

**Procurement of Community Forensic Step-down Service**

**Memorandum of Information (MOI)**

**NHS Croydon**

**Clinical Commissioning Group (CCG)**

# Purpose

The purpose of this Memorandum of Information (MOI) is to provide potential Bidders with an overview of the Forensic Rehab re-procurement, which is being undertaken by NHS Croydon Clinical Commissioning Group (CCG).

The MOI is intended only as a preliminary background explanation for the Procurement of the Service. It is in no way intended to form the basis of any decision on the terms upon which this CCG will enter in to any contractual relationship. This MOI is supported by further details provided in the Service Specification.

# Croydon CCG Forensic REHABilitation services Re-commissioning

**2.1** **Definitions**

The CCG wishes to commission a Forensic Rehabilitation service for Croydon residents ensuring a safe, high quality and innovative service provision across the London Borough of Croydon, in line with our strategic vision. The contract length will be for two years with the option to extend by a further two years. The Forensic Rehabilitation Service re-procurement is an opportunity to redesign the current provision and develop a service specification and model of delivery in line with National Guidance.

The Croydon vision for a Forensic Rehabilitation service is one that:

* Provides specialist assessment, treatment, interventions and support to help people to recover from complex mental health problems and to (re)gain the skills and confidence to live successfully in the community
* Always work in partnership with service users and carers, adopting a recovery orientation that places collaboration at the centre of all activities
* Works with other agencies that support service users’ recovery and social inclusion, including supported accommodation, education and employment, advocacy and peer support services.

The CCG is looking for a single integrated service contract for the whole of the requirement.  In light of the CCG's knowledge of and engagement with current providers and the wider market, it is recognised that this may be delivered through an alliance based model with a lead provider working alongside smaller, more specialised service providers, particularly where patient and stakeholder engagement has often identified a preference for non-statutory providers including from BAME communities.

The service model should be innovative and developed to support service users when they leave hospital and support the move to supported accommodation.

**2.2** **The Commissioning Organisation**

NHS Croydon Clinical Commissioning Group (Croydon CCG) is a membership organisation made up of all 57 GP practices in the borough of Croydon.  We were established in April 2011 as a shadow organisation and we received authorisation from the NHS Commissioning Board (now NHS England) in March 2013.  On 1 April 2013, we became legally responsible for commissioning (buying) healthcare services for the residents of Croydon.

We serve over 350,000 people across the very diverse borough of Croydon.  We manage local healthcare budgets in excess of £400 million and commission a range of healthcare services on behalf of Croydon patients.  These include services received at hospitals, in the community and mental health services.

As doctors, we came together to put patients first and improve health services in Croydon.  Our vision is to improve local health services and empower patients and communities to take more responsibility for improving their health.  To achieve this, we work alongside other health practitioners from nursing, pharmacy and secondary care and local partner organisations, such as Croydon Council and the voluntary sector.



We are made up of six geographically based networks, each with a GP lead who is also supported by a network coordinator and named leads for finance, business intelligence, public health and medicines management.

Our GP networks now have significant control over their own network plans and agendas. As a result, they have taken a fuller role in reviewing new projects, particularly pathway redesign, and have also successfully conducted a number of pilots which have gone on to wider roll-out. Peer review and sharing of ideas and good practice has become much more widespread with solid information on prescribing, acute provider activity and internal practice reviews. Our networks have been responsible for shaping localised commissioning plans.

The health needs of our unique population in Croydon continue to evolve. The population is growing and becoming more diverse. People are living longer, and an increasing number of younger people are moving into the borough. We need to make sure we commission the highest possible quality services to best meet our population’s changing health needs within our available resources.

## 2.2.1 Population

The first results of the 2011 census show that Croydon’s population has grown more quickly in the last ten years than was projected by the Office for National Statistics (ONS). If Croydon’s population continues to grow at this rate, there will be over 390,000 people in Croydon by 2021.

### 2.2.2 Age and Gender

Nationally the population is ageing as life expectancy increases and the baby boomer generation approaches older age. Compared to other areas, however, Croydon has a relatively young population. The present high birth rate and effects of migration are expected to result in growth in some of the younger as well as older age groups in coming years.

*Demographics - Age Profiles from Service User Access in 16/17*

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Age** | **Number of referrals** | **% Apr****2017** | **% May****2017** | **% Jun****2016** | **% Jul****2016** | **% Aug****2016** | **% Sep 2016** | **% Oct 2016** | **% Nov 2016** | **% Dec** **2016** | **% Jan 2017** | **% Feb** **2017** |
| **16-17** | 0 | 1.28 | 0.99 | 0.16 | 0.7 | 0.63 | 0.31 | 0.14 | 0.14 | 0 | 0.29 | 0 |
| **18-25** | 105 | 21.4 | 22.64 | 13.92 | 20.03 | 18.48 | 19.04 | 16.25 | 18.47 | 19.88 | 20.18 | 18.78 |
| **26-35** | 155 | 25.11 | 24.13 | 32.2 | 27.35 | 25.59 | 28.95 | 27.97 | 28.4 | 26.17 | 33.28 | 27.73 |
| **36-45** | 119 | 20.26 | 21.49 | 24.27 | 20.73 | 20.06 | 20.28 | 21.89 | 22.73 | 20.69 | 20.91 | 21.29 |
| **46-55** | 103 | 20.83 | 16.03 | 14.89 | 16.55 | 19.43 | 19.81 | 18.36 | 16.62 | 19.47 | 15.91 | 18.43 |
| **56-65** | 51 | 6.56 | 9.92 | 8.41 | 9.76 | 9.95 | 5.88 | 9.74 | 8.24 | 8.52 | 7.22 | 9.12 |
| **66+** | 26 | 4.56 | 4.79 | 6.15 | 4.88 | 5.85 | 5.73 | 5.65 | 5.4 | 5.27 | 2.21 | 4.65 |

### 2.2.3 Migration

Approximately 18,000 people move into Croydon and 20,000 people move out of Croydon from elsewhere within the UK each year. Croydon’s population is subject to a net north to south movement of people migrating from Inner South London to Outer South London and from Outer South London to South Eastern England. Croydon has 6,000-7,000 new immigrants from outside the UK per year and at least 3,000 emigrants.

The main areas immigrants have been coming from in recent years are:

* South Asia (India, Pakistan and Sri Lanka: 2,300 people per year)
* Eastern Europe (Poland, Romania, Lithuania, Bulgaria, Hungary: 1,100 people per year)
* Certain countries in Africa (Ghana and Nigeria: 500 people per year)

### 2.2.4 Ethnicity

Over half of Croydon’s population are from Black, Asian and minority ethnic groups, and the proportion is increasing over time. The most common languages spoken by people in Croydon other than English are Tamil, Urdu, Guajarati and Polish.

*Demographics - Ethnicity Profiles from Service User Access in 16/17*

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Ethnicity** | **Number of referrals** | **%** **Apr 2016** | **% May** **2016** | **%** **Jun 2016** | **%** **Jul** **2016** | **% Aug** **2016** | **% Sep 2016** | **%** **Oct 2016** | **% Nov** **2016** | **% Dec** **2016**  | **%** **Jan** **2017** | **%** **Feb 2017** |
| **Missing** | 20 | 8.24 | 9.72 | 5.09 | 6.2 | 6.67 | 7.12 | 7.84 | 8.46 | 18.69 | 6.64 | 5.42 |
| **White** | 208 | 52.62 | 54.06 | 58.45 | 55.83 | 57.86 | 53.56 | 58.17 | 52.69 | 50.16 | 57.74 | 56.37 |
| **Mixed** | 27 | 4.87 | 4.95 | 8.31 | 6.7 | 5.71 | 8.05 | 5.56 | 4.81 | 3.93 | 4.87 | 7.32 |
| **Asian or Asian British** | 39 | 10.86 | 8.13 | 7.77 | 10.67 | 10.95 | 10.84 | 9.15 | 11.92 | 7.87 | 9.95 | 10.57 |
| **Black or Black British** | 67 | 18.54 | 19.61 | 17.16 | 16.13 | 15.95 | 15.48 | 15.36 | 18.65 | 13.77 | 17.92 | 18.16 |
| **Other Ethnic Groups** | 6 | 3 | 1.59 | 2.14 | 3.72 | 1.67 | 2.79 | 2.29 | 2.12 | 3.28 | 1.11 | 1.63 |
| **Not Stated** | 2 | 1.87 | 1.94 | 1.07 | 0.74 | 1.19 | 2.17 | 1.63 | 1.35 | 2.3 | 1.77 | 0.53 |

### 2.2.5 Deprivation

Croydon is more deprived in the north of the borough than in the south, and there are also areas of high deprivation in the east of the borough in Fieldway, New Addington and the Shrublands estate in Shirley. In recent years, compared with England as a whole, Outer London has been becoming more deprived, and Inner London more affluent. Between 2004 and 2010, levels of deprivation increased in Croydon more than in any other borough in the south of London. Croydon is currently the 19th most deprived borough in London. If Croydon continues to grow more deprived at the same rate as recent years, by 2020 it will be the 12th most deprived borough in London.

Many of the risk factors for poor physical and mental health are associated with deprivation including poor housing, unemployment, poverty, poor education, and high crime.

**2.3 Forensic Rehabilitation Service in Croydon**

Evergreen Lodge service is a 12-bedded step-down forensic service. The financial value of the service is £1.068m and it is funded on a block contractual basis. The service provides 24 hour care in a step-down setting with supervision and structured interventions appropriate to the needs of Service Users who require a graded, monitored reintroduction into less supported accommodation in a community setting. The Care Home may be considered as a step-up facility, when deemed that admission into a hospital bed would not be appropriate

# Strategic and Local Context

## 3.1 National Drivers for change

The NHSE Five Year Forward View calls for the expansion of proven community based services to enable people of all ages with severe mental health problems who need support to live safely as close to home as possible. The guidance states that there needs to be more ‘step down’ provision from secure care such as residential rehabilitation, supported housing and forensic or assertive outreach teams.

This work should also tackle inequalities for groups shown to be over-represented in detentions and lengthy stays, and seek to ensure that out of area placements are substantially reduced. The programme should identify where and how efficiencies could be realised within the system and reinvested.

## 3.2 Local Drivers for change

The most recent local datasets available show that, in Croydon:

* An estimated 15.9% population aged 16-74 have a common mental health problem - approximately 42,245 people (2014/15 data)[[1]](#footnote-1)
* 5.6% GP practice register aged 18+ have a recorded diagnosis of depression (2015/16 data)[[2]](#footnote-2)
* 11.8% respondents aged 18+ of the GP Patient Survey in 2015/16 reported having depression or anxiety, and 4.3% reported having a long term mental health problem[[3]](#footnote-3)

Croydon CCG’s organisational objective is to commission integrated, safe, high quality service in the right place at the right time.

A Contract Review of historical contracts has led to the CCG identifying Forensic Rehabilitation as an area for service redesign. The aim of the re-procurement is to develop a service which aligns with national guidance around the forensic pathway for rehabilitation and also links with other agencies to ensure a seamless transition from secure services to community integration whilst achieving value for money. The potential benefits are reduced lengths of stay in rehabilitation, better planning around step down to supported housing and improved multi agency working to achieve better patient outcomes.

**Local Croydon Forensic Pathway use**:

Table and chart showing the ethnicity of service users in November 2015 and September 2016 (SLaM)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Asian | Black | Mixed Race | Other Ethnic Group | White | Unknown |
| 18-65 year olds in Croydon (Census 2011) | 16.3% | 19.9% | 4.8% | 3.3% | 55.8% | 0.0% |
| Forensic Pathway service users -Croydon (Nov 15) (n=143) | 1.4% | 49.7% | 7.7% | 3.5% | 37.8% | 3.8% |
| Forensic Pathway service users -Croydon (Sep16) (n=162) | 1.9% | 51.2% | 5.6% | 2.5% | 38.3% | 0.6% |

## 3.3 Patient, public and primary care feedback

To be confirmed

## Current Forensic Rehabilitation Service in Croydon

The current service is provided by Priory Group.

The service is currently provided from this location:

* 21 South Park Hill Rd, South Croydon, CR2 7DY

The current service is a 12-bedded step-down forensic service. The financial value of the service is £1.068m and it is funded on a block contractual basis. The service provides 24 hour care in a step-down setting with supervision and structured interventions appropriate to the needs of Service Users who require a graded, monitored reintroduction into less supported accommodation in a community setting. The Care Home may be considered as a step-up facility, when deemed that admission into a hospital bed would not be appropriate

* 1. **Current Service Model**

The service is delivered as residential provision that has the capacity to provide a minimum service as outlined below:

* An establishment of 18.7 FTE, equating to 701.75 hours per week. The care team will consist of 518 hours per week supported by non-clinical staff including an administrator, catering, domestic and maintenance staff
* A minimum of 4 care support staff during the day (07:30-20:30hrs)
* A minimum of 2 care staff at night (19:30-08:00hrs)
* Additional support can be provided in addition to this minimum level of staffing but will be subject to additional charging at an agreed hourly rate
* Plan and deliver individualised holistic care plans
* Integrated risk assessment and management in care plans
* Ensure service users have written and up to date collaborative care plans that are regularly reviewed and monitored
* Use evidence-based interventions including psycho-social interventions
* Prepare and present reports as required including monthly governance reporting to the Commissioner
* Attend and participate in relevant service user care reviews such as CPAs, case conferences, etc.
* Act as a functional part of MDT meetings
* Clinical communication with other members of the MDT

The current service staffing levels are:

* Manager – 1 FTE, no longer a requirement to be a nurse
* Deputy Manager – 1 FTE (50% supernumerary)
* Day – 1 Team Leader and 3 Support Workers, total of 4 on shift
* Night – 1 Team Leader and 1 Support Workers, total of 2 on shift
* Rehabilitation Coordinator – 1 FTE
* Admin – 1 FTE
* Domestic – 30 hours pw
* Maintenance = 22.5 hours pw
	1. **Proposed Service Model**

The CCG wishes to commission a proposed service model to include a broadened cohort of patients for the new service to reflect the current needs of the borough. The new service model will be in collaboration with mental health partner services. The cohort of service users being treated by this service will have a mental health diagnosis and a forensic background, which may include arson and a history of substance misuse.

Service users would be admitted via the community forensic service pathways once they are suitable for discharge from inpatient services. The new service will work function as an integrated working model with SLaM forensic team to support patients being managed and step-down into the service in a timely way to reduce the possibility of a delayed transfer of care.

The new service will provide 24 hour rehabilitative support within the community. The proposed service model would include significant therapeutic work in the areas of medication self-management, engagement in meaningful activities and assisting the service user to have a greater awareness of their illness and how to maintain their recovery. There would also be joint working with community organisations to address their offending behaviour.

The service model will have a step-down element that will support patients move-on into a less supported environment with the continuum of staff supervision and floating support. This will be for core hours each week and include the possibility of being flexed up or down based on the needs of service users.

The intention is to move away from service users being treated in a less institutionalised setting which will foster a continued dependency on services and service user remaining in the service for a number of years. The new service will focus on building resilience so that service users will be able to cope with managing their mental health issues and living independently. The maximum period for patient to remain in the service will be 18mths to 2yrs.

The lower support provision will support the service user to maintain their independence and promoting their health and well-being in the community.

The new provision would support service users that have a forensic background but may not meet the current threshold to be formally managed by this team. This cohort of patient has been identified in the CCG diagnostic report. It specifically identified a population of black young men with complex presentation – mental health and substance misuse that remain in hospital for significantly longer periods and had significant difficulties with stepped-down from inpatient care back into the community.

The service also has the potential to accept a small cohort of women with a forensic background. However we would need to consider carefully how this would be managed and whether there have a satellite element specifically for service users.

The revised model will include medium to low supported housing, which is only accessible to patients coming through this pathway of care. This will support patients with progressing on to the next stage of their recovery and reduce the current level of waiting times in the system for supported housing.

1. PHE Mental Health Fingertips Profile: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#page/1/gid/1938132720/pat/46/par/E39000018/ati/19/are/E38000040/iid/90853/age/240/sex/4> [↑](#footnote-ref-1)
2. PHE Mental Health Fingertips Profile: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#page/1/gid/1938132720/pat/46/par/E39000018/ati/19/are/E38000040/iid/90853/age/240/sex/4> [↑](#footnote-ref-2)
3. PHE Mental Health Fingertips Profile: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#page/1/gid/1938132720/pat/46/par/E39000018/ati/19/are/E38000040/iid/90853/age/240/sex/4> [↑](#footnote-ref-3)