South West Clinical Senate

Minutes of South West Clinical Senate Council

Held on Thursday 19th November 2015
In Taunton Rugby Football Club

Meeting Notes

Present:

Phil Yates, Chair	Georgia Jones, Core Senate Council
Marion Andrews-Evans, Core Senate Council	Bruce Laurence, Core Senate Council
Kate Archibald, South Gloucestershire CCG	Laurence Mynors-Wallis, Speaker
Sunita Berry, Senate Secretariat	Sarah Redka, Senate Secretariat
Tim Burke, NEW Devon CCG	Ann Remmers, Core Senate Council
Phil Confue, Speaker	Guy Rooney, Core Senate Council
Diane Crawford, Core Senate Council	Emma Stapley, Core Senate Council
Ellie Devine, Senate Secretariat	Debbie Stark, Core Senate Council
Sara Evans, Core Senate Council	Christine Teller, Core Senate Council
Richard Eyer, Senate Assembly	Guy Undrill, Speaker
Caroline Gamlin, Senate Secretariat	Malcolm Watson, Core Senate Council
Derek Greatorex, South Devon and Torbay CCG	Jenny Winslade, Core Senate Council
Deborah Howards, Somerset CCG	Paul Winterbottom, Core Senate Council
Peter Ilves, Speaker	Phil Yates, Core Senate Council

Apologies:

Trevor Beswick, Core Senate Council	William Hubbard, Core Senate Council
Chris Burton, Core Senate Council	Peter Jenkins, Wiltshire CCG
Paul Eyers, Core Senate Council	Martin Jones, Bristol CCG
John Graham, Core Senate Council	Ian Orpen, B&NES CCG
David Halpin, Core Senate Council	Sally Pearson, Core Senate Council
Paul Hardy, NEW Devon CCG	Linda Prosser, Invited
Susan Hawkins, Core Senate Council	Andy Seymour, Gloucestershire CCG
Jonathan Hayes, South Gloucestershire CCG	Margaret Wilcox, Core Senate Council

		Action
1	**Welcome, introductions and business items**	
1.1	**Public attendance and recording of meeting**	
	There was no public attendance at the meeting. The meeting was recorded for the purpose of minute taking. The recording will be deleted after the minutes have been agreed.	
1.2	**Minutes from last meeting**	
	The minutes from 17th September 2015 meeting were approved.	
1.3	**Conflicts of interest (COI)**	
	There were no COIs declared.	

1.4	**Membership Update**	
	The Senate Council is operating with the new membership as agreed at the last Senate Council meeting. There are a total of 23 spaces for core members, five of which still need to be recruited to. In addition to this there are 5 standing members on the Senate Council. Recruitment for these roles will now proceed. The revised membership has been incorporated in to the updated Operating Principles which will be available on the Senate Council website. CTeller confirmed that the Citizens' Assembly (CA) have agreed that the CA Chair (Deputised by the Deputy Chair when necessary) will attend council meetings supported by one other CA member elected specifically for each Senate Council meeting.	
	Action: Circulate the final Senate Council membership list including names to the Senate Council Members.	**EDevine**
1.5	**All Senate Operating Model**	
	EDevine also noted that a national all Senate Operating Model has been signed off and will also be available on the website.	**EDevine**
1.6	**Council to receive rehab' review report**	
	The South West Senate Council has provided a clinical review of the proposed service model for Rehabilitation, Reablement and Recovery for South Gloucestershire CCG. A panel of out of area experts from within this field were recruited from the other Senate areas nationally. A draft report with initial advice and recommendations has been provided to the CCG and circulated to Senate Council members, who accepted the draft. Areas for improvement were identified and there is now an ongoing dialogue with the CCG to agree next steps to ensure the review outcomes are incorporated to take the model forward. Once the report has been finalised it will be circulated to Senate Council members before going to the South Gloucestershire CCG Governing Body. It was noted that this was not a formal clinical review as part of the NHSE assurance process for large scale service change but that NHSE are currently in the process of reviewing its assurance model. EDevine confirmed that once this process is clarified she will share information with all the CCGs, as should NHSE directly, to ensure they understand when to follow the assurance process and at what points a Senate review would be required.	
	Action: Circulate the re-worked NHSE assurance model once finalised.	**EDevine**
	Additional note: PYates informed the council that he has recently met with Mark Cooke, Director of Commissioning and Operations, NHSE and discussed how to ensure meeting Senate recommendations is built into the assurance process for CCGs. He has also agreed to start attending MK's regular meeting with the Accountable Officers from the 7 CCGs across his patch. PY and ED hope to set up a similar link in the North of the patch.	
	Deliberative Session	
	Question: *As seen through the experience of service users and their family/carers is the current provision of mental health services and their configuration appropriate?* *How and where should services best be accessed for early help, ongoing*	

	support and in crises and what changes would the senate therefore recommend?	
2	**Introduction**	
	PYates introduced the topic. The following pre-reading papers were circulated to the Senate Council members prior to the meeting; • Collaborative care model – Health Home, Information resource Centre • Mental health reconfiguration – Journal of Health Science, Research and Policy • IAPT 3 year report – Department of Health • Crossing boundaries – Mental Health Foundation • Integrating behavioural and physical care - JABFM • Managing urgent mental health needs – Academy of Medical Royal Colleges • Mental health bulletin - HSCIC • Mental health under pressure – King's Fund **The pre-reading papers are available from the SW Senate website:** http://www.swsenate.org.uk/senate-council/meeting-archive/	
3	**Citizens' Assembly (CA) response**	
	CTeller, Chair of the CA presented the collated findings incorporating the feedback from each Healthwatch area and the findings from 194 responses to a survey monkey survey which was widely circulated via the 13 Healthwatch organisation across the South West. Feedback had extremely good coverage including an event that 900 people attended and a separate survey of 163 in one Healthwatch. In particular there was a good response from young people. Presentation slides are available from the SW Senate website. **Questions and comments:** Need to question what outcomes are important for people,? C) An outcomes based practice versus a recovery model is difficult to measure in mental health. C) Measuring a patient's belief that they are moving in the direction they want to be is a big challenge both in physical and mental health. C) The themes collated are universal to both mental and physical health – access, support and training. C) Young people's services are based on a medical model of health however they are requesting access to therapies. C) Strong link between mental health and social care. C) Mental health model should focus on 'public mental health' building good mental health at school and through housing. C) Four aspects of the 5YFV are of particular importance to mental health: prevention, user technologies, care in community, rebalancing investment.	
4	**Options appraisal for mental health services**	
	SBerry presented some data on mental health spend, contact figures, outcomes, the complexity of the Mental Health pathway and a possible options appraisal in response to the question to the Senate. Presentation slides are available from the SW Senate website.	

	The council discussed that whilst do nothing was not an option, they would not recommend major reorganisation as lots of remodelling previously undertaken is still in progress and this needs to be consolidated with a focus on building and strengthening what we have. It was noted that prevention also needed to be considered but that the question purposefully had a general focus and was not looking at specific stand alone areas such as CAMHS and perinatal care. The Senate Council agreed that they would debate the following two options in relation to the overarching question: Option 1: Focus on prevention, access, primary care and co-ordination with secondary care. Option 2: Focus on access in crisis, specialist care and links to physical health.	
5	**Maps**	
	EDevine presented the results of a piece of work baseline mapping home treatment & intensive teams for mental health within the South West Area. The raw data was collected from the teams by the Mental Health SCN and the map which is accessed online as an interactive tool includes information about: service provision, monthly caseload number by team, number of staff by team, bed numbers, S136 suites, LoS, core 24 staffing, drug and alcohol services and street triage It was noted that the maps show the variation of services across the South West and also where there is inconsistency in data the need for shared understanding of how services are described and what they entail The map is available from the SW Senate website.	
6	**How should mental health services work?**	
	This was presented by Phil Confue, Cornwall Partnership Trust. Presentation slides are available from the SW Senate website. Questions and comments: C) As a society are we pathologising stress? C) Use of HoNOS as a routine outcomes measure. C) Issue with using primary and secondary care terminology when referring to mental health. C) Difficulties with regards to prevention as conditions such as schizophrenia can be genetic. Cannot stop the illness but can better the outcomes. C) Duchy health charity provides health centres in schools for children to access. C) There are many reasons why it is better to keep mental health separate to physical health. Q) Are urgent care centres established to include mental health. Q) Is entry via MIUs the aspiration? A) Yes this is emerging. Q) How does this work with HWBB and are the CCGs involved? A) Providers working as a consortium to take services forward. C) Culture of mental health is so different – staff need to be adaptable. Some joint training required but only when necessary.	

	C) If mental health staff were able to do some physical interventions it would reduce the need for multiple contacts for patients. C) If mental and physical health staff training is to be more integrated there will need to be some flexibility. Also need to remember original rationale for separate training. C) There is a national increase in the percentage of foundation doctors with a placement in psychiatry to increase understanding and exposure to the speciality and way of working.It is also important for nursing staff to have experience of both physical and mental health environments. C) Mixing outcome themes – are you targeting better physical outcomes of health?	
7	**What should the future be for mental health services in the South West?**	
	This was presented by Laurence Mynors-Wallis, Clinical Director, Mental Health SCN. LMynors-Wallis stayed for the afternoon discussion session and to be available to answer questions. Presentation slides available from the SW Senate website.	
8	**Mainstreaming Digital Solutions**	
	This was presented by Peter Ilves, Big White Wall (BWW). Presentation slides available from the SW Senate website. Questions and comments: Q) How is BWW funded? A) Multiple contracts – CCGs, joint tenders, talk with multiple organisations Q) Does providing contracts for specific geographical areas cause funding issues? A) Ideally would have a national contract so available for everyone. Q) Are there any problems with recruitment? A) None. Q) Cost p/m is £24 which gives access to the wall – what is the cost per person for therapies? A) Support network is included – support groups and psycho-social information. Often offer CCGs 6 monthly packages eg a bundle of log-ins. Each therapy session is £75. Q) How are the risks managed? A) Multiple layers. Users can self-identify. Search engines in the system which search for risk words. The support network can 'report' if worried about someone – but wall guides assess. Risk watches brought up for wall guides to monitor. In extreme distress when could impact other users – someone can be taken to a safe place and dealt with separately – senior wall guides for each shift. Psychiatrist on duty at all times. Currently no signposting to other local organisations – but will follow soon.	
9	**Access in crisis**	
	This was presented by Guy Undrill, Consultant Psychiatrist, 2gether NHS Foundation Trust. Presentation slides available from the SW Senate website.	

	Questions and comments: Q) Dysfunctional system – silo'd. Difficult for patient to navigate. Therefore, do we want to continue holding that model? A) Would prefer to get this system working better rather than having a large scale reconfiguration and risk losing patients in this process. Q) Mental health services are under-funded. If there was greater funding more staff could be employed however there are not enough staff available with nurse and doctor shortages and more disincentives for juniors in the pipeline. How to proceed with this? Q) Need a single way into the system and then use technology so the service sorts out how to respond. A) Very important to have an IT system that integrates with other systems. C) To have a first point of contact service we need systems we all understand and where the patient is in the system so can properly engage with partnership working. C) Problem with recruiting and staff being down banded. When bids are put in for services, the staff grade is always lower, so no career progression. Must think about banding going forward. Q) Due to geographical distribution in the South West – does the CMHT actually deliver better care to larger proportion of patients? A) 24 hour liaison care – trade off accessibility. Q) If thinking about reconfiguring services – is the CMHT model suitable? A) Not to open hospital nearer, community services are still out there. C) Primary and secondary care working better – better communications. Face to face contact very important – informal sharing of information.	
10	**Discussion and constructing advice**	
	The Senate Council members split in to two groups to discuss: Option 1: Focus on prevention, access, primary care and co-ordination with secondary care. Option 2: Focus on access in crisis, specialist care and links to physical care. The two groups feedback and the summary for each group is as follows: Summary 1: 1. Consideration for entry into the system – single portal – right service at right time. 2. How to start the issue of integrating mental health services? 3. Mental health patients designed into not out of the system. 4. Linking mental health providers – third sector. 5. Use of technology. 6. Strengthening of 111 (correct protocols) and DOS. 7. Standardisation of provision. 8. Role of urgent care centres 9. Need to look at genuine demand 10. Test a system for shared outcomes. 11. Realistic and thorough workforce planning. Summary 2: 1. Apply the same principles to mental health crises as in the response to acute events and link into urgent care pathways as appropriate	

	2. Develop outcomes that are meaningful to patients 3. Ensure timeliness of access to urgent interventions (swiftly moved back into familiar teams/services when possible) 4. Develop a single point of access for patients in crisis (that clinicians can also access) – include MH in 111 clinical hub? 5. Ensure no out of area transfers (for non-clinical reasons – beyond what are considered 'normal' boundaries) 6. SCN to benchmark LoS of acute psychiatric inpatients and develop quality outcomes framework (include peer review of data) 7. Underpin services that wraparound patients with consistent note sharing policy – develop 'parity of esteem' for mental health notes 8. Identify a nominated person to help safely share information with carers 9. Ensure balance of inpatient beds with community provision Full notes from each group can be provided if required.	