

REVIEW OF MENTAL HEALTH INPATIENT SERVICE PROPOSALS

NOTES OF THE PUBLIC MEETING *

Town Hall, Lancaster

Thursday 21st October 2010 – 6.30pm to 8.30pm

Facilitators / staff		
Debbie Nixon (DN) (Chair)	Strategic Director for Mental Health	Lancashire
Rebecca Davis (RD)	Network Director – Mental Health Commissioning	Lancashire
Tracey Callaghan- Hayes (TCH)	Project Manager	Lancashire Partnership Team
Pat Rolph (PR)	Senior Project Support Officer	Lancashire Partnership Team

Apologies were noted from Julie Haywood (Associate Director for Mental Health, Prisons and Substance Misuse, NHS North Lancashire) due to sickness.

Audience – 10 people in attendance

Staff – 4 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).

Debbie welcomed questions and comments from attendees, and it was agreed that attendees would firstly split into two groups for informal discussions and that comments would be fed back at the end.

Group 1 was facilitated by TCH, group 2 by RD, with DN joining both groups in part.

When both groups had finished, both RD and TCH fed back a summary of the discussions which had taken place. Flip chart notes were taken from each group (*Appendix 1*).

A brief joint group discussion took place before the meeting closed, noted as follows:-

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.

RD noted there had been no discussions about the Dementia pathway.

DN noted that meeting discussions were determined by the people who attend. With regards to next steps, DN advised that a report will be written pulling together information including the discussions taken from all the public meetings held. DN noted that at the Preston meeting, people wanted information about the Avondale unit. In East Lancashire (Accrington meeting), discussions included travel issues across the county, and that a lot of people are being admitted out of hours. The report will be themed and include data and information collated, and should be made available on the Partnership Board's website by the end of November 2010.

DN advised that the report will be taken to GP Consortia and to PCT (Primary Care Trust) Boards during November.

C: Are there going to be any more meetings?

R: There may well be. (DN)

C: Will the results (of the review / retest) be going back to PCTs or the Department of Health (DH)?

R: That's a good question. We will report back to our PCTs but the DH will be scrutinising, and will be looking at information provided by the NHS North West Strategic Health Authority who will be monitoring the processes in their area. (DN)

C: Will this information be made available to the public?

R: Our report will be. (DN)

R: The 'Case for Change' will be going to part 1 of PCT Board meetings (RD) which means it will be a public document.

R: Yes the DH will hold us to account. (DN)

DN asked if there were any further questions or comments, but there were none, so it was agreed to end the meeting.

DN thanked everyone for their attendance.

Appendix 1

Group Flip Chart Notes – Lancaster 21st October 2010

Group 1: (Tracey Callaghan-Hayes)

EXPERIENCE

- Community input poor
- Lack of psychology
- Changes in personnel – negative effect on care and continuity
- Lack of continuity / poor handover of care
- Poor carer and family contact
- Only responsive when risk (suicidal)
- Inadequate early intervention / preventative
- How does preventative work in this model?
- Professionals do a great job

IMPROVEMENT

- Increased involvement with carers
- More integration with health and third sector
- Knowing where to go for help
- Reduce stigma
- Proactive planning – clear care plan
- Individualised
- Service talk to each other
- Increased therapeutic input

KEY ISSUES

- Travel – don't want to / can't travel
- Already difficult to travel around North Lancs (needs to be easier)
- Already patients on unit from other areas where family cant visit
- Want unit in my locality
- Regardless of admission, have nothing to do when admitted
- Staff on units specialist
- Atmosphere must be good – management and nursing staff
- Culture receptive to change – organisational change

Group 2: (*Rebecca Davis*)

- Having to have treatment out of area e.g. Liverpool / Cheadle / Chorley / Blackpool
- Can you have smaller units?
- Safety issues
- Crisis Resolution Home Treatment teams reluctant to come out – told to manage yourself
- What is the staff back up
- Confidence in people in teams
- Geographical area – distances to travel for staff providing services
- Consistency is good – get to know person
- Could teams be more integrated?
- Is it better for it always to be the same unit if further away? – would North Lancs / Lancaster patients just be a few and therefore not well known to staff
- Harvey House
- Separate rehab units a bit 'artificial'
- Supported Accommodation
- 530 / 260 / 420 beds
- Staff continuity
- What are the plans for Ridge Lea
- Peer support
- Local better