Funded by Kent County Council

Swale Mental Health Action Group

Meeting on Wednesday 1st November 2017, 2pm - 3.30 pm
At Swale House, East Street, Sittingbourne, ME10 3HT

Name	Organisation and Role
Brian Clark	Chair/Carer
David Garrick	West Kent Mind, Minutes
MT	MHAG Member
JSK	Expert by Experience & SURF (Swale Service User Representative Forum)
SA	MHAG Member
Paul Francis	SURF, Rethink Mental Illness
Lindsey Kennett	Carer's Support, Ashford, Sheppey & Swale
Naomi Hamilton	Swale CCG, Commissioning Programme Manager
Ken Pugh	Swale Borough Council/ KCC
Dominic Quinn	KCC, Kent Enablement & Recovery Service (KERS)
Teresa Snowden	Porchlight, Development & Monitoring Officer
Jenny Solomon	Insight Healthcare, Service Development Manager
Sarah Sales	Optivo, Tenancy Sustainment
Cathy Smith	Primary Care Mental Health Nurse
Irene Chivere	KMPT, Swale Primary Care Mental Health Specialist
Sarah Rodger-Smith	KMPT, Swale CMHT
Lisa Tweedy	KMPT, Student Nurse

Apologies	Organisation
Donna Lee	Riverside Care & Support
Sharon Jordan	Riverside Care & Support
Michael Foster	Shaw Trust
Sandra Bray	Swale Your Way
Sarah-Jane Radley	Swale Borough Council
Sarah Aldridge	Swale Borough Council

1. Welcome, Introductions & Apologies

The Chair welcomed the group and apologies were noted as above.

2. Live Well Kent (LWK) delivery partners update – Teresa Snowden

Teresa delivered a presentation about the Live Well Kent (LWK) service in Swale (please see the circulated slides). Information not included in the slides:

- 'Making Every Contact Count' (MECC) is a major part of LWK delivery.
- Individuals can self-refer into the service.
- Any lengthy contact times (e.g. 2 weeks) are investigated.
- The definition of SMI (Severe Mental Illness), for this purpose, means having accessed secondary care (e.g. The CMHT) in the past 5 years.

There was discussion surrounding how the 703 referrals within Swale in Year 1 relates to the number of people who will potentially have some form of mental health problem in Swale (e.g. 25000 people, if based on the 1 in 4 statistic).
Question: How is the LWK service being broadcast/promoted?
Response: The service is widely promoted e.g. through GPs and their protected learning time events, through Link Workers, etc.
Question: Which areas see the most referrals from GPs? E.g. on The Isle of Sheppey.
Response: The largest source of referrals is self-referrals, but GPs may be informing their patients about LWK, who then self-refer. On Sheppey, more referrals are received from some

GPs. GPs have a limited amount of time to see people and cannot know everything going on in that area. We may be able to identify the number of referrals from Sheppey through postcode. But this is a wider issue – not just GPs not knowing about LWK.

A service provider said that they contacted GPs where referrals to their service was low. The GPs replied that they gave out the service information to patients, but patients were then not self-referring. There is, therefore, an issue around patient uptake.

Paul noted question marks over the impact of Personal Independence Payments (PIP).
Action 1: Paul to circulate PIP information.

Question: Is marginalisation and deprivation on Sheppey being taken seriously?
Response: The outcomes relating to quintiles shows that we are reaching more deprived areas, although we are not saying that we are perfect *(see slides for data).*

Question: If LWK are engaging with those areas, are other stakeholders taking this on board and learning from LWK in terms of engagement?
There was discussion about bridging the gap between clinical services e.g. through social/ community support.

- LWK provides social/community support to improve mental health and wellbeing in a recovery focused way, however we are not able to provide a clinical role outside of this.
- Swale Your Way is funded because it is both good and necessary to bridge this gap.
- Increasing referrals to LWK:
  - Porchlight liaise with GP practice managers and the PLT to ensure people know about LWK.
  - Everyone is taking social prescribing on board, but services are not getting the referrals.
- On Sheppey, there is lots of isolation and loneliness. People leaving e.g. hospital, secondary care, etc, can feel on their own.
- Effective social prescribing requires connections between CCGs, councils and public health bodies. Getting the word out there about what is available will help.

The Swale Task & Finish (T&F) group was a fantastic exercise e.g. the pathway information, but nothing has been done with it. This information could be used to form a working group, to prevent occasions where individuals feel on their own outside of clinical services, e.g. when discharged from secondary care. This might involve understanding what each service provides (e.g. IAPT) and understanding how services can better work together. *(Based on earlier discussion, the working group could help to identify and bridge any gaps in available services. Increasing people's awareness/ engagement with LWK was also raised earlier).* See 8. Task & Finish Group below.

Question: Do the 7 funded services in Swale *(from the presentation)* include The CMHT?
Response: No, this includes services such as The Shaw Trust, Primary Care Mental Health Specialists, Community Link Workers, MEGAN CIC, The Community Inclusion Service and the Housing Service.

An MHAG member raised issues with waiting for counselling and with The CMHT. Teresa and Sarah R-S suggested meeting with the member afterwards. Sarah said that The CMHT should see individuals within 28 days and if the service is not suitable for you, then there should be a plan going forward at the end of your assessment.
Action 2: Teresa/Sarah R-S to meet/contact MHAG member

3. KMPT 'Caring for Carers' (C4C) Study Presentation - Cancelled

4. Minutes of last meeting – Approved without amendment

5. Action Points

From May:

1. Circulate cluster information via MHAG mailing list. Information requested again but no response received. **Carry forward.**

2. Investigate lack of GP support for mental health needs. Naomi's contact details have been forwarded to the individual. **Completed.**

From September:

1. Invite Naomi Hamilton (Swale CCG) to present to the MHAG how GPs are engaging with Primary Care Mental Health Workers (PCMHWs).
Written response: "*I am not sure if Porchlight were present at the previous Swale MHAG but it is important that they are given the opportunity to input in to discussion about this service because they hold the Lead Provider contract and subcontract for services such as this one. The Live Well Kent service integrates a multitude of mental health and wellbeing provision and will have an engagement plan in place across the whole service which will include the PCMHS. As I type, the GPs are attended their monthly Protected Learning Time event last week and Porchlight presented on the Live Well Kent Service and the PCMHS was part of that presentation, there was positive discussion about this service. GPs refer to the PCMHS as well as work alongside the nurses to support patients transitioning from specialist to community care services.*" **Completed.**

Cathy noted that when the PCMHS pilot started 4 years ago, there was more CCG involvement and initially some firm relationships with GPs. However, the service has changed and there are now fewer staff working to full capacity, which has affected liaison with GPs. Although the service is no longer on its own and can offer more services as part of LWK there has also been an increase in referrals and Cathy felt that more resources are needed.

Naomi is working with Porchlight to better manage the transition between children's and adult's mental health services, with a cohort of 17-25 year olds, to prevent deterioration / maintain the wellbeing of those who might fall between the cracks. It was noted, however, that individuals have an assessment when leaving children's mental health services.

2. Confirm how service users or carers can feed back any gaps in GP mental health knowledge.
Written response: "*Swale CCG has a Patient Liaison Group and Paul Francis sits on this group as a representative of mental health and wellbeing services. It may be suitable for concerns or queries to be shared with him for him to take to that CCG meeting.*" **Completed.**

3. Confirm what guidance and training is available to frontline staff (e.g. GP receptionists) to deal with a patient's mental health crisis. Naomi needs to meet with the GP workforce tutor. She will update in January. **Carry forward.**

4. Invite Cathy Smith to attend, to talk about the Primary Care Mental Health Specialist Service.
Cathy was in attendance. **Completed.**

5. Confirm how the planned 15% reduction in hospital-based mental health assessments will have an impact on access to GPs and the CMHT. Continuing care is not within Naomi's remit: She will update in January. **Carry forward.**

6. Confirm whether A&E staff receive training (e.g. from Liaison Psychiatrists) for situations when patients present with a physical complaint, but where their mental health subsequently deteriorates.
Written response: "*The contract that the CCG holds with KMPT requires the Liaison Psychiatry team to provide training to ED and ward based staff. I am sure KMPT would be happy to provide any further detail on this should it be required.*" **Completed**

7. Confirm when the Core 24 service starts at Medway Maritime Hospital.
Written response: "*The service at MFT has been a 24/7 service for a number of years but the Core 24 launched on 10 October as part of local responses to World Mental Health Day. More information on Liaison Psychiatry can be found on the NHS England website https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf but below is an extract with a summary of Core 24. To note, a Core 24 service requires a significant increase in workforce in order to meet the requirements so the expectation is that all elements of Core 24 are met during 2018-19.*

*3.3.1 **Core 24***

Where the hospital has a 24/7 ED, then it should have a core 24 service level as a minimum to ensure 24/7 mental health cover. The core 24 model provides the following functions on a 24/7 basis. This includes consultant psychiatrists being available 24/7 (on-call out of hours) to:

- *Provide a response to mental health crises in EDs and inpatient wards within one hour and to all urgent ward referrals within 24 hours*
- *Complete a full biopsychosocial assessment and formulation and contribute to treatment and collaborative care plans*
- *Offer brief evidence-based psychological interventions eg as inpatient or short-term outpatient follow-up*
- *Work with general hospital teams to reduce length of stay in general hospitals and improve follow-up care, particularly for older adults*
- *Provide advice and support to general hospital staff regarding mental health care for their patients*
- *Provide specialist care for older adults.*
- *This model provides urgent and emergency, as well as unplanned, care pathways (that is, non-elective admissions to general hospitals). The North West London model forms the basis of the core 24 model."* **Completed.**

8. Confirm whether free mental health training is available for Job Centre staff in Swale.
"This query would need to be raised with the Job Centre as to what their policies are regarding training for staff and who they have contracts with. It seems sensible to assume that training would be available to staff but the Job Centre would need to determine who they approach to offer that training."
Naomi added that The Job Centre could approach KCC Public Health Services. **Completed.**

9. Send information about services for circulation. Information requested from Riverside Care and Support. **Completed.**

10. Send any information to be circulated to MHAG. Information from Sheppey Matters was circulated. **Completed.**

11. Invite Dee to give a presentation on Universal Credit. Awaiting response – **carry forward.**

Question raised at County MHAG:
How is mental health training for GPs being addressed and funded across Kent?
From County MHAG minutes: "The group discussed the disparity of GP's knowledge of mental health and the Primary Care Mental Health Specialist (PCMHS) service which has been in existence for 3 years and the difficulty of communicating with GPs who are trying to do a difficult job under difficult circumstances. They get bulletins and Protected Learning Time (PLT) but it is often the people who are already interested that engage with this information.
Andy mentioned that in East Kent they are looking at a referral tool on GP internet sites to flag the options available.
West Kent primary care have given presentations and sent out a questionnaire to gauge GPs knowledge of the Psychiatrists hotline to call for medication and mental health advice and also the PCMHS.

Vicky advised that 8 new members staff have started in the PCMHS in the last 4-6 weeks so this should support the service.
ACTION 5: Invite Clare Lux to give share the results of the West Kent GP questionnaire and update how the service is being promoted."

Question: With 300-400 patients due to be discharged from secondary to primary care, are GPs really up to speed with Mental Health?
Response: Sarah R-S advised that patients would not be discharged from secondary care if they were not ready. Cathy noted that GPs are very busy and that the PCMHS service has a backlog of patients.

Question: Why does West Kent have 8 PCMHSs when Swale (a more deprived area) has 1.5?
Response: Commissioning operates differently in West Kent and there is a higher population. West Kent is also a more rural area, which presents transport difficulties. The service in Swale has been reduced from 2 whole time nurses to 1.5 whole time nurses and there is no more money to increase this service. Claire Lux has started in a new post to oversee the PCMH nurses currently under KMPT, these are in West and North Kent. She will be working with the CCG to look at service provision of these resources.

6. Service User & Carer Questions:

(a) Questions raised at the pre-meeting:
Statement: Statistics do not answer issues, such as my negative experience with a GP, similar reports received from others, issues with getting appointments and issues with reception staff.
Response: Naomi advised that the individual should give Paul (from SURF) some case studies to take to The Patient Liaison Group (PLG). Paul is happy to do this.
Action 3: MHAG members to give Paul case studies relating to GPs.
Action 4: Paul to take case studies relating to GPs to the PLG.

(b) Questions going forward to County MHAG: None taken forward.
The possibility of forming a Universal Credit T&F group was raised. Universal Credit was discussed, including rental evictions and assessments having an impact on mental health.

7. Information Sharing:

1. **County Update:** Please refer to the County draft minutes for full details of discussion, located at www.westkentmind.org.uk/mental-health-action-groups

2. **Commissioners Reports:** All reports have been circulated and are located at www.westkentmind.org.uk/mental-health-action-groups

From The CCG report, Naomi highlighted:

- From 1st September 2017, all Child and Adolescent Mental Health Services previously provided by Sussex Partnership NHS Foundation Trust transferred across to North East London NHS Foundation Trust (NELFT). On that same date, eating disorder services previously provided by KMPT for adults and Sussex Partnership Foundation Trust for children, transferred to NELFT.
- There is a 90-day consultation period before service models are changed. Real differences in care should be seen by April.

Question: Is an American company taking over parts of The CCG in Kent and Medway?
Response: Naomi is not the person to ask about this. She understands that they will only be providing a function.

3. **Service Update/Introduction for new members:** Please send any electronic information or leaflets to the MHAG admin team who will be happy to circulate them to the mailing list.

Insight Healthcare, Jenny: Insight are increasing their face-to-face provision. They are working in conjunction with Sheppey Matters, with services at the leisure centre and Seashells Centre e.g. for people with postnatal depression. Jenny will circulate finalised details.

Teresa noted that there were fewer referrals from IAPT to employment services (e.g. Shaw Trust). Jenny responded that, in LIW centres, they used to work in proximity to employment advisors. They are trying to re-establish those links in Swale. Teresa added that speaking to an employment advisor and putting people on the ground in touch would be useful. They can refer directly in this area.

Optivo, Sarah S: There is a job club/ Thrive drop in at community centres, as part of their community development.

KERS, Dominic: For individuals in both primary and secondary care, KERS provides short-term enablement, such as graded exposure and support in managing finances and living independently. This occurs over 12 weeks. Teresa noted that LWK works closely with The KERS team.

Swale CMHT, Sarah R-S: Since the CAPA (Choice And Partnership Approach) model has started, the DNA (Did Not Attend) rate in Sittingbourne has come down from 30% to 13.5%

SURF, Paul: There was a question and discussion in parliament about physical restraint in secure units.
Action 5: Paul to email MHAG the details of the parliamentary question.

There was a discussion about Universal Credit (UC). The following points were made:

- Insecurity surrounding UC is making people unwell.
- Is there still a council-employed specialist in UC?
- You can choose for UC to pay your rent directly.
- The monthly (rather than biweekly) payments could cause hardship.
- There is a transition period, with the expectation that payments will catch up. People shouldn't be left without money.

(There is already an action point for Dee to speak at this MHAG about UC.)

4. Staff Changes: None mentioned

8. Task and Finish Working Group

(In section 2, The MHAG discussed how the role of a Task and Finish Group could be taken forward and it was noted that there is a Primary Care Interface meeting which is managed through Live Well Kent and includes reps from local services, some of which are also members of the Swale MHAG. The MHAG suggested taking the T&F group findings to the Interface Meeting on 12th December.

Action 6: Naomi agreed to contact Kent County Council to determine how the MHAG could feed the T&F group findings into the Primary Care Interface meeting.

The group was unsure if the Interface Meeting is an open meeting. Naomi suggested contacting Lindsay Johnson, who leads the meeting, to ask if service users can attend. If this is not the case, Naomi will ask that service user attendance is put on the agenda.
Action 7: Naomi to contact Lindsay Johnson regarding service user attendance at the Primary Care Interface Meeting.

9. Vacant co-chair position

SA was confirmed as the new co-chair for The Swale MHAG.

Cathy asked how she could inform her clients of The MHAGs.
Action 8: Send Cathy MHAG posters/ information

Question: Will there be Psychiatric Liaison Teams at Urgent Care Centres?
Response: Yes, but as this is at the higher level of The STP (Sustainability & Transformation Plan) there is not much detail.
An MHAG member mentioned that parity of esteem and treating people holistically is raised at STP meetings, but more specifics/detail is needed.

Question: What is Ruby Ward being used for?
Response: It is not being used for Young People's Services. Bring up at the next Listening Post.

9. Date of next meeting

10th January 2018, 2pm at Swale House, East Street, Sittingbourne, ME10 3HT. Pre-meeting at 1.30pm for service users and carers only.

Action Table

No.	Action Points from May MHAG:	Responsibility	Status
1	Circulate cluster information via MHAG mailing list.	David	
2	Investigate lack of GP support for mental health needs.	Naomi/David	
	Action Points from September MHAG:		
3	Confirm what guidance and training is available to frontline staff (e.g. GP receptionists) to deal with a patient's mental health crisis.	Naomi Hamilton	
5	Confirm how the planned 15% reduction in hospital-based mental health assessments will have an impact on access to GPs and the CMHT.	Naomi Hamilton	
11	Invite Dee to give a presentation on UC.	David	
	Action Points from this MHAG:		
1	Circulate PIP information	Paul	
2	Meet/contact MHAG member about counselling/ The CMHT	Teresa/ Sarah R-S	
3	Give Paul case studies relating to GPs.	MHAG Members	
4	Take GP case studies to The PLG	Paul	
5	Email MHAG details of the Parliamentary discussion	Paul	
6	Take The T&F group to The Interface Meeting	Naomi	
7	Contact Lindsay Johnson about SU attendance at The Interface Meeting	Naomi	
8	Send Cathy MHAG posters/ information	David	

Administration :
Phone: 01732 744950
Email: mhag@westkentmind.org.uk

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Minutes and supporting documents are posted on:
https://westkentmind.org.uk/mental-health-action-groups