**Health & Wellbeing Board**
**2.00pm, 17 June 2021**

## PRESENTATIONS

**6.** **Integrated Care System update** (Pages 3 - 14)

To receive a presentation and discuss an update on the Integrated Care System (ICS).

**7.** **Health and Care Plan refresh update** (Pages 15 - 22)

To receive a presentation and discuss an update on the Health and Care Plan refresh.

**8.** **One Croydon - Integrated Community Networks update** (Pages 23 - 34)

To receive a presentation and discuss an update on Integrated Community Networks.

**9.** **Croydon Mental Health Transformation update** (Pages 35 - 44)

To receive a presentation and discuss an update on the Croydon Mental Health Transformation programme.

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# Integrated care system White paper Briefing



Matthew Kershaw

Place Based Leader for Health



June 2021

# White paper : integration and innovation

On 11 February 2021, the government published a white paper setting out proposed reforms to health and care. Many of the measures introduced under David Cameron's government through the Health and Social Care Act 2012 are set to be abolished, with a broad move away from competition and internal markets; towards integration and collaboration.

The Bill is set to be brought forward in the next, rather than current, parliamentary session. This means the timing is unclear at this stage, but is likely to be in early summer.

The **White paper** proposed that, subject to legislation, integrated care systems (**ICS) will:**

- Become statutory NHS organisations
- Incorporate the functions of current CCGs and some of NHS England
- Have two boards –an **NHS ICS Board**; and a **Health and Care Partnership Board**
- Take effect from 1 April 2022 (subject to legislation being passed) with shadow operation likely to be from October 2021

**Future focus of Health and Care, working in partnership to:**

- Improve population health and healthcare;
- Tackle unequal outcomes and access;
- Enhance productivity and value for money; and
- Help the NHS to support broader social and economic development.

# Social care

- The government says that reforms to social care and public health will be dealt with later in 2021 outside the Health and Care Bill addressed in the white paper, with some minor exceptions. These reforms have been long promised and are long overdue.

- There will be oversight of the provision and commissioning of social care, including embedding local authorities in ICSs, through health and care partnerships and a formal duty for ICS NHS boards to have regard to health and wellbeing board plans.

- There will be a new duty for the CQC to assess local authorities' delivery of adult social care and empowering the Secretary of State to intervene where there is a risk of local authorities failing to meet social care duties.

- A new social care payment power for DHSC will be introduced, overturning statutory limitations preventing the Secretary of State from making payments to all social care providers.

- There will be greater flexibility when discharging patients from a hospital to a care setting for assessment, putting in place a legal framework for 'discharge to assess', allowing NHS continuing healthcare and Care Act assessments to take place after discharge from acute care.

- A standalone power for the Better Care Fund will be created, separating it from the NHS mandate setting process.

# Public Health- including the proposed changes

- There will be a new Secretary of State power to direct NHS England to take on specific public health functions (complementing the enhanced general power to direct NHS England on its functions).
- Further restrictions on the advertising of high fat, salt and sugar foods will be introduced, as well as a new power for ministers to alter certain food labelling requirements to help tackle obesity.
- The responsibilities for the fluoridation of water in England, including consultation responsibilities, will be moved from local authorities to central government.
- A consultation has just finished about the relationship of the newly established UK Health Security Agency – which has many of PHE health protection functions – and local and regional systems and the wellbeing function of Public Health England, much of it will be located in a new Department reporting into the Chief Medical Officer in DHSC and some into NHS England. ( later in the year)

# ICS Health and Care Partnerships

- ICS Partnerships will be responsible for **developing a plan that addresses the wider health, public health and social care needs** of the system.
- Members of the ICS Health and Care **Partnership can be drawn from Health and Wellbeing Boards within the system, partner organisations** with an interest in health and care (including Healthwatch, voluntary and independent sector partners, social care providers and for example housing providers).
- **Each system will set up** its Health and Care Partnership and membership
- **Guidance to support the establishment of these partnerships** will be developed with NHSEI and the Local Government Association
- **All NHS and LA's will have a duty to collaborate** across the healthcare, public health and social care system.
- **The ICS will work closely with local Health and Wellbeing Boards-** as 'place-based' planners, -, the ICS NHS Body will be required to have regard to the Joint Strategic Needs Assessments (JSNAs)/Joint Health and Wellbeing Strategies

# The role of ICS NHS body

- The ICS NHS body will be responsible for:
  - **Strategic planning** to meet the health needs of the population and being accountable for the health outcomes of the population
  - The commissioning functions of CCG's and some of those of NHS England
  - Developing a **capital plan for NHS providers**
  - **Securing the provision of health services** to meet the needs of the system population
- Each **ICS NHS body will be directly accountable for NHS spend and performance** within the system allocative functions will be held by the NHS Body. **It will be able to delegation place and provider collaboratives**
- The ICS NHS body will be **responsible for the day to day running of the ICS**
- **The ICS NHS board will, as a minimum**, include a chair, the chief executive and representatives from NHS trusts, general practice and local authorities, with others determined locally.
- **Place-based arrangements will be left to local organisations to arrange.**

# Place will have four main roles

1. To **support and develop primary care networks** (PCNs) which join up primary and community services across local neighbourhoods.
2. To **simplify, modernise and join up health and care** (including through technology and by joining up primary and secondary care where appropriate).
3. To understand and identify – using population health management techniques and other intelligence – **people and families at risk of being left behind and to organise proactive support for them;** and
4. To **coordinate the local contribution to health, social and economic development** to prevent future risks to ill-health within different population groups.

**In addition, places are responsible for:**

- **Ensuring the full involvement of all partners** who contribute to health and care in place.
- Putting in place **important links with other public or voluntary services** that have a big impact on residents' day-today health, such as by improving local skills and employment or by ensuring high-quality housing.
- **Delivery of place plans** in partnership with NHS providers, local government, primary care and the voluntary sector working together in each place in ICSs, built around primary care networks (PCNs) in neighbourhoods.

# Croydon context

Each of SWL's six boroughs have been asked to identify a 'Transition Team'. In Croydon, the new Senior Executive Group (reporting to the Shadow Health and Care Board) will carry out this function alongside its other duties . The specific representative roles in that group are:

| Place | NHS Primary Care Lead | NHS Acute Care Lead | NHS Community Lead | Local Authority Lead | NHS Mental Health Lead | NHS Transition Place based lead |
|---|---|---|---|---|---|---|
| Croydon | Agnelo Fernandez/ Bill Jasper | Mathew Kershaw | Mathew Kershaw | Annette McPartland | James Lowell (Chief Operating Officer, SLAM) | **Mathew Kershaw** |



- In Croydon Place-based working is already well-advanced through the One Croydon Alliance.
- The message from SWL colleagues is that we should press on with:
  - Transformation of health and care on the ground
  - Refreshing/clarifying the outcomes we want to achieve, as these will form the basis of our contract with the ICS in the future.
- We are continuing to evolve our structures, including consideration of the place of GPs and the voluntary sector, and testing a health and care pooled budget in shadow form.

# Croydon focus

Each local transition team have been asked to begin to meet a focus on a number of key development areas:

1. Begin work across each local placed based partnership to **identify and develop a 6,12-and 18-month programme** to deliver place requirements outlined in the White paper.

2. Reviewing and developing **revised Local Health and Care Plans** built on locally identified priorities and linked to expected national planning guidance.

3. Set **clear expected outcomes** for place priorities and actions so that their impact may be tracked.

4. Engaging in the **Strengthening Communities Programme Group** to think through in more detail the approach to place-based development, share learning and support the system wide development of place-based arrangements.

# How we are implementing the tasks

One Croydon is in a very strong position to implement the developments required. **The One Croydon Alliance** has been operating for over three years and its strong partnership is underpinned by a robust integrated whole system Governance Structure. In April 2020 Croydon implemented a joint governance structure for the **aligned CHS and Local CCG.**

The One Croydon **Senior Executive Group** will undertake the function of the **Croydon Transition Group** and oversee the implementation of the four tasks, to be undertaken by the **System Design Group**; this group builds on the success of the Shadow Health and Care Budget Group.

## 1. Develop a 6,12,18 month programme

- A Place Partnership exists through the One Croydon Alliance
- The Workplan for the System Design Group will be completed by Q1 to include milestones:
  - Oct 21 – Shadow ICS (identified and commence testing delegations)
  - April 22 – go live (any variations to governance/Alliance Agreement)
- There will be a focus on PCN Development
- The Shadow Health and Care Budget for 21/22 and will test joint decision making including
  - Shift resources for improved outcomes
  - Whole system budget management
  - Model risk share scenarios

## 2. Review and revise the Health and Care Plan

- The current plan was developed jointly across the whole health and care system
- Resources currently being sourced to support the refresh
- The plan to refresh will be jointly undertaken & includes how we will:
  - Review progress
  - Review Performance
  - Refresh the ambitions
  - Meet the 1st October deadline
- There will be a focus on engagement with patients and people
- A greater focus on how we reduce inequalities and improving our ability to measure impact on these

## 3. Set clear expected outcomes

- Performance against Outcomes for the current Health and Care plan will be reviewed
- The One Croydon Outcomes Framework will be reviewed by the Quality and Performance Group to reflect new methods for monitoring outcomes
- One Croydon is developing better outcomes monitoring for social prescribing
- The Healthy Communities Together programme will strengthen the ability to monitor outcomes
- The Community Led support approach enables monitoring of impact on people's personal outcomes

## 4. Engage in Strengthening Communities

- Croydon will be actively involved with the programme board and share experiences of what is happening at Croydon place

# Further reading

- This report by The King's Fund considers the potential of place-based partnerships to improve population health and support truly integrated care, and highlights principles to guide their development and the support they might need from national and regional leaders. The report also explores the implications of these ways of working for the development of ICSs and for national bodies and regional teams as they approach the next stages of policy development and support for integrated care.

- A recent report by NHS Confed, Legislating on the future of health and care in England, outlines the views of healthcare leaders on the white paper, the implications for the forthcoming health and care bill and a set of recommendations to government as it develops the the legislation.

- One of the lessons learned from the COVID-19 pandemic is that people need support joined up across local councils, the NHS and voluntary and community organisations. This video explains how ICSs embed this collaboration, helping local services respond to the challenges of the pandemic and beyond.

- In this report, The Department of Health and Social Care (DHSC) sets out reforms to the public health system in England, focusing on structural reforms and inviting opinions to help shape its future. DHSC will publish a further update later in 2021 with final details on design, structure and implementation, and will also set out plans for the policies, delivery and outcomes for the reformed system to drive and deliver.

- This webinar looked at the role of ICSs in enabling people who use services to gain more control over their own health and care – ensuring people are at the heart of health and care services. The webinar explored what needs to happen at place and system level, with discussion on the importance and impact of giving service users more choice and how ICSs can create the right partnerships to support an increase in personalised care, social prescribing and community-based support.

- As part of NHSE/I development of integrated care systems, in partnership with the King's Fund, Stephen Rosenthal, Senior Vice President for Population Health Management at Montefiore, New York, talks about improving the health of deprived communities as part of a series of interviews with health and care leaders around the world.

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# Health and Care Plan Refresh

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- **The health and care plan can be found here: https://www.croydonccg.nhs.uk/get-involved/croydon-health-and-care-plan/Documents/4326v14_NHS_One_Croydon_Heath_CarePlan.pdf**

The Original Plan on a page is shown on slide 2.
The Plans can be found in the appendices from page 30

- We are setting out our progress against plans – the early sight of this is presented in slides 4 &5
- We will refresh the plan by October 2021:
  - Identify draft priorities for your area of focus
  - Articulate draft priorities for your area of focus by 16th July
  - Take part in the engagement event on the 27th July
  - Sign off – October

One Croydon
Your Health and Care partnership

## OUR VISION
*Working together to help you lead your life*

### STRATEGIC GOALS AND OUTCOMES

**Improve healthy life expectancy**
- People are living longer and healthier lives

**Reduce Inequalities**
- Gap between life expectancies across borough is closing

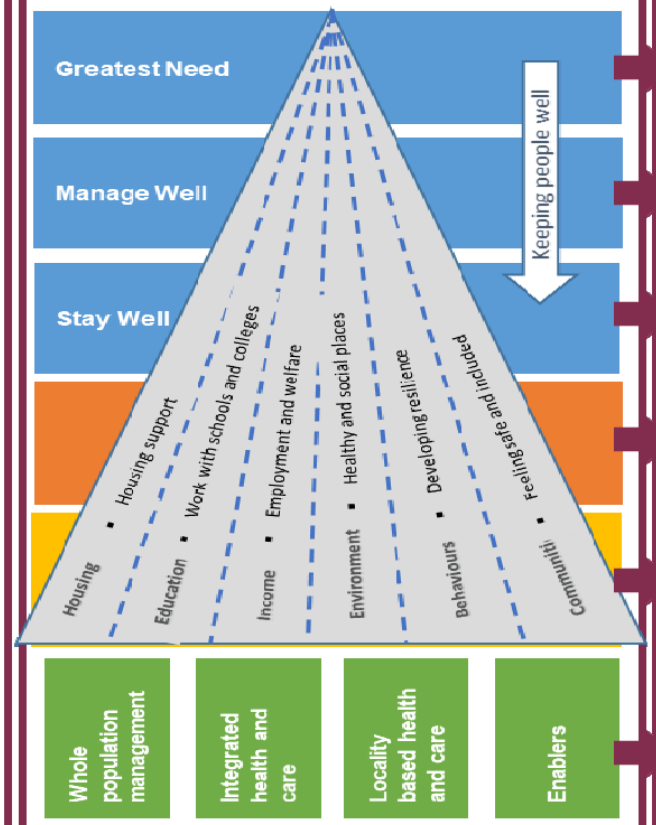
**A sustainable health and care system**
- Affordable models of care delivering improved outcomes

**Peoples aspirations**
- I am in control of my own health and well being
- I am able to stay healthy, active and independent as long as possible
- I live in an active and supportive community
- I can access the support my family and I need
- I can access quality services that are created with me and my family in mind

### STRATEGIC PRIORITIES

- Improve quality of life (4)
- Enable a better start in life (1)
- Improve wider determinants of health and well being (3 / 5)
- Integrate health and social care (8)

### STRATEGIC APPROACH (7)




### STRATEGIC INITIATIVES

- People have the support and access in the right place at the right time
- People are able to manage well
- People are able to stay well
- Healthy Weight
- Healthy Mind
- First 1000 days of life
- Immunisation in the Community
- Health, well being and care in all policy
- Housing support for mental health
- Working with schools
- Maximising income
- Supporting Carers
- Integrated Care System
- Population health management and evidenced based delivery
- Locality based care model development
- Integrated, multi skilled workforce, IT and estates
- Multi-disciplinary community led support

- Compassionate Croydon
- Prevention, early intervention, early detection
- Self care / self management, Community Led Support, choice and self control
- Active and supportive communities (2 / 6)
- Long term conditions and disabilities focus
- Mental health (4)



**(No.) = Supports delivery of Health and Wellbeing Strategy priority areas**
(1) A better start in life, (2) Strong, engaged, inclusive and well connected communities , (3) Housing and the environment enable all people of Croydon to be healthy (4) Mental wellbeing and good mental health are seen as a driver of health, (5) A strong local economy with quality, local jobs, (6) Get more people more active, more often, (7) A stronger focus on prevention (8) The right people, in the right place, at the right time

## Our One Croydon Health and Care Plan on a Page

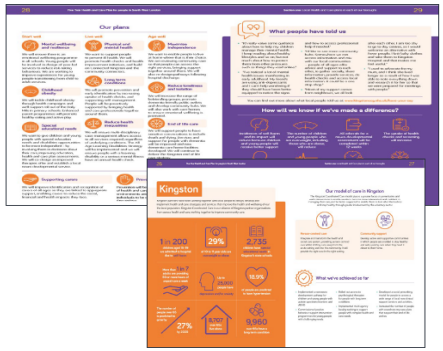
CROYDON
www.croydon.gov.uk

# Refreshing the Plan

## Developing refreshed Place based Local Health and Care Plans

South West London Health & Care Partnership

- Two year plans were developed by all boroughs in Autumn 2019 following local health and care events.
- We have signalled to each Place based transition team that reviewing existing local health and care plans should be a key priority
- It is proposed that plans should be reviewed and refreshed by Place based transition teams over the next 6 months and finalised by the 1st October 2021
- We propose that revised Health and Care plans should cover the period 1st October 2021-31st March 2023
- We now propose to begin a dialogue with local transition teams about what they should cover and how they might be produced




**Led by the Transition Team**

**Deadline 1st October**

**Cover period Oct 21-Mar 23**

**Address inequalities**

**Progress over the last 12 months**

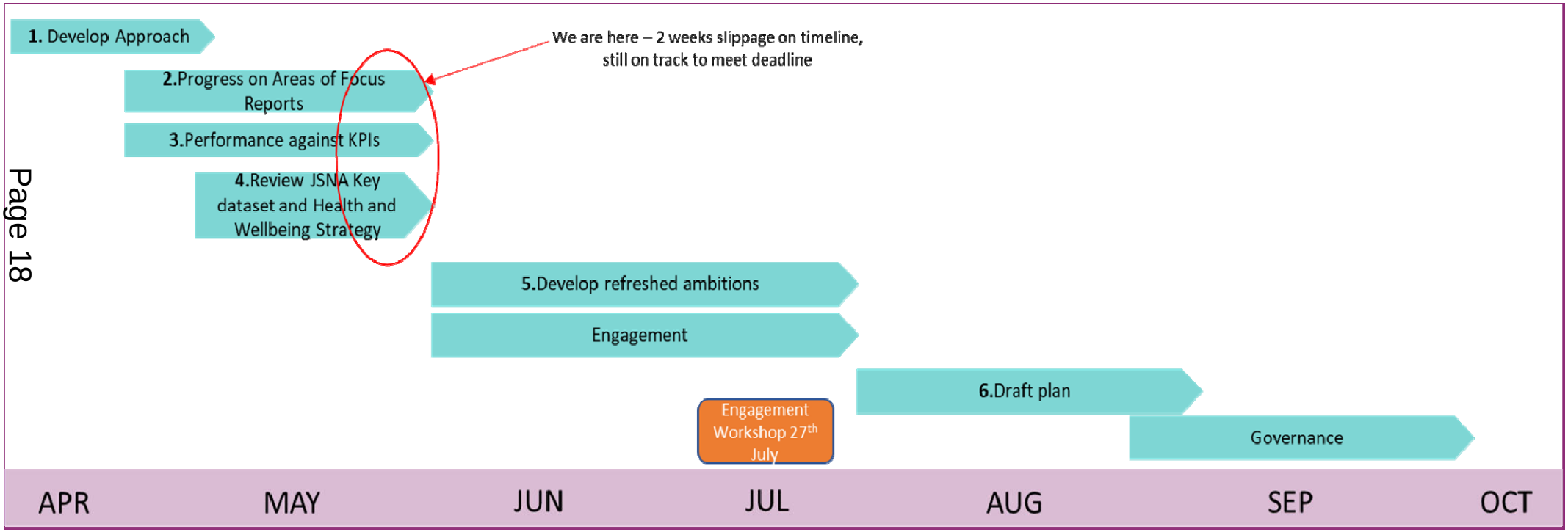
**Refreshed ambitions and local priorities**

## What might refreshed Local Health and Care plans cover ?

South West London Health & Care Partnership

- ✓ What they have achieved over the last 12 months including an update against key indicators in the SWL five year strategy
- ✓ How they will meet their local population needs (as per JSNAs) and existing health and well-being strategies
- ✓ Refreshed ambitions for each place and setting out local priorities
- ✓ How their plans will address local health inequalities and steps they will take to support the South West London Equality, Diversity and Inclusion programmes objectives
- ✓ How they will deliver any emerging national must-do's (from any future operational planning guidance)
- ✓ How they will make a local contribution to health, social and economic development to prevent future risks to ill-health within different population groups
- ✓ Key risks for delivery, mitigations and resources required and how transformation will be measured against locally set performance measures

# Timetable for Refresh



# Highlights from Progress Reports

| Area of Focus | Highlights |
|---|---|
| **Localities develop locality based ICN+ and a proactive preventative approach approach** | • The North East ICN+ site launched in July 2020 and has been operational for 10 months.<br>• Following the success of the early adopter site in the North East Locality, the ICN+ model is being rolled out across the remaining five Localities in the borough in 2021.<br>• One of the preventative interventions was the introduction of the Stay Steady, Stay Well clinic.<br>• The ICN+ has been facilitating themed huddles focussing on certain conditions e.g., Diabetes and Respiratory. |
| **Localities - GP /PCN** | • CGPC Set up and run a Clinical Director Cabinet which is held monthly and provides space for CDs to discuss issues, concerns and plans on how to work collaboratively including paramedics, pharmacists and social prescribing in each PCN.<br>• Provided the first mass vaccination site in Croydon for flu at Ikea and Crystal Palace Football Club.<br>• Integrated all Enhances Access Service booking system so practices and out of hours service can see all appointments available across Croydon,.<br>• During COVID CGPC supported Practices by getting laptops, webcams and set up Use Emis Enterprise to provide CCG with data on vaccine rollout.<br>• Found an area that needed significant input which was the number of patients requiring SMI health check |
| **Localities – Care Homes/Falls EoL** | • Introduced a Telemedicine service in 75 of our care homes which has enabled prompt assessment of clinical needs and coordination of care when urgent, unplanned needs arise in care home residents.<br>• A Care Home Liaison Coordinator has been introduced into the local hospital discharge team to reduce any unnecessary delays in transfer of care from hospital to a care home<br>• Remote monitoring of vital sign in Care Homes using telehealth technology to be rolled out during 2021<br>• Community falls pilot showed positive results but on hold due COVID-19 staff redeployment; service to be relaunched with a focus on prevention and alignment with the ICN+ localities.<br>• We have partnered with St Christopher's Hospice to work with community groups with the aim of helping everyone have a good death by encouraging local people to feel more comfortable about talking openly about death and dying and by recording their End Of Life Wishes |
| **Localities – LIFE** | • Due to the Pandemic, the Discharge to Assess (D2A) process was changed at the end of March 2020. The Council is the Single Point of Contact for all hospital discharges. The number of referrals to D2A increasing, as well as increased complexity of some of the patients discharged. This is tracked and a new D2A process is being designed taking into account new legislation in the White Paper on Discharge to Assess.<br>• In 2019/20, at the end of reablement, in 47% of cases the client received no ongoing package of In a further 17% of cases the amount of care decreased due to reablement. compared to 34% and 20% in 20/21 respectively<br>• The LIFE review paused during the pandemic, this has now been restarted and will look at more joined up ways to enables proactive case management to larger numbers of people across the different ICNs |
| **Mental Health** | • Implementation of the mental health community hub and spoke model Co-produced design phase complete and the pilot Mental Health Wellbeing Hub at the Whitgift Centre to be operational Q2 2021<br>• Crisis pathway improvements include the Recovery Space in Oct'20, Mental Health Crisis line expanded in Apr'20 and a Mental Health Clinical Assessment Unit at Emergency Dept<br>• Greater Support in Primary Care through Mental Health Personal Independence Coordinators (MHPICs) and Reshaping of (SLaM) Community Mental Health Services<br>• Improving Integrated housing is a Council led piece of work and was put on hold due to the pandemic. Work has restarted to develop a Temporary Accommodation Strategy<br>• Autism Strategy nearing completion |
| **Proactive and Preventative – Long Term Conditions** | • The LTC care model was implemented in 2020 including; Atrial fibrillation systematic case finding service and Group consultations programme to support patients with diabetes and hypertension<br>• LTC pro-active and preventative - Community outreach programme was developed and launched with BME forum and Asian Resource Centre<br>• LTC pro-active and preventative – Expert Patient Programme was developed and launched with BME forum and Asian Resource Centre for Croydon |
| **Proactive and Preventative – Local Voluntary Partnerships** | • Talking Points - operational since December 2019. Over 280 residents have been referred or contacted. Resident needs have ranged from housing and benefits to social isolation and low-level mental illness.<br>• Ten online 'Building Community Partnerships' events across all six localities have been held between November 2020 and May 2020. Events have been well-attended by an average of 30 VCS organisations and active citizens attending each one.<br>• The prevention framework was signed off by representatives from all sectors in the partnership in December 2020; priorities include Falls (and frailty)Healthy weight,Immunisation take-up and Mental Health and Trauma<br>• The Local Voluntary Partnership programme has supported the voluntary sector by awarding one-off and recurrent funding to small grass roots organisations; 69 funded initiatives.<br>• Phase 1 Healthy Communities Together programme underway |

# Highlights from Progress Reports

| Area of Focus | Highlights |
|---|---|
| **COVID Resilient and Recovery – Public Health** | • Upskilling community members to be able to offer initial support and signposting and increasing community awareness around mental health<br>• In addition, a community trauma training programme is currently in development (working with the buying team) for implementation by September 2021<br>• Supporting children at risk of food poverty: school programmes include - food vouchers, breakfast club and schools grant<br>• Public Health have commissioned 4 VCS organisations to deliver projects to vulnerable populations that aim to support residents to comply with infection control and isolation and improve vaccine uptake |
| **Healthy Weight – Public Health** | • Adult healthy behaviours programme now embedded in the localities.<br>• New Child Weight Management service proposed and awaiting approval to commission. Implementation expected by beginning of October 2021.<br>• Draft system weight action plan produced. |
| **Modern Acute – Outpatients** | • Optimise pathways - approximately 300 video consultations were taking place per week at CHS. Many services continue to use telephone and video appointments as a long term solution<br>• Patient Initiated Follow Up (PIFU) pathways changes have been made within gastroenterology (IBD)<br>• Proceeding with a patient portal solution that aligns with other providers in SWL. |
| **Modern Acute - Urgent and Emergency Care** | TBC |
| **Better Start in Life and Maternity – Redesign the Urgent Care Paediatric pathway** | • Paediatric Unit is still under development. The centre is looking to be open May 2022<br>• Completion and embedding of "Big 5" Advice & Guidance to improve consistency and quality of care<br>• Asthma pathway & development plan<br>• The Children and Young Persons Transformation Programme Board was re-launched in February 2021<br>• Improving data intelligence on urgent care pathway to support initiatives: CYP Urgent Care dashboard |
| **Better Start in Life and Maternity** | • Early help resources are deployed through three localities (North, Central and South) to provide better place-based services for the community<br>• A new partnership Early Years Strategy is currently in development for 2021-2024<br>• Progressing assessment and actions to meet Ockenden recommendations – service user engagement from Maternity Voices Partnership (MVP) involved in peer review<br>• CHS Maternity Services achieved 26.7% of women being booked onto a Continuity of Carer pathway at Match 2021<br>• Mental Health Investment Standard funding (MHIS) secured to deliver waiting time initiatives, increase CYP access to Emotional Wellbeing and Mental Health services and further develop digital services |
| **All Age Disability** | • In December 2019 Independent Lives were commissioned to train and develop new personal assistants, and provide advice and guidance to residents choosing to use a direct payment<br>• In April 2021, the disabilities service (18-65) moved to a localities model, enabling it to be comes aligned with the integrated community networks plus model<br>• In April 2021, the transitions service moved to adult social care. A programme will be built around the service to align it with the strengths based model / good conversations, and aligned to the locality integrated community network model.<br>• A strategic review of assistive technology opportunities was developed, post COVID this review will need to be revisited at a system / borough level<br>• The community led support model is now fully embedded in the working practices of the older adults and disabilities locality teams<br>• Autism Strategy Finalised and going through governance<br>• Learning Disability and Mental Health Commissioning Boards established to develop the next 3 year commissioning strategy |
| **Integration** | • One Croydon formally agreed to include the ICN+ model of care in scope of the Alliance Agreement and contracted for this using the Integrated Delivery Agreement. ICN+ will be rolled out across the whole borough during 2021/2022<br>• During 2020 One Croydon undertook a programme of work to develop a whole system pooled budget<br>• Croydon Borough Cttee of SWL CCG and CHS have fully aligned governance and leadership<br>• Transition planning in place for ICS |

## Next Steps: Stage 4/5

1. Continue with stages as set out
    - Leads to commence engagement on progress priorities for their area
    - Review JSNA and local needs assessments
    - Analyse impact on outcomes framework
    - Organise engagement event (27th July)

2. Governance
    - Scrutiny briefing 22nd June: establish sign-off required for the refreshed plan

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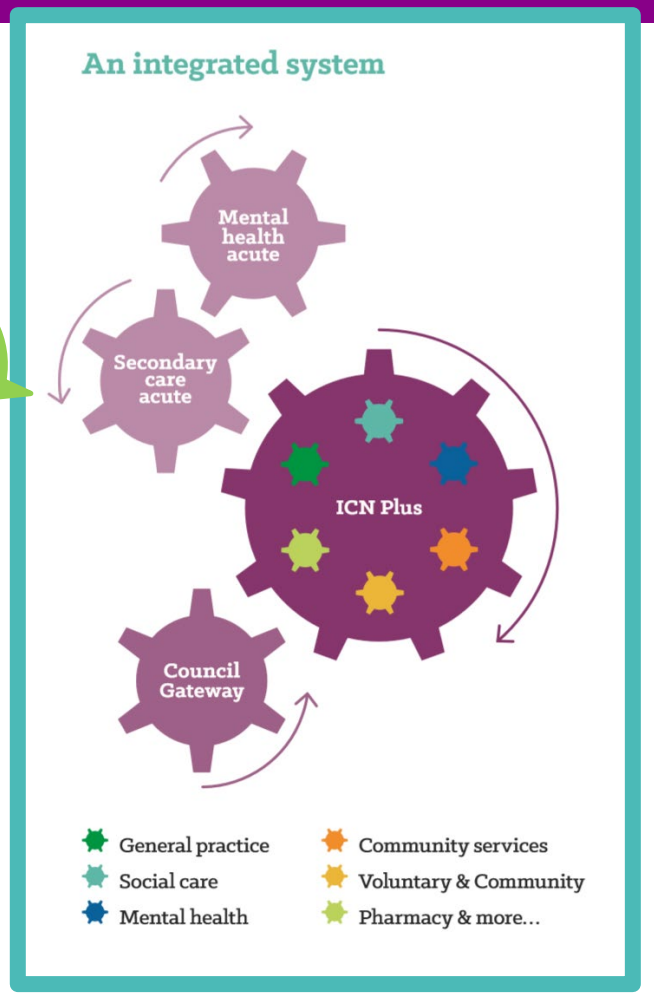
# Integrated Community Networks



Laura Jenner  Interim Deputy Director

June 2021

# Ambition


"Our ambition was to fundamentally change how our partners work together, using our combined resources wisely, to make sure we deliver the best health and care services for the people of Croydon. "

***Dr Gaj Sivadhas, Chair and Medical Director, Croydon GP Collaborative***

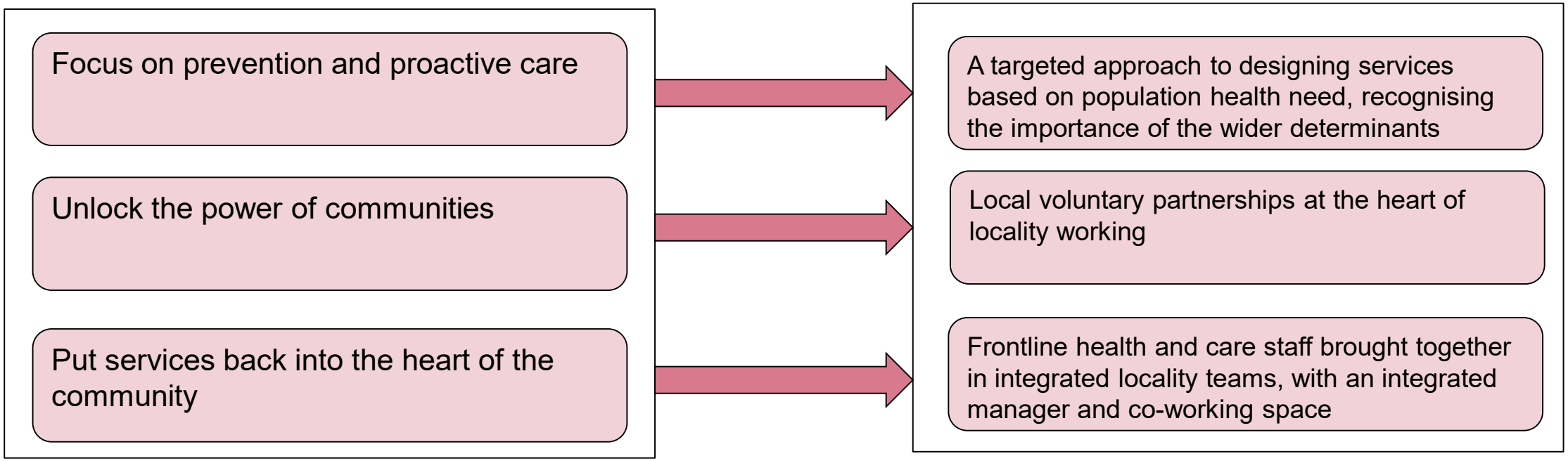
One Croydon
Your Health and care partnership

# Introduction ICN+

Integrated Community Networks Plus (ICN+) is a major programme of transformation and integration that will improve outcomes for Croydon people through a proactive and preventative approach within each of the six localities of the borough. It is focused on all adults and aligned with services for children and families. The following should describe our whole model:

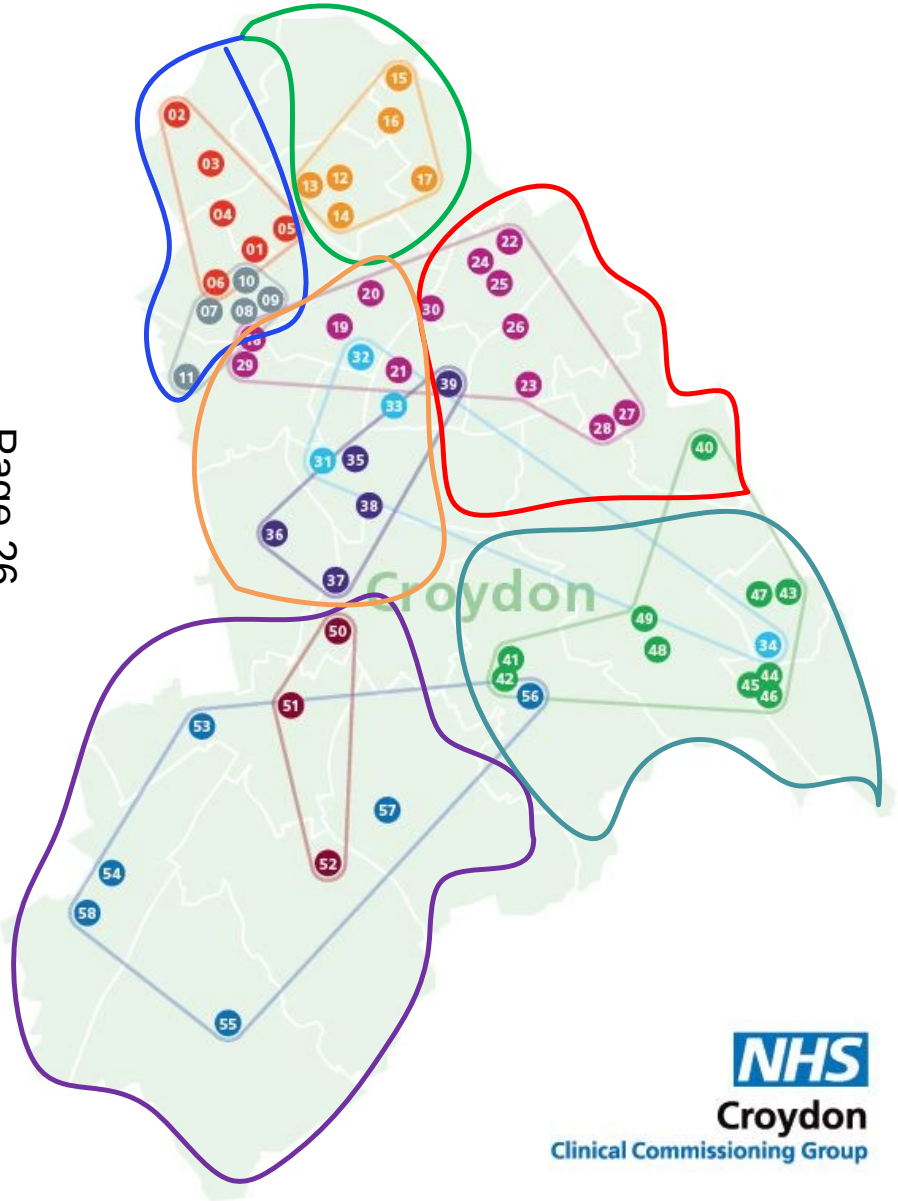
**Our Localities vision is - "Total Place"**
**Our Operating Model is - ICN+ (straddling PCN's)**
**Our Practice Model is - Strengths Based Practice**

One Croydon partners committed to a locality approach via ICN+ as a flagship initiative within our Croydon Health and Care Plan, which aims to deliver the three key objectives, as below.




The model of care has gone live in our early adopter site of Croydon North East (Thornton Heath) and we are now in the process of rollout the programme in the other 5 networks

# ICN+ and PCNs




| Geographical Locality Name | Numbers | PCNs Coverage |
|---|---|---|
| North West | 01-11 | Primary Care North Croydon, Mayday South |
| North East | 12-17 | One Thornton Heath |
| Central East | 22-28, 39,40 | Croydon GP Super Network, GPNET 5, Selnash PCN |
| Central West | 18-21,29, 31-33,35-38 | Croydon GP Super Network, GPNET 5, Croydon Central Network |
| South East | 34, 41-49, 56 | Selnash, Croydon Central Network |
| South West | 50-55, 57,58 | KMP Network, SPC Health PCN |

The six ICNs straddle the nine PCNs as shown. Each ICN+ will be developed with the PCNs to support local need.

# ICN+ model of Care

## ICN+ core team

- **Physical space** in each locality for co-working and joint clinics
- **IT solutions** for virtual MDT meetings and flexible working
- Management of **locality health and care budget**

- Integrated manager
- Social workers
- Community Nursing
- Occupational Therapists
- Physiotherapists
- Pharmacist
- Network Facilitator
- Personal Independence
- Co-ordinators
- Talking Therapist
- Mental Health Assessment & Liaison officer

Under 65s has also moved into localities and working closely with the other services

### Targeted support closer to home

- Group Consultations
- Diabetes service
- Joint over 50s clinic - frailty, healthy lifestyles, exercise
- Talking Therapy
- Podiatry
- Continence

### Locality Voluntary Partnership

- Development of existing local collaboratives
- Relationships and pathways between voluntary and statutory sectors
- LVP grant funding devolved

### TALKING POINT

- Access to VCS social activities
- Information and Advice
- Welfare Benefits
- Housing
- Health checks, healthy lifestyle
- PIC support
- Community connect

### GP huddles

- Improved ways of working to be agreed with GPs in each locality to maximise benefits
- Proactive case finding
- Joint support plans

### Links into specialist services

e.g. mental health drug and alcohol

### Innovative approaches

e.g. Telehealth

# What's worked well? (Benefits)

- Creating virtual space and co- location has improved relationships and communication, reducing bureaucracy and removing the need for long referral forms or complicated email chains.

- Training has allowed staff to develop a better awareness of other roles and develop their own skills. This has led to patient needs being identified by all staff members allowing for appropriate referrals to be made in a timelier manner.

- Networking with local voluntary groups to support assets based approach

- Virtual Talking Point has been a huge success, having supported **over 200** residents since June 2020, with connecting with the community, housing issues and benefits advice.

- Funding for 2 Community Network Facilitators in the voluntary sector to run the Talking Points.

- 6 new Mental Health PICs  joining ICN+ teams to people with mental health issues

# Case Study- Talking Point

## Background

- Ms A is a 42 year-old Iranian lady who had fled domestic violence and been placed in Croydon with her teenage daughter. Ms A struggles with chronic pain, depression and other health conditions.
- Ms A was unable to leave her home as she could not manage the stairs leaving her feeling trapped and was sharing a bed with her daughter.
- Ms A was also struggling financially.

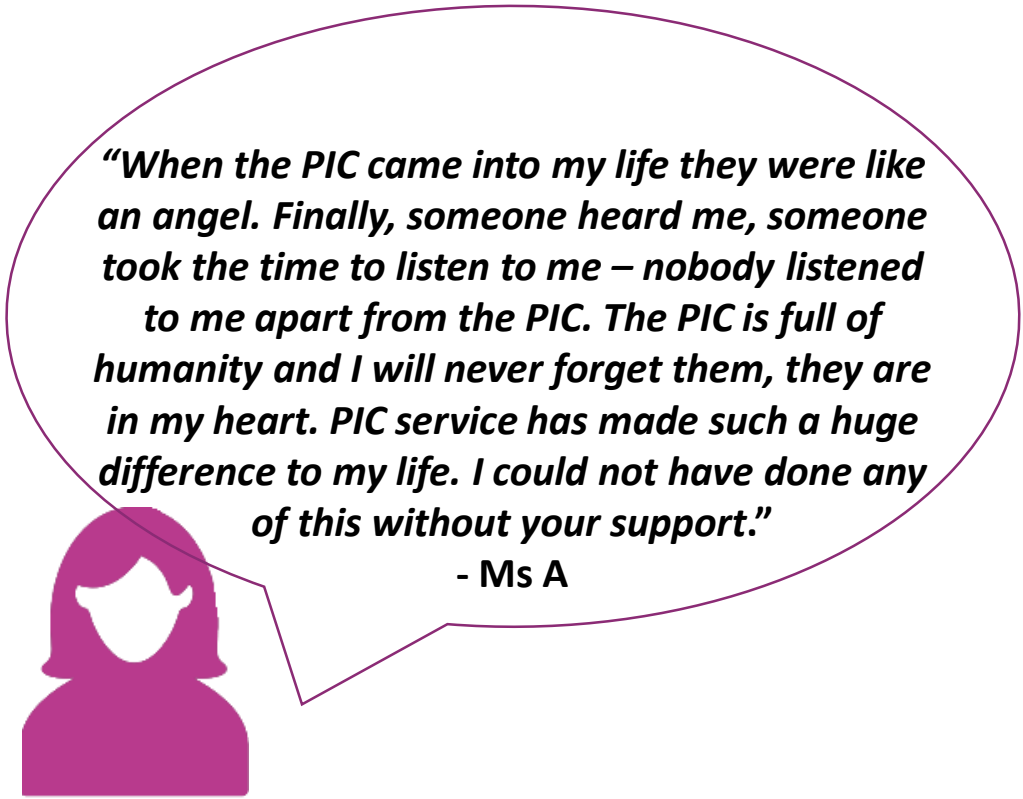
## What did we do?

The PIC worked with Ms A to identify goals to improve her independence. Three main areas were identified – mobility, finances, and housing. The PIC assisted with each of these areas, contacting the relevant people e.g Housing, Benefits and Occupational Therapy teams to ensure the right support was in place for both Ms A and her daughter.



**As a result of the ICN+ involvement Ms B is now…**

- Living in accommodation much better suited to her needs. She has enough room to use the equipment provided by the OT service and no longer has to share a bed.
- Able to get outdoors without having to navigate several flights of stairs. This has improved her independence greatly as she can go for short walks by herself whilst her daughter is at school.
- Using her equipment provided by the OT team to mobilise around the house and is able to wash and prepare meals independently.
- Awaiting her medical assessment for Personal Independence Payment, which if successful will entitle her to a significant additional payment each month



# Case Study- ICN+

## Background

- Mr A is a 64 year old gentleman who lives alone
- Has prostate Cancer, COPD and high blood pressure
- Mr A was referred to the District Nurse (DN) Service via his GP for Catheter care.
- DN identified Mr A was not managing his catheter well, was unsteady on his feet and that he was not managing with getting or preparing food

## What did we do?

Mr A was discussed at the daily ICN+ MDT where the DN requested a Social Worker contacted Mr A. Social Worker reported Mr A was known to adult social care and had declined Social Care involvement in the past.

## Services Involved

- Falls Physiotherapist
- Reablement Officer
- PICs



**As a result of the ICN+ involvement Mr A is now…**

- Confident to walk to the local supermarket with a walking stick alone to get his own shopping on a daily basis.
- Confident to go into the community and stop and have a chat to those he knows on the high street
- Preparing his own meals and keeping his flat tidy
- Caring for his catheter independently with no District Nurse concerns
- Continuing with exercises alone
- Managing his finances appropriately

# Local Voluntary Partnership

1. Leadership and Representation – this workstream group will create a shared leadership model with VCS partners, working with all voluntary groups and civil society in Croydon, improving connections with, across and between the sector. This group will ensure that the partnership has effective representation for the VCS across One Croydon governance and improved two way communication.

2. Local Empowerment and Engagement - this workstream group will develop an empowerment and engagement strategy with residents and the wider voluntary sector to help reduce health inequalities in Croydon by empowering local communities to co-produce the services they require.

3. Funding and Commissioning – this workstream group will review the totality of resource currently being spent in the voluntary sector and look at how this can be increased to support more people in the community without the need for statutory intervention. This may include the development of an investment strategy. The group will give consideration to current commissioned and grant-funded services with the voluntary sector such as those through the Community Fund and the Local Voluntary Partnership, floating support services, social prescribing and information and advice. The group is not responsible for making commissioning or funding decisions, but will make recommendations through the appropriate channels. This will include recommendations regarding best practice when commissioning with the voluntary sector, and reflect any changes to national policy and guidance regarding funding and/or commissioning with the voluntary sector.

# Involvement

"We have been able to work together to deliver integrated care for our patients with complex health and social needs living with long term conditions. "
GP

"There is a real willingness to work together and learn from each other. The involvement of colleagues from both housing and benefits has been amazing and brings a perspective we wouldn't be able to bring ourselves."
Talking Point staff member

"Staff cared about what they were doing and wanted me to get as much benefit from them as I could."
Service user

"Working in the ICN+ has broken down the bureaucracy of sharing information, referring clients to a particular service and holistically assessing a client/patient situation, which has made it so much easier to meet a clients holistic support needs, inevitably promoting their wellbeing."
Social Worker

"I was down a very deep hole and couldn't see the way out but now I am near the top – you've made a huge difference to my life this year."
Service user

"Really made a difference to my Mum."
Carer

# High Level Implementation Timeline

## ICN+ Key Milestones and Roll-out Plan

### Aug-Sep 2020

- ICN+ Model Agreed
- ICN+ Business Case to Localities Board
- Reset PDG to oversee whole Programme
- ICN+ Business case to Shadow Health and Care Board

- **Work with Council to align processes for locality workforce planning**
- **Commence mapping of all the workforce and use the model to say how many staff in each locality**
- Development of Comms and Engagement strategy
- Link in with Modern acute for Joint clinics and Diagnostics Offer
- Estates options identified in each locality

### Oct-Dec 2020

- Supporting and developing Locality Voluntary Partnerships
- Development of Budgets and contracting options
- Business case for Estates & IT for South East & South West
- Workforce mapping completed

- **Agree workforce and OD plan**
- Design of proactive and preventative offer for each network based on population health data
- Review and evaluate Early Adopter (NE) learnings
- Agree digital priorities and develop IT plan for ICN+ rollout
- Design schedule of teams' transitioning into virtual localities

### Jan-Mar 2021

- Start transition into Localities
- Develop North West IT & Estates BC
- Develop central West IT & Estates BC
- Team building sessions completed in remaining 5 Localities

- Implementation of Comms and Engagement plan
- Targeted interventions starting
- Team building sessions for remaining 5 Localities
- First webinar 11th of February
- **Deliver workforce and OD plan across all Localities**
- Locality packs disseminated to staff

### Apr-Jun 2021

- Develop IT& estate option for SW & CE
- South East & South West go-live
- Connect Your Care interface between Liquid Logic and EMIS
- Develop IT Primary care BC

- **South East and South West go-live 10th May 2021**
- Processes in place for all Localities
- Staff aligned from across partners into MDTs
- Second webinar held on 6th May 2021
- Coaching Circles & Creative Huddles in North East

### Jul-Sept 2021

- Draft proposal for King's Fund
- Central East, Central West & North West go-live
- Mental Health PICs attending MDTs & Huddles
- Clinical Governance pathway agreed
- Team transition into localities complete

- Draft proposal for King's Fund
- Central East, Central West & North West go-live July
- Mental Health PICs attending MDTs & Huddles
- Clinical Governance pathway agreed
- Quality assurance guide
- Therapies integration

### Oct-Dec 2021 and beyond

- Agree Management structure n
- Agree Population Health project
- Localities Dashboard agreed
- King's Fund model approved
- IT solution

- CQI Opportunities - Improve and Optimise
- Evaluation of integration so far
- Localities Dashboard developed and agreed
- King's Fund model approved
- IT solution agreed
- Integrated Management options presented

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

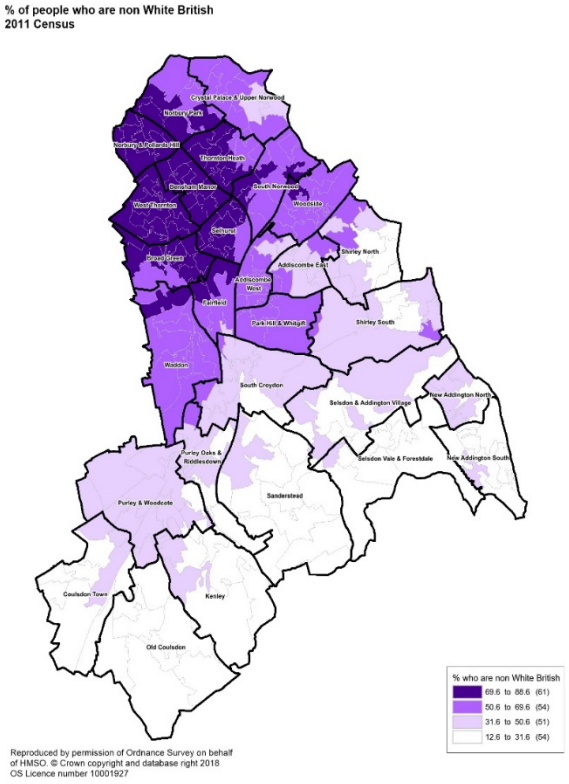
Adjust workstreams & implement phase 2

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)<br>• Turkish Youth & Community Association – MH Community Development Worker (CDW)<br>• Asian Resource Centre Croydon – MH Champions<br>• Croydon BME Forum – Wellness Advisor in addition to CDWs<br>• Croydon Drop-in – Young Adult Transitions<br>• Body & Soul – Legal, Practical Support & Counselling for HIV+ sufferers<br>• Disability Croydon – MH Drop-in Centre & Café and access to digital support<br>• Palace for Life Foundation – Coping through football (SMI Focus)<br>• 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.



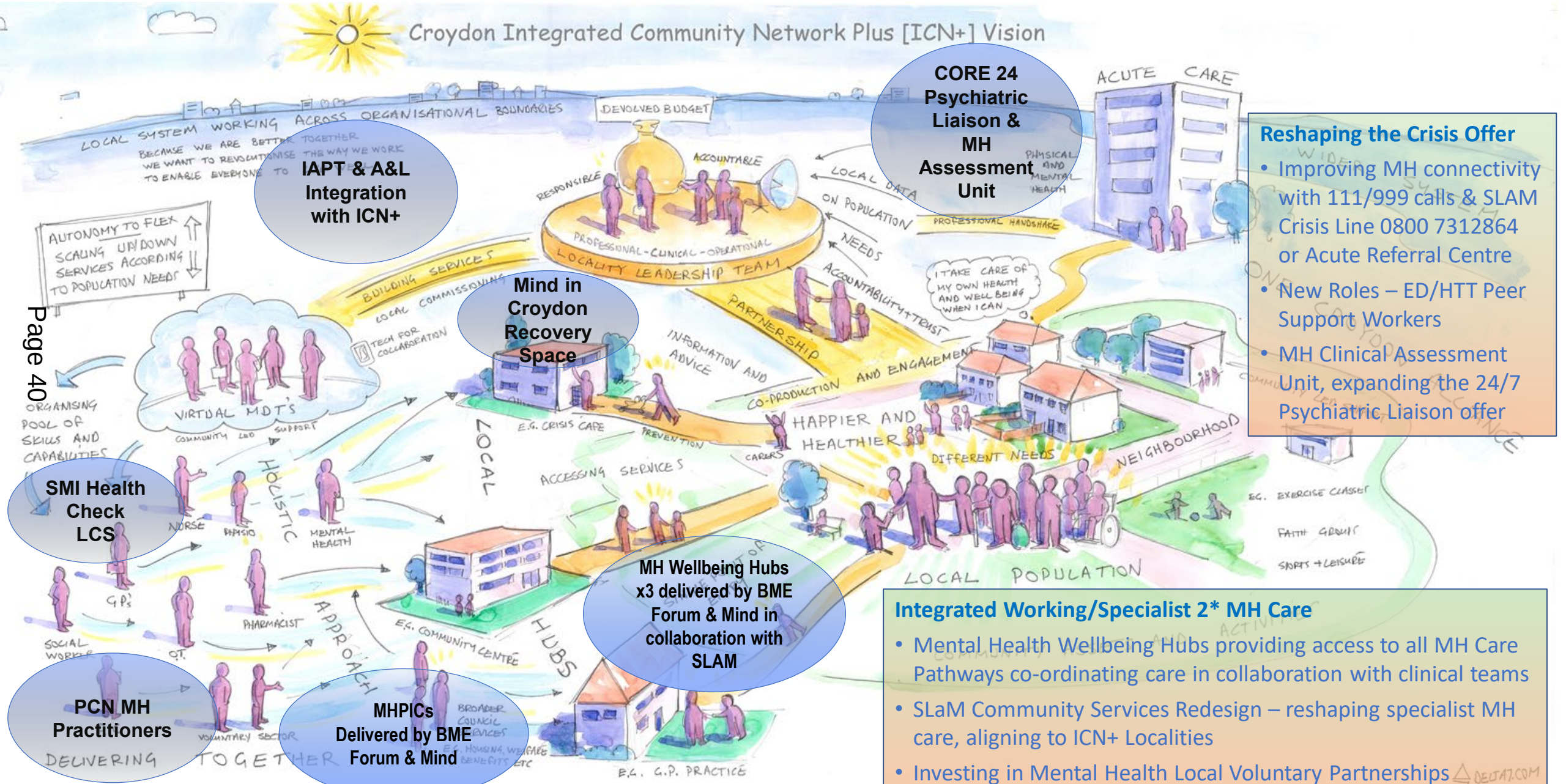

## Ethnic Minority Interventions:

- 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<br>Care at the Right Place, Right Time<br>Better physical health for SMI | QALYs<br>Improvements for society / employment<br>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<br>Bed Occupancy reduced (1st year) from 120% to 100% ; subsequent years to c85% | £585k (QIPP potential)<br>(full reduction is £1.7m)<br>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.