South East Coast Mental Health, Dementia & Neurological Conditions Strategic Clinical Network Development Workshop Report

26th June 2013
NHS England

South East Coast
Mental Health, Dementia & Neurological Conditions (MHDN) Strategic Clinical Network (SCN)

Development Workshop Report

26th June 2013

Organised by

Partnership Project

South East Coast Clinical Networks would like to acknowledge the support of Medical Management Services, Jane Keep, Associate, Health Services Management Centre, University of Birmingham and the following partners who have made the workshop and this report possible.
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1. **Introduction**

The South East Coast MHDN Strategic Clinical Network held a Development workshop on 26th June 2013 with a wide range of stakeholders. These notes outline the key discussion points from the breakout sessions and from questions and issues that arose during the day.

2. **Breakout Session – Current Challenges across all MHDN Conditions**

There was general consensus around the principles of how we work as strategic clinical networks:

- Inequalities and variation including access, post code lotteries and variations in CCGs’ priorities in each area
- The need to raise the profile of MHDN conditions as well as tackling stigma, stereotyping, culture issues and developing a shared language, avoiding jargon
- The need for common standards of care/using common evidence and sharing best practice, evidencing that changes to services will benefit not just health but social care, housing etc
- Lack of access to timely diagnostics and assessment
- Ensuring all services are appropriate for all ages
- Co-morbidity support and specialist input for people with co-morbidities
- Physical and mental health needs to be integrated with a holistic approach
  - Working with acute, community, primary care and care homes to ensure they provide a person centred approach
  - Proactive planning and advanced care planning
  - Defining integrated care and what this looks like across these conditions
- Timely discharges from acute trusts working with social care to enable care packages to be place
- Rehabilitation, re-enablement and long term conditions support across all disease groups
- Acute/urgent care and working with ambulance services so they know where best to take MHDN patients locally/preventing admissions. Overcoming the lack alternatives to A&E, looking at crisis prevention/intervention in the community to help prevent A&E admissions
- Treatment not just medical but psycho-social: access to specialist units essential
  Options for patients to choose provider in the future

- End of life care

- Education and awareness for public, patients, carers and health professionals/other agencies

- Funding issues e.g. PBR Vs block contracts. The need to develop patient experienced based commissioning/person centred care/individualised care

- Dual diagnosis - risks, fragmented services, fragmented commissioning

- Access to data/lack of Informatics/IT/information follows the patient

- Access to equipment

Condition Specific Challenges included:

**Mental Health**

- Management of acute psychosis/long term psychosis. Reducing prescribing of anti-psychotic drugs

- Unlike most physical conditions, MH patients have to be referred to specific areas or units due to the specialisation of services – ‘geography for the sake of high quality care’

- Fractures in specialist commissioning pathways and funding, and lack of prevention incentives, e.g. for low secure, eating disorder & CAMHS tier 4

- Perinatal MH

- Transition issues - only 5% successful in making a positive solution for youth MH/self harm

- Equity of access to Liaison & Health Psychology services (as per Surrey & Borders)

- Gap between IAPT and secondary care

**Dementia**

- Dementia friendly housing

- Coding issue on ‘Senility’ for data on admission rates need to query

- Putting awareness of Dementia into schools
Neurological Conditions

- Lack of clarity on commissioning roles for MND and the wider MHDN area.
- Lack of neurological levers
- Need set of single standards for groups of conditions e.g. Epilepsy, MS, MND
- Lack of access to specialists
- Young onset of conditions support is not consistent

3. Local Successes

There are many local successes and areas of good practice; for example:

Dementia

- Sussex Dementia Medical Conferences
- Professor Bannerjee bringing expertise into research and MSc. in dementia care
- Surrey Link CPNs working with practice nurses in identifying those at risk of dementia
- Dementia champions
- Dementia Wellbeing Centres in Surrey
- Dementia Crisis Services in West Kent to prevent admission
- Dementia Services Directory - Surrey
- Family Therapy Service in dementia in Sussex
- Dementia navigators embedded into CMHTs working with memory assessment services
- ‘This Is Me’ care passport combining Alzheimer’s society and acute documents to go into any care setting

Mental Health

- Surrey, Sussex and Kent - single point of entry for MH veterans/armed forces networks
- Self harm youth service - youth MH network with 500 members, two pilots for network
- Changing Faces Charity - services to help camouflage self harm injuries and psycho-social support, and provide training and workshops for professionals
- Psychologists integrated into physical care services (ESHT)
- New urgent care pathway in Brighton and Hove 50% reduction in non elective admissions - service being evaluated
- Local MINDs doing work with wellbeing services e.g. working with gypsies, travellers, asylum seekers
Neurological Conditions:

- Redesign of Parkinson's disease services
- Nurse specialists who educate GPs and help avoid hospital admissions
- Partnership working with hospices
- Multidisciplinary team for MND
- Greater awareness of conditions
- Personal point of contact e.g. with the nurse
- Kent MS service nurse specialists

4. What Would Good Look Like

Good for all MHDN conditions would include:

- Good IT systems that are well connected, information sharing/held by patient. Information as a care pack so that information in one place that travels with the patient
- Map of services/partnerships with third sector/social services/all stakeholders
- Patient and carer information improved, and sign posters/facilitators to appropriate services/clear directory of services. Strong support for families/carers and personalised and individualised care, co-production with families/carers/patients
- Early diagnosis, carers feel supported (e.g. self referral walk-in centres), good access to psychological care, early intervention
- Clear cohesive pathways and sustainable integrated pathways/whole system approach supported by clear outcomes and measurables, including person centred care, patient experience based commissioning and clinical reference groups advising commissioning
- Commissioners share a good understanding of what is needed/collaborative commissioning with third sector/service users, commissioning is more integrated joined up, no more variation. Partnerships between providers, CCG, community, third sector, LA/Social Services/Independent sector/Industry
- Education for patients and professionals, with core training for all MHDN conditions
- Mechanism where patients are able to access services regardless of how entered system/equality of access
- Use of support from Voluntary Sector as the norm e.g. Neurological Alliance, Headway
- No more stigma, awareness of MHDN conditions e.g. in schools/in wider population
In addition:

**Good for Dementia would include:**

- Identification of dementia care pathways - urgent care pathway
- Dementia friend environments everywhere

**Good for Neurological Conditions would include:**

- Data and more neurology levers
- Prompt integrated service when needed through GP triage, GP with specialist interest, community neurological team, social care, specialist services, patient support groups

**Good for Mental Health would include:**

- Mental health awareness with GPs (each GP practice has a lead GP), and public perception of MH has changed.
- MH workers being able to deliver physical care and visa versa
- Specialist emergency units for MH that ambulance can take people to like major trauma centres for trauma
- Early intervention for child psychotherapy

5. **Feedback on the SCN Draft/Emerging Work Priorities/Work Plan**

The SCN’s Emerging Work Priorities for Mental Health, Dementia and Neurological conditions were shared with the groups who discussed these on their tables and offered feedback about the emerging work priorities:

- There is a need for a ‘map’ of who is doing what, evidence, good practice, where research is going on, what works locally, and patient experience data, as well as evaluating service models.
- When developing the SCN priorities, it is important to work across the patch, across agencies, and not just focus on CCGs to develop integrated care and shared care pathways.
- There are too many priorities, we need a high impact/specific/shared vision with task groups of the right people (specialists, patients, carers, third sector, other stakeholders) around the table, and to focus on things that other networks aren’t focusing on. Focus on one or two areas that could have a real impact on other areas, working across the SCN/networks and being clear about the role of CSUs.
- No need to duplicate what is already there e.g. Dementia Strategy
With specific comments including:

- There should be emphasis on early intervention
- Explore linkages between MHLT and IAPT and IAPT and acute services - for whole pathway
- Why is there so much attention on acute psychosis?

6. Early Wins

Early wins arose throughout the day including:

- Map current legacy of services, Develop directory of good practice/Evidence directory with AHSN to support the development of integrated/seamless care pathways and good quality outcomes rolling out good practice. Have robust data collection and systems in place and IT that supports information sharing. Have facilitated meetings across the SCN to share best practice and joint initiatives and to avoid duplication
- Develop 111 acute directories of services for ambulance service/map of services and reduce acute admissions by having community crisis/urgent care, have an Emergency Department Clinician in our SCN
- Learn from other networks (e.g. Stroke Networks, Cancer Networks) - what worked, what didn’t work.
- Early diagnosis/ early intervention and, key workers/care facilitators/single point of contact/care coordinators for each patient.
- Engagement, raising awareness, and, educating all - population, carers, professionals, patients, public, all stakeholders, Government, on all MHDN conditions. Promotion of self care/prevention - public health agenda, supporting carers needs. Training e.g. All healthcare professionals in wellbeing/offering psychological support
- Rolling out the ‘This is Me’ patient passport that travels with patients with key clinical information/develop patient held records for all MHDN conditions.
- Focus on small but impacting changes such as persuading staff in care homes to wear PJs at night

7. Areas to Improve Patient Engagement & Co-Production

There is already a lot of good practice in patient/public engagement and co-production which can be built upon across the SCN/s. Examples of good practice in Engagement, and Co-production include:

- Carers partnership hosted in Guildford and Waverley work on supporting people with dementia
- LD Partnership Board (East Sussex Involvement Matters Team, feeds into Partnership board could use same model)
- Dementia Friendly communities - listening voice group
Alzheimer's Society – PPI/PPE service user review panels – could be used to review work plans and programmes

Suggestions for improving co-production, and engagement include:

- Clear KPIs, and quality indicators and outcomes about engaging and co-production and evaluating how it makes a difference for the development of person centred care, developing patient experience based commissioning
- Map all stakeholders, and map their engagement networks - don’t replicate other engagement e.g. with CCGs, and use national/local data from charities sharing tried and tested methods
- Find our champions, and those who are good communications/support
- Improve visibility with user friendly language, and better use of literature for education, raising awareness and patient information, also using patients/carers in training and education for healthcare professionals
- Have a website with good links, a regular jargon free Newsletter, bearing in mind different needs of different age groups e.g. young people and use of social media
- Ring-fenced budget for engagement/co-production – to ensure carers/patients are supported to get engaged
- Use interventions such as service user review panels and focus group networks to capture wider views

8. The Role of the SCN

Throughout the Development Workshop questions were asked about the role of the SCN.

The SCN can:

- Provide an advisory role for Commissioners brokering relationships between CCG and Specialised Commissioning
- Support development of PBR (and looking at funding anomalies)
- Have oversight of what is being commissioned across the whole SCN area and be a source of reference for commissioners
- Support the development of consistency across CCGs/Commissioners to ensure quality standards are maintained
- Support the development of a shared model of integrated care, looking at joined up working with other agencies
- Use the ideology of industrialising health care within the MHDN disease areas making big changes to and across the system which have the biggest impact to services and patient care
• Use stakeholders to identify principles for training and education for the public/patients and also for healthcare workers
• Share national priorities with local stakeholders so they are informed and aware
• Tackle organisational boundaries
• Baseline, map and gather intelligence
• Work across the Senate and other SCNs and with the AHSN to avoid duplication and to re-inventing wheels
• Look at evidence based pathways/care
• Understand demand across whole pathway/all conditions
• Lobby the central support team/government and other agencies

It will have an overarching Steering Group across Mental Health, Dementia & Neurological conditions as well as working on specific issues within conditions which could be addressed through Task and Finish work programmes. It will bring on board clinical leads to work on specific work plans and programmes.

The SCNs have up to a 5 year lifespan but once the Networks are established they should be self-perpetuating.

9. Next Steps

Suggested next steps following this MHDN SCN Development workshop are:

• Developing a database of SCN stakeholders and feeding back after this workshop
• Clarifying relationships and connections with other networks and organisations, e.g. AHSN, CSUs, HEKSS, HWB
• Share an outline of governance structures, roles and critical success factors of SCN
• Further engage all stakeholders on SCN work priority/programmes prior to setting up and disseminating work programme
Appendix 1: Comments, Questions & Answers on the Day

Will the SCNs come to an end in 5 years’ time?

The SCNs have up to a 5 year lifespan but once the Networks are established they should be self-perpetuating.

Any insight from fellow NCDs about intelligence network for MHDN?

Yes commitment from National Directors that there will be an NIN (National Intelligence Network) for MHND however support from all groups involved will help drive this forward.

Lack of clarity on commissioning roles for MND and the wider MHDN area. Will the SCN take on an advisory role for the Commissioners?

Yes the role will be the interrelation between CCG and Specialised Commissioning and brokering relationships between those organisations to take a whole pathway view.

In this SCN going to be working as separate entities for Mental Health, Dementia & Neurological Conditions?

There will be an overarching body which pulls the 3 areas together in the form of a steering group for governance purposes but there will also be separate clinical groups for specific expertise.

Will there be other clinicians / clinical leads on board with the evolution of the SCN?

There will be clinical leads brought on board within Task and Finish pieces of work within the areas informed by the relevant work plans/programmes. There could also be specific issues within conditions which could be addressed through specific T&F work programmes, e.g. Learning Disabilities, Alzheimer’s, Epilepsy, ABI (Acquired Brain Injury).

Do we have a shared model of integrated care which we can follow for these diseases / conditions?

Within the SCNs sights and the ideology of industrialising health care within these disease areas to develop this idea.

What does industrialisation mean?

Big changes to and across the system which have the biggest impact to services and patient care which are adopted by all to provide consistent high quality care.

Why is it that Mental Health patients have to be referred to specific areas / units unlike most physical conditions?

This is due to the specialisation of services – ‘geography for the sake of high quality care’. Treatment is not just medical but psycho-social therefore access to specialist units essential.

Mental Health needs to move to a place where the information follows the patient! There will be options for patients to choose providers in the future.

Needs to be clarity over defining integrated care and what this looks like across these conditions.

Coding issue regarding Senility on admission – wide variation and inconsistency. There needs to be cross cutting working in order to develop truly integrated care pathways.
## Appendix 2: Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>111</td>
<td>NHS 111 service for urgent medical help or advice where it's not a life-threatening situation</td>
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<tr>
<td>A&amp;E</td>
<td>Accident &amp; Emergency</td>
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<td>ABI</td>
<td>Acquired Brain Injury</td>
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<tr>
<td>AHSN</td>
<td>Academic Health Science Network</td>
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<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<td>CMHT</td>
<td>Community Mental Health Teams</td>
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<tr>
<td>CSU</td>
<td>Commissioning Support Unit</td>
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<tr>
<td>CPN</td>
<td>Community Psychiatric Nurse</td>
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<tr>
<td>IAPT</td>
<td>Improving Access to Physiological Therapies</td>
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<tr>
<td>ESHT</td>
<td>East Sussex Healthcare Trust</td>
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<tr>
<td>HEKSS</td>
<td>Health Education Kent, Surrey and Sussex</td>
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<tr>
<td>HWB</td>
<td>Health and Wellbeing Board</td>
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<tr>
<td>KPIs</td>
<td>Key Performance Indicators</td>
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<tr>
<td>LA</td>
<td>Local Authority</td>
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<td>MH</td>
<td>Mental Health</td>
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<td>MHDN</td>
<td>Mental Health, Dementia and Neurological Conditions</td>
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<td>MHLT</td>
<td>Mental Health Liaison Team</td>
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<td>MND</td>
<td>Motor Neurone Disease</td>
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<td>MS</td>
<td>Multiple Sclerosis</td>
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<td>SCN</td>
<td>Strategic Clinical Networks</td>
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<td>PBR</td>
<td>Payment by Results</td>
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<tr>
<td>PPI/PPE</td>
<td>Public and Patient Involvement (PPI) and Patient / Public Engagement (PPE)</td>
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<tr>
<td>NCDs</td>
<td>National Clinical Directors</td>
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<tr>
<td>T&amp;F</td>
<td>Task and Finish</td>
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