

REVIEW OF MENTAL HEALTH INPATIENT SERVICE PROPOSALS

NOTES OF THE PUBLIC MEETING *

Held at Central Library, Blackburn

Thursday 28th October 2010 – 6.30pm to 8.30pm

Facilitators / staff		
Debbie Nixon (DN) (Chair)	Strategic Director for Mental Health	Lancashire
Lynette Harwood (LH)	Head of Commissioning Mental Health and Substance Misuse	NHS Blackburn with Darwen
Pat Rolph (PR)	Senior Project Support Officer	Lancashire Partnership Team

Apologies were noted from Rebecca Davis (Network Director – Mental Health Commissioning) due to sickness

Audience – 10 people in attendance

Staff – 3 members of staff in attendance (*as above*)

Introduction

(DN) welcomed everyone to the meeting and introductions were made. DN explained the purpose of the meeting, advising that although the meeting was scheduled from 6.30pm-8.30pm, there was flexibility on timings to meet the needs of the group. DN acknowledged the short notice of the meetings, but stressed that this was not a formal public consultation but an involvement and engagement exercise. DN noted that she or a member of the team would be happy to come and meet with local groups/networks.

DN advised that a written record of the discussions * would be taken by PR, and a copy of the discussion notes will be made available, along with a report collating themes from all six public meetings held, on the Lancashire Mental Health and Social Care Partnership Board’s website by the end of November 2010. Copies could also be forwarded directly to anyone wishing to leave their contact details with PR.

**Every effort has been made to capture the discussion at meeting as fully as possible, especially comments and questions from people attending. However sometimes people spoke softly or quickly, or more than one person spoke at the same time. The notes are not a verbatim transcription or quotation. For clarity of reading the notes are mainly presented as short whole sentences, whereas of course people often spoke in more informal phrases. Acronyms are expanded in the text, where they may not have been at the meeting.*

DN delivered a powerpoint slide presentation (this is available on the website). This included LH talking about investment in local services for Blackburn with Darwen.

Due to the number of attendees DN suggested keeping the discussion to within one group. This was agreed by all participants. She welcomed questions and comments from attendees after the presentation. Questions and comments were made both during and after the presentation.

Meeting Notes

Please note comments noted in bold and labelled 'C', were made by members of the public in attendance. Comments labelled 'R' noted responses from members of staff present.

C: In the original model, there was a commitment to alternative crisis services as inpatient services were to be changed.

R: Happy to answer any questions after the presentation. (DN)

LH advised of IAPT (Improving Access to Psychological Therapies) service in primary care, having taken two years to implement the programme, resulting in 17 extra workers.

LH noted extra funding for Dementia services and that Pauline Walsh (Age Concern) chairs the Task and Finish Group looking to re-shape this.

C: Are you closing the Blackburn unit?

R: The original consultation set out that all existing units would be closed and a smaller number of new units developed. I don't have specific details about the timescale for closure of the current Blackburn unit. I would like to see that there is transparency about proposed closures moving forwards. (DN)

C: Are community services working as they should be? Are they safe? Can you cope if removing inpatient beds?

R: We have already made considerable progress in reducing the use of inpatient beds. We will always need to have some, but they need to be of good quality. (DN)

C: Community services are not working well.

R: There are variations across Lancashire, clinicians and patients have told us so, and we know there is room for improvement. (DN)

C: Surely community services should be tested across the whole patch before closures. The CQC (Care Quality Commission) criticise services.

R: We address this in the 'Case for Change'. It seems 24 hour response is not good enough, and too many people are for example going to A&E instead. We must look at quality and performance. Also there is some good experience of home treatment with positive experiences noted in Burnley. (DN)

C: Why don't you close Burnley instead, before sorting out Preston and other areas? 80 people died from suicide last year.

R: I don't have the details about all localities with me, but LCFT say Serious Untoward Incidents (SUIs) have decreased. (DN)

There was further disagreement about this issue.

C: People in supported living are not living independently. It can take twelve months to get talking therapies. You can't look at acute services in isolation. How many people have gone back into hospital whilst on a waiting list? The only thing that kept me from going back is my own determination, not buildings. It is staff that matter. I've been in Burnley, Blackpool, Blackburn and Cheadle Royal. Blackpool facilities are not good, but attitudes of staff were good and had a big impact. I know things have got to be set up. People need to take on board that fact. People are still going through the system. There will be teething problems, major failings, tried to work in partnership but its not working. Look at staff funding into steps 1 to 5, and informal carers, there is a massive discrepancy. It's a new world we've got to work with what we've got. It's difficult coming to these events, not having all the details.

C: This is not about primary care services. It is about a different client group.

R: I agree. (DN)

C: There needs to be a clear plan.

C: It would give reassurance, we never have concrete proposals.

R: We've got to stick to the bigger picture. While it is important to look at the entire care pathway, we do need to *focus* on the acute care service in this piece of work. (DN)

R: We are still working on the 'Case for Change'. This will go to public board meetings setting the pace for change. In respect of wards in Burnley, I believe the numbers of beds needed for the population size is not that different to what is there now. Unfortunately Rebecca Davis is unwell because usually I ask her to answer the detailed numbers questions. The issue about central Lancashire, data in the 'Case for Change' needs to include the high level of admissions. (DN)

C: It's the process.

C: Re Dementia, I'm concerned about the new builds. I don't think there should be new builds. That money should be put into crisis intervention beds. Noting two points:-

- 1. New builds – condition rather than age, a big step forward. Before I became ill I worked with older people, more functional with loss of spouse, loss of friends/family, loss of one's ability to be independent. We need to be careful.**
- 2. Alternative crisis intervention – I do not think sometimes it's appropriate to treat people in their own homes. People who are in the service, who are at risk, there needs to be blanket risk assessment. It makes things more**

confusing and doesn't improve your mental wellbeing. I'm not sure how it sits with restriction/human rights. The CQC would need to look at how that's being done. Sometimes you need acute care.

R: In 2006 Dementia did not have the prominence it has now, and so this area of the model was less developed. We are waiting for the final version of the NCAT Review (National Clinical Advisory Team), but we believe it will talk about finalising a model for Dementia. This is an independent review carried out by expert clinicians. Should Dementia beds be with functional mental health beds? (DN)

C: If I had been ill at 63 and not 43, would I have been classed as Dementia?

R: No, not necessarily. We are looking at the Dementia care pathway. (LH)

R: We want to move away from services defined by age, to need. (DN)

C: Can medication cause Dementia?

R: I don't know of any evidence that says that. (DN)

C: I could have had Dementia at 43. People will want to know that they won't be boxed off by age.

R: They won't, we agree. (LH)

C: Re crisis intervention, when crisis occurs how many people are known? Is it increasing, as an aging population?

R: We don't know that the incidence of crisis is increasing. (LH)

C: Referrals from where?

R: GP referrals or self referral. (LH)

C: Are GPs playing their part?

R: Through the primary mental health care teams. (LH)

R: The biggest transformation is around crisis teams. It could be that they are not as effective as dealing with people who should have been in primary care. For all people known to services, the point back into the service should be through the crisis resolution services, but this is not consistent. People still talk about going to A&E when they are known to the crisis team. Crisis Resolution and Home Treatment Teams (CRHTs), is there something else that also sits between home and hospital? (DN)

C: How?

R: The evidence base for crisis houses isn't that strong. In Blackpool their crisis service, Phoenix House, doesn't show an impact on admissions. (DN)

C: Looking at Blackpool, it has both. If you remove it from Preston there is nothing else, people will be going to Ormskirk. It's a concern for carers.

R: We have to recognise that. (DN)

C: Part of the work should be around alternatives for people who are not sectionable. I looked at alternative services in Rotherham a couple of years ago, and I understood that it had a big impact.

R: I would like to re-visit this and bring in outside independent advice, to tell us from the evidence what is needed locally. If we need something so let's get it right. (DN)

C: I went to the original meetings, this was a ten year plan, is that still the case?

R: Yes from beginning to end. In terms of a *building* process it's about five years, but not everything will start at the same time. (DN)

C: There have been a lot of changes, things closing down. We voice our opinion time and time again. They say they're listening, but it's already cut and dried. People think it's a waste of time.

C: This is why you have such a low turn out at meetings. I am sucking it and see. It's important to lay your cards on the table if decisions have been made. You're accountable.

R: We are trying to be open. We will be taking the Case for Change paper to PCT Boards, and feeding back to PCTs about what people have said. We invest more than the national average per person in mental health but we think too much is being spent on people being into hospital. We are not disinvesting in Lancashire – the reverse - but people don't feel confident in all the services. (DN)

C: Lancashire Care Foundation Trust (LCFT) is the Lancashire service provider, but also the local provider. Somehow LCFT have lost that. People can't afford to travel miles, it's a real concern.

C: How can we be confident with you? The consultation was flawed. You commission services. You've not bothered to get value for money. The Chief Executive (of LCFT) recently took senior staff to Stanley House. If you're re-visiting, you need to re-visit the number of sites.

R: Yes, we are saying that it's quite possible that the number of sites will be revisited. (DN)

R: Consultation? "Com-pulsation", you have to be careful!

C: What about the incidence of dementia?

C: You can get dementia at any age.

C: The consultation was definitely flawed. You're inheriting a group of people who are cynical.

C: This is an opportunity, one in four people have some kind of mental illness. Mental health affects us all. Our time is precious.

DN opened up the discussion inviting people, who had not yet spoken, the opportunity to put forward their views.

C: In my case, I was trying to get an assessment, I had to fight for it. The therapist for CBT (Cognitive Based Therapy) was very good. You feel like a piggy in the middle between LCFT and social services. I am wary of complaining. For Direct Payments, you have to be in a crisis, or have to live with packages of 'one off' payments. Why do we wait until people are in crisis?

C: Now, as a casual carer, you get bits of help, but there is a shortage of money. You have to fit into this little box, but I did get brilliant help from the therapist.

C: You have to have a care coordinator. People move. I've moved, but there were no follow up calls.

C: The day care centre closed down at Mount Pleasant, will they build something else?

R: There are no plans to do so. (LH)

C: Social services are not on the platform.

C: There are a number of people in hospital relating to substance misuse. What services are there?

C: What's the predominant need (in dual diagnosis presentations)?

R: There is a dual diagnosis service pathway locally. We have worked on that. Blackburn with Darwen is the first locality in Lancashire to have a dual diagnosis strategy. (LH)

C: When I was admitted to a psychiatric unit, I had the experience of being with drug and alcohol abusers. It took me five years to get the help I needed, but I know things have moved on.

R: One of the ways that the facilities can improve is to have single rooms, so more privacy, and more space for therapy. (DN)

C: The Trust (LCFT) want to move to new sites, new asylums.

C: Your terminology needs to be looked at.

At this point, people started to have separate break out conversations. DN asked if everyone had had a chance to contribute their views, and if so were they happy to close the meeting. She could wait to answer any individual points. No objections were received to this / it was agreed.

DN said she would be happy to come and talk to local groups, and that communications had already taken place with the chair of the SAFE (Safe Avondale for Everyone) Group about arranging to meet separately.

DN advised that the themes taken from this meeting and all six public meetings would feed into the board report, which everyone would be able to have access to.

DN thanked everyone for their attendance.

C: Can we have the opportunity to look at the meeting notes?

DN advised meeting notes would be typed up and made available (on the website) as well as the formal report.