnic minority groups

In addition, the Trust provides the following:

- Specialist psychology, psychotherapy, OT, social care and other therapy services in the Community Mental Health teams
- Personality disorder and Complex Care Teams
- Support to learning Disability Services provided by the Local Authorities