Croydon Mental Health Transformation Programme

June 2021

Version 1.0

Vision

Well co-ordinated mental health care and support in the most appropriate setting, which is truly person-centred and helps people to maintain their independence

The Challenge: The existing Model of Care is disproportionately provided in Acute settings particularly for people from Ethnic Minority backgrounds. There not being enough alternative provision in Primary Care and Community settings, provided by GPs, health and voluntary sector professionals, and peer support workers. Evidence demonstrates that patients spend too long in hospital, past the point of clinical effectiveness, and health professionals are spending a significant proportion of their working day providing support on non-health related social matters. Mental health patients report feeling support is over-medicalised, and they are not receiving the support they need to prevent poor mental health, self-manage their illness, and avert mental health crises. The current system of support for mental illness is both expensive and inefficient. The challenge is to provide alternative appropriate support – social as well as health related – in accessible settings at convenient times to avert crises, prevent admissions which includes appropriate alternative provision in community settings that promote well-being and recovery. The Model of Care therefore must be transformed to meet the need of the individual in the right place at the right time.

Objectives

The following are objectives of this business case:

- enable people to take responsibility for managing their own health and wellbeing in the most appropriate setting for them;
- deliver a Model of Care that ensures people are at the centre of their care, enabling them to achieve the outcomes that are important to them and promotes a shift in focus from dependency and ill health to independence and wellbeing;
- incentivise effective partnerships, providing care and support in and through the community;
- engage, empower and grow community networks and assets so they are responsive, timely and flexible to individual needs;
- reduce health inequalities and improve health and well-being outcomes across the borough;
- deliver transformation across the system in order to achieve optimum value for money and economies of scale and efficiency by leveraging resources and capabilities across the system.

Principles

- Acknowledging that the existing Model of Care is not optimum and is not supporting people to stay healthy in the community;
- And is not empowering people to look after themselves,
- Acting in accordance with the needs of people in Croydon, recognising the cultural diversity, the existing health inequalities, stigma and engrained attitudes;
- being collaborative, co-operative and timely in our approach to system transformation and decision making;
- invest, transfer funding appropriately to different settings of care to change the Model of Care;
- continuing to operate to principles of co-design and co-production through engagement with the people of Croydon and other key stakeholders, seeking their views and facilitating their involvement;
- committing to a culture that promotes innovation and transformation across the system, and organisational boundaries; making best use of available resources.
- The Model of Care and the Delivery Landscape will be based on that of the ICN+ and there will be close joint working.

Major Themes

Major themes and threads that run through the transformation work include but are not limited to:

- Tackling Inequalities
- Improving the transition from CAMHs to Adult MH Services
- Making the most of Digital Innovation
- Prevention and Public Health Mental Health: Education & Training
- Intervening ‘up-stream’ and averting crises
- Providing appropriate community-based alternatives to inpatient treatment / Depots in the community
- Social prescribing and emphasis on social support to prevent clinical crises
- Modelling the impact of increasing acuity and specialised support in secondary care settings
- Working in ‘alliance’, with outcome based commissioning and capitated budgets

Strategic Context – Phased Delivery of Vision

Our 'Blueprint' for delivering the 'vision': 'what good looks like'…

Phase 1: Meeting the Ambitions of the Five Year Forward View (FYFV)	Phase 2: Meeting the Ambitions of the NHS Long Term Plan	Phase 3: Shifting Settings of Care (Cultural Change; Workforce; Thresholds)
2019/20 – 2020/21 (Covid delayed starts)	**2021/22 – 2022/23**	**2023/24 – 2024/25**
Funding source: NHSE Crisis Transformation Fund **Strategic Aim:** Meeting the ambitions set-out in the 5yr Forward View (FYFV) • Establishment of a Recovery Space (crisis café) • Local Commissioned Scheme for SMI Health Checks and Longer Appointments • MH Advice Line for GPs • MH PIC workers in GP Huddles & ICN+ MDT's • Peer Support Workers • CMHT Restructuring • Stabilising Voluntary sector – longer contracts • MH Local Voluntary Partnership – Grant funded initiatives • strong focus on improving care for people with learning disabilities and autism • Strong focus on carers / families • IPS Wave 2 • Health Education England training for care coordinators	**Funding source:** Mental Health Investment Standard and Spending Review Allocation **Strategic Aim:** Meeting ambitions in NHS Long Term Plan • Establish a Pilot MH Wellbeing Hub – Open Access in Central area 2021/22, 2nd Hub North area 2022/23 • Intermediate supported accommodation for step down (Shared Lives – implementation started in 2020/21, Enhanced Crisis pathway in 2021/22) • MHW Hubs to work closely with each of the 6 ICN+ Localities & Talking Points (MHPICs) • Autism adapted support – Autism Strategy • Managing transition from CAMHs to Adult MH • Further support in workplace (awareness / resilience) • Ethnic Minority Focused Services - Ethnicity in Mental Health Improvement Programme (EMHIP)	**Funding source:** Mental Health Investment Standard / Shifting Settings of Care (i.e. transferring resource and activity from secondary care to community and primary care) **Strategic Aim:** meeting ambitions in NHS Long Term Plan / funding social care and housing • 3rd Hub in South area 2023/24 (may require 2 smaller hubs to cover the geography) • Benefits Realisation from phases 1 & 2 – Begin to see improved access, experience, and outcomes especially for Ethnic Minority Communities • Delivering a Modern Acute Mental Health Hospital • Shifting activity and resource from secondary care to primary care and communities • Enhancing primary care and community support further • Improved psychological support • Improved social care support

Mental Health Transformation Programme Plan

One Croydon
Your Health and Care partnership

All workstreams aim to address health inequalities & monitored quarterly with 6mthly evaluations to measure impact & system benefits

Agree what good looks like to address gaps
Design Phase

Test & Learn Approach
Evaluations 6mthly
Phase 1

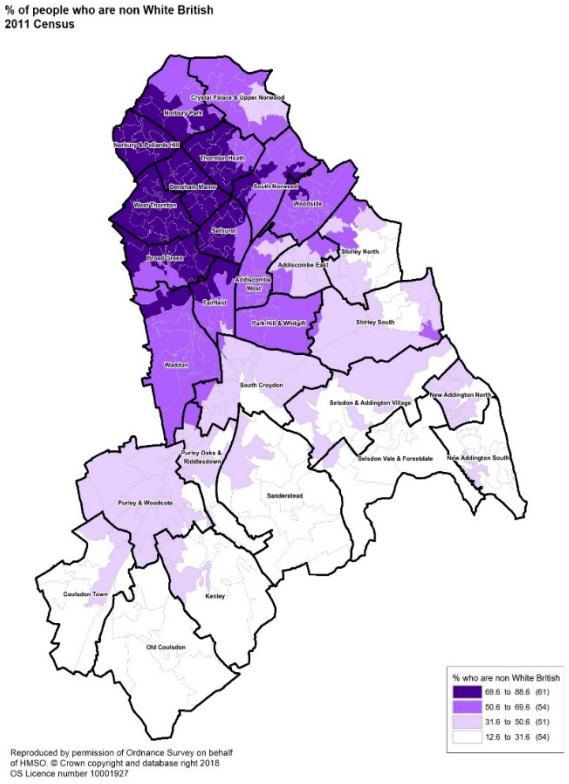
Adjust workstreams & implement phase 2

Adjust workstreams & implement phase 3
Commission Service

Scheme	2019/2020	2020/21	2021/22	2022/23	2023/24
Mental Health Local Voluntary Partnership Initiatives: (over 2yrs) • Turkish Youth & Community Association – MH Community Development Worker (CDW) • Asian Resource Centre Croydon – MH Champions • Croydon BME Forum – Wellness Advisor in addition to CDWs • Croydon Drop-in – Young Adult Transitions • Body & Soul – Legal, Practical Support & Counselling for HIV+ sufferers • Disability Croydon – MH Drop-in Centre & Café and access to digital support • Palace for Life Foundation – Coping through football (SMI Focus) • Mind in Croydon – Counselling creating surge capacity	One Croydon Local Voluntary Partnership Approach underway led by Council.	Mental Health Grant funding agreed with invitations to bid and 8 successful initiatives starting Mar'21	Quarterly Monitoring to evaluate impact and adjust service delivery where required	Evaluation of impact at 12-18mths to inform commissioning decisions for contracting Apr'23 onwards	
Recovery Space – alternative Safe Space to A&E for MH crisis. 6mths evaluation May 2021, 12mths Nov	Plans developed but delivery delayed (Covid)	Delivered Oct'20	12mth Eval decision to commission	18mth pilot ends – Commission Service	
MH Wellbeing Hubs / ICN+ Localities – "One stop" single point of access approach to delivering an integrated mental health offer.	Planning started Oct'19	Hub 1 Sept'21	Hub 2 Apr'22	Hub 3 Apr'23 – Commission Service	
Reshaping Secondary Care Community MH Services – simplifying the specialist mental health offer that aligns with MHW Hubs & ICN+ Localities. Phase 3 implementation to scale from Apr21	Phase - engagement, co-production & design	Phase1	Phase 2	Phase 3 implement at scale Generic Teams aligned to hubs, PCNs/ICN+	
Mental Health Personal Independence Co-ordinators (MH PICs) – A new Voluntary sector role to provide practical support for people experiencing MH issues across primary/secondary care. Mobilised Mar21. 6mth Evaluation by Q3	Planning started Oct'19	MHPICs start Apr'21	12mth Eval decision to commission	Hub 3 Apr'23 – Commission MHPIC Service	
Mental Health Assessment Unit (MHAU) at CUH – Full Business Case Feb 2021 to establish a MHAU near to the ED at CUH. Mobilisation by end of May21. 6mth evaluation due by Dec21		Phase - engagement, co-production & design	Delivered May'21	6mth Eval decision to commission	Commission Service
PHB for Mental Health - To test/pilot options to offer people (s117) a Personal Health Budget	Delayed (Covid)	Pilot delivered Q1'21	6 & 12mth Evaluation decision to commission		Commission Service
Shared Lives Enhanced Pilot – to enhance the shared lives scheme and offer placements to support people to avoid crisis admissions and also to step down people from inpatient beds.	Plans developed but delivery delayed (Covid)	Delivered Jan'21	12mth Eval decision to commission		Commission Service

Improving Outcomes for Ethnic Minority Communities

The Croydon transformation workstreams have initially focused on establishing the new infrastructure and roles e.g. Recovery Space, MHPICs hosted by Voluntary Sector in the Community to shift the emphasis from Acute inpatients to prevention and early intervention in the Community. This includes effective mental health service integration with physical health developments e.g. ICN+ Localities.
Diversity has underpinned each step, building on the engagement events. Co-production of design, recruitment of staff with Croydon BME Forum in Partnership with Mind to deliver MHPICs and MHW Hubs, and establishing Ethnic Minority champions to change practice, enable culturally sensitive service provision, and inform operational and commissioning decisions.



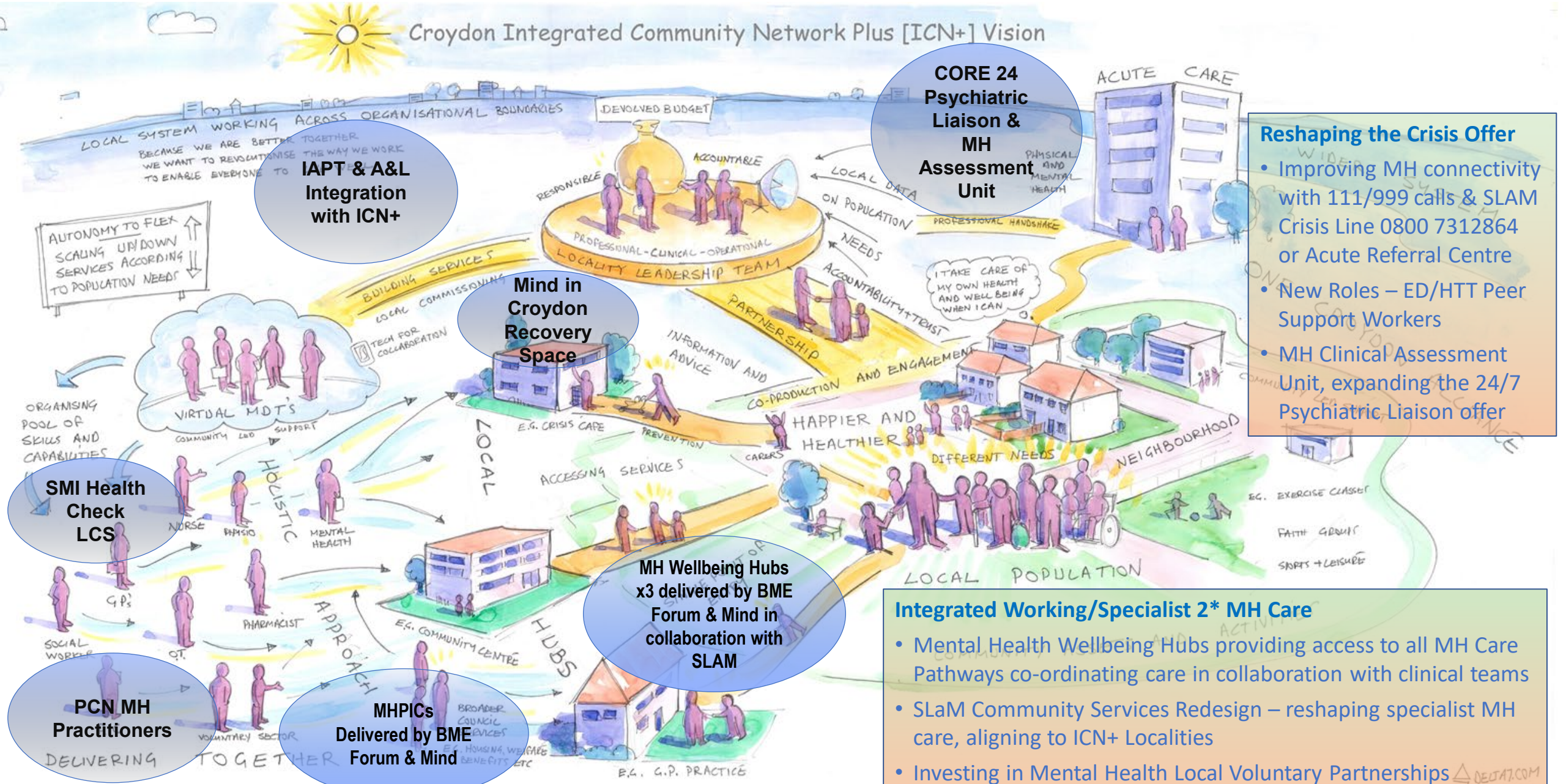
Ethnic Minority Interventions:

- Establish a Recovery Space (crisis café) with robust statutory referral links. Oct' 2020
- Recovery Space to increase referral sources e.g. GP's, CMHT's (Q4 2020/21) and to target specific under-represented communities (Q2 2021/22)
- Establishing new community based Mental Health Wellbeing Hubs. Contract awarded to Croydon BME Forum in partnership with Mind in Croydon. To start Q2 2021/22.
- New MH Personal Independence Coordinators (MHPICs) roles in place April 2021. Specifically recruited to ensure diversity, developing as Ethnic Minority champions and to target hard to reach communities.
- MH Local Voluntary Partnership Grant – the successful initiatives provide essential community development roles as spokes to the MH Wellbeing Hubs. Mar' 2021.
- Peer Support workers in Crisis Pathway initiatives e.g. MH Assessment Unit, HTT
- Right Care, Bed Flow and reshaping of SLaM MH Services enables better alignment with the MH Wellbeing Hubs, Spokes and new roles. Enabling the appropriate changes in practice to take place and creating culturally sensitive service environments.

NEXT STEPS:

- Ensure effective reporting of Ethnic Minority outcomes to further inform operational and strategic decision making across the health and care system.
- 'Test and Learn' approach to implementation allows for quick adjustments to service provision
- Robust local governance and commitment to ensuring a focus on Ethnic Minority communities at every organisational level of the decision making process.

Where we are….. Mental Health Transformation – Improving Outcomes



IAPT & A&L Integration with ICN+

CORE 24 Psychiatric Liaison & MH Assessment Unit

Mind in Croydon Recovery Space

SMI Health Check LCS

MH Wellbeing Hubs x3 delivered by BME Forum & Mind in collaboration with SLAM

PCN MH Practitioners

MHPICs Delivered by BME Forum & Mind

Reshaping the Crisis Offer

- Improving MH connectivity with 111/999 calls & SLAM Crisis Line 0800 7312864 or Acute Referral Centre
- New Roles – ED/HTT Peer Support Workers
- MH Clinical Assessment Unit, expanding the 24/7 Psychiatric Liaison offer

Integrated Working/Specialist 2* MH Care

- Mental Health Wellbeing Hubs providing access to all MH Care Pathways co-ordinating care in collaboration with clinical teams
- SLaM Community Services Redesign – reshaping specialist MH care, aligning to ICN+ Localities
- Investing in Mental Health Local Voluntary Partnerships

Milestones & Communications Plan

Aims and Objectives
To facilitate broad stakeholder engagement with the development of each initiative
To ensure there is ongoing communication about the MH offer & changes
To ensure people are aware of new initiatives going live

Key	Indicator
Engagement, Development, Delivery of New Initiative	●
Go Live (Evaluation ready)	☆

Key Milestones	March 2020/21	Apr 2020	May 2020	June 2020	Q2 2020/21	Q3 2021/22
1. **Recovery Space** – alternative Safe Space to A&E for MH crisis. 6mths evaluation for MHPB in May 2021, 12mths Nov	●	●	☆	●	●	☆
2. **Community MH & Wellbeing Hubs / ICN+ Localities** – "One stop" single point of access approach to delivering an integrated mental health offer.	●	●	●	☆	●	●
3. **Reshaping Secondary Care Community MH Services** – simplifying the specialist mental health offer that aligns with MHW Hubs & ICN+ Localities. Phase 2 test & learn by 31/03/21. Phase 3 implementation to scale from Apr21	●	☆				
4. **Mental Health Personal Independence Co-ordinators** (MH PICs) – A new Voluntary sector role to provide practical support for people experiencing MH issues across primary/secondary care. Mobilised Mar21. 6mth Evaluation by Q3	☆	●	●	●	●	☆
5. **Mental Health Assessment Unit (MHAU) at CUH** – Full Business Case developed by Feb 2021 to establish a MHAU near to the ED at CUH. Mobilisation by end of Apr21. 6mth evaluation due by Dec21	●	☆	●	●	●	☆
6. **PHB for Mental Health -** To test/pilot options to offer people a Personal Health Budget for those under s117 MHA	●	●	●	☆		
7. **Shared Lives Enhanced Pilot** – to enhance the shared lives scheme and offer placements to support people to avoid crisis admissions and also to step down people from inpatient beds. 6mths Evaluation	☆	●	●	●	●	☆
8. **Mental Health Local Voluntary Partnership (LVP) Programme** – Funding round with a focus on capacity building for local voluntary sector services to bid on services that support wider community transformation	☆	●	●	●	●	☆

Summary of Outcomes: Expected Benefits Realised

	Benefit	Saving
Service User	Improved Patient Access, Experience & Outcomes Care at the Right Place, Right Time Better physical health for SMI	QALYs Improvements for society / employment Reduced DALYs and improved wellbeing; better management for LTCs
A&E	Reduce mental health presentations to London average (e.g. not 20% year on year , but 10% increase for now) – 200 less people	Reduces breaches; enables CUH to hit target; better patient experience
Non-elective Acute CHS Admissions	Reduce by 10-20% (c1000)	£1,000,000
Acute SLAM Admissions	Reduce ALOS from 53.5 to national median 32 days Bed Occupancy reduced (1st year) from 120% to 100% ; subsequent years to c85%	£585k (QIPP potential) (full reduction is £1.7m) Patient experience more clinically appropriate support in community settings
Police / LAS	Conveyancing reduced by 15-20% ; reduce calls to LAS by 30%. Police calls due to mental illness – reduce by 1/3	System wide savings; and also patient experience
Social Care	To be evaluated: Lambeth experience shows use of supported accommodation down by 80% and increase in domiciliary care by 50%	Indicating more independent living

Before & After Case Study – MH Wellbeing Hub

Amy is 37. She has had a diagnosis of Schizophrenia for 15 years and has been living very stably for the last decade when she presented to her GP distressed, feeling paranoid and like she was losing control of her life. Having lost one of her two part-time jobs, she has fallen into arrears with her Housing Association. She ignored the last two letters, but on Friday received a letter threatening her with eviction should she fail to respond to this final notice. She is also being depressed about the weight she's gained on her medication, and she admits to skipping doses and to smoking cannabis to help her relax, due to the stress.

BEFORE

Amy's GP is very concerned about her mental state and welfare. She feels that a medication review is essential and agrees to refer her back to her old CMHT for this. The waiting time to be seen is roughly 10 weeks, she is told, and they will contact Amy directly at her address. Amy is at imminent risk of losing her tenancy, which doesn't meet the criteria as an urgent referral.

Her GP then advises her about a Citizen's Advice service run by the Council and suggests she goes there to get support with her flat and suggests they may also be able to give her debt advice. They can also be accessed on-line.

She asks Amy if there are other ways to relax that she enjoys, rather than relying solely on cannabis. She used to enjoy yoga but got out of the habit and now feels unsure about how she could afford to attend a class and feels that people would talk about her.

They agree to meet again in a week, but Amy doesn't attend that appointment. Four months later the GP gets a letter to say that she has just been discharged from an in-patient ward and is moving in to supported accommodation for a year.

AFTER

Amy's GP sends a 'task' via EMIS to the MHW Hub, a one-stop shop for mental health and well-being, requesting a same-day call back with a Psychiatrist to discuss Amy's medication. A full review is agreed, considering options that have fewer cardio-metabolic side effects to take place at the New Addington GP Huddle.

At the same time the GP updates Amy's "Well-Being Plan" with the latest information following their consultation. Amy identifies from the 'MHW Hub' website when the next Housing Advice session is running and arranges to see a Support/Peer Worker later that day. They agree to meet the Housing Association together.

In notes, her GP advises that Amy is feeling socially isolated and would likely benefit from some time with the Support/Peer Worker to access weekly yoga or mindfulness sessions near where she lives. When Amy is meeting the Support/Peer Worker in the MH Wellbeing Hub café space, she recognizes someone she once knew well from Rehab who's also going to yoga. She agrees to pick Amy up so they can walk there together.

The Support Worker updates Amy's "Well-Being Plan" on EMIS, so it is available when Amy's GP sees her in a week's time to review.

Before & After Case Study – MH Wellbeing Hub

Kevin is 29. He got his bipolar diagnosis aged 19. He's not had a job for the last few years, but prior had only had casual work in places like industrial kitchens and warehouses. He has been receiving benefits but is very anxious about the impact Universal Credit may have, having heard about it from others. He continues to receive a Depot injection at his local Trust, but otherwise has little contact with them or other services. He has no GP. His Mother died in 2012 and he's estranged from his Father. He's fills his days drinking and smoking, including cannabis with friends. He has no pastimes, doesn't exercise beyond walking and has a poor diet. Increasingly, as recently when a friend became unconscious, he has attended A&E and got some help and support there.

BEFORE

Kevin generally avoids health services if he can. He was registered with a GP shortly after his diagnosis but given that he moves multiple times in a year he's lost contact: and they, with him. When things get serious, he knows he can go to A&E and get some care, like when a cut recently got badly infected.

Sometimes he goes to a local voluntary sector drop in with some friends. He gets a free coffee and some food there, and if he needs to chat to someone he can. It's very busy, though, and it's just good for him to know there is a warm and dry place he can spend some time before he goes to the park with his friends.

No one reviews his needs, and he has no one coordinating his care overall, despite having multiple needs. He is vulnerable due to his mental health, his physical health which is at risk, and his social needs. These latter issues are a cause of worry. He feels little self-worth, very anxious at times, and self-medicates hazardously to help him cope.

The only help Kevin gets is that he asks for himself, usually when life has already become overwhelming or he's very unwell.

AFTER

Kevin's been really worried about losing his benefits. A friend tells him about the new integrated one-stop shop for mental health and well-being in Croydon. He drops into the East Croydon MHW Hub, one of the bases the new MH service operates from, and chats to a Team Member in the café area.

There is a slot available with an expert Support/Peer Worker: someone who really knows about benefits and housing and can assess his situation. She's immediately reassuring. He likes the Support/Peer Worker, he feels listened to and helped. During their meeting she asks whether he has a GP and, hearing he hasn't seen one for 10 years, tells Kevin about the new GP service that looks after all his needs in one plan and helps him with registration. She explains what he can expect from the MHW Hub, and that whilst there he has access to expert health professionals, it's not a clinical environment. He leaves with a booked appointment.

A month later he's had a full 'Recovery & Well-Being Review" with his GP and Support/Peer Worker. She had pre-briefed the GP on his social needs and discussed whether his Depot injection might be undertaken by his GP or given at the Hub depending on Kevin's preference.