NHS
Yorkshire and the Humber
Clinical Networks

Yorkshire and the Humber Liaison Mental Health Network
MINUTES
25th April 2017, 14:30-16:30
Horizon Leeds, 3rd Floor, 2 Brewery Wharf, Leeds, LS10 1JR

No.	AGENDA ITEMS	Action By
1.	**Welcome and Introductions, Dr Katie Martin, Clinical Advisor** Dr Katie Martin welcomed everyone to the meeting and introductions were conducted around the room. Katie advised that the slides for the meeting will be shared. In the interests of time some of the early slides which provide background were not covered in the meeting. These contained a summary of Liaison Mental Health Services in the region, followed by an overview of purpose and aims of the Yorkshire and the Humber Liaison Mental Health (Y&H LMH) Network. The first meeting of the Y&H LMH Network was held on 9th December and copies of the minutes were shared. Katie highlighted the summary of tensions and concerns raised on the 9th and then the creative solutions that were proposed. There were plans to discuss links with Urgent & Emergency Mental Health Care, but the planned guidance will be delayed so this was moved to Any Other Business.	**SW**
2.	**Plan for the Afternoon & Reflections on the Morning, Dr Katie Martin, Clinical Advisor** Katie asked each table to discuss any frustrations or reflection points from the morning session, the key points were then shared with the room and further discussion followed. *i. Acute Trust input* It would have been helpful to have colleagues from the Acute Trusts present. This would enable the building of relationships and sharing of challenges. It was agreed that there was a role for a meeting or sub-regional meetings to be set up with acute hospitals, although it was acknowledged that ensuring attendance would be challenging. Yorkshire Ambulance Service (YAS) colleagues agreed that the Y&H LMH meeting was a helpful meeting. It was also raised that there can be difficulties ensuring engagement of acute staff at training and that it would be helpful to consider solutions in this group. It was noted that links should be made with existing crisis care concordat groups. There are concerns regarding the CQUIN and it was proposed that this could be an agenda item for the next meeting. This would also theoretically appeal to acute staff. A comment was made that whilst it is helpful to have commissioners and providers attending these meetings, it is important to ensure that practitioners are not left behind. It is useful to listen to pan-organisational issues but it cannot just be a 'talking shop'. A developmental component may also be beneficial, for example, the Competency	

	Framework. *ii. Bungee Effect* This concept was highlighted in the morning and refers to the draw of staff back to A&E. It is unclear why this occurs. There some a suggestion that this relates to the complexity of training needs, and there is a link to the development of competencies. Further consideration should be given to training LMH staff and not just A&E staff. In relation to both this point and the one before, it is important to stress that the CQUIN does not just relate to mental health attenders. The biggest wins are non- mental health attenders who have presented before. Katie advised the group that the National Team will be running a Webinar soon to focus on the CQUIN and details will be shared when they are available. Katie also advised the group that the Northern Clinical Network has established a bi-monthly Liaison Nurses Forum. Rebecca Campbell attended this and reported that there were plans to extend the membership beyond Liaison Nurses. There was an interest in exploring the potential for this in Yorkshire & the Humber, either on a regional or sub-regional basis. *iii. Sites not at Core 24* There is a concern about services being left behind if they are not Core 24 and further clarification required about what is going to happen. The point from the morning that 24/7 Emergency Service needs 24/7 Mental Health input is idealistic. Alison Bagnall attended the workshop on understanding the characteristics of smaller liaison services without the demand for Core 24 which was a discussion group supporting development of national guidance. Alison fed back on the proposed solutions: • Monitor referral rates by day/time to establish any patterns although some Trusts felt that referrals can be very unpredictable • Upskilling staff who work in EDs/acute setting (e.g. Mental Health First Aider training/Triage skills etc.) to free up MH qualified staff • Training supervision to small teams • Publish minimum guidance for non-Core 24 services (specification/KPIs) but non-Core 24 services should have access to transformation monies to bring standards up to ensure patients are not given a 2nd class service if in a rural area /small trust • Consider telemed for rural areas such as video links • Hub and spoke models with big teams to allow cross cover for staff to train, teach, get supervision in robust manner etc. • First responder models • Central POA and single contact numbers • Hospital at Night schemes – one central resource across a region if lots of small hospitals in an area • Flexibility on out of hours • Develop KPIs and payment systems to encourage innovation for smaller sites Alison reported that these will be developed into guidance by the national team and would include examples of 'non-core' services. It was felt that services should be able to access funds to develop and achieve Core, if not Core 24. It was also commented that Core 24 is more than just A&E. There was also an observation from YAS attendees that more work can be done before a patient even	**KM/RC**

	arrives at A&E. A question was asked as to whether there were any smaller hospitals that bid for the wave 1 funding, and Katie responded that 500 beds was the smallest. *iv. IAPT Integration* In some areas pathways are being built for referral routes for self-harm, and there is an argument to suggest that IAPT services should be in A&E, discharge teams and clinics. Calderdale & Kirklees have a two year early implementation pilot to target high intensity users of A&E. However, there is a concern in the LMH service as to what will happen at the times when the IAPT service is not present. Is there an expectation that liaison will assess? It was noted that the development of Community services should not be neglected as people are only in A&E for 1% of the time and the rest of the time they are at home or in the community. The bigger shift is embedding mental health in physical health and training is required. *v. Sustainability & Transformation Partnerships (STP)* There was a comment that it would be helpful for the LMH Network to support STP working as the services are all at different points and there are lots of areas of good practice that can be shared. *vi. CQUIN & Data* In addition to the earlier comments, it was noted that the first year of the CQUIN is about evidence. There may be a role for the CN to build guidance about evidence and data relating to the CQUIN. There was a commitment in the bids to improving A&E coding and gathering information. A greater depth of understanding is needed regarding coding. It was highlighted that there is a need to document and get evidence to prove the demand, and this should include medically unexplained symptoms. There was a request for Else's outcome measures to be shared. *vii. Learning from Wave 1* The earlier workshop discussions had included a suggestion that a group of successful bidders is convened to share progress and best practice. It was proposed that the learning is shared with the Y&H Liaison Network. *viii. Alternatives to A&E* There were several comments that the Liaison Funding would increase demand into A&E and one group discussed whether it would be possible to look at other alternatives to A&E and ways for people to bypass A&E altogether if there is not a physical health need.	**RC**
3.	**Overview of the Bids - Summary of the Region, Dr Katie Martin, Clinical Advisor** Katie provided an overview of the seven successful bids in Yorkshire and the Humber, see table below.	

CCG	Acute Trust	MH Trust	Year Allocated
North Kirklees CCG Wakefield CCG	Mid Yorkshire Hospitals Trust	South West Yorkshire NHS Foundation Trust	2017/18
Sheffield CCG	Sheffield Teaching Hospitals NHS Foundation Trust	Sheffield Health & Social Care NHS Foundation Trust	2017/18
Vale of York CCG	York Teaching Hospitals NHS Foundation Trust	Tees, Esk and Wear Valleys NHS Foundation Trust	2017/18
North Leeds CCG South & East Leeds CCG West Leeds CCG	Leeds Teaching Hospitals NHS Trust	Leeds and York Partnership NHS Foundation Trust	2018/19
Rotherham CCG	Rotherham NHS Foundation Trust	Rotherham Doncaster and South Humber NHS Foundation Trust	2018/19
Calderdale CCG Greater Huddersfield CCG	Calderdale and Huddersfield NHS Foundation Trust	South West Yorkshire NHS Foundation Trust	2018/19
East Riding CCG Hull CCG	Hull & East Yorkshire NHS Trust	Humber Foundation Trust	2018/19

There was a query regarding the number of referrals to the Rotherham service and it was agreed that it would be helpful to collate a summary of information on the services. **RC**

Several of the areas (York, Sheffield, Mid Yorks) have also agreed to share their applications. **RC/SW**

4. Discussion: What next?

There was a general consensus that it would be useful for the Network to meet again and Katie asked the group to consider one or two items that could form the basis of the next meeting.

The following suggestions were made:

- Learning from wave 1 17/18
- Preparation for wave 1 18/19
- Consideration for wave 2 applications
- Shared learning about funding. What can be done other than waiting for wave 2
- Support for small services – problem-solving
- Interface with social care: barriers & enables
- Myth-busting: E.g. Clarification regarding national requirements of sites
- Workforce: skills framework; development of practitioners; development of strategy; sharing of job descriptions
- KPI / Outcome measures: Good practice; reporting and information
- Sharing of ideas and best practice

It was also noted that whilst it is helpful to have input from the national team, that future meetings would benefit from not having representatives from NHS England (National or DCO) to enable attendees to speak more freely.

5. Closing Remarks

Links with Urgent & Emergency Mental Health Care

	This has been discussed at various points throughout the meeting and the need for maintaining links with Crisis Care Concordat group and A&E delivery boards was stressed. *Northern Region LMH Nurses Forum* This was also discussed earlier in the meeting. There was agreement that consideration could be given as to the development of a similar forum in Yorkshire and the Humber. *Next Steps* Katie informed the group that the Clinical Network will continue to provide updates and share information as it becomes available. *Future Meetings* It was agreed that the Network should meet again in September. Further details to follow.	**SW**