County Mental Health Action Group

Meeting Held on 18th February , 2015, 2pm

Rother Room, Sessions House, County Hall, Maidstone, ME14

Present	Organisation/Email
Alan Heyes – Chair	Mental Health Matters
Marie McEwen – minutes	Sevenoaks Area Mind
David Hough	Co-chair Swale/Service User
Steve Furber	Co-Chair Swale/Casa Support
David Rowden	Co-chair Thanet/Speakup CIC
Brian Heard	Co-chair Thanet/Service user
Annie Jeffrey	Co-chair Ashford/Carer
Liz Tredget	Co-Chair Maidstone/Winter Shelter
Lynne Jones	Co-Chair South West Kent
Amanda Godley	Co-Chair Ashford/
Annabel Aitalegbe	Co-Chair Maidstone/Rethink
Sue Scamell	KCC Commissioner
Wayne Bennett	Sussex Partnership (CAMHS)
Carol Infanti	KCC (CAHMS)
Janet Lloyd	KMPT
Malcolm McFrederick	KMPT
Colbert Ncube	South East Commissioning Support Unit
Belen Toher	Activmob

Apologies

Nick Dent	KMPT
James de Pury	Co-Chair West Kent Clinical Commissioning Group
Richard Giles	Co-Chair Dartford, Gravesham & Swanley MHAG
Eileen Shrubsole	Co-Chair Canterbury & Coastal MHAG
Steve Inett	Healthwatch Kent
Karen Dorey-Rees	KMPT Assistant Director Acute Service Line

1.Welcome, Introduction and Apologies

The chair welcomed the attendees and everyone introduced themselves.

2.Minutes of last meeting - Approved

3. Outstanding Actions from last meeting

1. London School of Economics document circulated.
2. Malcolm McFrederick, KMPT Director of Operations, will attend the next meeting on 15th April to discuss the CQC Crisis Care Review.
3. Annie advised that she does not have permission to share statistics for out of area beds with anyone outside of Ashford.
4. Rheanna's response to Clive's question on Single Point of Access have been circulated and further questions raised by Clive.
5. Pat North has now attended the local DGS MHAG and will ensure a member of her team regularly attends the local meeting in future.
6. Trust Wide Patient Experience Group (TWPEG) report has been circulated.

4.Locality Chair Update

Ashford – Amanda Godley/Annie Jeffrey

Discharge process failure included people being discharged without notice, not receiving discharge letters. Not isolated to Ashford as this is a theme for other MHAG localities. We want to think about what is best practice and is it being followed?

David Hough reported that his experience has been very positive with his discharge and he has been referred to the Link worker. Lynne is not aware of anyone in South West Kent area who has met a link worker yet and that not everyone has received a discharge letter. It is more about the way it is happening rather than the fact they are being discharged.

Sue Scamell advised that there are two different services which are often confused:

1. Porchlight Link worker who works with anybody.
2. Primary Care Mental Health Specialist who assists with discharge from secondary care.

Not all areas have link workers at the moment as this is fairly new service in West Kent. Steve asked if strenuous efforts could be made to recruit a primary care mental health specialist worker in Ashford. Sue advised there are a variety of organisations who host them but Ashford has been difficult to recruit to.

David suggested it should be called transfer of care rather than discharge as this sometimes causes anxiety. Liz advised that the MHAG in Maidstone are working with KMPT to review the discharge pack. It was noted that there are different discharge processes in some areas and it would be better to have one system in place. Malcom suggested this could be driven through the MHAGs. Janet added that service users Linda Riley from SWK is doing some work on this for KMPT.

It was agreed there is a need to identify best practice by mapping what is already in place. Malcolm felt it was important to build the relationship between GP and the team; it also works well with GP calling consultant directly. Some CCGs are looking at different models but they should be looking at those who need support before secondary care. A lot of it is recovery journey. This gives us in secondary care the capacity to look after the next intake. Janet agreed to arrange a task and finish group to look at drafting a standard discharge letters for whole of Kent.

Action 1: Marie to email asking for expressions of interest in a one off meeting to draft a standard discharge letter.

It was agreed that Sussex Partnership will be included in this as will service users and carers. This will be a one off meeting with a two month timeframe. Malcom suggested gathering examples of good practice from other Trusts.

Amanda noted there is frustration trying to access services in Ashford due to lack of staff/recruitment. Alan advised that representatives from the Ashford MHAG are meeting with commissioner Lisa Barclay tomorrow to look at this.

Canterbury : No representative present to discuss their issues. Sue Scamell asked for correction to their issue 4. Carers Bill. It is not the Carers Bill it is the Care Act.

Dover, Deal, Shepway – David Rowden

1. Discharge issues raised and discussed above.
2. Lack of contact between assessment etc. 3 weeks to 3 months with no contact. Also same at Thanet. Malcolm confirmed he is aware of this in Thanet and DDS and is putting extra work into these areas as a priority.
3. Staff changes. No idea who to complain to locally due to staff changes. Would like a directory of staff and courtesy email to inform of any changes to managers etc. Malcolm advised that he is looking at this and would like to put staff photos at all entrances. If care coordinator changes it goes without saying that people should be informed. Janet added

that anyone can call Patient Experience Team for this information. West Kent 0800 587 6757 and East Kent 0800 783 9972
Steve added that communication with the team at Thanet has improved and is very successful.
It was agreed that the local agendas should add an item for local staff changes.
The new KMPT website was launched on Friday. Please look and feedback. http://www.kmpt.nhs.uk/

Maidstone Weald –Liz Tredget/Annabel Aitalegbe: Liz passed round some case studies. These are real people and we have permission to use their names. If some of these people were caught earlier the outcome could have been very different. This is not a singular incident. The voluntary sector agencies are pulling together to wrap around the client but this is not happening with statutory services. Nothing changes, there are huge gaps between being seen and not getting treatment. The voluntary sector have changed how we work but this needs to happen with statutory services too. If KMPT cannot recruit high qualified staff then lower level STR workers on the ground would make a difference. This needs a fundamental change to statutory services. We are asking for meaningful changes. Low level community support workers/linking voluntary and statutory services would be the first step. If there is a gap in statutory services then the voluntary sector can help, we need to bridge the gap. People need certainty and support. There is nobody at Kingswood to pick them up. Promises broken, appointments cancelled. Suggestions: Wellbeing Café/crisis house.
Malcolm agreed that processes are not always right but there is a massive piece of work happening and it will take time. The first part has started with the single point of access (SPA). By this summer SPA triage will be with a mental health nurse. From there it will be possible to book appointments for initial assessment or to see care coordinators. This takes control of rapid assessment. This ensures there will always be somebody there to answer the phone and will allow care coordinators do be out doing their job – not answering phones. SPA is always manned. Secondly, financial resources and staff recruitment. SPA allows us to look at role of care coordinator i.e. is basic admin right for highly qualified staff? It will take time to roll out and we are starting in Thanet. We will never be able to recruit all the highly skilled staff we would like.

Annie felt strongly that services are set up for the convenience of services not those using them. Continuity of care is very important. Staff are disenchanted with the expectation on them. Annie is delighted to be involved with Open Dialogue and agreed to provide a presentation on Open Dialogue to the County MHAG, also happy to do presentation to local groups. She noted that in five years her family never saw the same psychological team.
Annabel added that it is not possible to control staff leaving but asked that people are informed when staff changes happen. David H felt it was about the treatment not the person delivering the treatment. If there is good quality care it does not matter who delivers it. The care should reflect modern times. Steve added that at the old Locality Planning & Monitoring Groups (LPMG)s there were two regular themes, a) poor communication from CMHT – people did not know who their psychiatrists were. It is common courtesy to keep people notified.
b) Defensiveness. We bring the information to the MHAGs but Managers are protective of their team and this makes CMHT less likely to attend local MHAGs. Is there a less formal way to meet with local management? Cultural shift needed - we want to work together.
Malcom requested that everyone should notify KMPT's communication team about new things such as wellbeing cafes etc. communications@kmpt.nhs.uk He also advised that the Local Leadership Groups (LLGs) will be setting up a clinical discussion around each area with people from all different services, e.g. ward, crisis team etc. Malcolm will give some thought as to how this can be developed.
Amanda advised she had written a friendly email to try and address issues to Bob Ditchburn but he did not even reply. It is hard to build the relationship when he is defensive and resistant. Amanda acknowledged that Bob is under pressure with staff shortages. Alan agreed that they could all work together to try and build local links. David H noted that the Swale mhag has a lot of the unrest caused by individual instances whereas it is the process which needs to be looked

at. Steve queried if the same question is constantly raised by same people and there is no resolution to be had, should they continue to attend the meeting? Also Carers support is not working. Not full buy in – CMHT staff meetings do not invite us, we need more informal communication.
Malcolm advised that MHAGs should let Janet know if there is resistance from local teams to attend. Malcolm added that local managers can do nothing about the bed situation and no pressure should be put on them to respond at local meetings to this.
Annabel cautioned we need to be careful when talking about local historic problems as we do not want people to stop speaking up. Liz asked if it was possible to recruit lower level staff? Malcolm replied that the problem in secondary care is that voluntary sector have more control whereas he doesn't. This comes through in the Care Quality Commission (CQC) report and we are working with that. Liz stated that investment is needed in early intervention where services are not working at the moment.
Action 2 : Marie to email Wayne Bennett with dates for local mhags to arrange attendance by Sussex Partnership (CAHMS).

South West Kent – Lynne Jones

1. Term Service user – negative feedback. Don't like user, prefer client. Janet commented there has been debates for 20 plus years on this. When people are in hospital they want to be called patients and when out they want to be called people. The group considered terminology but everybody had different suggestions. Janet concluded it is not easy to please everyone.

2. Residential services feel they are left holding residents in crisis before any action is given based on the misconception they are residential and able to cope. In one instance the ambulance remained with the person from 9am to 4pm with no further intervention. Malcolm stated this is not an active policy decision by KMPT and advised that details are given to Janet Lloyd to look into and feedback.

Action 3 : Lynne to give details of residential services' problems accessing crisis services.

It was agreed that local crisis houses would give people support and prevent hospitalisation.
Sue pointed out that two services referred to were Richmond Fellowship who provide supported accommodation whereas Crossways is residential. Janet said she would be interested to talk to them to see what support they are getting before they got to that situation.

3. Employment Support Allowance (ESA). The Department for Work & Pensions (DWP) had advised that supporting documents needed to be dated within three months of the assessments and an out of date psychiatrists report is not acceptable. People are finding it hard to get these within date. Lynne asked that all KMPT teams are made aware of this and to ensure people receive these documents when requested. Janet agreed to do this.

Action 4 : Janet to advise KMPT teams that documents for ESA assessments should be within three months of the persons' assessment date.

5.Commissioners Reports

Kent County Council report from Sue Scamell circulated.
South Coast CCG report from Tamar Beck, circulated.
Dartford, Gravesham & Swanley CCG report from Naomi Hamilton circulated.
Swale CCG report from Naomi Hamilton circulated.
Thanet CCG report from Jess Andrews – circulated.
West Kent Clinical Commissioning Group report from James De Pury circulated.
Canterbury & Coastal CCG report from Lisa Barclay, none received
Ashford CCG report from Lisa Barclay, none received.

6.Patient Experience Team Update: Janet Lloyd

The Trust Wide Patient Experience Team now meet monthly. Marie will circulate the latest Report. The 11 page report tells you about complaints/compliments received for September/November 2014. Level 1/2 complaints are dealt with locally and level 3/4 are responded to by Managers.

Complaints are highlighting what you are saying here today. This goes from TWPEG to quality committee board and forms Malcolm's plans to address this. On average we have one complaint a day. With 13,000 contacts in services it is difficult to pick up specific trends. We also highlight learning. We have changed the form around complaints and concerns. We are asking staff what they have learned from the complaint to ensure no re-occurrences. We are doing a lot of work around carer engagement. Latest was on 4th February on the Carer Charter and following on with care planning and consultation events with carers. We discussed risk and safety strategy. Also rolling out further carer training and Walk a mile in my shoes training rolling out to all localities. I am still not entirely sure what you want in these reports so please email me and let me know. Friends and family data from across services showed only one person said they were unlikely to recommend our services. There are things going wrong and we are aware of that but we do have some satisfied customers also.

ACTION 5: Marie to circulate TWPEG report and ask for comments on what people want to see in future reports.

7.Any Other Business

Children & Adolescent Mental Health Services (CAHMS): Carol Infanti (Strategic Commissioning)

The consultation/strategy document has been signed off by Health And Wellbeing Board and we are now working out the procurement timetable. More consultations will follow then eventually procurement. This is a lengthy process and we will keep you informed as it progresses. Sussex Partnership are doing well and now meeting contracted times. It has been an uphill struggle but now working as it should be. Still some problems for some who are not using the referral system correctly to direct referrals to the right part of the service. There is a difference between emotional wellbeing and mental health. Wayne added that the Friends & Family Test is showing a theme in the criticism. Annie felt strongly that it made no sense how this service is commissioned – there are three different trusts involved, Kent & Medway Trust, Sussex Partnership and South London & Maudsley. Carol advised that they have no control over this as it is up to NHS England. Annie queried how there can be any continuity and is not working for many people. Carol said it should not be a problem as they are all working together. Annie suggested she should talk to the people who use the service. Carol advised that the Single Point of Access will change this. Carol and Annie agreed to discuss this outside of the meeting.

Sue Scamell: The Live It Well (LIW) strategy has been in place ten years and expires on 31st March 2015 and we are now looking at what happens next. Please send your feedback from your local groups to Marie on the impact LIW has had by end of March. We will definitely be keeping the LIW website, the LIW centres will become part of the mental health core offer – partnerships and collaboration are critical but whether the name changes or not the service provision is the way forward.

Action 6: Marie to request feedback on impact of the Live It Well strategy.

Liz Tredget asked for an email to be sent to local teams to ask them to engage with the voluntary sector. Janet agreed to arrange this.

Action 7: Janet to send email to local teams to ask them to engage with the voluntary sector.

Malcolm McFrederick KMPT Director of Operations : Crisis concordat - Disappointed to hear Kent police are withdrawing from street triage. Please discuss with your local police. The pilot showed a reduction in the number of 136 cases, which in turn reduced workload on AMHPs

(Approved Mental Health specialists) and the crisis team. We also recognise our crisis team do a lot of other things. Home Treatment is most effective. Good negotiations with CCGs had – you might want to ask your commissioners how they will demonstrate parity of esteem next year. They can give you the details.

BEDS: Putting people out of area, is wrong for the person, carer and staff. I am on same page as all of you on this. I wasn't in post when commissioners decided to build bed numbers. We build what we are told to build. More beds need more staff and I would struggle with staffing levels. It does not matter how many beds there are, it is availability when needed that matters. Crisis houses would be a good alternative as intermediate services. We currently have inpatient services and community services. Crisis housing would prevent people going into hospital which leaves the bed available for next person.
Two reasons people go out of area :
1. For specialist care not available in Kent. 2. Capacity of secondary acute care beds – overflow.
This overflow is caused by

1. delayed discharged, waiting for complex health and social care package. 1 in 5 older adults don't need to be in hospital.
2. lack of intermediate care which avoids admission.

We could become more efficient. (Out of Area bed chart for last two years was passed around – link to follow) this shows we have done something, but not enough.
Beds are commissioned on basis of CCGs entitlement. They put money into pot, sometimes they need more, sometimes they don't. Looking to provide 174 beds for younger adults. This chart shows how many beds CCGs have used and plan to have. Out of area might be acuity of need or availability. People with greater need stay in area.
If in black then less beds used. If in red it means we would have moved them elsewhere. This shows that in Swale you are never in the red and in theory we should be able to put Swale patients in beds most of the time. Swale had significant shortages of staff but they managed to provide beds. David H pointed out that Dartford is out of the local area for Swale patients and impacts on people's recovery. Malcolm acknowledged this and advised that Maidstone will be better for Swale people.
East Kent and Medway have greatest pressures, high usage. If you want to know what your CCG do, look at their website. Steve noted that Thanet and Medway were underpaid. Malcolm advised that all CCGs shared the risk, like an insurance policy. David H asked if Thanet and Medway are in red is there not an issue with community services – prevention/cure?? Malcom confirmed it could be the whole system or it might be they didn't commission the right number of beds.
Annie queried the comment that people with greater need do not go out of area. We were told intensive care beds were no longer needed and within two weeks the ward closed and people were sent out of area because there were no beds. Malcolm agreed to take the point and will respond to it shortly.

Action 8 : Malcolm to consider and respond to closure of intensive care beds in Ashford.

The average length of stay - nationally is 32 days and Kent is 29. Older adults is 72 days and Kent is 80 days, as there is need for complex care package. PICU is 43 days and Kent is 72 days; because we are holding people there who are unwell and are waiting in the safest place for them. They may not need to be on PICU or acute wards and could be better cared for elsewhere. There are variations on length of stay. In east it is longer, in north and west it is shorter. We are doing a piece of work to look at why this is.

We know there are issues, long term building and staff is an issue, and crisis teams are thinly spread. We need more home treatment and alternatives to admission. 136 admission means a long stay when they could be looked after for a few days to prevent admission. There are things we don't do well and we want to. There is disparity between east and west.

Annie commented that commissioning had gone very wrong in last two and half years. After the public engagement, wards were shut against our pleas and remain closed. It is not good care

sending people away. It is appalling that there is only one 136 suite in whole of Kent for young people and it is in Dartford.
David H asked why the £5m spent on out of area beds could not have been better spent keeping them in area? This shows that finance is there and is not the problem. Malcolm said it was a case of what do you do first? Alternative services needed to be put in place to swap from one to the other. Annie stated it was wrong to take crisis services away first. Malcom agreed and said he is trying to sort this out now. Malcolm is happy to discuss any of the above further with anyone who wishes to contact him Malcolm.mcfrederick@kmpt.nhs.uk.

MHAG Review: As a result of the review it was agreed that the agenda's and meetings should celebrate the successes of the MHAGs and all services who attend. The results of the review will be published shortly. There is a meeting for the co-chairs after this to discuss the review further.

Annie raised the point that NHS England states service users and carers should be included in all CAHMS performance meetings. (West Kent do these). Carol will take this back to her team.

Action 9: Carol to remind CAMHS team that service users and carers should be included in their performance meetings.

8. Date of Next Meeting: 15th April, 2015, 2pm at Rother Room, Sessions House, County Hall, Maidstone, ME14 1XQ

Action Table with responses

No.	Action	Responsible	Status
1	Email MHAGs asking for expressions of interest in a one-off meeting to draft a discharge letter.	Marie	Completed
2	Send MHAG date schedule to Wayne Bennett	Marie	Completed
3	Provide details to Janet of residential services' problems accessing crisis services.	Lynne	Completed
4	Advise KMPT teams that documents for ESA assessments should be within three month date of the persons' assessment date.	Janet	outstanding
5	Circulate TWPEG report and ask for comments on what people want to see in future reports.	Marie	Completed
6	Request feedback on impact of the Live It Well strategy.	Marie	Completed
7	Email local teams to ask them to engage with the voluntary sector	Janet	outstanding
8	Consider and respond to closure of intensive care beds in Ashford.	Malcolm	outstanding
9	Remind CAMHS team that service users and carers should be included in their performance meetings	Carol	outstanding

Please note that draft minutes/agendas/documents will be available via the Live It Well site on the following link: http://www.liveitwell.org.uk/local-news/county/

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