The Care Forum

B&NES Mental Health Network Meeting
14 February 2008

Attended: Bridget Smith, Chew Valley Befrienders; Sandra Niven, Vision Bath; Allan Trinder, Care Network, The; Janet E Cowland, Independent; Gill Hall, Solon Housing Association; Andrew Evans, Rethink; Paul Howard, Health Advocacy Partnership, The; Tracey Phillips,Bath Mind; Jill Tompkins, PPI- Bath; Anne Keat, PPI - Great Western Ambulance; Caroline Clark, Sue Sherrin Bath Mind; Jetta Found, PPI- Bath; Raj Lalla, Bath & North East Somerset Racial Equality Council; Tracy Whitfield, Out of the Blue; Caroline Jeffery, Out of the Blue; Susan Norfolk, Citizens Advice Bureau - Bath & District

Apologies: Bernard Barron, Bath & District Life Group; Anita Holden, Somer Community Housing Trust; Esther Harris, Drugs and Homeless Initiative - BANES; Dani Bown, Bath Mind; Christopher Hailstone, Bath Mind; Cathryn Booth, Royal National Institute for Deaf People ; Samantha Baldwin, ICAS; Mary 1, Samaritans - Bath; Veronica Parker, PPI- Bath; Helen Storey, Crossroads - Caring for Carers B&NES; Kay Barron, Bath & District Life Group

Presentation: Andrea Morland, Joint Commissioning Manager, Mental Health B&NES Primary Care Trust / B&NES Social and Housing Services

Andrea Morland explained that she was at the meeting in a different role: as part of the joint mental health commissioning meeting and that she is providing support for the general service improvement change programme.

Andrea explained that the impact assessment is taking place week beginning 18 February at which proposals will be talked about in more detail.

Presentation: http://www.thecareforum.org/publication_uploads/14%20Feb%2008%20-%20BANES%20MH%20Network.pdf

The key to reducing beds is to make sure there is a service available in the community. This has been done with Older People and is a key message across the country. Instead of a very bed based service, there will be a community service supported by specialist in service beds.

Q: Is the vision something you believe you can attain?
A: My impression is that in B&NES there hasn't been a clear strategy before. There is a lot of good will, working and talking. We've been really clear in this document that it's about things that we are going to do. We're revising the model of care, strengthening the primary care in place. The intermediate care teams have a lot of work and are now looking at Older People's services.

Q: The last point on the slide "Strong clinical standards and leadership" is vague.
A: Our provider arm Avon and Wiltshire Partnership Mental Health NHS Trust (AWP) provides us with good care. We want to make sure that we are doing things that meet national standards in quality as well as numbers.

Q: How culturally sensitive are counselling services and psychological therapies?

A: There is quite a lot of work to do. They are all working out of GP practices. The remit is to ensure that all services are accessed by all the population that needs them. There is more work to be done on making links to communities so that the service is wider.

Q: Are counselling services available in every GP practice?
A: Yes. In some areas, the counselling service has been put out to Southside family service. We have to be clear that we know what is being delivered by counsellors.

Q: Does it include CBT and group therapy?
A: We have to follow clinical guidelines. Beating the Blues is available, which is a computerized cognitive therapy. It is depression focussed, but helpful for people with anxiety. There is a health computer in the library in Bath, Keynsham, Radstock and Midsomer Norton. The librarian will help with the logging in and then there are weekly sessions. There is also available guided self help alongside GP and group work. We are aiming to give choice.

Q: How much group work is happening?
A: A lot, relative to the size of the team.

Q: There are not always enough groups for people and not much follow up. Some people also need support to get there.
A: We are interviewing for graduate mental health workers. A big issue is also about linking up with employment services.

Q: A hypothetical case: An elderly visually impaired person can't use the computer. They have come to my organisation and I can see that they have bad depression. When they see their doctor, they are bright and cheerful. How do I help them, if I am seriously concerned about the health of an older person?
A: The psychotherapy service is not age dependent.

Q: What is the key to getting them assessed?
A: It is to talk to the psychotherapy team about the best way of getting them to the GP. The care pathways team needs to work it out. I'll go to the psychotherapy team with that so that they pay particular attention to working alongside the voluntary sector. This is exactly the sort of practical issue they need to get care pathways working.

Q: The other element is that therapies are time limited. What then happens to people afterwards? Referral on to community based activities?
A: It is not just about onward referral. The graduate mental health workers need to know what's available in local communities and build relationships. You learn a set of tools to manage your experience, such as medication, practical approaches, more exercise etc, but there is not a cure for life. CBT is very successful at being able to alter people's behaviours and improving mood. When people revisit what is learning in CBT it can be helpful.

Q: Often people don't feel bad enough to go to their GP.
A: The key thing we want service providers to do is to think about self referral.

Q: Peer group support is important and there is huge scope in B&NES.
Q: Is there a list?
A: It's small, but being looked at.
A: It is something we need to build in, like the expert patient's programme encourages peer support.
Ronnie: We list any groups we find out about on our database, Room 102.

Q: Do you have funding as well as a vision?
A: Yes.

Q: There is a need for public access 24/7 when there is a crisis. Is there a number a badly disturbed person could access?
A: There is now a 24/7 crisis team now for adults of working age. The number is known to the people who understand about the service, but not known to the public. That team came about last year.
Andrew: It is not yet 24/7, there is overnight cover by telephone.
Q: I dispute that. The very disturbed person I referred to earlier is now receiving care. Their family was very supportive. But people are being told to go to A&E.
A: There is a psychiatric liaison service within A&E for emergencies. There is a small team in RUH.
Andrew: 24 crisis support is part of that service. The framework at the moment is 10am to 10pm.
A: There has been a huge improvement in the last year.
Andrew: It's about accessing those numbers. For a first time episode of psychosis, RUH would give you the duty team number.

Q: The problem is that the people that you contact don't know what to do. What do GPs know about access into the system? In my experience, the disturbed person spent 24 hours in A&E before they saw someone from the psychotherapy team. They discharged themselves.
Andrew: Service users and carers tell us all the time that it's about good information and good communication.
A: There is an issue about how people in mainstream services deal with people with mental health problems.

Q: Mental health provision at RUH is now working very hard at getting some training for general nurses in mental health issues. They are not at the moment required to do a mental health component.
A: Another element is about mental health liaison for older people with dementia , for example.

Q: There are so many changes with nursing staff, many of them are from abroad and they don't necessarily know what to do with someone with dementia.
A: We are looking at how we can address this in this area.

Ronnie: There is a whole issue about training. Assumptions are made about older people. The family should be talked to. Awareness and understanding is critical.
A: The area of training and how you should influence it is a big issue. The other issue is about how you make mental health services less specialist. We are clear in B&NES that it's not about something specialist. I am hearing that adult services are not yet perfect. There are improvements but we are not there yet. There is someone employed to get people out of RUH beds and we need an expansion of that service into community hospitals.

Q: Are there out of area placements if there are empty beds?
A: The beds are mostly in adult services.

Q: If there are beds that are not being used, do you take in people from Swindon and Wilts?
A: Yes we do take people from other areas. The model is not about shifting people across systems, however. We normally try to keep people close to home.

Q: What about day care provision?

A: In B&NES, we're building resource centres and moving away from the old model of people coming in and not doing anything active.
Andrew: There should be one in Keynsham in about 9 months.
A: We are trying to provide an NHS service in resource based service. We don't want to create a mental health ghetto.

The older people's wards at St Martins were in old workhouse buildings and needed updating. Wards 5 and 6 have moved up to a community hospital and are now a much better environment. We are still looking into older people being on wards that were built for the general population. We need a different environment.

Q: It's a pity you can't look at private mental health provision as they are more comfortable and homely.
Q: The Swedish route would be good. All sorts of things based on one site, children are taken there, get rid of labelling and become part of the community. There is a Quaker building in East Sussex that does that.
Q: If in a large hospital site, there is better integration. Nurses could have three month placements.
Q: I'm against that model. It's going for medical model. People have other problems, such as loneliness, too.
A: Older people wards are for assessment and treatment and not long term facilities.
Q: One of the most valuable things we used to have was a weekly visit from CPN to talk through the problems we had with patients. This is done better when everything is on one site. Younger people still have access to specialisms.
Ronnie: With a holistic model, there is a real benefit in bringing everything together.

Q: Someone could be employed to raise the profile of mental health.
Ronnie: Mental health promotion work has fallen off the PCT agenda.
Andrew: Is there a way of including that into day service provision?
A: We need room for the voluntary sector in this. There could be different voluntary sector organisations rotating their coming into NHS provision.
Andrew: The long terms plans are very good. At the moment we need to concentrate on improvements, particularly to older people's services and how the consultation is going to happen. The day services were to be up and running by April, but everything has dragged on.

A: I can't give you those exact dates. Our aim is to go through the process as soon as we are clear that we have done enough on engagement on these issues. I don't want to get the process wrong at this stage. We are almost there and have a self imposed timescale. **We have got an impact assessment on 18 March at the Winter Garden in St Martins. If anyone is interested in participating, please contact me.**

Q: Will it go to overview and scrutiny?
A: After impact assessment.
Andrew: Being transparent is important. Carers are happy if they know the reason for delays etc.
A: We are hoping that everything will be in a sound enough state to move forward for an early spring consultation. The stages will then be: feedback, report writing, overview and scrutiny, decision from AWP and PCT. This will take 6 months from the time we start.

There has been a good stakeholder forum. Part of that model produced a questionnaire taken into groups and then an event. We could follow this model. There will be three public meetings

across three months in different localities. We could also devise a questionnaire. The primary care questionnaire that was sent to GP practices had a 25% return rate. I know the enthusiasm and need being expressed in this community about mental health services.

Q: Why is the consultation about older people's services?
A: We have been given a strategic model and can see older people's services need an immediate change to get service improvement.

Q: Can action plans from other parts be added to the consultation document?
A: We are hoping to describe changes across the whole programme. The context is that this is what we're doing in mental health services in B&NES. There is a particular issue about older people that we want to consult on. We need to decide on a model then put things into place to make it work.

Q: Is an older person over the age of 65?
A: That's a misnomer. It's needs based.

Q: Is it flexible?
A: Yes, in terms of provision.

Q: If we're going along with options 1 and 2, are we saying that they should be co-located with other facilities?
A: That's what I'm hearing.

Ronnie: We are interested in feedback from the network on how the consultation will work. Voluntary organisations were amongst those taking out questionnaires.
Andrew: it's important to have that balance. The value of having someone coming to talk to your group is huge.
Ronnie: Questionnaires could be backed up with meetings within settings where people request them.

Q: People whose services overlap with mental health services could be used. Links could be made with the independent sector to get the information out.
Q: How do you get through to "hidden" people, for example, people who won't admit they have a problem, but have things to say. What about the WI in rural areas or townswomen's guild?
A: In the past we went to a WI meeting in Bishop Sutton.
Ronnie: We also are doing an older people's network meeting on this.
A: It is about trying to do more of that. Let us know if you want us to come and talk to groups.
Andrew: Local employers and the chamber of commerce could be another route.
Q: What about the media? Features around mental health issues could be flagged up in The Chronicle.
Q: Why not involve League of Friends at RUH?
Q: What about the people delivering services such as nursing staff?
A: AWP are planning staff engagement work.
Andrew: The most disappointing thing about the questionnaire what the lack of support from secondary care practitioners.
A: It is a helpful thing that AWP have a PPI lead in their organisation and a PALS team. I've attached myself to them.
Ronnie: They are still recruiting to that team. I am proposing to get someone along to speak to the next mental health network.
A: Alison Griffin is working alongside me. She is from the first hospital in the country to get Foundation Trust status and is a very good resource.

There is a steering group set up to run the mental health stakeholder event. If anyone is interested in taking part, let Ronnie know.

Notes from flipchart

Big hospital site
- Integration of staff and services. Better linkages into the wards. Medical model?
- Need room for voluntary sector.
- Employ someone to raise the profile.
- Mental health promotion fallen off the agenda by public health teams.
- Don't segregate.

Separate site
- Integrated – social care and voluntary sector (not Callington Road model).

Consultation
- Links with independent sector.
- League of friends at RUH.

Date of Next Meeting: to be confirmed