

CROYDON INTEGRATED MENTAL HEALTH STRATEGY FOR ADULTS

2014 - 2019

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Introduction

Mental health and wellbeing affects almost every part of a person's life. It has an impact on physical health, health behaviours, employment, education and quality of relationships with friends and family.

Mental health problems are common. One in four people will experience at least one mental health condition at some point in their life. They can affect anyone in Croydon, regardless of age, race, gender or social background, although some groups have a higher risk of mental disorder and lower levels of well-being. Mental ill health is the single largest source of disease burden, more than cancer and cardiovascular disease, and the costs extend well beyond health and social care.

The family and friends of people who experience mental health problems can play a crucial role in providing support and helping their recovery. But it is important to recognise that family carers can themselves have needs which arise from their caring responsibilities. The Care Act 2014 recognises carers distinct needs and introduces new duties to support them.

The foundations of good mental health are laid down in childhood. Half of all lifetime mental disorder (excluding dementia) starts by the age of 14 and 75% by the mid 20's¹. Good emotional health and well-being in children and young people reduces the risk of mental illness in adulthood and stronger integration between adult and children's services can improve well-being and reduce the burden of illness for adults.

Mental health problems are expensive and impact across the whole economy. Close to £7.5 billion is spent each year to address mental ill health in the London community². This includes spending on health and social care to treat illness, benefits to support people living with mental ill health, and costs to education services and the criminal justice system.

Mental health problems are more common in individuals who are already vulnerable and mental illness can exacerbate the costs and impact of adversity. Poor mental health is often an underlying factor behind risk behaviours and social and health outcomes, including violent or criminal behaviour, developing physical health conditions, smoking, substance misuse, domestic violence, homelessness, injuries and bullying. People with mental health problems are more likely to be both the victims of crime and the perpetrators. They are more likely to misuse alcohol and illegal drugs and substance misuse can itself trigger mental health problems and relapses.

Efforts to prevent mental health problems developing and to treat and support those with mental illness are enhanced through a focus on prevention and early intervention, through enabling our communities to develop resilience and through partnership working. The burden of mental health can be reduced through strong partnerships with agencies such as children's services, the criminal justice system, services that help people to manage their long term physical health conditions, substance misuse services and in the statutory and voluntary sector.

¹ Kessler RC et al, 2005 Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication Arch Gen Psychiatry Jun;62(6):593-602

² LONDON MENTAL HEALTH. The invisible costs of mental ill health. Greater London Authority , January 2014

Scope and purpose of Croydon's Mental Health Strategy 2014-19

This document sets out the Croydon integrated mental health strategy for adult mental health which is mainly focused on the needs of adults of working age. For completeness and to understand the broader context in which people live their lives, it also references the strategic priorities for older adults with mental illness and with dementia, but more detailed information on older adults can be found in the Croydon Dementia Strategy.

The recommendations from both the Dementia Strategy and recent review of older adults mental health services in Croydon is also informing the work of the Mental Health for Older Adults (MHOA) service re-design project which is underway during 2014-15.

The MHOA project is intended to focus on finding ways to address:

- projected changes in demographics - increase in ageing population, and increased demand for services
- need for increased service provision in the community, and improvements in early intervention and support
- increased awareness and support for carers
- better service provision in primary care and reduced reliance on inpatient care
- integrated and personalised health and social care, and better management of crisis and urgent care

This adults strategy should also be seen in close alignment to the developing Strategy for children and young people's emotional well-being and mental health 2014 – 2016. This is particularly important both in terms of the issues around prevention and transition from children's and adult services and also in terms of the impact of Mental Health issues in adults on children's mental health. There are also strong links with substance misuse services.

The strategy outlines the fact that mental ill-health has a broad impact across many aspect of society, not only health and social care services, but also on, education and employment and criminal justice including, police. The strategy covers the financial years 2014 – 2019, in line with the Clinical Commissioning Group (CCG) 5 year strategy. It will be refreshed and/or reviewed on an annual basis as appropriate. In addition to this strategy, yearly work plans will be developed which detail the work that Croydon CCG and social care commissioners will take forward.

We have decided it would be helpful to set out this strategy around the themes within the Department of Health (DoH) strategy 'Closing the GAP'. Each section therefore includes a summary of the priority outcomes for Croydon, main findings from the JSNA and key service user and stakeholder perspectives. Appendix 2 provides further details from stakeholder engagements held during the development of the strategy.

If Croydon's mental health services are going to be fit for purpose over the next three years and beyond, changing how we do things is of paramount importance. In meeting this challenge we will need to redesign our services in order to reduce our reliance on more expensive secondary and specialist mental health services. This will require more to be done in primary care and within community settings. There will also need to be more clarity about service outcomes, as well as us knowing what interventions are most effective. Putting services users and carers at the heart of the system can help develop an integrated approach to delivering mental, physical health and social care services.

Therefore the aim of the integrated mental health strategy is to create a shared transformational vision for mental health service provision in Croydon in the next 5 years. It is recognised that this strategy is been developed in the context of significant local and national challenges including:

- An increasing demand for mental health services (led in part by demographic changes and population growth), which has led to significant pressures on inpatient beds for Croydon's population.
- A challenging environment in terms of financial resources available to commissioners
- A service system that is imbalanced with a significant number of people in secondary care in the community that could be better managed in primary care, and an over reliance on inpatient provision.
- A low baseline for community services e.g. Improving Access to Psychological Therapies (IAPT) services.
- A need to develop further health and social care integration with the aim of promoting a whole person approach

By taking forward service re-design we plan not only to meet our financial challenge, but to raise the quality of the services we commission, and improve patient experience by ensuring that mental health problems are dealt with early and within non stigmatising environments.

Executive Summary

The strategy sets out the integrated strategic intentions for adult mental health in Croydon, which is mainly focused on the needs of adults of working age. The national and local context is reviewed including key policies, strategies and legislation and the implications and impacts for adult mental health services.

The strategy is structured around the themes within the Department of Health strategy 'Closing the Gap' and each section includes key findings and recommendations from the JSNA evidence base, service user perspectives from consultation engagements and the key outcomes that Croydon aims to achieve.

This executive summary provides highlights from each section to give an overview of the principles and priorities which will be taken forward by Croydon Council and Croydon CCH in partnership with all stakeholders.

Section 1: Increasing access to mental health services

One of the central priorities for the future is that primary care needs to be the main setting for supporting people with mental health problems. Evidence in Croydon suggests that currently a relatively high number of people with mental health problems are managed in secondary care, which is neither cost effective or in keeping with the vision to provide care in the least intensive setting. Services will need to ensure people are supported adequately at an earlier stage, reaching a 'crisis point' is avoided and people are supported to take a more active role in their own care.

Priorities include:

- Create care pathways that support referrals to community services (Clinical and non-clinical) at an early stage.
- Reduce the use of secondary care and increase use of community and primary care, as well as:
 - Ensuring development and investment in community teams
 - Reducing variations in primary care
- Increase involvement of primary care in the management of long term mental health conditions – ensuring primary care has the right resources and skills to responds to a wide range of mental health problems
- Improve access to psychological therapies, reducing waiting times and ensuring pathway is clearly defined
- Address inequalities in access to and use of mental health services for BME groups

Section 2: Strengthening partnership working, and integrating physical and mental health care

With mental health having a wide ranging impact across multiple areas including physical and wellbeing it is vital that maximum benefit is derived from opportunities to work more effectively in partnership and to promote integration and joint working with national and local initiatives, such as

the Better Care Fund (BCF) and the joint commissioning arrangements through the Integrated Commissioning Unit (ICU).

Mental health problems also impact on agencies ranging from health, children and young people, substance misuse, criminal justice, education training and employment. Taking into account the complexity of mental health and wellbeing there also needs to be closer working with transport, housing, green spaces and leisure services. It is therefore essential that there is a stronger infrastructure for joint working across all stakeholders.

Priorities include:

- Mental health services to be effectively integrated with physical health care at primary and secondary care levels – ensuring people with long term conditions and other physical health care problems are effectively supported
- Work collaboratively with other specialist services to deliver an integrated and effective response to people who have mental health co-morbidity
- Develop of a ‘whole population’ public mental health approach and better health promotion advice to reduce the risk of poor physical health
- Ensure stronger links between GP’s, other professionals, third sector and voluntary sector organisations in primary care, and between these groups and secondary care.
- Offer greater support for people with serious mental illness who are at risk of developing, or already have, physical conditions or unhealthy lifestyles.

Section 3: Starting early to promote mental wellbeing and prevent mental health problems

A strong emphasis on promoting good mental health, taking preventative action and intervening early are vital to increase wellbeing and reduce the negative impact of mental ill health. Providing and accessing early intervention and preventative support can also help people to better manage their condition and reduce the on-going need for services.

Self-care, self-management and shared decision making can also play a role by supporting people to maintain good physical health and mental health, make lifestyle changes which can improve mental health and work with service providers on treatment, management and support package options.

As already noted, this strategy must also be seen in alignment with ‘Nurturing for emotional wellbeing - strategy for children and young people’s emotional well-being and mental health 2014 – 2016’ and the links which exist around prevention, transition and the impact of adult mental health issues on the mental health of children.

Priorities include:

- Greater investment in prevention, early intervention and recovery
- Improved identification of those at risk of developing mental health problems in order to provide early intervention helping to prevent people experiencing a crisis

- Ensure voluntary/third sector service provision works effectively alongside both primary and secondary care mental health services - supporting people at an earlier stage to maintain social networks, retain housing, manage finances and have better access to education and training opportunities
- Deliver timely advice and signposting to reduce the risk of escalating problems, and improve availability and access to universal services
- Take a multi-agency approach to tackling mental health issues for children and young people, and promoting the emotional health and wellbeing of children and young people.

Section 4: Improving the quality of life of people with mental health problems

It is essential that people with mental health problems are supported to manage mental health problems effectively, live a full life and work towards achieving their own goals and aspirations. Information, advice and support around wider issues such as housing concerns, employment and training issues and opportunities and the impact of welfare reform also contribute to helping people to maintain health and wellbeing and quality of life.

Personalisation also plays a key role in giving people greater choice and control, with all new packages of council-funded social care in Croydon's Integrated Adult Mental Health Services now being provided through Self-Directed Support, often with Direct Payments. Measures being taken include delivery of personalised packages of self-directed support that are focused on promoting independence and resilience, recognising and supporting carers in their caring role, using care and support planning to put people in control of how their support is arranged and managed and promotion of direct payments.

Priorities include:

- People experience greater independence, choice and control through provision of personalised packages of self-directed support and the offer of direct payments
- Support for people with mental health problems to access the full range of housing options in order to meet their housing needs, prevent homelessness and maintain security of tenure
- Deliver housing support services which focuses on recovery, are outcome and person centred and help to avoid hospital admissions and live successfully
- Ensure a range of employment related services to help people successfully maintain, or return to, employment
- Offer a good range of wellbeing services which are aligned with the wider public health approach

National Context

The National Mental Health Strategy '**No Health without Mental Health**' was published in February 2011. The strategy sets out six main objectives and emphasises the role of the individual and that of the community, in strengthening and managing their own mental health, with appropriate support provided by statutory services. The strategy also describes a life course, outcomes based preventative approach to responding to mental illness and notes the importance of significantly increasing the involvement of primary care, education, employment and housing in the prevention of and recovery from mental health problems.

In July 2012 the '**No Health without Mental Health: Implementation Framework**', was published. The framework is set out in four parts and aims to provide guidance on translating the vision of the strategy into reality, by providing information on the actions that organisations might take to bring about real change and improvement.

More recently towards the completion of this strategy in January 2014 the DoH published '**Closing the GAP**' which aims to bridge the gap between long-term ambition and shorter term action in mental health. It therefore sets out 25 areas where people can expect to see, and experience, the fastest changes. The strategy sets out 4 priority areas, which Croydon's strategy is also structured around.

- Increasing access to mental health services
- Integrating physical and mental health care
- Starting early to promote mental wellbeing and prevent mental health problems
- Improving the quality of life of people with mental health problems

Launched in February 2014, the '**Mental Health Crisis Care Concordat**' seeks to improve outcomes for people experiencing mental health problems by ensuring services that may be involved at a time of crisis are working with a shared commitment to ensure the person in crisis gets the proper level of care in the right environment. Croydon CCG and Croydon Council will be working with partners from South London & Maudsley NHS Foundation Trust, Police, London Ambulance Service and the Voluntary Sector to ensure there is local agreement to support this national policy.

In addition there are numerous policy drivers which shape or influence mental health services, the following are some of the important elements at both national local level.

Mental Health Act 1983 (as amended by the Mental Health Act 2007)

The above Act and associated guidance places a statutory duty on Croydon, as a Local Social Services Authority, to exercise the following functions:

- Approving suitably qualified persons to act as Approved Mental Health Professionals (AMHPs), undertaking statutory functions under the Act (Section 114).
- Delivery of Approved Mental Health Professional services to meet the needs of the local area. This includes ensuring the provision of a sufficient numbers of AMHPs to provide an around the clock service, all year round (Code of Practice 4.33).
- Receive persons into Local Authority guardianship where this is assessed as the appropriate course of action (Section 7).

- To work in partnership with Croydon CCG and the voluntary sector to ensure ‘aftercare’ services are provided to those people who have been detained in hospital under certain sections of the Act (Section 117).

Croydon will continue to focus on quality through: commissioning first class services, working closely with voluntary sector partners, engaging with user and carer groups and investing in its frontline staff to ensure the above duties are discharged in line with legislation.

The Care Act 2014

The Care Act, which received Royal assent on 14 May 2014, places a range of new duties on local authorities. The aim of the Care Act is to put people and their carers in control of their care and support, and to change the way in which people are cared for with the concept of ‘wellbeing’ being central to the act. This means local authorities have a duty to consider the physical, mental and emotional wellbeing of the individual needing care. Key measures being introduced, and timescales for implementation, include:

From April 2015 -

- New duties, including -
 - to provide information and advice, including about paying for care
 - to shape local care and support the market, including production of a Market Position Statement
 - to arrange care for self-funders, including for residential care
 - to provide support plans and personal budgets for people with assessed eligible needs
 - to provide deferred payments (i.e. local authorities currently have discretion about when to offer deferred payments)
 - new duty of prevention and wellbeing to prevent or delay the need for care and support
- The introduction of national eligibility criteria for adult social care, covering both service users and carers (i.e. the removal of local discretion about setting eligibility). This includes a new duty to meet the eligible support needs of carers and new duties around the portability of assessments where people move to a different local authority
- The introduction of statutory Adult Safeguarding Boards and associated responsibilities for adult protection.

From April 2016 -

- The introduction of care accounts and a cap system where the local authority becomes responsible for the costs of meeting eligible needs once the cap has been reached
- The extension of the means test (upping capital thresholds for financial assessment) so that more people qualify for state funding towards the cost of their care
- A new duty to provide direct payments for people in residential care.

Tariffs & Mental Health Currencies

Formerly known as ‘Payment by Results’ (PbR), the new ‘National Tariff Payment System’ has been implemented nationally from April 2014. NHS England and Monitor have taken on responsibility for the NHS payment system from the DoH under the provisions of the Health and Social Care Act 2012. The national system sets out general rules for how local prices must be set for these services.

'Currencies' are the unit of health care for which a payment is made, and can take a number of forms covering different time periods from an outpatient attendance or a stay in hospital, to a year of care for a long term condition. 'Tariffs' are the set prices paid for each currency. The development and implementation of mental health 'currencies', is intended to improve payment approaches for mental health services.

In mental health, the currencies, known as 'care clusters', cover most services for working age adults and older people. The care clusters were mandated for use from April 2012 by the DH. In October 2013, NHS England and Monitor proposed that providers and commissioners should continue to be required to use the care clusters as national currencies for 2014/15.

As part of the rules in the national tariff payment system the 'mental health clustering tool' (MHCT) must be used by providers. Care clusters and initial assessments must be used as the currencies in the standard contract between commissioners and providers.

The approach aims to:

- support providers to better understand the care they provide to patients and the resources used to deliver that care;
- support clinicians to make decisions that deliver the best possible outcomes for patients and improve the quality of care provided; and
- provide information which will enable commissioners and patients to compare provider organisations and to make well-informed decisions.

There are 21 Care Clusters for mental health (see Appendix 1). Croydon CCG will be working closely with their chosen provider, South London & Maudsley NHS Foundation Trust, to agree packages of care, based on NICE and other best practice guidance, for each cluster and move towards cluster based service specifications. In line with recommended good practice, commissioners and providers will be seeking to involve service users, carer groups and GPs in this process.

Local Context

Croydon's population has grown more quickly in the last ten years than was projected by the Office for National Statistics. The most recent JSNA for Croydon estimates the population to be 363,400. The JSNA also estimates that as a result of migration flows into Croydon, from inner south London and out of Croydon to Surrey, Croydon's population is likely to become more deprived.

Over half of Croydon's population are from black, Asian and minority ethnic groups and this proportion is increasing over time. Age, ethnicity and deprivation will all have an impact on an individual's mental health and well-being, and the impacts of a growing population are also likely to impact the demand for Croydon mental health services over the next five to 10 years.

The Croydon Joint Strategic Needs Assessment (JSNA) provides information on key changes in the population profile and an insight into how this might affect the needs of Croydon's population in relation to mental ill health. The table in appendix 3 is taken from the same chapter and provides projections of the prevalence of mental health conditions up to 2021. It shows that whilst the common mental health disorders such as anxiety and depression are projected to increase by 5% over ten years, a much greater increase is projected in people with serious mental illness. Numbers

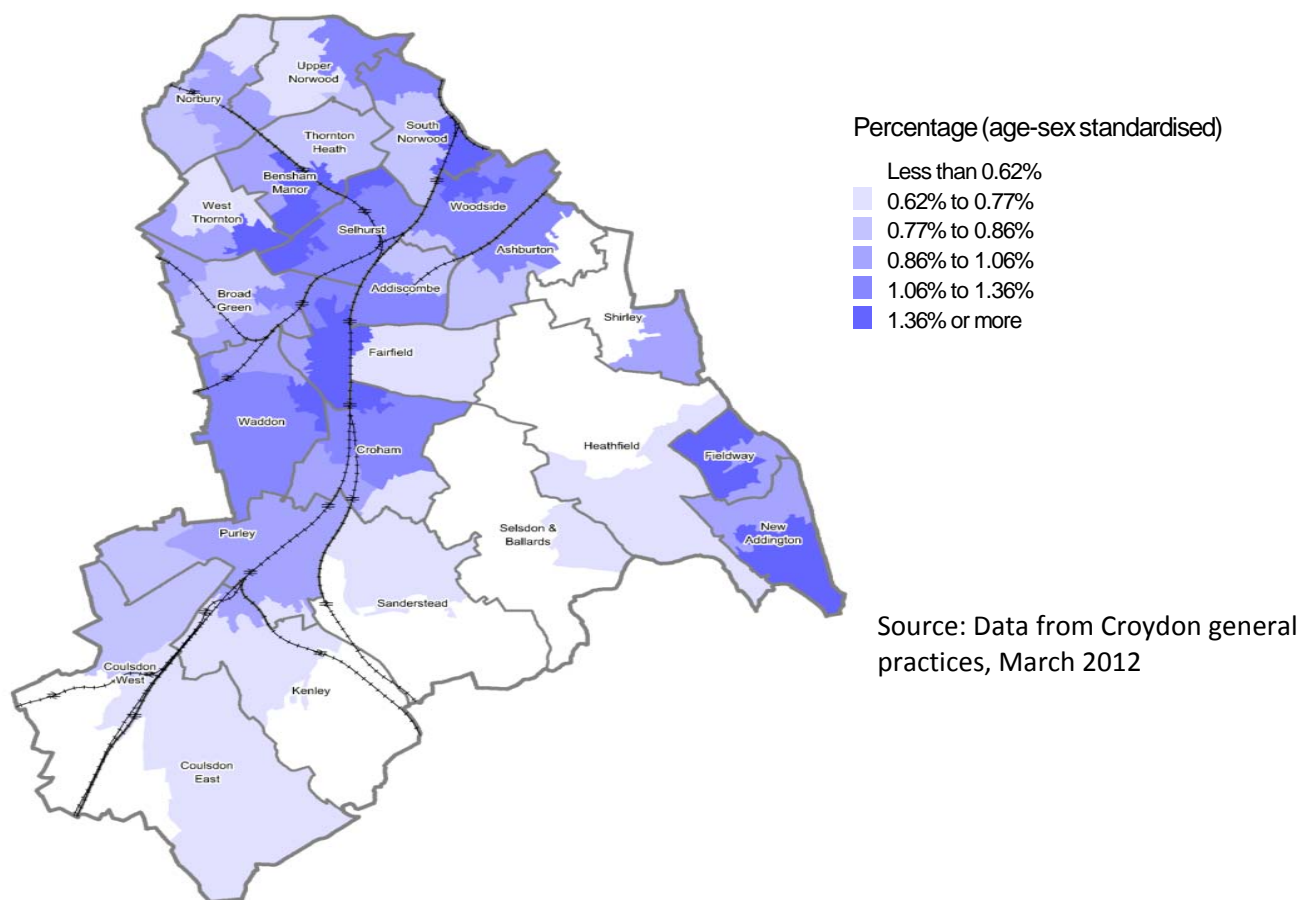
of people with schizophrenia, bipolar disorder and other psychoses are projected to increase by 23% by 2021.

The need for mental health services varies across the borough with greater need in the north and east as shown in figure 1 below. Our JSNA predicts an increase in the demand for services. Benchmarking of currently commissioned services identifies that we are spending more on inpatient services than other comparative Boroughs. A significant proportion of this spend is outside of our commissioned capacity within our block contract with South London and Maudsley (SLaM) NHS Trust and is sourced from other NHS and private providers by SLaM NHS Foundation Trust as overspill activity.

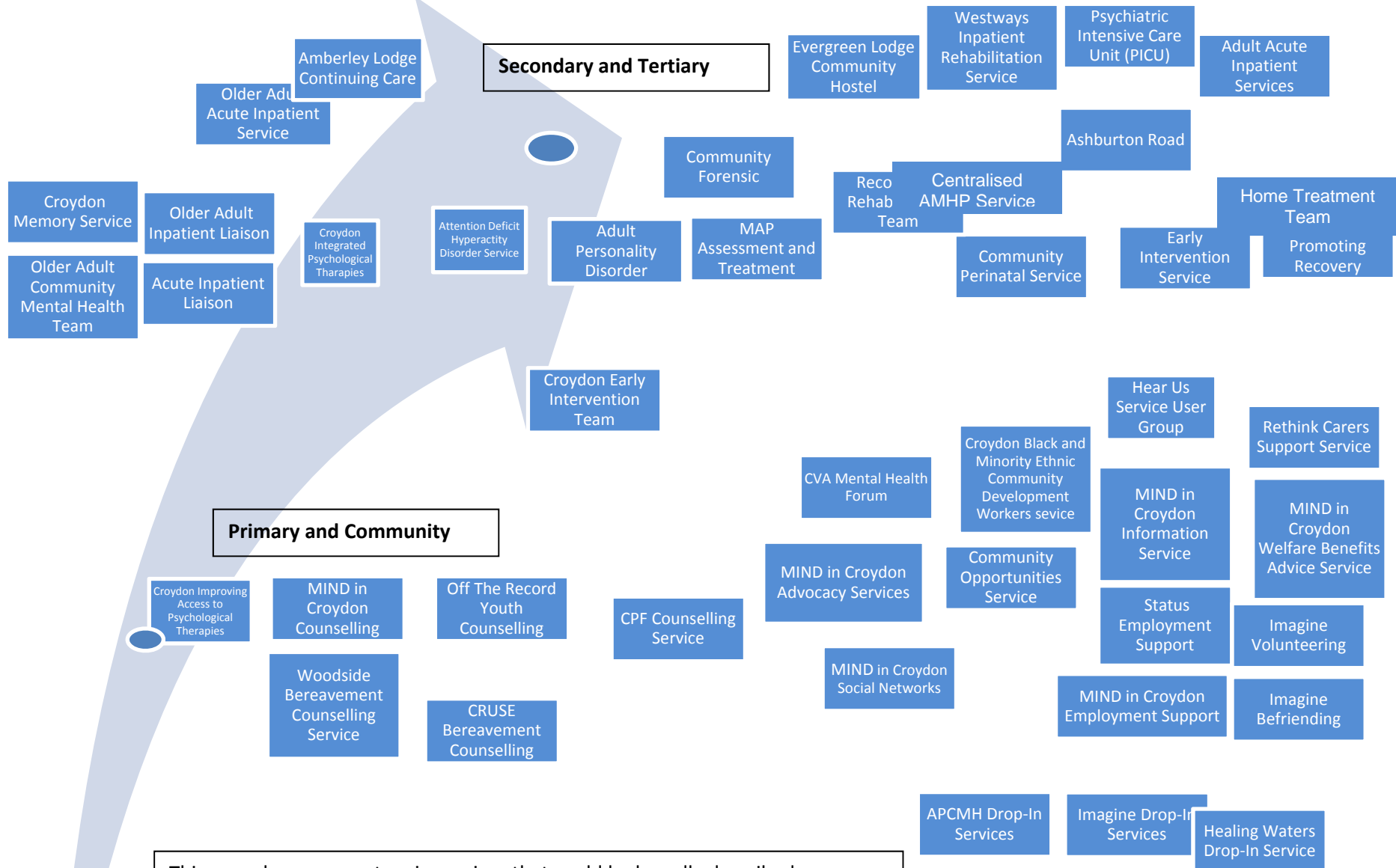
We are seeing a level of demand for our talking therapies that current provision is not meeting. This has led to waiting times for the IAPT service and the Croydon Integrated Psychological Therapies Service (CIPTS).

Health and Social Care commissioners will have less money to spend on all service provision including mental health. All this points for a need to do things differently and to make sure that through the implementation of the strategy we are taking measures to cater for increased demand, ensuring timely access to the most appropriate services for patients and more robust pathways that are effective in delivering end to end care including prevention and social care needs.

Figure 1: GP recorded prevalence of severe mental illness



Map of Croydon mental health services



This map shows current main services that could be broadly described as 'secondary & tertiary' and 'primary & community', it also does not set out dependencies and pathways.

Financial resources

Overall Croydon health and social care commissioners spend approx £60m on mental health services within this the CCG commissions a £37m block contract with SLaM (which covers adult mental health, older people's mental health and child and adolescent mental health services). The remaining money is spent on a range of other adult mental health services commissioned by Croydon CCG and the Council.

The budget structures of the Council and CCG are organised differently, and therefore it is not possible to do a straightforward comparison using the same budget headings. For example, the tables below reflects the fact that the CCG has a contract with SLaM which amounts to around 50% of the commissioners' budget, whilst in the Local Authority the majority of expenditure is on individual care packages involving service delivery from a variety of providers.

Croydon CCG mental health spend 2013/14	
SLaM	37m
Commissioning spend on placements	7.8m
Voluntary sector providers	1.1m
Various community support services	1m
Total	46.9m

Croydon Council mental health spend 2013/14	
Employees	3.7m
Care packages	11m
Voluntary sector	0.5m
Various community support services	0.3m
Income	3.3m
Total	12.2m

Public sector funding pressures

Croydon CCG and Croydon Council have historically been under-funded in terms of the levels of need experienced in the local population for a number of reasons, including population growth, increasing deprivation levels and migration.

The 2011 Census figures have shown that Croydon has experienced a greater increase in population growth to 2011 than was projected by the Office of National Statistics (ONS). This underestimation in population is greater for Croydon than across London or nationally and places the borough at a disadvantage for local government funding. As Croydon is expected to see further population growth which is higher than England and other regions this will lead to further inequity in funding distribution. GP registration figures for Croydon, compared to the Census, suggest that Croydon is also disadvantaged in respect of health formula calculation based funding.

Croydon is becoming relatively more deprived in comparison to other London boroughs and there is a recent trend for migration of people who are experiencing greater deprivation, which is known to be closely associated with mental ill-health, moving from inner London to outer London boroughs such as Croydon.

This lack of fairness in relation to funding from Government grant sources has been recognised, but it is not anticipated that major changes in the respective funding formulae for the CCG and council will take place in the immediate future.

Local mental health services and expenditure analysis

In 2011/12 a project, the 'Programme Budget Marginal Analysis' (PBMA) was led by Croydon Public Health to identify where expenditure was being made and to explore whether the balance was right in terms of different types of services, e.g. such as in-patient services, community teams, voluntary sector, prevention services and peer support. One of the key findings was that approximately half of commissioners' expenditure was on in-patient services. Overall, however the report highlighted the need for commissioners to strengthen prevention and early intervention initiatives and to improve integrated care delivery, drawing on the best available evidence. The report also highlighted the need to ensure that service user experience is at the heart of services.

Building on the PBMA report, in 2013 the CCG commissioned the consultants 'Mental Health Strategies' (MHS) to undertake further work to enhance understanding of local mental health services and expenditure, and to recommend changes and service improvements.

One of the key findings was around the balance of expenditure; a disproportionate share of Croydon's resources was spent on secondary care including with an over reliance on a bed based system including acute inpatient beds than on other community based services, including those delivered through primary care and the voluntary sector.

Another finding was that SLaM appeared to have a higher usage of inpatient beds than the national and regional average, and Croydon have a higher usage per head of population compared to the other SLaM boroughs.

The last year has also shown significant pressure on mental health inpatient beds. It has been estimated by MHS that significant saving could be achieved if admissions locally were bought more in line with similar places (estimated in the region of £2.4m) this would require other areas of potential efficiencies and some investment to strengthen community based services including services for people in crisis and home treatment team responses.

Analysis of mental health community team data also suggests that there is scope to move some of the more stable service users back to primary care. There are therefore real opportunities to improve and strengthen the role and effectiveness of these teams and other community providers so that they can deliver valuable prevention and early intervention work to reduce the likelihood of service users requiring a hospital stay. This would require some initial pump priming to achieve the required whole system service re-design.

Furthermore redesigning our local mental health system so that more people have their needs met in their local community through primary care, closer to home, would require resources to be made available to social care and voluntary sector partners so that they can be supported effectively and their wellbeing sustained.

The background context for this mental health strategy is the constrained resources within which all public sector organisations are having to operate. Croydon CCG has significant financial and efficiency challenges over the coming 5 year and Croydon Council is addressing how it will meet a

budget reduction in the order of £100m by March 2018. Strengthening services in community and primary care offers a sound option for the future, particularly in drawing on the strengths of the voluntary sector, on peer led local organisations and by having service user experience at the heart of our decision making including in relation to use of resources.

Section 1: Increasing access to mental health services

Community services

The consequence of our commissioning a highly bed based service means that we have a lower level of spend in community services. If we are to achieve our vision for mental health services this will need to change, with more resources made available in the community. These services must ensure that people are supported adequately at an earlier stage of illness to avoid crisis; supporting people to take more of an active role in their own care and reducing the time spent away from their homes and/or jobs as a result of ill-health.

To effectively do this it will mean creating care pathways that allow for and encourage referrals to community services (both clinical and non-clinical) at an early stage with extended front end assessment and treatment. In practice this will mean building stronger links between GPs and other professionals working in primary care and third/voluntary sector organisations, as well as between these groups and secondary care. The aim should be that if a person presents early on to their GP/Primary care health professional, appropriate support should be provided that enables people to manage their health problems, alongside receiving support to stay in work, reduce social isolation, or to manage financial problems. Often it will be the case that this non-health related support is not commissioned via Croydon's statutory service provision and we will need to work collaboratively with the voluntary sector to achieve these outcomes. The overriding principle will be to reduce duplication and to ensure that all support is provided by those agencies that can do it most effectively.

Reduced use of secondary care (especially acute inpatient beds) and increased use of community and primary care

An important element will be to reduce the variations in primary care. The JSNA showed that there is wide variation in GP performance, and only some of it can be explained by differences in need. Data shows that there are individuals currently being seen by community mental health teams that could be seen in primary care and this is also supported by primary care prescribing data. Linked to this will be the need to ensure that there is significant development and investment in the community teams that are most effective in preventing people from entering inpatient settings, including the Croydon Early Intervention Team (aka COAST).

Evidence in Croydon suggests that currently a relatively high number of people with mental health problems are managed in secondary care, which is neither cost effective or in keeping with our vision to provide care in the least intensive setting.

Croydon has a low level of primary care prescribing for people with mental illness when compared to the rest of the country, and the lowest prescribing rates when compared to neighbouring south London boroughs. This suggests that more can and should be done within primary care, beginning with the agreement and implementation of shared protocols.

Referral data from Croydon GPs also show a very mixed picture in terms of practice referrals to secondary care, and there is no correlation between areas of mental health need. The suggestion therefore is that there is a wide variation in practice in terms of how GPs are managing people with mental illness.

Most often it is the case that the first request for help from a person experiencing mental health problems will be to their GP. It is also national policy to increase the involvement of primary care in the management of long term mental health conditions. It makes sense therefore that primary care should have the right resources and skills to deal with as wide a range of mental health problems as possible.

We need to ensure that any new model of care transforms and innovates service provision, it will not be sufficient to create new teams that merely replicate what is currently undertaken in a secondary care setting. The strategy for Croydon has to be to modernise services and to do things differently.

As we move forward we want to ensure that primary care is the main setting for supporting people with mental health problems and we will explore the best way to do this by evaluating existing local initiatives and learning from what has worked well elsewhere.

Better access to psychological therapies

Currently there is a significant wait for step 3 services, which are provided through Improving Access to Psychological Therapies (IAPT), and step 4 psychological therapies, which are provided through Croydon Integrated Psychological Therapies Service (CIPTS) therapies in Croydon. Further work needs to be done to clearly define the pathway and the service offerings of the different therapies on offer, including those provided via the voluntary sector.

Addressing the needs of BME groups

The work undertaken by MHS shows a disproportionate use of acute inpatient settings for Black service users. The JSNA also showed a disproportionately low referral to talking therapies for BME service users, low rates of diagnosis in primary care, particularly for people with depression, anxiety and dementia and over-representation of young African and African Caribbean males in acute psychiatric inpatient to be turned around by the strategy.

The JSNA findings are reinforced by 'Mind the GAP' a report on BME mental health services provision in Croydon, which was undertaken by the Croydon's BME forum, Hear Us and Off the Record. This report aimed to explore BME Mental Health provision in Croydon and establish the inclusivity and accessibility of local mental health services. Key findings from the report included:

- Cultural competency and sensitivity within services - there can be a lack of understanding towards cultural difference and cultural requirements, ranging from the provision of food, overcoming language barriers and awareness of cultural issues
- Stigma and BME communities - the stigma of mental health illness amongst BME communities creates a barrier to BME service users accessing and receiving support.
 - Lack of knowledge and understanding of cultural beliefs has an influence on how service users and their families perceive mental health illness and treatment.
- Poor provision for refugees and asylum seekers - refugees and asylum seekers approach mental health services with complex needs, however not all service are well equipped to respond effectively.

- Talking therapies - there is a need for increased access to talking therapies for service users, which needs to be offered as part of an integrated, ongoing support.
 - The challenges in delivering talking services to BME service users also need to be recognised and addressed.

Developing clear care pathways for mental health interventions

For the mental health system to work better in terms of access to treatment and movement of clients through the system it is essential that there is clarity on the different levels and types of treatment on offer. A critical component of the redesign of services will entail outlining and mapping the care pathways. Linked to this, work has been undertaken by Mental Health Strategies to look at patient flow through care pathways and optimising the treatment system. Taking a co-production approach with service users and carers would also help to ensure integrated pathways.

Acute inpatient care

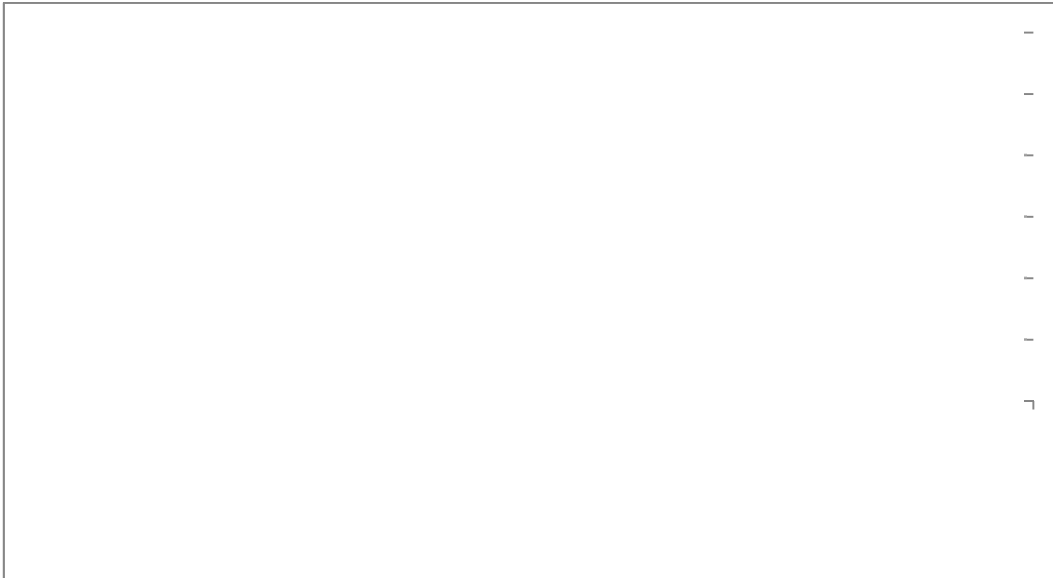
Commissioners want to ensure that the acute care pathway is fit for purpose and is configured in such a way that people receive the appropriate service and are admitted to a bed within a reasonable distance of south London, unless they need a highly specialist service not available within the locality.

As things currently stand in Croydon, we know we are commissioning a relatively high bed based service, when compared to other London localities and across England, and as much as 21% above average for the most statistically similar CCGs. Whilst acknowledging that there is still further work to be done to understand the high impact changes that we need to make; we believe that shifting resources into community services, and improving support in primary care will reduce the number of beds we need over the next three years and provide a better patient experience. In particular there is an urgent need to reduce the overspill of placements placed out of Borough, due to bed pressures which has a significant financial impact for both health and social care and can have a significant impact on the experience of patients and their family members.

There will still be a need for inpatient services within the overall mental health acute care pathway and commissioners want to ensure that not only will this provision be provided as locally as possible, but that it is also of high quality and therapeutic. Lengths of stays on inpatient wards should be no longer than is clinically appropriate and we will work with our providers to ensure they are based on evidence. All Croydon acute inpatient services will need to be fully integrated with Croydon community services in order to achieve this. It also will mean working collaboratively with other agencies and departments such as housing, to ensure people are not delayed in hospital for non-clinical reasons.

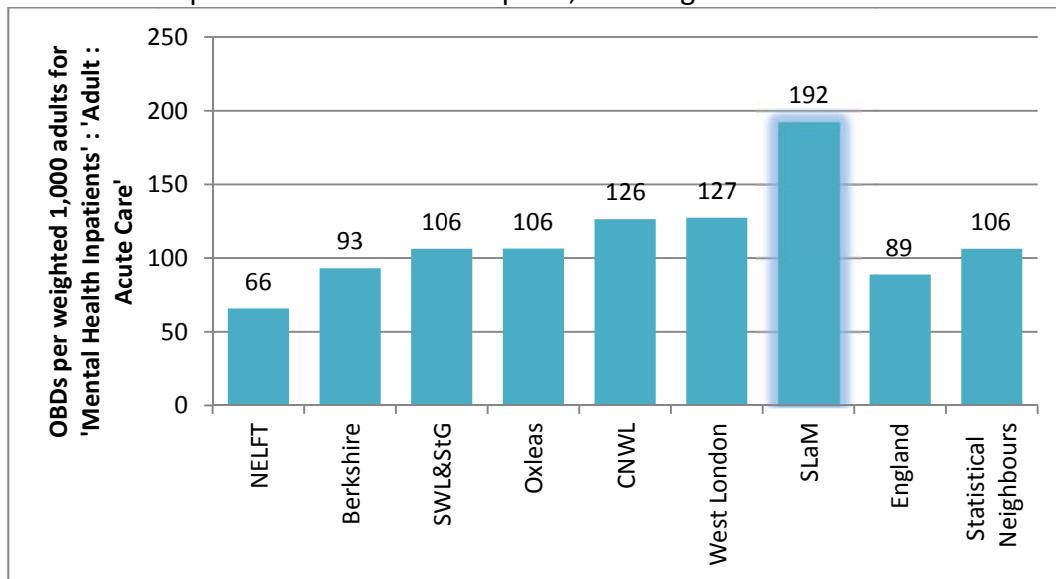
Commissioners would also like to see that the case mix of patients on inpatient acute wards is similar in order to ensure that appropriate and specialist skills are provided, and to ensure that ward environments are as therapeutic as possible. In order to achieve this, it is anticipated that Croydon will work collaboratively with other boroughs in South London who use SLaM inpatient services, to see if there are better ways to commission inpatient wards collectively.

Adult acute inpatient services – Spend per weighted adult



Sources: Reference Costs 2010/11, GLA/ONS 2011 based population estimates

Adult acute inpatient services – OBDs per 1,000 weighted adults



Sources: Reference Costs 2010/11, GLA/ONS 2011 based population estimates

Section 1: main findings & recommendations from JSNA addressed in this section

- Pathways - the interface between services and settings needs to improve, e.g. primary and secondary, social care and health care, recovery and treatment
- There are variations in the quality of primary care, especially around -
 - Physical health reviews for people with serious mental illness
 - Care plans for people with serious mental illness
 - Screening for, diagnosis and initial management of depression
 - Referral to services
- Inequalities were identified for people with mental health problems, especially:
 - primary care diagnosis rates of depression, and access to secondary care services for BME groups
 - existence of stigma and discrimination in community and in services
- Talking therapy services are seen as high quality service but capacity is low and waiting times are longer than in other areas.

Service user and stakeholder perspectives

- Greater use of primary care, when appropriate, is supported by many especially as for some the experience of secondary care can be damaging and stigmatising. However concerns included -
 - The individuals views must be sought and carefully explored
 - Impact on entitlement to benefits, possible reduction of income and negative impact on mental health, must be considered
 - Any move to primary care does not result in a lower level support or inadequate support leaves an individual vulnerable to crises / relapse
- There is concern about whether decommissioning inpatient beds would reduce the availability of crisis support
- There is a need to better understand and address the inequalities that exist for BME groups

Key outcomes for Croydon

Joint health and wellbeing priorities:

- **Increased resilience and independence**
 - When people become ill, recovery will take place in the most appropriate place, and enable people to regain their health and wellbeing and independence.
- **Increased healthy life expectancy and reduced differences in life expectancy between communities**
 - Local organisations will work together to address the factors that drive health problems amongst the poorest and most disadvantaged.

- Re-designed, fully integrated, mental health care pathways encompassing the full range of interventions from all sectors, for prevention, treatment and recovery. Developed in collaboration with all relevant partners
- Deliver new model of primary care, as the main setting for supporting people with mental health problems, delivering –
 - increased resources available in the community, offering adequate support at an early stage
 - integration with acute inpatient care services
 - reduced variation in the quality of primary care
 - reduced use of secondary care
- Reduced waiting times for psychological therapies and simplified referral routes into treatment
- Reduced use of 'out of borough' placements for acute inpatient care
- Use findings from Croydon's 'Mind the Gap' report and JSNA to develop actions to address inequalities in access to, and use of, mental health services for BME groups

Section 2: Strengthening partnership working, and integrating physical and mental health care

Integration and physical health services

“Currently, men with a severe mental illness die on average 20 years earlier than other people; women 15 years earlier. They have higher rates of cancer, heart disease, respiratory disease and diabetes.” (Closing the Gap: priorities for essential change in mental health)

Mental Health has a wide ranging impact across many areas including physical and social wellbeing. This relationship is two-way i.e. poor physical health can lead to or exacerbate a person’s mental wellbeing and the opposite is also true. The strategy will look to make the most of national and local initiatives that promote integration and joint working for example the Better Care Fund (BCF) and Croydon CCG and Local Authority’s plans on increasing joint commissioning arrangements through the Integrated Commissioning Unit (ICU). Another example will be the active involvement of mental health professionals in the Multi-Disciplinary Teams (MDTs) that support risk stratification, aligned to the six GP networks.

Commissioners understand the need to work with other specialist services in order that Croydon can deliver an integrated and effective response to people who have mental health co-morbidity. In particular there is a need to ensure that this mental health strategy and future planning of mental health services in Croydon adhere to the requirements of the national autism strategy, and the Autism Act 2009.

Croydon’s approach to implementation of the Autism Act is to ensure that services are developed and delivered in line with the requirements of the Act through commissioning and procurement processes. Local authorities and other public bodies, including the NHS, have specific duties and responsibilities under the Act, such as appropriate training for staff, understanding and responding to the support needs of people with Autistic Spectrum Disorder (ASD) and meeting certain requirements when carrying out commissioning and procurement activities. To support this service specifications will contain specific reference to the Act and providers will be required to demonstrate how they intend to ensure services are appropriate and accessible for people with ASD. Similarly, providers will be required to evidence how this has been achieved as part of the regular service monitoring with commissioners.

Mental health services will also need to be effectively integrated with physical health care at both primary and secondary care levels to ensure that people with long term conditions and other physical health care problems are effectively supported. Likewise well-established evidence shows the higher levels of physical health problems in people with both common and serious mental illness. We need to ensure people receive holistic responses in accordance with their needs, with the aim of reducing the mortality rates for people who have a serious mental illness.

Addressing areas of overlap between mental health and physical health

Poor mental health has an impact on a number of areas including physical health. Research by the Kings fund has highlighted the fact that clients with certain long term conditions including; COPD and Diabetes who also suffer from depression have worse outcomes and will cost the NHS more as a group than those that do not have poor mental health.

There is also additional cost associated for those suffering from mental illness relating to medically unexplained symptoms and to attendances at emergency care and hospital admissions. It will be important going forward for IAPT services to better support patients in long term conditions and to be integrated with the redesign of pathways in acute care.

Another area where we see the impact of mental ill health is on emergency departments. An audit is currently being carried out at Croydon University Hospital (CUH) to look at the nature and pattern of those who attend A & E where mental illness is a factor in their presentation.

Stronger joint working across key stakeholders

The strategy clearly outlines the fact that mental ill-health has a broad impact across many aspects of society. It impacts on agencies ranging from, health, children and young people, substance misuse, criminal justice, education training and employment. It is essential that in order for this strategy to deliver the intended transformation and impact that there is a stronger infrastructure for joint working across these stakeholders. It is proposed that current partnership working and governance should be reviewed with a view to establishing a revised mental health partnership board which will be responsible for the implementation of the strategy.

The board will need to be provided with good intelligence to determine the level of performance and quality of mental health provision in Croydon and provide clear targets to measure progress.

London street triage service

London is one of nine pilot areas across the country that received funding from the DoH to run a 'Street Triage' service. This service is designed to support front line police officers in dealing with people in mental health crisis, reduce the amount of police time spent handling mental health related issues, and to improve the overall experience of people with mental health problems who come into contact with police. The service is delivered by South London & Maudsley Foundation Trust and is in operation across the Boroughs of Southwark, Lewisham, Croydon and Lambeth, providing an invaluable service to front line officers and the communities they serve.

Section 2: main findings & recommendations from JSNA addressed in this section

- Mental and physical health are inextricably linked and should be treated together
- Collaboration between primary care and wellbeing and community services needs to be strengthened
- People most prone to depression include those with long term physical health problems, those with medically unexplained symptoms, those on low incomes, women, carers, asylum seekers and substance misusers
- Support needs to be strengthened for people with serious mental illness who are at risk of developing, or already have, physical conditions or unhealthy lifestyles.
- The wide ranging nature of mental health and wellbeing means that involvement is needed from a breadth of commissioners, including physical health services, transport, housing and social care, green spaces, leisure etc.

Service user and stakeholder perspectives

- Some people may be deterred from seeking help with physical health problems due to issues around their relationship with their GP as the 'responsible or lead clinician'.
- There is a need to consider how GP practices can become the most appropriate setting for to treat enduring mental health problems, issues include –
 - The need for practice staff and other patients to be sensitive in their response to behaviours sometimes demonstrated by people with mental health difficulties
 - waiting areas can be difficult places for anyone who is distressed/agitated
- There may be a need to have 'named GPs' to avoid problem of building a relationship when seeing GP's 'ad hoc'
- Carers can feel misunderstood and/or unsupported by professionals and emphasised the importance of being listened to, respected and involved in care planning and reviewing

Key outcomes for Croydon

Joint health and wellbeing priorities:

- **A positive experience of care**
 - People using health and care services will be protected from avoidable deaths, disease and injuries.
- **Increased healthy life expectancy and reduced differences in life expectancy between communities**
 - Local organisations will work together to address the factors that drive health problems amongst the poorest and most disadvantaged.

- Reviewed partnership working arrangements to ensure successful joint working and delivery of objectives within this strategy
- Whole system integration of physical and mental health services
- Introduce measures to address increased rates of physical health problems in people with both common and serious mental illness, and reduced mortality rates for people who have a serious mental illness.
- Development of a 'whole population' public mental health approach and better health promotion advice to reduce the risk of poor physical health
- GP's assisted to support people in managing and maintaining their mental health when stable
- A local agreement is in place to ensure services work together to improve outcomes for people experiencing a mental health crisis (in line with the national Crisis Care Concordat)

Section 3: Starting early to promote mental wellbeing and prevent mental health problems

Supporting people to stay well

Many innovative services are provided by non-statutory services in Croydon and play a valuable role in supporting people to stay well and out of hospital. These services are community based and often provide preventative support to individuals.

In the current configuration voluntary/third sector provision commissioned by Croydon CCG and the Council work primarily with people referred from secondary mental health services. If we are to reconfigure services to be more preventative and primary care focussed in nature, it may be more appropriate that these services are commissioned to be much more primary care facing. This would enable them to support people to maintain social networks, retain housing, manage finances and offer advice with routes into education and training amongst other things at a much earlier stage and before an individual reaches a crisis that may exacerbate existing mental health problems.

There are also options for the sector to draw on funding from outside of Croydon to benefit the population, as well as working with non-health and social care organisations in the development of innovative support services that have a primary function of keeping people well and out of hospital.

It will be of paramount importance to devise and implement appropriate referral routes into and out of these services in order to maximise the benefits to individuals who receive them. It is equally important that commissioners review the current voluntary/third sector service configuration in order to see how appropriate it is to Croydon's current need. There is no doubt about the importance that these services can play in supporting people with mental health problems in Croydon, but there needs to be more clarity about where services fit in overall pathways.

Postnatal depression

It is anticipated that rates of Postnatal Depression (PND) will increase in Croydon, with the JSNA Depression Chapter reporting that in 2012 an estimated 717 women had postnatal depression in Croydon and that taking into account predicted changes in birth rates, this will increase to 28% by 2021.

PND has a substantial impact not only on the mother, her partner and her family, but also on the longer term emotional and cognitive development of the baby. Although Croydon has seen its teenage conception rate drop dramatically over recent years it has also been widely shown that young mothers are three times more likely to suffer postnatal depression than older mothers and to suffer mental health problems for up to three years after the birth.

Children and Young People's Emotional Wellbeing and Mental Health

Croydon's published its Children & Young People's Emotional Wellbeing & Mental Health Strategy 2014-16 in January 2014. The strategy provides a clear direction for promoting the emotional wellbeing and mental health of Croydon's Children & Young People from conception to their 18 birthday (whilst also recognising that for some young people with significant special educational needs (SEN), the Council will maintain its responsibility until 25 years).

The Strategy sets out a multi-agency approach to promoting children's emotional well-being and mental health and needs to be considered in close alignment with this Mental Health Strategy for adults, both in terms of prevention and transition from children's to adult services and in terms of the impact of parental mental health issues on children's health.

The emotional health of any young person is crucial to their development, with the foundations being laid early in life, even before a child is born. There is increasing evidence of the cost benefit of early intervention especially in relation to conduct disorders.

Children and young people who are emotionally healthy achieve more, participate more fully with their peers and their community, engage in less risky behaviour and cope better with any adversities they may face during their life.

It is estimated that during 2011 there were around 21,000 under-18s in Croydon with some form of mental health need. By 2021 this figure may rise to 24,000. The number of children with an ASD is expected to rise significantly over the next decade. It has been estimated that the cost of treating child and adult mental health problems could double over the next 20 years. There are strong economic arguments for increasing the focus on prevention and provision of early intervention.

Prevention and early intervention

The government's mental health strategy has a strong emphasis on promoting good mental health, taking preventative action and intervening early. The overview chapter in Croydon's 2012/13 JSNA describes the evidence based actions needed to improve mental health across the 'life course', from birth to old age and the chapter shows the key factors that influence and protect mental health and well-being.

It bears repeating that some of the factors that influence well-being and prevent mental illness lie outside mental health services and include for example planning, transport, education, leisure and housing.

As well as addressing current presenting mental ill-health this strategy will also have a strong focus on prevention and early intervention. Early intervention in psychosis aimed at the ages of 14 – 35 can have a strong impact on preventing the development of more severe mental illness.

Croydon's Prevention, Self-Care and Shared Decision Making Strategy (PSS) aligns with the Local Councils Adult Care Commissioning Strategy which has a major emphasis on primary prevention as well as secondary care prevention. The four key components of Croydon CCG PSS strategy as they relate to Mental Health can be described as follows:

- **Prevention**

The negative impact of mental illness on an individual can be significantly reduced as a result of particular health and/or social care intervention received, and through some lifestyle changes. Providing and accessing early intervention and preventative support will help people better manage their condition and can reduce the on-going need for services. For example:

- Early detection for psychosis.
- Debt management and mental health

- Collaborative/integrated mental and physical health teams to support people with a long term condition (LTC).

- **Self-care**

The DoH has defined self-care as: ‘The actions that people take for themselves, their children and their families to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long term conditions; and maintain health and well-being after an acute illness or discharge from hospital’ (DoH, 2005). Examples of implementing self-care models will include:

- Raising awareness and providing information about service provision and other support available
- Ensuring that care plans for people are person centred and help people to take a lead in caring for themselves

- **Self-management**

Self-management is a sub-set of self-care. For people with long term mental health conditions, self-management will commonly involve understanding and following medical regimens, and making some challenging changes in lifestyle, to address issues which may be negatively impacting on the individuals mental health. Examples of implementing self-management models will include:

- Developing Croydon’s mental health strategy in order to redesign mental health care pathways so that there is clarity of the role of self-management
- Effective patient education
- Self-management of direct payments

- **Shared Decision Making**

Shared decision making is a process by which service providers and users work together to choose test, treatment, management or support packages. Service users will be increasingly involved in ‘shared decision making’. Examples of implementing shared decision making models will include:

- The use of person centred recovery based outcome tools
- Service user involvement in mental health service redesign and reconfiguration

Section 3: main findings & recommendations from JSNA addressed in this section

- High levels of wellbeing prevent depression and help those with depression to recover quickly and reduce relapse
- Early intervention in psychosis services should be reviewed and developed
- Early detection of people at high risk of developing schizophrenia can provide opportunities to prevent the onset of the condition - although early detection services in Croydon are limited.
- Advice and information about services, self-help strategies and ‘5 ways’ to wellbeing should be developed and promoted
- Collection and availability of data about outcomes, activity and access by vulnerable groups should be improved

Service user and stakeholder perspectives

- Greater investment in primary care, preventative and early intervention services is recognised as a sensible way to invest resources whilst optimising outcomes for people experiencing mental health problems – especially amongst those who have had negative experiences of secondary care.
- The heavy caseload for many GP's could be a barrier to taking a more preventative approach and there is a risk that some GP's may be less able than clinicians to detect, and effectively respond, to signs of relapse.
- The aim of greater investment in preventative, early intervention and crisis services is welcomed – especially to help address shortcomings crisis care services

Key outcomes for Croydon

Joint health and wellbeing priorities:

- **A positive experience of care:**
 - People using health and care services will be protected from avoidable deaths, disease and injuries
- **Increased resilience and independence:**
 - Earlier diagnosis and intervention means that people will be less dependent on intensive services
 - Everyone will have the opportunity to have optimum health throughout their life and proactively manage their health and care needs with support and information

- Increase in number of people receiving the help they need when they first present to mental health services – leading to a reduction in representations at A&E, police custody and acute psychiatric wards etc, and exacerbation of associated issues.
- A shift in the balance of investment towards prevention, early intervention and recovery and implementation of preventative, self-care and shared decision making initiatives in alignment with the PSS Strategy
- Timely advice and signposting to reduce the risk of escalating problems, improved availability and access to universal services and promotion of the '5 ways to wellbeing' initiative
- Reviewed voluntary/third sector provision in the borough, to deliver -
 - Greater focus on prevention and primary care links
 - Take up of funding opportunities to increase early intervention and prevention services
 - Effective referral routes, developed alongside wider pathways work
- Improved identification of those at risk of developing mental health problems, supporting early intervention to help prevent reaching a 'crisis point'
- Ensure work to improve transition between children's and adults services takes account of emotional wellbeing & mental health

Section 4: Improving the quality of life of people with mental health problems

It is important that people with severe and common mental illness are supported to manage the effects of their disability in order to live a full life. Whilst the majority of people will be treated in primary care, there will be some people who require a secondary/specialist care service that can provide intensive support when needed.

All interventions provided in secondary or specialist services will need to be able to focus on supporting people to identify and work towards achieving their own goals and aspirations. Services will also need to work closely with primary care and ensure people maintain links with other community services as appropriate. Providing services in non-stigmatising locations/environments and services that are culturally sensitive or targeted to particular groups as appropriate, will also help us address issues of inequity in access to services for BME groups.

Personalisation in Adult Mental Health

All new packages of council-funded social care in Croydon's Integrated Adult Mental Health Services are now provided through Self-Directed Support, often with Direct Payments. All staff in the integrated service complete comprehensive social care needs assessments against the government's Fair Access to Care Services criteria. Council social care staff, embedded in Community Mental Health services alongside their health colleagues, are able to champion the Personalisation Agenda and offer assistance with the assessment and support-planning processes where required.

In keeping with the prevention agenda, there is a strong emphasis within mental health on intervening early to prevent clients from deteriorating to the point where more expensive forms of support such as hospital or residential care are required. Experience has shown us that when a small amount is invested, for example in helping a person to maintain their environment, the positive impact on their mental health and wellbeing is enormous. Clients who in the past may have been in residential care are now empowered to remain in their own communities, with their own tenancy, with interventions now focussed far more on promoting independence and social inclusion.

As part of a whole-systems approach to mental health, the Council funds short-term packages of self-directed support that can be quickly introduced to facilitate early discharge from hospital. This occurs where it has been identified that a brief period of intense social care support following discharge can help reable clients back to more independent living and promote recovery. This serves to combat institutionalisation, reduce dependency on services and speeds the individual's return to their home environment. Outcomes are improved when service users can access their own social capital and support networks in the community. In a climate of constrained resources, this time-limited intervention also shortens length of stay on the ward, thereby minimising the use of high cost beds and maximising the number of people who can be treated within commissioned inpatient services.

Moving forward, mental health staff will focus support on keeping the service user journeying towards self-reliance and greater independence. This is in keeping with the recovery model and requires rigorous attention to reviewing the individual's needs. This attention will ensure the client is being supported to take positive risks in the interests of encouraging resilience and preventing

ongoing dependence on limited resources. Maintaining a throughput is essential to ensuring that the available resources can then be allocated to target other clients coming through the system.

In line with the principles set out within 'Working Together for Personalised, Community Based Care and Support – a partnership agreement 2014-17', developed by the Think Local Act Personal (TLAP) programme, and as part of the steps we are taking towards meeting the requirements of the Care Act our focus will be on:

- Providing personalised packages of self-directed support, according to assessed need, that have a strong focus on promoting independence and resilience.
- Giving carers the recognition and support they need to continue in their caring roles, to meet their own needs as well as those they care for.
- Ensuring that high quality, community-based support is available for people with the most complex needs.
- Using personal care and support planning to put people in control of how their support is arranged and managed.
- Promoting the use of direct payments so that many more people benefit, with a stronger range of options to support their use

Personal Health Budgets

The Government has made clear that individual choice and control in public services is a priority. Personal health budgets support this priority by enabling individuals to better manage their physical and mental health. Evaluation of the personal budget pilot programme showed that the groups who benefited most from personal health budgets were those with higher levels of need, including individuals in receipt of NHS Continuing Healthcare and those with mental health needs. Over the lifetime of this strategy guidance is expected from NHSE on how personal health budgets can be implemented in practice.

Improving quality of life and maximising opportunities for reablement and recovery

A reablement service is currently being piloted which aims to provide a brief but intensive service that aims to restore life skills and build resilience. The service is due to be evaluated but is already showing signs that this approach can be successful in reducing the need for on-going health and social care support.

Mental health day services

Mind in Croydon undertook a survey in February 2014 to help better understand people's needs in relation to day services and have produced a report 'Somewhere to go, something to do: a survey of the views of people using mental health day services in Croydon – MIND in Croydon' (2014) to detail the findings.

The report highlighted what people felt they needed in respect of day care services which included, having somewhere they could attend more regularly, including at evenings and weekends, more practical help with things such as managing daily admin tasks, outreach support and community issues and managing physical and mental health problems.

The report also includes recommendations such as, listening to the views of service users about the kind of services and support they would find helpful and supportive, ensuring there are sufficient, high quality services available and local providers working with commissioners on monitoring and evaluation processes to evidence the value of services.

Welfare reform

Teams working with customers affected by the welfare reform aim to encourage people into employment whilst offering support for those that have disabilities or are vulnerable. Employment rates for people with mental health problems is often low but it is widely acknowledged that having paid employment is good for mental health and can aid recovery from mental illness.

Croydon's response to the impacts of welfare reform is a holistic multi-agency approach, working with partners such as Job Centre Plus, benefit teams, social care team etc from across the Council and a range of third sector organisations. An inclusive approach is being taken, focused on outcomes for the customer of household which are 'safe, sustainable and affordable' but also ensuring that additional support needs are identified and met wherever necessary. Croydon is also looking at how best to respond to the longer term impacts of further changes, such as Universal Credit and the move from Disability Living Allowance to Personal Independence Payments, including the impact on particular client groups whose support needs may vary to achieve the best possible outcomes for customers.

Housing and housing related support

The current Housing Strategy 2011-15 highlights that housing issues such as homelessness and rough sleeping, affordability and security of tenure can all have impacts on mental health. Challenges in preventing rough sleepers from returning to the street include the need to ensure specialist services are available for those with complex needs, and making sure effective referrals arrangements are in place with health services, including mental health services.

A refresh of Croydon's Housing Strategy will commence in 2014-15 and will provide an opportunity to consider further measures that can be developed around housing development, homelessness prevention and provision of housing related support for people with mental health problems. Mental health leads for the CCG and the Council will engage with this work to ensure that the needs of people with mental health problems are fully taken into account and that the strategy action plan includes details of how identified issues will be addressed.

Housing support services for people with mental health problems are focused on a recovery based approach with the aim of developing and maintaining the person's independent living skills. A review of mental health commissioned supported housing services is being carried out in 2014-15. The review aims to ensure that housing related support services are outcome and person centred, through asset based assessments and support planning, with an emphasis on supporting people to avoid hospital admission and assisting them through transition to move on accommodation and de-escalation of services where appropriate. The review will also consider how services can better meet the needs of individuals stepping down from residential care and how peer-led support can contribute to better outcomes in mental health supported housing services.

Alongside this work a review of the Support Needs Assessment and Placement Service (SNAP) will be undertaken which will look at ways to ensure fairer access to the full range of housing options for

people recovering from mental ill health (alongside the needs of other client groups). The lack of supply for move on accommodation has also been identified as an on-going issue and the council continues to explore options to address this.

There are several future housing developments (a mix of new and re-developments) being proposed for people with mental health problems, comprising:

- A replacement for the current 24hr service at Glazier House and Croham Road, onto a single site
- An extra care supported housing scheme for older people moving on from residential care
- Refurbishment/replacement of shared housing with self-contained flats

Employment related support

The CCG and the Council currently commission a number of employment related services providing support to people who have been out of work as a consequence of long periods of ill health, providing assistance with returning to work and help for people who are recently diagnosed or experiencing mental ill-health.

The commissioning of the current suite of services began some 5 years ago and was designed in the context of the economic environment at that time. However, over the past years, there has been a significant economic changes both nationally and locally, the introduction of new legislation such as the Care Act, changes to services provided by other agencies such as Job Centre Plus, greater use of personal budgets and continuing reduced public finances.

In response to these changes the CCG and Council will undertake a full review of employment related services for those who are experiencing the long term effects of mental ill health as well as those recently diagnosed.

There is a need to establish closer working arrangements with established mainstream employment services such as Job Centre Plus, Disability Employment Advisors, adult learning and training services, information, advice and guidance providers and employers. Employment support services should be person centred, focussing on outcomes supported by clear goals and plans but most importantly designed for the personal budget market.

Primary Care, SLaM and the Council should work collaboratively to support employers, increase the resilience of their workforce and provide assistance in the development of employee assistance services which can improve support to the workforce, reduce the risks of mental ill-health and support return to work.

Section 4: main findings & recommendations from JSNA addressed in this section

- Services users, carers and other stakeholders want more community / wellbeing services to be offered in managing depression and they perceived a lack of information about existing services and low capacity
- Support for carers needs to be strengthened through information and advice, assessments and support services
- There needs to be a focus on development, promotion and better access to wellbeing and peer support services.
- Training and awareness needs to be made available for mental health workforce as appropriate and mental health training to wider workforce
- Services that promote recovery need to be reviewed as demand grows, especially around housing (with focus on increasing independent living), employment, benefits & debt advice and befriending / volunteering services.

Service user and stakeholder perspectives

- Long waiting lists for talking therapies and over reliance on powerful medications that do not address social and practical needs have been highlighted as concerns
- Service user-led initiatives should be considered, such as stress management and anxiety management groups – alongside drop in services with skilled staff providing meals and access at weekends
- A lack of housing options, and concern about use of bed and breakfast accommodation for vulnerable people, were raised.
- There is concern that front line staff are not always well equipped to deliver personalisation and application forms are complex

Key outcomes for Croydon

Joint health and wellbeing priorities:

- **Increased healthy life expectancy and reduced differences in life expectancy between communities**
 - Everyone will have the information and support they need to live healthy lifestyles and make healthy choices.
- **Increased resilience and independence**
 - Everyone will have choice and control and be able to manage their own support so that they can design what, how and when support is delivered to match their needs.
 - Carers will be able to balance their caring roles and maintain their desired quality of life.

- People experience greater independence, choice and control through provision of -
 - personalised packages of self-directed support
 - direct payment offer which support and enables people
 - Increased support for carers of people with mental health problems
- People with mental health problems are supported to access the full range of housing options in order to meet their housing needs, preventing homelessness and maintaining security of tenure
- Housing support services are in place which focus on recovery, are outcome and person centred and help people to avoid hospital admission and live successfully with effective and appropriate housing support
- Provision of a range of employment related services which -
 - offer support to help people successfully maintain, or return to, employment
 - are well co-ordinated across all relevant agencies
 - are effective at meeting the challenges of the current economic environment
- Good range of wellbeing services available which are well co-ordinated and linked with wider public health approach
- Strengthened engagement of service users in service developments and better collection and use of data about experiences, outcomes, activities and access

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APPENDIX 1: Payment by results care clusters

1:	Common Mental Health Problems (Low Severity)
2:	Common Mental Health problems (Low Severity with greater need)
3:	Non Psychotic (Moderate Severity)
4:	Non-psychotic (Severe)
5:	Non-Psychotic Disorders (Very Severe)
6:	Non-Psychotic Disorder of Over-valued Ideas
7:	Enduring Non-Psychotic Disorders (High Disability)
8:	Non-Psychotic Chaotic and Challenging Disorders
9:	Blank
10:	First Episode Psychosis
11:	Ongoing Recurrent Psychosis (Low symptoms)
12:	Ongoing or recurrent Psychosis (High Disability)
13:	Ongoing or Recurrent Psychosis (High Symptom and Disability)
14:	Psychotic Crisis
15:	Severe Psychotic Depression
16:	Dual Diagnosis
17:	Psychosis and Affective Disorder - Difficult to Engage
18:	Cognitive Impairment (low need)
19:	Cognitive Impairment or Dementia Complicated (Moderate Need)
20:	Cognitive Impairment or Dementia Complicated (High Need)
21:	Cognitive Impairment or Dementia (high physical or engagement)

APPENDIX 2: Themes emerging from stakeholder engagement meetings re: Croydon Mental Health Strategy for Adults 2014 –2019

Service users of the following organisations engaged with us:

8th Jan 2014 (18:30-21:00)	Rethink Croydon Carers Service, 24 George Street, Croydon, CRO 1PB - approximately 10 people attended.
8th Jan 2014 (13:45-16:00)	Hear Us , CVA Resource Centre, 82 London Road, Croydon, CRO 2TB.
15th Jan 2014 (11:00-12:30)	Talking Therapies Providers Forum , Family Resource Centre, 21-23 Woodville Road, Thornton Heath - approximately 10 people attended.
15th Jan 2014 (15:00-16:00)	Mental Health Forum , CVA, London Road, Croydon - approximately 30-40 people attended.
15th Jan 2014 (21:00-21:00)	NSF Carers Group , CVA Resource Centre, 82 London Road, Croydon, CRO 2TB - approximately 10 people attended.
21st Jan 2014 (10:25-13:00)	Off the record , CVA Resource Centre, 82 London Road, Croydon, CRO 2TB - approximately 30-40 people attended.
22nd Jan 2014 (14:00-16:00)	Mind in Croydon , Fairfield House, 10 Altyre Road, Croydon, CRO 5LA - approximately 7 people attended.
24th Jan 2014 (10:45-12:45)	BME CDW Forum , Palmcroy House, 387 London Road, CRO 3PB Croydon - approximately 15 people attended.
5th Feb 2014 (14:45-16:00)	Off the Record , CVA Resource Centre, 82 London Road, Croydon, CRO 2TB - approximately 40-50 people attended.
5 th Feb 2014 (14:45-16:00)	Imagine , CVA Resource Centre, 82 London Road, Croydon, CRO 2TB - approximately 20-30 people attended.

Overview/Summary:

The following themes seemed to emerge from the engagement process:

- Theme 1: Ambivalence towards the direction of travel as set out by the strategy.
- Theme 2: Problems envisaged if people experiencing mental health problems have their care managed by GPs instead of clinicians in secondary care -
 - 2a: 'GP to patient' barriers
 - 2b: 'Patient to GP' barriers
 - 2c: Systemic/organizational barriers
- Theme 3: The engagement process is in itself flawed unless real investment is made
- Theme 4: The need for alternatives to medical treatments
- Theme 5: Ideas for service models and designs
- Theme 6: Inpatient care
- Theme 7: Frustration with continuing inequality
- Theme 8: Personal budgets
- Theme 9: Carers issues

Theme 1: Ambivalence towards the direction of travel as set out by the strategy

There was some agreement from stake holders that transferring those who do not seem to warrant support from secondary care services into primary care seems, at least in principle, a worthwhile strategic objective to steer towards. In particular, some of those who felt that admission to inpatient services had been a traumatising, frightening, damaging and/or stigmatising experience for themselves and/or the people they cared for agreed that trying to reduce usage of inpatient beds by investing more in primary care, preventative and early intervention services would be a sensible way to invest resources whilst also optimising outcomes for people experiencing mental health difficulties.

However, the need for caution was expressed, mainly by carers. They warned that mere discussion about change in their care arrangements can stir up anxieties in seemingly stable service users, and thus lead to relapse or destabilization and so this work needs to be handled with tact and sensitivity. They also cautioned that although the *signs* may be that someone is ready for transfer to primary care from secondary care, the *service user's* views about this must be sought and explored.

Carers also feared that those service users without carers will be left with a particularly low level of support after transfer into primary care and may hence therefore be particularly vulnerable to the experience of crises and/or to relapse. Perhaps of greatest concern to carers was that point that it seems that people with severe and enduring mental health problems and complex needs will be left without the support of experienced and highly trained specialists if the strategy is implemented.

The question was also asked repeatedly where funding for community based services will come from in the context of a diminishing budget, given that these will clearly need to be strengthened in order to move the burden away from secondary care services.

Theme 2: Problems envisaged if people experiencing mental health problems have their care managed by GPs instead of clinicians in secondary care.

Theme 2a: 'GP to patient' barriers

GPs may lack the skills, the patience and the time to work with mental health patients. GPs' heavy caseloads may prevent preventative work from happening. The strategy may create a significant risk in that GPs will be less able (in terms of both skill and availability) than specialist clinicians to detect signs of relapse, thereby potentially leaving vulnerable people with undetected problems for longer periods of time. In evidence of this concern, carers reported direct experiences of taking their loved ones to visit their GP, reporting that there is something wrong, and then having their concerns dismissed by the GP and receiving no help. Consequently, their loved ones have developed serious mental health problems which might have been prevented had the GP intervened earlier. Service users likewise reported having their requests for help ignored by GPs.

Theme 2b: 'Patient to GP' barriers

Service users reported that in their experience, people with serious mental health problems are made to feel unwelcome by their GPs, and that GPs do not want to build relationships with these patients who end up getting 'bounced around' between GPs. GPs may be perceived by service users as having very different experiences and world views and so being unable to empathise with them. For example, GPs have little to no experience of being labelled, stigmatised, and forcibly sedated, of being routinely doubted and undermined and/or of living in poverty. Concerns were also raised that GPs might be perceived as taking a narrowly medicalised focus, ignoring psychological and social factors that might contribute to a person's wellbeing or distress. In addition, because the GP will be

taking up a position as a person's responsible or lead clinician, this new position of authority may deter some service users from seeking help with physical health problems where previously they may have done so for fear or being scrutinized by the doctor's 'clinical gaze'. Additionally, GPs might at times be called away for emergencies, leaving service users feeling frustrated, ignored and/or isolated.

Theme 2c: Systemic/organizational barriers

Perhaps most seriously of all, being moved from secondary care into primary care might result in a reduction in a person's entitlement to benefits. Any reduction in income will almost inevitably lead to deterioration in mental health.

The appropriateness of the setting of the typical GP practice as a place to treat people with enduring mental health problems was questioned by stakeholders. Stakeholders warned that some GP numbers are '0845 numbers' (meaning that they can be costly) and often patients have to discuss problems with a receptionist before being put through to a GP by phone, which feels quite intrusive. Practice staff and other visiting patients who are not sensitive to the difficulties of people with mental health problems might potentially find the behaviour of those with mental health problems to be distressing, disturbing and/or confusing and might thus respond in a way that is unhelpful to the person experiencing mental health difficulties. People in distress might express it inappropriately to practice staff, at might thus be blocked from accessing help, given the 'zero tolerance policy' that most, if not all, GP practices take towards aggression from the public. GP waiting rooms might not be suitable places for people who are feeling extremely agitated and/or restless (perhaps as side-effect of their medication) to sit and wait for appointments when they need to pace about instead in order to feel more settled. Concerns were raised that GPs will not have enough time to support those with mental health problems, and that nowadays it can be very difficult to get GP appointments in the first place; stakeholders warned that people are lucky if their GP sees them for 5 minutes, let alone on the day that they actually need the appointment.

Theme 3: The engagement process is in itself flawed unless real investment is made

Concerns were raised that the engagement process is merely a tokenistic exercise designed to appease stakeholders that decisions have already been made about cut-backs without discussing these with interested parties and that carers' opinions will not make a difference to commissioners' plans. Concerns were also raised that rhetoric regarding big investment in primary care and preventative services has been heard before, but the rhetoric was followed by very little action or change.

Theme 4: The need for alternatives to medical treatments

Throughout the engagement process, it was apparent that service users were dissatisfied by the long waiting lists for talking therapies, and the over-reliance on powerful medications that do not address their social and practical needs or the meanings they attach to their lives and their experiences. Concerns were raised about misdiagnosis by different groups. The unresponsive nature of crisis services and lack of out of ours services other than A&E were also seen as being areas for improvement.

Theme 5: Ideas for service models and designs

Stakeholders suggested that GPs with special interests in mental health might play an important part in implementing the strategy. They also suggested that having other mental health clinicians (e.g. CPNs) based in GP practices might help facilitate the strategy's goals. Stakeholders also pointed out

that nowadays it is uncommon for patients to build a relationship with one specific GP. It is more common that people are given appointments with different GPs on an ad hoc basis, and that nowadays people end up consulting with various GPs in a practice interchangeably. Therefore arrangements would need to be made to allow for meaningful and positive relationships to be built between people with mental health problems and a specific, named GP. This would allow the GP to come to understand the service user and vice versa and so set the conditions for the provision of an optimal level and type of support. The idea of GPs providing double appointments to those with more severe mental health problems to allow for communication to proceed at a gentler pace recurred at various engagement meetings. It was also suggested that practices might allocate a 'slot' for working with this client group, e.g. one afternoon per week, to make it easier for clients to get appointments.

There was agreement amongst stakeholders that greater investment in preventative, early intervention and crisis services (especially as the ineffectiveness of current crisis services was mentioned several times) should be welcomed and it was generally agreed that moves to divert people away from inpatient services are entirely appropriate. There were also calls for user-led services, e.g. stress management and anxiety management groups. However, at the same time, stakeholders called for money to be spent on drop-in services that provide meals, that have skilled and knowledgeable staff available to support clients and that are open on the weekend.

It was suggested that the eligibility criteria for some services, which currently only serve clients who higher levels of need, might need to be changed to allow these services to take preventative and relapse avoidance roles. The importance of open access services was also flagged up by stakeholders.

Concerns were raised regarding the lack of housing options for people with mental health problems and the placing of vulnerable people in bed and breakfast accommodation for long periods of time.

The services at Ashburton and at Foxley Lane were flagged up as being very popular amongst service users. These services provide an intermediate environment of care between primary and secondary services where people can access talking therapies and get away from stressful domestic environments, and provide a good example of something that might be found at a level of care between primary and secondary levels.

Attendees were cognizant of the cost implications of the strategy: that there will need to be increased investment in community based services (so as to support those who are moved from secondary care) before the budget for secondary care services is reduced.

Theme 6: Inpatient care

It was suggested during the engagement events that admission to the wards can often cause trauma and feelings of shame and isolation, that any positive effects of hospital treatment are often only temporary and relapse is common, and often the effects of treatment are damaging. Stakeholders complained that diagnoses are often inaccurate and stigmatising, their medications are ineffective and with unpleasant side effects, and that inpatient staff eat food made for patients, lack passion and can often treat patients harshly.

Despite this, concerns were also raised that the decommissioning of inpatient beds for Croydon residents could be unhelpful and against the wishes of some carers and service users. The hospital

environment gives people the chance to get away from stressful environments, whether this stress is caused by disharmonious relationships or by environmental stressors such as frightening and/or noisy neighbours, traffic, insecure housing etc. Decommissioning beds might deny people the kind of crisis support they need precisely when they need it the most. The scarcity of bed stock may also create additional pressure on clinicians to discharge patients quickly, so as to admit those whose crises have more recently blossomed, thus limiting the time available for healing and recovery in a hospital context. In addition, Croydon based service users are too frequently hospitalised in beds that are out of the area (e.g. Manchester or Sussex) and hence are left unsupported and isolated. This impedes their recovery and undermines wellbeing and is also stressful for their carers. Given these concerns stakeholders expressed anxieties that the decommissioning of inpatient beds seemed counter-intuitive and may cause more problems than it solves.

Concerns were also raised regarding the blocking of beds and costs created by delayed discharges, and the absence of anything detailed in the draft strategy specifying how these costs might be curtailed.

Theme 7: Frustration with continuing inequality

Stakeholders expressed frustration that inequalities still exist in terms of ethnic grouping and corresponding usage and experience of psychiatric services, despite huge amounts of research, time and effort being directed into redressing these imbalances.

Talking therapies providers pointed out that there has not been an adequate analysis of the reasons *why* BME clients are over-represented in secondary care, and that there is a lack of clarity regarding what is meant by the term “BME client” as this is a very broad and vague term, glossing over whether the clients are first generation immigrants, second generation immigrants or asylum seekers and what the diagnostic trends are within this group.

Stakeholders encouraged the commissioning team to use the findings from the Mind The Gap report to inform their strategy.

Theme 8: Personal Budgets

Concerns were raised several times that frontline staff are unable to implement the personalisation of the individual budgets directive, that the application form for personalised budgets are too complex, and people are put off because it is means-tested on the form, even though it is not a means-tested budget.

Theme 9: Carers Issues

Carers raised some specific concerns about the care of people with enduring and complex mental health problems being transferred to GPs (see above). They also suggested there is a need to make services more family oriented. For example, they reported that psychiatric wards are not welcoming to families and that families are often not engaged meaningfully in their loved ones care. Carers expressed feelings of being misunderstood and/or unsupported by professionals and asked instead that they be listened to, respected, involved in care planning/provision/review and that their needs be assessed where necessary. They also encouraged commissioners to finance training and/or support sessions for carers in order to allow carers to in turn more effectively support their loved ones to endure and even overcome their mental health problems.

Appendix 3: CHANGES TO CLIENT EXPERIENCE

These examples of change are described from the perspective of SLaM. They illustrate some of the benefits of moving to a new model of community based services that the trust could deliver. To implement this in Croydon we are working with stakeholders to ensure that these types of change are part of an holistic and integrated approach that is led by service user and carer experience.

Presentation	Now	In future?
Enhancing access		
<p>Patient A Discharged several months ago following treatment for severe depression. Presents to GP and describes return of symptoms and increasing suicidal thoughts as a result of benefits being withdrawn. It is not evident that hospital admission is required at this stage, but GP has concerns about the risk of further deterioration in patient's condition.</p>	<p>GP refers patient for an assessment by a SLaM Community Mental Health Team (CMHT). It is likely to take one / two weeks before the patient is seen by the CMHT.</p> <p>Once an assessment has been undertaken by the CMHT, the patient may be allocated a care coordinator and referred for ongoing treatment by secondary mental health services.</p>	<p>GP contacts the Assessment Team (available 8am – 8pm to match GP practice opening hours) who can for the patient to be seen by the Home Treatment Team.</p> <p>Home Treatment Team will provide a brief intervention (e.g. medication) with the aim of preventing the need for hospital admission.</p> <p>Home Treatment Team will arrange for the patient to have ongoing treatment from secondary mental health services if this is needed.</p>
Presentation	Now	In future?
Crisis care		
<p>Patient B Has previously received hospital treatment for psychosis. Describes intrusive thoughts and hallucinations to GP. Has stopped taking medication and clearly presents a risk to her.</p>	<p>GP advises the patient to attend A&E where he/she will be assessed by a doctor and psychiatric liaison nurse from SLaM's A&E liaison service.</p> <p>The patient will be transferred to a triage unit if further assessment and inpatient treatment is needed.</p>	<p>GP contacts the Assessment Team who can arrange for the patient to be seen by the Home Treatment Team.</p> <p>Home Treatment Team will provide a brief intervention (e.g. medication) with the aim of preventing the need for hospital admission if possible.</p> <p>If the Home Treatment Team determine that inpatient care is needed they will arrange for the patient to be admitted to a triage unit.</p>
Presentation	Now	In future?
Case management		
<p>Patient D Has been treated for psychosis. Currently displaying no symptoms. Is</p>	<p>Care remains under the psychosis community team.. Will be seen less often, especially if his / her care co-</p>	<p>New 'low intensity' team will work with primary care to support the patient's needs. The team has a caseload of about 300 people who</p>

stable and considered a low risk of relapse. Is receiving medication not currently prescribed within primary care.	ordinator has a caseload which includes increasing number of patients presenting possible symptoms of relapse.	need to be seen once a month, at most, and possibly only twice a year. Their role includes prescribing medication and ensuring the patient's social care needs are reviewed. They also provide education and training support to GPs in supporting people with ongoing mental health problems.
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Presentation	Now	In future?
Relapse prevention		
<p><u>Patient E</u> Has been treated for anxiety and depression. Beginning to display some symptoms which may indicate a possible relapse. This could also be someone who has not previously been treated by SLaM.</p> <p><u>Patient F</u> Has been treated for psychosis. Clearly displaying psychotic symptoms and considered a high risk of relapse.</p>	<p><u>Patient E</u> If patient has previously been discharged to GP, he / she will be re-referred to the community team for assessment. Will continue to be seen by care co-ordinator. Level of care provided will be monitored and reviewed in the light of whether symptoms persist / increase.</p> <p><u>Patient F</u> Will be seen on a twice weekly basis by the care co-ordinator. If symptoms persist and the risk of relapse remains high, then he / she will be transferred to the Home Treatment Team. This team will decide whether an inpatient admission is needed.</p>	<p><u>Patient E</u> Reablement team will review the patient's medication and determine whether the possible symptoms of relapse are being triggered / exacerbated by social care factors. The team will provide practical support on issues such as reapplying for housing benefit which may help stabilise their mental wellbeing. If the patient's symptoms persist or worsen after 8 – 12 weeks, then he / she will be transferred to the mood and anxiety treatment team.</p> <p><u>Patient F</u> Patient remains under the care of the psychosis treatment team, whose caseload comprises patients who are considered to present a significant risk of relapse. Following a review of the patient's medication by a consultant psychiatrist, he / she will be prescribed clozapine if needed. The patient will be seen more frequently and assertively. Treatment plan will include more intensive psychological interventions. The team's focus will be upon preventing relapse and hospital admission.</p>

Presentation	Now	In future?
Inpatient care		
<p><u>Patient G</u> Adult of working age with severe mental illness requiring hospital treatment.</p>	<p>Admission to triage unit and / or an acute admission ward providing treatment for all adults with severe mental illness (irrespective of diagnosis).</p> <p>Duration of inpatient admission should not be longer than 28 days. Home Treatment Team to facilitate discharge from hospitals and to refer patient to ongoing support from community services.</p>	<p>Inpatient care becomes an intervention along a pathway of care. Patients and staff work together to identify earlier if there is benefit in an inpatient stay and it becomes a planned admission. This leads to more voluntary admissions, shorter length of stay and less disruption to a patient's life. In some cases, a longer inpatient stay may be required to help the patient become stable and prevent multiple breakdowns. There are also direct admissions to complex care settings where longer-term rehabilitation is needed.</p> <p>The emphasis on early intervention/discharge prevention within community services results in fewer admissions. Patients with mood and anxiety disorders admitted to a separate ward for patients with similar conditions. As a result, bed occupancy can be managed at 85%, helping to create a more therapeutic ward environment.</p> <p>Patients who are ready to leave hospital will consistently be provided with support from discharge coordinators – including access to social care and practical support on issues such as housing benefit.</p>

APPENDIX 4: Estimated numbers of adults with mental health conditions in Croydon, projected to 2021

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
1) Dementia (diagnosed+undiagnosed)	3,250	3,291	3,337	3,387	3,443	3,514	3,587	3,663	3,738	3,821
2) Dementia (diagnosed)	1,540	1,575	1,653	1,732	1,812	1,890	1,970	2,050	2,131	2,214
3) Mild alcohol dependence (diagnosed+undiagnosed)	16,404	16,512	16,615	16,702	16,780	16,809	16,845	16,892	16,944	16,993
4) Moderate or severe alcohol dependence (diagnosed+undiagnosed)	1,407	1,413	1,420	1,427	1,434	1,435	1,438	1,443	1,449	1,455
5) Drug dependence including cannabis (diagnosed+undiagnosed)	10,385	10,446	10,508	10,552	10,585	10,594	10,617	10,653	10,694	10,735
6) Drug dependence excluding cannabis (diagnosed+undiagnosed)	2,745	2,761	2,777	2,791	2,802	2,807	2,815	2,826	2,838	2,850
7) Problem gambling (diagnosed+undiagnosed)	2,230	2,245	2,260	2,272	2,284	2,290	2,297	2,306	2,315	2,325
8) Serious mental illness (diagnosed)	3,922	3,985	4,094	4,203	4,314	4,418	4,523	4,630	4,738	4,847
9) Schizophrenia (diagnosed)	1,735	1,764	1,812	1,861	1,910	1,957	2,004	2,053	2,102	2,152
10) Bipolar disorder (diagnosed)	856	869	893	916	940	963	985	1,008	1,032	1,055
11) Other psychoses (diagnosed)	1,331	1,352	1,389	1,426	1,464	1,498	1,534	1,569	1,605	1,641
12) Depression at a point in time (diagnosed+undiagnosed)	6,949	6,995	7,041	7,084	7,126	7,148	7,171	7,195	7,223	7,250
13) Depression in last 5 years (diagnosed)	19,969	20,120	20,288	20,445	20,575	20,686	20,786	20,890	21,007	21,131
14) Mixed anxiety and depressive disorder (diagnosed+undiagnosed)	26,715	26,923	27,121	27,304	27,478	27,586	27,698	27,817	27,940	28,059
15) Generalised anxiety disorder (diagnosed+undiagnosed)	12,811	12,903	12,994	13,083	13,172	13,228	13,284	13,345	13,409	13,471
16) Phobias (diagnosed+undiagnosed)	4,289	4,315	4,343	4,373	4,401	4,420	4,440	4,461	4,483	4,504
17) Obsessive compulsive disorder (diagnosed+undiagnosed)	3,398	3,420	3,440	3,457	3,470	3,475	3,483	3,494	3,505	3,516
18) Panic disorder (diagnosed+undiagnosed)	3,207	3,229	3,252	3,275	3,297	3,311	3,328	3,345	3,363	3,380
19) Any common mental disorder (diagnosed+undiagnosed)	47,824	48,178	48,522	48,848	49,159	49,354	49,560	49,779	50,009	50,230
20) Postnatal depression (incidence, diagnosed+undiagnosed)	717	738	759	781	800	820	841	868	892	918
21) Post-traumatic stress disorder (diagnosed+undiagnosed)	8,922	8,980	9,036	9,085	9,127	9,143	9,161	9,185	9,213	9,239
22) Eating disorder (diagnosed+undiagnosed)	4,887	4,922	4,950	4,973	4,989	4,993	4,998	5,007	5,017	5,025
23) Personality disorder (diagnosed+undiagnosed)	2,550	2,572	2,591	2,606	2,618	2,624	2,630	2,636	2,642	2,647
24) Autism (diagnosed+undiagnosed)	3,156	3,180	3,204	3,227	3,250	3,267	3,284	3,304	3,324	3,345
25) Autism (diagnosed)	464	494	536	578	621	663	706	750	794	839
26) Learning disability (diagnosed+undiagnosed)	6,376	6,420	6,465	6,508	6,549	6,575	6,604	6,639	6,675	6,712
27) Learning disability (diagnosed)	1,376	1,422	1,462	1,502	1,542	1,580	1,618	1,658	1,699	1,740

Source: Croydon Joint Strategic Needs Assessment 2012/13 - An overview of mental health and well-being in Croydon

Equality Analysis Form

An Equality analysis enables us to target our services, and our budgets, more effectively and understand how they affect all our communities. It also helps us comply with the Equalities Act 2010.

For more information about when you should carry out an equality analysis, who should do this and the support available, go to the equality analysis intranet page.

This form has four sections

- 1: decide whether a full equality analysis is needed. If not, you do not complete sections 2-4.
- 2: gathering evidence
- 3: determining actions
- 4: decision and next steps

Appendix One – Decision-making process

Appendix Two - data broken down by Protected Characteristics

Name of document			CROYDON INTEGRATED MENTAL HEALTH STRATEGY FOR ADULTS 2014 - 2019	
Version	Date reviewed	Date of next review	Reviewed by	Changes made
0.1				

1. Decide whether a full equality analysis is needed

1.1 What are you analysing?

Question	Guidance	Answer
What is the name of your change or review?	<p>The change or review may involve:</p> <ul style="list-style-type: none"> o policies, strategies and frameworks o budgets o plans, projects and programmes o staff structures (including outsourcing) o the use of buildings o commissioning (including re-commissioning and de-commissioning) o services (for example, how and where they are delivered) o processes (for example thresholds, eligibility, entitlements, and access criteria) 	Croydon Integrated Mental Health Strategy for Adults 2014-2019
Why are you doing this?	For example, we are considering cutting a service.	The document sets out the Croydon integrated mental health strategy for adult mental health which is mainly focused on the needs of adults of working age. It also references, and is closely aligned to, the strategic priorities for older adults with mental illness and with dementia, the work of the Mental Health Older Adults (MHOA) project and the developing strategy for children and young people's emotional wellbeing and mental health. The strategy outlines strategic intentions for the borough and provides the foundations upon which a detailed workplan can be developed.
What is likely to be different when you have finished?		The Integrated Mental Health Strategy will set out the strategic intentions for the next 5 years for both the Council and CCG.

What will be the main outcomes or benefits from making this change?		The strategy covers the financial years 2014–2019, in line with the Clinical Commissioning Group (CCG) 5 year strategy. It will be refreshed and/or reviewed on an annual basis as appropriate. In addition to this strategy, a workplans will be developed which will detail the work that Croydon CCG and social care commissioners will take forward.
What stage is your change at now?	See appendix one for the main stages at which equality analyses need to be started or updated. In many instances, an equality assessment will be started when a report is being written for a committee. If that report recommends that a project or programme takes place, the same equality assessment can be updated to track equality impacts as it progresses. If the project or programme include commissioning or de-commissioning, the same equality assessment can be updated again.	There is a draft strategy in place and, as outlined above, detailed workplans are still to be developed, which will focus on how strategic intentions will be implemented.

An equality analysis must be completed before any decisions are made.

If you are not at the beginning stage of your decision making process, you must inform your Director that you have not yet completed an equality analysis.

1.2 Who could be affected and how?

Question	Guidance	Answer
Who are your internal stakeholders?	For example, groups of council staff, members	Members of staff from Croydon Council and Croydon CCG involved in and related to mental health service delivery and associated services. Council Members
Who are your external stakeholders?	For example, groups of service users, service providers, trade unions, community groups and the wider community?	External stakeholders identified as part of stakeholder consultations carried out in early 2014 (see 'evidence considered, below) and involvement of the Croydon Mental Health Partnership Group.

<p>Does your proposed change relate to a service area where there are known or potential equalities issues?</p>	<p>Please answer either "Yes", "Don't know" or "No" and give a brief reason for your response. If you don't know, you may be able to find out on the Croydon Observatory (http://www.croydonobservatory.org/)</p>	<p>Yes</p>
<p>Does your proposed change relate to a service area where there are already local or national equality indicators?</p>	<p>You can find out from the Equality Strategy (http://intranet.croydon.net/corpdept/equalities-cohesion/equalities/docs/equalitiesstrategy12-16.pdf). Please answer either "Yes", "Don't know" or "No" and give a brief reason for your response</p>	<p>The Integrated Mental Health Strategy is closely aligned to the following objectives in the Equality Strategy:</p> <ul style="list-style-type: none"> • Objective one: to build stronger communities by reducing deprivation • Objective seven: to improve health and wellbeing by reducing health inequalities • Objective nine: to improve support for vulnerable people by making it easier for them to have more choice and control over their lives
<p>Would your proposed change affect any protected groups more significantly than non-protected groups?</p>	<p>Please answer either "Yes", "Don't know" or "No" and give a brief reason for your response. For a list of protected groups, see Appendix Two.</p>	<p>Yes, the intention of the strategy is to identify and respond positively to any inequalities experienced by protected groups.</p> <p>The workplans which will be developed in order to implement the strategy will set out the detail of how any inequalities will be addressed.</p>
<p>Would your proposed change help or hinder the council in eliminating unlawful discrimination, harassment and victimisation in relation to any of the protected groups?</p>	<p>Please answer either "Yes", "Don't know" or "No" and give a brief reason for your response</p>	<p>Yes – the intention is for the strategy, and workplans to help eliminate any unlawful discrimination, harassment or victimisation.</p>
<p>Would your proposed change help or hinder the council in advancing equality of opportunity between people who belong to any protected groups and those who do not?</p>	<p>Please answer either "Yes", "Don't know" or "No" and give a brief reason for your response</p>	<p>Yes – the intention is for the strategy, and workplans to help in advancing equality of opportunity.</p>

<p>Would your proposed change help or hinder the council in fostering good relations between people who belong to any protected groups and those who do not?</p>	<p>Please answer either "Yes", "Don't know" or "No" and give a brief reason for your response</p>	<p>Yes – the intention is for the strategy, and workplans to help in fostering good relations.</p>
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1.3 Decision

If you answer "yes" or "don't know" to ANY of the questions in section 1.2, you should undertake a full equality analysis. This is because either you already know that your change or review could have a different/significant impact on protected groups (compared to non-protected groups) or because you don't know whether it will (and it might).

Decision	Guidance	Response
<p>No, further equality analysis is not required</p>	<p>Please state why not and outline the information that you used to make this decision. Statements such as 'no relevance to equality' (without any supporting information) or 'no information is available', could leave the council vulnerable to legal challenge. You must include this statement in any report used in decision making, such as a Cabinet report</p>	<p>Further equality analysis below.</p>
<p>Yes, further equality analysis is required</p>	<p>Please state why and outline the information that you used to make this decision. Also indicate</p> <ul style="list-style-type: none"> - when you expect to start your full equality analysis - the deadline by which it needs to be completed (for example, the date of submission to Cabinet). - where and when you expect to publish this analysis (for example, on the council website). <p>You must include this statement in any report used in decision making, such as a Cabinet report.</p>	<p>Further equality analysis below, also setting out documentation and evidence used.</p>
<p>Officers that must approve this decision</p>	<p>Name and position</p>	<p>Date</p>
<p>Report author</p>	<p>Tracy Stanley</p>	<p>23.06.14</p>
<p>Director</p>		

Please email this completed form to data.equalities@croydon.gov.uk, together with an email trail showing that the your director has approved it.

1.4 Feedback from the corporate equalities team

Name of equalities officer		
Date received by equalities officer	Please send an acknowledgement	
Should a full equality analysis be carried out?	Note the reasons for your decision	
Please send this document to - the person responsible for making the decision - democratic services, the corporate programme office or procurement as appropriate in time for the relevant decision making meeting		

2. Evidence Considered

List the documents and information that have been considered as part of this review to enable reasonable judgments to be made on the assessment of impact.

This section needs to include consultation data and desktop research (local and national data).

Quantitative Data	Qualitative Data
<ul style="list-style-type: none"> • Mind the GAP: A Report on BME mental Health Services Provision in Croydon (Hear Us, Croydon BME Forum and Off the Record Croydon) (2012) • Stakeholder engagement meetings during January to February 2014 (10 sessions) • Nurturing for emotional wellbeing - strategy for children and young people's emotional well-being and mental health 2014 – 2016 • Croydon Joint Dementia Strategy 2013-2016 – London Borough of Croydon (2012) • Croydon Joint Strategic Needs Assessment 2012/13: An overview of mental health and well-being in Croydon <ul style="list-style-type: none"> ○ Croydon Joint Strategic Needs Assessment 2012/13: Depression in Adults ○ Croydon Joint Strategic Needs Assessment 2012/13: Schizophrenia • Mental Health Value for Money Review – Mental Health Strategies (25 June 2013) • Service and financial mapping and investment options for mental health services – Mental Health Strategies (12 December 2013) • Croydon Mental Health Programme Budget Marginal Analysis Review Programme Budgeting (PBMA) – Bernadette Alves (April 2012) 	

2.1 Analysing Impact

Use the table below plot and identify where there is a potential impact on any of the staff and customers/service users by protected characteristic arising from the change.

The cells of the matrix should be filled in as below:

Key	
O	Indicates where the impact is unknown on Service Users/Staff, This is due to evidence not being available to indicate otherwise (neither positive nor negative impact).
P	Indicates the change may have a potential Positive Impact on Service Users/Staff
N	Indicates the change may have a potential Negative Impact on Service Users/Staff
P/N	Indicates the change may have both Positive and Negative Impacts on Service Users/Staff

An example of the chart filled in below:

Services		Protected Characteristics									
		Age	Disability	Gender Reassignment	Pregnancy and Maternity	Race	Religion and Belief	Sex	Sexual Orientation	Marriage and Civil Partnership	
Service Provision	Service Design	Capacity	O	O	O	O	O	O	O	O	O
		Availability	O	O	O	O	O	O	O	O	O
		Continuity	O	O	O	O	O	O	O	O	O
		Security	O	O	O	O	O	O	O	O	O
		Supplier Management	O	O	O	O	O	O	O	O	O
		Service Level Availability	P	P	O	O	O	O	O	O	O
		Service Catalogue Management	N	P/N	O	O	O	O	O	O	O

Description of Impact – Service User Related

Service Area	Protected Group	Description of Potential Positive Impact	Description of Potential Negative Impact	Evidence Source
Mental health services – working age adults	Age	<p>The Integrated Mental Health Strategy for Adults 2014-2019 focuses on working age adults, whilst also referencing work which addresses the mental health priorities for older adults and children and young people, clearly identifying the links and the need to take a joined up approach to developing the associated workplans.</p> <p>Older adults – A Mental Health Older Adults (MHOA) service re-design project is underway in 2014/15 and is taking forward the recommendation of the Dementia Strategy and review of older adults mental health services in Croydon. An equality analysis for the MHOA project is under development.</p> <p>Children and young people – The strategy 'Nurturing for emotional wellbeing - strategy for children and young people's emotional well-being and mental health' 2014 – 2016 (C&YP EW&MHS) was published in January 2014 and provides a clear direction for promoting the emotional wellbeing and mental health of Croydon's Children & Young People and includes a detailed action plan for implementation in 2014.</p>	<p>The strategy and workplan, seek to identify and address any inequalities and therefore deliver positive impacts, including in relation to access to, and use of, services.</p> <p>A detailed workplan will need to be developed, setting out proposed actions in detail, in order to fully assess any potential equality impacts.</p> <p>To ensure that potential positive or negative equality impacts are responded to appropriately this equality analysis will be reviewed and updated alongside the development of the integrated mental health strategy workplan</p>	See above, 'Evidence Considered'.
Mental health services – working age adults	Disability	<p>The strategy includes a section focused on 'integrating physical and mental health care', with a particular focus on people with long term health conditions. The strategy highlights the identified links between certain long term conditions and mental health problems.</p> <p>The strategy includes the key outcomes (to be taken forward in the workplan) –</p>	As above	See above, 'Evidence Considered'.

		<ul style="list-style-type: none"> • Whole system integration of physical and mental health services • Introduce measures to address increased rates of physical health problems in people with both common and serious mental illness, and reduced mortality rates for people who have a serious mental illness. 		
Mental health services – working age adults	Gender re-assignment	No equality impacts have been identified for this group within the strategy, however this will be reviewed alongside the development of the workplan, as proposals for service re-design and other activities are defined.	No equality impacts have been identified for this group within the strategy, however this will be reviewed alongside the development of the workplan, as proposals for service re-design and other activities are defined. .	See above, 'Evidence Considered'.
Mental health services – working age adults	Pregnancy & maternity	<p>The strategy highlights that rates of Postnatal Depression (PND) are expected to increase in Croydon and the substantial impact that this has on the mother, her family, and the longer-term emotional and cognitive development of the baby.</p> <p>The strategy includes a section focused on 'starting early to promote mental wellbeing and prevent mental health problems'. The key outcomes for this section (to be taken forward in the workplan) are intended to help improve prevention and early intervention, including for women who are pregnant or experiencing post natal depression, these include:</p> <ul style="list-style-type: none"> • Promote services that support mental health of pregnant women • Timely advice and signposting to reduce the risk of escalating problems, improved availability and access to universal services and promotion of the '5 ways to wellbeing' initiative • Improved identification of those at risk of developing mental health problems, supporting early intervention to 	<p>The strategy and workplan, seek to identify and address any inequalities and therefore deliver positive impacts, including in relation to access to, and use of, services.</p> <p>A detailed workplan will need to be developed, setting out proposed actions in detail, in order to fully assess any potential equality impacts.</p> <p>To ensure that potential positive or negative equality impacts are responded to appropriately this equality analysis will be reviewed and updated alongside the development of the integrated mental health strategy workplan</p>	See above, 'Evidence Considered'.

		help prevent reaching a 'crisis point'		
Mental health services – working age adults	Race	<p>The strategy (and evidence considered, as listed above) has identified a range of equality issues for BME client groups in relation to mental health issues, including around:</p> <ul style="list-style-type: none"> • Referral rates • Use of inpatient services • Diagnosis rates in primary care • Representation in acute psychiatric inpatient services • Experience of stigma, and the associated barriers to accessing & receiving services <p>The strategy includes the key outcome (to be taken forward in the workplan) –</p> <ul style="list-style-type: none"> • Use findings from Croydon's 'Mind the Gap' report and JSNA to develop actions to address inequalities in access to, and use of, mental health services for BME groups. <p>It is also anticipated that other priorities within the strategy will contribute to addressing the identified inequalities for BME groups, especially:</p> <ul style="list-style-type: none"> • Improving access to talking therapies • Creating a broader choice of services for people who should not require secondary mental health care • Reduce the requirement for acute inpatient beds. 	As above	See above, 'Evidence Considered'.
Mental health services – working age adults	Religion & belief	No equality impacts have been identified for this group within the strategy, however this will be reviewed alongside the development of the workplan, as proposals for service re-design and other activities are defined.	No equality impacts have been identified for this group within the strategy, however this will be reviewed alongside the development of the workplan, as proposals for service re-design and other activities are defined. .	See above, 'Evidence Considered'.
Mental health	Sex	The strategy and Joint Strategic Needs Assessment	The strategy and workplan, seek to identify	See above,

services – working age adults		<p>(JSNA), ‘Overview of Mental Health and Wellbeing Chapter 2012/13’ identify that there are differences in the way mental health presents between men and women, highlighting the following:</p> <ul style="list-style-type: none"> • Rates of anxiety, depression & self-harm higher in women than men • Men less likely to seek help for emotional health problems • Over-representation of Black African and Caribbean men in in-patient beds. <p>The strategy includes some overarching key outcomes which focus re-design of mental health pathways and a new model of primary care. The workplan will set out the detail of these activities (and others where there is a link to inequalities related to sex) and consider if there are any impacts that need to be addressed:</p> <ul style="list-style-type: none"> • Re-designed, fully integrated, mental health care pathways encompassing the full range of interventions from all sectors, for prevention, treatment and recovery. • Deliver new model of primary care, as the main setting for supporting people with mental health problems. 	<p>and address any inequalities and therefore deliver positive impacts, including in relation to access to, and use of, services.</p> <p>A detailed workplan will need to be developed, setting out proposed actions in detail, in order to fully assess any potential equality impacts.</p> <p>To ensure that potential positive or negative equality impacts are responded to appropriately this equality analysis will be reviewed and updated alongside the development of the integrated mental health strategy workplan</p>	‘Evidence Considered’.
Mental health services – working age adults	Sexual orientation	No equality impacts have been identified for this group within the strategy, however this will be reviewed alongside the development of the workplan, as proposals for service re-design and other activities are defined.	No equality impacts have been identified for this group within the strategy, however this will be reviewed alongside the development of the workplan, as proposals for service re-design and other activities are defined. .	See above, ‘Evidence Considered’.
Mental health services – working age	Marriage & civil partnership	No equality impacts have been identified for this group within the strategy, however this will be reviewed alongside the development of the workplan, as proposals for service	No equality impacts have been identified for this group within the strategy, however this will be reviewed alongside the development	See above, ‘Evidence Considered’.

adults		re-design and other activities are defined.	of the workplan, as proposals for service re-design and other activities are defined. .	
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Description of Impact - Employment Related

Service Area	Protected Group	Description of Potential Positive Impact	Description of Potential Negative Impact	Evidence Source
If is not possible to consider any potential impacts on staff until workplans for implementation of the strategy have been developed and any changes to services have been identified.				

2.2 Is there any evidence missing? If so, how will you gather this missing evidence?

If you do not have all the evidence you need to make an informed decision, talk to your departmental equality lead about practical ways to gather it. For example, if you do not have time to conduct a survey, is there a way can increase your understanding before undertaking more robust research at a later date? Perhaps by meeting with stakeholders. The depth and degree of any consultation or research will be determined by the relevance of the change or review to different groups. Those who are likely to be directly affected should be consulted. Read the corporate public consultation guidelines before you begin (http://intranet.croydon.net/finance/customerservices/public_consultation/default.asp).

If you really cannot gather any useful information in time, then note its absence as a potential negative impact and describe the action you will take to gather it in section 3. Insert new rows as required.

Do not continue onto stage 3 until your departmental equality lead is satisfied that you have gathered all the evidence you need.

Protected Group	Evidence missing	Description of potential negative impact

3. Determining Actions

The overall potential impact is the likelihood of the impact multiplied by the strength of that impact. The higher the score, the more significant the impact. The tables below identify actions to be taken to minimise negative impacts or maximise positive impacts within the programme.

Key

Likelihood score

- | | | |
|---|--------------|---------------------------------------|
| 5 | Most certain | In more than 80% of the circumstances |
| 4 | Most likely | In 51-80% of circumstances |

- 3 Possible In 21-50% of circumstances
- 2 Unlikely In 6-20% of circumstances
- 1 Rare In 5% of circumstances or less

Strength score	Degree of impact	Proportion of protected groups affected
5	Very great impact	Several protected groups in more than one category (e.g. religion and gender) would be differently affected (compared to non-protected groups).
4	Great impact	Several protected groups in one category (e.g. religion) would be differently affected (compared to non-protected groups)
3	Some impact	All of one protected group would be differently affected (compared to non-protected groups)
2	Little impact	The majority of one protected group would be differently affected (compared to non-protected groups)
1	Minimal impact	A minority of one protected group would be differently affected (compared to non-protected groups).