# CYGNET/CAS MERGER INQUIRY

## Summary of hearing with Mind on 28 June 2017

### Background

1. Mind said that it was a mental health charity and that it did five key things – public education around mental health; campaigning and influencing; national service provision; supporting its network of around 135 local Mind associations; and running national projects, for example working with Sport England to look at mental health in sport or the Blue Light Programme to help and support blue light service personnel.

2. Its national turnover was around £40 million and its local Minds helped and supported about 400,000 people a year, funded mainly by local Clinical Commissioning Groups and local government commissions. Therefore Mind was a federation and the local Minds were managed to a framework and community partnership agreement.

3. Mind said it did not run any clinical services at a national or local level, but mainly worked with people who had mild to moderate mental health problems and so needed community-based support. It said it did also work with people with quite serious needs and the vast majority of its work would be working as a sub-contractor to a Mental Health Trust, or working directly as primary care support.

4. Mind said it was a step-down from inpatient hospitals, such as locked rehabilitation, out into the community. In some parts of the country it ran advocacy services, but mainly its service provision was for people who had spent time in intensive inpatient care, either in the NHS or the independent sector, and who were now well enough to be integrated back into the community/go home.

5. It said that people would leave the independent sector and ‘re-enter’ the NHS and often people who would have been out of the area would come back into the care of the NHS at a local level and this was when they would occasionally come into contact with Mind. It would then transition them from independent sector inpatient care, such as locked rehab to NHS inpatient care by providing their accommodation or providing them with community service support.

6. Mind stated that mental health was very much in the spotlight at the moment, both politically and in the media, and it was driven by the significant shift in public attitudes around mental health that had been building for a while due to the various campaigns that had been launched. The campaigns had shown that the overall levels of care for people with mental health problems were well short of what was needed and there was a desire to change this. There had been a long period of stigma and discrimination on the grounds of mental health, so Mind was trying to move the NHS and society to a very different place.

7. Mind said that mental health was underfunded and that there were emerging issues around workforce availability and real pressure points on the system, particularly around crisis care, where people were not getting the best help and support. There was an emerging issue around safe discharge, so the big pressure points were around getting into and out of the system.

8. The CEO of Mind chaired the taskforce responsible for the Five Year Forward View for Mental Health. The three key areas to deliver the Five Year Forward View for mental health were additional resources; workforce availability; and transparency of data and information. Mind said a lot of work needed to be done to get everyone to a firm base and it thought the Care Quality Commission (CQC) may also say that some patients were not recovering as quickly as they could/should be.

## Diagnoses and terminology

9. Mind said that the term ‘long term mental health’ made no sense, it should be people with mental illness, or those with mental health problems. This included those with mild to moderate clinical conditions like depression and anxiety, along with more serious conditions like schizophrenia and bipolar disorder which were severe mental illnesses.

10. It said that the most obvious way to determine the severity was through mental health legislation. Admission to an inpatient setting was determined by how much therapeutic support was needed. The diagnosis did not automatically determine the severity as there were lots of people who lived in the community with schizophrenia or bipolar disorder, and they coped well. Whereas there were others who had the same diagnoses but who found it disabling and so would spend the vast majority of their lives in care.

11. Mind highlighted that there was very little transfer of information between Trusts, so if people moved between various ones, it was mainly up to the individual to decide how much information to share. Hence the system was

not very good at picking up people when they re-entered it at another entry point.

## Out-of-area placements and time spent in care

12. Mind said that often people with a personality disorder found themselves in inpatient settings because of the failure of community services to provide them with adequate help and support. The journey that they then had to go through to get back into the community was often very difficult and too long.

13. The Five Year Forward View for mental health had drawn attention to the average length of stay for people who were in secure care, and had highlighted that there was inappropriate out-of-area placement and that people often spent very long periods in secure care.

14. Mind referenced the work undertaken by the CQC on acute mental healthcare and (inappropriate) out-of-area placements. This work was being extended to look at locked rehabilitation stays and placements (now published). The CEO's personal opinion was that too many people were spending too long in locked settings and there was a risk of them becoming institutionalised.

15. Mind thought that too many people were going out of area unnecessarily or inappropriately and it cited the innovative work done by certain CCGs and Trusts in Sheffield and East London where all parts of the care pathway had been joined up so out-of-area placements had been eliminated altogether.

16. Mind said that the most effective way of delivering effective care for people was to make sure there was enough capacity in area. Sheffield had ensured that its patient pathways were connected so they had invested in community-based mental health services in order to reduce the number of people who needed to go into hospital in the first place. By decreasing the number of patients needing to go into hospital, and improving the quality of community-based care services and ensuring really good quality step-down facilities, key inpatient beds had been freed up and this had allowed the local authority to bring people back from inappropriate out-of-area placements. East London Foundation Trust had adopted a similar model and focused on a belief in strong community-based mental health facilities and support.

## The NHS, the independent sector and the merger

17. There had been pressure on the NHS to reduce its overall bed capacity and the independent sector had therefore stepped in and filled the under-capacity of beds in the system. Due to the lack of availability of local capacity, the independent sector was housing a lot of inappropriate out-of-area care, ie

which came from the lack of availability of local capacity, not due to the specific requirements of the patient.

18. However, Mind said that in some specialities it was not necessarily negative that bed capacity had decreased as the question was really about how best to use beds, not the actual number. It stated that it was key to see the link between beds and community services, voluntary inpatient services, locked inpatient services and out-of-area services in order to design an approach to reduce out-of-area placements.

19. Mind said that it had heard some good things about independent care in general and that for many it was a lifeline and had made a big difference to their lives. However, its view was that the majority of people's mental health support should be provided in an NHS environment. It supported giving the best possible choice to patients and said that having healthy, strong competition played a role.