NHS Cumbria Clinical Commissioning Group

NHS CUMBRIA CLINICAL COMMISSIONING GROUP
MINUTES OF MENTAL HEALTH PARTNERSHIP GROUP
Tuesday 1st September 2015 at 9.30am
Community Room, Penrith Community Fire Station

Chair:	David Rogers, Medical Director, CCG (DR)
Present:	Andy Airey, Deputy Network Director Carlisle & Eden, CCG (AA) Beren Aldridge, Therapeutic Coordinator, Growing Well (BA) Stuart Beatson, Associate Medical Director, CPFT (SB) Rosemary Berry, Lay Member, Best Life Wellbeing Network (RB) Andrew Brittlebank, Medical Director, CPFT (AB) Laura Carr, Lead Nurse Quality and Safety, CCG (LC) Simon Coope, Lay Member, Best Life Wellbeing Network (SC) Greg Everatt, Senior Comm Manager Child's & Families, CCG (GE) Joanna Forster-Adams, Director of Operations, CPFT (JFA) Jo Haig, Lay Member, Best Life Wellbeing Network (JoH) Janice Horrocks, Deputy Director MH & LD, CCG (JH) Amanda Lihou, Lay Member, Best Life Wellbeing Network (AL) Gary Malone, Commissioning Manager, NECSU (GM) Jane Mathieson, Public Health Consultant, PH (JM) Sue Stevenson, Chief Operating Officer, People First (SS) Pam Travers, Assoc Dir Social Care & General Manager MH, CPFT (PT) Andy Towler, Supt Operations, Cumbria Police (AT)
In Attendance:	Debbie Archer, Business Support Officer, CCG (DA) Harpreet Kaur, Programme Lead (Interim), CCC (HP) Rosemary Granger, Interim Mental Health Strategy Lead, CCG (RG)

1. Welcome & Apologies *Action*

DR welcomed the group. Apologies were noted from:
Julie Baillie, County Manager Specialised Commissioning, CCC (JB)
Marsali Caig, Interim Strategic Change Lead, CPFT (MC)
Rob Hulme, Vice Chair, CCG (RH)
Sara Munro, Director of Quality and Nursing, CPFT (SM)
Nichola Sanderson, Associate Director of Nursing, CPFT (NS)

2. Declarations of Interest

No declarations of interests were announced.

3. Minutes and actions from the previous meeting

The notes of the previous meeting held on 3rd March 2015 were approved as a true and accurate record following two amendments:

Jo Haig and Amanda Lihou to be removed from the list of attendance.

The action log was RAG'd and updated.

4. Introduction – Deputy Director Mental Health/Learning Disability Commissioning

JH introduced herself to the group.

5. Introduction – Vice Chair Cumbria Mental Health Partnership Group

The group listened to a pre-recording from Rob Hulme.

ACTION: DA to distribute recording and RH contact details to the group. DA

5.1 DR introduced a letter received from "Cumbria Mental Health Service User and Carer Forum". He proposed that it was important to consider the letter at this point in the meeting so that the group could consider the issues raised as the meeting progressed. The letter expressing concern on the following areas:

- Mental Health Strategy for Adults
- Crisis Care Concordat
- Distribution of the MHPG minutes
- Carers Breaks

Mental Health Strategy and lack of progress in recent months – SC emphasised that confidence has grown since Rosemary Granger's involvement with regards to the mental health strategy. RG mentioned the strategy would be discussed further in agenda item 6.

Crisis Care Concordat and lack of progress – SC highlighted concerns raised at a recent forum meeting and referred to concerns regards changes in relation to funding, staff and organisational changes, government changes and expressed worries that services may suffer due to this and not continue at a sustained level and patients may suffer due to delays in response to urgent care situations.

AT suggested an action plan is created for the Crisis Care Concordat. AA commented that resource to support implementation of the action plan needs to be discussed before progressing. The group agreed that accountability needs strengthening. AA reassured the group that things were happening and progressing and that communication may be the problem that needs to be addressed.

ACTION: SC, JFA and LC to meet and discuss concerns. SC/JFA/LC

ACTION: JH to help draft a response to the letter and meet with Lay Members and the forum at the earliest opportunity. JH

6. Mental Health Strategy Update

RG introduced this item by explaining the approach she has taken to the revision of the strategy. In summary, the feedback she had received from colleagues in the early stage of her work had been that the previous version did not meet the needs of all constituencies within the mental health system in Cumbria, nor was it clear about the ownership of the strategy or how the strategy would translate into improved service delivery. She therefore proposed that the strategy, under the banner of 'Mental Health for All', be broken down into three elements:

- The vision which would be owned by the mental health partnership group

- A proposal to develop a model of care for mental health services which would describe how the vision would translate into service delivery
- A joint commissioning strategy for mental health which would describe how the commissioners would bring their resources together to deliver the vision and implement the model of care

Better Mental Health for All:

- *The vision*

RG described how the vision document is broken down into sections and highlighted the fact that this is based on all the good work covered in the previous versions of the strategy and it contains very little new material. Section one identifies the vision, principles, ethos and scope of the five year strategy. Section 2 sets the strategy in context by identifying key national drivers in mental health and the local context that together create the case for change. Section 3 focuses on the potential impact of delivering the vision and highlights some of the key areas that need to be addressed to achieve this and section 4 sets out the arrangements required to deliver the vision.

- *Proposal to develop a model of care for mental health in Cumbria*

The current paper describes a starting point for the development of a model of care for adult mental health and sets out the potential benefits of undertaking this work. In other words the model of care will translate the vision into a blue print for services that will enable the whole system to work collaboratively towards its implementation. The paper also sets out suggested service principles, a possible structure for a model of care, 'food for thought' in terms of areas we might consider as part of the development of the model of care, an outline of the Cumbria health and social wellbeing system developed by colleagues in public health, key issues highlighted by research with users and carers that need to be addressed by the model of care and next steps.

RG highlighted that JH will need to take this forward as part of her new role.

- *Joint Commissioning Strategy*

This describes how commissioning colleagues will come together with resources to deliver the vision and implement the model of care. It reiterates the priorities identified by the Mental Health Partnership Group in recent months. It also describes key elements that will need to be addressed as commissioners work together to commission together, such as, commissioning for quality and best value, the need to achieve financial stability and improve financial planning, contract arrangements to support transformation, characteristics of providers of the future and how commissioners can work with providers to promote workforce development across Cumbria.

There was broad support for the approach RG had described and the documents that had been circulated. During the discussion the following comments were raised:
JH commented the need to focus on quality and ensure sustainability.
AT raised a query on resources that would be needed to implement the vision and the model of care
SC mentioned how to manage organisations shifting and moving on. AB emphasised the need to ensure we keep people safe during change. He welcomed the principals that will underpin delivery of the vision and highlighted the need to ensure there is capacity to enable us to identify best evidence to progress to best practice.
BA reminded the group that a proportion of the income that 3rd sector organisations

receive comes from sources outside the statutory sector and this needs to be factored into the work on developing a 'single version of the truth' and the forthcoming work on supporting the sustainability of the 3rd sector. He reinforced the need to carry out the work on the 'single version of the truth' so there is greater clarity on spend on mental health broken down into organisations.
HK commented on the need for a joint action plan involving CCG and CCC in order to work jointly together.
GE mentioned that links need to be made to the children's strategy, and pointed out that there is an expectation at national level that work on child and adolescent mental health will incorporate perinatal mental and this is a specific area where links need to be developed.
SB highlighted the need to understand the impact of any structural changes between services i.e. from acute to community and what the consequences may be.
PT commented on how all the mental health related groups fit into the programme structure outlined on page 26. LC and RG discussed this in Agenda Item 8. JFA commented on fitting in with the success regime. RG pointed out that these implications need to be shown in the governance arrangements for the mental health programme.
JH queried the ownership of the vision/strategy. The group agreed the vision needs to be owned by the MHPG and all organisations involved, to hold each other to account for its delivery, and not just commissioners.
HK discussed having a strategic review which should be governed by this group.
BA said he would like to see the vision agreed by this group and queried why it needs to be seen by outside organisations' governing bodies. JFA highlighted that she would want to ensure there is trust board endorsement and support for the vision in order to deal with possible change and using resources differently in the future.
AL had concerns if the document could be changed due to CCC electoral changes. HK reassured that the vison will be taken to the Director Team within the council for support and that it was unlikely that political changes would have a significant impact at this level. JH commented that the Health and Wellbeing Board will be interested in the vision and will be key to securing support within the council.

DR confirmed he is happy for the vision to be circulated outside this meeting for comments.

ACTION: AA will ensure RG has the correct crisis concordat declaration to insert into the document.	AA
ACTION: All group members were asked to send any additional comments to RG as soon as possible	RG
ACTION: RG to make changes as a result of these discussions and send out as draft for final comments.	RG
ACTION: PT to find out the County Council approval system.	PT
ACTION: DA to add revised paper to next agenda for approval.	DA

7. Update on priorities/workstreams and next steps

RG introduced this item, reminding the group that a number of workstreams had been proposed to address the priorities for action identified by the MHPG within the four broad elements of: Primary Care Mental Health and CHMTs; Urgent Care; Third Sector Development and Complex Care. However these workstreams didn't go ahead due to a risk of duplication with the Partnership Trust service improvement plans and lack of capacity in the system to progress some of the areas. RG tabled a flowchart showing progression of MHPG priorities in 2015/16. The flowchart highlights previous

and forthcoming work and how it might be managed going forward.
It is proposed that the work on implementing the strategy for the next year will be aligned to three areas

- **Transformation** - RG stressed that all members of the MHPG will need to be involved with the transformation as this will generate the Model of Care.
- **Delivery for Priority Areas** i.e. those areas not already included within the Partnership Trust service improvement plans – this year, these will cover Primary Care, Recovery, Crisis Care Concordat and 3rd Sector.
- **Reporting on work already underway** – we will establish a common and straightforward approach to reporting so that wherever the responsibility sits for leading on a particular workstream, the progress reporting to the MHPG will follow a consistent format and timescales.

There was broad support for this approach going forward and an acknowledgement that this would make better use of the service improvement resource across the system and it would improve the reporting to the MHPG to enable the group to maintain an oversight of the progress in these important areas.

In light of the fact that the Partnership Trust had already initiated work on a number of the workstreams identified earlier in the year, Trust colleagues had been asked to provide a progress report and this had been circulated to MHPG members.

The report focuses on the key areas for the Care Group:

- Inpatients – improving pathways and capacity
- Review of inpatient provision in Cumbria
- Assessment, liaison and intervention service (ALIS)
- Liaison services
- Mental health crisis concordat
- Provision of rehabilitation
- Personality disorder care pathways
- Primary care mental health services
- Improving CMHTs
- Physical health
- Suicide prevention and lessons learned

AA provided additional updates on the following areas:

- All the initiatives are supported through the joint CCG and CPFT contracting and commissioning process and are included within last year's CQUIN and this year's CQUIN and also the service development improvement plan. The performance is monitored against the quality schedule between the CCG and CPFT.
- With regards to inpatient services – Improving pathways and capacity - this was identified as last year's CQUIN process. AA reported attending two assessment and inpatient treatment units to observe the inpatient process.
- With regards to Liaison Services – CPFT used winter pressure and resilience monies to take forward liaison services.
- With regards to MH Crisis Concordat – the 72 hour assessment process and provision of rehabilitation needs to be included.

RG reminded the group that service users and carers had offered to be part of the workstreams, and it is important that they are connected with the relevant work of Trust colleagues.

SC expressed an interest on the Personality Disorder Care Pathway and commented that CMHT have advised not to refer to the Crisis Home Treatment Team. The second date for structured clinical management training had been cancelled due to lack of staff. SC expressed concerns regarding the closure of the CPFT NHS therapeutic community as at the end of this month, and the likelihood that personality disorder demands will accumulate into other areas. There is a lack of focus of therapeutic services. SB agreed the therapeutic model wasn't providing a comprehensive county wide service. SB assured the group that all skilled PD therapists will be maintaining their workload providing therapeutic services and will be working with teams to upskill other professionals across the county.

ACTION: PT agreed to investigate CMHT referrals issue.	PT
ACTION: CCC needs to be added to the reporting process going forward.	DA
ACTION: GM/RG to create a reporting mechanism to feedback into this group.	GM/RG

8. Connecting with the wider system

LC took the group through the draft governance structure set out in the vision document, highlighting that this was a first draft and that further amendments need to be made to secure links with and reporting to other programmes in Cumbria. She explained that the intention is for the former MH Leads group to evolve into the Clinical Leadership Group to act from an assurance/clinical governance perspective and that a delivery group of lead officers will be established to progress work on behalf of MHPG between meetings. Terms of reference for these groups will be drafted and brought to the next meeting.

It is important to ensure that mental health is included within the two key programmes in Cumbria: Better Care Together (part of the Vanguard programme) and Together for a Healthier Future (Success Regime). It is understood that there is provision within the TfHF structure for a mental health workstream and LC is meeting with Anthony Gardner in relation to BCT as there is currently no mental health pathway present.

LC requests colleagues inform her next week of meetings that need to be fed into the structure, suitable clinicians for the leadership group and thoughts on the delivery group.

ACTION: LC to feedback re BCT	LC
ACTION: Colleagues to inform LC of Mental Health Programme structure	ALL
ACTION: RG/GM to draft terms of reference for the Clinical Leadership Group and Delivery Group	RG/GM

9. Date, Time & Venue of Next Meeting

Tuesday 3rd November 2015 at 9.30am, Community Room, Penrith Fire Station