Better Mental Health

A joint mental health strategy for adults of working age in Waltham Forest

2013 – 2016 [Final Revised Version following consultation]

Working together for the local community:

NHS
Waltham Forest Clinical Commissioning Group
Waltham Forest
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Forward by Dr. Anwar Kahn, Chair of Waltham Forest Clinical Commissioning Group, and Dr. John Samuel, Mental Health Board Lead for Waltham Forest CCG, Dr. Paulette Lawrence, Mental Health Clinical Lead.

Mental health is something that affects us all – how we think and feel about ourselves and others, how we cope with difficult situations and how we manage our lives. NHS Waltham Forest Clinical Commissioning Group understands how widespread mental health problems are – from someone experiencing a period of depression due to personal hardship, to an individual living with long-term psychosis. This is why improving mental health outcomes for local people remains one of our top strategic priorities.

Stigma and discrimination often means that mental health problems are not openly talked about. However, illnesses linked to mental health account for a third of GP consultation, and research shows mental health issues are closely associated with poorer outcomes for employment, personal relationships and physical health. This is why the CCG, including our GP members, is committed to working with partners in the borough to improve the way in which people with mental health problems are supported and cared for in Waltham Forest.

This strategy is part of a life course approach to mental illness. This means in its simplest form that throughout our work on mental health we commit to improving outcomes for people with, or at risk of, mental health problems whatever their age. The CCG is working with the council to produce a CAMHs strategy within the next 12 months. A Dementia Strategy and Autism Strategy have already been developed and agreed between the CCG and LBWF. The missing piece of work for the CCG and the council is a plan for Adults of Working Age. This document “Better Mental Health” corrects this gap and needs to be seen in the context of the other available strategies as a call to action to improve services for people with mental illness.

In addition, the CCG will work with the council and Public Health to develop further work on prevention in the light of agreeing to work together on the Better Care Fund during 2014/5.

Our vision is to commission integrated mental health services that are safe and effective, with friendly staff that inspire confidence in the people and families using them, and which help people to take control of their own lives and recovery.

We believe this strategy and approach demonstrates our collective commitment in Waltham Forest to make a real difference to the lives of people with mental health problems and their families. This is a revised version of the plan we originally drafted for our Board in January 2013, amended improved in the light of public consultation and stakeholder discussion during 2013/4, this refreshed version underlines our ultimate aim to work with patients, carers, families and friends to ensure they are supported across local health and social care systems, and that they receive a first class experience of services.
Summary in the light of public consultation

This joint adult mental health strategy for adults of working age has been developed by NHS Waltham Forest Clinical Commissioning Group in partnership with the London Borough of Waltham Forest. It is a plan both for further work and where commissioners feel there is a need for change in services over the next three years.

The strategy is closely linked to the Joint Strategic Needs Assessment (JSNA) for Waltham Forest, which outlines the basic case for change in terms of the needs of local people and the development of care pathways. This document focuses on adults of working age for mental health needs but connects with other existing strategies, including: children, dementia, autism, carers, and joint prevention and early intervention.

The key focus of this strategy is the need to ensure that services are of high quality, ensure a good patient experience and are affordable. These factors have to be considered alongside other elements such as the predicted rise in population and the increase in the numbers of people experiencing mental illness in Waltham Forest, as well as the constraints of the current economic climate. In order to meet the expected demand for services and the health needs of local people over the next five years, the CCG and the council will need to work together to secure the best quality of care from the resources available to the public sector. Part of the solution to this position is to ensure that there is a relative switch of resource from the acute sector to the community sector via better integrated treatment of both physical and mental health.

Mental health is one of the CCG's local priorities for improving the overall health and health care experiences of people within Waltham Forest. The drive to integrating care – providing a seamless service for patients – underlines the ultimate aim of the joint adult mental health strategy, which is that patients, carers, families and friends are supported across the health and social care systems, and receive a first class experience of services. This is also one of the key themes of the “Better Care Fund” which has recently been agreed between the CCG and the Council for implementation in 2015.

The strategy has 3 main strategic objectives:

Objective one

To increase recognition of the growing evidence of a relationship between physical and mental health – this needs to be addressed to improve the holistic health of service users and to improve services.
Objective two

Use of clinical research and best practice to establish the best opportunities for improving access to affordable and effective mental health interventions and a reduction in stigma for service users so there is equality of care.

Objective three

Review and transform existing services to improve not only the quality of care but focus more care closer to home.

These objectives and the strategy were widely consulted on during 2013/4 and 77% of respondents strongly agreed with these broad objectives as being the key priorities and a further 13% agreed they were the right direction to take for the strategy. In general the production of the strategy was broadly welcomed.

A key principle of the strategy is that it takes a whole person approach. This means we want to commission services that work with people, not just the symptoms of mental illness. We will place importance on the role of service users as co-producers, not only in terms of input to service development and review, but also in shared decision making about their care and treatment.

We are committing through this strategy to make mental health everybody’s business. From children’s centres, schools and nurseries, through the way we work as employers and the care and support we commission and provider for people with multiple health problems. Underlying the strategy is a focus on quality and outcomes with an overriding commitment to improve services and standards.

The strategy suggests that mental health services for adults of working age are broadly stable at this present time. However there are opportunities for further improvement and development.

In particular we will continue to work to develop the relationship between GPs and secondary care mental health services, developing more services in primary care where this is appropriate. We also want to ensure that talking therapy services are more accessible and working effectively across the borough.

We want to ensure that crisis services are working as effectively and efficiently as possible, so that when people need to access support services they can do this quickly and in a safe high quality way as possible.

We want to ensure that all mental health services work together to promote choice and promote the “recovery approach”, including compassion, respect and dignity, shared decision making, and a culture that encourages and embraces hope and trust. We will also want to look at rehabilitation and accommodation services that provide effective support.

The evidence for the poor physical health experienced by people with mental health problems is overwhelming, and we want to work concertedly across all the NHS and the Council to do our very best to change this, to really work towards “parity of esteem” between mental and physical health. This will mean reviewing our current physical health work-streams to ensure that they properly take account of mental health.
Further information from the recent consultation on the strategy

There were over 30 replies to consultation which took place between October 2013 and December 2013 but pre consultation involved a number of workshops and stakeholder events with health and social care professionals and service users and carers. The key themes and issues that came back on the draft strategy document [version 9] were as follows:

- Strong support for the holistic approach highlighted in the strategy, supported by a greater range of services for people with Mental illness. These services should hold the SU in the centre with a range of treatment and support options available to meet their needs.
- There was general support for the adoption of a “recovery model” but to do this there needed to be further elaboration on the prevention initiatives that were currently available in the borough and further work from social care on the way recovery will be supported from the various LBWF services and by supporting social inclusion initiatives.
- There was a strong support that the top 5 areas for priority within the strategy should be as follows:

1. Better management of psychosis and long term mental health conditions in primary care. This includes up-skilling local GPs and having better support for people who are discharged from secondary care to primary care.
2. Reducing the need for inpatient care but in doing this ensuring the home treatment and community teams provided quality as measured by user's experience.
3. Better services and pathways for depression and anxiety.
4. More clarity on what day care opportunities there were and how personalisation in the future would support service users to manage their condition. In short how is recovery going to be supported?
5. Strong support for involving users and carers in any future development of implementing the ideas in the strategy.

There were a number of helpful suggestions and improvements made from the responses that came back from consultation. These have been included in this final version of the strategy. Annex A to this strategy provides a high level summary of the responses for future reference.

Further information in the light of national policy since the publication of the strategy in January 2013

The Department of Health has published its priorities for transforming support for people with mental health problems over the next two to three years. This was launched by the Deputy Prime Minster Nick Clegg and the Minister for Health Norman Lamb. There were 3 main priorities to be carried out at national and local level and include:

- A crisis care concordat setting out expectations for patients in crisis
- An “information revolution” to improve data, including working by Public Health England to gather information on promoting wellbeing and preventing mental ill health
- The development of the choice agenda in mental health with service users being offered maximum waits and choice of provider.
This policy initiative was called “Closing the Gap” which supports the measures in the national mental health strategy “No Health without Mental Health”, the national Mental Health Implementation Framework and the suicide prevention strategy. It included 25 priorities for action. In reviewing these priorities this strategy in its draft form had already captured most of the broad themes. The key areas where more emphasis is now needed are as follows:

1. Information revolution. Including developing better commissioning data for integrated care and commissioning services. As much as 80% of all mental health care takes place in GP surgeries and hospitals. There needs to be much stronger strategic focus on how information systems can talk to each other and more work on developing services which treat co-morbidities in one place working around the patient
2. Stronger focus on Crisis. This includes having 7 day response to crisis and crisis support that should focus on avoiding hospital admission
3. More focus on “parity of esteem”. Why is it important?
   - Mental illnesses are very common
   - Among people under 65, nearly half of all ill health is mental illness
   - Mental illness is generally more debilitating than most chronic physical conditions.
   - Mental health problems impose a total economic and social cost of over £105bn a year
   - Yet, only a quarter of all those with mental illness such as depression are in treatment
   - We tend to view physical and mental health treatment in separate distinct areas of the health services
   - People with poor physical health are at higher risk of experiencing mental health problems…
   - …and people with poor mental health are more likely to have poor physical health

Achieving ‘parity of esteem’ will require a fundamental change in the way services are commissioned. Consideration will need to be given to equitable distribution of resources and supporting the commissioning of services which tackle the association between physical and mental disorders. The commissioning cycle offers the ideal framework to achieve this change of emphasis, focusing on the key elements required to achieve transformational change. The DH has now set up a transformation board to focus on this area and during 2014/5 the CCG expects to be provided with further central guidance on the best practice, tools and guidance, data and information and advice on clear clinical leadership to support the local area to deliver the national ambition for parity of esteem.
CHAPTER ONE: Why do we need a mental health strategy?

1. National context

1.1.1 Nationally, one in four people will experience a mental health problem at some point in their lifetime and one in six adults has a mental health problem at any one time.

1.1.2 Among people under 65, nearly half of all ill health is mental ill-health. Over a third of GP consultations relate to mental health, with depression and anxiety a very common condition. Illnesses involving psychosis commonly referred to as “serious mental illness” affect roughly 1 in 100 people nationally, but importantly people with serious mental illness are known to have much poorer physical health than the general population and often die younger, experience social isolation, stigma and discrimination.

1.1.3 Around 1 in 17 people aged over 65 have dementia in England. Dementia can have a devastating effect on individuals and their carers and families, which is why there is currently significant national attention on improving services for people with dementia and their carers.

1.1.4 Half of people who experience a mental health problem at some point in their lives first experience symptoms by the age of fourteen. Mental Health problems in children and young people have a profound effect on their family relationships, education, and future employment.

1.1.5 In a recent report from the London School of Economics Centre for Economic Performance Think Tank, [The Scandal of Mental Illness 2012] it was identified that mental illness is widespread and is generally more debilitating than most chronic physical conditions; far more prevalent than diabetes or other long term conditions and far more costly. The researchers report that a third of all families in Britain have a family member with mental illness. Additionally, nearly half of all ill health in those younger than 65 years is due to mental illness and only a quarter of those needing treatment receive it. The report estimates that 6 million adults nationally have depression or anxiety and 700,000 children have a mental health disorder. The report also found that mental health problems account for nearly half of absenteeism at work and a similar proportion of people on incapacity benefits. The report states that the under-treatment of people with mental illness is the most glaring case of health inequality in the country. The report goes on to say that mental illness can increase the scale of physical illness and that the extra physical healthcare caused by mental illness now costs the NHS £10 billion. It says that much of this money could be better spent on psychological therapies or providing better integrated care because the average improvement in physical symptoms is so great that the savings on NHS physical care outweigh the cost of the psychological therapy or some of the mental health service alternatives.

1.1.6 Mental health currently has an extremely high national profile. The 2013 Health and Social Care Act for the first time ever in English law, requires the Secretary of State for Health to secure improvement in the physical AND mental health of the people of England, and in the
prevention, diagnosis and treatment of physical AND mental illness. The NHS England 2014-19 planning guidance to the NHS further places emphasis on the requirement of Clinical Commissioning Groups, and other NHS bodies, to work towards achieving parity of esteem between mental health and physical health, in particular the resources CCG’s allocate to mental health. In addition to identify and support young people with mental health problems and plans to reduce the 20 year gap in life for people with severe mental illness.

1.1.5 The National Strategy, “No Health without Mental Health” defines the outcomes that health and social care commissioners must seek to achieve for their populations, along with a series of recommendations for action. The Strategy in particular lays out a series of actions for Health and Well-Being Boards, Clinical Commissioning Groups, Local Authorities and other bodies, to improve outcomes for people of all ages, as summarized in the box below.

<table>
<thead>
<tr>
<th>NO HEALTH WITHOUT MENTAL HEALTH HEADLINES</th>
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<tbody>
<tr>
<td>▪ A life course approach, in particular focus on laying the foundations of good mental health for later life in children and young people</td>
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<td>▪ Tackling stigma and discrimination</td>
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<td>▪ Promoting early intervention</td>
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<td>▪ Tackling health inequalities by protected characteristics</td>
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<td>▪ Improving access to talking therapies, including children and young people and people with a serious mental illness</td>
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<td>▪ Improving offender health</td>
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<td>▪ Developing a recovery culture in mental health services</td>
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<td>▪ Developing new models including core responsibilities for mental health in school nursing and health visitors</td>
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<td>▪ Supporting clinical commissioning groups with developing mental health commissioning capability</td>
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Legislative and policy context: integrated care

1.1.6 More generally, NHS England, and Clinical Commissioning Groups have a statutory duty to work with local authorities to promote integrated health and social care, making person-centred coordinated health and social care the norm for people with multiple health problems, including mental health problems, with a focus on supporting people with multiple health problems outside of hospital seamlessly. In his Spending Review Statement on 26th June 2013, the Chancellor of the Exchequer promised that integrating health and social care would be “no longer a vague aspiration but concrete reality”. The creation of the Better Care Fund, a fund to promote integrated care that is overseen by Health and Wellbeing Boards is intended to support the delivery of this vision.

Integrated working can offer the opportunity for health and social care to operate equally, breaking down traditional barriers and creating seamless services. In particular, it provides the chance for the role of social care to be enhanced and recognised as a key contributor to the planning and delivery of services. Additionally the role of the third sector as an increasingly important partner in the planning and delivery of services creates a powerful triumvirate for local health and social care economies. The National Voices Narrative for Person-Centred Coordinated (‘Integrated’) Care defines the service user vision for integrated care.

Legislative and policy context: social care

1.1.7 Local authorities have over the past few years been working towards personalization of services for all users of adult social care services. Making it Real, the Think Local Act Personal framework for action, defines the national consensus vision on personalized social care. Take up of personal budgets, as an aspect of personalization, however, has traditionally been low amongst mental health service users.

1.1.20 A draft Care and Support Bill was published in 2012, which proposes a single legislative framework for adult social care, replacing the current complex framework of adult social care law. The Bill confirms a statutory duty on local authorities to promote mental health and emotional well-being, embeds the promotion of individual well-being as the driving force underpinning the provision of care and support and places population-level duties on local authorities to provide information and advice, prevention services, and shape the market for care and support services. These will be supported by duties to promote co-operation and integration to improve the way organisations work together. The Bill also sets out in law that everyone, including carers, should have a personal budget as part of their care and support plan, and gives people the right to ask for this to be made as a direct payment.

Legislative and policy context: public health

1.1.21 Public health is about improving the health of the population through preventing disease, prolonging life and promoting health. Local Authorities now have lead responsibility for public health, including public mental health. Commissioning responsibility for a number of

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1 http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf, para 14Zi
2 http://www.nationalvoices.org.uk/
3 http://www.thinklocalactpersonal.org.uk/
4 http://www.communitycare.co.uk/articles/06/08/2013/102669/direct-payments-personal-budgets-and-individual-budgets.htm
5 http://careandsupportbill.dh.gov.uk/home/
6 Guidance for commissioning public mental health services JCP-MH 2012
services that have a role in delivering mental health prevention and support has shifted to local authorities, including school health, health visitors (by 2015) and drug and alcohol services. This shift provides a platform for a more integrated approach to improving public health outcomes including tackling the wider determinants of mental ill-health.

**Legislative context: other**

1.1.22 The Children and Families Bill, which received Royal Assent in early 2014, will come into force in September 2014. The Act will require local authorities and other partners to ensure services are available for children and young people with special educational needs from 0 to 25. Some local authorities with partners are currently considering how CAMHS and Adult Mental Health services may be redesigned to align with the expectations of Children and Families Bill.

1.1.23 The Welfare Reform Act\(^7\) legislates for a range of changes to the welfare system some of which will have a direct effect on people with mental health problems. It now introduces a wide range of reforms including the introduction of Universal Credit, and changes to housing benefit. There has been concern amongst a range of mental health stakeholders nationally about the impact of welfare reform on people with mental health problems\(^8\).

**Quality**

1.1.24 The publication of the *Final Report of the Independent Inquiry Into Care Provided By Mid Staffordshire NHS Foundation Trust (the Francis Report)*\(^9\), which examined the high mortality rate, and poor patient and carer experience at Mid Staffordshire Foundation Trust between 2005-2008, and the *Winterbourne View*\(^10\) report following the Panorama programme on abuse of people with learning disabilities at a private hospital, have renewed the national focus on quality. This has resulted in tumultuous change to the regulation of health and social care, and an imperative on both commissioners and providers to ensure that patients are at the heart of everything that they do. Furthermore, the Keogh Report\(^11\) and the Berwick Report\(^12\) make clear recommendations for developing the learning culture of the NHS as part of an overall approach to quality.

1.1.25 This strategy also notes that the findings of the Winterbourne Review, published in December 2012, are vitally important and apply to the care and treatment of both mental health service users as well as those with learning disabilities. The CCG and the council will be developing rigorous quality monitoring of safeguarding issues for vulnerable adults as part of the contract process with providers. We will also take into account the guidance issued by the Royal College of Psychiatrists on commissioning services for people with learning disabilities who also have mental health conditions once it is published. Safeguarding and quality is at the heart of everything discussed in this strategy.

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\(^2\) [http://www.rcpsych.ac.uk/policy/projects/live/welfarereform.aspx](http://www.rcpsych.ac.uk/policy/projects/live/welfarereform.aspx)

\(^3\) [http://www.midstaffsinqury.com/index.html](http://www.midstaffsinqury.com/index.html)


Focus on Outcomes

1.1.26 The National Outcomes Frameworks for the NHS\textsuperscript{13}, the Commissioning Outcomes Framework for Clinical Commissioning Groups\textsuperscript{14}, and the Adult Social Care Outcomes Framework\textsuperscript{15} and Public Health Outcomes Framework\textsuperscript{16} for councils, all include outcomes that both directly and indirectly relate to mental health. These can be found at Appendix One.

1.1.27 The National strategy, \textit{No Health without Mental Health} defines the outcomes that health and social care commissioners must seek to achieve for their populations, along with a series of recommendations for action. The strategy places emphasis on laying the foundations of good mental health in children and young people, integrated health and social care services that support early intervention, and high quality productive services.

<table>
<thead>
<tr>
<th>NO HEALTH WITHOUT MENTAL HEALTH OUTCOMES</th>
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<tr>
<td>• More people will have good mental health</td>
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<td>• More people with mental health problems will recover</td>
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<tr>
<td>• More people with mental health problems will have good physical health</td>
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<tr>
<td>• More people will have a positive experience of care and support</td>
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<tr>
<td>• Fewer people will suffer avoidable harm</td>
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<td>• Fewer people will experience stigma and discrimination</td>
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The mental health market

1.1.28 Although the NHS has traditionally been the predominant provider of local mental health services, a number of independent and voluntary sector organisations have played a key part in delivering specific services to complement those in the statutory sector. The new \textit{NHS Procurement Patient Choice and Competition Regulations}\textsuperscript{17} place requirements on commissioners to improve the quality and efficiency of services by procuring from the providers most capable of meeting that objective and delivering best value for money. The market environment in the NHS and social care will expand to admit a wider range of providers. This greater plurality of providers means that the NHS may no longer be the default option for commissioners and enable independent including third sector providers to deliver a greater range of services.

Finance, efficiency and productivity

1.1.29 No other health condition matches mental ill health in the combined extent of prevalence, persistence and breadth of impact.\textsuperscript{18} The annual cost of mental ill-health in England is

\textsuperscript{16} www.gov.uk/government/publications/public-health-outcomes-framework-update
\textsuperscript{17} http://www.legislation.gov.uk/uksi/2013/257/contents/made
\textsuperscript{18} Promoting mental health & preventing mental illness, Freidli, L & Parsonage, M 2009
estimated at £105 billion\textsuperscript{19}. By comparison, the total costs of obesity to the UK economy is £16 billion a year\textsuperscript{20} and cardiovascular disease £31 billion\textsuperscript{21}. In 2010/11, £12 billion was spent on NHS services to treat mental disorder, equivalent to 11% of the NHS budget\textsuperscript{22}.

1.1.30 The financial climate for the public sector in England has rarely been as challenging, for either the NHS or for councils. For the NHS, whilst the government has committed to maintain growth in real terms of 0.1% to 2015/16, there are also major challenges, not least an estimated £30bn funding gap by 2020\textsuperscript{23}, in addition to a short term requirement to continue to deliver the Nicholson challenge of circa 4% per year efficiencies for providers to 2014/15, and for Clinical Commissioning Groups to part fund a £3.8bn integration fund and deliver 10% management efficiencies into 2015/16.

1.1.31 The June 2013 Comprehensive Spending Review requires very significant savings from local government into 2015/16, including a likely average additional 10% saving on local government in addition to three years to date of intensive savings measures. This is expected to have a significant impact in Waltham Forest.

1.1.32 In mental health, work continues on developing a mental health tariff specific to mental health, a new payment mechanism based on actually delivered care. A shadow form of mental health tariff has been put in place which will become live from 1\textsuperscript{st} April 2015. This is likely to have major implications in terms of choice and opening up the mental health market as block contracts are ended with NHS providers.

1.2. Waltham Forest local context

Waltham Forest has a detailed Joint Strategic Needs Assessment (JSNA) which features a substantial mental health section. A basic summary of the key points show that Waltham Forest is in the top 30\% of the most deprived areas in England, it is also the 15\textsuperscript{th} most deprived borough in London. Whilst our growing and diverse population has many factors that protect individuals and communities from mental health problems, we also face many of the issues common to other inner city boroughs, like poverty, a high population turnover, and alcohol and substance misuse, all of which can have a significant impact on the mental health of the population. As a result, demand for mental health services is high in the borough, and increasing. The population in Waltham Forest is approximately 262,958 people and it is expected to increase by 12.6\% over the next 10 years.

1.2.1 Further information on prevalence and incidence of mental health illness is provided in the Waltham Forest JNSA 2013:


And in the community mental health profiles produced nationally are useful context:

\textsuperscript{19} The Economic and Social Costs of Mental Health Problems in 2009/10 Centre for Mental Health 2010
\textsuperscript{20} Tackling obesities: future choices. Project report Government Office for Science Foresight 2007
\textsuperscript{21} Prevention of cardiovascular disease at population level NICE 2010
\textsuperscript{22} Programme budgeting tools and data. National expenditure data Dept of Health 2012
\textsuperscript{23} http://www.hsj.co.uk/news/kelsey-nhs-faces-30bn-funding-gap-by-2020/5060745.article
The statistics in the above report tend to suggest Waltham Forest has high directly standardised rates for hospital admissions, about average spend for mental health per head, further work to do on improving access to psychological therapies, high use of CPN contacts but under recording of people on CPA [suggesting unmet need]. There is also further work to do in managing the wider determinants in health, particularly in getting mental health users back into employment. There are an estimated 30,000 people who have common mental health disorders such as depression and about 2947 people with severe mental illness including psychosis registered with GPs. At the same time the CCG spends over £32m on Mental Health and the Council spends at least a further £5m on the programme budget.

1.2.2 When planning mental health services, there is a need to ensure that services are commissioned to meet demand, this includes responding to cultural diversity and to ensure it is appropriately balanced to the age profile of the population. In recent years Waltham Forest health and social care organisations have worked hard to improve the range and quality of services for people with mental health problems in the borough, but have often had to deal with change in organisations due to national reform and also financial constraints in the last few years as the recession has limited public spending. In preparing the strategy we have undertaken a service review of local services and spoken to a wide range of stakeholders. The general consensus is that Waltham Forest has some good core statutory services but voluntary sector and community organisations need more support and service users and carers need to feel more involved in a way that can make a difference. Service users have told us that the quality of services, and in particular the quality of relationships with staff, is absolutely crucial. They have told us they want to have better information, better communication, better access to services, and more choice and control over their care and a focus on recovery. The stigma and discrimination people with mental health problems have experienced is a major area in which people would like to see concerted action.

1.2.3 We also need to recognise prevention. There has been a major economic downturn in the last few years and changes in housing. In particular, the reassessment of people claiming housing incapacity benefit and their capacity to work will have an impact on people with mental health problems who are deemed fit to work and supporting these people with mental health problems through these changes is a prevention/demand strategy. Likewise, access to benefits and house advice in primary care is a well-evidenced strategy for prevention. The strategy therefore does have a section on some of the key social care issues and suggests that detailed work with Waltham Forest Public Health Team is needed in this area to develop future commissioning intentions.

1.3 Our Vision

1.3.1 The approach to deliver our vision is summarised in the key outcome objectives identified in the figure below. It is built around the three pillars of building resilience in our population, ensuring high quality treatment and support, and supporting people to live well with a mental
health problem. The foundations lie in the shared values that underpin a whole person approach and the principle that mental health is everybody’s business. The overarching principle that governs the Strategy is that it takes a life-course approach, actively considering how the whole population can be supported to be mentally healthy from cradle to grave. We believe that in delivering the commitments that we will detail in this Strategy, we will measurably improve outcomes for people with mental health problems and their Carers.

1.3.2 In many ways, the single biggest action that we can take to secure better outcomes for people and the communities who live in Waltham Forest for the future is to support children and young people. The council has announced a strategy called Best Start in Life for
Children. In addition over the next 12 months in 2014/5 the CCG and LBWF will develop and publish a new CAMHs strategy and also work together on implementing the SEN reforms.

1.3.3 The CCG will also work with the council and the public health department to develop better prevention strategies for mental health with a focus on well-being and recovery. Initial work has already been done on producing a new suicide and self-harm prevention strategy and this will be available on the CCG Website.

1.3.4 We believe by working together, across health, social care, education, the voluntary sector and with services user and carers we can more effectively develop and deliver a range of services and interventions that can help to alleviate the impact of mental health problems on individuals, families and communities within the borough. To support effective working across the partnership, once this strategy is agreed by Cabinet and the CCG Governing Body, we will set up a regular MH Forum to enable all stakeholders to come together to consider the strategy action plans for the year ahead.

1.3.5 We believe that a joint commissioning approach across health and social care, with aligned resource mobilised through a strategic health and social care commissioning team with links both into the CCG and the Council, is the right strategic direction to take in terms of securing high quality mental health services for our population, We believe that clinical leadership in commissioning is of critical importance, and to this end have an identified CCG Board lead and clinical lead for mental health, who is actively involved in leading the mental health commissioning partnership.

1.3.6 The CCG has published a new patient engagement strategy and will ensure that Mental Health issues are part of the work the CCG undertakes to undertake service planning and delivery. Service users are “experts by experience” who must be involved in the development, planning and review of local services to ensure they are relevant and effective.

1.3.7 In 2011/12, approximately 11% of the budget of the Waltham Forest PCT was spent on Mental Health. We spend about the average for a London inner city CCG. Nationally the spend on mental health has gone down over the last 3 years but in the last year the CCG has not reduced Mental Health budgets and in fact has increased the cash value of its investment in mental health in local services above the level of inflation. There are a number of complexities in measuring the overall balance of programme area spend against the needs of the population, and then comparing spends with similar areas. However there are currently some tools emerging that might help CCG’s to review the overall balance of spend to inform future strategic financial planning. Once we have better data from implementing Mental Health tariffs we shall also review where the balance of spend within the programme also best resides.

1.3.8 Our broad financial policy frame work is to focus more on out of hospital and primary care as described in the diagram below:
Developing primary care and mental health provision

1.3.9 There are many advantages to providing mental health care in the primary care setting, from the perspectives both of people who use services and of the health and social care system. Care can be provided closer to home, in a setting that does not carry the stigma associated with mental health facilities, by a health care worker who will ideally know the person and his or her family. The care worker will also be able to provide holistic treatment and continuity of care for a full range of problems including physical health needs, and will have good links to local mainstream services to help with associated social issues.

1.3.10 Primary care is also best placed to manage problems that affect both mind and body, such as co-morbidity and multi-morbidity, including medically unexplained symptoms. There is also

Source: “Companion to Primary Care Mental Health”, Radcliff Publishing, 2012. This model was chosen after discussion with the stakeholder group and is only meant to be an ideal type to give heuristic understanding for the reader.
some evidence that it will in the medium term be an approach which provides services at less cost as primary care for mental health also facilitates community outreach and mental health promotion, as well as long-term monitoring and management of affected individuals. In addition, patients and families avoid indirect costs associated with seeking specialist care in distant locations.

1.3.11 In terms of the overall “vision” for the partnership - the diagram below shows that the ideal system for Waltham Forest is to move towards increasing primary care capacity and adopting a stepped care model – this means people only access secondary and tertiary care when their needs cannot be met by the enhanced primary care service. This model also fits in with the need for cost effectiveness of care and developing primary care networks within the CCG area. This vision is strongly supported by the current Clinical Board Lead for Mental Health, Dr John Samuel who works in the Leytonstone area and follows discussion with work that has already been done in the borough of Tower Hamlets.

1.3.12 This is a bold vision requiring sharing of provider resources and integrated care as GP practices work together to improve the capability and capacity of primary care in order to develop the new tier of managing mental health to manage more of the supply chain and range of patients that previously would have gone to NELFT and other secondary care providers. This will need be backed up by the development of staff and achieved in the context of a specific primary care strategy which is being developed by the CCG in consultation with its partners and key stakeholders.
1.3.13 There are five main reasons for including mental health within the vision for local health care service improvements in Waltham Forest:

- Improved focus on population health across a geography – looking closely at the people who live and work within the community;
- Collaborative relationships with a wide range of partners;
- Sufficient scale for some specialisation of staff; capacity to utilise rare skills and ensure access to resources;
- Integration with estates planning and ICT development; and
- Developing systems to support best practice and outcomes

In terms of mental health there are many conditions that require secondary care expertise or where the council care services cannot be diluted to network level; the integrated vision is for multiple primary care networks to work together.

This also means there can be intensive focus on the underlying causes of mental disorders:

- Health inequalities and deprivation;
- Capturing and improving the patient experience;
- Developing pathways of care and performance of care at a local level;
- Focus on improving the health and wellbeing of the population;
- Development of more integrated and more localised services;
- Promoting independence, choice and self-care; and
- Investing resources effectively and in a more targeted way.

1.3.14 The key objectives will be to reduce variability through the use of evidence-based pathways and transparency of data at individual patient, clinician, practice and network level. Facilitating a coherent approach will be critical and the first step will be to confirm the exact nature of the networks and the organisational development plan that needs to go with it. This includes the capabilities, systems, processes and engagement that will underpin the new way of working and commissioning services.

1.3.15 Transforming the mental health landscape will need GPs and other primary care professionals to be involved in redesigning and managing the new pathways based on care closer to home and enhanced primary care provision. Presently, few GP practices have the adequate resources and skills mix to be able to effectively identify mental health problems and provide holistic care. This is not to imply criticism of the clinical judgement of local GPs, but research shows that 250 people in every 1,000 have some sort of mental health issue. Most attend their GP surgery for assistance, however only 130 people who present to their GP are diagnosed as suffering from a mental health problem.

1.3.16 Given the new model of care being proposed, which provides a better level of care for patients with long term mental health conditions and reduces secondary care expenditure, it
is important that local clinicians are given as much support as possible to help them better understand how to manage patients with co-morbidities and multi-morbidities. It is also vital to assist practices in increasing the skill mix of their workforce. In Waltham Forest, staffing is not uniform and some practices have a range of mental health workers, whilst the majority have none. This means many patients experience variable care. Where long-term illness is concerned, some services are duplicated by primary and secondary care, which is inefficient.

1.3.17 The CCG in setting up primary care networks will help ensure mental health expertise is present in all networks and an overall programme to improve and raise primary care provision to a higher level can be achieved. The vision for developing these networks will be underpinned by the following principles:

- That secondary to primary care training is consistently delivered;
- There is a focus on patient-centred care in a primary care setting via collaboration between primary and secondary care professionals, family and carers to effectively manage patients with a range of mental health and physical problems;
- All practice nurses are fully trained around medication and injections;
- The primary care community is enhanced by the appointment of navigators, Community Psychiatric Nurses (CPN) and specialist psychiatrist expertise;
- Practice managers share expertise, ICT and other infrastructure resources to better manage their patients with co-morbidities or multi-morbidities; and
- Development of alternative providers of medical services (APMS) and other contractual incentives at network level so that mental health is given a higher profile in terms of performance review and payment.

1.3.18 Operating behind this “vision” is the need for good information. Whilst traditionally data in mental health has been poor, the introduction of payment by results is sharpening the quality of data. The use of high quality data is particularly useful in understanding the use of services by people with protected diagnosis, thereby helping to understand how we can develop services that genuinely promote equality of access. In the context of our work to develop integrated care teams more generally, we will work with primary care networks and GPs to develop both a primary care IT strategy and also look at how mental health problems can be managed via an integrated care risk stratification approach to support integrated care management to help plan future mental health services.

1.3.19 Developing primary care services and transforming secondary care is a prime vision for this strategy but it will not alone provide the best outcome for residents. One of the highest priority for service users in feedback received is that we may talk about a recovery culture in Waltham Forest but on the ground there needs to be more work to make service users and carers feel supported and more work has to be done on supporting voluntary groups and peer support for local people with mental illness. In mental health, recovery does not always refer to the process of complete recovery from a mental health problem in the way that we may recover from a physical health problem. Recovery means the process through which people find ways of living meaningful lives with or without on-going symptoms of their
condition. The guiding principle is the belief that it is possible for someone to regain a meaningful life, with social inclusion, despite serious mental illness. Recovery emphasises that, while people may not have full control over their symptoms, they can have full control over their lives.

There are several building blocks that we set out in this strategy that we believe are central to this way of working. Many of the commitments are linked to the concept of recovery, from the delivery of preventative services, day care opportunities and social care aspects of the strategy to support service users through their personal journey in managing their mental health illness.

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24 Supporting recovery in mental health NHS Confederation 2012
25 Recovery definition Mental Health Foundation
CHAPTER TWO: Turning Vision into Reality

Background and looking for early transformational priorities

2.1 In undertaking the ground work for the strategy a service mapping of existing services was undertaken in 2012/3 to back up the initial JSNA needs assessment. This revealed in Waltham Forest that:

- There was no community eating disorder service unlike other boroughs
- The personality disorder service “IMPART” was about to be decommissioned as it had been funded by research money which was now running out. The prevalence of antisocial personality disorder in the general population is approximately 3% in men and 1% in women. This disorder is often associated with criminal and offending behaviour and some studies suggest that the prevalence of the disorder amongst prisoners is just fewer than 50%. During 2011/12 the total number of booked appointments for Waltham Forest was 3,259 and contacts were 2,562.
- The Psychiatric Liaison Services at Whipps Cross Hospital although valued was so small it could not function to properly support the elderly care pathway and failing to achieve the level of an accredited model of care in terms of the view of the Royal College of Psychiatrists.
- The psychological medicine service [IAPT]s was half the size it should be to meet local need and national targets [using recognised capacity and analytical models] and its ability to manage co-morbidities was limited by historical investment and service capability.
- There was a strong understanding that many people with long-term physical health conditions also have mental health problems. These can lead to significantly poorer health outcomes and reduced quality of life. The costs to the health care system are significant. By exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45% for each person experiencing a long-term condition and co-morbid mental health problem. This suggests that nationally between 12% and 18% of all NHS expenditure is spent on long-term conditions. However there was little understanding or previous work on how mental health could be part of an integrated care management solution.
- When applying the national audit benchmark tool to the local mental health provider [NELFT] it was clear there was scope for less inpatient beds and in return more investment into care closer to home. There was no older people home treatment team in Waltham Forest.
- In reviewing the memory clinics and older persons pathway the service hadn’t been through accreditation and the size of the service was relatively small compared to other parts of London.
- Although not mental health specifically it was recognised that people with autism spectrum disorder often fall outside the eligibility for adult social care and mental health services. However there was no commissioned adult ASD assessment and diagnosis service in the borough.
- Although a key part of prevention there was no suicide and self-harm strategy or a strategy for CAMHs for Waltham Forest.
In terms of dual diagnosis and the interface with substance misuse care the number of GPs undertaking shared care and management of co-morbidities was limited. The first step was clearly to undertake a more detailed needs assessment and treatment review of care. It is estimated approximately 1400 people are in drug treatment with a further estimated 2500 heavy drinkers in the borough. There are increasing hospital admissions and 4% of hospital admissions in 2011/12 were for drug related mental health issues.

There was no agreement between the former PCT and council on how to manage and fund mental health users needing aftercare following inpatient stay and in fact there had been previous legal dispute.

2.1.1 It seemed obvious from this service mapping and background that the CCG working with LWBF in the first 2 years [from 1st April 2013] and by April 2015, should “fix what was obviously broken” in terms of existing mental health pathways and services for mentally unwell people in the borough. This would form a basic plan for the first 12-18 months focusing on quick wins as follows:

We will commission a new service for community eating disorders during 2013/4 for the first time providing better quality of care and less need to use tertiary care by earlier and appropriate intervention. In making this recommendation, our service mapping acknowledges that Waltham Forest has little or no community eating disorders service available compared neighbouring boroughs. Unlike residents of other areas in outer north east London, who can access specialist NELFT community eating disorders services, Waltham Forest residents receive only a small outreach service from St Anne’s Hospital in Haringey. It is not NICE compliant due to the lack of effective community interventions for children, adolescents and adults with eating disorders.

The proposed model of care will be as follows:
We will commission during 2013/4, as part of the NELFT contract, to sustain and keep the IMPART service for local residents with severe end personality disorders. Access to care will be a psychological triage panel so that the service focuses on the more severe end of personality disorder.

We will give psychiatric liaison a higher priority, including it in the integrated programme for the CCG, undertaking a review of the literature and business case to expand the service especially for older people’s liaison at Whipps Cross so a bigger and better service is in place by 2014/5. This will include producing a new revised service specification for commissioning the service. By 2014/5 we expect to have commissioned a stronger core service which is clinically led by a consultant psychiatrist working closely with the acute clinicians in Whipps Cross Hospital for local residents.

We will undertake a strategic review of IAPTs, set up a task group led by clinicians to produce a new service specification in light of NICE guidelines, invest in the service over the next 2 years to allow 15% of depression prevalence to be treated in the service, ensure increased recovery rates and lower waiting times by improving capability and capacity. This will include linking the service more to the localities and GP practices in the borough.

The strategic intention of the CCG is to pilot a primary care discharge scheme for patients with psychosis and long term Seriously Mental Ill conditions during 2013/4. This will involve commissioning additional navigator support to the pilot GP practices and then after the year ends undertake evaluation. During 2014/5 the CCG working with its stakeholders intends to use the learning to work up a pilot and model of care for how SMI patients, as part of integrated care management can be better managed in primary care. This will involve research of the various service models around the country, better development of clinical protocols and work on information flows between secondary and primary care for mental health service users.
The CCG working with LBWF and NELFT will set up a task group to review acute mental health pathways so that by 2014/5 a new home treatment team is commissioned for older people in Waltham Forest. This will also involve a consultation on change of use of the beds for inpatient care at Naseberry Court. This will be a major transformation in line with the strategic objective in the strategy to promote out of hospital care. Inpatient care will become more specialised with functional teams (i.e. teams which only work in the hospital setting) offering focused, evidence-based treatment.

The following table shows how the existing new model of care does operate for the adult mental health care pathway in Waltham Forest. The focus is on having single point of access and more emphasis on out of hospital care:
The CCG will have a focus on improving diagnosis of dementia. Although not an adult of working age target, in making the interface with a life course approach and the dementia strategy, by 2015 the CCG will commission with LBWF a new dementia adviser service for the borough, undertake an education programme for GPs, increase its delivery against the prevalence target so that we will move from 51% [in 2013] to 57% by 2015 with a view to getting to 67% in line with “parity of esteem” [NHSE targets] by the end of the strategy. This will involve benchmarking the memory clinic service against the Royal College of Psychiatrists tool in 2014/5 and working with primary care to implement an enhanced payment with GPs [DES] for dementia to encourage screening. During 2014/5 we will also work to refresh our existing dementia strategy which was published in 2010.

The CCG will look at existing mental health budgets and transfer resource from distant providers to commission a new ASD service for adults locally by 2014/5. This will be for diagnosis and assessment. A new service specification will be produced for this purpose and to monitor quality of care during this year. This will also link back to the action plan in the published Autism Strategy for the CCG and LBWF.

The CCG will work with LBWF to produce a new Suicide and Self Harm Strategy during 2013/4. During 2014/5 the clinical lead for mental health will join a new steering group across the borough to ensure progression and implementation for local people.

The CCG will actively take part in the CAMHs partnership board and in the light of this strategy and the need to have life course approach will help produce a new strategy for this area in 2014/5 which will be consulted on and implemented by 2015.

The CCG will work with the council to produce a new needs assessment specifically on drug misuse for the borough. This will lead to a review of treatment services by the end of 2014/5, including the potential for procurement of better services in the light of the needs assessment and revised model of care needed by 2015. The CCG will support implementation of any recommissioning plan to be produced by LBWF.

The CCG will work with the council and mental health providers to develop a new policy and protocol for managing section 117 of the MHA cases and have this implemented during 2014/5.

As this document is being refreshed in May 2014, the implementation plan for the 3 year strategy records the progress that has been made in these areas but also notes where further work is required.
The recovery model and developing the health and social care agenda for mental health services [including longer term priorities for the strategy]

2.2 Building community resilience to poor mental health and promoting the wider protective factors of maintaining good mental health is also a key principle for this strategy. This responsibility has largely transferred to the council in April 2013 particularly in relation to public health commissioning now being transferred to the council and also in terms of developing social care services. It is clear that if we are going to get the best outcomes for mental health users then action is required in housing, education, employment, voluntary and community services and areas like exercise and sport.

Stigma and discrimination

2.2.1 Tackling stigma and discrimination is one of the areas of highest priority that service users told us should be included in this strategy. Many people with mental health problems experience stigma and discrimination. Nationally 87% of service users reported the negative impact that stigma and discrimination had had on their lives, including discrimination by other people, employers, and self-stigma which significantly impacts on self-esteem and confidence. There are many misconceptions and myths about mental health that are all too readily reinforced by the media, and there are also a number of important cultural factors that influence attitudes to mental health. Stigma and discrimination have a significant impact because very often they:

- Prevent people seeking help
- Delay treatment
- Impair recovery
- Isolate people
- Exclude people from day-to-day activities and stop people getting jobs.

Stigma and discrimination can be magnified for specific communities, where mental health problems may be considered taboo, for example some Black and Minority Ethnic communities, or, where people already experience stigma and discrimination on account of a protected characteristic, for example the Lesbian Gay Bisexual and Transgender community.

Time to Change is a national anti-stigma campaign run by Mind and Rethink Mental Illness. This is a major initiative to encourage and promote quality and a reduction of discrimination by training and a change in attitudes within employers.

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26 ibid
27 Stigma Shout Time to Change 2008
28 Funded by the Department of Health and Comic Relief, Time to Change is now in its second phase, running to the end of March 2015. www.time-to-change.org.uk
Having listened to public consultation on the draft strategy and reviewed the work in Tower Hamlets CCG we will seek to get the CCG and LBWF to sign up to the Time to Change Agenda and ensure the Health and Well Being Board sees this area as one of its priorities. We will achieve this by 2015. Tackling stigma and discrimination through multi-agency working and by utilising the Time to Change partnership model is the best means to achieve change. However, we will be realistic about how quickly we can bring about change and how it can be effectively measured.

People will have access to improved information on what services are available

2.2.2 Service users have told us that finding information about the services that are available and how to access them can be confusing and difficult for people, their families or friends.

Having access to up to date, accurate and accessible information about services and how to get help and support is an important part of reducing stigma, enabling access and raising awareness.

We will develop a new web resource that will provide easily accessible information on mental health services for children and young people, adults, and older people. The resource will act as a directory of mental health services for the borough, and an up to date repository of information about mental health related activities and events in the borough. This will happen by March 2015.

We recognise that the internet is not accessible for all our communities, particularly where English may not be a first language.

We will ensure that the web resource is publicised with community groups and services that support people who may not use the internet, so that people can be supported to access the information the web resource will hold. We will also ensure that providers publish relevant information in appropriate languages working with Health Watch to advise us on the best way to do this for Mental Health.

Mental health awareness and prevention initiatives across our communities, schools and employers and in the health, social care and education workforce will improve

2.2.3 Awareness of mental health problems is closely related to stigma and discrimination. If people are more aware of mental health problems, stigma and discrimination is less likely. Many mental health awareness programmes, for example Time to Change, and Australia Mental Health 2020, combine mental health awareness with tackling stigma and discrimination.


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During the next 2 years we will work with the council’s public health team and LBWF to develop a mental health prevention strategy which will target how we can raise mental health well-being and public health and mental health initiatives, to help us tackle stigma and discrimination and also the more people there are with robust emotional, psychological and social wellbeing in a community, the better able the community is to support those with mental health problems.\(^{30}\) Investment in effective prevention makes sense, both in terms of promoting better outcomes for service users and in terms of promoting value for money.\(^ {31}\)

We will deliver our approach to raising mental health awareness through the commitments identified to tackle stigma and discrimination, as above. We expect to complete a prevention strategy briefing or strategy by 2015 to compliment this strategy, the CAMHs strategy and Dementia Strategy to provide a “menu suite” of action which supports a life course approach to commissioning.

We recognise, however, that we need to go further in developing awareness, skills and knowledge around mental health across our workforce, including further training for GP’s on specific aspects of mental health, for example on the mental health of children and young people, which the Royal College of GP’s has recently identified as a priority\(^ {32}\). We also need to develop GPs within primary care networks to manage mental health service users with the right support and more direct payments to primary care.

By 2015 we will develop a rolling programme of training for GPs and other primary care staff on specific aspects of mental health – this will be led by the MH clinical lead in the CCG.

**Psychosis and early detection/awareness**

2.2.4 We already commission an Early Detection Service, to identify and support young people at risk of psychosis, as part of our effective Early Intervention Service pathway, provided by North East London Foundation Trust. As part of reviewing this service we have found that it is NHS Policy compliant and we will continue to support this valuable service in terms of the work it does on the psychosis pathway.

One of the key areas we need to develop in primary care is managing psychosis patients effectively and supporting early detection. This links to integrated care and the recent report by Rethink on “Lethal Discrimination” (2013) which shows how primary care has a long way to go in order to reduce early death and manage psychosis patients in terms of their health checks. The national mental health strategy ‘No Health without Mental Health’ makes it very clear that one of the biggest financial savings for mental health is for early intervention teams to target people in the general population who are aged 15 to 35 and are experiencing a first episode of psychosis. The London School of Economics recently suggested that the cost benefit of investing in early intervention teams and early detection was substantial and that the NHS would directly realise the benefits within a three year period. An accompanying meta-analysis from pooled data of three trials showed that early intervention services

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\(^ {30}\) Mental health, resilience and inequalities Copenhagen: WHO Regional office for Europe Friedli L 2009

\(^ {31}\) Guidance for commissioning public mental health services JCP-MH 2012

significantly reduce the risk of a second relapse and also appear to be highly valued by service users and carers.

As a priority from consultation and from recent evidence nationally, such as by the Schizophrenia Commission, the CCG will work with GPs during the next 24 months [by 2016] to review how the psychosis pathway in primary care is working. This will link to work on integrated care management within primary care more generally. Part of this work will be about prevention and access to the EIS team for advice. This may lead to further service transformation in future years.

Of particular success in the development of the primary care mental health service has been the development of regular practice based multi-disciplinary team meetings with consultant psychiatrists that has occurred in Tower Hamlets. This has helped to develop good working relationships between primary and secondary care. As part of looking at SMI and primary care:

We will work with North East London NHS Foundation Trust to further develop the interface between primary and secondary care, with a particular focus on provision of population based advice and support to practices, and the development of primary care consultation by consultant psychiatrists and other mental health professionals, learning from the East London FT model for primary care liaison where possible. We will do this by the end of the period of this strategy.

Service users have told us that they would like to see more specialist support being delivered in primary care settings, and some practices are keen to see secondary care clinics and CPA meetings being held in practices, where there is appropriate clinical space.
With North East London NHS Foundation Trust, we will further develop opportunities for practice based clinics and at very least explore how the link worker model going back in to GP practices can be developed as part of integrated care. This will be achieved by March 2016.

Service users have told us that consistency in the GP that they see is very important.

We will work with NHS England, networks and practices to ensure that people who have a serious mental illness have access to a “usual GP”. This includes completing health checks and providing access. As part of developing a primary care strategy for Waltham Forest we will by 2015 ensure that mental health issues are considered as a key priority for this strategy.

**Day Care Opportunities and personalisation**

2.2.5 For adults of working age, there are many opportunities for preventing mental health problems. From prompt access to support in the event of a significant life event, to support from targeted universal voluntary sector services and access to self-help resources when necessary.

Working as a partnership, during 2013-5, we will refresh our review of voluntary sector day opportunity and support services, with a view to considering how the expertise and dynamism of voluntary sector services, and more importantly to look at how personalisation as an agenda can be developed. This will also link to a work-stream as part of the Better Care Fund that prevention and early intervention has to be part of the answer for joint commissioning and working for adult mental health.

Personalisation is about putting people in the driving seat by building a system of care and support that is designed with their full involvement and is tailored to meet their unique needs. This is a different approach to the historic “one size fits all” system of individuals having to access, and fit into, care and support services that already exist. Personalisation means that individuals will receive their own budget for health and can decide how, when and where they wish to spend that money.

The individual budget scheme will align assessments from different funding streams and encourage self-assessment. It uses a Resource Allocation System (RAS) to distribute funds effectively and transparently, and unlike a direct payment, can be deployed in several ways:

- By the individual as cash direct payment;
- By the care manager;
- By a trust;
- As an indirect payment to a third party;
- Held by a service provider.
As part of the Transformation Agenda, the London Borough of Waltham Forest Adult Social Care team, along with NELFT, plan to implement personal budgets for people who have diagnosed mental health needs (primarily focused on the seriously mentally ill) There are a number of issues to resolve before the scheme can be expanded further, these are:

1. Information technology
2. Agreement of an integrated mental health resource allocation scheme
3. Ensuring governance and good business processes
4. Training for staff and users on payment options
5. Communication and provision of information

The CCG is at an advanced stage of developing personal budgets with its partners and a recent paper went to the Governing Body in 2014 on adult personal budgets so that by the end of 2014 eligible service users will be offered plans for personalisation in a way that will move more towards a recovery model where choice and emphasis on self-help and early intervention/prevention are part of service delivery.

The CCG working with LBWF will ensure that anyone who is eligible for a continuing care budget will have the right to a personal budget by October 2014 and further that by 2015 existing day care opportunities funded by LBWF will have been reviewed with a greater emphasis placed on getting a personal budget for SMI patients and a focus on around more choice.

Families and carers will feel more supported

2.2.6 Carers play a vital role in the lives of many people with a mental health problem. Up to 1.5 million people in the UK care for someone with a mental health problem. It is known that:

- 40% of carers experience psychological distress or depression, with those caring for people with behavioural problems experiencing the highest levels of distress
- 33% of those providing more than 50 hours of care a week report depression and disturbed sleep
- Those providing more than 20 hours of care a week over an extended period have double the risk of psychological distress over a two year period compared to non-carers. Risk increases progressively as the time spent caring each week increases
- Caring can also limit carers’ ability to take time out to exercise. Reduced income and lack of cooking skills may contribute to excess weight gain or loss. As many as 20% of adult carers increase their alcohol consumption as a coping strategy
- Emotional impacts such as worry, depression and self-harm have been identified in young carers.

The Carers and Disabled Children’s Act 2000 states that all carers aged 16 or above, who provide a ‘regular and substantial amount of care’ for someone aged 18 or over, have the right to an assessment of their needs as a carer. In 2010, the council released a Joint

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33 The Princess Royal Trust for Carers www.carers.org/key-facts-about-carers
34 Carers and Disabled Children’s Act HMSO 2000
Carers Strategy, which was developed as a local response to the National Carers Strategy. It aimed to raise awareness and understanding of local needs and priorities for carers and to ensure that provision reflected the needs of the local population. The consultation on the strategy identified the need to develop responsive and personalised services to support carers, as they are not a homogenous group, and experience specific requirements and challenges.

There are a range of services currently provided for carers in Waltham Forest:

**Waltham Forest Carers Hub** - Supports carers to access independent information, advice and advocacy support, provides emotional support and training to enhance their general wellbeing and promote their independence. This service also offers benefit checks and works closely with Job Centre Plus.

**Carers’ Support Groups**: Provision of a range of structured activities in the community to empower and connect carers, in order to alleviate isolation. The following support groups have been set up across the borough; Dementia, Mental Health and Isolated Carers.

**Replacement of Care** – These are planned breaks either in residential homes or at a carers’ home to enable carers to take a break from their caring roles. Named services currently available to carers in Waltham Forest are: Take a Break, Home Based Respite or Residential/Nursing Respite. These can be accessed by carers providing regular and substantial care, and are granted following a carers’ assessment.

**One off Direct Payment** – This is to support carers who are unable to access other carers’ services to meet their own self-defined outcomes. The one-off direct payment can be used to purchase equipment, travel, driving lessons, help with housework, membership fee for leisure centres, home improvement work, and enrolment on study courses but cannot be used to pay for holidays. The carer is required to provide documentary evidence of spend.

However, despite these initiatives, the general feedback from consultation was that further work is needed. The LBWF supported by the CCG will produce a revised Carers Strategy in 2014/5 and will also seek to have further discussions with the Carers Association about how we can improve the number of carers getting assessment and how their needs can be more systematically reviewed for Carers of MH service users. This will lead to the use of contractual levers with providers where needed to improve the experience of carers of people with mental health problems and produce an action plan by 2015.

**People will experience smooth transitions between services**

2.2.7 Poor transition between stages of the life course, or services, can contribute to poor outcomes in the short, medium and long term. It can impact upon a person’s chance of achieving employment, accessing education, maintaining independence, moving on from services or accessing services in the future. Conversely, effective transition can have a
positive effect on peoples’ life chances and their future mental health and wellbeing\textsuperscript{35}.

Transition for young adults is particularly important. Its aim should be to help to improve the chances of recovery and independence through the provision of high-quality, effective health and social care services that continue seamlessly as the individual moves from adolescence to adulthood.\textsuperscript{36} We want to ensure that the transition for children and young people to adult mental health services and the transition for adults to older people’s mental health services are improved as part of our life course approach to mental health and wellbeing.

The Children and Families Bill, due to receive Royal Assent in early 2014, will come into force in September 2014. The Act will require local authorities and other partners to ensure services are available for children and young people with special educational needs from 0 to 25. Some local authorities with partners are currently considering how CAMHS and Adult Mental Health services may be redesigned to align with the expectations of Children and Families Bill, including consideration of how the current age boundary between CAMHS and Adult mental health services may change, with some areas proposing a “soft” transition point\textsuperscript{37} of age 25.

As part of our coordinated work to design new pathways of support for children and young people, we will ensure that they take account of the requirements of, and emergent good practice in relation to, the Children and Families Act 2014\textsuperscript{38}. We will complete this task by the end of 2014.

Developing Employment Support

2.2.8 This links to the discussion about depression, IAPT\textregistered s and sustaining mental health users out of hospital/crisis. Improving support for service users to gain employment and other meaningful daytime activity will focus on a number of areas. Being in employment is increasingly recognised as one of the essential parts of the recovery programme required by people with mental health problems. This will enable them to regain their independence and maximise their potentials to live a rewarding and fulfilling life.

The Implementation guide for No Health without Mental Health (2012) is specific about employment as key factor in improving mental health wellbeing and recovery:

- Productive and meaningful daily activity associated with work can have a profound positive impact on someone’s mental health and on the national economy. The cost of mental health to business is just over £1,000 per employee per year, or almost £26 billion across the UK economy. Effective management of mental health at work can save around 30% of these costs.

\textsuperscript{35} All JSNA Evidence Review on transition.
\textsuperscript{36} Tools for Transition Anderson, Y. HASCAS
\textsuperscript{37} This is a “soft” boundary in the sense that it is driven by the needs of the individual service user.
\textsuperscript{38} Transition: Filling the Void? - Hewson, Dr L. National Advisory Council, February 2010
In order to have the best chance of recovery, it is important that people with mental health difficulties are sufficiently catered for within national and local access to work schemes.

Current employment support related services are mainly comprised of day, vocational, job retention and Individual Placement Support services (IPS). IPS has proven to be the most cost-effective solution and is about recovery focus workers integrated into CRTs. These services bring together people experiencing mental health problems, and provide them with information and advice, peer support and group therapy sessions. They also offer activities to occupy service users’ time and interests and promote the development of social networks that aim to prevent isolation and social exclusion.

Following investment by central government, the responsibility for supporting people into employment sits with Job Centre Plus. Local authorities and partner agencies are also required to work together to develop tailored support for local people.

In Waltham Forest, the council regularly measures the “proportion of adults in contact with secondary mental health services in paid employment”. The target for 2013/4 is 6% but the performance in February 2014 was only 3.1%. We also know that about 50% of MH users who go to A&E are unemployed. This group faces exclusion from employment markets and suffers from stigmatisation. For people with mental health problems who are in employment, the aspiration is to help them to remain in work as there is a risk of people losing their jobs when they have a mental health crisis.

The 2010 Strategic Review of Health Inequalities in England set out proposals to reduce health inequalities. The review, chaired by Professor Sir Michael Marmot, concluded that income inequality is often a consequence of poor mental health and that unemployment is a major cause of health inequalities.

The CCG in the light of this strategy has decided to pool its resources with the council for employment support and work as a partnership to undertake a review of how employment support is commissioned by 2015. This may lead to a change in how services are commissioned in 2015/6.

Reducing numbers in residential care/increasing supported living

2.2.9 Good quality, affordable, safe housing underpins our mental and physical well-being. All too often, severe mental ill health can lead to homelessness. People with mental health problems, particularly those with a serious mental illness can sometimes find it difficult to secure and maintain good quality accommodation.

A settled home is vital for good mental health. When it is part of an effective recovery pathway, housing provides the basis for individuals to build a more independent life, in many cases returning to work or education, whilst still receiving the support and help they need. By working together, mental health and housing providers can make those transitions easier and
provide advice and support to help people navigate the system.\(^{39}\)

People with mental health problems are far less likely to be homeowners and far more likely to live in unstable environments. Homeless populations are a vulnerable ‘marker’ group in several respects; they have poorer physical and mental health status.

Housing with support can improve the health of individuals and help reduce overall demand for health and social care services. When housing is part of an effective recovery pathway, it provides the basis for individuals to build a more independent life, in many cases returning to work or education, whilst still receiving the support and help they need.\(^{40}\)

There are compelling arguments for both the increased investment in housing and the reconfiguration of services in mental health to include a stronger housing element. There has been recognition of this locally and a reconfiguration of hostel provision is being proposed currently to better meet these needs. There are a number of ways in which housing and housing related support services contribute to improved outcomes at lower cost. For people with mental health problems this means a focus on four areas:

- Risk reduction;
- Prevention and demand management;
- Early discharge from acute settings to step-down facilities;
- Ending of out borough placements.

The CCG intends to work with the Council to particularly focus on the proportion of adults in contact with secondary mental health services living independently, with or without support. The current target for 2013/4 is 92%. The current performance as of February 2014 is 89.5% but this is far higher than the London average of 67%. By 2015 we expect to expand supported living by an additional 20 units for people with complex needs by a combination of new builds and change of use. The focus will be a move away from residential care to supported living.

We will continue to implement our Commissioning Strategy for the Accommodation of Working Age Adults with a Mental Health Problem (AWA) which includes increasing supported living but at the same time the CCG will pool its resource with LBWF to create one lead commissioner for accommodation, following this 2014/5 will see a review and procurement exercise of existing providers to ensure we get the best value from services. This will also include developing a new service specification and a strong focus on quality of care for the future. By 2016 the council and CCG will have transformed its accommodation portfolio with more people being supported with less intensive packages where this meets their needs.
Developing reablement - a cost-effective route to better recovery

2.2.10 Reablement and recovery are critical for mental health, as they support service users to keep their independence, and enable people to have their care managed closer to home and within primary care. Research by NICE has shown that: ‘Reablement is significantly associated with better health-related quality of life and social care-related outcomes, compared with conventional home care’. The evidence is that up to 60% in savings can be made on the cost of their subsequent social care provision by having good reablement and there currently exists close working relationships between community mental health teams, particularly between social workers and Occupational Therapists (OTs) in Red Oak Lodge and Woodbridge Unit. Together, they support clients in their recovery and resettlement back into their own homes. The service now provides up to six weeks of reablement care packages which include setting personalised goals, working on activities of daily living, re-assessing progress and sign-posting services.

The CCG and the council will monitor the progress of reablement initiatives in mental health, and success criteria for this approach will include:

- For patients: increased independence, autonomy and choice, being enabled to remain living at home, regaining skills and increased confidence;
- For staff: Continued development of staff, utilisation of transferable skills, increased confidence and job satisfaction;
- For service: effective targeting of services, increased savings, system efficiency, staff retention and enhanced skill-mix.
Reviewing the quality of what the Home Treatment Teams provide for service users in order to prevent and manage crisis.

2.2.11 The strategy acknowledges that we have developed early intervention teams, community recovery teams and home treatment teams but the feedback from consultation on the strategy was that more should be done to review self-referral back into the system and also more should be done on the management of crisis. There is strong feedback that this is because patients seeking informal admission are sent away only to need formal admission later on. Some will go to A&E instead which is not what we would like people to do as a first choice. There are also issues about response times from home treatment teams and that many people see them not as a crisis resolution service but a medicine delivery service. This needs to be addressed.

The CCG along with service users and carers will work with NELFT to develop better access and treatment for GPs and service users by 2015/6. This will include reviewing extended opening hours and the patient experience of access from a service user’s perspective. We will engage health watch to help us with this work to inform future commissioning intentions in 2015/6.

People in Mental health crisis should be able to access mental health services with the same speed as if they had a physical health problem. Crisis support is a national priority, and a new good practice guide called the “Crisis Concordat” [2014] has just been published on the NHSE website. This places emphasis on whole system working and the importance of working with the Police and London Ambulance services to improve responsiveness in the management of mental health problems.

As part of work on urgent care the CCG will review how this new Crisis Concordat should be implemented with other agencies and look at how the pathway can be improved by 2015.
At risk communities will have access to targeted preventative support

2.3. There are a number of local mental health user forums, initiatives and third sector bodies in Waltham Forest. This strategy recognises that, in line with the Equality Act 2010 and public sector equality duty, equality is integral to all aspects of community participation. Also service users should be treated with dignity and respect at all times and recognised as valued citizens.

Recognising the valuable contribution of local charities and interest groups

2.3.1 While some groups of people within the community are very visible, others are yet to be seen or feel heard. For example, focus group discussions conducted in Waltham Forest with Black, Asian and Ethnic Minority (BME) service users, showed that socio-economic issues, and culture and belief systems common to these groups, contributed to stigmatisation; this in turn prevented people from seeking early support from services. We know from analysis of acute mental health pathways that BME groups in Waltham Forest use more inpatient beds as a proportion of the population, than Caucasian groups.

2.3.2 The following are examples of current local groups that help to support people with mental health problems in the community:

- Hearing Voices Group
- Kiran Women’s Aid
- QALB (Asian Group)
- ELOP (East London Out Project)
- Waltham Forest Black People’s Mental Health Association
- Ashiana Project
We need to support and develop these organisations. In terms of community groups, we recognise that voluntary, community and user and carer-led organisations have considerable knowledge and experience of local services and of the needs of local people. Their focus may not necessarily be on mental health, but they will have a significant understanding of the issues affecting members and of how they relate to local mental health services.

The CCG therefore intends to have at least one stakeholder event a year for all the voluntary groups to discuss this strategy and inform future commissioning. This is likely to be held in the autumn of each year with the next one being held before March 2015.

The mental health of offenders

2.3.3 The health of offenders is now a recognised major public health issue. The connections between mental illness and social exclusion are as well-known as they are between deprivation and offending behaviour.\textsuperscript{41} People with mental health problems are over represented in prison and across the criminal justice system. The Bradley review\textsuperscript{42} laid out a series of recommendations aimed at improving the health of offenders, and placed a strong emphasis on mental health. The national \textit{Offender Personality Disorder Strategy}\textsuperscript{43}, details in particular proposals to improve the recognition and support for people with personality disorder in the criminal justice system.

The landscape of offender management is current changing significantly. Whilst some forensic services are the responsibility of NHS England specialist commissioners, including in-patient services and some community outreach services, general mental health services for people with a mental health problem and a forensic history are the responsibility of the Clinical Commissioning Group and the Council. At the same time, there is significant proposed change to the organization of probation services across the country\textsuperscript{44}.

The Thames Magistrates Court is based in Tower Hamlets. Commissioning responsibility for court diversion services has transferred to NHS England. We believe there are opportunities for a more in depth understanding of the health, including mental health needs, of offenders in the borough to inform the development of a future commissioning plan. The issue is that

\textsuperscript{41} Social Exclusion and Mental Health, ODPM, 2004

\textsuperscript{42} http://www.prisonreformtrust.org.uk/ProjectsResearch/MentalHealth/TroubledInside/Bradleyreviewcallsfonewapproachtooffenders

\textsuperscript{43} http://www.personalitydisorder.org.uk/criminal-justice/about-dspd-programme/

\textsuperscript{44} http://www.justice.gov.uk/transforming-rehabilitation
the police may often take service users to a place of safety or arrest them rather than deal with their clinical needs.

With NHS England and public health within the Council, we will develop a JSNA factsheet specific to the mental health needs of offenders to help inform future commissioning arrangements. We will by 2016 also work with NELFT to develop local protocols and review how the function of a court service should operate. This should also some reference to the safety of carers and include both LD and MH service users.

The London Pathways Project is part of the local delivery of support to the Probation Service to recognize and support offenders with a personality disorder. Its primary aim is to support the probation workforce to develop their skills and knowledge in working with people with a personality disorder, to improve screening for personality disorder, and develop more psychologically informed environments.

We will work with probation and mental health service providers to ensure the successful delivery of support for offenders with mental health problems including personality disorder. This will result in a clear protocol or action plan for local services and be in place by March 2016.

**People who are homeless**

Good quality, affordable, safe housing underpins our mental and physical wellbeing. All too often, severe mental ill health can lead to homelessness, and people with mental health problems, particularly those with a serious mental illness can sometimes find it difficult to secure and maintain good quality accommodation.

Many homeless adults have chaotic lives and therefore require holistic and co-ordinated support to live independently and feel empowered. Vulnerable adults often have multiple needs and experience multiple levels of exclusion. A report by the charity Homeless Links showed that 8 out of 10 homeless clients have one or more physical health need and 7 out of 10 clients have one or more mental health need.

In Waltham Forest, Locally, the majority of single homeless approaches to the Council are assessed as having a low level support need which may include depression or minor intellectual impairment, with a small, but important number having high level mental health needs. Around 46% hostel users in the borough have some form of mental health support need.

As part of work on the JNSA in future years we will keep this area under review and develop action plans as required to support this vulnerable group working with the council.
People from Black & Minority Ethnic [BME] communities

There are different nuances to the ways people from different communities and cultural backgrounds understand and respond to mental health problems in themselves, their families and communities. Equally, professionals might not always understand the sometimes subtly different way in which mental health problems might present in some individuals from some communities, and some services may not be configured in a way that feels accessible to people from BME communities. As a consequence, the take up of mental health services is not always as we might expect it to be in line with the demographic breakdown of our communities.

Ensuring that mental health awareness raising activity is specifically designed to meet the needs of our diverse communities, as identified above, is particularly important as is ensuring that there are appropriate voluntary sector services close to communities to provide sign-posting and support. Ensuring that services provide culturally and language appropriate support in statutory services to promote access is of importance.

Specific areas for action are identified in the course of the Strategy.

We will monitor access to inpatient services against the demographics of the population and we will also monitor the % of BME groups accessing psychological therapies as we expand the service. The CCG will work with our Commissioning Support Unit, as part of our responsibilities under the Public Sector Equalities Duty, to a dashboard for access to services by race and other equality strand, to inform future commissioning. We expect to have this in place before the end of this strategy by 2016.

People from the Lesbian Gay Bisexual Trans [LGBT] community

There are no clear figures indicating how many gay, lesbian bisexual or transgender\(^{45}\) residents there are in Waltham Forest. National estimates indicate that between 5 – 7% of

\(^{45}\) The expression Trans is often used synonymously with transgender in its broadest sense. Where Tran’s people have transitioned permanently, many prefer to be regarded as ordinary men and women, without any reference to their former gender role or previous trans status. (Gender Identity Research and Education Society website)
the population is gay, lesbian or bisexual, and that the proportions may be higher in London than elsewhere in the UK. People from the LGBT community are more likely to experience depression, anxiety, self-harm and suicidal behaviour. Locally, recording of sexual orientation by statutory and voluntary sector services is often poor, so it is difficult to establish the extent to which services are accessible to people from the LGBT community, although from the consultation on the strategy “Positive East” made the clear point that we need to have prevention and that we need personalised services for this client group including psychological medicine as this group can often be a high cohort for self-harm.

We will work with providers to improve recording of sexual orientation as part of equalities monitoring requirements to inform future commissioning. We expect to have achieved this by 2016.

People who are new to the Borough

Waltham Forest has experienced a large change in ethnic mix over the last 10-years and one of the highest speaking languages after English is Polish. If you are known to secondary care mental health services, you are comparatively less likely to be admitted to hospital than in many other London boroughs. However Waltham Forest has a low level of people on CPA compared to the population and high numbers of admissions to the secondary care sector for mental health. People new to the borough may also go to A&E as a substitute for knowing where they can get care in the community.

Working with NELFT and Bart's Health we will carry out an audit of the people who are admitted to hospital who were recorded as not previously known to mental health services in the borough. We will use this information to help plan how to better support early access to community services for this group of people in the future and produce a report by 2016 for further action.

CHAPTER THREE: Mental Health Commissioning Issues

3.0. This chapter covers some of the underpinning and enabling issues for the strategy to be implemented over the next 3 years.

Mental Health Tariff as a key source of transformation

3.1 In December 2012, the Department of Health issued guidance which stated that a new Payment by Results (PBR) system would be put in place to provide a transparent and rules-based system for paying health trusts. It is intended to reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. It will also ensure a fair and consistent basis for hospital funding, rather than being reliant principally on historic budgets. From 2014/5 the CCG and LBWF will be able to use this information to inform contract negotiations with providers going forward. By 2016 it is expected that having a tariff will allow commissioners to better map services by pathway and to also look at whether there is scope for moving money to alternative providers away from block contracts.

3.1.1 Implementing PBR for mental health may appear particularly challenging in the current climate of change. However, two benefits make it a worthwhile task:

- It provides the opportunity to better understand the needs of service users and ensure that service responses to their needs are high quality (safe, effective and a positive experience) and good value (by being efficient and productive);
- It provides the opportunity to make informed operational and strategic decisions for mental health services by improving the information available to commissioners.

Beyond these two key benefits, there are a number of other related advantages for commissioners, providers and people using services, not least clearer a definition about what is being commissioned within provider services. This approach could support the setting of personal health budgets by allowing funding to be aligned with people’s individual needs.

3.1.2 As part of this debate we have to recognise that NELFT is currently a monopoly provider of mental health services in Waltham Forest. We need to aim to transfer some of the care it carries out back into primary care and also stimulate the market. The first areas where we are likely to develop and change services in relation to the mental health tariff are around the issue of cross-borough flows. Waltham Forest has many service users who use NHS East London Foundation Trust (ELFT) and access services west of the borough such as at Homerton University Hospital Foundation Trust (HUHFT). At the moment this is a cost pressure and represents uncontrolled financial risk as it is largely on a cost per case basis. There is also the issue of repatriation to local services including social services.

3.1.3 The NHS Operating Framework and No Health without Mental Health Implementation Framework both emphasise the importance of choice within mental health. Currently patients are not offered a choice of mental health services in the way that they would be for acute health services.
services, and there is no performance regime in this area. Without a tariff for mental health services, a payment mechanism to support patient choice is not obvious. The use of Approved Qualified Providers (AQPs) and other mechanisms to offer choice, will be explored during the life of this strategy, both to improve the patient and user experience of services, and to improve the quality of provision.

By 2015 the CCG will work with providers and the CSU to develop a clear action plan to implement both the information flows and costing’s behind the mental health tariff. This will involve assessment of risks and setting up revised contracts to reflect the new policy.

Developing a better performance framework

3.2 In order to take forward this strategy an implementation plan in summary is attached as annex 1 to this document.

3.2.1 A copy of how this strategy links back to the national strategy and an analysis of all the key national outcomes indicators is included as annex 2 and annex 3 to this document.

Developing Joint Commissioning and Finance Issues

3.3 This document has to be seen in the context of a life course approach and therefore other strategies need to sit side-by-side with this document:

- Autism Strategy
- Carers Strategy
- CAMHS Strategy when completed [late 2014]
- Public Health and Mental Health prevention strategy [2015]
- Dementia Strategy
- LD Strategy [to be developed in 2014/5]

3.3.1 In the light of work on the Better Care Fund and working across health and social care it is expected that this document will help promote joint working and commissioning with providers.

3.3.2 We will develop a detailed finance plan to support and implement this strategy. We will do this to be more transparent on our current spend on mental health with LWBF and to inform the commissioning cycle for 2015/6. This will also lead to the refreshing of this strategy by 2016 in the context of implementing the Better Care Fund with the council which also includes mental health spend.
By 2015 the CCG will work with LWBF to review the MH programme budget spend with a view to looking in the light of MH Tariff how we can support and develop prevention and out of hospital care. This will include producing a financial annex to this plan and involve assessment of risks of not taking a longer term view on mental health budgets given the increasing population and change in demography. This will inform the refresh of the plan in 2016/7.

Ensuring that service users and carers help develop this strategy

3.4 Service users have been involved identifying the priorities in this strategy at every step of the way. Three events and seminars have taken place in March 2012, July 2012 and end of October 2012. This included table and focus group type work. There was then a stakeholder engagement event as part of consulting both on the acute mental health pathways change proposed in the document, the consultation on the strategy itself [over 30 organisations replied] and there has been a presentation to at least 2 overview and scrutiny committees. The CCG Board agreed the strategy in January 2013 and this version will now go back to the Board for further engagement in May 2014. The strategy will be used with service users and carers as a living discussion document to develop commissioning and change in mental health services for Adults in Waltham Forest.

Below is a summary of just some of the feedback from service users and carers which we have used to shape the content of the strategy. The comments are grouped into primary, secondary or community care:

Primary care

- Getting rid of expensive 0845 telephone numbers
- More time with the GP and less time spent waiting in reception
- Certain mental health services to be located at the GP surgeries so that patients don’t have to travel between services and can feel confident that they can receive the help that they need within a primary care setting (where possible)
- Customer service training for practice staff (particularly receptionists)
- Layouts of practices should be addressed so that there is more privacy for patients
- Patients, carers and family members to be taken seriously and for GPs and other clinicians to listen to what they have to say properly and without prejudice
- An identified person within the surgery to coordinate ‘care treatment’ across the three service domains (primary, secondary and community)
- Quicker access to GPs for mental health patients, as lack of intervention can bring about a crisis situation – no more waiting up to a week for an appointment
- Patients should be able to see the same GP wherever possible as they will be
Secondary care

- More regular appointments with a dedicated psychiatrist – bimonthly or as needed
- The duration of time that a patient spends accessing psychology services should be open-ended and based on need, not arbitrarily restricted
- Psychology top up sessions to be made available, to be accessed quickly if needed
- In inpatient care settings staff need to be more interactive, engage with the patients more and behave in a more cheerful manner
- Many inpatients are bored during their stay and the way to manage this is not to have the TV on all day, but to provide more activities for patients
- When inpatients are discharged, access to medication should be quick, so patients are not discharged in the morning and then have to wait hours for their prescription
- Inpatients should be able to see the consultant psychiatrist quicker on admission
- Crisis care for patients experiencing emergencies after 5pm needs to be improved; too often people are told to go to A&E which is not the best place for people in crisis
- A person’s complete needs should be taken into consideration by the service as there can be other elements that contribute to a crisis, such as having no money
- The Home Treatment Team (HTT) sometimes focus too much on medication, when want a patient needs is for the team to spend more time with them at home
- Secondary care service operational hours should be flexible and longer
- Patients prefer to see the same staff member each time they access a service, this is what ‘continuity of care’ means from a service user perspective
- More support is needed for carers of people with mental health needs
- More communication is needed with primary care upon discharge from secondary care to avoid patients being discharged without any support, as this can often provoke another crisis and results in the patient being returned to secondary care
- There should be more collaboration between secondary and primary care to provide a stepped down process, that provides support until the patient becomes well again
• Information should be sent to GPs quickly after a patient is discharged as delays may mean that a GP changes medication without having the full picture – often the delay seems to rest with medical secretaries or administration staff
• Staff need to take more interest in Wellness, Recovery, Action Plans (WRAPs), rather than just asking patients to fill them in by themselves, and use them as documents that can help to assess the whole wellbeing of the service user
• Psychiatrists, whilst they may be medically qualified, do not necessarily understand how a patient is feeling – they need to listen more to patients
• There is a lack of cultural awareness and different cultural values within secondary care services, so sensitivity training needs to be given to staff

Community services
• More funding is needed to keep services open longer and to make them easier to access – this needs to be a priority for commissioners
• More self-help groups which are led by service users need to be set up
• More information needs to be made available to clinicians, carers and service users as to what community services are out there and can be accessed by patients
• Accessible and more detailed information on medication is needed
• A wider focus is needed on services or activities that promote social inclusion
• Better and wider access to cheap breaks, holidays and day trips (with funding for carers and family members) would be of immense benefit to most service users
• More preventative programmes are needed, which enable people to address their own mental health needs and to provide support so people are less likely to relapse
• More opportunities need to be made to allow service users to meet with one another, such as forming local social networks and discussion groups
• Concessions should be made for staff or family members to accompany clients who wish to participate in social and leisure activities that are not funded by the NHS
• There has been a demonstrable loss of funding for carer and service user groups, meaning that many have closed – these need to be given investment as a priority
• A regular community services newsletter should be made available to service users, so that people are informed about any changes and know where to go to get help
• More campaigns are needed to battle against mental health stigma within borough (like the Time to Change campaigns) and to raise awareness of mental disorders
• A diversion team is needed to support people within the criminal justice system

In Summary the key headlines from the above are:
• Improved Access to Services
• Better information and appointments systems
• More focus on physical and mental health together
• More community services and social inclusion and campaigns to avoid stigma and discrimination
• Better staff training
Finally

In summary, improvement in access, service delivery and knowledge on mental health was a key theme throughout the discussion as well as the importance in a higher number of accessible and secure community services that support users in developing coping strategies to maintain and manage their own mental and physical health while aiding them to develop stronger links with the community, encouraging social inclusion therefore aiming to minimise stigma and discrimination.

The key concern that came up was that in Waltham Forest there has been a lot of service reductions in mental health and for the recovery model to work there needs to be better access to services in the community – both commissioned by the council and the CCG to allow mental health users to be supported in their own homes and local community. Broadly however the draft strategy was welcomed as a step forward and felt to include the key points within mental health services that needed change and development over the next few years.

The CCG and LBWF will continue to see user and carers experience as being the centre of everything we do and in developing the implementation of this strategy we fully expect to continue to consult and co-produce solutions with them in commissioning services.

In developing any task group for major transformation or implementation of any major work stream in this strategy, we give a commitment to always engage with a user and carer in taking things forward as part the group and to consult where necessary. We will also seek advice from the CCG’s reference group for stakeholder engagement if this is appropriate.
Annex 1. High Level Implementation Plan – 2013 to 2016:

This follows the recommendations as they are made throughout the document in the same order. It has to be recognised that the CCG/LWBF cannot do all the changes it needs to do in the light of the strategy and work needs to be phased. In some cases behind this high level plan there are more detailed project plans but in a strategy it is not possible to record all this information without making the document excessively long.

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<th>Action Agreed</th>
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<th>Progress as of May 2014 &amp; Further Comments</th>
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<tr>
<td>We will commission a new service for community eating disorders during 2013/4 for the first time providing better quality of care and less need to use tertiary care by earlier and appropriate intervention. In making this recommendation, our service mapping acknowledges that Waltham Forest has little or no community eating disorders service available compared to neighbouring boroughs. Waltham Forest residents receive only a small outreach service from St Anne’s Hospital in Haringey. It is not NICE compliant due to the lack of effective community interventions for children, adolescents and adults with eating disorders.</td>
<td>April 2014</td>
<td>This has been achieved on target.</td>
<td>Jane Mehta, CCG</td>
<td>New service that is NICE compliant. Less out of area care.</td>
</tr>
<tr>
<td>We will commission during 2013/4, as part of the NELFT contract, to sustain and keep the IMPART service for local residents with severe end personality disorders. Access to care will be a psychological triage panel so that the service focuses on the more severe end of personality disorder.</td>
<td>By April 2014</td>
<td>This has been commissioned and operates for WF residents as planned</td>
<td>Chris Soltysiak and John Samuel, CCG</td>
<td>Better Personality Services pathway.</td>
</tr>
</tbody>
</table>
We will give psychiatric liaison a higher priority, including it in the integrated programme for the CCG, undertaking a review of the literature and business case to expand the service especially for older people’s liaison at Whips Cross so a bigger and better service is in place by 2014/5. This will include producing a new revised service specification for commissioning the service. By 2014/5 we expect to have commissioned a stronger core service which is clinically led by a consultant psychiatrist working closely with the acute clinicians in Whips Cross Hospital for local residents.

| April 2014 with further evaluation in the following 12 months | The CCG has supported an enhanced service. This is not yet an accredited service but further review and work will take place during 2014/5. Part of urgent care and integrated care. | Jane Mehta, CCG |
| April 2014 with targets met by October 2015. | Review is complete. New service specification has been drafted. CCG invested in the service and is now on track to hit the nationally required targets. Further work to do in 2014/5 on linking IAPT to integrated care. | Chris Soltysiak, CCG with Dr Paulette Lawrence, Dr John Samuels, Dr Paulette Lawrence, Chris Soltysiak and support from LWBF. |
| April 2015 | The LTC Pilot is being evaluated and a task group will be set up to respond to the outcomes. Work is likely to commence from July 2014. | Better management of depression and outcomes. Targets met. GPs having better waits and access for their patients. |

The strategic intention of the CCG is to pilot a primary care discharge scheme for patients with psychosis and long term Seriously Mental Ill conditions during 2013/4. This will involve commissioning additional navigator support to the pilot GP practices and then after the year ends undertake evaluation. During 2014/5 the CCG working with its stakeholders intends to use the learning to work up a pilot and model of care for how SMI patients, as part of integrated care management can be better managed in primary care. This will involve research of the various service models around the country, better development of clinical protocols and work on information flows between secondary and primary care for mental health service users.

| April 2014 | The CCG has supported an enhanced service. This is not yet an accredited service but further review and work will take place during 2014/5. Part of urgent care and integrated care. | Jane Mehta, CCG |
| April 2014 with targets met by October 2015. | Review is complete. New service specification has been drafted. CCG invested in the service and is now on track to hit the nationally required targets. Further work to do in 2014/5 on linking IAPT to integrated care. | Chris Soltysiak, CCG with Dr Paulette Lawrence, Dr John Samuels, Dr Paulette Lawrence, Chris Soltysiak and support from LWBF. |
| April 2015 | The LTC Pilot is being evaluated and a task group will be set up to respond to the outcomes. Work is likely to commence from July 2014. | Better management of depression and outcomes. Targets met. GPs having better waits and access for their patients. |

Part of innovation for integrated care. Responds to “parity of esteem” so that service users are managed for both physical and mental health in primary care with better outcomes.
<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
<th>Authors</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2014</td>
<td>This has been completed successfully and a new home treatment team has been commissioned for older people in the borough.</td>
<td>Chris Soltysiak, Eloise Barnes and Dr Samuels</td>
<td>Less need for beds and more home treatment in the borough. Overall cost saving and more focus on the recovery model with better quality of care. Further review on home treatment in future years to develop crisis response function.</td>
</tr>
<tr>
<td>April 2015</td>
<td>CCG has met its targets for 2013/4 and in the following 2 years needs now to work with the council to increase performance further. This is a key CCG target with NHSE. A Dementia Forum with key stakeholders has been set up to do this.</td>
<td>Dr John Samuel, Dr Paul Russell, Dr Syed Ali, Eloise Barnes from the CCG Pratima Solanki from LWBF</td>
<td>Better diagnosis leads to better integrated care [ICM] and planning. Parity of esteem and national targets met. Pathways between physical and mental health clarified. Dementia Strategy updated to provide further framework for a “life course approach” to mental health.</td>
</tr>
<tr>
<td>The CCG will look at existing mental health budgets and transfer resource from distant providers to commission a new ASD service for adults locally by 2014/5. This will be for diagnosis and assessment. A new service specification for the service will be produced for this purpose and to monitor quality of care during this year. This will also link back to the action plan in the published Autism Strategy for the CCG and LBWF.</td>
<td>June 2014</td>
<td>This has been commissioned with a new service specification by April 2014. There is further work to do in explaining the service to CCG members.</td>
<td>Chris Soltysiak and Dr Samuels, CCG</td>
</tr>
</tbody>
</table>

| The CCG will work with LBWF to produce a new Suicide and Self Harm Strategy during 2013/4. During 2014/5 the clinical lead for mental health will join a new steering group across the borough to ensure progression and implementation for local people. | April 2015 | This has been completed on time. Further work is required, particularly on self-harm MH Users going to A&E during 2014/5 | Vicky Hobart, Director of Public Health, LWBF Dr Paulette Lawrence, CCG Jane Mehta, CCG – for urgent care links | New strategy in place. Reduction in self-harm going to A&E and more compliance with NICE guidelines. HWB able to monitor national targets/benchmarks. [part of outcomes frameworks] |

| The CCG will actively take part in the CAMHs partnership board and in the light of this strategy and the need to have life course approach will help produce a new strategy for this area in 2014/5 which will be consulted on and implemented by 2015. | April 2015 | Work has started on the new strategy and this is available in draft form. Further work to do but this should be on target. | Dr Tonia Myers, Kelvin Hankins, CCG, Pratima Solanki, LWBF | Key for work on MH transformation and prevention. Part of developing the “life course approach” for mental health. Over time allows discussion about resource allocation towards early intervention and better transitions to adult care. |
The CCG will work with the council to produce a new needs assessment specifically on drug and alcohol misuse for the borough. This will lead to a review of treatment services by the end of 2014/5, including the potential for procurement of better services in the light of the needs assessment and revised model of care needed by 2015. The CCG will support implementation of any recommissioning plan to be produced by LBWF.

April 2015

The needs assessment is complete and plan are in place for 2014/5 to redesign the service.

This is a priority for year 2 of the plan.

Vicky Hobart and Pratima Solanki, Clinical support from Dr Samuel, CCG, Dr Paulette Lawrence Jane Mehta, CCG for urgent care and Bart's Health issues.

More focus on out of hospital treatment and development of primary care model. Better “dual diagnosis pathway with MH saving resource and providing better quality of care. Targets to be agreed as part of any future plan.

The CCG will work with the council and mental health providers to develop a new policy and protocol for managing section 117 of the MHA cases and have this implemented during 2014/5.

March 2015 but policy agreed by April 2014

This has been written and agreed at JCB on time. Officers are meeting in June 2014 to discuss implementation.

Chris Soltyksiak, CCG, Sue Boon of NELFT, Senel Arkut of LWBF, Peter Keirle of NELCSU.

Clearer eligibility criteria and health and social care working together to get the best for patients. Link to the BCF.

Having listened to public consultation on the strategy and reviewed the work in Tower Hamlets CCG we will seek to get the CCG and LBWF to sign up to the Time to Change Agenda and ensure the Health and Well Being Board sees this area as one of its priorities. We will achieve this by 2015. Tackling stigma and discrimination through multi-agency working and by utilising the Time to Change partnership model is the best means to achieve change. However, we will be realistic about how quickly we can bring about change and how it can be effectively measured.

March 2015

This is new and comes from comments received from consultation. It is suggested that this is a priority for action in 2014/5 subject to Board approval – year 2 of the plan.

Terry Huff, Dr Anwar Kahn, CEO of the Council and Leader of the Council.

Jane Mehta and Helen Davenport to manage any organisational and development or communications plan implications.

Potential to get funding grants from national sources. Part of the prevention agenda for mental health with increased awareness and education and training. Clear statement about complying with the equality agenda..
<table>
<thead>
<tr>
<th>We will develop a new web resource that will provide easily accessible information on mental health services for children and young people, adults, and older people. The resource will act as a directory of mental health services for the borough, and an up to date repository of information about mental health related activities and events in the borough. This will happen by 2015.</th>
<th>March 2015</th>
<th>The CCG has recently updated its website. Further review and improvement to be made in consultation with key stakeholders for MH during 2014/5 – year 2 of the plan.</th>
<th>Dr John Samuel, Dr Tonia Myers, Dr Paul Russell, Dr Paulette Lawrence, Chris Soltysik, Anna O’Sullivan from the CCG. Pratima Solanki from the LWBF – To review the existing information and develop the site in time for the next commissioning cycle and launch of the BCF.</th>
<th>Responds directly to the public consultation on the strategy. Provides more opportunities for self-help and service users to navigate the system. Supports people to engage in co-production as the strategies are implemented</th>
</tr>
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<tbody>
<tr>
<td>We will ensure that the web resource is publicized with community groups and services that support people who may not use the internet, so that people can be supported to access the information the web resource will hold. We will also ensure that providers publish relevant information in appropriate languages working with Health Watch to advise us on the best way to do this for Mental Health.</td>
<td>March 2015</td>
<td>Initial discussions have taken place with Health Watch about supporting the best way to take this forward in 2014/5.</td>
<td>John Samuel, Paulette Lawrence, Anna O’Sullivan, CCG, Health watch.</td>
<td>Supports the meeting the needs of a diverse community. See the section in the strategy on developing “preventative support”</td>
</tr>
<tr>
<td>We will deliver our approach to raising mental health awareness through the commitments identified to tackle stigma and discrimination, as above. We expect to complete a prevention strategy briefing or strategy by 2015 to compliment this strategy, the CAMHs strategy and Dementia Strategy, to therefore provide a “menu suite” of action which supports a life course approach to commissioning for MH.</td>
<td>March 2015</td>
<td>An initial draft of a prevention strategy went to LWBF scrutiny in March 2014. Further work to be done on this after the JSNA is revised.</td>
<td>Vicky Hobart, Pratima Solonski and Dr Samuel</td>
<td>This is known to be cost effective in the medium term and provides better care. Links also to a BCF work stream on prevention for 2015 implementation</td>
</tr>
<tr>
<td>Date</td>
<td>Activity</td>
<td>Responsible Parties</td>
<td>Notes</td>
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<td>March 2015</td>
<td>By 2015 we will develop a rolling programme of training for GPs and other primary care staff on specific aspects of mental health – this will be led by the MH clinical lead in the CCG.</td>
<td>Dr Anwar Kahn, Dr Samuel and Dr Lawrence with support from the CCG.</td>
<td>More capability and capacity to commission care from primary care networks. More understanding and engagement by primary care practitioners on the key work streams in this strategy. Better communication and understanding of existing services.</td>
<td></td>
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<tr>
<td>March 2015</td>
<td>Extensive training linked to the long term conditions pilot was given 12 months ago but there needs to be further work by locality done on this in 2014.</td>
<td>Dr John Samuels and Dr Paulette Lawrence, with support from Jane Mehta and CSU contract team for NELFT.</td>
<td>This is a priority for 2014 – year 2 of the plan.</td>
<td></td>
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<tr>
<td>March 2016</td>
<td>As a priority from consultation and from recent evidence nationally, such as by the Schizophrenia Commission, the CCG will work with GPs during the next 24 months to review how the psychosis pathway in primary care is working. This will link to work on integrated care management within primary care more generally. Part of this work will be about prevention and access to the EIS team for advice. This may lead to further service transformation in future years.</td>
<td>Dr Lawrence has started to do some initial work and has attended various conferences. This is a major piece of work and links to the introduction of the mental health tariff and clusters. This is a priority for year 3 of the plan.</td>
<td>Part of integrated care. Crucial for cost saving given MH tariff that we have better early intervention. Linked to both the outcomes framework, parity of esteem work and national developments on CQUINS. Part of the future Primary Care Strategy work for the CCG. The JSNA also focuses on how the psychosis pathway needs review.</td>
<td></td>
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<tr>
<td>March 2016</td>
<td>We will work with North East London NHS Foundation Trust to further develop the interface between primary and secondary care, with a particular focus on provision of population based advice and support to practices, and the improvement of access and treatment services.</td>
<td>Dr John Samuels, Dr Paulette Lawrence, Chris Soltysiak CSU contract team for Waltham Forest.</td>
<td>Improved integrated care. Development of the access to secondary care. More shift of work towards primary care by giving GPs and service users the right support which will lead to better outcomes.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Dr John Samuels, Dr Paulette Lawrence, Chris Soltysiak CSU contract team for Waltham Forest.</td>
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**Better Mental Health: A joint adult mental health strategy for Waltham Forest**
With North East London NHS Foundation Trust, we will further develop opportunities for practice based clinics and at very least explore how the link worker model going back in to GP practices can be developed as part of integrated care.

March 2014

As part of developing the discharge arrangements for service users to primary care this work needs to be included in developing the model of care/learning from the LTC pilot.

As above

As above – part of integrated care and developing better communication between GPs and NELFT

We will work with NHS England, networks and practices to ensure that people who have a serious mental illness have access to a “usual GP”. This includes completing health checks and providing access. As part of developing a primary care strategy for Waltham Forest we will by 2015 ensure that mental health issues are considered as a key priority for this strategy.

March 2016

This will be picked up as part of developing a primary care strategy for the CCG. Work has started on this during the next 12 months.

Jane Mehta, CCG, Dr John Samuels from the CCG. Input from Health watch as required.

Parity of esteem and response to the feedback from consultation. Less people going to A&E or into crisis as a result of improved services by 2016.

Working as a partnership, during 2013-5, we will refresh our review of voluntary sector day opportunity and support services, with a view to considering how the expertise and dynamism of voluntary sector services, and more importantly to look at how personalisation as an agenda can be developed. This will also link to a work-stream as part of the Better Care Fund that prevention and early intervention has to be part of the answer for joint commissioning and working for adult mental health.

March 2015

An initial review including stakeholder workshops were completed in 2013/4. Over the next 12 months this will be part of work between the council and the CCG.

Senel Arkut and Pratima Solanki, LWBF

Improved focus on care around the individual with a clearer service offer to local people on day opportunities and support from social care funded initiatives to aid mental health recovery.

The CCG working with LBWF will ensure that anyone who is eligible for a continuing care budget will have the right to a personal budget by October 2014 and further that by 2015 existing day care opportunities funded by LBWF will have been reviewed with a greater emphasis placed on getting a personal budget for SMI patients and a focus on around more choice.

March 2015

A paper on the plan for this was submitted to the CCG governing body earlier in the year. See above for further comment on day care opportunities.

Helen Davenport with input from NELFT and LWBF

National targets met. Increasing focus by 2015 on monitoring the number of SMI patients with personal budgets.
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
<th>Responsible Party</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>March 2015</td>
<td>This will be picked up by the Carers Partnership Board and in discussion with the local Carers Association about how we can improve the number of carers getting assessment and how their needs can be more systematically reviewed for Carers of MH service users. This will lead to the use of contractual levers with providers where needed to improve the experience of carers of people with mental health problems and produce an action plan by 2015.</td>
<td>Pratima Solanki from LWBF, and Jane Mehta from CCG supported by Carers Strategy Group.</td>
<td>New Carers Strategy available and understood by carers. Improved monitoring and targets for carer’s assessments and reviews for MH clients. Stocktake of progress for 2015/6 commissioning cycle.</td>
</tr>
<tr>
<td>Oct 2014</td>
<td>There is now a dedicated SEN Programme Board with the CCG actively involved on making sure that children with complex and emotional needs are met. This is a priority legally for 2014/5.</td>
<td>Dr Tonia Myers supported by Kelvin Hankins. Pratima Solanki.</td>
<td>Implementation of SEN reforms. Link back into CAMHs strategies and Best start in life strategies. Not directly relevant to this strategy but part of developing a life course approach to mental health and special needs.</td>
</tr>
<tr>
<td>March 2015</td>
<td>A grant for employment support is being paid to LWBF. During the year the CCG will work with the council to review the contracts held for MH.</td>
<td>Pratima Solanki, LWBF with support from Chris Soltysiak, CCG and Dr Samuel</td>
<td>Improved response to current targets. Improved MH wellbeing given the evidence of the impact of unemployment on service users.</td>
</tr>
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We will continue to implement our Commissioning Strategy for the Accommodation of Working Age Adults with a Mental Health Problem (AWA) which includes increasing supported living but at the same time the CCG will pool its resource with LBWF to create one lead commissioner for accommodation, following this 2014/5 will see a review and procurement exercise of existing providers to ensure we get the best value from services. This will also include developing a new service specification and a strong focus on quality of care for the future. By 2015/6 the council and CCG will have transformed its accommodation portfolio with more people being supported with less intensive packages where this meets their needs.

The CCG will, with service users and carers, work with NELFT to develop better access and treatment for GPs and service users by 2015/6. This will include reviewing extended opening hours and the patient experience of access from a service user’s perspective. We will engage health watch to help us with this work to inform future commissioning intentions in 2015/6.

As part of work on urgent care the CCG will review how this new Crisis Concordat should be implemented with other agencies and look at how the pathway can be improved by 2015.

<p>| April 2016 | A new working group has been set up with a view to developing a service specification and taking forward a procurement exercise to be completed by the timetable. | Pratima Solanki, LWBF Chris Soltysiak, CCG, Dr John Samuels | Better value secured for the partnership whilst at the same time showing a movement of accommodation away from residential care solutions. |
| March 2015 | Work has started on improving the access and treatment service and how GPs/Service Users get into secondary care. The 2014/5 contract includes better standards for waiting times and advice given to GPs. Also increase of opening hours. <strong>This is a priority for 2014/5 – year 2 of the plan.</strong> | Dr John Samuels, Dr Paulette Lawrence, CSU Contract Team, Support from Health watch and Sus, Chris Soltysiak from the CCG, Senel Arkut from LWBF | Major transformation of crisis response for GPs and improved standards of care. Improved single point of access arrangements for MH by 2015. Links to the BCF. |
| March 2015 | No action so far. | Dr John Samuels, Caroline Gilmartin; Urgent Care Board | Part of improving urgent care with less people being taken to A&amp;E. Responses to government policy. |</p>
<table>
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<tr>
<th><strong>The CCG therefore intends to have at least one stakeholder event a year for all the voluntary groups to discuss this strategy and inform future commissioning. This is likely to be held in the autumn of each year with the next one being in 2014.</strong></th>
<th><strong>March 2015</strong></th>
<th><strong>No action so far.</strong></th>
<th><strong>Dr John Samuels , Dr Paulette Lawrence, Chris Soltysiak, Anna O Sullivan from CCG, Pratima Solanki from LWBF</strong></th>
<th><strong>Improved engagement on the strategy and ability to have forward planning discussions as part of the commissioning cycle for MH.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>With NHS England and public health within the Council, we will develop a JSNA factsheet specific to the mental health needs of offenders to help inform future commissioning arrangements. We will by 2016 also work with NELFT to develop local protocols and review how the function of a court service should operate. This should also some reference to the safety of carers and include both LD and MH service users.</strong></td>
<td><strong>March 2016</strong></td>
<td><strong>No action so far.</strong></td>
<td><strong>Vicky Hobart and Dr John Samuels</strong></td>
<td><strong>More targeted preventative response with less service users ending up in criminal justice and getting better local care.</strong></td>
</tr>
<tr>
<td><strong>We will work with probation and mental health service providers to ensure the successful delivery of support for offenders with mental health problems including personality disorder</strong></td>
<td><strong>March 2016</strong></td>
<td><strong>No action so far – year 3 of the plan.</strong></td>
<td><strong>Dr John Samuels</strong></td>
<td><strong>Better court diversion systems in place with NELFT for service users leading to improved pathways of care and better outcomes</strong></td>
</tr>
<tr>
<td><strong>As part of work on the JNSA in future years we will keep this area under review and develop action plans as required to support this vulnerable group working with the council.</strong></td>
<td><strong>March 2016</strong></td>
<td><strong>JNSA is currently being revised.</strong></td>
<td><strong>Vicky Hobart with Dr Samuel</strong></td>
<td><strong>Better response to the homeless who also have MH conditions. Information to commission and plan services more effectively in the future.</strong></td>
</tr>
</tbody>
</table>
We will monitor access to inpatient services against the demographics of the population and we will also monitor the % of BME groups accessing psychological therapies as we expand the service. We will work with our Commissioning Support Unit, as part of our responsibilities under the Public Sector Equalities Duty, to a dashboard for access to services by race and other equality strand, to inform future commissioning.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>Responsible Parties</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>March 2015</td>
<td>Will be picked up as business as usual contract discussions</td>
<td>CSU WF contract and performance teams, Jane Mehta CCG, Sue Boon NELFT</td>
<td>Compliance with Equality Act and ability to target services towards early intervention more effectively.</td>
</tr>
<tr>
<td>March 2015</td>
<td>As above</td>
<td>As above</td>
<td>As above</td>
</tr>
<tr>
<td>March 2015</td>
<td>Year 3 of the plan</td>
<td>Dr Paulette Lawrence, CCG, Chris Soltysiak, CSU Contract team</td>
<td>Better crisis response in the future. More ability to target this group and predict unmet need. Increased level of people on CPA who should be under care and not unknown. More appropriate future use of services.</td>
</tr>
<tr>
<td>March 2015</td>
<td>Task and finish group has been set up by the CSU.</td>
<td>Ian Clay, CCG Finance, John Samuel, CCG, Chris Soltysiak, CCG, Brenda Pratt, CSU contract team for the CCG.</td>
<td>Benefits of having a MH tariff realised including potential for QIPP. Risks managed. New service specifications developed and signed off for contracts.</td>
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</tbody>
</table>

We will work with providers to improve recording of sexual orientation as part of equalities monitoring requirements to inform future commissioning.

Working with NELFT and Bart’s Health we will carry out an audit of the people who are admitted to hospital who were recorded as not previously known to mental health services in the borough. We will use this information to help plan how to better support early access to community services for this group of people in the future and produce a report by 201 for action.

By 2015 the CCG will work with providers and the CSU to develop a clear action plan to implement both the information flows and costing’s behind the mental health tariff. This will involve assessment of risks and setting up revised contracts to reflect the new policy.
### By 2015 the CCG will work with LWBF to inform and influence the Health and Well Being Board so that Mental Health is part of the regular process of monitoring improvements in care. The indicators supplied in annex 3 may help inform this action.

**March 2015**

Further discussion required.

Dr Anwar Kahn, Dr Samuel, Terry Huff, CCG

Parity of esteem evidenced for NHSE. No Health without MH approach adopted which delivers integrated care and recognises at the top level the importance of this strategy for health outcomes and reduction in costs across the whole system.

### By 2015 the CCG will work with LWBF to review the MH programme budget spend with a view to looking in the light of MH Tariff how we can support and develop prevention and out of hospital care. This will include producing a financial annex to this plan and involve assessment of risks of not taking a longer term view on mental health budgets given the increasing population and change in demography. This will inform the refresh of the plan in 2016/7.

**By March 2015**

Further discussion required.

Les Borritt with LWBF finance lead; Jane Mehta and Pratima Solanki with support from Chris Soltysiak and Dr Samuel

Current system in the long term is not affordable. Part of 5 year planning and work on how to deliver QIPP by greater integration and strategic commissioning across health and social care.

### In developing any task group for major transformation or implementation of any major work stream in this strategy, we give a commitment to always engage with a user and carers in taking things forward as part the group and to consult where necessary. We will also seek advice from the CCG’s reference group for stakeholder engagement if this is appropriate.

**Ongoing**

Part of the CCGs Engagement plan already in place. Chris Soltysiak and Dr Samuel will help engage with Health watch during 2014/5 to promote this objective for this plan.

All above work stream leads. Dr Samuel and Alan Wells OBE PPI CCG board lead. Anna O’Sullivan. LWBF officers as required.

Better implementation of the strategy and recognition that we are here to improve care for local people. Less “diversionary costs” by not having to explain proposals retrospectively.

**END.**
ANNEX 2 - How does the strategy will help meet the objectives in the national mental health strategy “No Health without Mental Health”

The diagram below summarises how we believe our objectives and the context of this strategy will deliver against the national outcome indicators, and details the links to the national NHS, Public Health, and Adult Social Care Outcome Framework indicators.

<table>
<thead>
<tr>
<th>No health without mental health outcome</th>
<th>Vision statement objectives</th>
<th>Linked indicators from national outcomes frameworks</th>
</tr>
</thead>
<tbody>
<tr>
<td>More people will have good mental health</td>
<td>People will have access to a range of preventative and health promotion services</td>
<td>People with dementia prescribed anti-psychotic medication</td>
</tr>
<tr>
<td></td>
<td>Mental health awareness across our communities, schools and employers and in the health, social care and education workforce will improve</td>
<td>People in prison who have a mental illness or significant mental illness</td>
</tr>
<tr>
<td></td>
<td>At risk communities will have access to targeted preventative support</td>
<td>Emotional well-being of looked after children</td>
</tr>
<tr>
<td></td>
<td>People will have timely access to specialist mental health services</td>
<td>Self-reported wellbeing</td>
</tr>
<tr>
<td></td>
<td>People will have access to high quality mental health support in primary care, including GP practices and primary care psychology</td>
<td>Suicide rate</td>
</tr>
<tr>
<td>More people with mental health problems will recover</td>
<td>People will have access to high quality mental health support in primary care, including GP practices and primary care psychology</td>
<td>Access to community MH services by people from BME groups</td>
</tr>
<tr>
<td></td>
<td>People will have timely access to specialist mental health services</td>
<td>Access to psychological therapy services by people from BME groups</td>
</tr>
<tr>
<td></td>
<td>People will receive a diagnosis and appropriate support as early as possible</td>
<td>Placeholder: Access to psychological therapies</td>
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<tr>
<td></td>
<td>People will be able to access timely crisis resolution, close to home</td>
<td>Recovery following talking therapies (all ages and &gt;65)</td>
</tr>
<tr>
<td></td>
<td>People will have access to support from peers and service user-led services</td>
<td>Estimated diagnosis rate for people with dementia</td>
</tr>
<tr>
<td></td>
<td>People will be able to make choices about their care, including through personal budgets</td>
<td>Proportion of adults in contact with secondary mental health services in paid employment</td>
</tr>
<tr>
<td></td>
<td>People will feel supported to develop relationships and connections to mainstream community support</td>
<td>Placeholder: Dementia, measure of effectiveness of post-diagnosis care in sustaining independence and improving Quality of Life.</td>
</tr>
<tr>
<td></td>
<td>People will have access to support to find employment, training or education</td>
<td>Mental health readmissions within 30 days of discharge</td>
</tr>
<tr>
<td></td>
<td>People will have access to accommodation that meets their needs, in the borough</td>
<td>Proportion of adults in contact with secondary mental health services in paid employment</td>
</tr>
<tr>
<td></td>
<td>People will have access to a range of preventative and health promotion services</td>
<td>Adults in contact with secondary mental health services who live in stable and appropriate accommodation</td>
</tr>
</tbody>
</table>
| More people with mental health problems will have good physical health | People in general settings like schools and hospitals will have access to mental health support  
When they need to access multiple services, people will feel that they are joined up  
People will have access to high quality mental health support in primary care, including GP practices and primary care psychology  
People with a mental health problem will have high quality support with their physical health  
Mental health is everybody’s business | People with severe mental illness who have received a list of physical checks  
Severe mental illness: smoking rates  
Excess under 75 mortality in adults with serious mental illness  
Health-related quality of life for people with a long-term mental health condition |
| More people will have a positive experience of care and support | People will have access to improved information on what services are available  
People will feel that mental health services treat them with dignity and respect, and inspire hope and confidence  
Families and carers will feel more supported  
People will experience smooth transitions between services | Patient experience of CMH services |
| Fewer people will suffer avoidable harm | Focus on quality improvement | Hospital admissions as a result of self-harm |
| Fewer people will experience stigma and discrimination | Fewer people will experience stigma and discrimination  
Mental health awareness across our communities, schools and employers and in the health, social care and education workforce will improve  
Shared values: a whole person approach |  |
### ANNEX 3: Summary of mental health specific indicators in the NHS, Public Health and Adult Social Care Outcomes Frameworks

<table>
<thead>
<tr>
<th>Framework</th>
<th>Domain</th>
<th>Indicator (note indicators highlighted in orange are in the CCG outcome indicator set)</th>
</tr>
</thead>
</table>
| NHS Outcomes Framework | Domain 1: Preventing people from dying prematurely | People with severe mental illness who have received a list of physical checks  
Severe mental illness: smoking rates  
Excess under 75 mortality in adults with serious mental illness |
| | Domain 2: enhancing QoL for people with LTC | Access to community MH services by people from BME groups  
Access to psychological therapy services by people from BME groups  
Recovery following talking therapies (all ages and >65)  
Health-related quality of life for people with a long-term mental health condition  
Estimated diagnosis rate for people with dementia  
People with dementia prescribed anti-psychotic medication  
Employment of people with mental illness  
Placeholder: Measure of effectiveness of post-diagnosis care in sustaining independence and improving QoL |
| | Domain 3: Helping people to recover from episodes of ill health/injury | Placeholder: Access to psychological therapies  
Mental health readmissions within 30 days of discharge  
Proportion of adults in contact with secondary mental health services in paid employment |
| | Domain 4: Ensuring people have a positive experience of care | Patient experience of CMH services |
| Public Health Outcomes Framework | Domain 1 Improving the wider determinants of health | Adults in contact with secondary mental health services who live in stable and appropriate accommodation  
People in prison who have a mental illness or significant mental illness  
Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness |
| | Domain 2: Health improvement | Hospital admissions as a result of self-harm  
Emotional well-being of looked after children  
Self-harm  
Self-reported wellbeing |
| | Domain 4: Healthcare public health and preventing premature mortality | Excess under 75 mortality in adults with serious mental illness  
Suicide rate  
Estimated diagnosis rate for people with dementia |
| Adult Social Care Outcomes Framework | Domain 2: Enhancing QoL for people with care and support needs | Proportion of adults in contact with secondary mental health services in paid employment |
| | Domain 2: Delaying and reducing the need for care and support | Proportion of adults in contact with secondary mental health services living independently, with or without support  
ANNEX 4: Brief Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>APC</td>
<td>Area Prescribing Committee</td>
</tr>
<tr>
<td>APMS</td>
<td>Alternative Provider Medical Services</td>
</tr>
<tr>
<td>AQP</td>
<td>Association of Quality and Participation</td>
</tr>
<tr>
<td>BCF</td>
<td>Better Care Fund – a fund where health and social care pool resources to improve pathways from hospital to out of hospital care</td>
</tr>
<tr>
<td>BHRUT</td>
<td>Barking, Havering, Redbridge University Hospital Trust</td>
</tr>
<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child &amp; Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive behavioural therapy</td>
</tr>
<tr>
<td>CRT</td>
<td>Community Recovery Team</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>CSU</td>
<td>Commissioning Support Services</td>
</tr>
<tr>
<td>CPN</td>
<td>Community Psychiatric Nurse</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardio Vascular Disease</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CMHT</td>
<td>Community Mental Health Teams</td>
</tr>
<tr>
<td>CMDS</td>
<td>Community Mental Health Data Set</td>
</tr>
<tr>
<td>DTG</td>
<td>Drug Therapeutic Group</td>
</tr>
<tr>
<td>DSH</td>
<td>Deliberate Self Harm</td>
</tr>
<tr>
<td>DGH</td>
<td>District General Hospital</td>
</tr>
<tr>
<td>ELFT</td>
<td>East London Foundation Trust</td>
</tr>
<tr>
<td>EDMR</td>
<td>Eye Movement Desensitisation and reprocessing</td>
</tr>
<tr>
<td>GAD</td>
<td>Generalised Anxiety Disorder</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
</tr>
<tr>
<td>ICM</td>
<td>Integrated Care Management</td>
</tr>
<tr>
<td>IAPTs</td>
<td>Improving Access to Psychological Therapies</td>
</tr>
<tr>
<td>ICP</td>
<td>Integrated Care Pathway</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment done by Public Health</td>
</tr>
<tr>
<td>LMC</td>
<td>Local Medical Committee</td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Condition in mental health</td>
</tr>
<tr>
<td>LSE</td>
<td>London School of Economics</td>
</tr>
<tr>
<td>LBWF</td>
<td>London Borough of Waltham Forest</td>
</tr>
<tr>
<td>LA</td>
<td>Local Authority</td>
</tr>
<tr>
<td>LSU</td>
<td>Low Secure Unit in mental health – usually a locked or monitored inpatient environment</td>
</tr>
<tr>
<td>MUS</td>
<td>Medically Unexplained Symptoms</td>
</tr>
<tr>
<td>NCA</td>
<td>Non Contracted Activity</td>
</tr>
<tr>
<td>NELFT</td>
<td>North East London Foundation Trust</td>
</tr>
<tr>
<td>NELC or NELCSU</td>
<td>The local commissioning support unit for Waltham Forest CCG</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute of Health and Clinical Excellence</td>
</tr>
<tr>
<td>OCD</td>
<td>Obsessive Compulsory Disorder</td>
</tr>
<tr>
<td>QOF</td>
<td>Quality and Outcomes Framework for primary care and GPs</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post Traumatic Distress Disorder</td>
</tr>
<tr>
<td>PBR</td>
<td>Now called Mental Health Tariff – a way of paying for care in mental health services</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust – now replaced by CCGs and different health organisations</td>
</tr>
<tr>
<td>QIPP</td>
<td>Quality Innovation Productivity &amp; Prevention</td>
</tr>
<tr>
<td>RAID</td>
<td>Rapid Assessment Interface and Discharge [Psychiatric Liaison in acute hospitals]</td>
</tr>
<tr>
<td>RCTs</td>
<td>Random Control trials. A research method to prove effective care</td>
</tr>
<tr>
<td>SMI</td>
<td>Serious Mental Illness. A common term used for severe mental illness and psychotic disorders</td>
</tr>
<tr>
<td>SCIE</td>
<td>Social Care Institute of Excellence</td>
</tr>
<tr>
<td>WXUH</td>
<td>Whipps Cross University Hospital</td>
</tr>
</tbody>
</table>
### ANNEX 5 – Acknowledgements and contributors.

The following colleagues have helped to shape the ‘Better Mental Health’ strategy, including regular members of the mental health strategy working group.

Please can we also thank all the individuals and organisations who responded to “formal consultation” - The feedback helped refresh the priorities and content for the strategy into its current version.

Over the last 12 months the CCG has been working with other CCGs across London. We should thank all the people who have helped develop the ideas and priorities for change that are given in this document as a result of regular discussion.

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</tr>
</tbody>
</table>
Document version control

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Contact us

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