Bristol Mental Health Network Meeting

14 December 2011

Attended:

Kyra Bond	Womankind
Collette Bourn	Second Step Housing Association
Michelle Bradford	Bristol Mind
Piers Cardiff	Volunteering Bristol
Debbie Charman	Bristol City Council
Paul Davey	Rightsteps
Denise Donovan	Changes Bristol
Rosalind Dorman	Motivation
Aileen Edwards	Second Step Housing Association
Diana Elliott	National Autistic Society (NAS)
Frances Fox	The Bridge Foundation
Ainslie Green	The Green House
Helen Gunson	Hartcliffe and Withywood Community Partnership
Phil Harrison	Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Mark Hayman	NHS Bristol
Catherine Heal	Self Help Community Housing Association
Steve Heigham	Help! Counselling
Ross Hughes	People Can
Caroline Hukins	The Harbour
Jacky Humphreys	The Green House
Maria Jimenez	Spring House Care Home
Richard Kimberlee	University of the West of England (UWE)
Ian Lawry	Wellspring Healthy Living Centre
Rhian Loughlin	Wellspring Healthy Living Centre
Heather Lowe	British Red Cross
Geoff Loydon	Bristol LINk
Janet McHale	Action on Hearing Loss
Patrick McKee	Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Carol Metters	Missing Link Housing Association
Louisa Newman	NHS Bristol
Dawn Osborne-Tiller	St Mungos
Lena Pascoe	Dean Crescent Womens Hostel
Suzanne Pearson	Chair of Bristol Mind and Freelance Trainer
Marvin Rees	NHS Bristol
Tracey Richardson	Kinergy
Emily Ruthven	University Hospitals Bristol NHS Foundation Trust (UH Bristol)
Jean Smith	Nilaari
Nicola Taylor	AWP
Lucinda Thelwell	Volunteering Bristol
Hannah Tracey	Fairbridge West/Prince’s Trust Bristol Centre
Sue Walker	Hartcliffe Health and Environment Action Group
Jason Washbourne	Changes Bristol
Catherine Wevill	Bristol City Council
Erica Wildgoose	Bristol MDF The Bipolar Organistion
Amber Williams	West of England Centre for Inclusive Living (WECIL)

Apologies:

Joe Abel	Mental Health Matters
Angela Cockram	
Jim Conley	Easton Community Centre
Andy Coombs	Bristol LINk/WECIL Trustee
Annie Crocker	Bristol City Council
Nola Davis	Bristol Survivors Network
Deborah Evans	NHS Bristol
Simon Greaves	Bristol Drugs Project (BDP)
Tess Green	Bristol City Council
Katrina Hinkley	Connect Psychotherapy Practice Ltd
Kathy Holland	Marie Curie Helper Programme
Gus Hoyt	Bristol City Council
Sue Kelly	Fairbridge West/Prince's Trust Bristol Centre
Laurie MacGregor	Action on Hearing Loss
Matthew Martin	Stonham Housing
Judy Mead	Care and Repair Bristol
Netta Meadows	Bristol City Council
Victoria Morris	Knowle West Health Park
Lorraine Munro	Action for Blind People
Florence Owolabi	Salvation Army
Carrie Piper	Headway
Kate Segrave	Action on Hearing Loss
Cath Twine	Supported Independence Ltd
Louise Wearne	The Care Forum
Salena Williams	Bristol Royal Infirmary
Stephen Williams	Member of Parliament

Presentation: Introduction to Contracting using Care Clusters: Payment by Results (PbR), the mental health care clusters and how it works. Patrick McKee, Head of Quality and Practice Improvement

http://www.thecareforum.org/assets/files/Volunatry%20Sector/Presentations/Bristol%20/PbR%2011-11-11.pdf

Paddy explained that he has a background in nursing, has worked with service users and carers and is on the regional board for PbR. PbR has been around for two to three years, but there has been fear about it within mental health services. The aim is for consistency in outcomes and contracting and transparency around what is available. Local prices are being built up and bench marked across the country, with the aim being to have one national price per cluster.

There will be a time period with a start and finish for clustering. People will be re-measured and it is probable that people will move clusters. Everyone is required to use one standard tool, called HONOS (health of the nation outcome score) for the start and end of clustering. This was adapted during the pilot and there is a body of weight behind why it would be used.

The government is committed to not just going on price. It is about who does this, at what cost and how well they do it. How to track changes and monitor them has been challenging. Everyone is expected to be using the system from 31 December 2011. Clusters are based on clinical presentation/need. It is expected that people will change cluster regularly.

Clusters currently relate to adults and older people services. They are not optional, everyone has to work according to them. They were developed by social workers in Yorkshire and modified by pilot sites. There has been a realisation that certain things didn't fit into the clustering, for example autistic spectrum disorders, and that is being developed. It is work in progress, and getting transparency and clarity as to what providers provide is needed.

Q: If someone has depression with psychotic features, they would mostly fit into clusters 5 to 8. If they had a psychotic episode, they would be in 14 or 15. From a management point of view, where would you put someone?
A: Wherever dominant presentation is.

Q: How easy is it to move clusters?
A: To make this work, all of us could be providing a part of a cluster. There is a need to be in a room to discuss when transfer takes place from one provider to another to get a pre agreed cluster point. The aim is not to repeat assessments. Commissioners may get you to agree up front the transfer points. If you habitually got it wrong, you would go into mediation with commissioners.

Q: It is good to see forensic work being included. Is that going to tender?
A: It is relatively contained, very much about inpatient care and based on risk profile. Now we are just using HONOS. There is a community forensic opportunity for general providers.

Q: It is difficult to measure outcomes, for example how well you do with people with depression.
A: That has to be agreed locally. There will be a cautious approach in the first couple of years. You will be paid up front and your success measured. They haven't worked it out.

There are three triggers for clustering: new referral; CPA; any significant change in presentation. There is a second tranche of work going on at national level. The CAST tool has been developed to measure, for example, employment, length of stay etc.

Local prices are likely to be crude for the next year. AWP has set up a system where a service user is automatically clustered when seen by AWP. The service user can then see a drop down list of services, and a set of interventions have been developed for every cluster. The service user selects interventions, which gives them the template for the care plan. The price has to be coded and work needs to be done with commissioners and the third sector.

The readiness reports commissioned by SHAs are about to come out. The SHA for the south of England has been asked to draft an action plan. Action plans will be driven through PCTs and the new GP commissioners. People are being asked to sign up to a Memorandum of Understanding for sharing information. The recommendation is that each cluster has someone who leads it and they will become the subcontractor who is responsible for governance and risk issues.

The process has been very positive for AWP who are changing the way they run services and it has helped their managers to manage.

Q: Presumably, the lead agency for a cluster could be a GP.
A: That is the recommendation, but it is up to commissioners to unpick that. We've done the work.

Q: If three agencies, would every agency have to do HONOS?
A: You'd agree the primary one and the lead would have to make sure it's done. This has to be worked on.

Q: There are concerns expressed by service users that they are being allocated to clusters without consultation.
A: I've heard this. We're looking for people to let us know where that is happening. We're in the change process.

Q: Care coordinators and service users work in partnership, ideally. If the service user doesn't agree with the cluster they are allocated to what advocacy support will there be?
A: It is down to commissioners to agree as part of a local contract. My argument is there should be an arbitration rule. There is no national rule.

Q: If there is another tranche of clusters, will the social outcomes timescales be the same?
A: One of problems with clustering is that it is very health driven. A piece of work is being developed about how local authorities develop equivalent interventions and to fit into local Fair Access to Care (FACs) criteria. There will be a pilot.

Q: Employment interventions, for example are not being seen within this model.
A: You can identify other needs eg social components/occupational needs, but can't access them unless the local authority has agreed what they are. The question is what do PCTs fund and what do local authorities fund. Across the country, there is partnership working with clear delineation of budgets. We're learning as we are going along.

Q: There is concern about how prescriptive care clusters are.
A: There is no national rule. Some at the lower end are very specific to conditions, but a lot of it is very common, for example, physical intervention is in every cluster.

Q: Is it imaginative and flexible?
A: There is NICE guidance against each cluster and there are core packages in every cluster.

Q: Where do personality disorders fit in?
A: The common view is cluster 8 (challenging/chaotic)

Any Qualified Provider - mental health services and talking therapies in Bristol: Mark Hayman, Associate Director for Procurement, NHS Bristol

Presentation on AQP

Mark explained that he had attended a conference the previous day at which further changes were announced and a number of issues raised.

Approximately 10,000 people took part in a listening exercise. Following that the Extending Patient Choice document was published. The supply2health website has guidance www.supply2health.nhs.uk Information packs for eight services went to the Department of Health (DH) two weeks ago and were launched last week by minister.

Application will be via the supply2health website for any of the eight services. In Bristol, something more than the standard IAPT has been designed to link into the modernisation plans, called IAPT Plus. The intention is to link with employers, get people back to work and also to pick up on groups of people, such as the homeless, or self referrals. There will be packages in it with between 15 and 20 areas of speciality, such as divorce counselling. The DH has assumed that the site will do standard package work. On the website will be the advert and service specification, which is called the offer. The price will be based around a local tariff. Accreditation will be done on line.

The specification as it stands will be viewed by one of eight stations around the country, for example, Newcastle could be responsible for muscular skeletal bids. They will validate all the information. The DH has accepted that Bristol wants to do something different in IAPT, so it maybe evaluated in Bristol. The framework is to start on 1 April, with advertisements due to go out in January. The opportunity is for three years from April. They will probably then go to others to join the market in November time. The intention is to get as many providers in market as the market will sustain. You tell us how to do it and how you want to do it. If you meet the outcomes we will require you to get accredited.

Q: Can you print off the whole application process?
A: They are going to try and make it so it can be printed off. It is work in progress. Have a look on the website.

Q: What about the local Bristol requirement?
A: We argued that Bristol will have to have what is right for Bristol. There was agreement yesterday that the first part of general accreditation can be done in Newcastle, for example, but we will have a different set of answers for the second part and they will send it back to us to do in Bristol. The questions we will be looking for are fairly clear. I need to know how good you are. If you've not answered the question or I don't understand what you're writing, I want the opportunity to put it on hold and for it not to be a simple pass or fail.

Q: You mentioned a question about IT (information technology) in part one, presumably that relates to outcomes?
A: They couldn't answer the question yesterday.

Q: Are you looking for any qualified provider in IAPT services as well as additional services?
A: IAPT is now renamed, I prefer to call it 'plan A'. There is a part in that which we are looking at for multiple providers of services. There will not just be one for each DV, there will be 15 or 20 boxes. The service specification is coming to the market in Bristol for plan A, there will probably be a marketing event in late January, and advertising fully in February. We are hoping to have people accredited by the end of April for service to start on 1 June. That is the timeline. The main mental health service is to be ready by next April, we have done a lot of work on pathways. I'm now going to do the procurement part. Tomorrow, there is a meeting of commissioners, the PCT are looking at pathways. They are going to review the procurement of various parts.

Q: For a smaller organisation, is a list to be made available to help build up the specification for an organisation to become accredited?
A: For the main mental health one we've said openly that we do not believe one bidder will do a whole service without a range of partners working with them. We have already given two caveats in the main procurement about the crisis houses. You will have to work with the two incumbents.

Q: If, for example, there is a small organisation providing counselling in South Bristol, is there an opportunity for them to say they just want to work in South Bristol?
A: Hopefully, there will be more than one provider so that shouldn't be a problem. I am not sure about the rules. We have talked about whether providers should do the whole or a defined area. A lot of people say that they know their patch.

Q: If there is a tariff for intervention, agencies need to prepare to have a flexible infrastructure to meet variable demand.
A: You will have to be able to sell your services to GP commissioners or to self referrals.

Q: What is in IAPT plus?
A: CBT is in there. The IAPT devised by the DH is very restrictive. We made it clear to the DH that we didn't want IAPT, but IAPT plus with talking therapies. We know from the engagement what Bristol needs and have come up with a different model. Pure IAPT is not right, the plan is to have CBT, DBT etc and lots of opportunities. The whole market is changing.

Q: Is there a list of 20 categories?
A: It is not yet available, but possibly in the new year when the pathways have been sorted out.

Q: How onerous is part two in terms of information? How much is track record relevant?
A: Yes and no to track record. It is one of the thoughts in the work in progress. Part B will be onerous in a reasonable way. You'll be demonstrating how you are going to do the service.

Mark reiterated that if people are looking at the supply2health website, the IAPT package there is not the one that will be used in Bristol.

Q: Louise asked for confirmation of timescales.
A: The new service starts on 1 June 2012. Accreditation will be finished by the end of April, the advert is to be placed around 1 February. The main one is going out in March through to May and we will be putting on a 'speed dating' event to get providers to meet. I can let you have the information about the boxes, if I can find it. Email if you have any questions.
mark.hayman@bristol.nhs.uk

Report back from Suzanne Pearson, Voluntary Sector Representative on Bristol's Mental Health Partnership Board (Formerly the Bristol Mental Health Local Implementation Team)

Suzanne introduced herself as one of the elected Voluntary Sector reps on the Bristol Mental Health Partnership Board, the other Vol sector Rep is Jim Conelly. The Board meets on a monthly basis and its function is to oversee development of mental health provision in Bristol.

There will be elections for voluntary and community sector reps in a year's time. On the Board are also: service users reps; carers' reps; local authority and NHS commissioners ; public health reps. NHS Bristol, lead on the evaluation of commissioned services in Bristol; Geoff Loydon from Bristol LINk (soon to be HealthWatch); AWP and IAPT representatives; Marvin Rees DRE lead and others representing BME community; representatives from Drug and Alcohol services etc.

The Health and Wellbeing Board, led by Liz McDougall is becoming a more central forum for Bristol. The Bristol Mental Health Partnership also has working groups, e.g.mental health and employment; personality disorders; connecting physical and mental health and a service user subgroup.

The Care Forum's Bristol Mental Health Network is a very important place for the voluntary and community sector. It is an important place to feed into and get information out. The voluntary and community sector can raise concerns, get updates etc. In the last couple of months in the Bristol Mental Health Partnership there has been a focus on modernisation of mental health in Bristol. The voluntary and community sector has had a lot of input in that. There was a lot of talk at the last meeting about the issue of local authority staff moving out of community mental health teams. We also heard from public health that more headway is being made in the need to link up emotional health needs along with key physical targets. There are opportunities for

voluntary and community sector in the future. It is difficult to know how to best serve the voluntary and community sector. We rely on The Care Forum as a channel of communication. You can send Suzanne and Jim direct emails about things of concern by emailing louisehudson@thecareforum.org.uk . Jim Conley is the second VCS rep on the Bristol Mental Health Partnership.
Email:Jim Conley jrc32@columbia.edu or Suzanne Pearson <suzanne_pearson@yahoo.com

Q: How does a group get involved?
A: There are service user reps, and service user forums. SURG is there and Bristol survivors network.

Date of next meeting: Thursday 23 February, 9.45am-1pm, The Vassall Centre.
Subject: Re-commissioning of mental health services in Bristol: Update and Primary Care Psychological Therapies (IAPT) Engagement Event.

Evaluation:

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

- Update on AWP and tendering process
- The composition of the new organisation and difficulties for third sector organisations and emerging organisations
- Understanding of AQP
- Networking
- Learning from the reorganisation of the NHS Service
- Networking and up to date info on PbR and IAPT plus
- Information update
- Clarifying processes and how to access further info
- Learning a bit more about PbR and clusters
- A greater understanding of the process; explanation of clusters. Questions asked by attendees also helped with my understanding
- Explanation of cluster process, implementation discussed and handouts received
- Information about Bristol process of AQP
- AQP - info, updates, dates etc
- Learning more about the procurement process
- Made 1 networking contact
- Learning about how, as a small organisation, we can begin to get involved in AQP.
- Better understanding of care clusters
- Clearer understanding of what is required for seeting up a service specification
- Gain an understanding of payment by results

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

- More on AQP and clustering
- Update on AWP stuff
- More knowledge surrounding the processes today
- Meeting with other organisations to learn/share ways of measuring and monitoring outcomes

Are there any other comments you would like to make?

- The fact that the first speaker over ran by half an hour really detracted from his presentation and the event as a whole - which the second speaker did an excellent job of rescuing

- Always find Mark H always says he doesn't know about mental health
- Shame Mark didn't have more time - it was quite rushed. From the pre-event information, I wasn't completely clear, however attending this meeting has really helped
- Thank you
- Would be great if people wore name tags. I'm new and found it hard to meet and mix with people

Content	Average mark (out of 5)
Understanding of subject at start	1.8
Understanding of subject at end	3.6
Sessions	
Speakers – Patrick McKee	4.0
Speakers – Mark Hayman	3.8
Other elements	3.6
Organisation	
Pre-event information	3.7
Facilitation	4.1
Organisation on day	4.1
Venue	
Access	4.7
Refreshments	4.3
Standard of room	4.5