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Scrutiny Health & Social Care Sub-Committee Agenda

To: Councillor Sherwan Chowdhury (Chair)
Councillor Andy Stranack (Vice-Chair)
Councillors Pat Clouder, Toni Letts, Andrew Pelling and Scott Roche

Reserve Members: Jamie Audsley, Jan Buttinger, Patsy Cummings, Stephen Mann, Helen Redfern and Callton Young

A meeting of the **Scrutiny Health & Social Care Sub-Committee** which you are hereby summoned to attend, will be held on **Tuesday, 20 November 2018** at **6.30 pm** in **Council Chamber - Town Hall**

Jacqueline Harris Baker
Director of Law and Governance
London Borough of Croydon
Bernard Weatherill House
8 Mint Walk, Croydon CR0 1EA

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www.croydon.gov.uk/meetings
Monday, 12 November 2018

Members of the public are welcome to attend this meeting.
If you require any assistance, please contact the person detailed above, on the righthand side.

N.B This meeting will be paperless. The agenda can be accessed online at www.croydon.gov.uk/meetings

AGENDA – PART A

1. Apologies for Absence

To receive any apologies for absence from any members of the Committee.

2. Minutes of the Previous Meeting (Pages 5 - 14)

To approve the minutes of the meeting held on 25 September 2018 as an accurate record.

3. Disclosure of Interests

In accordance with the Council's Code of Conduct and the statutory provisions of the Localism Act, Members and co-opted Members of the Council are reminded that it is a requirement to register disclosable pecuniary interests (DPIs) and gifts and hospitality to the value of which exceeds £50 or multiple gifts and/or instances of hospitality with a cumulative value of £50 or more when received from a single donor within a rolling twelve month period. In addition, Members and co-opted Members are reminded that unless their disclosable pecuniary interest is registered on the register of interests or is the subject of a pending notification to the Monitoring Officer, they are required to disclose those disclosable pecuniary interests at the meeting. This should be done by completing the Disclosure of Interest form and handing it to the Democratic Services representative at the start of the meeting. The Chair will then invite Members to make their disclosure orally at the commencement of Agenda item 3. Completed disclosure forms will be provided to the Monitoring Officer for inclusion on the Register of Members' Interests.

4. Urgent Business (if any)

To receive notice of any business not on the agenda which in the opinion of the Chair, by reason of special circumstances, be considered as a matter of urgency.

5. King's College Hospital NHS Foundation Trust - Community Dental Service (Pages 15 - 18)

To receive an update from representatives from King's College Hospital NHS Foundation Trust on the Community Dental Service provided by the Trust in the Borough.

6. Croydon Health Service NHS Trust (Pages 19 - 28)

To receive an update from Croydon Health Service NHS Trust on the action taken following the Care Quality Commission (CQC) inspection in July 2018.

7. **Healthwatch Croydon** (Pages 29 - 154)

To receive an update from the Croydon Healthwatch Manager on their recent activities in the Borough.

8. **Health & Social Care Sub-Committee Work Programme 2018/19** (Pages 155 - 156)

The Sub-Committee is to consider whether it wish to make any additions, amendments or changes to the agreed work programme for the Committee in 2018/19.

9. **Exclusion of the Press and Public**

The following motion is to be moved and seconded where it is proposed to exclude the press and public from the remainder of a meeting:

"That, under Section 100A(4) of the Local Government Act, 1972, the press and public be excluded from the meeting for the following items of business on the grounds that it involves the likely disclosure of exempt information falling within those paragraphs indicated in Part 1 of Schedule 12A of the Local Government Act 1972, as amended."

PART B

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Scrutiny Health & Social Care Sub-Committee

Meeting of held on Tuesday, 25 September 2018 at 6.30 pm in Council Chamber - Town Hall

MINUTES

Present: Councillor Sherwan Chowdhury (Chair);
Councillor Andy Stranack (Vice-Chair);
Councillors Pat Clouder, Toni Letts, Andrew Pelling and Scott Roche

Also Present: Hugh Jones, Clinical Director SLAM
Dr Faisal Sethi, Service Director SLAM
Beverley Murphy, Director of Nursing SLAM
Annie Callaghan, Independent Chair, Croydon Safeguarding Adults Board
Guy Van Dichele, Executive Director Health, Wellbeing& Adults, Adult Social Care and All Age Disability
Andrew Eyres, Accountable Officer NHS Croydon Clinical Commissioning Group
Stephen Warren, Director of Commissioning Croydon Clinical Commissioning Group
Dr Agnello Fernandes, Clinical Chair Croydon Clinical Commissioning Group

Apologies: None

PART A

25/18 **Minutes of the Previous Meeting**

The minutes of the meetings held on 27 March 2018 and 23 April 2018 were agreed as an accurate record.

26/18 **Disclosure of Interests**

There were none.

27/18 **Urgent Business (if any)**

There were no items of urgent business.

28/18 **South London and Maudsley NHS Foundation Trust - CQC Report**

The Director of Nursing presented the findings and recommendations as well as the improvement work to date arising from the Care Quality Commission (CQC) Core Service and Well Led inspection of July- August 2018.

The Sub-Committee learned that the inspection took place over a two week period. Five pathways as well as 20 acute wards were inspected.

There were two key areas of concern which resulted in the issue of warning notices under the Health and Social Care Act which were:

•Concern about the governance systems in a small number of wards.
•Lack of oversight of senior management on the significant issue of lack of beds on 36 occasions, 12 months prior to the inspection.

Since the inspection and feedback received there had been eight meetings of the Trust management team to address the highlighted areas of concern and had focussed upon the following:-

•The adoption of a borough by borough model of operational directorate, as well as a Clinical Director supported by a multi professional leadership team to look specifically at Croydon issues.
•Addressing issues within the clinical leadership in order to achieve parity of esteem.
•Recruitment and retention of staff and the voice of the staff across the whole organisation.
•Receipt of the draft findings from the CQC inspection and working to a strict timeline to submit to the Board as well as the CQC the improvement plan.
•Addressing challenges arising from funding challenges

In response to a Member question about what was being done to strengthen the leadership of the Croydon directorate, officers advised that many of the senior posts had been recruited and there was now a robust senior management team in place who had been devising and working on the delivery of the implementation plan. The team would be tracking and managing facilities and teams as well as focusing on patient experience.

A Member commented that the report highlighted concerns that Croydon had specific difficulties with a lack of patient discharge plans. Officers agreed that the Trust had experienced commissioning issues and which had impacted on the quality of service. The introduction of a borough based leadership and management structure would ensure that these issues were managed as a priority.

In response to a Member concern about the financial implications in terms of displacement to other services if patients were accelerated through the system too quickly, officers stated that it was important to ensure that service users were not kept as in-patients for longer than required. Indications show that the Trust was not being proactive enough in moving patients on from one

system to another and the CQC had made it clear there was a need to provide care to patients in the least restrictive environment.

It was commented that it was disappointing to learn about SLAM's rating, which had usually been good, and it was questioned whether this could be attributed to the directorate having lost line of sight. It was confirmed that lack of oversight was a key issue and one which the Board and Executive will have to prove to the Sub-Committee that they had regained oversight.

Members' requested that officer's return to provide an update on progress made at a future meeting, in particular, understanding of their roles and how they were able to demonstrate the effectiveness of their leadership through visibility and transparency. Officers agreed that more work was needed to address problems and that the new structure should improve visibility. The senior management structure was now well organised, more targeted, focused and sighted on variance in front line teams. Additionally relationship building was key to understanding views of staff through leadership engagement to ensure positive outcomes for patients as well as staff.

Staff had been open and honest about the work environment and culture, including the acceptance of the pressure within the service, which the leadership had needed to take on board. There was also a need to be clear on the required quality of care across the whole organisation.

The Sub-Committee was informed that the results from the staff survey showed that BME staff reported a better experience of working in the organisation than their colleague, yet during the inspection had been vocal about the negative aspects of their working experience. It had been recognised across the Trust that more work was required to improve staff satisfaction and that it would take time to implement improvements to longstanding issues. The commitment from the Chair was evident through the championing of and focus upon addressing issues for BME staff.

It was agreed for further scrutiny to take place in December 2018, as the Trust would have had time to imbed some of the actions arising from the Improvement Plan.

In reaching its recommendations, the Sub-Committee reached the following **CONCLUSIONS**:

1. The CQC ratings for SlaM were disappointing and concerning given that in recent years the performance of the trust had been good. This rating was despite the fact that they were the most improved NHS Trust in the last year.
2. There was concern that the Executive had lost its line of sight and this lack of sight had contributed to the key issues highlighted by the CQC in areas of inadequacy by the Trust.
3. The Sub-Committee welcomes the new structure which meant that Croydon will be geographically led. This way of working presented an opportunity to understand funding issues and implications. In particular, issues surrounding underfunding and its contribution to inequalities of health.

The Sub-Committee **Resolved** to recommend that:
1. SLaM to return to a meeting of the Sub-Committee in December 2018 to provide an update on the actions that have been put in place in response to the CQC findings.
2. SLaM to provide explicit reference of line of sight of senior management in order for the Sub-Committee to appropriately hold the Executive to account about the visibility of their leadership.

29/18 **Clinical Commissioning Group Update**

The Director of Commissioning gave a presentation which provided an update on their operating plans for 2018/19 and the draft commissioning intentions for 2019/20.

During the presentation the following points were covered:
•The strategic vision and how challenges would be managed
•Addressing the imbalance in systems relating to the Strategic Transformation Plan (STP).
•Significant improvement had been made with the out of hospital programme including the development of improved community services, life programme and other social care initiatives.
•Improvements to the accessibility of community based services were being explored with business cases for various potential improvements being prepared.
•Further challenges were identified in planned care services due to complexities
•Mental Health Services continued to be an area of challenge and remained a priority.
•Further work on action planning around discharged patients would be implemented.
•Commissioning intentions had incorporate working together to ensure service provision was in line with people's needs.

In response to a question about what was hoped to be achieved through commissioning intentions, officers stated that they were trying to achieve a more integrated service and encourage effective partnerships through building networks with the voluntary sector, SLAM, and NHS, as well as ensuring services were being commissioned appropriately. It was important that partners worked together due to the complex needs of patients and to ensure their needs were being met, which could be achieved by working in partnership.

It was questioned whether there were commissioning challenges in terms of employment of European Union (EU) staff, officers responded that workforce in general was a challenge for the borough which was not limited to the recruitment of EU staff.

A Member questioned the waiting times for GP appointments in the borough and if any noticeable trends had developed. Officers responded that generally people could get an appointment with a GP on any day, but there were more

difficulties getting an appointment with a specific GP and there was variation in different areas. Demand would always outweigh supply and the key was to change culture by empowering people to self-care where appropriate as a proportion of appointments made do not require GP interface.

It was commented that inequality was mentioned through the final pages of the report and not the beginning and that there was a need for this to be more explicit in the report. Officers agreed that it was important for this to be highlighted at the forefront and more in depth work was needed in the areas mentioned.

A Member queried the optimism of the financial proposals and questioned the feasibility of the predictions made for the coming year. Officers advised that they were now out of special measures and were in a good place to fulfil the predictions made in the financial proposals.

In response to a question about how confident officers were that the new Accident and Emergency unit at Croydon University Hospital would open in 2018 and what was being done to change the culture of patients wanting to attend neighbouring hospitals for acute health treatment, officers stated that they were on track as planned for the opening later in the year. Intensive work was being carried out to improve health provision, including getting the message across that it was in residents' interest to choose local services and that the offer at CUH was good. The legacy of the hospital's old title was something that would take time to overcome but this was being achieved gradually.

Members' highlighted that further work was needed to support carers, commission services for the drug and alcohol services and improve the offer for those with learning disabilities. Officers responded that joint commissioning and other opportunities were being investigated in order to realise the best outcomes for communities. The interrelationship with mental health and drug and alcohol was also being explored by working closely with public health to identify and implement preventative as well as interventional policies and methods.

The Chair questioned what was being done to address the growing issues with children's mental health in the borough. Officers responded that this remained an area of priority for the CCG as well as the Local Strategic Partnership (LSP). More work was to be done with schools, strengthening of the current mental health steering group and supporting the Voluntary sector were all part of the transformation plan.

The Chair thanked officers for their responses to questions

In reaching its recommendations, the Sub-Committee reached the following **CONCLUSIONS**:

1. It was encouraging to learn that they were no longer in special measures and hope that they continue to work hard to drive through improvements.

2. The various partnerships and relationships built was positive and was improving outcomes for residents.
3. Inequality was mentioned throughout the report but this should have occurred at the forefront in order to promote transparency in all areas of service.

The Sub- Committee **Resolved** to recommend that:
1. Explicit reference of inequalities to be provided in the revised report as accountability is more difficult if not referenced explicitly.
2. The CCG to work closely with partners on promoting access to services and intervention for young people with Mental Health issues.

30/18 **Croydon Adults' Safeguarding Board Annual Report 2017-18**

The Independent Chair, who was appointed in January 2018, presented the draft annual report. The report was an amalgamation of work from the agencies involved as well as contributions from the groups and sub-groups of the Croydon Safeguarding Adult Board (CSAB).

The priorities set for 2018/19 was to build on the work of the priorities from 2017/18 which were deemed to be good strategic priorities and included the following:
•Prevention and early identification of adults as risk of abuse
•Improved commissioning of services
•Improved and effective communication with residents, boards, partnerships and agencies
•Voice of service users to be central to the work of the CSAB
•Safeguarding to be at the heart of commissioning and delivery of services.

It was also noted that more work was needed to ensure the involvement of BME groups in the work of the CSAB and that improved engagement with colleagues would enhance the quality and increase the number of referrals.

It was commented that the report highlighted that 18% more female than male experienced abuse but the report was not explicit in stating what types of abuse was experienced and as a result there was no real sense of what the main issues were.

A Member commended the work that had been done to highlight the serious illness of hoarding and praised the Council for championing this area of focus.

A Member questioned what had been done to address some of the issues identified through the feedback received from the interviews post safeguarding process, in particular where the feedback stated:

'*Worse part of the process was being anxious to attend meeting, communication poor, drawn out process and length of safeguarding processes.*'

The officer responded that they were investing in communication, training and development of sub-groups. The information received was fed back to staff, through training and development in order to improve practice over time.

It was suggested that it would have been useful if the report had contained comparative figures for other local authorities on the safeguarding referrals received during 2017/18 as it was difficult to determine if the figures for enquiries that turned into substantiated referrals were average figures. The officer stated that this cross matching of data was not common practice and that it was important to note that conversion rates of referrals to investigation was more about the level of understanding of what a safeguarding referral was, additionally it was difficult to compare figures with other local authorities due to complexities and uniqueness of each borough.

A Member stated that in relation to learning and development of staff, the report suggested that there was a low uptake of e-learning. Officers replied that whilst e-learning had its benefits, it was important for staff to have more face to face training and staff were being encouraged to sign up for these sessions.

A Member enquired about the lessons learnt from the Ofsted report on Croydon Children's Services. Officers advised that it had resulted in a refocus of the whole service and an internal independent audit had been completed for areas such as staff caseload and management support.This had resulted in appropriate measures being put in place to address areas highlighted as being of concern.

In response to a Member query on the effectiveness of partnerships in Croydon and how a judgement could be made on its strengths, officers advised that partnerships working in the borough was good and there was strong evidence of engagement across the organisation. Additionally evidence contained in dashboards would be more reliable and management would be able to supply accurate narrative of the evidence. Risk registers would also highlight what was required to improve outcomes and this would evidence the work of the partnerships.

Officers informed the Sub-Committee that the sub-groups were exploring ways of effective engagement with BME groups to ensure that they were kept up to date with safeguarding procedure, measures and channels of reporting.

It was agreed that more work was needed to improve upon communication of awareness of safeguarding issues in areas such as domestic violence by working with council partners such as trading standards as well as businesses in the community to promote increased awareness amongst staff.

The Chair thanked officers for attending to answer questions, and for the opportunity to feed into the report before being presented at Cabinet.

In reaching its recommendations, the Sub-Committee reached the following **CONCLUSIONS**:

1. The Sub-Committee commended the report, noting that it was very detailed and informative.
2. Croydon was to be congratulated for highlighting the serious issue of Hoarding and should be proud of championing exposure of this serious illness.
3. The report should have provided a clearer breakdown of the different types of abuse experiences by service users.
4. The report did not fully highlight the effectiveness of partnerships and further evidence of strong partnership would be useful in the report.

The Sub-Committee **RESOLVED** to recommend that:
1. Figures on safeguarding referrals made by internal and external organisations to be provided to the Sub-Committee.
2. Evidence of outcome of partnerships to be presented in 2018/19 report

31/18 **Joint Health Overview Scrutiny Committee Update**

The Chair and Vice-Chair informed the Sub-Committee that they would be attending future meetings of JHOSC and were awaiting dates to be finalised.
Members encouraged the Chair and Vice Chair to write a letter to the South West London STP regarding the lack of consultation with Croydon regarding the proposals under the STP which they were legally obligated to consult on.

32/18 **Work Programme 2018/19**

The Sub-Committee stated their interest on possible items to scrutinise in future meetings which included the following:
- Closure of New Addington Community Dental Service
- Croydon University Hospital A&E
- Update on London Ambulance Service following special measures status
- Croydon Drug and Alcohol Services
- NHS England's commissioning strategy for Croydon

The Sub-Committee also discussed the possibility of an additional meeting to be held in January 2019 in order to be able to accommodate the amount of topics that required scrutiny.

The work programme was noted for the remainder of 2018/19 municipal year

33/18 **Exclusion of the Press and Public**

This was not required.

The meeting ended at 9.15 pm

Signed: .....

Date: .....

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King's College Hospital
NHS Foundation Trust

Briefing: Future of Community Special Care Dental Service provided at Parkway Health Centre

Briefing for: Croydon Health and Social Care Scrutiny Sub-Committee

Briefing from: King's College Hospital NHS Foundation Trust

Date October 2018

Subject Relocation of Community Special Care Dentistry service from Parkway Health Centre to other primary care sites in Croydon

Contents

1. Introduction

In 2016/17 NHS England carried out a competitive tendering exercise for the provision of Community Dental services across London. The service specification was new and differed in many ways from the historical patterns of service.

A number of the new contracts for were awarded to King's College Hospital NHS Foundation Trust (King's) and these included the contract for Croydon, Merton and Sutton.

The Community Dental service in Croydon, Merton and Sutton is delivered from a network of Health Centres across the boroughs. The health centres are not owned by King's; the dental clinic space in them is rented from NHS Property Services. This arrangement applies to the dental clinic space in the Parkway Health Centre.

Since the award of the contract King's has sought to further improve the quality of the service for local patients. One element of this has been a review of the estate with the aim of:

- Ensuring that all clinic space is well utilised and that resource is spent on service delivery rather than on under-used buildings.

- Ensuring that clinic space supports contemporary best practice for models of care, particularly by consolidating services into larger clinics with multiple dental surgeries so that groups of clinicians can work together.

More recently the Trust's financial position has become extremely challenging to the extent that King's has been placed in financial special measures by the NHS regulator. This has prompted detailed scrutiny of all services to ensure that they are financially sustainable over the longer term.

The Trust has since set about an ambitious savings plan and all services including the Community Dental service are required to contribute to savings targets.

2. Review of community dental service clinics and conclusions

As part of King's ongoing Cost Improvement Programme a detailed review of patient activity throughout the Community Dental service has been carried out. This has included services at the Parkway Health Centre where levels of patient activity were set against site rental and running costs to assess the long term affordability of the clinics there.

The review found that the utilisation of the clinics at the Parkway Health Centre was very low compared to other King's run sites. Only 50% of available appointment slots were being used and only 125 patients were being seen each year.

On this basis the continued operation of the site is not deemed cost effective and the service could be relocated to other health centres with no reduction in the number of patients seen but with a significant saving in terms of rental costs.

As well as being poorly utilised the clinic space at the Parkway Health Centre is dated in terms of design and layout. Due to space constraints it is not possible to provide dental treatment, under sedation, for patients who are phobic or who have high levels of anxiety. Changing this and redesigning the clinic is simply not possible within the space available. The existing building is due for demolition in the next two to three years and health agencies in the borough are planning a new Health and Leisure Centre to be based in New Addington.

As a result of the review the Trust has taken the decision to close the dental clinic at the Parkway Health Centre and to move the patient activity to other nearby clinics that are also operated by King's - the Thornton Heath Health Centre, the Edridge Road Health Centre and the Jubilee Health Centre in Sutton. All of these Health Centres are within a reasonable travel time by public transport or by car from Parkway Health Centre. Where clinically appropriate King's can arrange for transport to and from one of these alternative clinics for non-ambulant patients who require specially adapted vehicles and / or a support crew.

King's will continue to work with other health agencies on the planning of the new Health and Leisure Centre in New Addington and – subject to cost- may opt to develop a new dental clinic on this site.

By spending less on renting under used sites King's can continue to treat the same number of patients as now and can also continue to provide other dental services for patients in the borough. For example:

- Our dental staff will continue to carry out approx. 110 domiciliary visits each month to patients in Croydon who are housebound or otherwise unable to visit one of our clinics.

- Our Oral Health Promotion teams will continue to visit target schools in Croydon – two of which are very close to the Parkway Health Centre – as well as visiting Children's Centres, Best Start groups and children's play groups.

In summary, the closure of the dental clinic at the Parkway Health Centre can be achieved with minimum impact on patients and the resulting rental savings will help to ensure that the service as a whole is sustainable and we can continue to provide community dental care to those who need it.

3. Future plans for delivering the services

The process for our withdrawal is as follows:

- Notice served to NHS Property Services of intention to vacate the site.
- All patients who had been seen in the dental clinic at the Parkway Health Centre over the preceding two years (250 patients) have been notified of the change by letter and offered support in transferring to another King's run site.
- The clinic space will be returned to NHS Property Services to be made available to other tenants on the site.
- The proposed service transfer date is 1st November 2018.

King's remains committed to the provision of high quality dental care to the people of Croydon and we look forward to continuing to delivering services from our remaining sites in the borough.

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Croydon Health Services NHS Trust

REPORT TO HEALTH & OVERSIGHT COMMITTEE (HOSC)	
Date:	Agenda No.
Date Paper produced: 9.11.18	Croydon Health Services NHS Trust – Care Quality Commission report – July 2018
Sponsoring Director: (responsible for signing off report)	Matthew Kershaw, Interim CEO, Croydon Health Services NHS Trust
Author:	Wendy Frost, Quality, Experience & Safety Programme Manager
Purpose/Decision required:	• To inform the HOSC of actions taken by Croydon Health Services (CHS) following the Care Quality Commission (CQC) inspection in July 2018. The CQC inspection report was published on 28th September 2018.
Impact on Patient Experience:	CQC inspections are an indicator of the quality of care provided by Croydon Health Services NHS Trust for the people of Croydon
Impact on Financial Improvement:	N/A
History: (which groups have previously considered this report)	N/A

Executive Summary:

This report provides an update of the actions taken by Croydon Health Services (CHS) NHS Trust following the CQC inspection of core services in July 2018. The core services inspected on this occasion had previously been rated as Requires Improvement in July 2015:

- Community Children & Young People
- Community Adults
- Medical Care i.e. inpatient wards (not including gynae, maternity or surgical wards)

The CQC published their inspection report on 29th September 2018.

The CQC highlighted 10 actions that the Trust must address in order to be compliant with the Health and Social Care Act 2008 (Regulated Activities). Two of the actions relate to the provision of information in other languages and have therefore been amalgamated into one Trust wide action. The CQC also recommended 11 actions which the Trust should complete to improve the quality of services that we provide. One action relates to Community Children & Young People audit which duplicates a 'must do' action and has been amalgamated into the 'must do' action. The Trust CQC action plan therefore includes 9 'must do' actions and 10 'should do' actions.

The CQC requires Trusts to complete a 'Report of Actions' to state the actions that will be carried out to address the 'must do' actions. The Trust submitted the report to the CQC following review and approval by the

Executive Management Board (EMB) and the Quality sub-Committee of the Trust Board.

The Integrated Adult Care (IAC) and Integrated Women's, Children and Sexual Health (IWCSH) Directorates have developed comprehensive action plans to respond to the 'must do' and 'should do' actions. The CQC action plans are being delivered and the progress is reported each month to the Executive Management Board, the Quality Committee and quarterly to the Trust Board.

The Trust is currently developing a range of quality improvement initiatives to drive quality in acute and community services and support the delivery of the quality priorities in the Quality Strategy and Quality Account. Further detail is included in the report.

Key Issues for Discussion:	CQC inspection report – July 2018 CHS quality improvement agenda

Related Strategic Objectives

Trust's Strategic Objectives 2016-17: Links to corporate objectives to improve quality and manage resources.

Please tick the objectives relevant to your report and explain how it is related.

Strategic Objective	**How is the objective related to the report?**
X ***Strategic Objective*** 1 **To deliver high quality, integrated, people-centred services that meets the needs of the people who use our service**	
X ***Strategic Objective 2*** **To ensure staff are able, empowered and responsible for the delivery of effective and compassionate care.**	
☐ ***Strategic Objective 3*** **To secure value for money and ensure the financial sustainability of the Trust**	
X ***Strategic Objective 4*** **To work with partners to improve the health and wellbeing of the people of Croydon.**	
Related CQC 5 Key Areas of Care:	X Safe; X Responsive; X Well-led; X Effective; X Caring

Has an equality impact assessment form been completed? **Yes / No**
If not applicable, please state why not
Has legal advice been taken? **Yes / No**

Does this report have any financial implications? **Yes / No**
If so, has the report been approved by the Financial Department **Yes / No**

1. Introduction

The Care Quality Commission (CQC) carried out a Trust wide inspection of all Croydon Health Services (CHS) NHS Trust core services in July 2015, resulting in an overall rating of 'requires improvement'. In 2017 the CQC moved from routine Trust wide inspections to focus on re-inspecting a Trust's core services that had been previously rated as 'requires improvement'. The CQC also added the additional domain of use of resources, to be included in inspections by 2019. The Trust has not yet been inspected for this domain and has not been given an indication of when this will be carried out.

In October/ November 2017 the CQC inspected the Trust's core services of surgery, end of life care, outpatients and critical care, previously rated as 'requires improvement'. Three of these services improved to a rating of 'good', although critical care remained as 'requires improvement'. The overall domains of safe, responsive and well led were rated as 'requires improvement' and caring and effective were rated as 'good'.

On 10th, 11th and 16th July 2018 the CQC inspected further core services previously rated as 'requires improvement':

- Community Children & Young People
- Community Adults
- Medical Care i.e. inpatient wards (not including gynae, maternity or surgical wards)

The CQC published its inspection report on 29th September 2018. The core services inspected remained as 'requires improvement' and the domains of safe, effective, responsive and well led were rated as 'requires improvement'. The domain of caring has consistently remained as 'good' since the 2015 full inspection.

The Trust was not given any enforcement notices following either of the inspections.

2. CQC 'must do' recommendations

The CQC have advised the Trust that it must address 10 actions within the following regulations to be compliant with the Health and Social Care Act 2008 (Regulated Activities):

- Regulation 9 – Person-centered care
- Regulation 17 – Good governance
- Regulation 12 – Safe care and treatment
- Regulation 18 – Staffing

Two of the actions relate to the provision of information in other languages and are therefore being treated as one Trust wide action for the purposes of the Trust's action plan. We will therefore report on 9 actions. The key themes and the actions that are being taken by the Trust are included below:

2.1 Access and flow of patients recommendation: The Trust must work to improve the access and flow of patients from admission to discharge. Further the patients should be cared for in the right ward for them from the beginning to avoid being moved, especially at night.

Actions: The Trust is currently carrying out a programme of work to improve access and flow through the hospital. This includes a 12 week turnaround plan which started in September to drive earlier discharges in the day, improve the number of patients who are in the right ward and improve Emergency Department waiting times. A Trust Integrated Discharge Team with social services has also been introduced to support timely discharge. These are important enablers to ensure sufficient Trust bed capacity and ensure patients are admitted in accordance with the Emergency Recovery Programme.

The new Emergency Department is due to be open and fully operational in December 2018. There will be improved emergency pathways to reduce waiting times and help to ensure that patients are admitted to the right wards through the effective use of assessment wards.

Trust wide Access and Flow Key Performance Indicators (KPIs) are being developed and will be implemented once they have been agreed and have passed through the governance process. These KPIs will include monitoring patient moves at night and the number of patients who are not in the 'right bed' to effectively monitor performance and evidence positive change. This action will be ongoing to monitor performance and trends.

2.2 Governance – risk and audit recommendation: The Trust must ensure that there are effective processes to identify and manage risk with actions taken to eradicate or mitigate risks.

Actions: The IAC Directorate has strengthened its established governance processes, including reviewing all risks at monthly Clinical Business Unit (CBU) and Directorate meetings. Risks will continue to be reviewed at the monthly Risk Assurance and Policy Group, with the minutes being scrutinised at the Trust monthly Quality Committee.

The IWSCH Directorate will develop a robust audit plan by December 2018 which will be monitored at both Directorate and Trust level to ensure actions are completed and re-audits carried out as required. The audits will also be included in the Trust annual national and local audit plan which is monitored at Directorate and Trust level and reported to the Trust Audit Committee for assurance purposes.

2.3 Speech and Language Therapists (SALT) - Community Adults recommendation: The Trust must ensure that there are sufficient numbers of speech and language therapists in the community to meet the needs of the population.

Actions: Recruitment of an additional speech and language therapist is ongoing and it is anticipated that the process will be concluded by December 2018, with the vacancies being filled by March 2019. A full review of the community SALT service is currently being carried out and will be completed by January 2019. This review will include assessing the demand, productivity and access criteria.

2.4 Electronic Patient Record (EPR) systems recommendation: The Trust must take steps to integrate their EPR systems to enable a shared care record, including social care and GP records.

Actions: A new Croydon Health Information Exchange (HIE) has been implemented at CHS which enables all clinical staff to access both the acute (CERNER) and community (EMIS) summary patient records when caring for patients. A South West London Interoperability Programme Board has been set up to deliver further advances in phases to connect all Croydon GPs with the Croydon HIE. The next phase is to deliver connectivity with Social Care by 2019. This longer term plan aims to join the HIEs of Croydon Health Services, Kingston and St Georges to enable easier access to patient record summaries to improve the delivery of integrated care across South West London.

2.5 Access to interpreters and information in other languages recommendation: The Trust must ensure patients have access to interpreters when required. It must also ensure service information on how to access services and other information leaflets are available in other languages.

Actions: The Trust currently provides comprehensive and professional language interpreting services - both face to face, including British Sign Language (BSL), and over the telephone - to patients registered to a Croydon GP with language needs in a healthcare setting. Face to face interpreters can be booked in advance through Croydon Translation and Interpreting Services (CTIS) or if a British Sign Language interpreter is required, via Sign Solutions (SS), while telephone interpreters can be accessed through Language Line (LL).

Patients can request information in a different language and this will be provided. The Trust internet webpage has a Google Translate function to allow the content to be automatically translated into the required language.

The Head of Nursing Patient, Experience and Quality has completed research of existing national guidelines from NHS England and the Department of Health, and has also met with the Head of Patient Experience (HOPE) network and NHS Improvement to discuss how other Trusts approach this issue. As a result of this research the Trust will take actions to ensure compliance with the

Accessible Information Standards issued by NHS England in August 2016 and updated in 2017. The intended actions to be completed by March 2019 will focus primarily on raising the awareness of patients and staff of the existing support and how it can be accessed. The information on the internet and intranet will be reviewed and updated and patient facing posters will be displayed in clinic areas. This will also be included in a planned Patient Engagement Listening Event in Quarter 4, which will include service users and external stakeholders, e.g. Healthwatch Croydon.

2.6 Lone working resources recommendation: The Trust must ensure all lone working community staff have phones provided in order to avoid risk of harm.

Actions: The Trust's Lone Working Policy provides a wide range of measures to keep all staff as safe as possible while carrying out their duties throughout the Trust in accordance with the Health and Safety Executive (HSE). These include clear and robust management procedures, control measures to address identified and potential risks, training, sharing of information, as well as the provision of personal safety technology, e.g. mobile phones and the Skyguard application.

The number of lone working staff requiring a mobile phone has been confirmed by the Trust Chief Nursing Informatics Officer and a business case approved to purchase 100 more phones and 25 laptops. The phones have been procured and will be rolled out to applicable lone working staff from 12th November 2018 by the IT team. A minimum of 20 new phones with the Skyguard application will be deployed each week and the anticipated completion date is 31.12.18. The Trust is awaiting delivery of the laptops and these will be distributed once received.

A Senior Administrator working within Community Nursing is proactively undertaking the administration of the Skyguard application. Skyguard software will be installed on all new lone worker phones prior to issue to staff. For lone workers who already have a mobile phone, the current usage of the Skyguard phone application is being reviewed to ensure that they are registered correctly on the system. There are currently 345 Skyguard licenses in use by staff in the Trust.

2.7 Health visitor high caseloads recommendation: The Trust must take steps to reduce the high caseload for health visitors.

Actions: The Trust is having ongoing meetings with the Commissioners to agree a plan around acceptable health visitor caseload numbers, taking into account the financial value of the current contract, recruitment and management of risk. A review of additional mitigations has been carried out and as a result of this a review of the safeguarding supervision model has been identified. The Director of Nursing, Midwifery and Allied Health Professionals has met with the Director of Public Health, Director of Children's Services, Chair of Croydon Safeguarding Children Board (CSCB), the Head of Commissioning and the Director of Quality CCG to review the controls that have been put in place and to discuss the ongoing governance process. It has been agreed to share the health visitor caseload and performance figures with the Chair of the CSCB each month.

The CCG Director of Quality, as a member of the Executive Safeguarding Board, will continue to work in collaboration across the system to support this work.

In the interim the Trust has confirmed and agreed the risk management of high health visitor caseloads. Actions that are already being taken include:

- Weekly review of clinical records for all children reported as not having had a mandated review (in place).
- Increased monitoring of caseload acuity and appropriate actions taken (due end of December 2018)
- Ensure all staff are aware of and engage with the escalation process (in place)
- Align Band 4 Community Development Advisors to named health visitor caseloads (in progress – due January 2019).
- Ensure all Health Visiting staff have access to remote working devices to increase productivity (in progress – due end March 2019).
- Increase frequency of safeguarding supervision – (in progress)
  Maintain or improve performance against the five mandated checks.

2.8 Community CYP audit recommendation: The Trust must develop a clear audit plan to ensure services are being delivered in line with local and national guidelines and that audit findings are acted on and re-audits are planned to monitor improvement. (This is also included as a 'should do' recommendation for Community CYP).

Actions: The Directorate is identifying a Clinical Lead for Community CYP audits to champion audit across all clinical practice. The audit plan will be developed by December 2018 and will be added to the Trust's audit plan of local and national audits. This will enable the Clinical Audit team to monitor the delivery of actions arising from audits and ensure that re-audits are completed in the required timeframes.

2.9 Electronic patient record systems recommendation: The Trust must take steps to integrate their electronic patient record systems to enable a shared care record, including social care and GP records.

Actions: A new Croydon Health Information Exchange (HIE) has been implemented at CHS which enables clinical staff to access both the acute (CERNER) and community (EMIS) summary patient records when caring for patients. This is available for use by all clinical staff working in community and acute services at Croydon Health Services. A South West London (SWL) Interoperability Programme Board has been set up to deliver further interoperability in phases.

Phase 1: This will deliver connectivity of all Croydon GPs with Croydon HIE. The rollout is planned to commence mid-January 2019. GPs will be connected in tranches.

Phase 2: Connectivity with Social Care is planned for December 2019.

The aim of this programme of work is to join the HIEs of Croydon Health Services, Kingston and St Georges in order that a summary of the patient record is available to enable better integrated care across South West London

3. CQC 'Should do' recommendations

The CQC also made 11 recommendations to improve the quality of the services the Trust provides, One of these duplicates the Community CYP audit 'must do' action as per 2.8 above and will be addressed within that action. The Trust's key actions are summarised below:

- Staff inductions – the Trust is reviewing the existing induction packs in clinical areas and will carry out an audit of completed Trust and local inductions for both substantive and Bank staff by 31st December 2018.
- Monitoring of community pressure ulcers – the Trust will carry out a benchmark audit and follow-up audit of community pressure ulcer assessment to monitor whether there is a reduction in acquired pressure ulcers as a result of new processes by 30th April 2018.
- Appraisal rates (Community CYP) – appraisal rates have improved since the inspection and the Directorate has committed to meeting the appraisal target of 90% by 1st December 2018.
- Community infection control compliance – the Dress Code Policy and the Infection Control Policy is being relaunched and compliance will be audited and reported to the CBU governance meetings and to the Directorate Board by 31st December 2018..
- Strengthening Community CYP governance - the IWCSH Directorate are developing their Directorate and Clinical Business Unit strategy and business plan to link with the overarching Trust Strategy for Q4 2018/19 and 2019/20. This will be completed by 31st December 2018 and will then be communicated throughout the Directorate. Included in this strengthening of Directorate governance is improving audit responses and continuing to support the embedding of a culture of incident reporting.
- Development of a transition policy for children and young people to adult services – a gap analysis is currently being carried out by the Planned Care Matron, looking at current service provision and identifying any divergence from NICE guidelines on transition of care NG43 (https://www.nice.org.uk/guidance/ng43. The resulting action plan will focus on addressing the gaps and creating seamless transition pathways by 30th April 2019.

4. Action plan delivery and reporting governance

The IAC and IWSCH Directorates have developed their action plans to address both the CQC 'must do' and 'should do' actions and are delivering the actions within them. These plans are included in the Trust wide CQC action plan which is discussed each month at the Quality, Experience and Safety Programme Group meeting chaired by the Director of Nursing, Midwifery and Allied Health Professionals. Membership of this meeting include the Medical Director, Associate Directors of

Nursing for each of the directorates, along with representatives from community services, pharmacy, estates and facilities, learning development and patient experience.

The timescale for delivery of the actions is as follows:

	Dec 2018	Mar 2019	April 2019	Dec 2019
Must do	44.5% (4/9)	44.5% (4/9)	-	11% (1/9)
Should do	20% (2/10)	20% (2/10)	60% (6/10)	-
Total	31.5% (6/19)	31.5% (6/19)	31.5% (6/19)	5.5% (1/19)

The delivery of the Trust's CQC action plan is monitored each month at Directorate level Quality Boards and reported to the Executive Management Board which is chaired by the CEO. As part of the governance process the progress is also reported for assurance purposes to the monthly Quality Committee, chaired by a Non-Executive Director and attended by senior colleagues from the Croydon Clinical Commissioning Group (CCG). Progress is also reported quarterly to the Trust Board which is led by the Chairman.

5. Croydon Health Services' Quality Agenda – 'Requires improvement' to 'Good' and 'Outstanding'

Quality is one of the Trust's three key priorities that underpin the care that we provide, along with performance and finance. The Trust recognises the value of the CQC inspections to provide one of the key indicators of the quality of the care that we provide. We will continue to work closely with the CQC, NHS Improvement, commissioners and all our partners as part of our quality improvement journey to good and then outstanding. It is however important to emphasise that this is part of our wider quality agenda to ensure we consistently provide safe, caring, effective, responsive and well led care to the people of Croydon.

To support our quality improvement journey we are developing a range of quality initiatives to deliver the priorities outlined in our Quality Strategy and Quality Account, as well as responding to the actions within the CQC report.

The Trust is currently carrying out a restructure of our quality teams; bringing together quality, patient experience and patient safety to support the delivery of quality objectives within the Trust and to support closer working relationships with our partners. This will streamline existing teams, provide greater sustainability and cross-cover and strengthen the capability and capacity within the team to deliver local and national objectives. It will also improve quality performance data such as audits, quickly highlight areas that require additional support and improve the response to serious incidents and complaints.

The initiatives also include the development of our own quality improvement methodology to drive further quality advances in both our community and acute services. In order to learn from

other Trusts who have recently been rated as 'Good' or 'Outstanding' we will be carrying out a 'learning from peers' event to identify areas of best practice. We will be holding Quality Summits in the community and in the hospital to listen to our teams and encourage the sharing of quality improvement ideas and plans.

In order to further support our quality improvement journey the Trust is developing a robust communication strategy to help staff to understand how the CQC inspection reports and domains relate to 'real life', i.e. what the CQC domains mean and how we can showcase the good quality care that we are already providing every day. We will also hold quality focus groups, refresh our Quality Guides and ensure that we give staff the resources they need on the Trust intranet.

6. Conclusion

The Trust is committed to providing consistent, high quality care to all of our patients, however they access our services. The delivery of quality care is important at every stage of a patient's pathway throughout our integrated community and acute system; from maternity to end of life, first contact to discharge and supporting those patients who have short or long term conditions.

We will continue to prioritise the ongoing delivery of all of the CQC recommendations that followed the inspection in July 2018 and ensure that by April 2019 we are compliant with the Health and Social Care Act 2008 (Regulated Activities),

We will also concurrently be carrying out the other important elements of our quality improvement agenda to strengthen the quality of patient pathways across the Trust, working in partnership with our commissioners and other stakeholders, e.g. through the One Alliance, or SWL Partnership.

Street Homeless Experience of Health Services in Croydon

June 2018

1 Background

1.1 Executive Summary

Following our previous report published in February 2018, on homeless living in hostels, Healthwatch Croydon wanted in understand the views of those living on the street.

This report looks at those rough sleeping in Croydon and raises the following issues:

- Nearly one in five (19%) had not registered with a GP, even though they have the right to do so.
- Nearly half (47%) had a negative experience of using GP services.
- Nearly half (47%) would consider GPs as the first place to go for support.
- Very few found it difficult to be referred, but 33% had no experience of referral suggesting they were not aware that they could be referred.
- Over one in four (28%) did not receive the mental health services they felt they needed.

Healthwatch Croydon recommends some areas for consideration:

- Increase training around registration for homeless people.
- Better information for GPs on services available and appropriate ways of access.

1.2 Context

Healthwatch Croydon published a report in February 2018 about homeless people's experiences of GP services while living in Evolve Housing + Support hostels.[1] We heard some did not have access to a GP, and others were travelling far out of the borough to access primary healthcare.

These findings led us to question if people who rough sleeping had similar experiences.

Healthwatch approached Crisis during the scoping for this work. We found that Crisis were doing their own research into their members' health. To become a member of Crisis, you must be homeless (which includes rough sleeping, sofa surfing or living in temporary accommodation), be at immediate risk of becoming homeless or have been homeless in the last two years. To avoid duplication with the Crisis members health research, it was agreed that we would collaborate with them.

[1] https://healthwatchcroydon.co.uk/wp-content/uploads/2017/10/Healthwatch-Croydon-The-Experiences-of-Homeless-People-using-Health-Services-in-Croydon-February-2018.pdf

Healthwatch and Crisis interviewed attendees at Crisis and the Salvation Army rough sleepers' specific services over a period of one week from 8 January to 12 January 2018. These attendees were a mix of Crisis members and other rough sleepers, for this report we will refer to these groups of members and attendees as either service users, participants or respondents.

For further reading into why this this survey was conducted and the current rough sleepers' initiative please see the work Crisis, Evolve Housing and Support, Expert Link and Thames Reach are undertaking in correspondence to the campaign CRZero 2020; to end chronic street homelessness in Croydon by the year 2020. For more information about this campaign see www.evolvehousing.org.uk/understand-our-work/cr-zero-2020

Healthwatch would like to thank the volunteers and members who took the time to undertake these surveys.

1.3 Method

Healthwatch and Crisis staff and volunteers worked with participants to complete 36 surveys. The surveys were conducted at the Salvation Army – specifically at The Well which is a weekly drop in for people who are homeless and at a breakfast club at Crisis Croydon which is for members and non-members of Crisis.

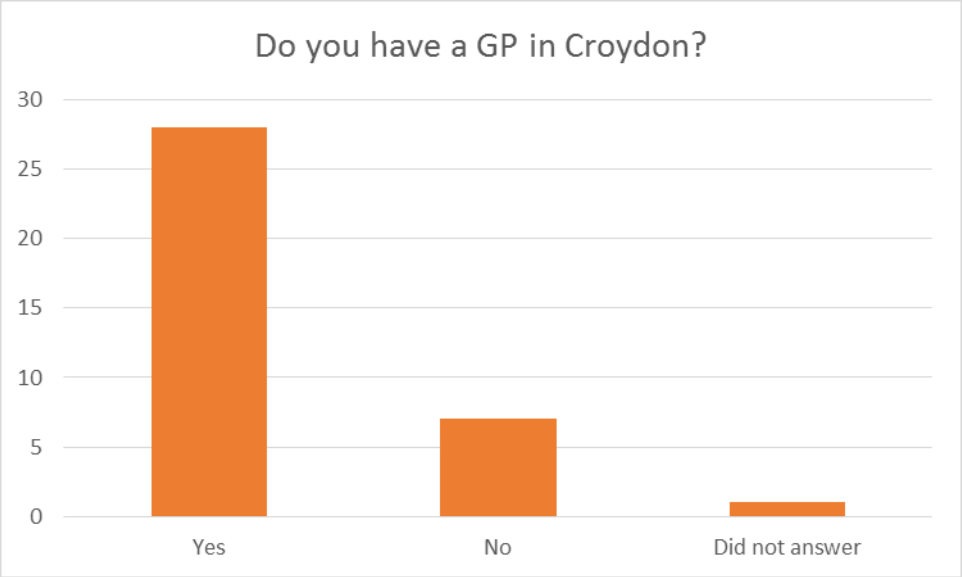
We asked the following series of eight questions:

- If they are registered at a GP in Croydon,
- What their experiences were at the GP (good and bad),
- Where would they initially go if they were unwell,
- If their GP has made referrals for them, how difficult or easy it was for those referrals to be made,
- If they were able to access the services needed
- What has been stopping them from accessing any health support they need.

All surveys were filled in on a voluntary basis, all participants did not answer all questions. We appreciate all the responses we received from Service Users during what may be an unsettled time of their life.

2 Survey results

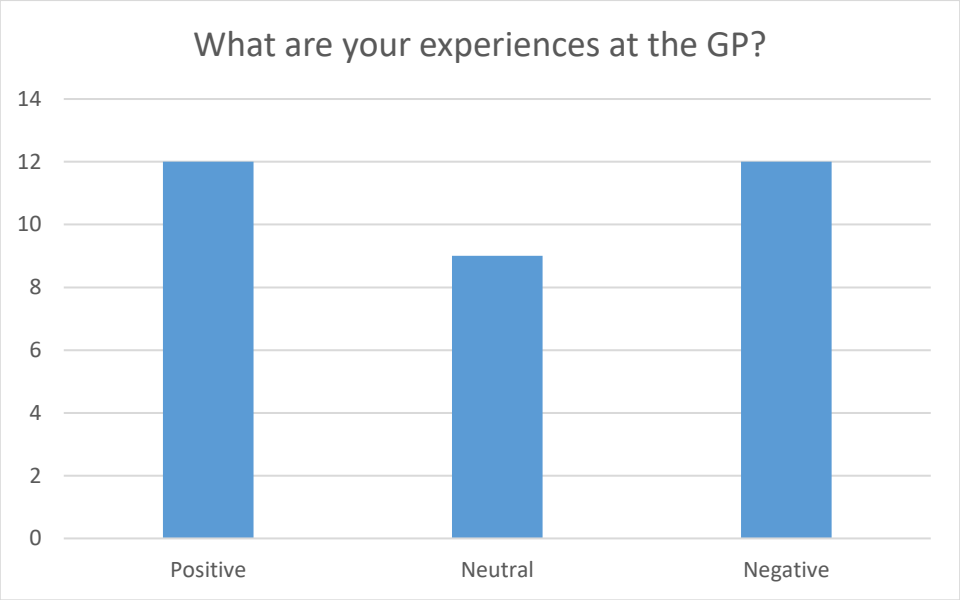
2.1 Did they have a GP in Croydon?



Of those asked, 81% of participants confirmed that they were registered in Croydon, while 19% told us they were not. Two said that this was because they did not know how to register, and another told us that they had been 'deregistered'. Other respondents (11%) told us that they had been refused registration based on not having an address, another was too fearful to attempt registration and told us 'I don't know which GP to go to…I might get turned away', while one said that they have not found the time to sign up.

One commented; 'I just joined at GP 4 months ago… I'm a refugee so I wasn't entitled to any, they told me this in Wood Green…I went in twice…they wanted evidence.'

2.2 What were the experiences at the GP?



We received 47% negative sentiments and 33% positive sentiments when we asked participants about their experiences at the GP. Responses showed that 22% of participants struggled to make an appointment and 11% found registration difficult; one said that it was due to him not having the right identification and another was asked to bring their own supply of dressings which was impossible at that time.

"All the experiences with the NHS have been very good… and had no problem."

"New GP is very good, doctors are helpful, and receptionists are very nice and know me by name."

"Never had a bad experience at the GP surgery."

"Very professional and kind."

"Always had a good relationship (with their GP)."

One respondent had mixed experiences telling us:

"Receptionists were lovely and friendly, but the doctors didn't seem to want to understand and did not want to refer me to the hospital."

In addition to this, the service user reported a language barrier.

One respondent told us that despite having a 'My right to access healthcare' card produced by Healthy London Partnership[2] - which details that people do not need an address to register at a GP practice- seeing the GP was still problematic, they told us:

> "Bad experiences… every time I see the doctor, I don't feel better… it takes a long time to get an appointment, difficult to register as I don't have the right identification… I have the homeless card and problem accessing."

One young service user told us that they felt the notion of the community and family Doctor had vanished, that there was:

> "No relationship...no trust in doctors. GPs fill you with pills that kill your body...five minutes is not long enough'

This respondent felt uneasy that they were diagnosed without being seen and told to 'go online' which can create barriers for this group.

Another respondent told us that they were struck off due to their homeless status:

> "Last year I went to the Doctor...got signed off as no fixed abode."

Another service user said they had a wound in their back which opened up again:

> "The GP told me to bring my own bandages and plasters to the surgery."

We heard from a refugee:

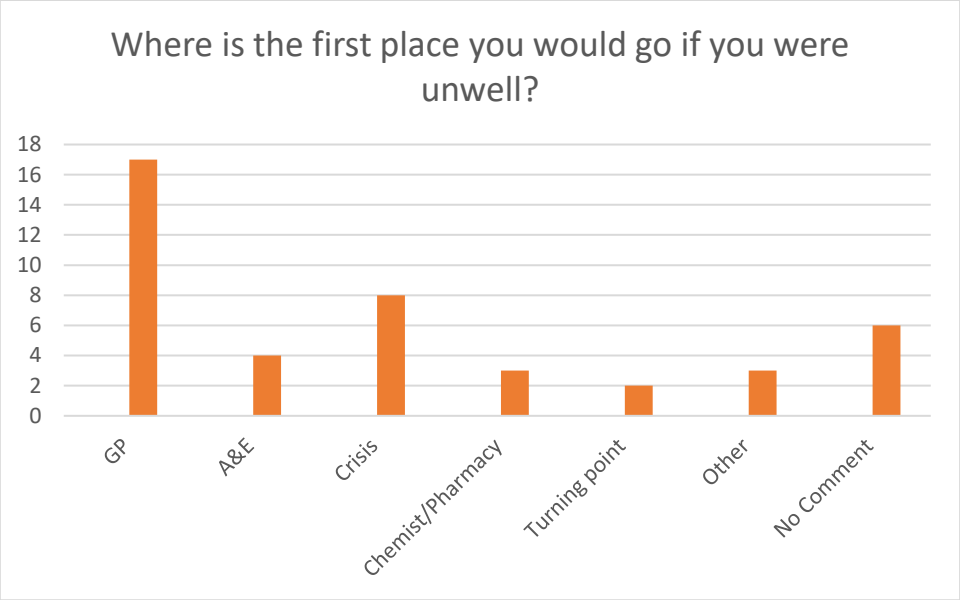
.

> "I went 14 years with no GP, they wouldn't let me register… no help… had to rely on paracetamol, or what I could find in the Pharmacy…(my) mouth was swollen, I had to remove an abscess with a needle myself."

[2] See https://www.healthylondon.org/our-work/homeless-health/healthcare-cards/

General comments included 14% of respondents not having had any experience with a GP due to not being registered or not having presented for an appointment.

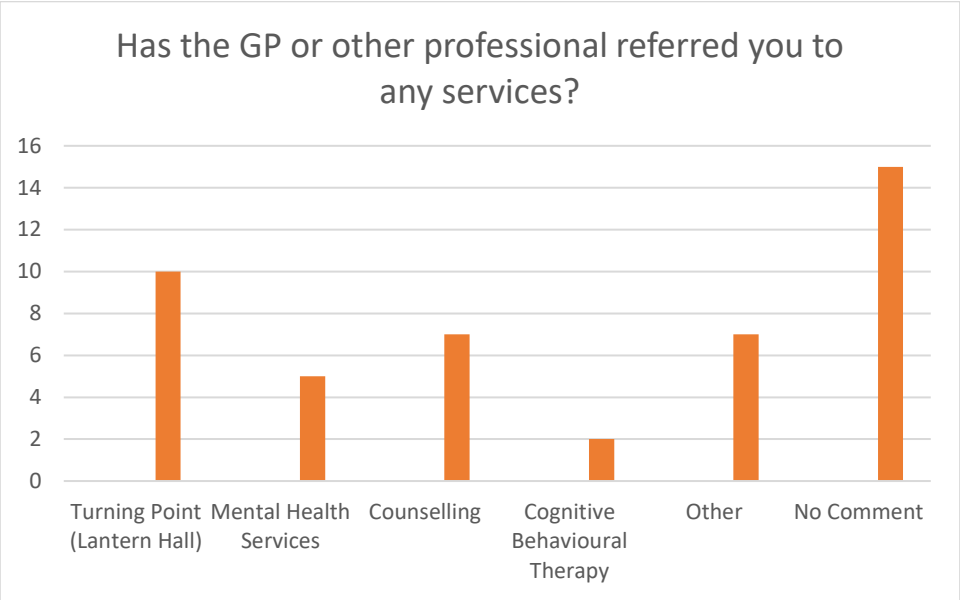
2.3 What is the first place that they would go if they were unwell?



Almost half (47%) of participants stated that they would initially go to a GP, whereas 22% would go to Crisis. A respondent told us: "Crisis (are) very helpful compared to GP". One expressed that they had "nowhere to turn" while three said that they would go to their friends for health-related support.

A service user told us that "GP (was) going too slow, and Salvation Army… Turning Point (is) best." Whereas a service user shared that it was their "first time asking (for) help.

2.4 Did the GP or other professional refer them to any services?

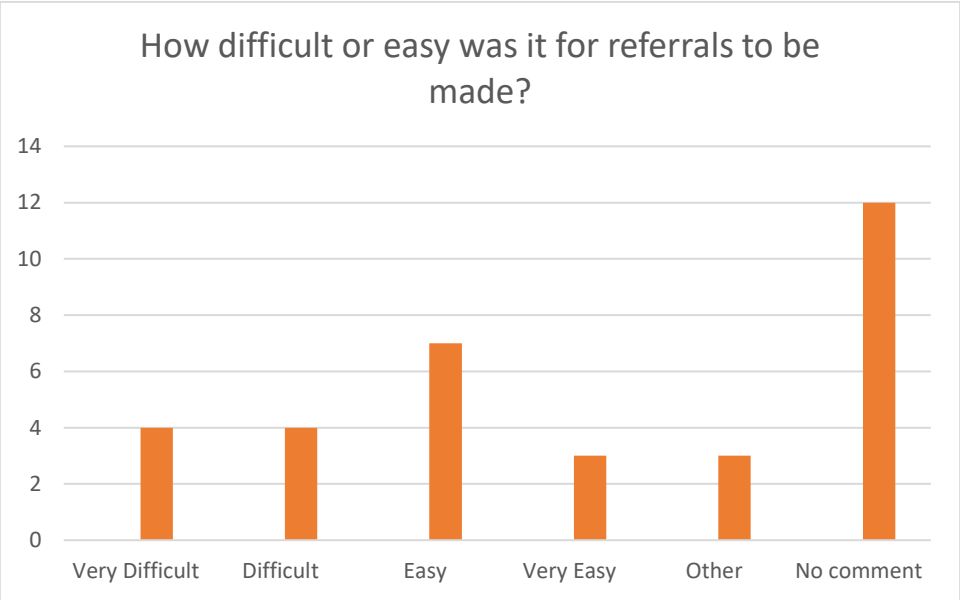


Responses show that 28% of participants had been referred to Turning Point by the GP; following that, counselling and other services represented 19%.

The survey showed us 8% of service users have been referred by the GP but are on a waiting list; with one being referred by Crisis. However, 11% of service users were never referred or still waiting to be referred, whilst 8% of participants report that they never been to a GP, which follows that there would be no referral.

One negative response was that a service user had been offered medication by a health service, rather than a referral to appropriate services, where another was referred to mental health services they commented; 'sectioned a year ago…was on (a) ward and investigated… monitored'.

2.5 How difficult was it to be referred?



A third of participants (33%) have had no experience of referrals to speak of. Where referrals were made 28% of service users answered positively with 19% finding the referrals process easy, and 8% very easy; one participant told us it "all worked as it was meant to be."

It may be that participants had no experience of referrals as they are unaware of the sort of support they can receive from services outside of primary care, particularly if they are not from Croydon as service provision varies from borough to borough.

However, 22% found it challenging for the referrals to be made with 11% finding it both difficult or very difficult.

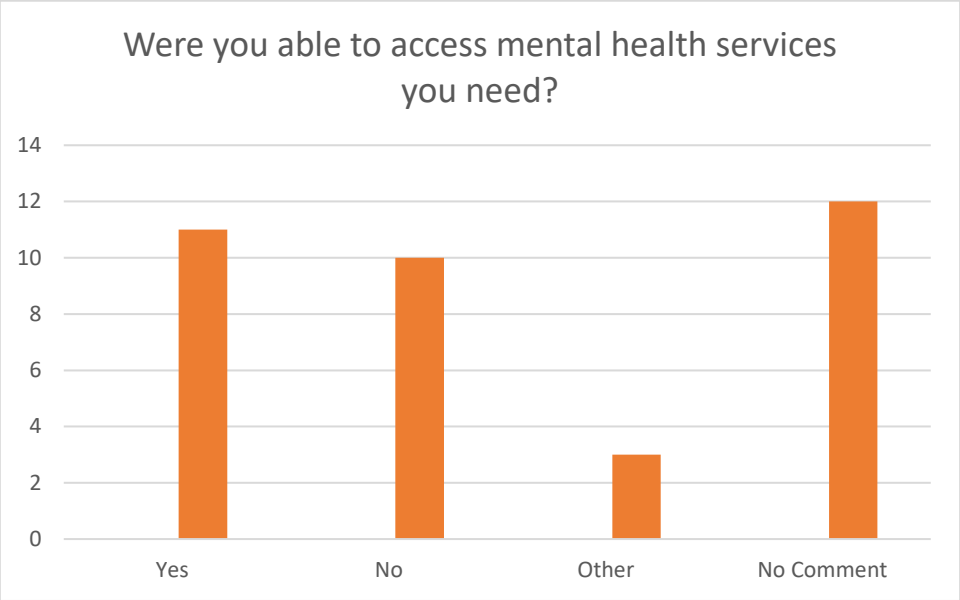
We heard a variety of reasons as to why respondents found it difficult to obtain referrals, comments included:

> "The doctors don't even want to chat one to one… and seem to close the application without being seen."
>
> "Long waiting list."
>
> "The GP receptionist is saying clients require address. Been in UK for two years, originally from Europe."

One respondent was at the point of suicide before they received help:

"Things did not move on getting referrals, although I was asking all professionals… until I tried to kill myself and (was) admitted to Bethlem."

2.6 Were they able to access the mental health services they needed?



31% said yes whereas 28% said no.

One participant told us that although their medication was not working, they were not able to change their medicine when needed and their review did not happen.

Another participant tried to refer himself and two mental health doctors suggested that he 'should face reality'.

One service user commented 'first time in Crisis (where they were surveyed) and hoping that they can help me.'

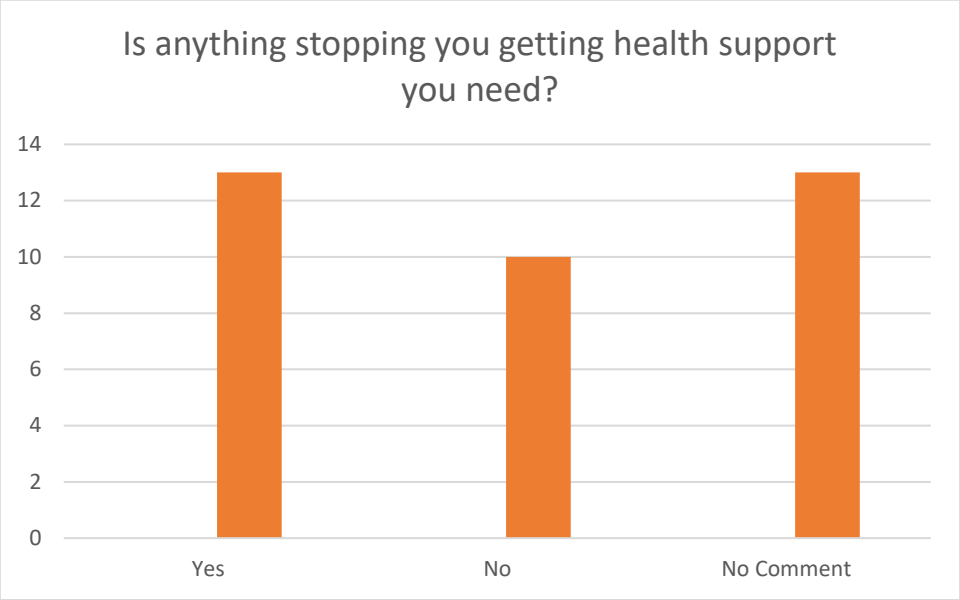
A high number of service users have mental health needs from this response, with almost half not getting the support they need.

The mental health charity MIND estimates that one in four people have a mental health problem each year[3]. We can see that this group is over represented with mental health issues at more

[3] https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/#one

than one in two. Crisis have published more information on the link between homelessness and mental health here[4].

Participants were asked to share what has been stopping them accessing the health support they need.



36% of participants stating that there was something hindering them from accessing the support they needed, while 28% of service users who reported no barrier. A high number (36%) did not respond to the question.

One of the 36% of service users who responded Yes' told us:

> "Lack of trust with GP… circumstances have disorientated me… appointment time (is) too short… rushed (and) no relationship. I feel it is all about money… don't want to support me in my efforts, with the council."
>
> "If I complain, I'll be in the wrong because of my status, they won't hear my complaint, if I was suited and booted, they would help."

[4] https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/health-and-wellbeing/

Comments from the service users who had no problems accessing healthcare said;

> "There are no barriers stopping… my needs."
>
> "There is nothing to stop me accessing the support I need."
>
> "I had help getting an eye test and new glasses."

These responses suggest the possibility of more complex social problems that are resource heavy are presenting as barriers for service users, and in this case, the service users perception of their situation and status.

Another participant we spoke to told us that they had visited five services on foot, back and forth across the borough that day before ending up at Crisis. They were destitute, with no money, no identification, no access to benefits, and had fled domestic violence a few weeks previously.

3 Areas for consideration

Increase training around registration for homeless people

As in our previous report in February 2018 Healthwatch Croydon that suggests that GPs are offered training materials, we extend this recommendation to receptionists to be made aware of the a 'My Right to Access Healthcare' card (produced by Healthy London Partnership as the message seems not to be filtering through. It is very difficult for the Service User to assert themselves, so the GP staff teams need to be aware of what this card means. Details are registration of patients appear in the Primary Medical Care Policy and Guidance Manual.[5]

Better information for GPs on services available and appropriate ways of access

There needs to be better information shared with GPs about services people can access, and an increased awareness from GPs about the difficulty in accessing these for people who are homeless – for example, a GP may advise someone to make a self-referral to IAPT but this can be complex for someone who is homeless (i.e. needing access to a phone and/or computer)

Recent experiences received in May and June 2018

Since the compiling of this report, Healthwatch Croydon have been contacted by homeless people or services supporting them in the borough telling us that barriers persist for this group in registering with a GP in the borough. Of Croydon's 56 GPs, six are reported to be refusing to register this group and Healthwatch Croydon have since been informed that the My Right to Access Healthcare' card is continuing to be misunderstood.

Public Health England 2017 guidance for better care for people with co-occurring mental health and alcohol/drug use conditions (p.25)[6] states 'Commissioners and providers have a shared responsibility to meet the needs of people with co-occurring conditions. Commissioners are key influencers of provider behaviour…Providers in alcohol and drug, mental health and other services (should) have an open-door policy for individuals with co-occurring conditions'.

[5] See https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/

[6] See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

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All available online on 21 June 2018.

User Perception of the Personal Independence Coordinator Service

June 2018

Contents

1 Introduction

This report documents the results of a survey by Healthwatch Croydon of users of Personal Independence Coordinators, or PICs, in Croydon and their experience of the service. PICs is an output of the One Croydon Alliance of NHS providers, Croydon Council and Age UK Croydon.

1.1 Organisational Background and Involvement with PICs

Six organisations formed an alliance of health and social care providers and commissioners, under the **One Croydon Alliance** Agreement. These organisations are:

- Croydon Council
- Croydon Health Services NHS Trust
- Croydon GP Collaborative
- Age UK Croydon
- South London and Maudsley NHS Foundation Trust and
- NHS Croydon Clinical Commissioning Group.

These organisations entered into an alliance agreement for the delivery of health and social care to over 65s in Croydon on 1 April 2017. This Agreement was for a term of one year (Transition Year) with an option to extend; On 29 March 2018, the Alliance partners signed an agreement to extend this arrangement for a further nine years.

PICs are a key component of the **Integrated Community Networks Programme** (ICN) of the Alliance. The ICN Programme is comprised of the following features:

- **Huddles** (proactive weekly or fortnightly case management by multi-agency team working from GP practices);
- **Complex Care Support Service** (specialist support for issues such as mental health and frailty and support for care homes);
- **My Life Plan** (Co-ordinate My Care – shared care plan);
- **Personal Independence Coordinators** (PICs – person centred support for non-medical issues) and
- **Active and Supportive Communities** (people and communities as assets).

These were referred to as models of care by the Croydon CCG in their report Patient and Public Engagement in Croydon 2015-16 Outcomes Based Commissioning: Five Models of Care.[1]

A key aim is to engage, empower and build-up the Huddles so they are responsive, timely and flexible to individual needs. Care will be organised around the

[1] See page 31 in http://www.croydonccg.nhs.uk/get-involved/Documents/Patient%20and%20Public%20Engagement%20in%20Croydon%202015-16-%20final.pdf

individual, breaking down the boundaries between health and social care and the voluntary and community sector, and between formal and informal support.

Huddles will focus on:

- Preventing Hospital admissions
- Focusing on high risk and need e.g. people who have more than one long term condition (initially) and
- Enabling individuals to support their own health and independence.

1.2 Personal Independence Coordinators (PICs)

Personal Independence Coordinators (PICs) are key components of the ICN programme. The PICs are a member of the core ICN team and are independent of health and social care services; they work intensively with people with long term conditions. Initial data shows an increasing trend in the number of guided conversations and the proportion of people meeting their goals.

PICs have the following features:

- Each PIC is a member of the core ICN team, bringing together the voluntary and community sector and health and care organisations to support people predominantly over 65.
- Independent of social services and the NHS, and not part of the person's family; and
- Works intensively with people with long term conditions and those with social, emotional and/or financial needs who would benefit from such engagement.

Initially implemented in two and at the time of this survey five ICNs, the PIC concept is intended to extend to all six ICNs in Croydon by March 2018.

1.3 National Background

The PIC concept was introduced by Age UK based on work carried out by the World Health Organisation. The trial and introduction of PICs has been phased nationally, the original timeline shown below being very nearly followed on time. Croydon is in Phase three.

Phase one (2013)	Cornwall
Phase two (2015)	Portsmouth, North Tyneside, Ashford and Canterbury, East Lancashire, Blackburn with Darwen, Redbridge, Barking and Havering, Sheffield, Guildford and Waverley

Phase three (2017)	South Gloucestershire, North Kent, South Kent, **Croydon** and Northamptonshire.

1.4 Healthwatch Croydon

Healthwatch Croydon is the consumer champion for users of health and social care services. Our purpose is to listen to and understand the needs, experiences and concerns of people who use health and social care services in Croydon. We support patients, residents, and service users to voice their views and opinions on services. Healthwatch Croydon works to get the best out of health and social care services by responding to the voice of local people.

2 Acknowledgements

The questionnaire used in this survey was devised by a panel of volunteers of Healthwatch Croydon. Much thought was put into this and the effort of the panel is gratefully acknowledged. The survey results were tabulated by Darren Morgan.

Analysis and interpretation of the results, and the final form of the report was completed by Healthwatch Croydon volunteers Pat Knight and Tariq Salim, who were part of the panel, with input from Healthwatch Croydon CEO Jai Jayaraman.

From outside of Healthwatch, Rehan Qureshi and latterly Dawn Richardson of provided initial background data on the One Croydon Alliance's perspective. Dee Bushell of Age UK made comments on some question wordings at a late panel meeting and they also made use of their database of PIC clients to send survey questionnaires.

Many thanks for their valuable help.

3 Survey Objectives

In November 2017, the One Croydon user group requested Healthwatch Croydon to carry out a survey of the PICs clients to obtain their view on their engagement with the PICS and the benefits they had experienced as a result. This is the resultant report.

This survey is part of our task as information gatherers on the community's behalf. The use of PICs is a new initiative, one which potentially has significant benefits. We want to know whether these benefits are realised. The user's own report of experience with PICs is a key source for this.

The survey intended to determine user perception of PICs, and how they affected user physical and mental health circumstances, and overall feelings of wellbeing. Particular examples of data the survey sought to identify include the following as related to the impact of PICs:

- Client perception of impact on hospitalisation rates
- Changes to perception of health and wellbeing
- How PIC interaction frequency related to the various measures.

It is to be noted that this survey was not designed to measure changes over time; it is a snapshot of user perception at a point in time.

This information will be fed back to the One Croydon Alliance. They may use this to correct problems and make changes to the way this new service works in the light of the experiences reported. In future, this information may form a basis for comparing how the scheme works as time passes.

4 Methodology

A number of methodologies for conducting the survey were considered, including focus groups, personal visits, telephone interviews and questionnaires. The questionnaire approach was decided upon as it offered the following benefits.

- The ability to reach a larger sample size;
- Logistical ease in terms of dealing with data protection and safeguarding issues and accessing the client group; and
- More controlled process.

Ideally, the questionnaire approach would have been complimented with focus groups to provide richer experiential information but given time constraints this was not possible. The questions for the survey were constructed iteratively by Healthwatch Croydon volunteers with some input from Age UK Croydon. Questionnaires were provided to the One Croydon Alliance for distribution, to avoid data protection issues. Age UK provided the incentive of a £100 Sainsbury's voucher to a randomly chosen respondent. A total of 279 surveys forms were distributed and 84 replies received within the cut-off date for analysis which represented a 30% response rate.

5 Conclusions

A number of salient points come out of this survey. In particular, the following can be said.

- The PIC Service was well received by its users and they are broadly satisfied or very satisfied with its working.
- An expected conclusion is that satisfaction across some dimensions increased as PIC contact frequency increased.
- It is not possible to infer that hospital usage is reduced. This being a significant objective for the One Croydon Alliance, other research is required to determine the impact of PICs here. Such research would involve a control group of those not engaging with PICs to enable comparisons.
- Further surveys at annual intervals will enable the impact of PICs over time to be evaluated. This would allow, for example, assessment of whether changes to the quality of life of service users are sustained.

6 Survey Analysis

The response to the survey consisted of 84 PICs clients out of 279 questionnaires sent, a 30% response. This excellent response provides a sufficiently representative sample to enable fair confidence that the views of PICs clients across the borough are represented here. Care also has to be taken in that there may be some self-selection here but given the response rate this effect will be small.

Respondents variously omitted to answer some questions. Please note the percentage figures quoted here exclude the percent of 'not stated'.

For ease of understanding, the questions are analysed below in groups, reflecting the themes covered in the questionnaire. These are as follows, the last being left open for clients.

- Group A: Frequency of contact (Q1, Q10)
- Group B: Client engagement (Q2, Q3, Q4)
- Group C: Benefits for clients (Q5, Q6, Q7, Q8, Q9)
- Group D: Suggestions and freeform comments (Q11, Q12)

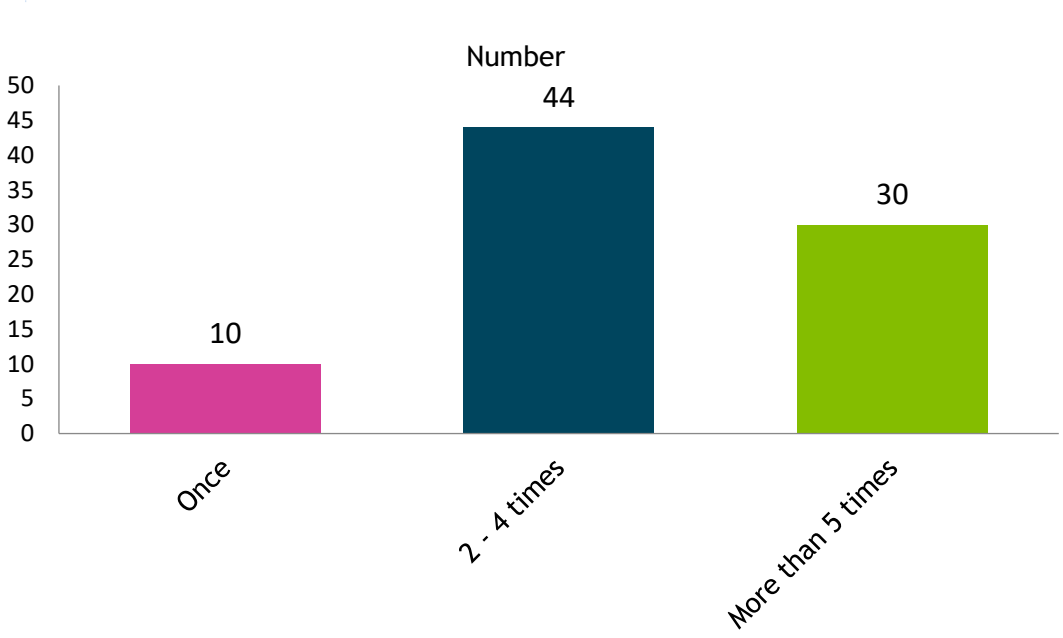
The first question of the survey requested information on the number of times that the respondent had seen their PIC. In the analysis below, the perception of PICs clients on various criteria has subsequently been cross tabulated against the frequency of exposure to the PIC to provide added insight.

These cross-tabulations combine where appropriate the 'Definitely agree' and 'Mostly agree' numbers, and sometimes also show the one or more of the disaggregated columns as well.

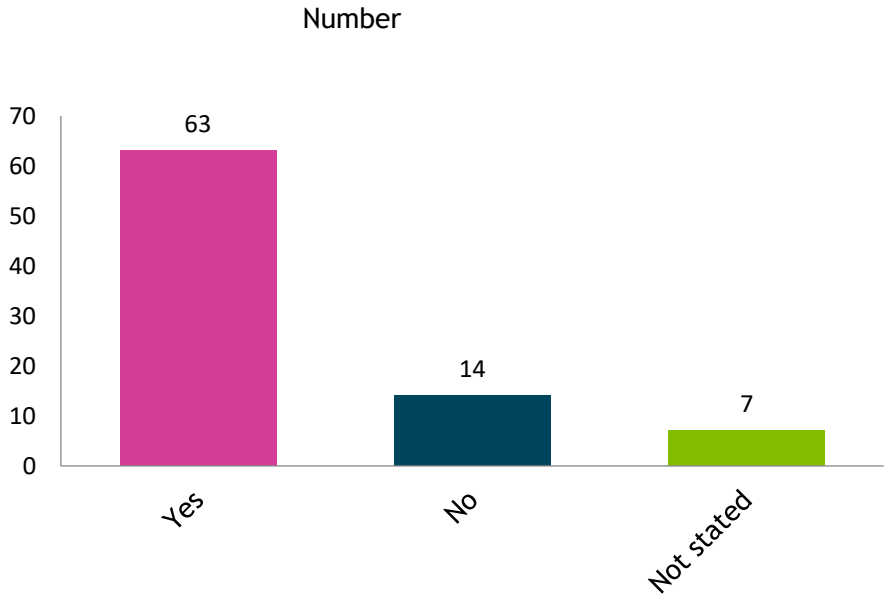
All free form comments are included in Appendix 8.1, and graphs for all the numbers are included pictorially in Appendix 8.2.

6.1 Group A: Frequency of PIC Contact (Q1, Q10)

Q1. Approximately how many times have you met with your PIC?



Q10. Were you able to meet with your PIC as often as you would like?



Respondent Category	Number	Replied Yes	Replied No	Not stated
All	84	63(75%)	14 (17%)	0
Saw PIC once	10	4 (40%)	2 (20%)	4 (40%)
Saw PIC 2-4 times	44	35 (79%)	6 (14%)	3 (7%)
Saw PIC 5+ times	30	24 (80%)	6 (20%)	0

Though the figures for clients seeing PICs only once are small, the responses unsurprisingly indicate that clients seeing PICs two or more times were more likely to feel that had spent sufficient time with their PIC.

6.2 Group B: Clients' Engagement with PICs (Q2, Q3, Q4)

Q2: I felt my PIC has been good at listening to me

Respondent Category	Number	Definitely agreed	Mostly agreed	Mostly disagreed	Disagreed
All	84	68 (81%)	16 (19%)	0	0
saw their PIC once	10	8 (80%)	2 (20%)	0	0
saw the PIC 2-4 times	44	35 (80%)	9 (20%)	0	0
saw their PIC 5+ times	30	25 (83%)	5 (17%)	0	0

This response illustrates that most respondents felt listened to by PICs. In all categories the 'definitely' agree response was 80%; to 83%. Clients who saw their PIC more than five times were marginally more satisfied with this aspect of their engagement.

Q3: My wishes were considered during my engagement with my PIC

Respondent Category	Number	Definitely agreed	Mostly agreed	Mostly disagreed	Disagreed	Not stated
All	84	60 (72%)	23 (27%)	1 (1%)	0	0
saw their PIC once	10	6 (60%)	3 (30%)	1 (10%)	0	0
saw the PIC 2-4 times	44	32 (73%)	12(27%)	0	0	0
saw their PIC 5+ times	30	22 (73%)	8 (27%)	0	0	0

There was also a high level of client satisfaction in this area, more so with clients who saw their PIC more than once, perhaps illustrating the value of continuity.

There were no appreciable differences in the experience of clients who saw their PIC 2-4 times or 5+ times.

Q4: I was given a choice to involve my relatives/carers in my engagement with my PIC

Respondent Category	Number	Definitely agreed	Mostly agreed	Mostly disagreed	Disagreed	Not stated
All	84	58 (69%)	14 (17%)	5 (6%)	3 (3%)	4 (5%)
saw their PIC once	10	6 (60%)	2 (20%)	1 (10%)	0	1(10%)
saw the PIC 2-4 times	44	32 (72%)	6 (14%)	1(2%)	3 (7%)	2 (5%)
saw their PIC 5+ times	30	20 (67%)	6 (20%)	3 (10%)	0	1 (3%)

There was also a large positive response (86%) to this question.

However, 14% did not agree, and it may be that it is sometimes difficult for relatives and carers, to be present at meetings between PICs and clients.

6.3 Group C: Benefits for clients (Q5, Q6, Q7, Q8, Q9)

Q5: Do you think your quality of life has improved as a result of your engagement with your PIC?

Respondent Category	Number	Yes, significantly	Yes, a little	No improvement	No, it's worse	Not stated
All	84	30 (36%)	42 (50%)	9 (11%)	0	3 (2%)
saw their PIC once	10	3 (30%)	4 (40%)	1 (10%)	0	2(20%)
saw the PIC 2-4 times	44	14 (32%)	24(55%)	5 (11%)	0	1 (2%)
saw their PIC 5+ times	30	13 (43%)	14(47%)	3 (10%)	0	0

In total, 36% of client's quality of life improved significantly as a result of their interaction with the PICs and 50% improved a little. The most beneficial results were achieved by the group who saw their PIC more than 5 times. The longer the interaction with the PIC the better the outcome for the client.

Q6: If not, what do you think was the reason for this?

There were 15 responses to this question: 18% of all respondents.

- In two cases the clients had been recommended exercise classes but had found it difficult to continue with these due to medical conditions such as arthritis.
- In other cases, PICs suggestions had not been able to be followed up due to clients' health conditions.
- One client was unhappy that the PIC had not been able to organise a taxi card.

However, the great majority of clients felt that it was not the PICs service but the severity of their health conditions that was responsible for any deterioration in quality of life. As one commented

- "PICs are 'unable to work miracles" and "although my health has

  deteriorated, no PIC can help that."

Five were positive examples (despite the wording of Q6):

- "Did all my paperwork, did an excellent job by taking to me etc."
- "Looking into help from social services."
- "Given me new ideas."
- "They were very professional."
- "My problems are physical. I enjoyed our meetings, but they cannot help with this."

Q7: I feel more informed after meeting with my PIC

Respondent Category	Number	Definitely agreed	Mostly agreed	Mostly disagreed	Disagreed	Not stated
All	84	50 (59%)	27 (32%)	4 (5%)	0	3 (4%)
saw PIC once	10	5 (50%)	3 (30%)	1 (10%)	0	1(10%)
saw PIC 2-4 times	44	28 (64%)	13 (30%)	2 (4%)	0	1 (2%)
saw PIC 5+ times	30	17 (57%)	11 (37%)	1 (3%)	0	1 (3%)

The majority of clients felt better informed; overall 59% definitely agreed with this statement. Clients who saw their PIC more than 2 times were better informed than those who saw their PIC once.

Q8: My PIC has helped me to live independently

Respondent Category	Numbers	Definitely agreed	Mostly agreed	Mostly disagreed	Disagreed	Not stated
All	84	28 (33%)	38 (45%)	10 (12%)	3 (4%)	5 (6%)
saw PIC once	10	3 (30%)	3 (30%)	1 (10%)	0	3 (30%)
saw PIC 2-4 times	44	14 (32%)	20 (45%)	7 (16%)	1 (2%)	2 (5%)
saw PIC 5+ times	30	11 (36%)	15 (50%)	2 (7%)	2 (7%)	0

The majority of clients have been able to live more independently as a result of their interaction with their PIC. Benefits to clients in this respect increased in proportion to the number of times they saw their PIC.

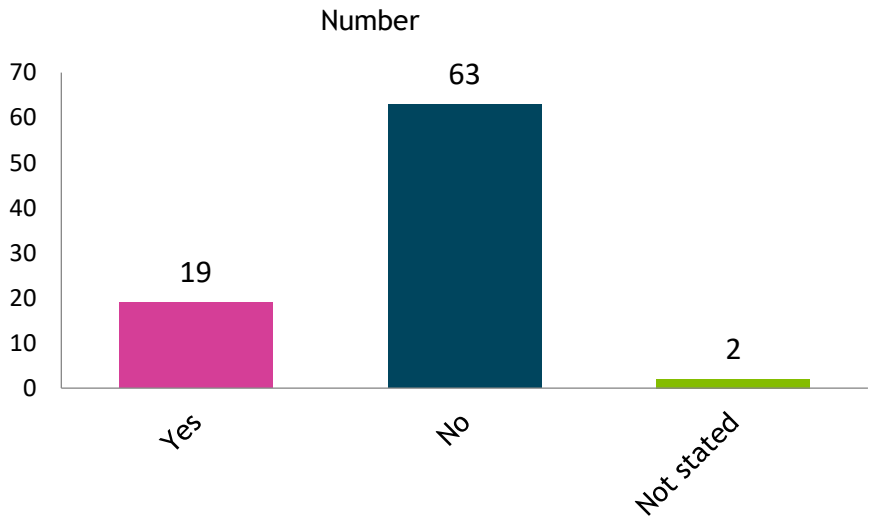
Of these responses, 33% strongly agreed with this statement, indicating significant improvements in independent living; 45% reported that they did experience some improvement.

Sixteen percent of those surveyed felt that the PIC had not helped them to live more independently.

As one client commented:

- "The PICs cannot work miracles."

Q9. During or since your engagement with your PIC, have you been admitted to hospital



Respondent Category	Number	Yes	No	Not stated
All	84	19 (75%)	63 (23%)	2 (2%)
saw PIC once	1	1 (10%)	8 (80%)	1 (10%)
saw PIC 2-4 times	44	7 (16%)	36 (82%)	1 (2%)
saw PIC 5+ times	30	10 (37%)	19 (63%)	0

A primary aim of the PICs initiative is to reduce hospital re-admissions. There appears to be no substantive difference in hospital admissions for clients who saw their PICs up to 4 times. The number of hospitals admissions increased for the group who saw their PIC more than 5 times. The following insights are of particular interest:

- We cannot draw any conclusions as to whether the PIC scheme results in less hospital visits than if there wasn't a PIC scheme. To assess this, we would need a control group to compare with.

- However, our data does suggest that there is no correlation between increasing the number of PIC visits and decreasing visits to hospital. This may reflect the greater severity of these clients' health conditions and therefore the requirement for the PIC to devote more time to these clients.

6.4 Group D: Freeform Comments Analysis (Q11, Q12)

Q11: How do you think the service provided by your PIC could be improved?

There were 42 responses to this question, 50% of the total, with 26 replies (62%) indicated that no improvement was needed:

- "She is extremely helpful, and I don't think it could be improved."
- "I would like this service extended to more people in Croydon."
- "Top marks to my PIC. The service provided was excellent."
- "She was a star."

There were 16 clients (38%) suggested improvements with seven clients stating they would like more visits/more time with their PIC.

- "They should call more often."
- "Possibly a longer time commitment for those who need more support."

- "More time with clients, because if you have mobility problems you can be lonely."

Two clients wanted more resources/funding to be put into the scheme and two clients suggested more PICs should be recruited.

In three cases there had been problems with contacting the service and continuity of the service when a PIC left:

- "When our last PIC left us, it was said that someone else would take over. My daughter texted this person twice while I was in hospital and never got a reply."

One client said they would have liked more local information.

The responses illustrate that the majority of clients were happy with the PICs service and did not identify any improvements to the service.

Almost all the improvements identified were not critical of the PICs; as indicated by the 11 clients who wanted more visits, more time, more resources and more PICs. This illustrates the extent to which the PICs are valued by their clients.

There may be a need to improve communications between the client and the PICs service and facilitate continuity of service.

Q12: Please add any other comments

There were 41 responses to this question, 49% of the total responses. Within those who responded 34 gave positive responses, which equalled to 83%:

- "I was always pleased to see her. Such a nice lady."
- "Very good efficient service that is very long overdue. Informative and very helpful coordinator. Achieved in the course of two appointments what has taken me before a lot of difficulty to receive any useful help."
- "After losing my wife in 2014 and my grandson in 2015, I was feeling pretty down and really flat, I didn't want to see or speak to anyone. 2017, along comes PIC and things start to change, and they did and what a difference. I am going to miss seeing you."
- "The benefit to me is enormous. I no longer obsess about my illness and am back to enjoying life."
- "As I have my wife caring for me at home I only saw my PIC a few times … She was very knowledgeable and empathetic and gave me some good advice on coping with my treatment. Great service."

The PICs had helped in the following various ways:

- Obtained Attendance Allowance for one client
- Introduced another to the Age UK Readers' Group; and
- Arranged carers

Seven replies were negative, equalling to 17% of the responses received:

- “I was concerned that the PIC had access to my private and confidential medical records without my consent.”
- “I now realise I have signed several documents without reading and knowing their content.”

Three referred to not seeing their PIC a sufficient number of times (see Q 11):

- “I was told I was allowed 12 visits, but I have had only eight. I don’t think this is fair as I do meet (the criteria) for the 12 as was stated originally.”

The answers to this question are a further illustration of the value the PICs add to their clients’ wellbeing.

7 References

NHS Croydon Clinical Commissioning Group (2016): *Patient and Public Engagement in Croydon 2015-16 which can be accessed at* *http://www.croydonccg.nhs.uk/get-involved/Documents/Patient%20and%20Public%20Engagement%20in%20Croydon%202015-16-%20final.pdf*

References accessed on 28 June 2018.

8 Appendices

8.1 Full Client Comments (Q6, Q11, Q12)

These comments are included "as is" without emendation.

	Textual Comments		
Client	Q6 (re Q5)	Q11	Q12
1		They should call more often to see the patient - how they are, and if they needed more help.	
2			
3		My PICs service is up to the standard and helpful. No negative comments.	I am still waiting for my MRI scan result since 25/01/18. I would like to get proper treatment/referral to the specialist ASAP.
4		She was extremely helpful and I don't think it could be improved.	
5		You need more to look after old people most of all.	Patients that work all your life get less care in all they try.
6			I was always pleased to see her, such a nice lady.
7		Just by having more resources available so that they can meet with clients more often.	Very good efficient service that is very long overdue. Informative and very helpful co-ordinator. Achieved in the course of two appointments, what has taken me before the appointments a lopt of difficulty to receive any useful help.
8		I have been very pleased with the service I have received from my co-ordinator and colleagues. I would like this service extended so more people in Croydon would benefit.	My thanks that I was given the chance to take part in this PIC scheme.
9		Possibly a longer time commitment for those who need more support after the initial three months.	It's a good idea and I hope it can be developed as a valuable adjunct to established social services and provide help for people in need.
10			
11			
12			
13	Given me new ideas.		Everything is right - nice lady, talks nice, listens to me.
14		Top marks to my PIC. The service provided was excellent. This is why I had to write a little note to my PIC.	After losing my wife in September 2014 and November 2015 my grandson passed away he was just 38. I

			was feeling pretty down and I was really flat, didn't want to see or speak to anyone. 2017 along comes PIC and things start to change and they did, and what a difference. I am going to miss seeing you.
15		By giving all 12 visits as stated in the first place.	I was told I was allowed 12 visits but I have only been allowed 8 visits. I don't think it is fait to do that as I do need the 12 as was stated to me originally.
16		Contact details more evident.	Very polite and informative service. Thanks.
17		Well done! I am very much happy with the service my PIC provided for me. Many, many thanks!!	
18			
19		I am answering this questionnaire on behalf of my elderly mother. We have only just started to use this service so it's difficult to answer at the moment. So far we are happy how things have gone.	
20			
21			I am concerned and upset that the PIC had access to my private and confidential medical records without my consent before our meetings. I now realise that I have signed several documents without reading and knowing the content of the documents. I now, hereby rescind all documents signed and withdraw all authority given at my meeting with the PIC and respectfully request your written confirmation that the PIC and your organisation will have no interest in me or my medical records.
22	Did all my paperwork. He had done an excellent job by talking to me etc.	To help more people.	He has done a very good job.
23		I thought the service was excellent.	I am not sure why I was selected to have a PIC? As I did not apply.
24		More time with clients, because if you have mobility problems you can be lonely, especially in the winter. Confidence is also an issue.	I found the service very beneficial, because when I came out of hospital I was alone. This was after I had had a very busy life looking

			after my mother and husband. I also and, still have, a lot of medical issues, including mobility. The service gave me more confidence and I will now go on a train again.
25			
26			I would like my PIC to visit more often.
27		The service I received was specific for my requirements/needs so I am not able to say if there is any room for improvement in other areas of the service.	I feel very lucky to have had the opportunity to have been allocated a PIC. The benefit to me is enormous. I no longer obsess about my illness and am back enjoying life. This has meant no admission to hospital and only one visit to the GP (unrelated to my main issues).
28			
29			It was a good and positive experience. My PIC was very helpful.
30			
31	Unable to perform a miracle.		
32			
33			
34		More visits!	
35		It was good enough.	
36			They helped me to get a blue badge for my car. Thankyou.
37	He was very professional. However what he was offering was not received, but he's looking into help for me with social services.		
38		Please is an excellent initiative and should be developed by greater provision of services (eg nail/hair cutting).	We found our sessions with X both supportive and informative, it would be good to take ongoing meetings with her. Thank you for advice and assistance in applying for Attendance Allowance.
39			
40			
41			We both found X extremely helpful and the results discussed at her visit proved most helpful, she got results.
42	No action was taken or required after the visits. I did not ask for any help.		Although I haven't yet asked for any help from my PIC, I know that it is available if I should require it, which is reassuring.

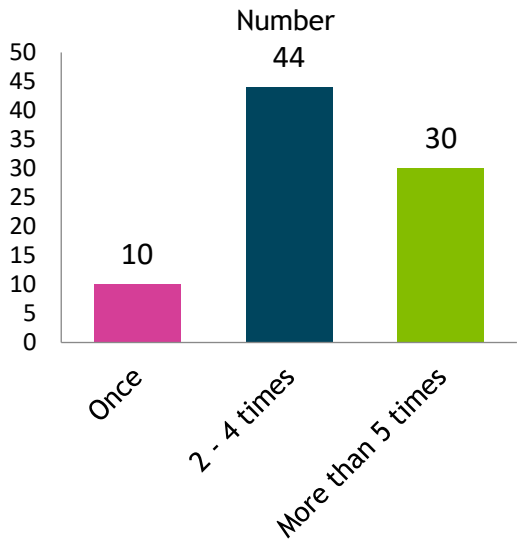
43		When our last PIC left us said someone else would take over, however my daughter texted this person twice while I was in hospital and never got a reply. Get someone to continue PIC support when colleague leaves.	We had a lovely lady called X helped myself and daughter while I was very ill. Without her support we would have been in a worse situation. Since X left we have not had contact with anyone from the PIC team. We miss X as she shlped us through a difficult time. Thankfully I am slowly on the mend.
44		I don't.	It makes you feel so much better.
45		When someone leaves continue the support as PIC left us and was told this would continue, however this did not happen.	The support we received from PIC a lady called X was lovely as helped my mother during a very bad time. Health wise at the time I did know what to do. X was my rock, and I know we miss her. Thankfully my mother is a lot better with support from, the hospital and daughter.
46			My PIC was excellent and most helpful.
47			
48		Right as it is.	
49	Mostly though mny health has deteriorated but no PIC can help that!		X was the PIC concerned. He was attentive and helpful and a good listener who delivered on all elements that he said he would.
50			
51		I was quite happy with my service as I have good family + friends support. Also because I do some voluntary work when I am able I have plenty of contact.	The lady that came to see me was very pleasant and made sure to ask me it I needed any other help or advice.
52	My problems are physical - ageing/palaplegia. I enjoyed our meetings but they cannot help with this.	I think the service is excellent for some people.	I was living and continue to live an independent life at home with my wife. We have no carers and have a good social network and belong to several organisations and get out quite a bit so needed to help in that direction. We always looked forward to our visits though.
53			It was helpful to chat with someone.
54	My personal family problem in the middle.	If they ring every week then they know their every-time problem.	
55		I did not take up all the suggestions that my case officer put forward. It all seemed quite flexible and I feel sure if I asked for	My case officer was X, just one of the things she did was to introduce me to the 'Readers Group' held in Age UK's offices. In my opinion

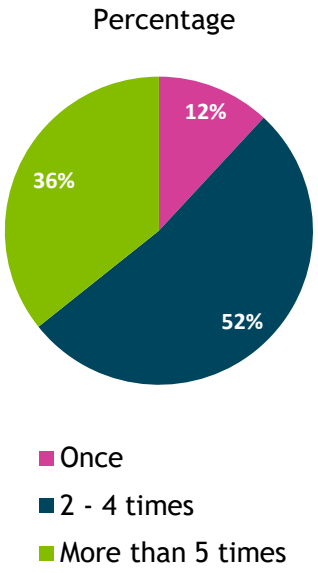
		something other that had been suggested my case officer would have helped me in the furtherance of it. I am very satisfied with the scope and presentations of these services.	Age UK are doing a great job in helping us old people, if nothing else they can flag up a problem that might have escaped the over-stretched GPs.
56			
57	Seen weight nurse at Farley Road. Problem identified - weight control - arthritis prevents too much activity. Recent problem with driving. This will be a major detriment to shopping or active social life. Various transport schemes for pensioners - at present paying £5 a time to go to Selsdon or Warlingham (each way).	More frequent contact needed to be any use with immediate problems. Do own shopping - help neighbours with car - probably coming to an end.	Fair social life as health and weather allow. Local church. WEA. The Arts Society/Lecture Outings. Holiday 2016 with Croydon Centre for Elderly, Sainsburys Selsdon.
58	I have only had my initial visit from the PIC, awaiting a further visit with support worker.		
59			
60			
61		Everything is so excellent and I am so very pleased to have someone so helpful as X, she is a star!	
62	I have an ongoing condition - polymyalia.	Everything ongoing - need a lot for improvement.	
63		The service is very good.	
64		I was happy with the service I received so cannot find an answer to this question.	As I have my wife caring for me at home I only saw my PIC a few times. She was very helpful and caring. She was very knowledgeable and empathetic and game me some good advice on coping after my treatment. Great service. Thankyou.
65			I feel fortunate, to have met the two ladies, who visited and helped with walking and socialising. Helpful + good ideas. Thank you so much.
66		Nothing at present.	Very pleased with my PIC.
67		More visits.	
68	I found exercises difficult to stick to		I am Mrs X's niece and have filled this form up on her

	and am reluctant to persevere (not the fault of the PIC).		behalf and with her permission. The opinions here are the own observations of my aunty whom I know to be very set in her ways. Unfortunately this does get in the way of her taking advantage of the services suggested to her by the PIC. Thankfully, carers are now in place twice a day (co-ordinated + facilitated by PIC). This has helped aunty and uncle immensely. I continue to monitor their situation.
69			
70		Happy with services.	
71		More paper work of after help groups.	
72		No improvement required.	
73			
74	My wish is which I wanted she could not provide help with a taxi service. As I am 78 years old I thought I would get help with my taxi as I struggle to walk.	I think it would be a good thing if they had more funding to help disabled people like myself.	The PIC person that I saw was nice and very understanding and helpful, but her hands were tied as she couldn't help me with the things I needed.
75	Because I have had periods of ill health and with consequence backlog of things needing my attention. Therefore I have been unable to follow up on suggestions given.		Just to add how pleasant and helpful my PIC has been. It was very enjoyable meeting such a pleasant person. I wish I could see more of her, particularly as my close friends have all died during the last few years and my deafness makes it difficult to join in large gatherings.
76			
77		As a first user of the service I find it very helpful.	At the moment I have no comments. Only grateful for the help.
78	Don't know.		Seeing PIC is not long enough.
79		Would like more visits, once a month is not enough.	
80		Maybe needed more local information. I did not have enough knowledge to make suggestions.	The help I received was good.
81			
82		Not aware of any improvement.	A very satisfying and rewarding experience.
83			
84			

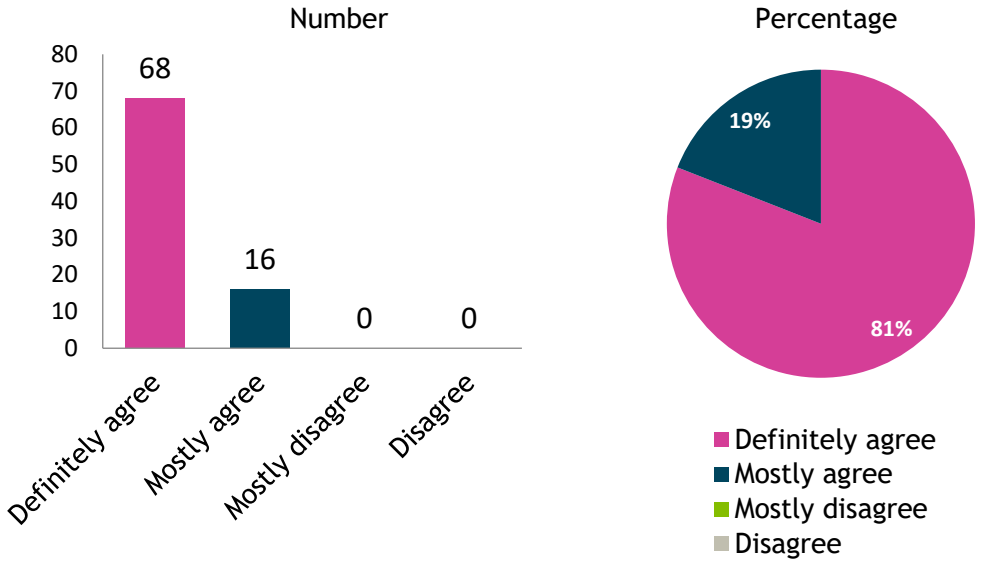
8.2 All Graphs

1. Approximately how many times have you met with your PIC?

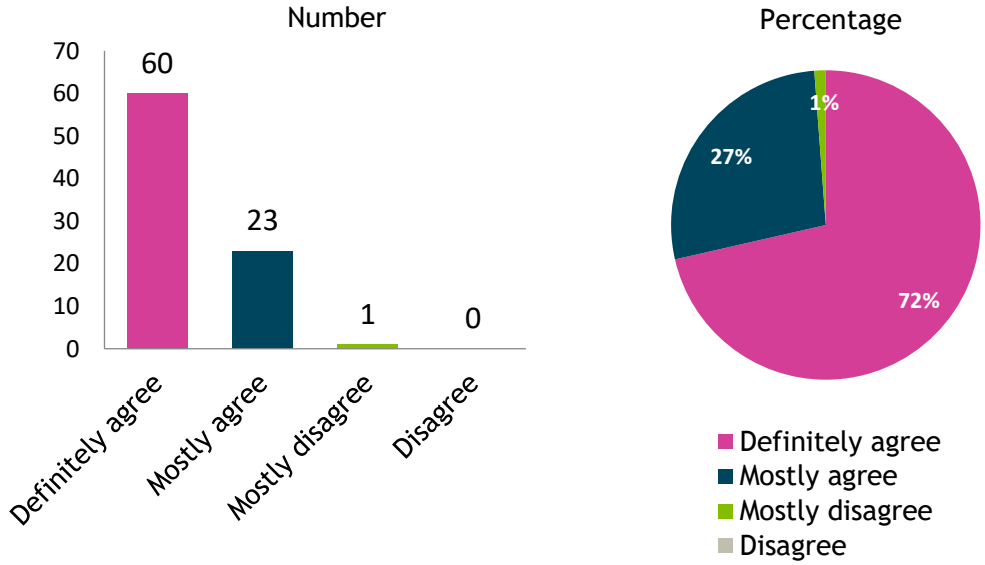




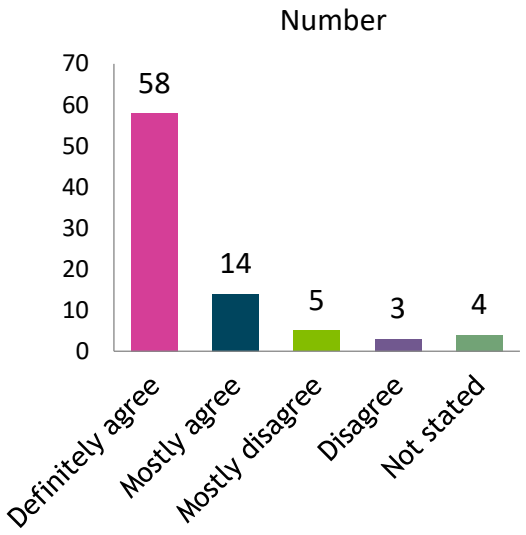
2. To what extent do you agree? I felt my PIC has been good at listening to me.

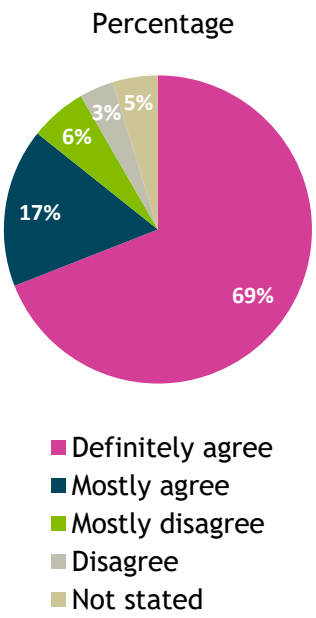


3. To what extent do you agree? My wishes were considered during my engagement with my PIC

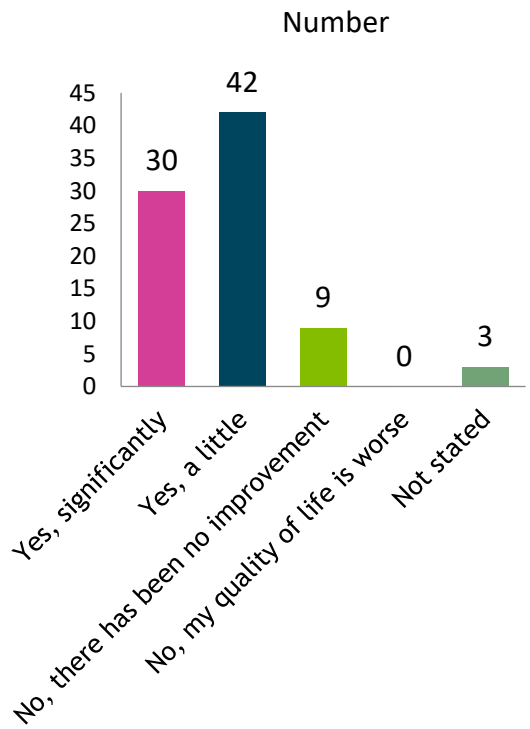


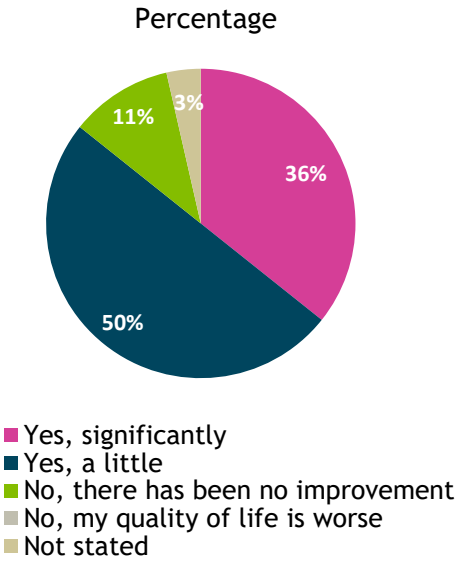
4. To what extent do you agree? I was given a choice to involve my relatives/carers in my engagement with my PIC.



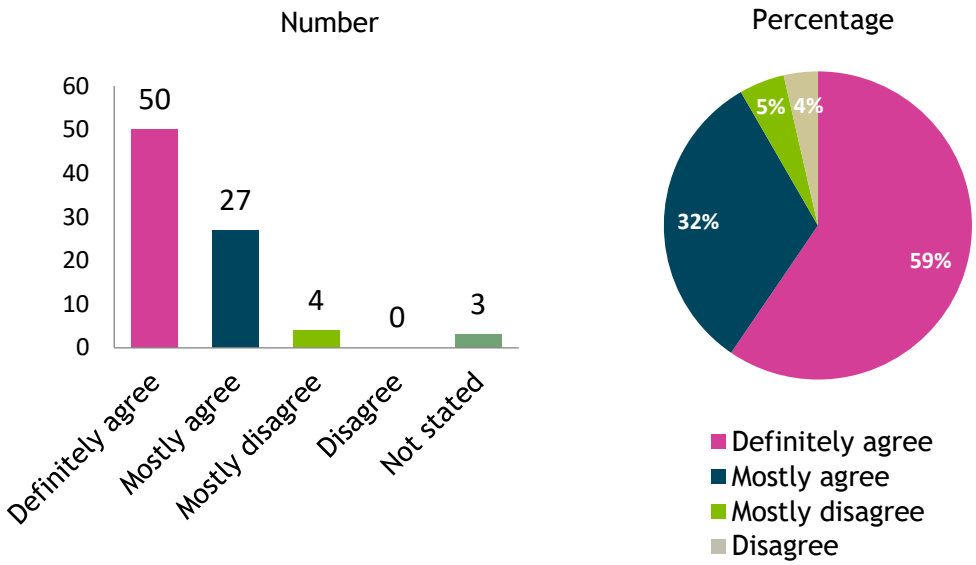


5. Do you think your quality of life has improved as a result of your engagement with your PIC?

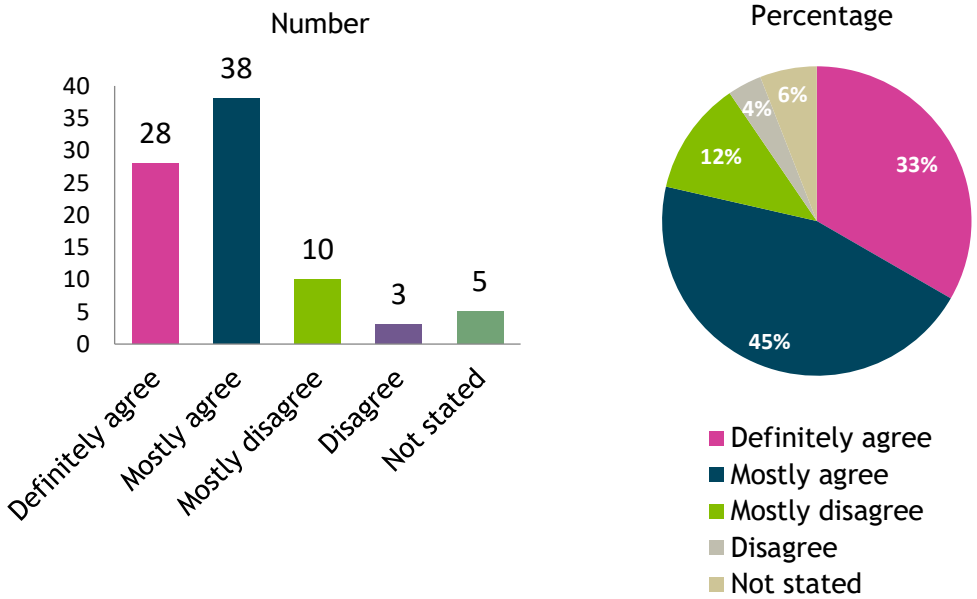




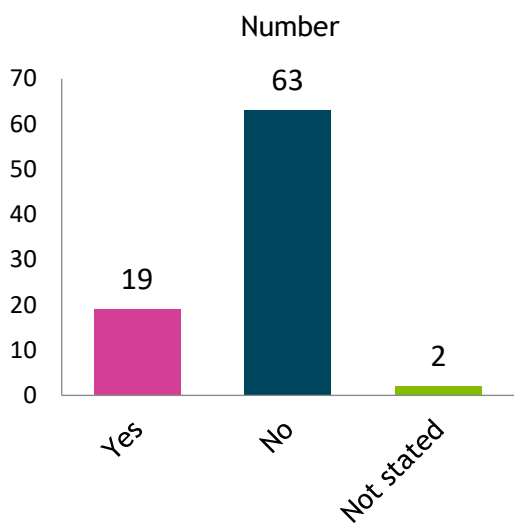
7. To what extent do you agree? I feel more informed after meeting with my PIC.

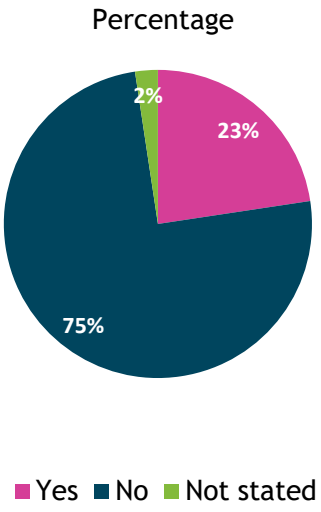


8. To what extent do you agree? My PIC has helped me to live independently.

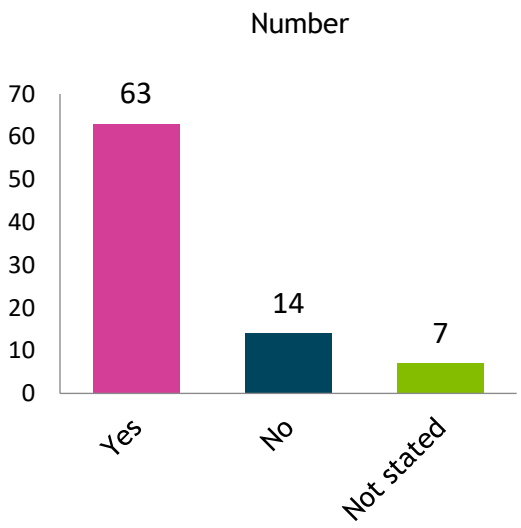


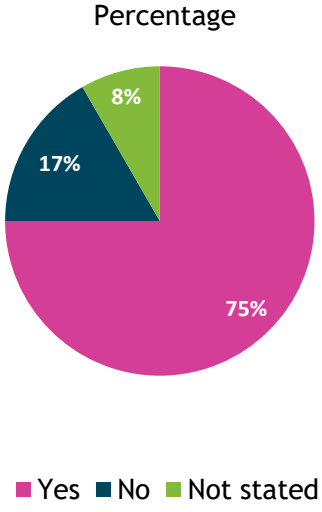
9. During or since your engagement with your PIC, have you been admitted to hospital?



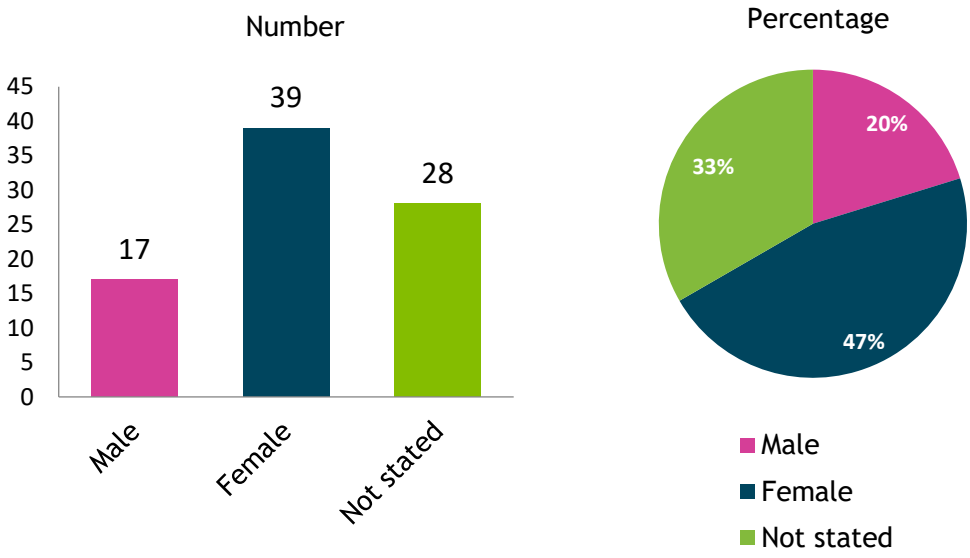


10. Were you able to meet with your PIC as often as you would like?

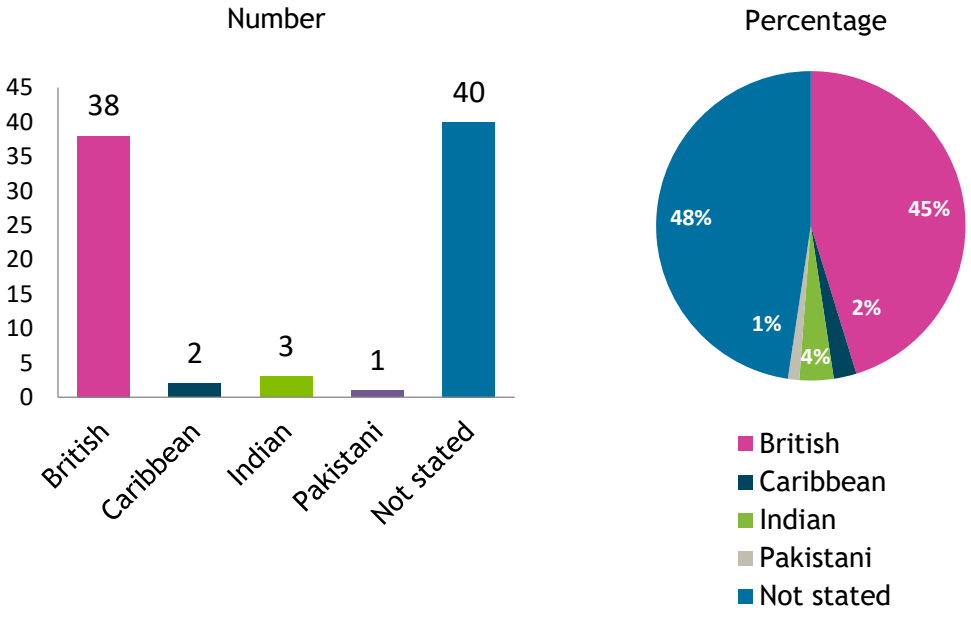




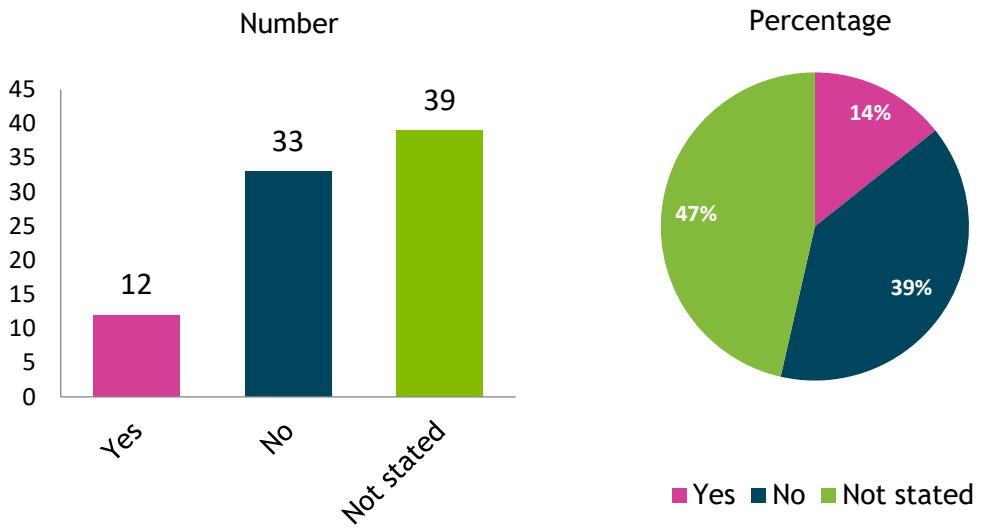
Monitoring Information: Gender



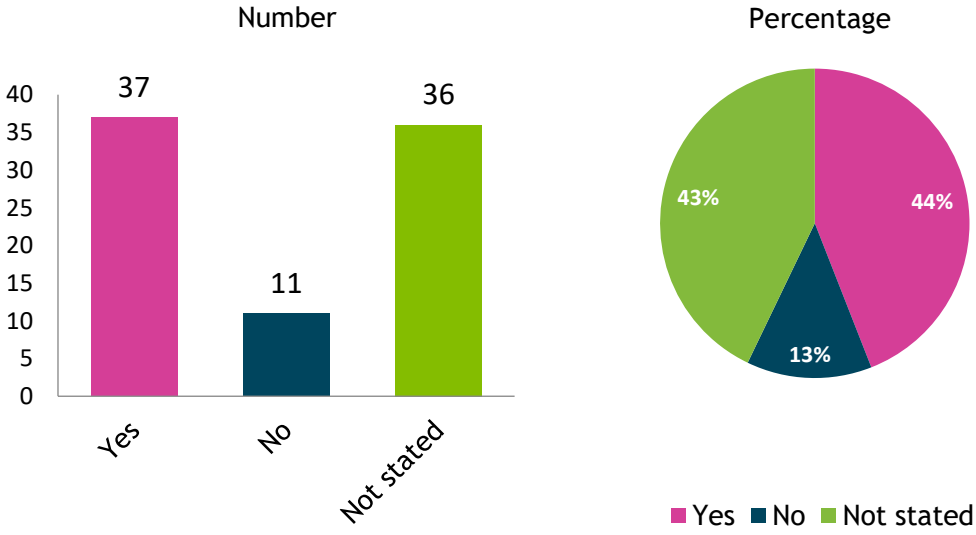
Monitoring Information: Ethnicity



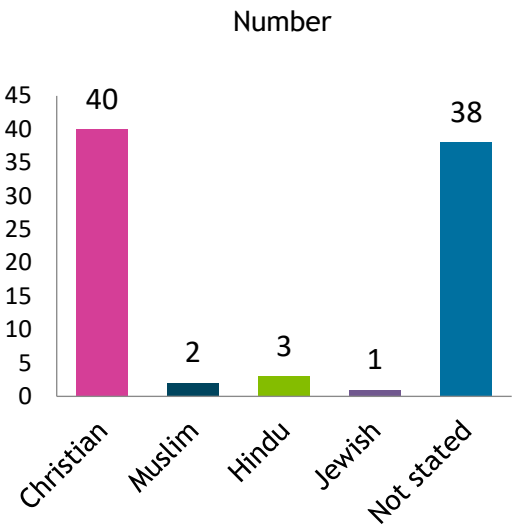
Monitoring Information: Carer?

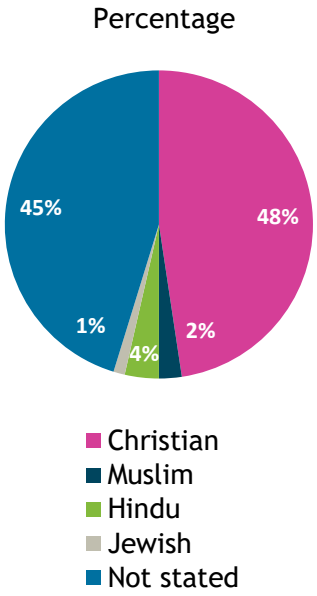


Monitoring Information: Disability?

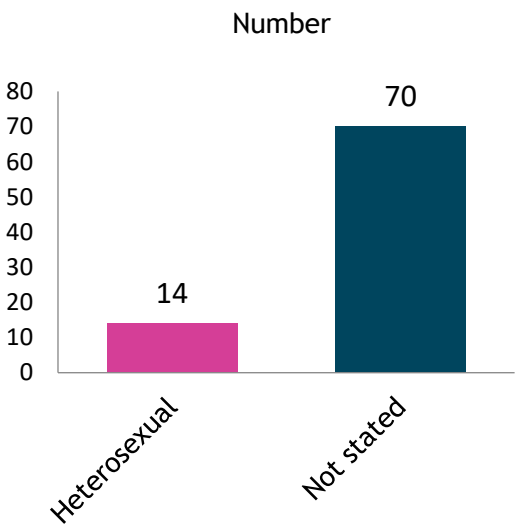


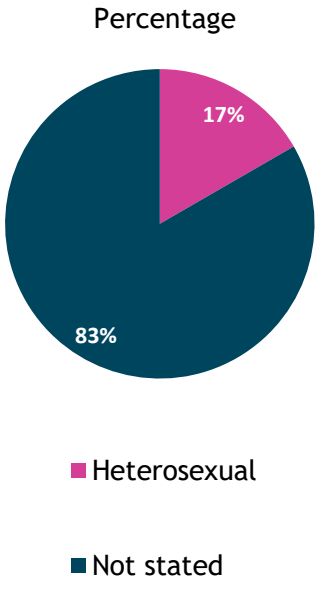
Monitoring Information: Religion





Monitoring Information: Sexual Orientation





8.3 Questionnaire

This appendix includes the Questionnaire as sent, and the accompanying covering letters from Healthwatch Croydon and from the One Croydon Alliance, also as sent.

healthwatch Croydon

Age UK Croydon / Personal Independence Coordinator (PIC) Client Experience Survey

This survey relates to the service you received from your Personal Independence Coordinator (PIC) from Age UK Croydon. Please complete and return in the **self addressed envelope** to Healthwatch Croydon. Please ensure that the survey is posted by the 28th February 2018. Many thanks for your help.

1. Approximately how many times you have met with your PIC?

- ☐ Once
- ☐ 2 – 4 times
- ☐ More than 5 times

2. **To what extent do you agree?** I felt my PIC has been good at listening to me.

- ☐ Definitely agree
- ☐ Mostly agree
- ☐ Mostly disagree
- ☐ Disagree

3. **To what extent do you agree?** My wishes were considered during my engagement with my PIC.

- ☐ Definitely agree
- ☐ Mostly agree
- ☐ Mostly disagree
- ☐ Disagree

4. **To what extent do you agree?** I was given a choice to involve my relatives/ carers in my engagement with my PIC.

- ☐ Definitely agree
- ☐ Mostly agree
- ☐ Mostly disagree
- ☐ Disagree

5. Do you think your quality of life has improved as a result of your engagement with your PIC?

- ☐ Yes, significantly
- ☐ Yes, a little
- ☐ No, there has been no improvement
- ☐ No, my quality of life is worse

6. If no, what do you think was the reason for this?

7. **To what extent do you agree?** I feel more informed after meeting with my PIC.

- ☐ Definitely agree
- ☐ Mostly agree
- ☐ Mostly disagree
- ☐ Disagree

8. **To what extent do you agree?** My PIC has helped me to live independently.

- ☐ Definitely agree
- ☐ Mostly agree
- ☐ Mostly disagree
- ☐ Disagree

9. During or since your engagement with your PIC, have you been admitted to hospital?

- ☐ Yes
- ☐ No

10. Were you able to meet with your PIC as often as you would like?

- ☐ Yes
- ☐ No

Monitoring Information

Gender	☐ Male	☐ Female	☐ Other
Ethnicity			
Carer	☐ Yes	☐ No	☐ Prefer not to say
Disability	☐ Yes	☐ No	☐ Prefer not to say
Religion			☐ Prefer not to say
Sexual Orientation			☐ Prefer not to say

11. How do you think the service provided by your PIC could be improved? Please state below.

12. Please add any other comments.

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Find us on Facebook

Charity number: 1166038
Company number: 08429604 (England and Wales)

healthwatch Croydon

Who We Are

Healthwatch Croydon is a charity that work on behalf of the public and patients of Croydon to get the best out of local health and social care services. We are an independent organisation and are not part of the council or the NHS.

The job of Healthwatch is to hold health and social services to account on your behalf. We gather the views of citizens in Croydon on the performance of the services such as Hospitals, GPs, Care Homes, Pharmacies and Opticians We have the powers by law to ask these bodies to respond, on behalf of the public.

From improving services today to helping shape better ones for tomorrow, we listen to your views and experiences and then try to influence decision-making using what we have heard.

Why We Are Doing This Survey

This survey is part of our role to gather information about patient experience. The use of Personal Independence Coordinators (PICs) is a new initiative, one which potentially has significant benefits. We want to know how you find the service and whether you feel you are getting benefit from it. This means that we need your views of your experience with PICs, since you and others like you are our main source for judging this.

We are asking service users involved in the PIC scheme to respond to this survey.

What We Are Trying To Find Out

We want to know how your experience of PICs went, and how it affected your overall feelings of wellbeing.

This information will be fed back to One Croydon, the originators of the PIC initiative in Croydon. They will use this to correct problems, and make changes to the way this new service works in the light of the experiences reported by you and the other patients in this scheme.

What would we like you to do?

Please complete the attached questionnaire and return it to Healthwatch Croydon in the prepaid envelope. All answers will be treated completed confidentially. You are not required to give your name which means that nobody will be able to attribute your answers to you. **Please make sure that you post reply by the 28th of February 2018.**

Croydon ageUK

The new name for AGE Croydon Concern

12 February 2018
Dear Sir/Madam

Independent Evaluation of
Personal Independence Coordinator (PIC) Service

I am writing to you because you are one of the 350 people in Croydon who have received support from the new PIC service started a year ago.

We have asked Healthwatch Croydon to carry out an independent study of people's experience of receiving this service as we want to learn what works well and how we can make any improvements. Please find enclosed a message from Healthwatch Croydon.

What would we like you to do?
Please complete the attached questionnaire and return it to Healthwatch Croydon in the prepaid envelope. All answers will be treated completely confidentially. You are not required to give your name which means that nobody will be able to attribute your answers to you.

In appreciation for participating, you could win £100 in Sainsbury vouchers. For every questionnaire received by Friday, 2 March, we will enter their name into a draw and one lucky person will win these vouchers. Please add your name, address and telephone number to the entry form if you wish to enter the draw. This will be separated from your answers.

Please ensure that you post your reply by 28 February 2018.

Your feedback is valuable and I want to thank you for your support in helping us to improve the support you receive.

Yours sincerely

DD RJardin

Kate Pierpoint
Chief Executive

Enclosed: Healthwatch Croydon covering message, Questionnaire,
Entry form for prize draw and prepaid envelope

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e auko@ageukcroydon.org.uk
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www.croydon.gov.uk

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healthwatch Croydon

Meet the changemakers… and get involved

Adult Mental Health services

Self-care

Questions and answers

Wednesday 18 July 18.00-20.30

CVA Resource Centre, 82 London Road, Croydon

In association with

NHS Croydon Clinical Commissioning Group

NHS South London and Maudsley NHS Foundation Trust

Table 1 - Session 1: (17.08 to 17.29)

Tom Cox, Mental Health Commissioner, NHS Croydon CCG: (TC)
Resident 1
Resident 2
Resident 3
Resident 4
Resident 5

Themes that came out of the discussions:

Services:

- Costs charged by GPs for essential letters which affect patients' wellbeing.

Knowledge and com

- Knowledge of self-care support services.
- CCG need to better market and communicate these services.
- Assessment of effectiveness of these services.
- A bigger focus on public health engagement on the street and with relevant community group.
- Need to focus service user minds towards non-medical services that will help their wellbeing.

Support:

- Motivation to use such services.
- Need support initiatives to maintain good personal relationships, avoid relationship breakdown and the mental health issues that follow including use of mediation.
- Using community spaces like parks to support better mental health for active sport to help wellbeing
- Facilities should relate to needs across the borough. Make parks a resource for social wellbeing for young and old.

Full Discussions

Resident 1: I've got a point which Tom knows about. The benefits situation for vulnerable people is quite a crucial issue in relation to people's well-being. Somebody vulnerable, not necessarily mental health. To apply for benefits you need evidence. Often there are patients, especially adult mental health patients, who comply with the medication and have seen their psychiatrist once a year. They've found they can survive without support from secondary services, so they are referred back to the GP. In relation to some evidence, letters from the GP are needed to support their application for PIP and also ESA. I've asked Tom, in his role as commissioner, to ask this. What's come back is that this is

discretionary. My GP charges £30 per letter whether you are vulnerable or not. It is classed in a category. If you are a lorry driver renewing your license that would be £30. If you want an insurance enquiry that's also £30. There are others, I know at least three GPs in Croydon out of 62, who provide this service for free to vulnerable people. It says vulnerable people on here under the three to five years plan. Now, support for them.

Tom Cox: Can I pause there? That issue ties in more with the GP table.

Resident 2: I agree with you.

TC: Before we continue, first of all, so we know the context. My name is Tom Cox, I am one of the commissioning team. We have been asked on this table to think about self-care provision in the borough, what the issues are and what we need to change. What support is out there to help people care for themselves.

Resident 1: On that point, to help to get benefits, to help support themselves financially and not get back into hospital, and save the NHS money, they have to have evidence. To pay sometimes £30, some charge £50 for a letter.

Resident 2: I'm hearing what you're saying.

Resident 3: You don't get all that detail from the media, it's only when you're faced with these problems at your worst moment. You won't have your payment, another four weeks without any money and you need that support.

Resident 2: I can hear those problems but I've got a problem. You're describing difficulties in accessing different levels of care, but specifically describing an issue that arises in an area that we've been asked to not look at. We are looking at self-care. Whilst you describe something that limits the ability for some people to actually carry that out, I am also interested in what Tom has got to tell us about what the CCG sees as the current problem in either providing or asking itself whether there should be self-care.

TC: This is a good point. Look again at the pathway maps that we shared round before. We are looking at the left-most side of the chart, green section. This is the as-is situation at the moment.

Resident 4: Would self-care be more towards social prescribing?

TC: It would include social prescribing in terms of other services that GPs can refer onto. This chart mentions the Just Be Croydon website, where there is a range of support and information about how to be active, eat healthily. To help well-being. By being informed and helping in that kind of way, that prevents mental ill-health down the line. It might help prevent depression, anxiety. By being active, getting enough exercise.

Resident 2: We get that and can see how things can deteriorate if this isn't available.

TC: Issues include awareness around the services, not enough people know about them. Or, they know about them but they don't feel motivation to use them.

Resident 2: Is that the issue?

TC: The purpose of the table is to get your view on what the issues are.

Resident 2: Every time I come to one of these meetings, everybody agrees that there should be more communication. Clearly, once we've all agreed that, we need to move onto something more practical. Brands want to get their names into the marketplace, in competition. You're no different from everybody else who wants to sell their wares. Any organisation who wants to make an impact must have a highly professional marketing and selling team. CCG hasn't got that. Once you've got that, the next question is what good do these things do? We know that all these things are helpful and prevent deterioration, but I wonder to what extent there is any sort of assessment of the effectiveness of what's being done. She told us that from 2008 onwards, the world has turned and CBT became a big thing, everybody said it works. That's been the gospel for the past 10 years.

Resident 1: Only for some people with common problems.

Resident 2: Yes, and this is meant to deal with common problems. A lot of money is being spent on these online resources and I wonder what sort of effectiveness anybody is gauging of the appropriateness of these things.

Resident 3: You've been doing very well at talking to people as they passed you in the community. Last Saturday you did the HIV testing and approaching people. What struck me was going out there and talking to people, the thing about sexual protection. There were sometimes about 5 or 6 people all actively absorbing and asking questions, all afternoon. There were no holds barred. The information was brilliant. I was shepherding people to tables to get their HIV status test.

Resident 1: HIV is more in primary care.

Resident 3: What I'm focusing on is getting out there and giving messages in public places, so that people can actually engage in the street and public places around the borough. This could be done in Croydon High Street, wherever. It could be mental or physical health. There's nothing like neighbour telling neighbour what the thing is, and actually describing where the place is to go.

Resident 1: I used to a mental health day with somebody else, but there's also been a pop-up bus for the elderly people, to go round with information. They tried it that way, but are they still going?

TC: I just want to try to get comments from everyone. Is there anything you want to add?

Resident 5: Prevention methods?

TC: Looking at the prevention side of things, so people with no mental health needs or low mental health needs. Do you feel there are there issues with the current support available or things that may need to change or improve? To help people care for themselves better?

Resident 4: I think relationship breakdown is quite an important thing. It can be tense.

TC: That's something that can lead to mental health, yes. So, maybe something about maintaining good relationships.

Resident 4: Mediation or something can prevent it.

Resident 1: In relation to being active, you've got some active groups that do walking. They encouraged people with mental health problems who had problems with stigma. People treated them differently.

Resident 5: Lifestyle issues, I was thinking of. They have the largest section of open space in London, there are many uses of open space. It is scientifically shown to be a therapeutic environment. Not enough use is made of it for mental health.

TC: Better use of community spaces?

Resident 5: Yes, a therapeutic environment for mental health.

TC: Like parks?

Resident 5: Yes, there should be programmes and projects in the parks. Preventative measures as well.

Resident 1: On a Saturday morning in 3 places in Croydon, there is the 5K free Park Run. You just get your time later on, a lot of people with mental health problems have used it to keep their weight down or fitness up. It's a way to perhaps meet people.

Resident 5: I'm talking of more innovative ideas, not just walking. Innovative ideas. Projects I have in my mind.

Resident 1: In Lloyd Park they have fitness machines, I've never tried them. There is an obstacle sort of thing, you can climb it, pull it, jump over logs and things.

Resident 5: Yes, but Croydon is very big. What is there in Selhurst?

Resident 1: I don't know.

Resident 5: Exactly. It should be in proportion to the needs of the community.

Resident 2: In Selhurst there is a park by the railway station.

Resident 5: Yes, there's nothing there.

TC: Do you mean open spaces?

Resident 5: There's nothing.

Resident 2: Having said that, you have to know where they are. You know the Selhurst garage depot where the trains are parked. There's a park there. There's another one in Thornton Heath up on the hill.

Resident 3: Oh, Grangewood, but that's miles away.

Resident 2: I'm afraid you do have to walk to it.

Resident 3: The point you're making is a demand on the council who has responsibility, to make the parks or in this instance the park, more attractive as a resource that people can use.

Resident 5: There's a resource centre there for old people, what is there for them? Nothing in this park? People with dementia.

Resident 1: Young children. When I was a youngster, there was a park where I lived. All my mates used to play football, cricket.

Resident 2: When I was young the boys used to go out in the road because there weren't any parks. They used to play cricket and football all day long.

Resident 3: If I remember some of the stats at the Thrive LDN presentation, there are still a very low number of people actually accessing services, even these ones. The ones in red are that your doctor or the police send you to. These are the ones you choose yourself. When one is not feeling well, where do you go? The doctor, physically. When you're feeling depressed and down, does it naturally follow that you find these?

(Session ends)

Table 1 - Session 2 (17.34 to 17.53)

Tom Cox, Mental Health Commissioner, NHS Croydon CCG: (TC)
Steven Warren, Head of Commissioning, NHS Croydon CCG: (SW)
Resident 1
Resident 2
Resident 3
Resident 4

Themes that came out of the discussions:

Services:

- Concern of use of psychotic drugs, based on misdiagnosis.
- Lack of home-based therapies.
- Lack of funding for autism unit in Croydon which could solve these issues, focus on autism specific needs as CBT does not work for them.
- When some people have an added complexity on top of the mental health issue, they cannot be neatly diagnosed and so fall through the gaps.

Knowledge and Communications:

- Communications with adults and young people who have mental health problems; How mental health patients are helped at A&E.
- Lack of awareness of support services particularly talking therapies.
- Need to focus on prevention.

Support:

- Understanding by all services about supporting those who have mental health issues and autism and lack of therapies for this group.
- Concern about transition between child and adult services at 18. Various autism groups provide support but there is not a central place of them to voice their experiences.

Tom Cox: I'm one of the mental health commissioners. This is Steven Warren, deputy commissioner.

Resident 1: I teach drama as therapy. I worked for a cancer charity, doing a performance around various issues and bringing the issues alive. Through work I recently had to use IAPT (Improving Access to Psychological Therapies) services. I just came here to see what was going on. One of my main concerns was issues with communications with adults or young people who have mental health problems. I'm just really concerned about some areas to do with that and care receiving at A&E.

Resident 2: I'm a parent of a child with autism. I've found a big, big gap in Croydon with mental health. My child's just come out of a catatonia breakdown where the brain shuts

down and the limbs stop working. We've got no high-functioning autism school in Croydon, social care has to pick up the problem. I've found that NHS weren't very useful during the breakdown, everybody from GPs to psychiatrists. They knew about mental health but not mental health and autism, they admitted it. I am here to say there is a big difference between mental health and autism, they have to be treated differently, but these young adults are being sectioned, creating more problems. We've got nine beds in the autism unit at Bethlem which is gold dust if you get a bed there. He's had medication but no therapy offered at all. I'm constantly trying to find therapy for him. They wanted to section him, but I refused. I had to nurse him back to health at home, I didn't have any help or intervention.

TC: It's the community and GPs.

Resident 2: We want therapies at home. Even that young lady, she doesn't offer it. NHS doesn't offer it. He was bed-ridden for 4 months. I couldn't physically get in there. Nobody would come to the house. A crisis team said they don't deal with autism. Who does? I had psychiatrists who would have made a misdiagnosis if I wasn't there. They wanted to prescribe anti-psychotic drugs which would have made it worse. It was a complete disaster. We are in need of help when it comes to high-functioning autism. They're the ones who need help. If I wasn't there, there are three ways my son would have gone. He would have died from stopping eating, he would have been sectioned and in prison. They are still vulnerable and end up getting themselves into trouble.

TC: We'll feed that back to the other table. This is the self-care table.

Steven: It's a massive gap.

Resident 2: It's also education and we need to deal with it early in life.

Resident 1: I know you're speaking as a mother. Part of the self-care would be what is there for you?

Resident 2: Exactly. I know a lot of parents on anti-depressants because they can't help. After the carers act, they aren't getting the support they need. When my son was bed-ridden and I needed someone to come in and clean him up, there was a certain time they had to come in, it just didn't work.

TC: Why couldn't you get access to Talking Therapies?

Resident 2: I've been waiting for a year. I had to complain to the CCG about it. They kept going from one panel to another then it fell off the radar altogether. It was just a pattern of errors.

Steven Warren: That sounds terrible in terms of your whole experience. It would be good to have it as a case study to look at.

Resident 2: Apparently, they were supposed to set up an autism unit in Croydon. That was getting funded two years ago but the funds got taken away. My son's referral was made but then it didn't manifest. The same with social care, the autism people don't come under any banners. You don't come under learning difficulties, mental health. I

have to go from team to team. Social care is non-existent for the last 6 months. We need something for autism.

Resident 3: A group.

Resident 2: You know, there are plenty of groups, but at the top nobody is doing anything. You would free up a lot of beds and resources if you could really recognise what the problem is amongst autistic people. They are vulnerable, they need different therapies. CBT doesn't really work with autism. They need more psychotherapy but it's hard enough just getting CBT.

SW: How old is he?

Resident 2: 21, he was diagnosed at 13. I've tried to deal with education, but he's a lot better now. He's come out of his breakdown. It was inevitable, they do get traumatised and it does come out as a nervous breakdown. Early prevention would really help and make things better for mental health.

SW: That's a good case study of how it shouldn't happen. If you give your details afterwards we might get in touch.

Resident 2: I wrote to CCG and they wrote a letter back acknowledging all the errors they had made, which was fine. They admitted it, but it's not a solution. Me and my husband helped him recover but there's nothing documented. No one recognises catatonia in autistic people, they just put it down as a nervous breakdown. My GP said it was common among young adults. What are they putting in place? It's quite normal now for that to happen. How have we got to this place where we think something like this is normal?

Resident 4: I think it's' really unfortunately common when people have an additional complexity that they fall through the gaps, if they don't have a neat diagnostic label.

SW: Yes, also in the transition between children to adult services.

Resident 2: As soon as the day he turned 18, that was it, he was in adult services and then you're waiting. I was mentioning medication. This is what I don't understand. Why are we prescribing medication without therapies? Really, you should give therapies, then if they don't work, do it side by side. We've got young OCD kids who they are prescribing anti-depressant tablets to without the therapies in place. We don't help wean them off, it's left to the family. The times that I've had to wean off and no one wants to help. They're happy to put him on there.

Resident 1: In terms of your self-care and support, what is it that you're doing?

TC: Just briefly, we're looking at this pathway map that we've got here. Looking particularly in the green section, the no to low level of need. This is what services are currently being provided. My head of team gave an overview earlier on. Some of the issues that have come up in previous events are the lack of awareness, for example in terms of self-care. Being active, eating healthily, having healthy lifestyle choices and approaches. Sometimes the support that's available in terms of the Croydon Talking

Therapies, that's something that there's a capacity for. Opening it up to you, what are your views on the current provision?

Resident 2: The NHS are wonderful people but you only know when you access it, when you really need it, that you know all the flaws. When it came to my son, the help is not there. What surprised me was that the top psychiatrists had not a clue. I know autism is still quite new, people are learning about it and it's varied, but I was still surprised at how they are mixing it with mental health. That is a big danger.

Resident 1: Are they doing that in your communities?

Resident 2: Yes because there are no provisions for autism so they've got no choice. They need special help and attention. They cannot be put into a mental health facility, all you're doing is traumatising them more.

Resident 3: We need to address it because the diagnoses of autism are going up. I think what you were saying about that transition time, it's a really tough time. Young people experience such a difference between the services under and over 18. Your son has got a supportive family but some people do not. Navigating that is key.

Resident 2: They have usually fallen off the cliff by then. They need to really be strong, and get the support. I think the prisons are full of autistic people.

Resident 4: There are well-established support groups.

Resident 2: There are autism groups, adult services at Chatsworth Hall. They are very small groups, everyone gets together and talks but they are all having the same problems.

Resident 4: Is there a national society as well?

Resident 2: There is the National Autism Society, that's where I found out about catatonia. To get it to the psychologists and the specialists, it's about education.

SW: Yes, we were talking about different communities and community groups to get feedback more systematically.

Resident 2: Aren't the CCG the top, main people who can make the changes?

SW: Yes.

Resident 2: I know there are many people who have similar experiences but they're not documented. How are we supposed to make changes? I feel like I had to document it and write to the CCG just so it's out there, so people know the difficulties I had and the gaps in the system. The gaps are very big all the way through.

Resident 4: The other thing around prevention, I know there has been some discussion about how we connect better to communities and get messages out. There are lots of ways to do it. That's key.

(Session ends)

Table 1 - Session 3: (17.58 to 18.17)

Tom Cox, Tom Cox, Mental Health Commissioner, NHS Croydon CCG: (TC)
Resident 1
Resident 2
Resident 3
Resident 4
Resident 5

Themes that came out of the discussions:

Services:

- Need for a personal approach. Some may use acute service for a short while, but then spend the rest of their time in self-care. Users should not be defined by a condition or the services they use or are offered.
- There are issues in the way the psychiatrist talks to the patient, language issues but also ways of relating. More information needed on medications and their side effects given by the psychiatrist, with pharmacists having a role here.
- The good benefit of community gardening to help people turnaround.

Knowledge and communications:

- Careful with the messaging as providers don't want to bombard people and put them off.
- People know they have issues but don't want to show it due to stigma that needs to be overcome.
- Need for a leaflet distributed across Croydon for all services at various stages.
- Better promotion of IAPT services.

Support:

- Boredom and loneliness - how can this be overcome?
- The sense that other people with mental health issues are weird, so why does someone with mental health issues want to spend time with another person in a similar way?
- Success with the Recovery College in helping those with mental health issues, more promotion and knowledge about this is needed.
- Helping people recognise they need help early on – mental health first aid.
- Mental health telephone support and advice is needed, or if it exists better promoted.
- Talking positively about mental health – taking care of the mind as well as the body.

Full Discussions

Tom Cox: My name is Tom Cox, I am a mental health commissioner for NHS Croydon CCG. This table is thinking about self-care. We've previously showed this table of the as-is pathway, so the services that are being provided at the moment. We are looking at the green side on the left which is the services available for people with no to low mental health need. So, what is out there at the moment to help people care for themselves, and in terms of mental health particularly. Services available at the moment are information services such as the Just Be website for Croydon which gives information and advice on being active and exercise, eating healthily, engaging socially with people. Things that can help prevent mental health issues. There are other options such as the Croydon Talking Therapy service, we had a presentation from the lady earlier. Opening it up to you. In terms of the issues around lack of support, capacity of the mental health services. What can we do to help people care for themselves?

Resident 1: My loved one has got a quite severe mental illness, but when he is well, the thing he says to me most is that he's bored and lonely. He also doesn't eat very well because his medication increases his appetite. When I suggest anything to do with mental health, he thinks it's loads of weird people. How can we change that stigma?

TC: Any thoughts?

Resident 2: I know you've got other services, but the South London and Maudsley Recovery College doesn't seem to be mentioned once in Croydon. For my daughter who has a severe diagnosis but functions well, that's been a lifesaver. They do come out to Croydon but a lot of care coordinators and staff don't know about it. The concept is fantastic and works very well. I think it should be advertised.

TC: Is it just for mental health issues?

Resident 2: Yes.

Resident 3: There's one in Slough, really successful.

Resident 2: It's a different, model, more health and well-being. Having conversations, involving service users and other things. It never ends once you get into the system.

Resident 4: Where is it coming from? Very close friends, in the early stages of illness or later on. As Jane was mentioning, how do you change the attitude? This has to be very personalised, very casual, gradually changing. If you bombard people with lots of messages they are lost. Stigma is another thing. This is where lifestyle comes into it. This is important. I travel 50 miles each way to see an old friend of mine, he has serious, acute stress. He still doesn't want to go and see a psychiatrist. This is the problem. He is changing rapidly, asking if he will survive. It's reaching that stage. I go because he likes me, I feel it can be dealt with. Now, he is beginning to understand and beginning to make a small recovery.

TC: Just to check what you were saying, about the benefit of people having a personalised approach?

Resident 4: Yes, especially from close friends and close relations. Social psychologists don't necessarily help all the time.

Resident 2: In our case, our loved ones need medication as well, but in addition to that.

Resident 3: I think the point you're making is that people can be here in the red area and be diagnosed, but they live most of their life like the rest of us. The stigma prevents them from living their lives in the way they ought to. That's an interesting conundrum. That needs family members to advocate, access to appropriate services. Why should you have to go for services for people like you? Why can't you go to services for people who like the same music as you, or art? We are not defined by our conditions but ourselves. What the system tends to do is see things through a service lens but not a personal lens, that's where we need to actually see the world through the eyes of the person. Not what services we think they need, but how they would like to experience their lives.

Resident 4: I started telling my friend, it's a cycle, start with medicine then reduce treatment.

Resident 2: We did that, in the beginning you don't believe it, they get better and then they get ill again.

Resident 1: You have to trust the professionals.

Resident 4: There is the clinical psychiatrist and the social one. The clinical one. This guy was in an acute situation, within 15 minutes he was out of there. There are problems, the language problem, the way they speak and are coming across. There are a lot of problems between the psychiatrist and the patient.

Resident 2: The other thing about medication, there's been a lot in the press about sodium valproate which is given for epilepsy. It's now been found that it affects women with children, it affects the foetus very badly. They are going to take people and tell them, but they weren't told this a few years ago.

TC: So, there's not enough information about side-effects. There needs to be more information out there.

Resident 2: A lot more. The pharmacies need to guide the psychiatrists.

Resident 5: One thing that occurs to me is that quite often the person with the problem doesn't admit to it, but friends and family are living with it. They don't have a way to find out what they can do to help.

Resident 3: Maybe a more generalised approach to mental health first aid, being able to recognise what positive mental health is.

Resident 2: There's lots out there, but you don't get it at the beginning.

Resident 5: Yes, you have no source of information, no way to find it.

Resident 3: I think that's true at different stages, for parents with children, for people with an older loved one with signs of dementia. There is support there but it's finding it.

Resident 5: There's no single point to find it.

Resident 3: You can phone Healthwatch.

Resident 5: That hasn't got a good reputation.

Resident 3: It's a new provider, we have an information signposting service but people don't know it exists. There isn't enough knowledge. Sometimes you need to know what the question is to ask. There is a dearth of telephone support. You need to phone someone up and say you're worried.

Resident 5: It's even worse when you're saying, 'My family member is doing some strange things, what can I do?' It's difficult to do anything even if you have the details and are the husband or wife.

Resident 4: They can become very defensive.

Resident 5: The easiest one to find out about, is if your child is diagnosed on the spectrum when they're at school, but if they're teenagers or older you are on your own.

Resident 4: I was wondering. You know there are a variety of leaflets from IAPT, I have not seen anything.

Resident 2: It's in this month's IAPT, and there has been a leaflet.

Resident 4: Perhaps there is one leaflet alongside one about the bins, but we need to tell people the resources available. If CCG give money to Croydon they can get the leaflets out there. A small one, nicely designed.

TC: Of all the services available?

Resident 4: Yes, at different stages. I don't know. You have to monitor to see how many people respond.

Resident 2: I wanted to ask a question. When it said 1 in 4 adults have a mental health problem, 4,500 have serious problems, was it in Croydon?

TC: In the borough.

Resident 5: In the population, 1 in 1,000 are very serious.

Resident 2: I think the 1 in 4 is not serious.

Resident 5: No it can be anything, reactive depression.

Resident 2: So, it's 4,500 people with a serious problem going to Jeannette Wallace House, it's no wonder it's quite busy.

Resident 5: Totally anecdotal, gardening therapy. It's amazing how effective it is. It kicks them enough to get out of a rut.

Resident 3: I know someone, exactly that, had depression and started volunteering in the community garden. It absolutely turned him around.

Resident 2: There is a group in Croydon.

TC: In terms of the stigma, I wanted to mention that there one way of addressing it, in terms of promoting awareness and moving away from thinking of mental health as a negative. More talking about taking care of your mind as much as your body. If something happens you need to care for your mind to prevent worse conditions. One other thing than promoting that is also talking about services available. One suggestion has been to still have the services provided as they are but not label them as mental health services as such, as one way of getting around that stigma.

Resident 1: Yes, it is a stigma, isn't it?

TC: Has your son ever tried them?

Resident 1: He used to join gyms and play football but he can't afford it regularly. I said, 'I am sure there must be some services.'

TC: It might be worth looking at that leaflet in terms of things they suggest, the websites.

(Session ends)

Table 2 - Session 1: (17.10 to 17.29)

James Du Bray: South London and Maudsley NHS Foundation Trust <<role>>

Paris Cosgrave: Lead for IAPTS (talking therapies) for long term conditions, South London and Maudsley NHS Foundation Trust
Resident 1
Resident 2
Resident 3
Resident 4

Themes that came out of the discussions:

Services:

- Services for those whose English is not their fluent language.
- Concern that cancer psychotherapy services may be closing – what is happening to the service?
- Self-referral pathways: People can self-refer, but for long-term conditions it is easier to go by GP – hard to do by self-referral.
- Charging process: This means GPs charge each other in Croydon to see patients from other surgeries. This is not true of other services – mental health should be seen like these.

Knowledge and communication:

- Difficulty in raising awareness of mental health with certain cultural groups, with only 66 referrals from the Asian community.
- Too many people go to GPs, but they are seen as the reliable place to go
- Different language and approach depending on age, ie focus on isolation for older people.

Full Discussions

James: What did you discuss on the other table? This session is on psycho-therapy.

Resident 1: Trying to find something that's even better than talking therapy. Thinking about different languages. You have to have practitioners who are fluent in the language when dealing with patients.

Resident 2: I'm a resident. I volunteer for the NHS. I've used psychological services and other services. I think the cancer psychology services may be going in Croydon which really disappoints me. I don't know how that impacts on community services.

Paris: I don't know if James knew about that but I certainly didn't know about the cancer service closing down. We certainly have the resources to deal with that, to help those people.

Resident 3: Which service was that? I'm not sure it's closing. I think there's just a discussion about it.

Resident 2: Oh okay, that's good.

Paris: One third of people with a long-term illness have a mental health issue.

Resident 4: Can anyone self-refer for help?

Paris: Yes, anyone can self-refer.

Resident 4: If someone with a long-term condition phoned up and asked for a service, would they then have to go back to the GP?

Paris: We'd suggest that they go to the GP first. I have someone at the moment who's been referred without such a form, which is often very difficult.

James: We know if you have one long term health condition that you're very likely to have one alongside it. You still need the ability to treat both at the same time, which is very challenging.

Paris: If someone did call through with a long-term condition, there's no reason they can't self-refer if their issue isn't related to that condition.

James: We want to encourage others to use the service.

Resident 4: The list you gave was quite helpful in understanding what the different things are that can help.

Resident 1: You want to say that we have this fabulous way of helping your wellbeing in Croydon. We were talking about how within some cultural groups the stigma is so great that they won't even admit that they have a mental health issue, so you're expected to interpret that that's what they're talking about.

James: Only 66 referrals were made to the service last year from the Asian community. That's woeful in a society as diverse as Croydon. Too many people are heavily reliant on their GP's.

Resident 1: Traditionally, the only gatekeeper for the mental health society is the GP and if you go they tell you go to walk in centres anyway. To try to get people to go to A&E who don't really want to go is very tough.

James: Croydon is quite unusual in the sense that a lot of GP surgeries charge to run a service out of them. Others won't actually see patients from other practices at their surgery, which is ridiculous. Mental health should be brought more into the mainstream.

Resident 2: Having it in different centres makes it more accessible.

Paris: People do find accessibility hard if they have long-term conditions. Like James says, it's important to destigmatize what we're doing and to make it available in the same building. We do work with interpreters so any therapist we have that don't speak certain languages, we can do telephone or online interpreters.

James: There are some specialist services for people who are hard of hearing too. There was a service at St George's.

Paris: Any tips that we should take away and consider?

James: Shouldn't we be thinking about different age groups?

Resident 1: I think it's essential that for older people the attitude changes. Maybe the language should change from mental health and therapy to something like better wellbeing. I find it heart breaking when people still can't let go of the negative thoughts that make them miserable when they don't need to be. It's the isolation too. It doesn't need to be terribly complicated.

Paris: Other services do have older groups. We don't run that at the moment but it is something we need to focus on more really.

James: There are more and more students who are recognising mental health issues so that is something that does need focus on too.

(Session ends)

Table 2 - Session 2: (17.34 to 17.53)

James Du Bray: South London and Maudsley NHS Foundation Trust <<role>>

Paris Cosgrave: Lead for IAPTS (talking therapies) for long term conditions, South London and Maudsley NHS Foundation Trust
Resident 1
Resident 2
Resident 3
Resident 4

Themes that came out of the discussions:

Services:

- 18-week wait for therapy.
- GP said they would refer but said it would take so long that patient should go private. Mental health issues of those with autism compounded by the wait.
- Telephone service to support after initial home visit for those house-bound.
- Tailoring anxiety and depression services for those with autism – risk of sectioning if there is not the right support.

Knowledge and communications:

- Need to GPs to be better informed of mental health services so they can refer better, for those with and without autism.

Support:

- Need to know range of services – a more integrated approach.
- It takes courage to make a self-referral, so waiting times need to be shorter.

Full Discussions

Resident 1: I've had leaflets through the door but only in the last year or so. My son was waiting for therapy for 18 weeks.

James: How old is he?

Resident 1: He's over 18.

Resident 2: My son was diagnosed late as having autism. The GP said she could refer him but that it would take so long that we should go private, which cost a fortune.

Resident 3: Because there's no help it develops into mental health issues. There's no help all the way down the line.

James: The issue is that you as members of society only see one service.

Resident 1: You say that, but the service isn't there. I've had psychiatry say to me that they know about mental health but not enough about autism.

James: We have to work towards a more integrated approach.

Resident 1: I heard there was going to be a university in Croydon specialising in it. Going back to therapies, if a person is house bound, where do they go as in Croydon there is no help for those who are house bound?

Paris: Although we don't offer home visits, we did initially actually go out to a lady and then continued on the telephone with her, which was something that works very well.

Resident 1: Then you don't offer therapy for people with autism

Paris: We actually do but their prime problem would be anxiety and depression.

Resident 1: It is still anxiety and depression but it's not exactly the same. Until the NHS realises that there is a big difference between mental health and autism then it is going to carry on. When we're talking about mental health we're putting vulnerable children and adults into mainstream psychiatric wards. It's a big problem, you're sticking them in there and traumatising them even more as they don't belong there.

James: Yes, I do agree.

Resident 1: A lot of people on the spectrum are shut down.

Paris: In terms of psychotherapy, we have Cripps, which offer longer term treatments.

Resident 1: It is really hit and miss. It doesn't work for them with how their minds work. My son had 6 sessions. He was offered CBT.

Paris: It seems like you're saying that there's still a gap?

Resident 1: There's a big gap. My son had a catatonic breakdown with autism and no one understood it. They misinterpreted it as a mental health issue and tried to prescribe a drug that made it worse. Time and time again there are people who end up being sectioned which actually makes them worse before they can get better. The information just isn't out there.

James: Maybe things are slowly changing. It's a horrible thing to be on the receiving end of.

Resident 1: I was at the point over choosing whether to get my son sectioned or try to manage it myself. I nursed him back at home myself. It's not something that's even documented.

James: The National Health Service must commission a service.

Resident 1: We're traumatising a bunch of people and the majority even end up in mental institutes or prison or, are dying. When I needed the help, I had a GP come round and he said to me when he's in and out of consciousness, just call for the ambulance.

James: I think we need to educate our GP's more.

Resident 1: The GP knew that he couldn't advise me as he was aware that there wasn't the help out there.

Paris: The waiting times have dropped. At the moment waiting times are actually quite good. We're not talking about months anymore.

James: There are specific standards that we hold them to account. 75% of all people must have their first treatment within 6 months. If you think about how much courage it takes to make their own referral, 6 months is still too long but the idea is to have 6 to 12 sessions. It's not a long-term panacea. It is to give you a brief solution at that particular time.

Resident 3: When you offer therapies, do you offer therapy and medicine?

Paris: We only offer therapies but we do have that conversation with people. If they say they're not on medication, we usually point them in the direction of the GP. It takes quite a while for medication to kick in sometimes.

Resident 2: Yes, I'm on the highest one and it's working now. I had a bad point last month with anxiety and panic attacks.

Paris: Have you ever considered talking therapies?

Resident 2: The doctor said CBT might be helpful but I don't know. I feel like there's a stigma with it.

Paris: It's a massive barrier we try to overcome. It's completely confidential so even if you come along and think, 'no, it's not for me,' then you're able to leave. What we're trying to do is break that stigma. It depends on the type of therapy you're put forward for. They draw out a cycle for you and they might draw out different techniques.

Resident 2: When I get anxious, I can't breathe and I yawn a lot. I keep taking deep breaths. I think I'm scared and then I get frightened because I can't breathe.

Paris: We can talk you through the thought process and what we can do. Counselling would talk more about your past history and childhood, but CBT focuses on the here and now, so you don't have to discuss your history.

Resident 4: I think you need motivation for CBT to work. My son just doesn't have any motivation needed for it.

Paris: Yes, for CBT, you do need some motivation. You need it to turn up really.

Resident 4: Also, to do the homework in between sessions?

Paris: Yes, with CBT there's quite a lot of thinking in between sessions. There's a level of motivation but if we can get someone into the service we can talk it through. We would hope the GP would make contact and once they are in our system we can discuss what's wrong and how we can get that motivation back for them. It's a bit of a vicious cycle otherwise.

James: How can we make the service more appropriate to your needs?

Resident 3: After a year I had to make a complaint as my son got lost in the system. Social care is non-existent at the moment and they don't even respond to my emails. Nobody is talking, which needs to change.

(Session ends)

Table 2 - Session 3: (17.58 to 18.17)

James Du Bray: South London and Maudsley NHS Foundation Trust <<role>>

Paris Cosgrave: Lead for IAPTS (talking therapies) for long term conditions, South London and Maudsley NHS Foundation Trust
Resident 1
Resident 2
Resident 3
Resident 4

Themes that came out of the discussions:

Services:

- A GP doesn't like referring because it costs her surgery. Due to this some people don't ask to be referred.
- A walk-in might work, but it depends how far it is from people who need it.
- Need for a more instant service when someone is in crisis.

Knowledge and communications:

- Lack of knowledge of service, particularly for those with dementia.
- Need for GPs to know more about services, or to point to nurse who can provide the service just as well for the patient.
- However, there is an expectation that a patient should see a doctor, which needs to be managed.

Support:

- Bibliotheraphy - link between learning and well-being.

Full Discussions

Resident 1: My task is to follow the patient experience.

Resident 2: I'm from the Inaspectrum autism group. We did have some information given to us about IAPT. A friend of mine was referred to it.

Paris: Did he find the process quite helpful?

Resident 2: Yes, he said it was helpful.

Resident 3: I'm shadow deputy to the Counsellor. I'm here in that role but also because I've been around and am interested in Healthwatch.

James: Do you get people go up to you and talk about mental health issues?

Resident 3: No, strangely not. Most of my patients are older.

James: I think part of it is not necessarily the stigma but the lack of education and the understanding that the service is available to everyone. We know that there are lots of people out there with dementia who haven't actually got a diagnosis.

Resident 4: We have a GP in our area who doesn't like referring because it keeps down her figures and expenditures. The thing that gets to me the most is that someone in crisis won't necessarily make a phone call.

James: So, do you think we should just make it a walk in?

Resident 4: The issue with that is how far it is between the residents and centres.

Paris: We're trying to reach out to surgeries. We did have a point of time where we would call the person and you'd call and they wouldn't be in, or the person wasn't particularly motivated. It was very difficult to get hold of them and by the time that's passed you could have seen someone for treatment, so we found it was easy for people to call in rather than the other way around. That's why we changed it.

Resident 4: The difference is that if people make a booking they actually expect something to happen.

Paris: We would make exceptions for people at the stage of really making an effort to get in touch, but the majority would call in. We're dealing with people with mild to moderate mental health issues.

Resident 4: I got your point about referring yourself online but then I'm not sure that having to make a phone call works with the person in crisis.

James: I suppose it is very much a structured programme. There are times when people will need a more immediate response.

Resident 4: But it's about flexibility above the approach.

James: When I first started, the GP's weren't educated enough to know how it could support them. Maybe there needs to be an exercise of educating GP's. The problem again is that there's too much tendency to think the GP is the answer to all of your problems. You could talk to a practice nurse or someone else.

Resident 4: I think if people go to seek help, they should expect to see a doctor though.

Resident 1: My wife, Carol did have a heavy panic breathing attack. The doctor did recommend talking therapies. The doctor didn't say anything that I hadn't told her already but once the doctor told her her breathing and everything was alright, she was fine an hour or so afterwards. I thought, 'Geographically, where is this place, is it going to take a long time to get there?'

Resident 4: My frustration is that my husband can't get into the local practice, so he has to travel far despite hardly being able to walk at the moment.

James: My last job was working for a service provider online. A therapist was available as you typed.

Resident 4: So not talking, just texting?

James: Yes. A lot of people were having therapy in that way.

Resident 2: What about more old-fashioned bibliotherapy? I did see on your website that there were references to it.

Paris: We have leaflets that we hand out. In terms of our self help, that tends to incorporate a lot of bibliotherapy. They'd come back in a week or so and talk through what they've learnt which helps consolidate what they've learnt.

Resident 2: I think there's a strong connection between learning and well-being. That in itself probably makes you feel better.

Paris: Yes, and you can take that with you and keep learning and going over it.

Resident 3: I'm diabetic. My daughter was 7 when she was diagnosed and I was only diagnosed 10 years ago. My granddaughter struggles with it as she's different to her peers. What's interesting is that we are all different in how we deal with things.

James: Different generational things too. The younger generation seem to be more anxious.

Resident 3: Yes, social media and the internet make you know more and you might be better off not knowing it.

Paris: The younger generation have too much knowledge about what's normal and what isn't.

Resident 1: There's a will for conformity.

Paris: It goes back to that cycle of the thoughts you have over a situation.

Resident 4: In my father's generation you wouldn't talk about it at all.

Paris: You'd just get on it with it, that stiff upper lip attitude.

Resident 4: I often think we don't support each other as we are all too busy.

Paris: Yes, definitely. It goes back to that discussion about social media.

(Session ends)

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healthwatch Croydon

Meet the changemakers… and get involved

Adult Mental Health services

GP and community services

Questions and answers

Wednesday 18 July 18.00-20.30

CVA Resource Centre, 82 London Road, Croydon

In association with

NHS Croydon Clinical Commissioning Group

NHS South London and Maudsley NHS Foundation Trust

Table 3- Session 1: (17.10 to 17.29)

Gordon Kay: Healthwatch Croydon Manager (GK)
Valentine Nweze, Service Lead for Mental Health Assessment and Liaison in Croydon, South London and Maudsley NHS Foundation Trust
Resident 1
Resident 2
Resident 3
Resident 4

Themes that came out of the discussions:

Services:

- GP surgeries and staff need to have a good understanding of mental health services locally. Individual GPs may not feel confident to diagnose.
- People not getting support as not considered ill enough – bouncing between services.
- Consider co-location of services.
- Avoiding having to wait three months to get a referral because it all has to go via GPs – meaning a delay in referral and treatment.
- Need for specialist mental health training in GP surgeries both at GP and health professional level.
- There is no funding for dedicated services for those on the Autism spectrum in Croydon unlike other boroughs. Residents have to apply to the panel for specific funding and usually do not succeed.

Knowledge and communications:

- Better knowledge and advice of services and what is out there is needed.
- A list of facilities that people have early access to.

Full Discussions

Gordon Kay: You have heard a lot in these hours. Which questions do you feel you should be asking? So, from what we've heard, this is specialism in GP and community service.

Resident 1: I think ensuring that general practice staff, so GPs and other clinical staff in practices, have a good understanding of mental health services locally and how they affect people generally. GP services can be difficult if you're mentally unwell. They need to find wider support. They need to have on hand advice and support on GPs. If it's like anywhere I work, GPs will refer, and they are bounced back. They struggle with people who are psychiatrists as they considered as not mentally ill enough. That bouncing in between services is difficult for the patient. You would expect them to be well equipped.

GK: Are the options available when you're considered as quite serious? It has to be something quite dramatic. Does something need to be done around communication?

Resident 1: I think it's really useful to co-locate the services and it helps with access. If someone is struggling without a diagnosis, that's a problem. A GP may not feel comfortable with diagnosing mental illnesses.

Resident 2: What we follow is a step to step guideline. We are thinking about people who bounce back we think about self-help in our community. Talking to GPs or people who work in clinical settings, that should be the first point. If there were supports from GPs and given sometimes. How do we get that information? I don't get the feeling that we know what's out there in the community. I've been to a lot of these and they talk a lot about mapping.

Valentine: I want to contribute to this. If you look at this diagram, you can see there are levels. In practice, in an inclusive model. At one point, there is a capacity issue. We are working with local authorities to explain why we need a list of facilities where people can have easy access to. For example, if you refer someone and they are here, it will take three months to see them. They don't need to be here. The other aspect is that we are going to GPs and they have the same view that referrals are being bounced back. We have an issue with the fact that people aren't getting to that point. In reality, we spend 45% referrals and some of the GPs referrals that should be here aren't here. It delays time, and treatment. We've tried to support GPs by separating our team into two teams, so each unit can focus on graphical network by GP hub. In addition to that, we have two teams handling referrals which mean that the GP can link better. Our GP services can be adapted to people in their area. The second thing is to help the GP because the referrals bounce back. We are creating a form for referrals which will help the GP. We've also designed signposting which links all people who have mental illnesses. They look at that list and they click on the signpost and it opens up information about those services. They can make that decision right there and then.

Gordon: It's almost reflecting what Paris was saying. It's doesn't have to be the GP being the middle man. It can be a community centre setting.

Valentine: That's the ideal position. We are trying to see if we can do anything different in the meantime.

Gordon: That's a great overview.

Resident 3: I was just wondering if there is specialist training in GP settings?

Valentine: It's something we're not ruling out. We have templates. We have people working with GPs and colleagues that support them.

Resident 2: List is the head of nursing is linking with us. One of the GPs set up a training and I think I'm going.

Resident 3: Refusing to go and see doctors and GPs, there is an overemphasis of needing to get GP trained.

GK: There is a GPSSI. It might be a thing to develop that in different communities.

Resident 4: My interests are quite specific. I've got some tough questions. In terms of topics of GPs, there is a lack of strategy. Neuro development services are falling between mental health and learning disabilities. GPs don't know what to do.

Resident 2: There have been conversations about that. It had to go to tertiary panels for funding.

Valentine: I think you're right. One of the conversations is that some of those conditions, like Asperger's syndrome, there are services for that. Even people who show traces are given support. In Croydon, there is no funding. This place is already locked out with numbers there is a delay for those people to get treatment. The pathway is convoluted. It's because of funding. It needs to be given to the CCG.

GK: The challenge is autism overlaps with mental health, learning disability, and education. Easily people are falling through because no one knows where to place it. The stress that is involved with normal services if you have autism causes mental health.

Resident 3: They also need to safeguard the children.

(Session ends)

Table 3 – Session 2 (17.33 to 17.53)

Gordon Kay: Healthwatch Croydon Manager (GK)
Valentine Nweze: Service Lead for Mental Health Assessment and Liaison in Croydon, South London and Maudsley NHS Foundation Trust
Resident 1
Resident 2
Resident 3
Resident 4
Resident 5

Themes that came out of the discussions:

Services:

- Difficult to access secondary care unless you have a mental health diagnosis, which means those with long-term non-mental health conditions find it difficult to access services.
- Reconsider inconsistent GP charges for essential letters that helps those with mental health conditions get on with their lives.
- Need for a focus on community services for those with severe mental health conditions. Neighbouring boroughs have funding, but Croydon does not.

Knowledge and Communications:

- Patients need to be better communicated to, not just through letters which might be ignored.

Support:

- Talking therapies for those with long-term conditions, whose mental health had been affected by their condition.

Resident 1: I was diagnosed as a diabetic and one of the things I noticed was the people there were deeply depressed. Later on, I went to Diabetics UK and I was the only one who was type 2 on the table of type 1. I didn't realise how fragile they were. I didn't know talking therapies were available for diabetics. I don't think I need it. The ones who are there really need to get referred very quickly.

GK: Are you aware of this?

Valentine: The last meeting we had it was mentioned that they provided talking therapies for long standing conditions. If it starts to manifest as emotional disturbances, they are the best for that. We do have managing emotions group. It can be depression or anxiety. We have a higher-level pf physiotherapies groups. Our problem is that unless your presentation is coming from a head condition, it's difficult to meet the criteria for the secondary level of mental health care.

Resident 1: Newly diagnosed diabetics are depressed to start with. You need to pick them up to start with and not 5 years later.

Valentine: You are right. It needs to be preventative. They need to have access. You don't have criteria excluding people from assistant services. In Croydon, we want to set up services to guide these people to the right services. I would recommend they self-refer themselves. Some of these meetings should be passed to people through their council letters. When they get council tax letters, it should be placed there. If you don't want to include your GP, it can get you into contact straight away. We are thinking about this with CCG.

Resident 2: The leaflets are amazing. It's happened so quickly.

GK: It's tailoring it to people who have had a dramatic change in their life. There's a mental health service as well.

Resident 3: Physical checks require GPs. Especially those under prescribed medication. A lot of people becoming well under secondary stations. Often, the way they communicate with patients is thorough letters. They might not even read them. A person I heard a talk from was a psychological nurse and she had managed to keep track of people who hadn't turned up, via letter invitation, and followed up. This lasted for a year.

GK: So, you're asking for GPs to be proactive in their roles. It's a case of proactive follow up. It may not be an assessment which needs to be done by a GP.

Resident 1: You've got a parallel with diabetics. They're not carried out by GPs.

Valentine: Those who are on benefits, and on assistance, have gone from being assessed by somebody to being referred. To get their independence, vulnerable people need letters and support. I know of 3 GP practices that don't charge. I've raised it with CCG. My GP charges £30. For other people who haven't got big income and need £30. I'm saying GPs should not charge for letters. They don't charge at secondary services. A lot of people with adult mental health are referred back to GPs.

GK: It's a challenge because GP services are private services on a public contract. It's a good point to raise. It'll roll on and cause problems later.

Resident 4: What community services were available to people with severe mental health?

Valentine: They can be here or here. Usually people who come through diagnosis get here. They can be managed by the GP. There are some risk issues and if this is the case, it will be passed to here where all the referrals are passed to. From here, it is decided where they are best allocated. The only problem is that we need funding for them.

GK: There is a potential for the services, but we need the money to fund it. Is it a general service? Can the GP refer them to the CCG? And request a specific service?

Valentine: No. The money has to come from somewhere. It has to come through us so that we can properly allocate them.

GK: How do you decide you budget?

Valentine: They're saying at the moment that. In Lewisham, Lambeth, and Sutton you can. In Croydon, they don't have the money to do that. They need to make a decision on whether they need to go to CCG. We see the patients and then we refer them.

GK: As what was being discussed, they're trying to reorganise each service for each borough. If Lambeth already has that service, why hasn't Croydon?

Valentine: We need the money for diagnosis and assessment. They need a direct way to refer it.

Resident 5: My son is under the COAST team. They have a psychologist there. They have talking therapies, but he doesn't feel like he needs it. People who need it often feel like they don't need it. Some people get sent letters saying if they don't come again, they won't get another session. Often these people are in denial.

GK: GPs need to follow up letters. What do you feel as someone who knows about those teams?

Resident 5: I think they're really good. My son has a number for her CPA. It's really direct access. If I'm concerned, I just send her a text message. They don't always get it right away but 80% of the time they are.

GK: Texting must be an improvement?

Resident 5: He's medicated and watched anyway but it's an easy way to keep access. He had his physical test done there too. It's so simple. It's just a text message.

Resident 3: We're thinking of booking appointments by text.

GK: There have been issues when we were doing research on adult carers weren't allowed to do see the prescriptions for the severely mentally ill adults.

(Session ends)

Table 3 - Session 3: (17.58 to 18.17)

Gordon: Healthwatch Croydon Manager (GK)
Valentine Nweze, Service Lead for Mental Health Assessment and Liaison in Croydon, South London and Maudsley NHS Foundation Trust
Resident 1
Resident 2
Resident 3
Resident 4
Resident 5

Themes that came out of the discussions:

Services:

- Taking time to get access to mood, anxiety and emotional services, due to delay in panel decisions for specific funding, as the CCG does not generally find this service.
- Impact of the panel decision process.
- Services exist in Lewisham which have to go via panel in Croydon. The impact of special measures.
- Issues with trauma services, with some too traumatised to access services, particularly refugees/ asylum seekers. Perhaps a dedicated service is required.

Resident 2: For the last 18 months, we've had many people walk through the door. My son is 21. I've been waiting for 18 months for therapies. He was going to the panel and discuss the matter. It's been dragging on.

Valentine: It's being funded by the CCG. There is a long wait. There are other things which cause delays. The CCG want to make sure they have all the information. There is a cost involved. There are other service available in the right place. We need a quicker response.

Resident 2: That lady was offering six weeks. Personally, the people who need the help aren't getting them. Also, why can't we have people who are housebound given therapies through sending people there?

Valentine: Firstly, specialised therapies are completely different. You can get a wide variety of therapies. There are so many. It doesn't need to go to funding. It must be a very specialised therapists which isn't provided, and they don't have the funding.

Gordon: There isn't defined funding, so it has to go to a panel.

Resident 1: How often do they meet?

Valentine: They meet every 2 weeks. They meet regularly.

Resident 1: Is it because there is a shortage of social workers?

Valentine: No. They a variety of people. They are senior managers. People like me are not involved.

Resident 3: If we talk about people who already have pre-diagnosed conditions. My son was diagnosed for over 25 years. Are you saying this panel is made of multi-disciplinary panel? Where is the mental health expert on this panel? Who is going to make that decision about that individual current mental health and their need?

Valentine: Let me explain more. It's a special panel. Everyone else that needs diagnosis and assessment which may include treatment do not need to go through to the panel. It's only with special people who have special treatments go to the panel.

Resident 2: My son went there, and they put the panel on wait because there was no funding. He went through three panels. I had to write to CCG to see what was going on.

Valentine: I think it's the right place to raise these issues.

Resident 2: They had gone over the budget that year illegally and put the panel on hold.

Resident 4: Community care means more patients are being put into care homes?

Valentine: You live in the community and they need help.

Resident 4: How do they provide that?

Valentine: We discuss that with people and we help them with support in their own homes.

Gordon: Is that a Croydon issue?

Valentine: The CCG have a tertiary panel everywhere but not all requests go to that panel.

Resident 3: Do they have more services?

Gordon: They're not commissioned in a block?

Valentine: Difference between Croydon CCG and Lewisham CCG. If you don't have enough money to contribute to the pot, that's where there is problem.

Gordon: It already exists in other boroughs?

Valentine: They're making the decision whether to fund Croydon. It's not making that decision.

Resident 2: Where problems arise is where the CCG want a service by a provider and they want this, this and this for some much of this budget but they can't provide

that service with the money which is being provided. Regardless of what is happening in other boroughs, Croydon which has been in special measures has really affected the funding. They've moved to required improvements. It's not straight forward.

Gordon: If this service is going to save money down the road, we need an earlier intervention. The experience of going into acute conditions due not getting the right service

Valentine: Croydon have an unusual population. They have a lot of newly created buildings which draws people here from outside who then also compete for funding.

Resident 5: We have a huge issue in terms of new people in a state of trauma who are considered so unstable that they can't receive state trauma therapy. They don't know whether their status Is confirmed or not. That is hugely delayed. We're carrying them and they're suicidal and traumatised, but they have no access. They can't stabilise. It's a mad circle.

Valentine: I think you're right. There are people who we can treat straight away such as bereavement. In the guidelines, there needs to be a timeline in between for them to stabilise.

Gordon: How old are they are?

Resident 5: 17-21. They're in that transition period.

Valentine: If they're both 18 and referred to treatment.

Resident 5: We do but they're rejected.

Gordon: What I hear is that we need a special treatment. Traumatised refugees might need an access course to help move them into the system.

Valentine: I work in an assessment team. I need to know why they're being rejected.

Resident 5: We need to swap contacts. They're being called into home office for interviews, being kept in detention and the health services are not responding.
Valentine: The reason is we have a service which is specifically for that. If they are rejecting people, I need to find out why.

(Session ends)

Table 4 - Session 1: (17.10 to 17.30)

Elsie Sutherland: Facilitator (ES)
Dr Agnelo Fernandes: Chair of NHS Croydon CCG and GP
Resident 1
Resident 2
Resident 3
Resident 4
Resident 5
Resident 6

Themes that came out of the discussions:

Services:

- A hurdle to get to IAPT services, but promise this will is improving.
- More professionals supported and more service users and carers going into different places such as schools and community centres, not just GPs.
- Role of social prescribing as a starting point.
- Focus on services in the south of the borough, not just the north.

Knowledge and communications:

- Need for better ways of communication IAPT services.
- Change of name to talking therapies may help reduce stigma.
- GPs feel that things could be done differently in the same way social prescribing has been introduced.
- Marketing services better for different age groups and background.

Full Discussions

Elsie Sutherland: Let's introduce ourselves first. My name is Elsie Sutherland, I am a facilitator here and I volunteer for CCG and Healthwatch.

Resident 1: I work for CHASE Residents' Association.

Resident 2: I am a Croydon resident and a governor of SLaM.

Resident 3: I am also a Croydon resident and a governor of SLaM, and I have been a carer for over 25 years for people with mental health issues. I am familiar with CCG and CQC.

Resident 4: I am a carer.

Resident 5: I am in the process of setting up coffee mornings specifically relating to mental health.

Resident 6: I work with the elderly community to combat isolation. We have a monthly tea and chat with elders. We also try to bring issues alive through drama by going to schools and day centres and doing performances based on these issues. I also have a general interest because I have used IAPT myself and cared for someone with mental health issues for a number of years.

Agnelo: I am a GP and chair of CCG. I'm stepping in because our clinical leads aren't here. We are here to discuss talking therapies. The first step we have taken is changing the name from IAPT to Croydon Talking Therapies.

Resident 2: Previously Improving Access to Psychological Therapies?

Agnelo: The last time, we talked about communication between SLaM and Croydon. We had some leaflets that came through my door last year. They didn't mean anything to my wife, they just didn't make sense to her. I didn't even know the drop was going to happen and the numbers and other information were wrong. We fed that back to the communications team, but a lot of people had seen that and it ended up in the bin. We need to consider how we market these services.

Resident 1: I should let you know that I have just recently retired, I used to be a specialist in sickle cell. We have referred some of our patients to the long-term conditions team, but it was such a hurdle to get them into it. Once they were engaged most found it helpful.

Resident 2: I had an experience like that, too. My partner had a breakdown a few years ago and was referred to IAPT through her GP and it was a hurdle. It's not easy to get a hold of them.

Resident 1: I'm hoping that that's better now.

Agnelo: It's certainly better now. There isn't a surgery that goes by where I don't advise people to contact IAPT. People don't realise that it's multifactorial, so it may be that you're talking to somebody or you're using it online. At the moment, I'm seeing someone who is very depressed and needed a form of therapy but didn't want to talk to anyone. He's a type 1 professional in the UK Space Agency and for him the online service worked really well.

Elsie: Sometimes they don't want to talk face-to-face. There's a stigma.

Agnelo: Now that we've got more capacity in the system and we're changing the name, we need to ask how to get people to use the service. Some people's experience has been positive and they can tell people. We've got lots of people who have had positive experiences. One aspect of it is getting in and the other is the responsiveness.

Resident 6: My experience was to do with employment. I knew about the service but finding someone to talk to who doesn't just tell me what to do empowered me. I left with things to think about and things to do. For me, it was about taking control.

Agnelo: Now that we have got a service it's about how we get people to access it. There is still a stigma. People don't want to access specialised services even though they come see you regularly as your GP with these problems and you suggest that someone else might be better qualified to help.

Resident 2: My friend was referred by the GP but we had to wait for them to contact us.

Agnelo: Now you can just ring the number yourself. You can go through online as well but doing it by telephone is much easier.

Elsie: That word 'therapy' frightens a lot of people. It puts some people off.

Agnelo: We need to figure out how to get more people to use it. One in four people are going to have some kind of psychological need, so how do we signpost people? We are launching beta testing live tomorrow on the app Health Help Now of a button for mental health assessment. It will take people to a series of questions and if they need help it will point them to IAPT.

Resident 1: It is the Croydon app?

Agnelo: It is used in other areas but this is the Croydon version.

Elsie: How many people have apps? Not everyone is computer literate.

Agnelo: The people who ask me for apps the most are the older people in my surgery. They haven't got a smartphone but they say ask for it anyway, and say they'll get their grandson or daughter to do it. In any case, the older age group are the smallest one, and the ones who don't have smartphones in that population are a very tiny group.

Elsie: How do you deal with those people?

Agnelo: You've got different channels. In being more digital, age is not the issue

Resident 3: Your point about communication is a very valid one. I also think you need to market these things in places where people actually go irrespective of age, and we know that more young people are affected. We mentioned more capacity in the system, I don't know exactly what you mean by that, but I would like to see more professionals supported and more service users and carers going into different places. Let's start at schools. Let's go to community centres. What about the GP federations being more active? I know that GPs are overburdened and overstressed but so are service users and carers. I would like to see my GP practice at the end of the working day being opened up to invite some of the community to come in and learn about Croydon Talking Therapies.

Agnelo: That is part of the social prescribing offer for every practice.

Resident 3: There is an incorrect assumption that things in the south of the borough are easier than in the north of the borough. I know the data and I know there are

huge pressures and changes. The fact is that 1 in 4 people have mental health issues and they are based all over. I think it's about time that more positive action was taken in the south of the borough.

Resident 2: Like this lady's coffee mornings.

Agnelo: All GP practices are promoting talking therapies all the time and have got loads of leaflets.

Elsie: If they have a day centre or places like that they need to be involved.

Agnelo: Part of social prescribing is community hubs. When I talk about social prescribing, even the GPs believe something can be done differently.

Resident 3: How is the CCG going to encourage that?

Agnelo: I wasn't at the meeting yesterday, but the network had their meeting and my project manager texted me saying they all want it now. I don't need to move them along. There's a lot more happening at the moment. The other thing is that some practices have the talking therapies located in the practice themselves.

Elsie: I think that is helpful.

Resident 2: You know where your GP surgery is so that's helpful.

Agnelo: The whole point is to build resilience rather than dependency. If people are in need they should be helped to get back to normal. The other thing is how to prevent people from needing it at all, so we have to start at schools as well. We know that young people are under enormous pressure. Last week we had five young people at Croydon hospital that have self-harmed.

Elsie: I called in at 5:30pm yesterday to talk about the computer and the things that affect the children. Before you're 25 there's something in the brain that is turned off and that's why these young teenagers behave in this way.

Agnelo: Now they've got social media.

Resident 1: I think about all the foolish things I did when I was a teenager, but nobody knows about them because they're not on social media or anywhere online.

Elsie: The abuse, too.

Agnelo: The talking therapies are for adults but in Croydon you've got fantastic younger people services. There is Croydon Drop In, in the south, and Off the Record, in the north. I've only heard good things.

Elsie: We heard this young girl today (at BME Mental Health event) who worked with the young carers.

Agnelo: I know you're governors of SLaM and as a commissioner it's about spending resource. Are we spending the money the right way? For younger people for example

we've got CAMHS (Children's and Adolescence Mental Health Services). It's about how we can use our resources differently and how we change our statutory services.

Resident 2: We need to know how they're performing now to see whether they're attracting people.

Elsie: You started to gather evidence and that's what you're moving on.

Agnelo: I think the talking therapies went out of fashion in Croydon because it took so long to get an appointment, but now the waiting time is less than 2 weeks.

Resident 2: My friend had to wait very long.

Agnelo: We need to consider how to market it differently. It's about approaching each different age group.

(Session ends)

Table 4 - Session 2: (17.34 to 17.53)

Elsie Sutherland: Facilitator (ES)
Dr Agnelo Fernandes: Chair of NHS Croydon CCG, and GP
Resident 1
Resident 2
Resident 3
Resident 4
Resident 5
Resident 6

Themes that came out of the discussions:

Services:

- How can we get the community more involved, use volunteers to support services?

Knowledge and communications:

- Diversity of population make a challenge, particularly over 150 languages. How do we communicate and deliver services better?

Support:

- How do we provide support to diverse audience?
- Are there ways of connecting with people not in a focus of needing mental health? Promoting mental wellbeing as much as mental health services.

Full Discussions

Elsie Sutherland: Let's introduce ourselves. My name is Elsie Sutherland, I am a facilitator here but we have a doctor who can put information to you. I volunteer for CCG and Healthwatch.

Resident 1: My name is Dominic, often shortened to Dom, and I work in patient participation in the north of the borough.

Resident 2: My name is Jill, I'm living in the south of the borough now. I have been a governor of SLaM representing my constituency in Croydon now for 4 years. I've found that it is very difficult to get a hold of the public in Croydon, although we did have a meeting which was well attended.

Resident 3: My name is Angela. I'm a Croydon resident and governor of SLaM and have been a carer for over 25 years.

Resident 4: My name is Raghu Shetty. I am the president of Asian Resource Centre of Croydon. Before Healthwatch was born there was something called CLCC, of which I was a member. I live near Kenley but spend most of my time around here.

Resident 5: I'm Jane, I work for SLaM. I used to work in psychiatric clinics, and I have just started to work to help patient involvement in adult mental health services in Lewisham and Croydon.

Resident 6: I'm Gloria and I'm a semi-retired nurse in the health service. I run a few awareness groups and work with young people

Resident 7: I'm Agnelo Fernandes and I'm a GP in Croydon.

Agnelo: We recently rebranded IAPTS as Croydon Talking Therapies. However, based on the size of our population we are not getting enough referrals, so there is an unmet need and we now need to ask how to get people to use the services. We recently sent rebranded leaflets with correct information to households in Croydon, which we are hoping people will keep and use. There are two groups we try to target. The first is people with long-term conditions, who are likely to have a psychological need upon diagnosis. We hope that their GP or practice will encourage care. The second group is people with any other form of mental illness where they feel they need support. We've got a whole list of them on the leaflet, which is now available in all practices. Our services can be used online, face-to-face individually or as a group of about a dozen people at a time. We are rolling out group consultations for many long-term conditions. The last discussion was about empowering practices, but we also need to consider how to get the community involved. This service is for adults but we also have a voluntary sector for younger people. This is about minor mental illness, but people with major mental illness who might still benefit often don't get access.

Resident 2: I think it's quite daunting for some people to meet someone and just talk about it. It can be daunting to go to a party as well when you're not in a mood. There must be a way to ease people in. What's the process?

Agnelo: You have an assessment on the phone.

Resident 2: Some people don't like to talk on the phone.

Elsie Sutherland: Somewhere in the GP surgery they should have voluntary trained people who can listen face-to-face, because that is better to build a relationship. That's how I would like to see a way forward.

Resident 6: I suppose if you treat it like you're having a party you should invite people that you know. We can just say we're having a general talk and take it from there. If you have that on a regular basis, then you start getting to know people a bit better. It might take a longer time but it could be arranged at a GP surgery.

Agnelo: One of the things I noticed is the diversity of the population of Croydon. Over 50% is not Anglo-Saxon white and 150 different languages are spoken. It is especially hard to involve the Asian and Eastern European communities whose first language is not English.

Resident 5: Talking therapy is difficult if you don't have the language or don't have a verbal way of communicating. The word 'talking' is still quite a barrier to me.

Elsie: It's like a medical term.

Resident 5: Everyone who uses the word 'therapy' thinks their way is the only way to do it.

Resident 2: If you meet somebody who is not familiar with your background, culture, or language there is immediately a barrier.

Elsie: Once a month on a Wednesday we have the 'A Place at the Table' thing where you have speakers and people doing different activities, and most of the people there are from the Asian community. We go on outings and sometimes they go to the seaside with us.

Resident 2: You get to know them. You need an immediate rapport if you're approaching a stranger.

Elsie: One pulled me aside to talk to me about mental health and the services available.

Agnelo: My mother could not comprehend mental illness. If over 50% of the population does not speak English as their first language, how do we break away that taboo and encourage them to use any form of therapy or recognise mental illness?

Resident 5: Can we sell it as mental wellbeing?

Resident 3: That's a WHO term.

Resident 5: Mental health is not just the absence of mental illness but about having a good life. I don't know if it would be considered too much an unfocused use of public money to offer it as wellbeing.

Resident 4: How do you go about identifying the languages and cultures and then actually targeting them. That is not easy.

Resident 3: You're right about cultural differences in how people respond to mental illness. I come from an Italian background and we look after our own, as Asian cultures do, and there's often a stigma. Why don't we invest in some chain of development for people from those diverse ethnic backgrounds who can actually engage with their own populations. Not in a hugely difficult or very high-level way, but marketing and introducing them to this service. Maybe it would be somebody who has actually used it themselves.

Resident 5: Like a health champion. For a lot of people just a warm conversation and introduction helps.

Resident 2: They need to find their way to somewhere where they feel happy and at home.

Elsie: That lady knew me from going to dance class, and something I said made her think I seem knowledgeable so she pulled me aside.

Resident 4: It's quite complicated because if you do that you'll be accused of bias towards one group or other. This is what happens. That is why you've got a limitation of budget. You can't train so many when you've got 150 languages.

Resident 5: You could start with the bigger ones.

Resident 6: I find that food is the way to get people together. Dancing, too.

Resident 4: In my company we eat together all the time.

Agnelo: For example, the ARCC could promote it.

Resident 4: There should be some mechanism whereby we can refer them to somebody responsible.

(Session ends)

Table 4 - Session 3: (17.56 to 18.16)

Terence: Facilitator
Dr Agnelo Fernandes: Chair of NHS Croydon CCG and GP.
Resident 1
Resident 2

Themes that came out of the discussions:

Services:

- Which services are being used well and which not?
- GPs and other areas of access need to be mental-health friendly locations in a similar way that they are dementia-friendly, from receptionist to health professional.

Knowledge and communications:

- Message needs to get out about capacity.
- People with low level mental health issues don't realise that the service is for them.
- Need to get out into the community such churches, mosques rather than relying on online resources.
- How do we normal discussion of mental health issues?
- Promote mental health first aid training

Support:

- Difficulty in filling in assessment forms for those who cannot read and write.

Full Discussions

Resident 1: My name is Shirley. I am from the ABM Forum and I am trying to start an organisation called Health News.

Resident 2: I'm Jo and I'm a health and wellbeing worker at Crisis UK.

Terence: I'm Terence.

Agnelo: I'm Agnelo Fernandes and I'm a GP. This discussion is about general practice in the community in terms of how we identify people who might be suffering from minor mental illness and getting them to access services. The service in Croydon is currently underutilised. We have a national target to meet and there has been a lot of investment, but people are not using the services. IAPT has recently been rebranded Croydon Talking Therapies. We have done a leaflet drop in the last month or so but we haven't seen any change so far. We have online and face-to-face individual or group therapies. It's easy to access, people can self-refer online or by

telephone. Why are people not using them, considering that 1 in 4 people are likely to benefit?

Terence: I remember from the IAPT talk that there are online services, one-day workshops, six-week groups, guided help, counselling, and CBT. If it is not being used then the possibilities are either that the service is not needed, people don't know enough about it, or the barrier to entry is too high.

Resident 3: Everybody who has been to it has benefited.

Resident 2: I stopped referring people because there was such a long waiting list, so it's news to me that there's all this capacity. I think the message needs to get out.

Terence: IAPT being underutilised is interesting. It might be useful to see which services are utilised and which aren't. What are the barriers? These could be a lack of knowledge or a lack of easy access.

Agnelo: Access is easy.

Resident 2: Another barrier is that once you're accepted you have to fill out those scales. I support a lot of people who can't read and write so they can't do the questionnaires.

Resident 4: That can be done on the telephone.

Terence: There is demand, but a lot of people who have these low level mental illness don't recognise that they can be helped by somebody other than themselves. They don't realise it's a service for them. I don't know to what extent this is the issue.

Resident 2: Possibly.

Resident 1: I think it's a conflicting statement that you didn't refer because of the waiting time and he said it's not used.

Agnelo: The waiting time has come down.

Resident 1: Yet the uptake is still not good.

Agnelo: It's not being used across the board.

Resident 1: How many BME specific trained CBT therapists are there in proportion to the BME statistics in mental health?

Agnelo: The problem exists even before they get into it and before they contact the service. The dropout rate is negligible.

Resident 1: When you have a therapist, you need to have certain things like culture and faith. All that impacts your therapy. I think the public should go to the mosques or the Christian churches to make them aware of the service. Some people can't

even go online or don't bother to go online, so you have to go them. Go to the barbershops, the hairdressers, or the mosques.

Terence: We want people to feel it's a service for them. As a member of the public I would want somebody who comes to me who is my kind of person, and who says they are either a user or provider of the service.

Resident 1: We need people specifically trained in each person's issues.

Agnelo: That hasn't been the barrier so far. The barrier is getting people into the therapies in the first place. 50% of the population in Croydon is BME and we've got 150 different languages spoken. I know from my own patients who are Eastern European, Asian, and Afro-Caribbean, that it's very difficult to get them to think they've got a mental problem and that talking therapies will help. They want something physical, like tablets.

Terence: In those cultures, talking issues are dealt with by family or their network.

Agnelo: There is a cultural issue in people thinking they can't benefit.

Resident 1: Back home people don't get tablets, they talk. You've got extended family. They go for natural therapies or talking to the family.

Agnelo: Back home there is also a stigma attached to mental illness. My own mother didn't understand the concept of depression or mental health. Things get swept under the carpet rather than addressing them. But you're right, churches, mosques, faith groups, and barbershops are important. I didn't realise that young black men spend more time in barbershops than anywhere else, so we started a barber project with Nike.

Resident 1: Youth clubs.

Terence: If there is a cultural issue of stigma, I don't know, but normalising mental health issues is a big, critical issue. One idea was having ambassadors in the workplaces. We give them a template saying they should have an ambassador with certain traits and we help them with information. They keep tabs on people, so they don't suffer in their careers or are stigmatised because they have a periodic mental health issue.

Agnelo: The workplace and all these other areas are important. The message to employers is that 1 in 4 members of your workforce will have some kind of mental illness at some time. The bottom line issue is that these people will be off sick and affect your productivity.

Terence: What you've given us here doesn't tell us why people are not coming in. It could be stigma, it could be cultural, it could be lack of information, I don't know.

Agnelo: It could be a combination of all, but we don't know because those are the people who are not engaging.

Resident 2: Do GPs check in to see if people they've suggested the service to have used it? Should there be someone who facilitates referrals? In my role, a lot of what I do is making referrals and going to appointments with people because they just don't get there. It's a lot of picking people up and taking them places. It could be that there's a group of people who feel the stigma or are shy or whatever. You need an extra person.

Resident 1: Maybe we have to start to think outside of the box. We could use innovative ideas like drama and music to educate people.

Agnelo: We need to consider the different communities that might respond to this. We've got a lot of Eastern Europeans who aren't connected to the local community.

Resident 1: You're bringing culture into the drama and the music to communicate it.

Terence: I came here as a child and it took me 11 years before I felt I knew the system. I think people just don't know enough. GP awareness of mental health is very good. However, people can be very sensitive and if the first interaction with the system is negative then they retreat, especially if it's a lower level issue. The first interaction is the person who answers the phone, and this is not a medical professional. They could be having a bad day and if the person comes in and sees that they will not interact with the system at all again.

Agnelo: I think you've hit the nail on the head with that. We're talking about GPs but it's actually about GP practices. We've got dementia friendly places now, so why can't we have mental health friendly practices? We could have basic training and awareness training in terms of how you interact with people. The first point of call is the receptionist, so how do they respond?

Resident 2: I went to mental health first aid training, which was a bit too low for me but that normalises it and asks people not to be so scared of it. The Mental Health Foundation runs it. It's not free. It's ideally for people like receptionists.

Agnelo: We should emphasise this.

Resident 1: Sometimes you go to the GP and the receptionist asks why you want to see the GP. They should stop doing that.

Agnelo: It's a double-edged sword. As a GP I get people who don't want to tell the receptionist why they're there but it's for something somebody else is meant to do. They end up seeing the wrong person for the wrong thing.

Terence: Related to that, no shows are a problem but the number of no shows could be reduced.

Agnelo: Every practice has got policies in terms of how they address this problem, but it's about one fifth of all patients.

(Session ends)

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healthwatch Croydon

Meet the changemakers… and get involved

Adult Mental Health services

Acute hospital services

Questions and answers

Wednesday 18 July 18.00-20.30

CVA Resource Centre, 82 London Road, Croydon

In association with

NHS Croydon Clinical Commissioning Group

NHS South London and Maudsley NHS Foundation Trust

Table 5 - Session 1 (17.08to 17.28)

No notetaker in place

Table 5- Session 2: (17.29 to 17.52)

Tariq Salim: Facilitator (TS)
Pat Knight: Facilitator (PK)
Christopher Fox: Clinical Services Lead (CF)
Resident 1
Resident 2
Resident 3
Resident 4
Resident 5

Themes that came out of the discussions:

Services:

- Care Programme Approach relating to home visits.
- What rehabilitation services and therapy are used while people are on the Bethlem wards, particularly as gym and swimming pool are currently closed.
- Inconsistency in environment between locations at Bethlem and the Maudsley.

Knowledge and Communications:

- Lack of consistency of awareness between GPs. Information and education of GPs is needed to inform and refer patients better.
- Better mapping of services would bring improved signposting.

Support:

- Support services for those being discharged including onsite welfare office and advice on benefits and further support provided by Mind.

Full Discussions

Tariq Salim: Acute Hospital Care is the topic.

Christopher Fox: Somewhere highlighted the difficulties around head pressure. Does anyone have any additional thoughts on their experiences?

Pat Knight: I was just thinking, when people leave hospital, what provision is there for advice on benefits? People are made very anxious on having access to housing benefits and all that, so what is the provision there?

Christopher: We have a welfare office on the site in Bethlem, or home treatment, and they can all access this forum. When someone is well enough, in terms of their mental state, they can then access this forum. If someone's discharged without that in place, it'll cause additional stress.

Pat: They might have somewhere to live, but don't know how to claim benefits.

Christopher: That's why we have the welfare office on site. They'll be supported. In some places, they'll be provided with monitoring.

Pat: Is there ongoing support?

Resident 5: Unfortunately, our care coordinators are not experts on benefits so what we do is link in with Mind. The benefits people on the ward are proactive.

Pat: Does SLAM link like Mind?

Christopher: We do, and we have Look Ahead. The role is to go to the ward and work around issues that cause stress, to make sure that before we discharge, those environmental factors can be addressed. Anything else around the acute side for mental health?

Resident 3: Who is there in contact for when people are discharged?

Christopher: It depends on the individual and their needs and we have obviously, the relevant community teams and ongoing care if it's felt that it's needed. The main thing for us is to really listen to individual needs and put in a package that's suitable for them, upon discharge. It's about how to support them.

Resident 5: Everyone that is discharged from hospital will get a seven day follow up from community teams? Everybody will be given that?

Christopher: People who have more needs upon discharge will come to my team. We try to support them with that recovery so, it's very much tailored to the individual.

Resident 3: What services are available for people who have to come in and then we can contact the Care Programme Approach?

Resident 5: I don't work with all the ages at the moment, but we have specialist older adults who have more access to what people over 65 would need in the community. These are people that will go in or Peer Support.

Resident 3: Especially the older people, because I do a lot of home visits. The only contact they have is a carer who comes in. These people are becoming more and more depressed.

Christopher: They have home treatments as well as adult services. I think that's something that SLAM will be looking at. A way for that isolation will make sure that people can actually engage in what they need to. I don't think that's necessarily when they leave hospital.

Resident 5: They've got more links in with GPs to think about how we work with the older adults, and I don't have all that information but I'll take it back.

Christopher: Are there any other experiences? Anything else in terms of acute or home treatment experiences?

Pat: What about people who are in Bethlem over several weeks? Is there any meaningful activity provided for people who didn't engage with?

Christopher: To clarify, in terms of the activities that we do?

Pat: Just rehabilitation activities and therapy.

Christopher: I think, looking at the patient, once they have a lot of services around, in terms of physical activities, wellbeing and all those things to support individuals, it very much depends on where an individual is, in terms of their care. We try to support an individual's need when it's appropriate for their care. We have lost the gym and swimming pool in Bethlem because the building structure is not sound. I don't know what they're doing about it but I'll have to find that out and speak to my colleagues.

Pat: In terms of surveys of the patients, what kind of patient feedback do you get? I know you have an annual report. What issues does that raise?

Christopher: The trust has an anonymous service that comes back.

Pat: What do patients like and don't like?

Christopher: Home treatment teams like the frequency of seeing people, and the fact that our staff can come and sit around for half an hour. On the flip side, we struggle with consistency in terms of the way that we treat patients. Because we see people so frequently, we are not able to send the same people so it can be different people. We know a lot about every individual.

Pat: There's quite different services in the services in Bethlem and across King's. In terms of provisions for patients, my husband had dementia and he was admitted to the one in Maudsley, and he came back to Bethlem and Bethlem is very good. It has good outside space. Not only was it miles away, but I mean, it was very claustrophobic in the Maudsley one.

Christopher: We recognise how lucky we are with the Bethlem site.

Pat: It also wasn't a very nice place to go to. Chelsom House is very attractive and there was always someone to talk to.

Christopher: That's very good for you and your partner.

Resident 5: Our sites are different, you are right. With Maudsley, it was built a long time ago but it might look a bit different if you go back. There's always feedback and one-to-ones, and these are some of the things we've picked up as a trust and are working on.

Christopher: Is there anything else in terms of home treatment teams?

Pat: The gap is due to the lack of consistency within GPs. Some of them are less aware on mental health.

Resident 5: That's interesting because I manage IAPT service. It's interesting that they all give the same information. We were talking about whether there is more training and teaching that we can do with the GPs.

Christopher: The theme I heard from the earlier session is that it's not just giving the information to GPs but also education of the GPs. What came across was that people were seeing GPs and were told to go to places and didn't know where they were going. We try to highlight all of these problems and that's going to be fundamentally important.

Resident 5: For Croydon, there are lots of services in Croydon that not everyone knows about, so there needs to be a bigger mapping.

Resident 3: Do you have any contact for those services that have been referred to by GPs?

Christopher: Age UK. I don't know what the leads are, unfortunately, but I can find out for you, for sure.

Resident 5: We can check.

Christopher: I'll make a note of that.

(Session ends)

Table 5 - Session 3 (17.56 to 18.16)

Pat Knight: Facilitator (PK)
Christopher Fox: Facilitator (CF)
Resident 1
Resident 2
Resident 3
Resident 4
Resident 5
Resident 6
Resident 7
Resident 8

Themes that came out of the discussions:

Services:

- Difficulty in terms of distance to go to Bethlem for acute services – could some of these be provided nearer?
- SLaM services are now divided by borough – what does this mean?
- Working on the barriers to access of services based on geography for Croydon residents.
- Issues when medical services are under South West London NHS but mental health services sit under South East London NHS.
- There is a grey area with secondary care and community-based care. Clarity needed that community services is the access point to community care

Knowledge and Communications:

- Outsource of signposting number to another trust who does not know the information.
- Better information sharing is needed between GP, hospital and other provider, so that provider knows each patient's specific needs.
- If someone goes to A&E and it out of hours where do they go for information.

Full Discussions

Resident 1: I'm here because the concerns I have about the Croydon University Hospital, SLAM, and some of the other services available.

Resident 6: It's over 30 years since I've had a relative who actually died of the psychosis. Apart from that, I know very little about the conditions that people turn up with in Acute.

Christopher Fox: There are a number of layers of acute services in Croydon. We have Psychiatric Intensive Care Unit wards which are more intense, and we also have our home treatment team.

Resident 6: If I turned up with a rash, it's a rash. The only condition that I know is acute depression and psychosis.

Christopher: Ultimately, it means that you need to have an individual crisis. It's the crisis and the mental state of the individual, and that could be anything that affects their mental state, such as depression, anxiety, and it can be anything in terms of learning difficulties. There are a number of factors in terms of mental health, the main thing is how severe the crisis is, rather than a diagnosis.

Resident 8: What does IP mean?

Resident 6: Internet protocol.

Christopher: If an individual wants access to the acute treatment, the assessment team and the acute professionals will contact the Acute Resource Centre and will discuss the best treatment for that time. The primary thing here is to achieve recovery in the home and to look at whether we can avoid admissions.

Resident 6: It really means that it's going to go to Bethlem, which is out of our way. Those distances, particularly for families in financial difficulties.

Resident 8: They were sending people to Burgess Hill. I have a question in relation to your telephone number. The telephone number on the SLAM number is a 600 number. There is no Janice Wallace House number on there. This switchboard is administered by an agency which doesn't know what is going on.

Christopher: It's outsourced to another trust switchboard. The number for Janice Wallace House is there. The problem we have is that when it's outsourced to this number, they don't necessarily know what the different names are.

Resident 8: They should have some line directory.

Christopher: I will feed this back, because it's something that I feel that we need to work on.

Pat Knight: When you talk about just providing for Croydon, rather than all the boroughs, what exactly does that mean in practice?

Christopher: It's an open book. The division is rather than having services go across boroughs, we'll have smaller sub-sections inside of Croydon. We have control now, of the senior management for Croydon. We have a Croydon ownership and we will listen to individuals to find out what Croydon needs.

Resident 8: In a nutshell, it's going back to when Tony Goss and Steve Davidson were the borough directors.

Pat Knight: Does that mean that residences of Croydon would go to Bethlem?

Christopher: Older adults are slightly different. It'll be the aim for Croydon residents to go to Croydon hospitals. That's why we want to prevent admissions.

Resident 8: I know somebody who had already set up for sectioning. The ambulance, doctors and police were all ready, but there were no beds so, the home treatment team stepped in. I raised this with Michael and Beverly and they said that it shouldn't happen, but it did happen.

Christopher: I can only talk in terms of our vision. Our vision is creating a much more efficient London Borough of Croydon services right across the community. We want to be able to treat people appropriately and quickly. The nature of that will mean that we will have a lot more bed capacity. We want to do work in communities which work on the barriers for every individual. We want to make sure that if they end up admitted, that information will already be there.

Resident 1: I think you've spoken about the acute referral centre. One of the issues is that in terms of medication, when someone comes in a crisis, do you have all the information about them? It doesn't seem that the university and the GPs communicate a lot of information. For example, if someone has a serious allergy to lactose and is given a medication which has lactose.

Christopher: We definitely have to better the communication. The systems used are quite different. I'm going to write that down so that I can take it back.

Resident 8: Croydon's medical services come under South west London. For Lambeth, Southwark and Lewisham, they come under the same region. They can't do it here because it's different regions.

Resident 1: That's what I'm trying to say.

Resident 6: Croydon is only just starting over the next couple of months to do that because when you phone 111, at the moment, the doctor gets asked to go to a care home, and he will have the record when he goes to the care home. He will have your personal record. That is coming but it's lagging behind a little bit. All of these people have to be connected to the system.

Resident 1: I know but, in the process,, you are losing people.

Christopher: There are systems in place but I think that we still need to take your point. That's something that SLAM have struggled with. If someone goes into A&E and it is out of hours, how will they get the information?

Resident 1: That's right.

Christopher: We will take that on board.

Resident 3: There's a grey area as these are technically under the secondary care but are community-based.

Christopher: They're trying to get across here that this is the access point. This down here, which is our community service, if it is decided that we need to make

an assessment, you can come to assessment liaison. This is a structure created around the old pack model. That's where that happens. Some of these over here are more into acute. These teams are all our acute services, so it's almost like another layer.

Resident 3: What about the specialist services?

Christopher: They come from us, but they have to come from here. We are looking in the next 3 to 6 months to look at quick ways to improve the services that we have now to make the services better than there have been.

(Session ends)

Table 6 - Session 1: (17.08 to 17.29)

Ros Spinks: NHS Croydon CCG Engagement Manager, Facilitator
Marlon Brown: Head of Mental Health Commissioning NHS Croydon CCG
Resident 1
Resident 2
Resident 3
Resident 4
Resident 5
Resident 6

Themes that came out of the discussions:

Services:

- To many people arriving at A&E or in acute care when they don't need to be there.
- Heavy demand on forensic services.
- Role of pharmacies in delivery some services.
- Need to deliver change in phases.

Knowledge and Communications:

- Sharing information to improve services.

Support:

- Lack of suitable housing and support for those rehabilitating from acute care.
- Role of voluntary and third sector organisations in providing services.

Full Discussions

Resident 1: I'm a Croydon resident.

Resident 2: Deputy Shadow for Health and Wellbeing.

Resident 3: (Inaudible).

Resident 4: Jo, I'm a Health and Wellbeing officer (ph) at Crisis.

Resident 5: My son has mental health issues.

Resident 6: My daughter has severe mental health issues.

Marlon: I'm Marlon, I work for the CCG. Mental health and acute care, both accessing, and many individuals who are in crisis care and acute care need to come back into the community. Crisis care, individuals presenting at A&E. We've seen huge increases so far. With the amount of mental health attendances that we do have at Croydon University Hospital. Increasing delays with having many individuals who are just left unfortunately within the A&E setting. Some are there so long they're admitted to a non-mental health acute setting. Just a mismatch of provision. Not good for them or other patients. Across South East London, we're talking about bed pressure. When you used to find things like that happening, you could get a private bed. Nationally, there have been a number of instances where there aren't even private beds available. We've just got blockages across the system in that way. People are going into hospital in crisis, not being seen in the right amount of time, not being transferred to the relevant mental health providers. Still in crisis without being seen or being admitted into a non-mental health acute setting, which is not where they want to be.

Individuals leaving hospital from crisis care, as pointed out, our biggest issue is housing. So we've got a lot of individuals who are clinically ready for discharge but have lost tenancies, supported accommodation providers sometimes don't want them due to level of complexity. So if someone has a mental health issue but has had a couple of instances of arson, at the moment that's a big issue. Potentially even if it's years ago. Adequacy of provision regards what is acceptable to put someone with a mental health condition in, to allow them to continue to receive treatment in Croydon. Someone leaving an acute setting, putting them in the worst possible accommodation, surrounded by individuals who might have substance misuse issues. Not a conducive environment. That pretty much sums up the issue. Bit of a vicious cycle around acute crisis care. We're very open to potential suggestions individuals have to tackle some of those issues.

Ros: One phrase you said, 'Ooh I'm not sure what that means.' Forensic inmates?

Marlon: Offences of the forensic nature. Sexual assault, murder, high levels of violence. Once it's gone to court, if the judge or jury have decided that those actions, criminal activities, have been done under the influence or due to a mental health ailment, they're not sent to jail. They access forensic services. Nationally as well as locally. Some of those individuals will eventually be able to be discharged into community services. You might have a treatment order of 2 years in a rehab setting when your mental health condition and your offence are addressed at the same time. Then individuals will be discharged into the community. However, you cannot not disclose the index of offences. Lots of providers don't want or aren't geared up to what they feel will be the disruption. We are very much struggling around that.

Croydon has become a net importer. Due to how the borough is set up in terms of the land, lots of providers can come in, find land, set up care homes, private mental health accommodation. If they're not commissioned through Croydon CCG, they can go and get service users from other areas, to fill their placements within Croydon. Which the CCG can't stop. All that means is if a person is imported from another borough and becomes ill, it becomes Croydon's responsibility. That is affecting capacity and the bed base issue.

Resident 6: Just recently I feel there's been a massive impetus. Talking therapies service, IPAT, has really taken off. It's easy to access. Long may that continue. Also, things like Recovery College, another innovation that is happening in Croydon. Doing a great job. I'd like that to continue. What's been said today, the nurses going out with (inaudible). That seems a no brainer. We want more of that straightaway. Nothing worse than going to A&E.

Resident 5: All the questions I was going to raise, you've covered and more, because the A&E issue, I've been through all of that, sat for hours with a mentally ill loved one. He's absconded, a nightmare, police were involved, missing persons, it was terrible. It didn't improve a year later even though it was highlighted. Then you have this Core 24.

Marlon: Nationally prescribed service. Most A&Es have a psych liaison team. It's not enough. Lots of service provision isn't enough. They were provided with more money for CCGs to enhance the psyche liaison service already there. Core 24 has been given that name because what they class as core team around psychiatry liaison and regards 24, it runs 24/7. At no stage of time should you be short of a psychiatry liaison nurse or a psychiatrist at any point of time. Ours is not the best. It needs drastic improvement. We're working closely with Croydon University Hospital and SLAM who provide that service. Lots of it is around the scenes. Lots of the escalation processes. How we share information at the right time. How we can improve pathways that already exist by using more resource without draining capacity. It can get better. It's improving.

Resident 6: Pharmacy service is pretty good. They've now said that they're going to have a pharmacist resource centre. Why didn't that happen before? I'd like that to be done as soon as possible. They're the ones with the great expertise with medication.

Marlon: I was at an NHS England conference 3 weeks ago and had a presentation from a chief pharmacist where they have begun providing the physical health test. Our expectation would be that SLAM do that and GPs do the other 10% but these are our other existing services. They can be provided by community providers.

Resident 2: Yes.

Marlon: I have a question. Where do you think organisations such as yourselves, voluntary sector organisations and infrastructure in the borough, how would you feel you can support crisis care in Croydon? The focus always seems to be at the acute end, secondary care, so it's around prevention, even at the point of crisis arising. How can I manage in the community?

Resident 2: When crisis is happening that does need to be secondary services, although there is a role. There is some talk about crisis café ideas. The third sector can play a role there. Services outside office hours, so you pick up people who are starting to struggle as the day goes on. We also have online services who come to us at 9 o'clock at night. Prevention is about making sure community-based services are well known about, well linked in, and pathways in both directions are working. So GPs are aware of where they can refer people, but if people are with us and we're concerned about deterioration, we have an easy way. It's got to be two-fold.

Resident 1: Is there a plan for mental health staff?

Marlon: CCG or hospital?

Resident 1: Also talking about communities, do you know where those gaps are for staff?

Marlon: From the CCG point of view, commissioned services are provided by SLAM, and there are local providers of community voluntary services. There is a mental health strategy devised and written by the council. How much of that is being delivered? I won't be able to give a sense on that. One thing we're trying to get away from, since I've been here. I've seen the mental health strategy, Mind the Gap Report for Croydon, we've done engagement events like this over and over again. What we've realised is we're going to be very focused on what we're trying to achieve. Split it into phases. Not to do everything but focus on what we need to do now. Crisis care is one of those. How we use existing community resources. Primary care as well. Vital, that needs to be addressed. If we put the right infrastructure in place, we might need investment. It's not a business case where we're expecting things to happen magically. We're going to ask for money to deliver. We don't want to deliver services in silo.

(Session ends)

Table 6 - Session 2: (17.33 to 17.54)

Ros Spinks: NHS Croydon CCG Engagement Manager, Facilitator
Marlon Brown: Head of Mental Health Commissioning NHS Croydon CCG
Resident 1
Resident 2
Resident 3
Resident 4
Resident 5
Resident 6

Themes that came out of the discussions:

Services:

- People being medicated to manage them because there are not enough beds to support them.
- How do we reduce frequent attenders going round the system?
- How do we stop people getting in crisis?
- Homeless people are regularly signposted to A&E because they can get instant care, which does not seem easy of speedy via GP – need for a homeless mental health service, with direct access. It exists in other boroughs.

Support:

- Some can leave acute beds but due to their complex needs cannot be housed.
- Other suffer from the impact of being in acute wards, means that people lose their housing and can end up homeless.
- Real emphasis on prevention - focus on trauma in childhood so issues don't escalate later in life.

Full Discussions

Ros: Let's go round and say your name. I'll be facilitating the table. Marlon's going to give you 2-3 minutes. Headlines for the CCG.

Resident 1: I'm here to represent Chase Residents Association. I also have a background because I'm a recently retired nurse. I have referred people to the talking therapies. I've moved to this table because I'm interested in the interface between the acute hospital and acute mental health. Having spent quite a bit of time in A&E and seen people very, very distressed an obviously not in the right place.

Resident 2: I'm a Health and Wellbeing worker at Crisis.

Marlon: I work at the CCG.

Resident 3: Mental Health Doctor Croydon.

Resident 4: Croydon Alliance SLAM.

Resident 5: I'm from Healthwatch Croydon.

Resident 6: I'm from Healthwatch Croydon, and Mind.

Marlon: High numbers of people presenting at acute settings. That movement on is not picking up. Individuals are leaving the hospital not being seen or are breaching the waiting times that the hospital has and are admitted to non-mental health settings.

Resident 1: They're ending up in the wrong place.

Resident 6: They leave the hospital into limbo.

Marlon: Yes, without being seen, or being admitted to beds not conducive to them in terms of the right treatment, or other patients, families, and carers based on that ward and having distressed individuals. We had a young man who presented at A&E with high levels of autism and learning difficulties, 16 but built like a wrestler. No movement. He was in the A&E for nearly 3 weeks. An extreme case.

Resident 1: He's not old enough to go into adult care.

Marlon: Our transition age.

Resident 1: Children's ward in Croydon is not conducive to him either. 14-year olds. The setup of the wards.

Resident 6: An example at the table I just came from. Someone was sectioned. There were no beds. He was going through a psychosis episode. No beds in the whole of South East. He was getting chemical injections so he was kept on a trolley for 3 days.

Marlon: I can confirm the bed issue, 100%. It's not something that's specific to Croydon only. It's across the whole of South East London. Probably a national issue to be honest with you but we need to focus on what we're doing in Croydon. We are talking with other commissioners locally about what we can do as a system but at the same time that probably won't address what we need to do in Croydon as quick as we want to do it. The key things I would like to ask is what you think you can do beyond what's currently happening in an acute crisis perspective.

Resident 6: The stream coming in, you want to decrease the size of that stream. You need to identify people to make preventions. Where are the people coming from? Homelessness, indebtedness, previous patients coming round the loop, and they have different ways of coming in. How can we intervene earlier and identify the streams coming in?

Marlon: The ones going round the system, definitely. We have a piece of work linked called Frequent Attenders. That is that group that just go round and are known by community, hospital, SLAM.

Resident 6: They know the system very well.

Marlon: Yes and how to navigate it to fit their needs. Crisis care. The other point you were raising. We always seem to be so focused on when people are in crisis. From a national perspective, the CCG have been asked to provide crisis care. They haven't told us, 'Stop people getting into crisis,' it's, 'When people are in crisis, have Core 24,' etc. We've already organised that. It's still not. At the end of the day we will have to throw more money in it if we're not addressing what is making people hit the crisis point.

Resident 2: I'm representing homeless people but I often have to advise them to go to A&E. They can't attend GP appointments, it's 3 weeks. I send them to A&E. It needs to be prevention but you get someone to the GP that takes weeks, they don't have a phone, sleeping on the streets. GP doesn't really understand how mental health works. They write a letter to SLAM. Doesn't get through. Assessment liaison find them too complicated. I end up sending them to A&E.

Resident 1: The people turning up on your frequent attenders.

Resident 2: 100%.

Resident 1: What's the input for those frequent attenders?

Resident 5: With homelessness, is there no dedicated mental health outreach?

Resident 2: No, that's what we need. We have a massive street homelessness issue but no mental health services for that.

Resident 6: What's hindering that?

Marlon: We had some money to address homelessness. We had an engagement meeting last week. My council colleague has the purse strings. Employing someone specific, clinical, to work with homelessness. It is there in other boroughs. Homeless mental health service. We are going to have that.

Resident 2: It's costing so much money.

Resident 4: Is there a time between being admitted to hospital, is there a time limit?

Ros: Do they have to be seen in a certain time?

Marlon: Yes.

Resident 1: Four-hour clock is clicking.

Marlon: Nationally there is a lot of pushback. They're trying to keep it equitable. The argument is the time for mental health intervention should be two hours instead of four.

Resident 6: It's four hours currently.

Marlon: If it has to be. Two hours for physical health to make it equitable, it needs to be that as well.

Resident 5: There isn't the resource to do that? Four-hour waits are breached all over the country.

Resident 1: If you're seen by a clinician or the right clinician because yes, they're seen by somebody.

Marlon: At triage point it doesn't have to be a mental health individual. As soon as that person's triaged, you've met the triaging nurse, she can tell you're in crisis. It will only be one of two things. Someone is highly intoxicated, or they're in crisis. Easy to differentiate. Sometimes it can be a combination but with triage, and whether the substance misuse nurse comes first, she will quickly maintain that it's the mental health that is the most predominant factor. At the moment, Croydon University Hospital, we have so many that the team are struggling to get through and see them appropriately. They see people in wards who potentially are having mental health issues. They have a role for existing patients even if they're not known to mental health services. Someone has gone in and suffered a really bad physical injury. That can impact their mental health immediately. A nurse or a consultant may say, 'I think you need to speak to one of our mental health nurses.' Core 24 as well.

Resident 1: How is this staffed?

Marlon: I was looking at this the other day. We have a full complement. Core 24, national service, you can find information online very easily at NHS England's website. You'll find the staffing profile, which is nationally done.

Resident 4: Which hospital?

Marlon: Anyone who needs to be admitted with an acute problem should be admitted to one of our beds.

Resident 6: The number of people presenting with multiple issues is increasing. I suspect a large proportion. Is the system geared with silo issues? Is there a problem moving from one kind of treatment to another kind within mental health? Are there bottlenecks, people moving back and forth?

Marlon: There are bottlenecks within some of our community teams. Anecdotally you can draw those conclusions if people are seen in the community, are they reaching crisis point quicker? We don't have the data to support that.

Resident 6: You're talking about the input stream. There is an output stream. Minimising the numbers being taken care of in Acute. If you can increase the speed of people in the output stream, that's good. A bottleneck of the output stream is housing. Liaising with housing, with the Croydon Council, and housing departments. I presume there are issues there.

Marlon: Yes, in terms of issues, the complexity. We do have a growing cohort of individuals whose complexity in terms of the range of issues that they have on top

of their mental health ailments makes them unhouse-able, unfortunately. Providers, private, community, they're just not taking them. They're clinically ready for discharge from our acute beds. There are also individuals who do have tendencies, fall ill, end up in acute, lose the tendencies, and effectively become homeless.

Resident 3: How many people do you get who are homeless who have to use A&E every week?

Resident 2: Absolutely no idea. Lots of people end up calling 999. I don't know how many. Also we're not working with every single homeless person in Croydon. We certainly call 999. Lots of people go there. A group of people who have lots of needs. It's about prevention at a children's stage. People have always experienced trauma and substance misuse and families aren't there to support them. Prevention needs looking at.

Resident 1: I was just thinking about CAT (Crisis Action Team) car. When a family member phones 999 because someone's in crisis, is that how they could respond?

Marlon: Yes and no. In the sense of we can't guarantee that every caller will get a CAT car.

Resident 6: They sit with the ambulance.

Marlon: Between a fifth and a sixth will be by the CAT car. That's still good. The follow on for that individual will be greater. Services like London Ambulance and Met Police are better at identifying crisis. Some don't do an arrest or section, they call up and get advice if that's a service available. We have that through our Acute Referral Centre. CAT car is all managed by ARC. At Acute Referral Centre, police and London Ambulance can fill in.

Resident 1: Are London Ambulance well versed in this?

Marlon: We had someone out. Bill is our London Ambulance lead for Croydon. We've got it in Croydon, Met police car. CCG have just funded our own CAT car for Croydon for another year. We'll continue to get that. (Inaudible).

Resident 5: Crisis cafes. They've been very successful in some cases. An alternative to A&E. The thing with the word 'crisis', what the system says is a crisis isn't necessarily what someone feels like. Someone may feel they're in crisis, call up Crisis Team, 'You're alright.' They don't feel they're alright. It might be 2:00 in the morning, have taken various things. Crisis cafes, they can feel safe, someone they can chat to, a clinician there. Often after a few hours they feel alright, back on track. A practice model happening elsewhere.

Resident 1: It hasn't been mentioned.

(Session ends)

Table 6 - Session 3: (17.58 to 18.17)

Ros:	**Croydon CCG, Facilitator**
Marlon:	**Head of Mental Health Commissioning**
Resident 1	
Resident 2	
Resident 3	

Themes that came out of the discussions:

Services:

- Need to find a solution for those that need mental health services in the community after 5pm. We need a buffer, a breathing space for this – an enhanced community hub.
- Need to reduce the number being admitted via A&E into non-mental health acute wards.
- Joining up the fragmented range of services into something more integrated.
- Community hubs a combination of health professionals and voluntary community organisations

Knowledge and Communications:

- Need to do effective handovers between services, particular if one is closing for the night.
- Develop or prioritise an integrated care record.

Full Discussions

Ros: I work for Croydon CCG. I'm your facilitator. I'm going to be hands off. Marlon's going to do a few minutes' introduction and we'd love you to talk about crisis cafes. It was brought up.

Resident 1: Here to represent Chase residents. Formerly a nurse.

Resident 2: I work for SLAM. General Manager for community team.

Resident 3: I'm retired from a career in adult social services and just become a volunteer with Healthwatch.

Marlon: Head of Mental Health Commissioning across the CCG and Croydon. This table is going to be looking at acute and crisis care. Crisis care in Croydon is not as good as it could be. A high percentage of attendances in Croydon University Hospital, not our main mental health provider. Due to increased attendances, individuals not being able to be seen in the right space of time, we have individuals leaving the hospital site still in crisis, going back to the community doing god knows what, unfortunately. Or individuals who breach the four-hour waiting limit so they have to be admitted to non-mental health acute wards. It's not the best place for

the patient to be, not the right environment to have their care provided, and for other patients, family and carers, they've got someone in high distress, a non-similar ailment, but housed in that same place. Those are some of the issues we're having. Heightened by the fact that we have a lack of community raised prevention and wellbeing services as well as real issues around mental health housing for people who are ready to be discharged for individuals waiting at CUH or waiting to be moved to the SLAM provision.

We were talking about developing a crisis café. That idea actually has moved on. You're probably not aware of that. It's going to form part of the community hub we were talking about. What started as a crisis café, as you've heard from earlier presentations, there's a 5 o'clock pm service shut down for mental health services. We looked at the café for having a place people can go and relax after hours, probably take part in some mindfulness, calming techniques, see if they can calm down. At which point they can be discharged home or if services are open then, or a referral to hospital. That service would be able to pre-empt that, 'We've had someone here since whenever,' or 'We have to close down, if we don't send them to A&E, we are worried about what might happen.' A kind of buffer. In terms of breathing space. We were playing with the idea of making that a place of safety. Which means Met police and ambulance can take them there. We're not able to do that but we found a model that started as an enhanced community hub in Surrey. Astronomical reductions in A&E, knock on impact on average length of stay. Patient quality has improved. Last thing is occupy bed days. Individuals who needed to be out of those beds were discharged into the community.

We've moved from a crisis café model. Everything they were doing will still be done, it's going to be bolstered. Welfare advisors, benefits advisors, Community Psychiatric Nurses (CPNs) and potentially a consultant psychiatrist. Maybe not every single day but might be 5 days a week.

Resident 1: Good to have extended hours.

Marlon: Yes, the times we've spoken about are an 8:00am start to 1:00 minimum. We know it has to run for 5-6 hours after mainstream service cut down. If someone has turned up, between 05:00 or whenever else, haven't been able to dial back the level of anxiety or crisis, more than likely they need hospital. At the moment there is no buffer. No way to hold that or try to manage that. It's either crisis, hospital, crisis at home, families trying to deal with it on their own. We're talking about GPs, community mental health teams, pharmacists. Anyone who comes across people as they're about to close can call up, 'I've sent them up to you, please look out for them,' and can give them background and history. By the time that person gets there they should have a brief plan for that individual.

Resident 2: My experience is that after 4:30, things close up. There's something about conveying. Doing a handover.

Marlon: So the hubs will be open from 08:00 through to 11:00. The point you make is that it's the quick link in and the quick link out. That's come up the most throughout the day. How are people available to get into these things? Lots of that ties into information sharing. Some robust data sharing agreements. I attended the NHS England event the other day, presentation from West London. The whole

system's integrated care record, council, social care, housing, GP, mental health background on this one record. All these organisations, with permission of the service users. The GP who presented it, one of the clinical leads from Barts, was singing its praises. It's seamless, how she can link in the care of her patient who has to access so many services around their mental health. You touched on the homelessness issue. It's on the record now. A GP is, like, 'Ooh, an issue around this person's house, that's going to impact on their mental and physical health.' They can see, 'Actually that accommodation is always going to have this person going into crisis.' They can get in touch with housing. 'This person has X, Y, Z, so you can't put them in that accommodation.'

Resident 1: Croydon is one trust for acute and primary. When I left they weren't quite sharing. I think they are all now.

Marlon: Yes, what service are GPs on?

Resident 2: EMIS.

Resident 1: Yes and the Trust are on GCIS.

Marlon: None of them work with each other. Everyone's got a different system containing relevant information to the other parties. Even if you wanted to, it would be how? The systems just don't link up.

Ros: Was it Swift?

Resident 3: Yes, in Croydon. I've been involved over the years in a number of IT initiatives trying to get systems to work together. It always falls down somewhere. I would love it to be achieved. It would be so much easier. It's getting better. I had a telephone consultation with a consultant at St George's, physical health, he could see the results of the bloods I'd had at Croydon University Hospital.

Resident 1: All routine bloods go to George's now. So some things have been centralised anyway, all the routine bloods, not the A&E bloods.

Resident 3: I was going to ask about this concept. Would that be as well as what we've got now?

Marlon: As well as. You can call it my little vision. When it comes to this community hub, it's not just about having 2-3 centralised locations where you throw everything in and hope people access it. It's not just hubs, it's everything we've talked about to do with transformation. It's not that there's not enough out there already. There is. When you look at that-,

Resident 1: Not joined up.

Marlon: The most fragmented system. I'm the commissioner. If I struggle to navigate this, god knows what it's like for patients or carers or families. The hub is going to be the heartbeat. GPs doing primary care should be linked into that. SLAM should have direct links. All the community groups people are part of should have access or a point of contact within the hub. There will have to be a management

element in the hub. People there doing the strategic stuff of linking everything together and that operational delivery on site. A management team on hub, 'How are we working with SLAM?' 'What's happening after hours?'

Resident 1: Are they going to do it with each GP group?

Marlon: What you've already got is integrated care networks. They were initially set up as part of the alliance focusing on older adults. 65 and above or individuals 55 and above with long term conditions and mental health. That alliance or how they were delivering those services should be an all age population now. The community hub will have to be linked into the integrated care networks. That's where you already have some of your existing Personal Independence Coordinators working. GPs should be calling into someone, 'I need a personal independent coordinator, here's some information, when can you book an appointment?' There's a lot out there already. Doing a lot of good work but it's not linked in well enough to do any better work. No synergy at the moment between provisions.

Also capacity within teams, not just SLAM but community as well. Some small organisations have too much with caseload. Individuals who are reliant on community groups rather than GPs, secondary care services, if they hit crisis point, not able to be seen, they're straight back into A&E. These hubs need to link in with integrated care networks so that nobody is potentially left languishing or slipping through the gap.

Resident 2: Thinking about how we're going to staff this. One of my issues is getting staff. You're talking about psychiatrists, nurses.

Marlon: Clinical input into community hub. We're not making another clinical setting. We just feel it's important to have that there should there be any escalation. Anyone else is going to have to call police or ambulance. If there's a CPN and a quiet area for triage, whatever recommendation is made is followed. Everything else will be provided by existing community services, volunteers, employed staff. A service for the people by the people. Everyone's fed up of seeing the likes of myself. It's easy to be very standoffish when you have the corporate end of health services for these individuals. We want them to be services that they want to come and access. Most importantly, meet the need. So it's trying to marry all of that together.

(Session ends)

Implementation project until 31 March 2019

Area of work	Project	Project Description	Delivery time	Completion time
Gaining views	Weekly outreach	Meeting residents and getting their views at Croydon University Hospital and GP Hubs as well as other locations.	Continuous, reviewed quarterly	Continuous
	Listening Tour	Meeting residents and getting their views on tours in specific areas based on NHS network. First one at Woodside/Shirley. Next one Addington/Selsdon.	Aim to do an area every three months	Aim to completed Woodside Network by end of November, Addington and Selsdon in February.
	Grassroots	South West London NHS sponsored programme of supporting engagement events which Healthwatch Croydon recruit and manage. We also do outreach at these seldom-heard and hard-to-reach groups.	Completes in November	
Specific insight	Dementia Carers	Asking carers of those with dementia their experience of using services to support the Croydon Dementia Awareness Alliance.	Six months	Publish in January 2019
	GP Mystery Shopping	Assessing the experience of enquiring to register with a GP.	Start in November	Publish in January 2019
	BME Mental Health	Asking BME people how they access mental health services. This will help	Start in November	Publish in March 2019

		support the work of the BME Wellbeing Partnership Board		
	Adult Autism services	Asking those who have autism and those caring for those with autism their experience of using health and social care services.	Start in November	Publish in March 2019
Governance	Board Recruitment	Currently recruiting the new Local Leadership Board in line with agreed governance structure.	November	December
Influencing	Attendance at key meetings	Official attendee at Croydon CCG Governing Body and regular attendee at other meetings including Croydon Health Services NHS Trust Board meeting.	Continuous, reviewed quarterly	Continuous
Communications	Newsletter	Regular round-up of Healthwatch activity and other useful information.	Monthly	Continuous
	Website and social media development	Source for information and for giving views via our response form.	Continuous, reviewed quarterly	Continuous
Volunteers	Outreach	Volunteers are regularly involved in our outreach, gaining views from the public.	Continuous, reviewed quarterly	Continuous
	Data processing	Volunteer are trained to use our Salesforce database, learning a new skill and significantly supporting our work.	Continuous, reviewed quarterly	Continuous

For general release

REPORT TO:	**HEALTH AND SOCIAL CARE SCRUTINY SUB COMMITTEE** **20 November 2018**
SUBJECT:	**HEALTH AND SOCIAL CARE SUB-COMMITTEE WORK PROGRAMME 2018/19**
LEAD OFFICER:	**Simon Trevaskis** **Senior Democratic Services & Governance Officer - Scrutiny**

ORIGIN OF ITEM:	The Scrutiny Work Programme is scheduled for consideration at every ordinary meeting of this Committee.
BRIEF FOR THE COMMITTEE:	The Sub-Committee is to consider whether it wish to make any additions, amendments or changes to the agreed work programme for the Committee in 2018/19.

1. EXECUTIVE SUMMARY

1.1 This agenda item details the Committee's proposed work programme for the remainder of the 2018/19 municipal year.

1.2 The Sub Committee has the opportunity to discuss any amendments or additions that it wishes to make to the work programme.

2. WORK PROGRAMME

2.1 The work programme is attached at **Appendix 1.**

3. RECOMMENDATIONS

3.1 Agree any changes or amendments to the Work Programme.

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BACKGROUND DOCUMENTS: None.

APPENDIX 1

HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE

Work Programme 2018/2019

Meeting Date	Item
3 July 18	• Learning & Development Session
25 September 18	• Adult Social Care Peer Review • Annual Adult Safeguarding Report • CCG Update • SLaM Feedback on CQC Report • Joint Health Overview & Scrutiny Committee (JHOSC) Update
20 November 18	• Croydon NHS Health Service review of CQC report • Kings College Hospital NHS Foundation Trust • Healthwatch • JHOSC Update
18 December 18	• SLaM (Update following CQC Recommendations) • Healthwatch • JHOSC Update
12 March 2019	• Cabinet Member Q&A Families, Health & Social Care • Annual Report of the Director of Public Health • Health Devolution • Healthwatch • JHOSC Update