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)