Governors Patient Safety & Experience Group – 15 September 2015 **B2**

Recommendations from the CMHT Task & Finish Group

The Governor Council meeting on 11 March 2015 recommended that the Patient Safety & Experience Group continue to monitor the quality of support being delivered to CMHT patients to ensure that a return to traditional support levels is, as a minimum, achieved. This report provides an update to the specific questions raised in this respect.

1. **The number of Service Users where personal budgets are still not agreed/activated.**

   Janet Hathaway clarified this question as "How many people are spending their budgets on an agreed plan, and how many are not doing so because their choice has been refused, or the service they have been offered has been declined as unsuitable? Is it typical that a budget accrues unspent in the bank?"

   Once approved, PHB accounts are monitored by the Monitoring and Payments (MAP) team at NCC. The MAP team monitor accounts at 12 months for those with one-off payments and at 3 months and 15 months for those with weekly payments. This monitoring schedule for one-off payments is designed to allow the PHB holder the full 12 months to spend their Direct Payment according to their plan, e.g. a college course may not start until January 2016, and so there wouldn't be a benefit to monitoring the account in October 2015.

   In addition to this, the PHB plan is reviewed at least twice in the 12 month period of the PHB to observe progress against the identified health and wellbeing outcomes as well as provide the opportunity to make changes to the plan. Reviews are requested by the PHB office at 6 months and 12 months, although a PHB holder is welcome to review their PHB plan at any point should they find that their current plan is not successfully allowing them to achieve their outcomes.

   With these methods of reviewing the PHB plan and monitoring the Direct Payments, the earliest the PHB office will be aware that a PHB holder is not spending the money as detailed in their PHB plan is at the 6 month mark, unless they are informed earlier by one of the following: the service user, their family/carers, their broker/advocate, an NHFT clinician, the MAP team or the CCG.

   There are currently 56 service users with a mental health Personal Health Budget (PHB) in Northamptonshire. They are assumed to be spending their budgets on their approved PHB plan unless the PHB office is otherwise informed. A PHB is not designed to be monitored on a more frequent basis than that described above; a PHB holder should have the freedom to spend the money in ways and at times that make sense to them, as agreed in their PHB plan. The PHB office are not aware of any PHB holders who have not spend the money according to their agreed PHB plan specifically because parts of their original plan were not approved by the PHB panel. The exact reasons why a PHB holder

has not spent their Direct Payment are not always known if there is refusal to complete a review of their PHB plan or to communicate with the PHB office or their NHFT clinician.

Any unspent money remaining in the PHB at the end of the 12 month period is required to be returned to the NHS, or can be offset against a payment for an additional 12 months of a PHB should the service user remain eligible.

2. The Number of Service Users identified to receive personal budgets.

Janet Hathaway clarified this question as "How many patients overall have been classed as suitable for these budgets?"

Service users are identified for Personal Health Budgets (PHBs) through NHFT clinicians. Suitability for a PHB is a decision jointly made by the NHFT clinician and the service user. There are currently 18 service users who have been referred for a PHB and are in the process of writing their PHB plans.

Records are also kept of when NHFT clinicians speak to the PHB office about service users who could be a potential candidate for a PHB. There are currently 12 service users in this position. The NHFT clinicians for these service users are then chased on a regular basis for a possible referral for a PHB.

3. CMHT are now working as a 'team approach' what is different to how it was before?

Prior to the consultation, the CMHTs had a very flat hierarchy, consisting of Band 6 practitioners (both nurses and occupational therapists). They supported the medics and the psychologists, by acting as Care Co-ordinator for any patients that required it.

In recognition that the hierarchy was flat, Band 5 Nurses/Occupational Therapists and Band 4 support staff have been introduced to all teams. This enables a team approach to be adopted in regards to managing patients for both their mental and physical health needs.

A few examples:

- A Band 6 worker may require a Band 4 support worker to undertake some dedicated work with the patient to support the Care Plan – ie to help the patient access a GP appointment or to support them to attend volunteer work.
- A Band 4 worker may undertake physical health care checks, (ECGs blood tests, etc) to support the medics with their decision making around prescribing.
- A psychologist may organise some group therapy, and the Band 5 OT may support its delivery.

This team approach is also evident in the newly introduced Morning Meetings. Prior to the consultation, CMHT staff used to work quite autonomously. This meant they only met with their peers infrequently - sometimes only once per week at a team meeting, or in passing during their working day. It was recognised that this was not conducive to team working, led to staff stress as they were managing complex cases independently,

and poor sharing of knowledge across the team in regards to other staff member's patient caseloads.

The morning meeting now occurs across all of the CMHTs, and all nursing, occupational therapy and support staff are expected to attend, as is the team manager. The medics and psychologists attend as required. This is protected time where patients who are causing concern for that day/week are discussed and tasks identified and shared.

This enables staff to share the issue, support each other and for the team to actively participate in the management of the current situation with the patient identifying '*what needs to happen, when and by whom'.*

This has proved to be a popular forum and staff have identified that they feel more supported and that the teams feel more cohesive. Difficult issues that arise are shared, and the patient hopefully benefits from this.

For example:

Patient A is pregnant and due to give birth imminently – this person remains on the list for discussion in morning meeting in order for all the team to be aware of the current and potential issues. Therefore, when baby is born all are aware and able to react/support as required.

Patient B is currently unwell – the main care co-ordinator is due to go on holiday. Information about that patient and the current issues is shared in the morning meeting so all staff are aware should the need arise to give the patient extra support.

4. **How many patients who previously formally received care co-ordinator care are now receiving alternative care?**

This is quite difficult to quantify and many patients will still be Care Coordinated they as they were before the consultation.

Care co-ordination is determined by need. Through care planning and discussion, individuals may be stepped up from being solely under Outpatients for extra support. Alternatively, they could be stepped down from Care Co-ordination to solely Outpatients should that need be resolved, but they still require medical overview due to the medication they are on.

On occasion, some patients may be discharged from Care Co-ordination straight to Primary Care if this is deemed suitable. This may be after they have attended some OT/psychology group work. This may include the Moving On Group, or the Lifeskills Group, which empowers patients to manage their recovery without requiring further secondary care input. Again, this would be after discussion with the both the responsible psychiatrist and the individual.

5. **How many patients have been referred to Mind and other agencies and how is their quality of service monitored?**

On the whole, CMHT would not be the main referrers to organisations such as MIND. Self-Directed Support packages of care can be requested via CMHT referrals to the Social Care teams, who may then fund attendance at MIND or similar agencies.

Wellbeing Navigators, who support patients on discharge from CMHT to primary care, would utilise the Mental Health Collaborative as part of the discharge plan as appropriate.

As well as other services and agencies referring to the Wellbeing Navigation Service the Improving Access to Psychological Therapies (IAPT) will often refer clients to the service who require a counselling service. The Wellbeing Navigators will in turn refer clients for counselling to any of the 14 agencies that make up the Mental Health Northants Collaboration (MHNC), which includes seven MIND agencies countywide.

MHNC are jointly working with NHFT to deliver the Wellbeing Navigation Service.

6. **Can the focus group of service user and carers report to the Governors PSE as well to PEG? (copies minutes)**

   Yes, notes will be provided via the Foundation Trust office.

Gordon King
Deputy Director of Mental Health, Learning Disability and Specialty Services
03/09/2015