

# Mental Health Community & Crisis Pathway Transformation

10<sup>th</sup> April 2019

Version 3.0

## Report to Health & Wellbeing Board

A new way to deliver community and crisis mental health services for people with chronic & serious mental illness

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# Background: Engagement & co-production

- Transformation Workshop (MHPB) – June 2018
- All MHPBs transformation is a standing item – monthly 2018
- Grassroot events – July 18 & November 18
- Community Hub Delivery Group 17 September 18
- Enhanced Primary Care Delivery Group 14 September 18
- Community Hub Delivery Group 1 October
- Croydon MH Forum (Hear Us) - February 2019
- Healthwatch Croydon. Meet the Changemakers Mental Health - July 2018
- With Public Health - Thrive London Borough wide event - July 2018

## **Other Grass roots events**

- with South-west London Association for Pastoral Care in Mental Health -Sept 2018
- With AGE UK & ASKI BME Elders - MH prevention - March 2017 & May 2018
- Croydon College - LGBT group - June 2018
- Engagement will continue with design and development based on principles of

**Recurring themes:** services feel fragmented, hard to access, poorly-tailored to different BAME communities, too focused on crisis and reactive treatment not well-being and prevention; a need to rebalance this and ensure a greater role for 'Navigators' to support people, for 'champions' embedded in community groups, third sector and peer support, self-care and opportunities to improve well-being through work, social activities and exercise.

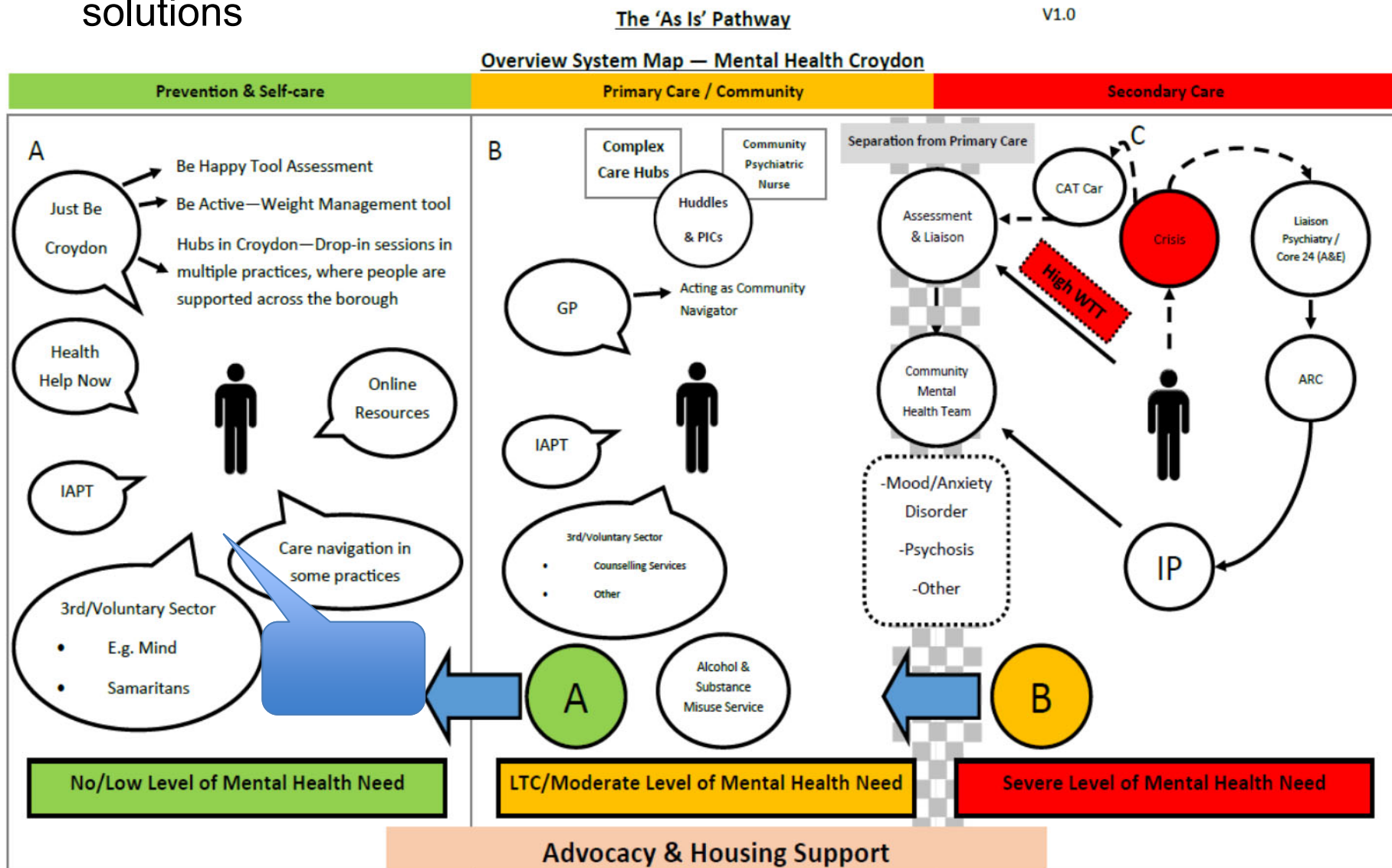
## Estimation of need / unmet need

- A high-level of mental illness and need exists in Croydon.
- The prevalence of long-term, complex mental health needs higher in Croydon than the national average, with an NHSE mental health needs index of 1.21 (where 1.0 is the national average), making it comparable to many inner-London, high-prevalence London Boroughs
- The CCG has a registered Serious Mental Illness Population of 4,610 people, or 1.11% of the adult population (QOF 2017/18). People with SMI are responsible for a lot of activity: A&E visits, calls to 999, high re-admission rates etc; and they experience long lengths of stay
- In addition, whilst no formal GP register exists, there is a significant group of people - numbering c16,000 - with complex non-psychotic conditions such as severe anxiety, depression and personality disorders
- Need profiles vary across the Borough, from more affluent areas to more deprived, each presenting mental health and well-being support needs
- Primary care support for people with Serious Mental Illness (SMI) is poor when compared with the national picture: 5.5% achievement (of SMI population) compared to national averages of 24.2% (top achievers > 45%).
- Engagement with service users has illuminated significant 'unmet need', particularly out-of-hours, in non-clinical community settings and involving non-medical social interventions and support, such as social prescribing and assistance with housing, benefits inter alia.
- The needs of service users are complex, numerous and varied: there is a strong case for combining physical, mental and social health services in a single 'wellbeing offer'.



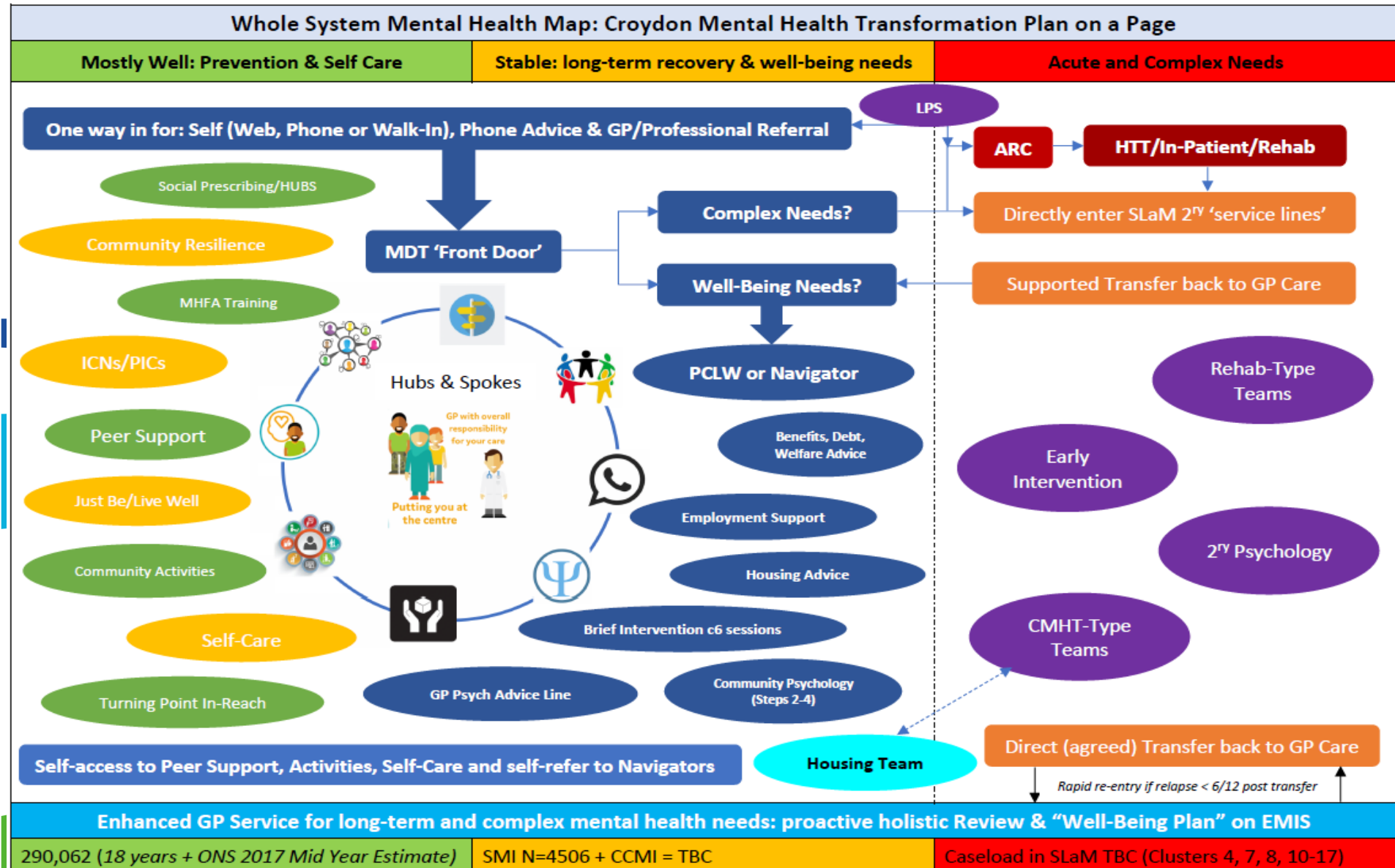
# 'As Is' Pathway Map ; Gaps in Services

- In May-18, we developed 'As Is' pathway to take stock of the current Mental Health offer, identifying issues, gaps and potential solutions



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# New System: 'As Will Be' Pathway Map



# 1 PRIMARY CARE

- Primary care services do not meet the physical health or mental health needs of people with SMI or other mental health patient cohorts, meaning it is very difficult to discharge patients into the care of their GP.
- Increased physical health checks, increased availability of talking therapies and other 'wrap-around' social support, and longer appointment times are required to meet the needs of people with mental illness.
- GPs currently do not have access to consultant psychiatrist advice and support.
- We need more proactive population-based approach: enabling GPs and the community to promote and retain well-being: social, mental & physical 'living well' and 'managing well'
- GPs need more time to go 'above and beyond' for complex MH needs patients: bio-psycho-social care planning with follow up time, in-year review, measuring impact. A dedicated GP advice line could support more people to 'manage well'.



## 2 SECONDARY CARE

- The existing secondary pathway isn't working: waiting times are too long, there are multiple teams/assessments, and services are inefficient/duplicative, and suffer from poor productivity, and variable support for Primary Care/GPs. **Integrated multi-agency and multi-disciplinary teams spanning across health and social care, and operating out-of-hours and in community settings are required to meet patient need and deliver effective and efficient services.**
- Acute services are delivered in distinct separate silos and are not integrated seamlessly with community services; furthermore, handovers between different organisations (both health and social care) can be problematic and there is no links with community-based voluntary sector provision. **A seamless, singular access route is needed for assessment and access to SLaM.**
- Bed Occupancy Rates at SLaM are c120% and average length of stay is 58 days – compared to a national average of 30 days – illustrating a high level of difficulty in facilitating early or timely discharge of patients. Mental health patients are being kept on wards longer than is clinically appropriate and this has adverse consequences for patient outcomes. **Without community-based alternatives SLAM are unable to apply appropriate clinical thresholds; and the CCG is unable to initiate a programme of 'Shifting Settings of Care' to transfer activity out of acute settings and into community settings.**

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## 3 COMMUNITY CARE

- Psychiatric liaison services and crisis response and treatment services are not available out-of-hours 24/7, nor in accessible community. On any typical weekend A&E will host several people with only mental health problems who are not able to access suitable treatment or assessment and breach the 4-hour waiting time target.
- Some secondary care services feel off-putting and overly-clinical to service users: de-stigmatizing, welcoming community-based spaces are needed. Whilst MIND and a few other voluntary sector organisations provide drop-in centres offering wrap-around social support (employment, benefits, housing etc), there exists no comprehensive or collaborative approach towards community-based support for people with mental health problems.
- Long waiting times, high levels of referrals (currently no self-referrals are accepted) and extremely over-subscribed services demonstrate high levels of unmet need for social 'wrap-around' support in the community.
- To 'patch a gap' in services, Croydon experiences the inefficient and ineffective stop-gap measure in which scarce clinical professionals are providing social support to patients in order to improve treatment and facilitate discharge.
- Service users in crisis do not have a Single Point of Access to assessment and treatment linked in to 111; and they either present at A&E or call 999.
- There is a need to co-locate services and staff in locality Hubs, with far-reaching community spokes to ensure they are accessible and localized and reflect diverse needs.





# Woodley Review

The Woodley Review echoed the issues on the preceding slides, emphasising:

- Long waiting times.
- Delays in hospital admission.
- Voluntaries disenfranchised from decision making & strategic thinking.
- Commissioners working in silos

and making the following recommendations which are picked up in the Transformation work:

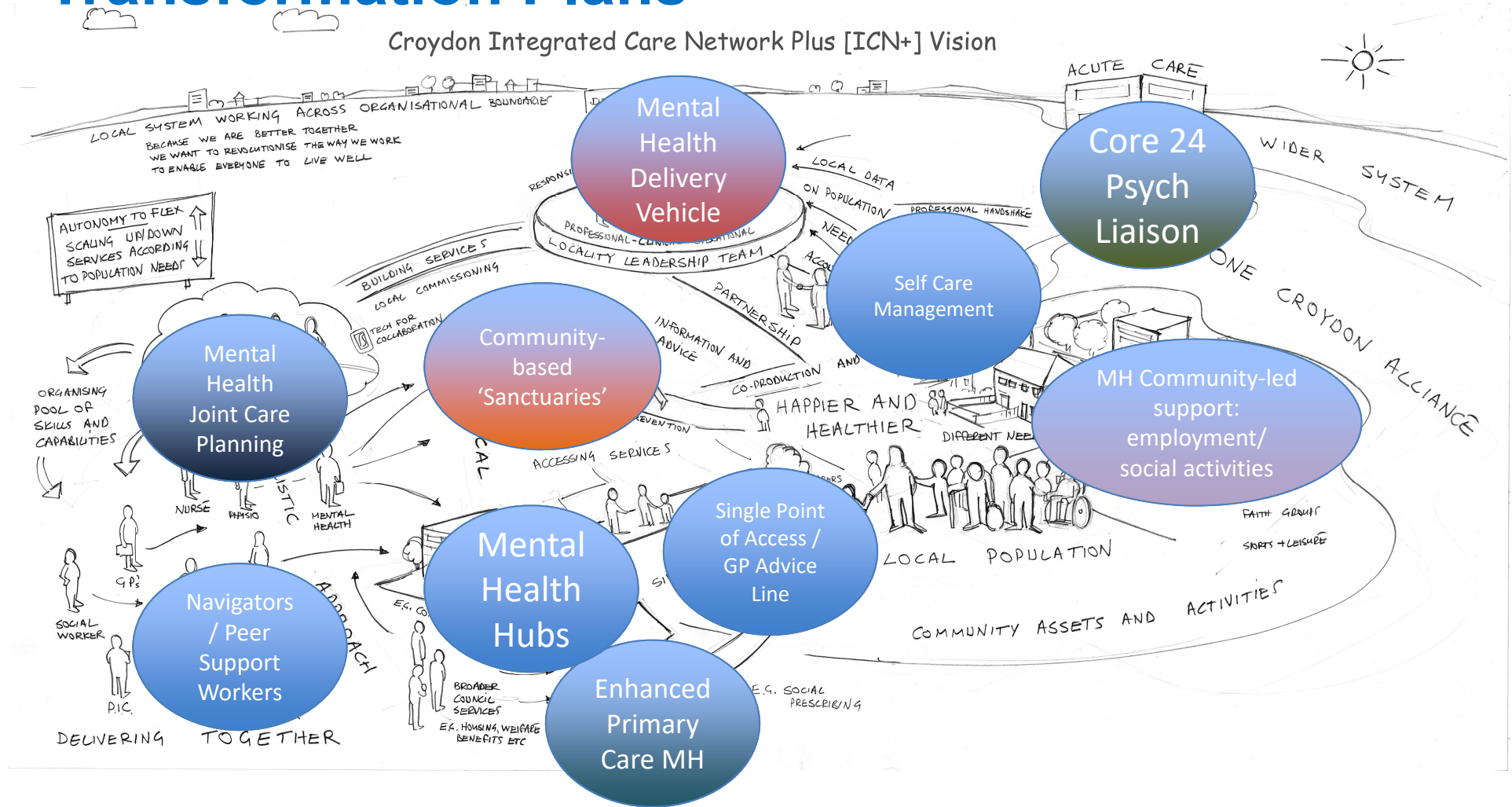
- Shifting resources towards earlier intervention and prevention with an emphasis on:
  - Well-being & primary care,
  - mentally healthy communities,
  - importance of good physical health,
  - suicide prevention,
  - concentrate on high risk factors: loneliness, schools, debt / financial challenge
- Co-production in service design, help build community capacity & ensure adequate focus on BAME communities.
- Better partnership working through improved governance oversight of the MH strategy & improve contract monitoring processes.
- Use existing service user & stakeholder forums.
- explore opportunities to use technology.

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# Draft ICN+ Vision, overlaid with MH Transformation Plans

Croydon Integrated Care Network Plus [ICN+] Vision



presented to CTB 21st March

# Overview Model of Care: what's in scope

Croydon's New Integrated Mental Health & Well-Being Model of Care: our vision on a page.

### For the whole system

- Centre of community for mental health & well-being
- Mental Health expertise into locality 'gateway' centres
- Crisis avoidance should reduce MH presentation to A&E
- Reduced reliance on secondary MH
- Reduced reliance on A&E as default
- Reduced OBDs – in MH and acute hospital
- Strong links to ICNs, Huddles & with PIC
- Right care, right time, right place.

### For Service Users & Carers

- Non-clinical, warm and welcoming environment
- Single way in for all non-crisis MH services
  - Walk-In, Telephone and Self-Referral
  - Find or keep paid work or volunteering
- Expert advice on debt, benefits & housing
  - Peer support and social activities
  - Care and support to match needs
- One care plan, services wrapped around you
- Convenient locations: Hubs and Spokes
- Supportive, instilling hope and well-being
  - Accessible opening hours



### For providers

- Co-location in Hubs & Spokes.
- Partnership for Integrated Care.
- Better waiting times management.
- Co-location of staff = easier co-working.
- Easier flow of people across pathways.
- Whole population approach: less reactive, more planned care.
- MDT approach – enabling whole person support and care for clients.
- Efficiency via Shared IT, Comms/Marketing, Branding, Website, Back Office and Management.

### For GPs

- Single point for all 1<sup>st</sup> and 2<sup>nd</sup> MH need
  - Dedicated GP clinical advice line
- Direct admission to 2<sup>nd</sup> without re-referral
  - One stop access to all services
- Community-embedded Psychiatry Service
  - JPN and H&SC Navigator Case Management
  - Single MDT Careplan on EMIS
- Support and services delivered in Practices where possible
- Primary access to IAPT and Step 4 Community Psychology



**Enhanced GP Service for Serious and Complex Mental Health Needs: Annual Bio-Psycho-Social Review & Well-Being Plan**

*Single Care Plan on EMIS, extended appointments, proactively drawing on services integrated services in new model of care*

# Phased Delivery: high level summary

(Draft – subject to approval)

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## Phase One A. & B.

### **Initial development and core service integration / Piloting and Evaluation of Test Sites (2019/20)**

Delivery Group Terms of Reference refreshed and used as a developmental Task & Finish Group  
A 'Mental Health Alliance Group' established as part of One Croydon Delivery Group  
GP Advice line to be launched Q1  
Review of Advice Line in Qs 3 & 4  
Review of management information from SLAM CMHT Q1 (Management Information CQUIN) Q1  
LCS to be launched Q2 /Q3  
Potential LCS Pilot test site in New Addington developed with TfL funding Q3  
Enabling programmes & contractual levers and incentives developed and implemented Q1/Q2 - including business intelligence, Organisational Development, IT, Comms, SDIP – managed by post within the One Croydon Programme Office  
Implementation of Hub Pilot stage at either MIND or Edridge Road Community Health Centre in Q3  
New community pathways implemented and piloted in Q2/3

## Phase One A. & B.

### **Full Model Developed and Implemented 2021 / 2021/22**

Locality Hubs – x3 sites – developed and implemented from 2021 onwards  
Full LCS scheme implemented in 2020/21  
SLAM OBD Trajectory achieved in Q4 2020/21  
Shifting Settings of Care Programme developed and implemented to transfer patients from acute to community settings, once Locality Hubs and LCS are fully operational and capacity exists in Primary Care and Community Settings 2020/21  
Schemes and operations externally evaluated and reported to governance boards

# Finance: realising benefits and releasing savings for reinvestment in transformation

- The key design principles of the Transformation are improving patient outcomes through better provision of primary care and community-led support
- It follows therefore that we should see savings delivered through reductions in A&E attendance, admissions and re-admissions
- The principle means of funding the investment required will be a reduction in OBDs ; SLAM have provided a trajectory to reduce bed occupancy from 120% to 85%
- Work is required to identify the interventions required to accompany this transformation work to deliver this trajectory
- 2018/19 Winter Monies were secured for a 'Discharge Facilitator' – the impact of the role on OBDs will be evaluated and a decision taken on whether further support in the role of a 'Patient Flow Coordinator' is required

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# Development of the Delivery Model through the One Croydon Alliance

- Business model to be completed
- Full Business Case approval
- Discussion at One Croydon commercial group regarding the options around incorporating MH transformation and how to work with wider partners in the system
- Identification of key partners for delivery
- Discussion with South London Partnership regarding complex patients and commissioning options
- Next steps discussion at Croydon Strategic Delivery Board and Croydon Transformation Board

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## Appendix I – Croydon Transformation Whole System Governance

