

B&NES Mental Health Network Meeting Thursday 3 November 2011



the care forum
voluntary sector service

Attended:

Annamma	Cedar Care Homes
Wendy Barker	Dorothy House Hospice
Ron Bevan	Sirona Care and Health
Andy Bowles	Second Step Housing Association
Duncan Brimble	Blue Light
Paula Cannings	Develop
Andrew Evans	Rethink
Margaret Fairbairn	NHS Bath and North East Somerset
Steve Forge	Third Sector Solutions
Tom Fox-Proverbs	Bath and North East Somerset Carers' Centre
Jaki How	Somerset Care and Repair
Michaela Knighton	Cholwell House Nursing Home
Belinda Lock	Way Ahead Care
Andrea Morland	NHS Bath and North East Somerset
Andy Roger	Bath Mind
Sakuntala Singh	Cedar Community Care
Richard Smith	Way Ahead Care
Karen Stephenson	Family Information Service
Jill Tompkins	Bath and North East Somerset LINK
Basil Wild	Bath and North East Somerset Council
Jill Willcox	Norton Radstock College
Robyn Williams	St Mungos
Anita Worcester	Somerset and Wessex Eating Disorders Association

Apologies:

Helen Bennett	Barchester Health Care
Paula Blight	Somerset and Wessex Eating Disorders Association
Melina Buckling	Somerset Care and Repair
Martin Colley	NHS South Gloucestershire
Hannah Cullip	Second Step Housing Association
Lorraine Davis	Whitehaven Care Home
David Donaldson	Bath Care And Repair
Anita Ford	The Rookery
Christopher Hailstone	Bath Mind
Claire Kendrick	Local Medical Practice
Chris Mahachi	Cedar Care Homes
Helen Mason	Soundwell Music Therapy Trust
Lisa Otter-Barry	Soundwell Music Therapy Trust
Doreen Paisley	The Rookery
Ben Rogers	Bath and North East Somerset LINK
Aubrey Sibaya	Cedar Care Homes
Paul Solly	Genesis Trust

**Andrea Morland, Associate Director Mental Health and Substance Misuse
Commissioning**

**Basil Wild, Commissioning & Contracts Officer - Mental Health, Adult Health,
Social Care and Housing Partnership Trust**

Mapping Mental Health Services and Payment by Results

Payment by results (PbR) and care clusters are the new payment methodology being developed by specialist mental health services. At the moment, there are block contracts and Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) gets a certain amount of money for their services. In acute services, they have started paying by activity – known as Payment by Results. This is being rolled out across a wider range NHS services. In mental health services, the idea of packages of care has been developed. AWP and NHS North Somerset have picked up and run with this idea and developed care pathways that acknowledge the contribution of all providers to people's care. AWP has developed a tool to help clinicians cluster their clients and is further ahead than most areas in the South West. AWP had clustered 96% of its client base by the end of September. The cluster is a way of describing someone's needs, who might help meet those needs and interventions and approaches that would be helpful.

Q: Can you only be in one category?

A: Yes. It's not about diagnosis, it's a description of need. You can move in and out of clusters quite quickly.

Q: What about dual diagnosis?

A: It is in the detail of the clusters. I can send an email. There may be a "0" cluster. Some conditions have not yet been definitely captured in the clusters nationally, for example, Aspergers.

The CAST tool has been developed by AWP and service users in North Somerset understand it. Everyone is using the same scale, so there is a common language of assessment. It is not diagnostically led. The clustering descriptions have been put together by clinicians in Yorkshire and the North East. In B&NES, we are talking to a working group, including voluntary and community sector members, GPs and clinicians about how to develop the national model locally building on the North Somerset work. GPs often don't know where to refer to, so it is important that this is mapped against clusters and we work out how to do it. The B&NES project group are also looking at review times within this process.

Q: Has there been any discussion about how to involve service users in the assessment process?

A: Yes, it's a collaborative process. North Somerset had a lot of service user involvement and we asked North Somerset to do that on our behalf. We want service user involvement and negotiation. Staff are learning this, too. There is no national tool. Staff members have done the clustering and then had the conversation. It is a very powerful vehicle for engaging someone: "this is what we've assessed and these are the ways in which we think we can help".

Q: Are you looking at how this would integrate with the Recovery Star approach?

A: Yes. B&NES did a pilot last year around the Recovery Star. Those that want to use Recovery Star as a care planning approach. The North East Somerset team based in the Swallows in Paulton are piloting using the Recovery Star.

Q: What is the GPs role in all of this? Will they do the initial clustering?

A: At the moment, they are not. AWP has to do the clustering to get their funding. We're trying to get the GPs to understand the whole clustering methodology. The GPs in North Somerset like the clustering. Eventually, it would be good if everyone was able to use the that AWP has developed or at least understood it.

Q: For people who have a care coordinator, will they still have someone like that?

A: Yes. With the redesign of mental health services, we are looking at putting in primary care liaison for advice, signposting and brief interventions. There will be a recovery team working with people longer term and that team has an assertive outreach service within it ; an intensive team for crisis and reablement etc and an early intervention team. They are still there, but the model is re-worked.

Q: (Ronnie) How does clustering work in terms of links with strategic decision making? How do you identify gaps?

A: In terms of knowing what AWP are doing, they are clustering clients, but the government has not worked out how to pay. The big question is how to shift the resource if we find it is not within the right area of service. In the longer term the money has to follow the client. It is tricky, but it is the direction in which things are going. In the longer term, I think the care clusters will be a good lever as it will become clearer where the gaps are. The overall national commissioning structure is still difficult to understand, it is a bit of a confused picture in terms of how everything will fit together.

Q: Will personal health budgets fit into this?

A: Yes. They could fit; the issue is fitting it in when health services are being delivered through competition.

Basil Wild outlined the focus for the work group discussions. There were five groups looking at three different sets of questions.

Workshop Discussions – Flipchart Feedback

- What is the current referral route to your services – how do you get your business?
- Does this route work efficiently, or could it be improved – if so, how? How might a referral route work - are GP's best placed to make judgements about which services to refer clients?
- Several services were not on Wellaware – how should this be addressed? The Building Bridges service is one way of looking at this.
- Should Wellaware be freely accessible in GPs surgeries, libraries etc? How might this happen?

Green Group 1 - Notes

- CPN/DN
- Social Services:
- Community mental health/St Martins
- GP (rarely)
- Word of mouth/private
- Hospital:
- GPs not aware of all services
- Practice service coordinator? Refer to building bridges?
- Potential duplication of referrals
- No joined up working between GP/social worker/ CPN/DN/third sector groups
- Yes!
- Access to Well Aware: more accessible the better
- Resources – computer/PC?
- Training and support

Green Group 2 - Notes

- What is the current referral route to your services? How do you get your business?
- GP referral – ‘budget limitations?’ ‘are we satisfied that all GP practices are properly aware and equipped to assess and diagnose mental health conditions?’ ‘Time limitations?’
 - Voluntary sector referral
 - Self referral
 - Single access point of referral
- Does this route work efficiently?
 - Non statutory clients not being caught by net
 - Service navigators/route maps are needed
 - Are GPs best placed – primary care mental health specialists?
- Services not on Well Aware – how should this be addressed? Building bridges?
 - Every agency should be able to add services to Well Aware
- Should clusters be given/to access services through Well Aware?
 - Concerns about clusters replicating old problem or systematic diagnosis – fixed not fluid, labelling?
- Do you agree with the categories given? Currently they are quite broad. The aim was to avoid having a long list of narrow categories. Should they align with Wellaware categories (see over).
- Who would this spreadsheet (or booklet) be useful for – would it just be people referring clients?
- What should differentiate it from Wellaware – the clusters being an example?
- Should or could Wellaware be adapted to show services by clusters (for referrers specifically to use and semi hidden from ordinary use?), or should the two resources be kept separate?

Blue Group - Notes

- Better to adapt Well Aware to include clusters
- Add tags for clusters and categories
- Use Well Aware categories (may need updating/extending)
- Only one resource to keep up to date
- Very beneficial that both referrers and clients are seeing exactly the same information
- Only printed thing you need is flyer to remind referrers to go to WellAware
- Keep clustering (e.g. advance search by cluster) discrete
- Are there any services missing?
- Are there any services misplaced, ie in the wrong cluster?
- Many services overlap several clusters. Should the clusters -
 - Just reflect the majority / focus of a provider’s work or
 - should it cover everything they do, no matter how untypical / small part of their work - would there be a danger of the list becoming too long and meaningless if this was the case?

Red Group 1 - Notes

- Some services may be relevant to most or all clusters – should they be put into a separate category? e.g. family services, advocacy, carers etc
- Big Issue missing?
- How will the choice of services be kept up to date?
- SWEDA missing (just started in Bath)
- BEACH? BREC? MOSQUE

Red Group 2 - Notes

- The idea of service navigators – could everyone become this?
- There may be the same services on the borders that are not included, e.g. Frome, that people use
- The Big Issue maybe missing from the list
- YMCA may be missing. Care and Repair, churches, Positive Action on Cancer (PAC)
- Well Aware site – services – some are free – need to state/categorise?
- Self help groups – include? E.g. Inspirational Arts
- Care clusters should personalise needs. Provision of services with clusters, e.g. Anxiety/Depression groups from clusters 1/2
- Transparency over clustering - open access to providers and users/referrers

Feedback

Q: If you put someone in a cluster, isn't that replicating the old problem of diagnosis and also stigma? Would clustering prevent people accessing services relating to other clusters?

A: (Ronnie) In his talk, Paddy McKee explained how voluntary organisations can be involved and provide information and advice around the system.

A: (Andrea) What we don't ever want is people only being able to relate to things that are in a particular cluster. It's not prescriptive, it's a way of organising care. Some people at the moment, for example, might not think that they can go to an ordinary education event and we would not want clustering to support the idea that some services were not accessible to that person if they were. That is definitely not the intention and it would be a disaster if clustering made people feel they were prevented from accessing other community services.

Q: What about training for the voluntary and community sector about the nature of clustering?

A: It's a matter of judgment about putting information together and being very clear what your service is providing and who it can work with.

A: (Andrew Evans) It gives more people a good chance for good support. A lot of people say when they find out about a service "I wish I'd known about this 10 years ago".

A: We have held service user engagement meetings in Keynsham, Midsomer Norton and Bath about changes in services. There was a lady in Keynsham who only found out in that meeting so much about things going on which had been part of AWP's services for quite a long time.

Q: There is nothing about organic mental health issues, for example, the onset of dementia.

A: This is the first stage of the work and we are trying to get this model working. The dementia care pathway group has made use of the guide star trust. This is a sign posting web based service focused on Dementia services. We need to look at how we link the work of the two streams together because in B&NES dementia sits with the long term conditions team.

Q: What about young people aged 18-24?

A: We should be looking at people from 16. When people are putting information onto Well Aware, it would be helpful to include the age range of people you are working with. Also, how much you have to contribute or pay to do something.

Q: Well Aware covers a lot of social areas, covering the main areas of people's lives.

Basil: Well Aware should be a vehicle rather than a separate sheet only relating to clusters. It is really good if those who are doing referrals are seeing the same information as the people receiving the referral. Advance search criteria, that is only of interest to referees for example, could be semi hidden.

Andrea: Ron has had the idea of service navigators. All of us are service navigators, the government model encourages competition, but if we see ourselves as service navigators, it would be a very empowering way for people in the community to help people access services.

Q: If PbR is an activity payment, what incentives are there for getting good outcomes?

A: This is the danger of focusing on payment by activity. The DH is trying to work out this model in mental health care, but doesn't yet have a model regarding how to pay for outcomes. That is what we are trying to work out. We could pay by intervention, but there is a danger then of people doing more interventions to get funding. It is very complicated. More important is the clusters and getting the care pathway right. Sorting out a tariff is very tricky.

Q: Apart from Care Coordinators, who decides what needs are? What about people outside the statutory service allocating people to clusters? What is their role?

A: I think one of benefits of services existing outside the statutory system is that those services don't cluster people. There is more flexibility outside of AWP. Clustering is just a way of targeting interventions to level of need, often people want to step out of it as soon as they can.

Q: You need continuity of care.

A: The Recovery Star might be a way of ensuring continuity. This would show the key organisations someone is linked into outside NHS organisations. People who are discharged should then have an easy access route into, for example, community services. They should have a plan of how to step back into services quickly. In the past, and it still happens, if someone starts to wobble in one area of their life, they can get sucked into secondary mental health services then all the other elements of support that are set up for them fall away. Suddenly the care pathway has disappeared. It can be very problematic. You're very right to point that out. How we pin it down safely is what we need to keep talking about.

Ronnie: If people have a relationship of trust with a particular group, it could be less disruptive for that person to be assessed by that organisation rather than being passed on to someone else to assess their needs. They could say they would like it to be done by the group they are with.

A: You could do that, but remember that the clustering is primarily about access to secondary mental health services. It is about how and where AWP does the assessment and if it is done jointly. It is all about relationships and care pathways. It could have a local flavour to it.

Q: What about the interface with physical healthcare services? Complex physical conditions can be ignored because of mental health issues.

A: All of the evidence nationally points to the fact that this is not being done well. There are a lot of issues that we need to address, including at public health level. Linkage of needs, anti stigma, the way public health improvement team in Sirona behaves out in the world needs to be more explicit. There is a real opportunity in mainstream health and social care services in Sirona. GPs need to do better assessments. The national QOF (Quality and Outcomes Framework) programme asks that physical health assessments are more robust. It is beginning to all be pulled together.

Evaluation

What was the most significant outcome of the event for you?

- Learning more about Well Aware - related workshop and networking opportunity
- Introduction to current developments - new to the B&NES area (recent role change)
- Updated information about the proposed cast tool
- Increased knowledge about mapping and networking around this - clusters/mapping etc
- The need to be aware of how this new system will work; also, the awareness of how all agencies link in with one another
- Learning about clusters
- Understanding of systems - appreciate AWP are open to debate and input from different participants, queries etc
- Getting a real understanding of the ambitions and plans for mental health services and the role I and my organisation might play in contributing to this
- Update on new information
- Update on new proposals. Chance to network with other agencies
- Meeting some new people involved in mental health provision

Do you have any suggestions regarding topics/speakers for future meetings?

- Would like this to develop
- These sessions are always interesting. No specific requests
- Issues around GP consortia and how to negotiate budget requirements unduly influencing decisions about care needs
- Role of third sector in contributing - some examples of good practice
- More updates as changes occur

Are there any other comments you would like to make?

- As this network group develops, I would like to gain greater understanding of the wider services represented.
- Good session, well done
- How we can forge stronger links between statutory and third sectors
- Excellent presentations, interactive and relevant
- Good interaction

Content	Average mark (out of 5)
Understanding of subject at start	2.2
Understanding of subject at end	3.8
Sessions	
Speakers	4.5
Other elements	4.1
Organisation	
Pre-event information	4.2
Facilitation	4.6
Organisation on day	4.6
Venue	
Access	4.7
Refreshments	4.2
Standard of room	4.2