County Mental Health Action Group

Meeting Held on 17th June, 2015, 2pm
Rother Room, Sessions House, County Hall, Maidstone, ME14 1XQ

Present	Organisation/Email
Steve Furber - chair	Co-Chair Swale/Centra
Marie McEwen – minutes	Sevenoaks Area Mind
David Hough	Co-chair Swale/Service User
David Rowden	Co-chair Thanet/Speakup CIC
Brian Heard	Co-chair Thanet/Service user
Annie Jeffrey	Co-chair Ashford/Carer
Amanda Godley	Co-Chair Ashford/service user
Annabel Aitalegbe	Co-Chair Maidstone/Rethink
Steve Gill	Co-Chair Maidstone/V.A.M.
Richard Giles	Co-Chair DGS/MIND
Janet Lloyd	KMPT
Belen Toher	Activmob
Jeanette Dean-Kimili	CCG South Kent Coast
Naomi Hamilton	CCG Swale & DGS
Yasmin Ishaq	KCC
Matt Stone	Sussex Partnership NHS Trust (CHYPS)
Theresa Breakspear	Richmond Fellowship
Hannah ?	Invicta Advocacy
Heather Randle	KCC
Audrey Quansah-Akabah	KMPT Equality & Diversity

Apologies

Jo Miller	Co-Chair Dover, Deal & Shepway
Aileen Shrubsole	Co-Chair Canterbury & Coastal
Mark Kilbey	Co-Chair Canterbury & Coastal
Sue Scamell	KCC Commissioner
Malcolm McFrederick	KMPT Operational Director
Alan Heyes	Mental Health Matters

1.Welcome, Introduction and Apologies

The chair welcomed the attendees and everyone introduced themselves.

2. Peer Support Open Dialogue : Annie Jeffrey/Yasmin Ishaq

Yasmin is the service manager for Early Intervention in Psychosis. Annie is a carer who felt services were not working and investigated the Open Dialogue system which has been running in Finland for 30 years with staggering outcomes. KMPT got behind this and arranged training from the Finish service for 18 staff, including Annie. Training started in October and lasts a year.

Open Dialogue has seven principles:

1. **Immediate help :** anyone can self-refer. Seniors answer the phone and will decide what needs to happen next, whether immediate or next week. That person has responsibility from the beginning to arrange the next step. Whoever makes the call should be included in the first meeting to ensure everyone knows what is happening and why the crisis has occurred.

2. **Social network perspective** : The inclusive approach often shows a richer picture and greater variety of answers/opinions which affects their family, community and culture. All voices will be heard and this can include advocacy, drug/alcohol agencies etc or whoever is in the persons' social network. No assumption is made about the person and their network. We ask the person who their social network includes.

3. **Flexibility and mobility** : Meetings can be at home or other appropriate place. Sometimes home is best place, hospitals still have stigma. Service user makes the decision and are not told what to do.

4. **Responsibility** : The first person to answer the initial call takes responsibility throughout.

5. **Psychological continuity** : A team of 2/3 people will stay with the person throughout. Problems occur when people are sent between services. Seeing too many people and having to repeat their story over and over again is not helpful.

6. **Tolerance of uncertainty** : Network meetings take place in front of the family and service user. They can then see that we do not always know what has gone wrong or have the answers. Medication is openly discussed in the first three meetings but no decision is made. Some people in crisis are not on medication and in Finland within 2 years only 20% of people with psychotic illness take medication. Research from Finland shows it is helpful to understand this from a personal perspective rather than as an illness.

7. **Dialogue (& polyphony)** Continuous dialogue happens by asking "what do you think?" "Am I right in thinking this?" Then agreement is reached as new ideas and thoughts evolve. Getting in at the early stage of distress is important as delays in access causes conversations to be more complicated and difficult. No decision is made about the person outside of the room which allows people to speak up if it they don't agree.

This will be a big shift in our mental health services. KMPT are taking a big risk with this. Doctors and medical director are doing the training. Also happening in Germany, Norway, America and in pockets in UK. KMPT are part of 4 trusts taking part here. We are planning an Open Dialogue conference on 11th September in Kent and will ensure information is sent to MHAGS. Our Keynote speaker is from Finland. To conform with National Institute of Clinical Excellence (NICE) guidelines we are doing a Randomised Control Test (RCT) trial with 8 families in Birmingham who will attend and share experiences at the conference. We are collecting quality data from families and practitioners. Practitioners are liking the approach so far. There is no time limit on meetings but around two hours seems to be about right to allow dialogue to flow. Trials include young people and are across age spectrum but under 65 at present. Trans-diagnostic including personality disorder and dual diagnosis. Drug workers and criminal justice/social workers are included in the network and not confined to specific category of mental health professionals.

Finland are closing beds because they are not needed. Incidents are reduced and 75% are back to work within two years because people are getting help sooner. In the long term people are not relapsing and they are getting better. Lots of other countries are taking up the training, including New York.
Open Dialogue is not an easy fit onto our NHS system and there are big challenges ahead, we don't even have funding for second cohort training yet. We would like a standard stand-alone team eventually. Not sure how the Single Point of Access will fit with this 7 days a week as they are only operational 5 days. It is as much about what we let go of as about what we do. Power levels within a system will have to be let go. Philosophical approach – not a manual.
Our approach will include peer support which follows the American model, (Parachute Project) which looks for peer support for those who do not have a strong network or family. This is being taken up by American health insurance companies as they can see good outcomes for the money and has grown substantially in New York.

Money is saved on medication and qualitative targets are about getting back to work/education. Finland has 83% of people with schizophrenia and psychosis back at work. In the UK treatment can be as debilitating as the condition and can stop people from working. Allowing space and time for people to talk – networks talk and professionals listen, they come up with their own solutions rather than being told.
Timeframe – the application for Programme grant will be made in October this year Steve Pilling leads on NICE guidelines and result will be heard until next year. No guarantees we will get it.

If the person does relapse, meetings can still take place in hospital but this has not happened yet. The process does not re-start after relapse as it is continuous. Some families decided they did not need weekly/monthly meetings and agreed they would call us if needed.
If the person is resistant to treatment the network can still go ahead with the meetings and leave the door open for the individual to join in. This has happened before and eventually the person joined in and spoke up saying he did not want to take medication. The network worked with him. Suddenly stopping medication is dangerous but by discussing at the meetings it can happen slowly and be monitored, people then have a choice.
This will work across Black, Minority, Ethnic (BME) needs also as we would ask the person who they wanted to be included from a cultural perspective. Not a one size fits all, it fits around the person.
The group thanked Annie and Yasmin for their time and information and agreed this was a real opportunity to change mental health services in this country. Annie & Yasmin will be attending local MHAG groups in July. Further information can be found here http://opendialogueapproach.co.uk/ and here https://www.youtube.com/watch?v=ywtPedxhC3U

Audrey advised that she is organising a conference on Equality & Diversity later this year to look at how far we have pushed the conversation. There will be different workshops to input where people feel we should co-design, taking views from whatever angle they are coming from.

3. Minutes of last meeting - Approved

4.Action Points from Last Meeting

1. Tim Hill and Paul Williams from Kent Police have attend Swale MHAG.
2. Matt Stone from Sussex Partnership is present today.
3. Jeanette confirmed the CCGs have worked closely with KMPT who provides data. Previous Out of Area Bed information was in number format only with no narrative or context. The new draft format report will include a snapshot of details including the reason for delay in discharge or admission. This will highlight need for care package/community adaptations/completion of assessment from third party/waiting nursing home placement/housing issues/supporting narrative. The East Kent Performance group need to agree to the format and the East Kent Service Improvement Group will meet on 2nd July to confirm they are happy with this to be shared with MHAGs. We have all acknowledged there is a lot of work to do around movement and we have worked out agreements. The system is fragmented and costing a lot of money. If the system is improved we can use the funding better. Everyone is on board to make a difference with this.
4. Outstanding action from Steve Inett, Healthwatch. Marie to chase.
5. Jo Scott is no longer CAMHS lead at Sussex Partnership. Matt Stone is the interim replacement and agree to provide Local bi-monthly updates for the MHAGs.
6. Angus Gartshore has taken on the outstanding actions from Maidstone on behalf of Malcolm McFrederick.
7. See 6 above.
8. SMART is a risk assessment tool used by Liaison Psychiatry Services in partnership with the acute trust, it supports triage of a patient by A&E departments prior to referral to the Liaison service. For more information please contact service manager Teresa-Marie.Barker@kmpt.nhs.uk
9. Janet agreed to provide a brief verbal update from the Patient Experience team in future rather than circulating the Trustwide Patient Experience Group minutes.

10. Overview of past working groups is included in the MHAG annual report which has been circulated.

5.Local MHAG Questions

Canterbury/Swale: Financial cuts: Jeanette responded on behalf of Lisa Barclay the Canterbury CCG Commissioner : There have no identified or agreed cuts to mental health finances. If this is specific to Canterbury the local MHAG group should contact Lisa.
Janet noted there were press reports of £8m being cut from KMPT budget. Jeanette explained that budgets move around within the mental health system. IAPT provision in East Kent has gone up to £4m in the last five years. Placement budgets have gone up exponentially and mental health funding has also increased. Commissioning in NHS England shows that in real terms there is a greater spend in mental health services. IAPT criteria now includes 17 year olds which will increase our spend, this is not capped, contract estimated at £4.5 million. Providers more inclusive to people on autistic and ADHD spectrums
Annie added that Kent is still not spending same as national average on mental health. Jeanette advised that CCGs set out their spending and each CCG does this differently, some might include only secondary care, some might not include prescription charges or young people services. It needs to be made clear about what is included. If the finance department put the figures together it might not include all areas. We need to ask for the totality of spend including primary and secondary care etc.
Naomi added that national targets for IAPT across CCGs show areas with prevalent need at 10,000 people with mild to moderate needs. The budget will not decrease. We look at re-referral rates and if anyone is re-referred within 12 weeks we would talk to their GP. In Kent we are on the 15th percentile in England for recovery rates. South Kent got 5th highest access rate in England. There is more focus on early interventions to catch more people before they need secondary care.

Dover/Deal : Hospital hopper bus query. Janet confirmed that KMPT do not provide this service. There is a volunteer transport service in place with six drivers who can travel anywhere in Kent. The ward manager will give details to the patient. This is managed out of Priority House and the ward will assess the carer's needs and if they meet the criteria the ward will book the driver. Only one use a week allowed. There has been a huge decline in its use but it is used more in Maidstone. Janet added that the service is not advertised as capacity is limited. If anyone knows any volunteer drivers please let Janet know.
Most Volunteer Bureaus run a volunteer service at a charge but is cheaper than a taxi. It was agreed that local MHAGs will contact local volunteer bureau for details.

Action 1: All MHAGs to contact local Volunteer Bureaus to find out about volunteer driver service.

South West Kent: Supported Permitted Work query - response from Sue Scamell : The new community mental health and wellbeing service is currently out to tender. We are moving away from prescriptive services and outputs to outcomes. This will give new providers the opportunity to design services very differently. Providers will be expected to adopt the Individual Support best practice model to support individuals back into the workplace. We have not stipulated the length of time that people can be supported. Providers are currently paid through a grant mechanism which means that funding is awarded on a yearly basis. With the new contract this will be extended to a five year period with the option to extend for a further 2 years. This will give providers more financial stability. Shaw Trust are working with KCC to agree terms for current services.

Swale : Finance cuts - see response above to same query raised by Canterbury. Naomi reported that funding in Swale has increased. Media reports not always correct and if anyone has any questions they should email Naomi directly.

Thanet: 1. Waiting times for psychological therapy. David explained that a service user who had been assessed was told there is a 6 month waiting list. The Thanet service manager, Cathy Nymeck, has provided waiting times for Thanet but the group would like Kent Wide figures to make a comparison.
2. Thanet are using group therapy where possible to get people off waiting list and wondered if this is happening anywhere else. Janet will find out and report back.

Action 2: Janet Lloyd to source psychological therapy waiting times for Kent and confirm if other localities offer group therapy to alleviate waiting lists.

Matt advised that the average wait across Kent for CAMHs assessment is 7 weeks with treatment in 15/16 weeks. Janet confirmed it should be 28 days for assessment and has to be within 18 weeks for treatment.

6. Commissioners updates

The CCG and KCC Commissioner updates are circulated to local MHAGs. The group felt it would be helpful for all commissioners updates to be circulated to the County MHAG mailing list before each meeting. Naomi asked if local chairs could also provide a short update from their localities before each County MHAG meeting. The group agreed and will discuss this further at the Co-Chair meeting later.

Helen Randle (for Sue Scamell) added that the results of public Health & Wellbeing consultation have been circulated. There are 8 strategic partners going forward, details to follow shortly.

7. Patient Experience Team Update

Janet confirmed that the initial Discharge Letter meeting had agreed a first draft but was 6 pages long to include everything. Input included from consultant psychiatrist Peter Knynenburg. Sandra Harvey and Linda Riley will produce a more streamlined second draft which will be circulated after their next meeting. This has been well received within KMPT.

An Out of Area leaflet has been prepared and is ready to go to printers. This is for people within Kent sent out of their local area, not for people sent out of Kent. The Carers Guide to Confidentially A5 booklet is also at the printers.

8. Any Other Business

Children & Adult Mental Health Services (CAMHS) – Matt Stone: New in post. Kent is a big county and faces big challenges but the picture is no different here than nationally. Referrals are up and are high. Levels of distress are higher than before which is alarming. The contract expected 10 emergency referrals in a month but reality is 100. We are struggling but average time for assessment is down to 7 weeks. We met with 7 CCGs recently and recognise we do not have enough capacity in the system. Whichever bit we improve it causes increase elsewhere. CCGs have a new strategy plan and the new contract going to tender is based on this model to ensure people do not fall off system at 18. The eligibility for different services is a national issue. Kent have the Emotional Wellbeing Strategy based on being clear on early interventions to prevent build up in services later. We need to think about step down and how people are supported. This meeting gives us some platforms to find out which youth groups we need to talk to.
Jeanette advised that CAMHs will have agreed service development improvements with commissioners as this is standard with NHS contracts in partnerships. It would be useful for us to know what areas of concern have been raised and what is planned to address them. Matt agreed to look into this and provide details.

Action 3: Matt Stone to report back on the concerns identified under the agreed service development improvements for CAMHS and actions planned.

Guardian article 8th June states that £15m of new funds are to be made available to provide a place of safety for people suffering a mental health crisis. Naomi advised that there are some pilot projects happening nationally. Further guidance will be available October.

Annie asked if there is any update on the crisis concordat/crisis houses? All CCGs have been saying for two years that Crisis Houses are the way to go but nothing has actually happened. Naomi agreed to ask Dave Holman for update.

Action 4: Naomi Hamilton to ask Dave Holman to provide an update on the Crisis Concordat and Crisis Houses.

8. Date of Next Meeting: 19th August, 2015, 2pm in Room Swale 3, Sessions House, County Hall, Maidstone, ME14 1XQ

Action Table with responses

No.	Action	Responsible	Status
1	All MHAGs to contact local Volunteer Bureau to find out about volunteer driver service.	MHAGs	Details for all areas provided by Canterbury Chair
2	Confirm psychological therapy waiting times for Kent and confirm if other localities offer group therapy to alleviate waiting lists.	Janet Lloyd	Ongoing
3	Report back on the concerns identified under the agreed service development improvements for CAMHS and actions planned.	Matt Stone	Ongoing
4	Ask Dave Holman to provide an update on the Crisis Concordat and Crisis Houses.	Naomi Hamilton	DH is attending October County MHAG

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/your-community/county-mental-health-action-group/

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