South Glos Mental Health Network Meeting

6 December 2011

Attended:
Alan Altoft, Milestones Trust; Kyra Bond, Womankind; Una Corbett, Battle Against Tranquillisers; A De Groot, Milestones Trust; Diana Elliott, National Autistic Society (NAS);Jean Grant, NHS South Gloucestershire; Lyn Mitchell, Bristol LINk; Pat Penny, Developing Health and Independence; Joy Rodwell, Kinergy; Guy Stenson, South Gloucestershire Council; Colin Young, Battle Against Tranquillisers; Gillian Turner, Katharine Gonzales, The Care Forum.

Apologies:
Gill Pickford, Second Step Housing Association, Vicky Baker, Headway; Andrew Birch,South Gloucestershire Council; Gill Clayton, South Gloucestershire Libraries; Derek Dominey, Alzheimer's Society; Alex Hayes, South Gloucestershire Council; Terry Jones, Survive; Heather Lowe, British Red Cross; Ceri Naylor, Knightstone Housing Association/ S Glos LINk;

Report from Voluntary Sector Rep on the Mental Health Local Implementation Team (LIT),

Gill Pickford, the voluntary sector rep, was unable to attend at the last minute and sent her apologies.

Gillian Turner, The Care Forum said that there are two places for voluntary and community sector reps on the LIT but there is only one rep at the moment. The reps have built up a good relationship with the LIT and as a consequence we have a much better flow of information between us and there is regular feedback from this group at the LIT. Gill emphasised the importance of having a second rep from this group and Guy Stenson, Community Care and Housing Department, reiterated this. Alan Altoft, Milestones offered to step in for six months. Gill will take up Alan's offer, unless anyone else offers after the meeting.

Gill gave feedback from the care clustering and Payment by Results meeting that she had attended:
Preparations for clustering and Payment By Results (PbR) are continuing. The model proposed for mental health places service users into "clusters", based on their care needs and the expected costs of treating them. From 2012-13, providers, whether in the NHS or independent sector, will be paid according to the number of patients they treat in each cluster over a given period, on the basis of locally agreed prices. It is important that voluntary sector organisations understand this.
The meeting looked at which services might be on the drop down menu in each cluster – which means there is the potential to be included in the care package.
A number of VCS organisations were at the meeting including Milestones, Second Step, BAT, CRUSE which was really useful as The Care Forum can put the general point about VCS involvement but these organisations were able to talk specifically about what voluntary sector services were able to offer at all levels so thanks to them for their really valuable input.

Una Corbett: There was an assumption at that meeting that the voluntary and community sector would not be involved in any except clusters 1 to 3. The VCS organisations were able to demonstrate that they were involved in other clusters.

Gill said the main points she had been making were:

- Ensuring that appropriate VCS organisations are included in the options for potential care packages. And ways to ensure that list is not exclusive
- VCS organisations to make sure all their activities are registered on the Well Aware database so when commissioners, whoever they are, are looking for services they can find them
- Funding for VCS organisations – awareness that many of our services are supporting people who are not eligible under Fair Access to Care Services (FACS). How will they be funded?
- Training about how PbR might work for VCS at the right time – ie when it has been decided how it will operate

Caring for our Future Consultation

Guy Stenson, Community Care and Housing Department: This was a Department of Health consultation about the future, in terms of the funding of social care. Proposals will be published in April next year. The consultation was intended to get feedback from social care. In particular, they have looked at five areas. The key areas are:

- the right work force and quality;
- recognising personalisation is here to stay and has to work effectively;
- increasingly dependent on a vibrant diverse market of providers;
- recognising prevention and early intervention are critical.
- commitment to integration across health and social care and how to make that a reality.

There is an attempt to look at long term equity in the system. The role for the financial sector is being looked at, for example, the potential role personal insurance could play. We know that a huge number of people will be requiring care in the future. There have been a number of events across the region and we hosted an event locally in south Gloucestershire.

Q: What is the status of those proposals?
A: It is intended that it will result in new legislation for social care, bringing together everything within a single Act covering social care funding. At the moment, there is a collection of legislation, some of it very old, and a lack of consistency in its application across the country.

Q: Health has more central control.
A: There is guidance from NICE, but PCTs can still decide locally what they want to fund around the margins. With social care, there is consistency around what should be provided. The inconsistency is about who pays for it.

The consultation has finished. South Glos Council has put in a response incorporating views from the consultation event it held in November.

AWP Specifications

Network members have been asked for comments on the Avon and Wiltshire Mental Health NHS Trust (AWP) primary care liaison service specification. Gill Pickford has compiled comments and produced another response for the LIT. The primary care liaison service is the new route into primary care mental health services. They will be doing assessments and short term interventions. Terry Baker spoke about it at a recent meeting, held jointly with South Glos

Guy: AWP is rolling this out across the whole locality for all adults. This service has been developed and running in South Glos for approx three Years. Terry Baker has been running it here, focusing on older people and dementia and it has been very successful.

Gill: At the last meeting VCS organisations which had contact with the service were very positive.

Guy: It has informed and raised awareness amongst GPs of supporting people with dementia. This service targeted itself at GP practices with a lower level of understanding of the issues around older people and dementia.

Gill thanked Gill Pickford for putting together the response and thanked everyone who had contributed.

Report from service user involvement meeting

Nisba Ahmed, South Glos Community Care and Housing has held meetings with service users and produced a report on the progress so far. One of the main aims is that service user involvement stays high on the agenda. It is a positive initiative.

Guy Stenson: The team had hoped it would move quicker than it has, but recognise it will take a lot of time to build up people's confidence. Mental health is a top priority from the point of service user engagement, as they want people to have a stronger voice. Nisba is on maternity leave, so the post will be covered for the next six month, with the mental health work being top of the list. Nisba had also had conversations with people in Bristol, which was helpful.

Information share

- Womankind has produced leaflets to mark its 25th anniversary.
- There is autism training on offer from South Glos Council. If the dates offered are not convenient contact Diana Elliott
- Bristol has put out a tender for a male crisis house.

Q: Would South Glos buy into Bristol's provision?
A: It is not something they're actively doing. If the need is small, they might link with Bristol to ensure there is capacity to cover the area.   If distance is an issue, or level of demand greater, then it would need to be offered in South Glos.
The Lead for Commissioning in Bristol is Netta Meadows.

Q: How do you identify the need?
A: In part from what organisations are telling us. That is why having a voluntary and community sector rep on the LIT is so positive. An organisation in direct contact is an effective way of identifying need, it alerts us to gaps and we can then understand if it is a genuine gap or a one off. Our Joint Strategic Needs Assessment (JSNA) colleagues in Health try to build on all the information we have and then identify commissioning priorities. Then there is a balance between need and finance.

Q: What is happening with the JSNA?
A: In the Health and Social Care Bill, the JSNA keeps its name but is changing.
At the moment, it is a big document, with a lot of information and statistics. The Health and Social Care Bill requires the JSNA to move to the next level and inform the Health Wellbeing Strategy. The Director of Public Health in South Glos is leading a piece of work which is due to make those developments to the JSNA. Probably by July next year there will be something that looks different and which should be a tool for commissioners and provider organisations.

Q: It is very important that VCS organisations are able to input into the JSNA and can see the route to commissioning decisions

A: The idea is to draw conclusions from facts and figures. North Somerset has started already and is trying to identify key priorities. A letter is going out today from Peter Murphy, The Care Forum's Chief Executive and Care and Support West. The letter seeks thoughts and ideas on the Futures Forum, likely to be a six monthly event which would bring commissioners and providers together. The intention is to have more of a conversation over time. It will include the private sector and voluntary and community sector.

Fairer Contributions Policy Consultation

Guy Stenson, Community Care and Housing Dept.

The council is seeking views on changes to the way that social care users contribute to the support they receive. Health care is free at the point of delivery, but social care is not. All local authorities are required to have a policy around the contribution individuals make to their care package.

There are two types of assessment - an assessment of need and a financial assessment.

In South Glos under the Fair Access to Care Services (FACS) assessment anyone who is assessed as having critical and substantial needs is eligible for support from the local authority. A social worker works with the individual to look at how to meet their needs and a separate financial assessment decides how much they will have to contribute, based upon their personal financial circumstances.

At the moment we ask people to make a contribution for residential and domiciliary care but not for day services.

Personalisation and personal budgets have changed the world of health and social care. By the end of this year, theoretically, everyone who is eligible under FACS will have a personal budget and the service user will decide how to spend the money to meet their needs. The current charging policy does not fit with that model.

The proposal now is that service users will know from the beginning what their Personal Budget is. They will have a financial assessment and know what contribution they will have to make. Some people who have not paid a contribution in the past will now have to pay but some who are already paying may well pay less. The intention is that it will be more equitable and transparent to all.

Traditionally there has been block funding, for example, the contract with Rethink. We are working with them to put individual payment rates on that service. This has been done successfully with other day services, particularly around learning difficulties and older people. Some services will continue to be universally available to all and free including carers services and we are not talking about those, but services that meet people's individual assessed need. The consultation is on the council's website and they are seeking feed back until 27 January. If you have an event with service users you can invite Andrew Birch from Community Care and Housing to discuss the proposals with you.
https://consultations.southglos.gov.uk/consult.ti/FairerContributions/listdocuments

Q If you only fund critical and substantial care needs who funds the other categories?
A: The individual. Most councils support people in the top two categories only. For those assessed at low and moderate information and guidance is given to assist people to meet their needs. The FACS criteria and contributions are separate. It could be that you are at a critical level but you fund your own care, depending upon your individual financial circumstances. If you can't afford it, the council funds, but not at the lower levels. We can signpost to services.

Q: If the main change is to day care, and there is a means test for domiciliary and residential care, will you use the same benchmark?
A: Slightly different rules currently apply for residential care.

Q: What about domiciliary care?
A: It is more complicated, we look at a whole range of factors including ensuring that you are getting the maximum benefits you are entitled to.

Q: It is still a reason why people don't ask for help.
A: Part of this is about trying to make it simpler and consistent. Collection of financial contributions will not be the responsibility of providers. If we have a direct payment, we will reduce what we give them, we will pay the providers the rate. Anyone coming new to the department for assessment is given a personal budget.

Q: On the last page of the document, there is an error relating to age groups.

Q: Is the assessment of money on the person receiving their care and not to do with their families?
A: I'm afraid I need to check the answer to this question. I will forward a response to the Care Forum as soon as I have it.
NB. Guy has since provided this answer from the council: 'Contributions are normally based on the individual's financial position, however if the client is part of a couple we are happy to assess them as a couple and take the assessment which is most beneficial to the couple. The partner would have to disclose his or her financial position in order for us to do this but they are under no obligation to so.'

The post April 2012 world in Mental Health Jean Grant, Joint Commissioning Officer (Mental Health) and Guy Stenson

Some of the changes in the NHS dovetail with what is going on in the local authority. There is a move to bring mental health services into Payment by Results (PbR) or payment by activity. It will effectively mean a move away from block contracts. Which is a positive change as it is very difficult to know if block contracts are value for money. PbR will be a good thing in terms of being clear about outcomes. It will hopefully help us to understand unmet needs. And free up funding to develop services accordingly.

In Payment by Results there are 21 care clusters, although cluster 9 (drugs and alcohol) has been taken out. There is also a zero – when someone doesn't seem to fit into a cluster. Each service user is placed in a cluster, which are linked to diagnosis but are essentially about current needs. People can be re-clustered as their needs change .The first three clusters (non-psychotic) are more likely to be what GPs will oversee. The Primary Care Liaison service will have an advice, support and signposting role. AWP should then spend less time on people who don't meet the criteria for secondary service. Within each cluster there will be a menu of possible responses to need. There will be a range of possible ways of meeting someone's need and those ways will be costed. At the end of each month, depending how many people are in the cluster, the provider will be paid according to demand and the agreed tariff for each cluster. It will hopefully be straightforward, but will raise some interesting questions, such as how to cost a package. There will be no more money than is in the current contract.

Guy: Nationally in terms of Payment by Results mental health has been put in the "too hard box". Social workers tend to meet people in a time of crisis. Personalisation is engaging with individuals at a more sensible time. For social care services, the money is from the local authority. There has to be a unit cost on the service purchased, no matter who is doing the purchasing (GP or social worker). We will then have clarity about what we are paying for.

We will hopefully be able to work with provider organisations and give them money in advance on the basis that they will work with x service users over a specified period of time at an agreed cost. Provider organisations will need to have clarity about the cost of a unit. For example, there might be 15 units of chiropractic service

From the provider prospective, they will need to understand what their unit cost and what they can offer and this will need to be publicised so that services users can choose how their needs will be met. Previously, providers have not had to share that with service users and commissioners.

Q: What if you provide more units of service than you have been paid for? Can you be re-assessed?
A: The change ought to mean that there's greater flexibility. You have 15 units which you've negotiated with the provider, for example, 4 units this week and no units next week. There will be a formal reassessment if 15 units do not meet your needs. The conversation then maybe is that you need something different; you need more or less of something.
A: As people's needs change, they can be re-clustered and a new care programme would be agreed.
A: The model has to have flexibility around how it is delivered.

Q: How will an organisation be paid, if there is a block unit and it is not working at the end?
A: The provider will be paid for agreed units.
A: The review focused on outcomes. There will not be a penalty if is not achieved. A number of contracts are being looked at for ways to provide incentives to providers. The reablement service is about keeping people out of hospital. After 90 days, an additional payment kicks in. There is a commitment to pay for all activity delivered. The majority of services purchased on spot purchase are paid monthly in arrears. An option we don't yet have in South Glos is a process where we can park money with a provider up front, although that would be a sensible way of doing it. We can work with providers in terms of cash flow.

Q: Kinergy is outside that loop at the moment. We get referrals but no funding.
A: This provides an opportunity. The social care side has two routes: the individual taking a personal budget as direct payment and direct marketing to the individual. Well Aware, brokerage, DHI and promoting the organisation with social worker teams and health teams. The council will only purchase from providers on our list. Any organisation that wants to be on the list needs to meet quality standards and can apply to be there. Some organisations are not interested, they just want to go down the direct payment route and, promote themselves to service users.

My guess is that health would pay for sexual abuse counselling. My sense is that it comes up a lot. Hopefully it will be on the clustering list. It is important we know what your hourly rate is. You need to get that information available so when the care plan is being done, it can be costed.

A: We are talking about meeting assessed needs. We still recognise that prevention and early intervention are universal services and really important. It is more cost effective if someone goes to get guidance and information without contacting us. This is about streamlining our processes. Cruse, for instance, was previously funded by part of the council. We need to look at what is out there.

Jean: Any qualified provider. The government asked each primary care trust (PCT) area to pick three services to pilot any qualified provider. Bristol and South Glos have chosen the Improving Access to Psychological Therapies (IAPT) service, which might be chunked up to be provided

by a number of agencies. The idea is that you will have a process of accreditation, so people will be on a list. There will be a service specification with areas or models of care to be provided and providers can make a bid for elements of this.
The PCT will do the accreditation of therapist. We will make it public how people apply.

Q: If you are being referred to IAPT, will there be a choice of several providers?
A: We will be making it easier for people to choose and be channelled to the right service.
A: In South Glos, we have IAPT and the primary care mental health service that we developed before IAPT. There is a range of different models, bereavement work, post natal depression, post traumatic stress etc. Sex counselling is one which is not provided within IAPT or PMHS.

Q: Will there be separate lists for accreditation? Will you have to apply to each council or PCT separately? It would be easier for VCS organisations if there was one accreditation process.
A: Whether the accreditation process from across the border will be accepted is an interesting point and Jean will feed this into the process.
A: In some areas that happens, there is no reason why it can't work here.
A: Work will be done on what the accreditation process looks like between now and June.

Q: At the session run by The Care Forum, we were told about IAPT and about referring to mental health services. One of my concerns is that the systems have the propensity for tightening up access so the single point of entry is only through the GP. Both speakers said it needed to be looked at.
A: That is an issue and we are obliged to look at that. We have shied away from it as other authorities got quickly swamped by a huge waiting list when they went for self referral. The Chinese community, for example, refers directly; we are gradually introducing self referral.

Jean: This session is just to make you aware of the changes that are coming. We want to get you thinking in terms of costs and marketing. We are still doing the work but we will eventually get something in writing.

Overview of the new mental health framework - No Health without Mental Health

Jean Grant

The government has embraced the concept of New Horizons in the new mental health framework 'No Health without Mental Health'. There is potentially a huge cultural shift. It is supposed to be a cross departmental, cross agency process. Like New Horizons, it is based on prevention and early intervention. The intention is to raise the status of mental health to be the same as physical health. Each locality will work across the barriers which we know exist.

Mental health is everyone's business. The IAPT service is a good example of something already in place. Work has been done with young people around offending, to stop them getting into trouble. Work has also been done with marginalised communities. There are interesting statistics in the report about the prevalence of mental illness. The key messages are that a healthy economy and health and wellbeing are interlinked.

Main areas of work are:
Peri natal services, working with pregnant women through midwives and district nurses and education. Early intervention and prevention, extending IAPT programme to thinking about older people who tend not to have depression diagnosed, also to young people. A new scheme is being piloted to work with CAMHS services (not yet in South Glos). It is about developing more ability to respond to unexplained medical symptoms. There are issues about reducing the stigma around mental health difficulties.

A wide far-reaching workshop model helps people to do general awareness raising around the management of the symptoms of stress through which people can be identified as having more serious issues.

The physical health of people in mental health can be neglected. Some communities express mental health needs in physical terms. People with psychotic illness may complain of physical illness and be ignored. There is a safety issue around suicide.

Q: A representative from the gypsy and traveller community came to a LINKs meeting. There are young men in the community who commit suicide.
Within that community, there might be people on the autistic spectrum. It is concerning if they know nothing about it.

A: There are cultural issues, and roles in families. We are working on engaging this community and as yet have only engaged a few women. The idea is to do awareness rising about self esteem, stress and how you can help yourself or get help. Some GP practices have good links with gypsies and traveller communities. I take your point about autism. The idea was also to signpost to any services. It is a very slow process.

The possibility of running a seminar for voluntary sector agencies in relation to the funding changes was discussed and thought to be a good idea
The point about the need for a common accreditation system will be fed back.

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

- Information.
- Information given.
- I understand the changes and processes more.
- Information: changes in commissioning; personal budgets.
- Getting more information about developments in personal budgets, any qualified provider status etc.

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

- More on the internal market systems.
- More of the same. It's so important to feel informed about the new infrastructure and commissioning arrangements.

Are there any other comments you would like to make?
[none]

Content	Average mark (out of 5)
Understanding of subject at start	2.6
Understanding of subject at end	3.8
Sessions	
Speakers	4.2
Other elements	3.7
Organisation	
Pre-event information	3.8

Facilitation	4.0
Organisation on day	4.0
Venue	
Access	4.4
Refreshments	4.4
Standard of room	4.2