

REVIEW OF MENTAL HEALTH INPATIENT SERVICE PROPOSALS

NOTES OF THE PUBLIC MEETING *

The Ecumenical Centre, Skelmersdale

Wednesday 27th 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
Jan Ledward (JL)	Head of Health Inequalities & Prevention	NHS Central Lancashire
Pat Rolph (PR)	Senior Project Support Officer	Lancashire Partnership Team

Audience – 14 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).

It was agreed the discussion would continue in one group with the following set of notes taken.

Debbie welcomed questions and comments from attendees:-

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: What were the proposals, estates?

R: Lancashire wide, buildings. (DN)

C: It's not supposed to be changing for something smaller.

R: It may mean fewer sites. (DN)

C: What you are saying now applies to Lancashire wide, not just this area?

R: Yes. (DN)

C: There was a great deal of disagreement about being annexed for West Lancashire. That outline doesn't apply here.

C: Ormskirk is not in that category of being 'not fit for purpose'.

R: 'Fit for purpose' means single sex accommodation, single rooms, en-suite, therapeutic environment, there being space and privacy. 'Not fit for purpose', it's not just about whether the building is in a poor state, we know that Scarisbrick is seen as a nicer building than many. (RD)

C: A positive is its smallness.

R: The Trust proposals say therapeutic.

Looking at the presentation, have we spent enough on Community Mental Health Teams (CMHT)? Yes, more than the national average. (DN)

R: The National Service Framework sets out the requirements. (JL)

C: You know they are amalgamating teams (community teams locally).

C: What do you mean by treatment in the community?

R: Early Intervention Service (EIS), delivery of crisis response and home treatment. (DN)

C: What do you think about day centres? Too many people are falling down the cracks. We can go there and talk, help each other, a smiley face, but we are getting our funding cut and being told to go out in the community. Social inclusion is supposed to be important, but nobody wants us.

C: I went into hospital and had a horrendous time. I paid to go to a hypnotist, £40 an hour. Ok, nice hospitals, but it's the people, talking, caring. The hypnotist helped.

C: We're missing therapy, we're only getting medication.

C: I was on a waiting list to see a counsellor, but had to travel from Burscough to Preston.

R: I'm happy to take your name and contact you afterwards if you want me to follow that up. (JL)

C: My friend contacted the crisis services, and was told "what do you expect me to do at 5am in the morning?"

R: That's the sort of story we are hearing consistently at these meetings. (DN)

C: I was self harming, my wife called a friend who worked in a day centre. She was transferred to the Crisis Team, and was told "if you hear voices" then ok they will see you but if not, no.

C: The Crisis Team should help the most vulnerable.

C: Give it a week or two, then bye bye.

C: It's about quality.

C: I am a grandparent of two children with special needs (autism), and a volunteer worker for the Princess Royal Trust, and have come across CAMHS (Child and Adolescent Mental Health Services). There's pressure on the parent to help the child. You're lucky to get help with a diagnosis, you're left floundering. Do you look at a main or special school, the family has to cope. My grandson is now 15. He will soon be a young adult but will never be independent. I am concerned about the services available once he is an adult.

C: I'm not a service user, I'm a councillor, an elected member. There is a wider issue, how service is provided, gaps in the system. I can remember the original consultation. There were arguments for Ormskirk. What are the "four tests", what's different to the original consultation? We need to understand what's changing.

R: The government has asked us to re-examine, has the world changed, do these proposals that were a result of a public consultation still make sense? One of the key things that have changed is that we are already using fewer beds and there are more community services. We may be able to manage with even fewer beds and fewer sites. There is a greater discussion around Dementia. I've seen an early draft of an assessment done by the NCAT (National Clinical Advisory Team), which says there are two options for

very specialist inpatient Dementia services – either with mental health inpatients or with general hospitals. Do we re-look at those choices? (DN)

C: I'm not being rude, there's not a reduction in beds, it's because people are being discharged. A lot have been discharged from the service.

R: And what does it feel like? (DN)

C: My son, he was in ten different wards in various places.

C: We've heard that Ormskirk is closing and going to Preston.

C: Services used to operate from Ormskirk, there are fairly new structures. Ormskirk was in at the beginning but it's evolved since then. We didn't know what we were supposed to do; we've not had a chance to stabilise. Assertive Outreach is moving out of the locality to Chorley.

C: What has Chorley got that we haven't got?

C: Nothing

C: Are Crisis Resolution and Assertive Outreach the same?

R: No. We should operate a CRHT (Crisis Resolution and Home Treatment) model, it should gate keep, be 24 hours, but what should home treatment look like? It will be different in more dense population. What's local, who is gate keeping? (DN)

C: There is a situation with transport. One bus service, it doesn't run on time and doesn't run on a Sunday.

C: There are big issues with the consultation. At this consultation we've got to reiterate that issue. There is a need for the NHS to address the situation; it has not been addressed so far. Transport for patients.

C: And families.

C: A strategic look at the transport system.

JL asked how people get into services if they are in crisis. Was it through A&E?

C: Through the crisis team. My husband was away, two men came to the house, I felt extremely intimidated. I kicked up a fuss about it. Others have had similar experiences. Now they have a woman but she's not always on duty.

C: What am I hearing, that people can't access services via the crisis team, they have to go to A&E?

C: I had a heart attack before Christmas. If you have that condition you have a pathway to go through. Should we not have a pathway for mental health?

C: Or go by GP for mental health service users.

C: It's ok if I'm ill during the week, but we get ill at weekends and bank holidays.

C: How do patients get an address for the pathway or system?

R: The CRHT was put into place to prevent you going into relapse, a traffic light system. It's increasingly patchy. There does seem to be variation. People should only need to go to A&E where it is their first case of mental crisis – or they have suffered some physical harm which needs attending to as well as being in crisis. We are hearing it's very patchy, experiences are very different, some say, good, some not. (DN)

C: There isn't an A&E in this area.

C: I rang the crisis team at 2am in the morning and was told to go to A&E.

C: It's changed since I last used the system. My husband and I ran a Bi-Polar Group. I am lucky I am through social services; I have a very good CPN (Community Psychiatric Nurse) who supports me at Daniels Lane. People are on call over the weekend through social services. If people are having a problem over the weekend, Daniels Lane will see them.

C: It's also geographic. If you live in Ormskirk, you don't fall under Daniels Lane.

C: There are inconsistencies in services, too many gaps in the system. There is a need to have a much more robust method and system, and higher quality training.

C: We need the same sort of thing as a paramedic.

C: The crisis team lack bedtime manner.

C: I trained as a nurse in 1959, training's not the same now.

C: Would training make a difference to caring?

R: We should have a standard model across Lancashire. Talking about access to sites, how do you deliver real alternatives, how quick is the response? What does home treatment look like? (DN)

An example of someone's experience of calling a crisis team during a period of domestic violence was given.

C: I'm still waiting to find out what's assertive about Assertive Outreach.

C: I was supposed to see someone at Daniels Lane but had the appointment cancelled three times for different reasons due to a person being off sick for a long time.

C: They stopped Support Workers using their cars from Daniels Lane. A petition was signed, now they are allowed to use their cars again.

C: If their system doesn't work, it hurts us.

C: I got most of my support from Daniels Lane.

C: When you're discharged, you can wait up to six months to be seen by someone from Daniels Lane, a Community Mental Health Team (CMHT) run by social services.

R: Do you mean that if you ring, you don't ring the crisis team? (DN)

R: This is our fifth meeting, and we've heard similar and different things. We've not had a meeting yet where they haven't questioned the crisis team. What would it take to have confidence? When in Accrington last week, we had an interesting conversation about the CMHT in one location. We understand that people would like CMHTs to feel more local. Are services becoming more centralised, what would make you feel confident? (DN)

C: People are treated differently. There are problems around dual diagnosis, that's when people go to A&E.

C: CMHTs tend to be strongest, crisis teams seem to be attracting the most problems.

C: The Assertive Outreach Team turn up, but won't advise.

C: Assertive Outreach are supposed to be more creative.

R: To summarise; there are very different experiences of crisis, chaotic, people are still accessing CMHTs. If you were to travel to more distant inpatient services, if crisis home treatment was coming to your, this should work, but you are having to travel to them. (DN)

C: The CMHT is very good, people are going there with their key workers. I have experience of someone admitted to Scarisbrick and they are now with the CMHT and doing well.

C: That model works well for those people.

C: Occupying a patient during the day is important, and day centres are going.

C: I came from Kent, the South East, the level of support down there was better. People [NHS staff] came, travelled.

C: Manners, just to phone if they are going to be late.

C: It could be one of twenty four different people that you could see.

C: Whenever an appointment's made, it should be through a central system. They should say there is a two hour window. Why can't they introduce that system to stop having to wait in all day?

C: Or even worse, they don't turn up.

C: Support in the community, the principle is to integrate people into the community. If so, how are they integrating with other services in the community? Education is an issue. How are you using other stakeholders? I am a member of a stakeholder board in Digmoor, you get everyone around the table. It's not the sole responsibility of the police or the NHS, it's how you are managing integration so people can be educated, housing etc.

C: Education is key. The housing department refuse to recognise depression as an illness.

C: Many people prefer to be on their own. I prefer to go to church. You have back up. A lot of people don't want to know. It's about wanting to engage.

C: There is an issue that you can't live a normal life until integration. It's up to the health service to lead on this.

R: It's fair, as the NHS is leading on mental health wellbeing, for example IAPT (Improving Access to Psychological Therapies). This is focussing on a small number of people; we are still spending too much money on inpatient care. (DN)

C: A lot of negative comments, it's not about you. Our comments are about Lancashire Care Foundation Trust (LCFT).

C: The idea of a Partnership board, I've heard it referred to as an elephant, too wide. Beds are a starting point; when discharging people the structure has to be there.

C: Is that structure just mental health, or is it a bigger community cohesion agenda? Change is not easy but we've got to start somewhere.

R: What would it take? What would success look like? I'm saying money has already been put in. (DN)

C: At Charnley Fold in Chorley, I did attend a workshop on Dementia. I felt there was room for development, for the voluntary sector. I came back and set up a meeting with the Alzheimers Society, to put a bid in for older adult services. I felt there was room to do this. Here in Ormskirk, Brookside and Moss Side Care Homes have been demolished. Should services and supported living be for the voluntary and statutory sectors? It's not the same for adults as for older adults. I have been at training assessments for carers, around the Carers Strategy. It was older adult themes. Some groups there said they could do assessments but don't have the power as only social services can do them.

C: Bickerstaff has older peoples' services.

C: I was on a Task and Finish Group during the last Labour government; we produced a Dementia strategy. Where's the talking to GPs, who has the direction?

R: Specialist Memory Clinics to get diagnosis. GPs are not necessarily expected to diagnose but to sign post on. The research I've read, very often the GP has a good idea about what's going on. GP recognises then sends to the Memory Assessment Clinic. (RD)

C: It's about that information being made available to the general public. There is a big issue around Dementia. That initiative in Ormskirk is going the right way. We are talking about large numbers, we'd like to see the money moving from domiciliary care, moving through to Dementia services (an example of visiting a care village in York was given).

R: What does a successful system look like? (DN)

C: I would say CMHT.

C: On the positive, if patients are in a new bigger hospital, all services are of better quality care in one location, albeit out of area.

R: It has been said that it is important to people to have familiarity with services, to know staff, rather than shuffling around. If there is one bigger place, at least you know where you are going. (RD)

C: There was talk of half way houses in the community, six to ten beds for short periods of time, but nothing more has been done.

R: There is a crisis house model in the Phoenix Centre in Blackpool. (DN)

R: You're right it was in the original consultation, crisis and respite. What we know of crisis services around the country is that they can be very valued, but don't necessarily make a lot of difference to the rate of admissions and therefore the need for beds. However that is focussing on crisis and there is still respite to consider. Carers say they need access to respite, they are not forgotten. Perhaps the existence of such a service would give you confidence. (RD)

R: The crisis house model was four to five years ago, since then we've done some learning. (DN)

C: Phased discharge would be helpful if more was available in Ormskirk.

C: Clearly Dementia is on the radar, but is Autism on the radar? Lots of people have Autism, a lot are adults. There is a huge pressure on frontline families with young people confined to the house who cannot speak for themselves. How do they have access to services?

C: If you're interested in talking to us, there is advocacy support to help.

C: Part of the question is around an exit strategy. There are serious problems. Older people are being 'put out' with no one there to help. Information needs to be made available.

C: Voluntary organisations help a lot of people live with Autism in supported living areas.

DN summarised and it was agreed by everyone present to draw the discussion to an end.

DN thanked everyone and advised comments from the meeting would be written up and themes fed into the report, and both would be made available on the Partnership's website. DN noted this was just the start, and not the end of the discussion.