County Mental Health Action Group

Funded by Kent County Council

Wednesday 17th October 2018, 2pm-4pm at Maidstone Community Support Centre, 39-48 Marsham Street, Maidstone, ME14 1HH

Attendee	Organisation & Title
Alan Heyes	County MHAG Chair/ Mental Health Matters
David Garrick	Minutes/ West Kent Mind (WKM)
Sue Sargeant	WKM, MHAG Coordinator
Nick Dent	KMPT, Patient Experience M'ger
Victoria Stevens	KMPT, Deputy COO
Naomi Hamilton	Swale & DGS CCG Commissioning
Sharon Dosanjh	Medway CCG, Head of MH Commissioning
Nicola McLeish	KCC Commissioner
Ali Marsh	Maidstone & SWK MHAGs Co-chair/ Thinkaction, Ops Manager
Amanda Godley	Speakup CIC, Project Co-ordinator
Annie Jeffrey	Ashford MHAG Co-chair
David Rowden	Thanet & DDS MHAGs Co-chair/ SpeakUp CIC
Hilary Johnston	Porchlight Live Well Kent
Steve Inett	Healthwatch Kent, CEO
Dawn Grant	DWP Community Partner for Mental Health
Rosalynne Styles	Sanctuary Supported Living, Deputy Local Service Manager
Claire Thomas	Sanctuary Housing, Support Worker
Mike Bassett	KMPT, Consultant Psychologist
Liz Bailey	Shaw Trust
Clive Wanstall	Canterbury MHAG Co-Chair/ East Kent Carers Council
Andy Oldfield	East Kent CCGs
Cathy Bellman	Kent & Medway STP

Apologies	Organisation
Jo Miller	DDS Co-chair
Emma Jarnell	DGS Co-chair
Ellie Williams	Canterbury Co-Chair
Jenny Solomon	Swale Co-chair
Phil Davis	SWK Co-chair
Lizzie Lowry	Maidstone Co-Chair

Apologies	Organisation
Tony March	DWP
Rachel Hussey	NELFT
Diane Marsh	KCC
Martine McMahon	West Kent CCG
Tim Woodhouse	KCC
Cheryl Fenton	KCC

1. Welcome, Introductions, Apologies & GDPR Update

The Chair welcomed the group, apologies were noted and an MHAG membership/data protection update was read out.

2. Minutes of Last Meeting

Nick advised that action June.18-2, about avoiding gaps in KMPT services knocking on to emergency services, had already been addressed by Vincent in June.

Action 1: David to clarify KMPT gaps/ emergency services question.

3. Redesign of CMHT Treatment and Care Pathways – Dr Michael Bassett, KMPT

Key points from Mike's presentation included:

- Multi-Disciplinary Teams (MDTs) will deliver more psychosocial treatments. So clients will access some talking therapies from professionals who are not psychologists/psychotherapists.
- 3 main pathways are being piloted: Initial Interventions, CHANGE and long-term conditions.
- Initial Interventions: Being piloted in SKC. Involves 4 sessions: A taster package of treatment.
- CHANGE: Piloted in Medway and already established in Devon. It is an 8-session model for Borderline Personality Disorder (BPD). Of the 3 pathways, this is the most developed. 3 CPNs in Medway are currently using this. Both patients and staff are happy. Likely to be rolled out.
- Long-term conditions: Piloted in Albion Place, Maidstone. For people without Personality Disorder (PD) but with, for instance, severe and complex anxiety or psychosis.

Question: How will this improve waiting times?

- Currently have an odd design, where all patients want therapy, but only a small workforce of highly paid professionals can deliver it. Instead, therapy will be delivered by both psychologists and the wider team (both qualified or sometimes unqualified, but trained and supervised).
- V. high drop-out rate in first 4 sessions: People might wait a year to find that treatment isn't what they expected. Instead, shifting treatment to the front end: Can see if therapy is for them.
- Vicky added that the whole team will receive ongoing training and have a core skillset. So as well as being able to access the right package for them, there are more people to deliver it.
- The Initial Interventions pathway will prepare clients for e.g. the LT condition pathway, thus reducing later dropout.

(Responding to questions): The Initial Interventions pathway is CBT-based. CHANGE is classed as structural clinical management: A hybrid of 2 other therapies.

The lead for the CHANGE programme is keen to provide services to families and plans to run a support group for these clients.

Clive requested more information about pathways and their relevance for carers.

Steve advised sharing information at local MHAGs about the redesign of therapy pathways.

Service User/ Carer involvement on boards and workstreams was discussed.

Annie, who is involved with KMPT's Open Dialogue work, raised concerns about continuity of care e.g. if admitted to a hospital ward, it is not local and you see a different Psychiatrist. Same with IAPT: See a different therapist for each course.

(Responding to questions): Clients may not move on to see a psychologist or therapist – it is about bringing therapy forwards – clients may just get treatment from CPNs. Psychologists/therapists will still see clients but also train and oversee other staff members.

Vicky gave the example of the PD pathway – all will go through the CHANGE process and then may get escalated to specific therapies. Mike added that clients will be seen sooner rather than later. Might see a CPN then get a referral to a therapist or a support group, if suitable.

Sharon – not just benefits for clients, but also for staff who may e.g. feel nervous about working with those with PD. Clive raised that these staff need more time if training is to help them.

Action 2: Vicky to provide a highlight report of care pathways with details of SU/ carer involvement (inc. current engagement and spaces available) and an update on the 3 psychological services pilots to be circulated to local MHAGs.

4. KCC Drug and Alcohol Services – Nicola McLeish, KCC

- They commission CGL in West Kent and Forward Trust in East Kent. Both contracts are long-term, which helps commissioners to work with them.
- Young Person's contract: More focus on prevention: Works with early help and Social Services.
- Deliver services via hubs (e.g. Gravesend) and satellite services in community buildings and pharmacies. Both offer psychosocial interventions, and have doctors for prescribing.
- Support recovery via screening, identifying needs, planning recovery and safeguarding the individual. Lots of group work therapy and a co-ordinator who leads, but is also participatory. Also look at health and wellbeing, vaccinations and harm reduction (e.g. clean needles)
- Closely linked to criminal justice system to help transitions. Work closely with prison providers when clients are released.
- Want to better understand when to refer to e.g. KMPT or Live Well Kent (LWK) – to get that consistency across the County. Also, would like feedback about how those with co-occurring

conditions receive support in the whole: Jess Mookherjee has provided a number of questions to ask the MHAGs.

Action 3: David to circulate questions about drug and alcohol services to the MHAGs.

Question: Are numbers of substance users on the increase and how do you measure success?

Response: There are about 5000 people in adult treatment services (with serious substance misuse problems) across Kent. Levels are stagnant, but depends on the drug. Heroin is a dying drug and more of an issue in East Kent. Younger people: Novel psychoactive substances e.g. via mail order. The value of dedicated dual diagnosis workers was discussed. Ali raised the issue of cuts leading to fewer hubs: In Canterbury opiate deaths are increasing: Now have 5 clinics instead of the hub. Nicola advised that the loss of the hub was not related to cost-saving: There were issues with the landlord. Additional issue in Canterbury: Lots of service users are not within the city walls.

5. Action Points

Apr.18-11: *Link up supported housing providers who attend MHAGs, to take forward the issue of finding suitable accommodation for those leaving supported housing.* **Closed.**

Action 4: Alan to arrange a meeting immediately prior to January's Dartford MHAG meeting, to discuss how housing is affecting mental health and to take action.

Jun.18-2: *David to ask Vicky Stevens for any further information about avoiding gaps in KMPT services knocking on to emergency services.* See Action 1 – David to clarify. **Closed.**

Jun.18-4: *Invite a representative from Horizons Supported Housing (or its current equivalent) to speak about their service and how it fits into the future model of Health & Social Care (STP).* Linda Hardy (Service Manager) has been invited to December's meeting. **Carry forward**

Jun.18-5: *Ask an MHAG representative to attend the next Kent Housing Options Group (KHOG) meeting, to discuss difficulties finding suitable accommodation for those leaving supported housing.* **Expired**

Jun.18-9: *David to circulate KMPT's response to Clive's letter about the recent CQC report.* There are a number of other KMPT documents related to the CQC inspection that may be appropriate to circulate. David, Clive, Nick and Vicky to discuss what to circulate. **Carry forward.**

Aug.18-1: *Circulate Cheryl's KCC/KMPT transformation update to local MHAGs.* **Completed**

Aug.18-2: *Circulate draft care home contract spec (when ready) to local MHAGs for feedback.* This draft is nearly ready for circulation. **Carry forward.**

Aug.18-3: *Circulate anonymised housing case studies or information about where gaps/areas of risk have been identified.* Teresa has provided anonymised housing case studies that can be discussed at January's housing meeting in Dartford. **Closed.**

Aug.18-4: *Look into the prospect of GP receptionist signposting in East Kent.* Andy and Cathy will cover this in their presentation. **Completed.**

Aug.18-5: *Invite Cathy Bellman (Local Care Lead) to speak about GP receptionist signposting in East Kent and local care in general.* **Completed**

Aug.18-6: *Ask DGS MHAG to gather information about the housing hub.* They are awaiting a response from Dartford Borough Council about this. **Closed.**

Aug.18-7: *Provide Vicky with GP visit data (24x/year), stratified by gender.* David will remind Tim. **Carry forward.**

6. Locality Questions

Dover, Deal & Shepway: *There are reports of clients being discharged back into the community from KMPT acute services and placed into apparently unsuitable, unsafe housing. What is KMPT's vetting policy for post-discharge housing?*

Responses from KMPT and KCC were kindly sent ahead of the meeting. In summarised form:

- From KMPT's perspective, it is not their responsibility to vet housing. Supported/residential accommodation is vetted and viewed by the KCC Contracts Team. If patients do not meet KCC Social Services criteria for supported/ residential accommodation and are homeless, they are discharged to the council homeless, who then take responsibility for placing them. KMPT have limited influence over patients' own rented accommodation, unless a safeguarding concern is raised.
- From the perspective of the SKC (DDS) Social Care Team, if they are aware of any supported accommodation with issues, they would look not to use it. In SKC, KCC are looking to allocate housing as a lead role to one of the social workers in the team, to regularly attend meetings with the council to discuss available housing and any current concerns/trends/issues. This information can then be shared with the rest of the team, so that workers know which areas are having issues. There is always the issue of demand and capacity. Sometimes clients are discharged very quickly and so sometimes the options are limited.

Action 5: David to invite Lyndsey Johnson, SKC MH Social Care Service Manager, to give an update about housing at the next DDS MHAG meeting.

Rosalynne and Claire advised that Ashford Borough Council are doing a lot of work surrounding housing (e.g. have started their own lettings agency). The national shortage of housing was discussed. Amanda – instances of people being discharged onto the streets.

Action 6: Sanctuary Housing to feed into January's housing meeting in Dartford.

Action 7: Vicky to highlight referrals to inappropriate housing to KMPT's patient discharge team.

Swale: *How many frontline services have been under review in the past year and how do these reviews impact on vulnerable people, in terms of change, uncertainty and clients getting lost in the system due to changes? How can we minimize the impact of such reviews on these individuals?*

Action 8: David G to ask Swale MHAG for a more specific question about service reviews.

Thanet:

1. Why do you have to pay for prescriptions on ESA? There is no consistency between anti-psychotic medication given as a tablet or liquid and as a depot injection. Further info below from the Thanet MHAG meeting:

- *Not everyone on Universal Credit or contribution-based ESA get free prescriptions*
- *GPs can sign an exemption letter, however this is only applicable for some long-term **physical** conditions, not mental.*
- *There is a prepaid prescription card which is £8.67 per month for unlimited items/prescriptions.*
- *Joy Brown added the following:*

"Anyone on a low income not automatically entitled to free benefits should be completing an HC1 to see if they are eligible for an exemption certificate, and can also use the HC5 forms to request a refund of travel, eye tests, dental work, optical charges etc. Each case will be looked at on an individual basis.
https://www.nhs.uk/NHSEngland/Healthcosts/Documents/2016/HC1-April-2016.pdf "

Tony March, DWP, advised by email that people can input their details at the following link, to check if they are eligible for free prescriptions: https://www.gov.uk/help-nhs-costs

Action 9: Dawn to follow up on details of free prescriptions for people on benefits, including contribution-based ESA and Universal Credit.

David R advised that many clients in supported accommodation in Thanet have to pay for prescriptions. Now being on Universal Credit/ benefits does not automatically entitle you to free prescriptions. Andy advised that when the CCG looked at this, they thought that this would virtually never happen (in the case that it did occur, they gave an exemption).

Hilary raised that the GP medical exemption letter should not draw the distinction between mental and physical conditions – parity of esteem.

Action 10: Steve to flag the disparity in medical exemption letters for those with physical and mental conditions

Action 11: David G/Annie to check whether this disparity is being addressed nationally e.g. by MIND/Rethink

2. The CMHT is changing from October to become more specialist, before primary care mental health services have been fully developed. It is more difficult to get people back in to the CMHT and voluntary sector and primary care services are seeing more people presenting with higher needs. What is being done to support these people?

(Andy and Cathy will cover this in their presentation).

Vicky advised that this is likely related to the work that KCC are doing around caseloads. Some clients may be discharged from KMPT who still require a large element of social care, (i.e. the MH need is secondary to the social care need.)

Clive mentioned that some clients have had care coordinators taken away as a result of this process – difficult for clients who cannot handle change. Vicky responded that, in the main, this is being handled sensitively and KMPT are working closely with KCC. Under the CAPA model, you shouldn't have social workers who are coordinating care. Over the past few months, staff have been looking over caseloads and considering who is the best person to look after each individual, so clients are being transitioned over.

7. Integrating Mental Health into Local Care, Cathy Bellman & Andy Oldfield

For further information, please see the **circulated slides** that accompanied this presentation.

- The STP is not a new concept: Involves all organisations coming together. Have got huge pressures on the system, but if there was lots of money available, then wouldn't have the situation where organisations work together to solve this problem.
- National direction of commissioning over last few years: Put up brick walls and not share information due to tenders. Need to break down walls and work together.
- Note that there is a specific workstream for East Kent. Also have a new workstream for Primary Care: If this is not supported, the pillars will fall down.
- Local Care: Not trying to innovate, but rather go back to how it used to work 30 years ago. Real involvement of the voluntary and care sectors to support other orgs. 'Industrialising' care navigation, social prescribing, etc, so asking GP practices to come together to form populations of around 30-50,000 people. To survive, must work with other practices.
- The 'Dorothy' Model: From point of view of a frail older individual with 3 or more conditions. Keep Dorothy at the centre and what matters to her – not over-medicalising. Having one care coordinator and a 24/7 team. If ambulance called in middle of night – will have access to her care plan, which says, ie that her oxygen is always at that lower level. Should be the same for MH care.
- Have been implementing this at a vanguard site in East Kent. When working in multi disciplinary teams (MDTs), more likely to decide to keep someone at home than if someone is making the decision alone.
- Not seeing local care as separate to acute hospital care – having truly integrated teams. Will involve looking at how the Patient Tracker List and IT are used.
- MH is a broad spectrum: Perhaps have more specific roles than MH worker.
- Andy announced that they now have the opportunity to expand the Primary Care MH Specialist Service, which was originally a pilot, to reach all hubs and GP practices in East Kent this year. Want them integrated into practices. This wider, expanded MH service will look at feeding into what has just been presented.

Action 12: Clive to send questions to Andy about the newly-announced PCMH service.

Question: How will PCMH Specialists link with Social Care Workers in East Kent?

Andy responded that they will work in a seamless way with IAPT and social care providers. Also, the link between primary and secondary care is crucial. Have been working closely with providers and holding workshops. Some workers are out there already – this will be an expanded service.

Question: All East Kent CCGs are in special measures e.g. huge overspend in Ashford. How will this pressure impact on MH? E.g. still don't have 24h psychiatric liaison.
Andy responded that commissioners have a target to provide 24h liaison by 2021, but hope to have it before then. Pilot at William Harvey – little demand out of hours.
Question: Are there plans for GP receptionist signposting in East Kent?
Andy responded that they are waiting for the outcome of the West Kent pilot, but the new expanded PCMH service has an element of receptionist training.
Action 13: David G to circulate presentation slides

8. Travel Costs for Carers Visiting Relatives Placed Out-Of-Area

Tony March (DWP) kindly provided information via email that the DWP no longer offer Social Fund Payments (only Social Fund Cold Weather Payment) to cover such eventualities, but repayable budgeting loans are available to people who have been on out of work benefits for 6 months. They would not be able to use the Flexible Support Fund as this is for barriers to work and would not cover the cost of travel for carers. Alternatively someone on Universal Credit can ask for an advance during their first payment period but again this would be repayable monthly from their Universal Credit award.

Clive advised that a particular carer is travelling from Thanet to Burgess Hill and walks the last hour of the journey. Has amounted £2000 in travelling costs. This case is currently being dealt with by Helen Greatorex (a voluntary driver has been arranged). According to KMPT, there are 8 people placed outside of Kent.
Patients are no longer being sent out of area, except for specific treatments. CCGs are governed by the reimbursement rules set down by NHS England but Andy has been looking at voluntary transport and drivers. He is also involved in a MDT meeting to keep time sent out of area to a minimum.

9. Information Sharing

10. Date of next meeting

The group agreed to move future meetings half an hour earlier (1.30-3.30).

Wednesday 12th December 2018, 1.30pm-3.30pm at Maidstone Community Support Centre

ACTION TABLE

No	Action	Responsibility
Jun.18-4	Invite a representative (such as Linda Hardy, Service Manager) from Horizons Supported Housing (or its current equivalent) to speak at the next MHAG, about their service and how it fits into the future model of Health & Social Care (STP).	David
Jun.18-9	Circulate KMPT's response to Clive's letter about the recent CQC report.	Clive/ David
Aug.18-2	Circulate draft care home contract spec (when ready) to local MHAGs for feedback.	David
Aug.18-7	Provide Vicky with GP visit data (24x/year), stratified by gender.	Tim
Oct.18-1	Clarify KMPT gaps/ emergency services question.	David
Oct.18-2	Provide a highlight report of care pathways with details of SU/ carer involvement (inc. current engagement and spaces available) and an update on the 3 psychological services pilots to be circulated to local MHAGs.	Vicky
Oct.18-3	Circulate questions about drug and alcohol services to the MHAGs.	David
Oct.18-4	Arrange a meeting immediately prior to January's Dartford MHAG meeting, to discuss how housing is affecting mental health and take action.	Alan/David

Oct.18-5	Invite Lyndsey Johnson to give an update about housing at the next DDS MHAG meeting.	David
Oct.18-6	Sanctuary Housing to feed into January's housing meeting in Dartford.	Rosalynne /Claire
Oct.18-7	Highlight referrals to inappropriate housing to KMPT's patient discharge team.	Vicky
Oct.18-8	Ask Swale MHAG for a more specific question about service reviews.	David
Oct.18-9	Follow up on details of free prescriptions for people on benefits, including contribution-based ESA and Universal Credit.	Dawn
Oct.18-10	Flag the disparity in medical exemption letters for those with physical and mental conditions.	Steve
Oct.18-11	Check whether the medical exemption letter disparity is being addressed nationally e.g. by MIND/Rethink.	Annie/David
Oct.18-12	Send questions to Andy about the newly-announced PCMH service.	Clive
Oct.18-13	Circulate presentation slides.	David

Administration :

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