

Bradford District Care
Patient & Public
Involvement in Health
(PPI) Forums

“Our Legacy!”

2003-2007

*What we have achieved and what LINKs
can learn from our work.*

INTRODUCTION by the Chairman

The Bradford District Care Trust PPI Forum will cease to exist as of 31st of March 2008. Its successor, along with other Forums will be replaced by Local involvement networks from the 1st of April 2008. This 'legacy document' from the Forum has been composed so that our concerns, discussed time and again during the life of the Forum may be passed on to the new regime for their consideration.

Since the early years in the present decade Government strategy on Disability has shifted away from the policies first established with the advent of the Welfare state to support people in a state of well-being but marginalized from local community life. Accordingly Bradford District Care introduced its Social Inclusion agenda in 2004/5 in anticipation of changes in government policy to be introduced in the later years of the decade, through legislation being introduced in 2008 by Department for work and Pensions (DWP)

Over 10 years ago the Department of Health established the National Service Framework for Mental Health to address decades of under investment in NHS services. The framework did not connect with other Government departmental policy development on Social Inclusion.

It is to the credit of BDCT that the Board recognised and acted on the need to develop an additional approach to its core provider services. The Forum gave a positive reference to a new management approach in its 2007 Health Check submission.

In 2005 a meeting was convened with BDCT Medical Director about Prescription Medication of Service Users. At the time BDCT was conducting a series of consultations about "The Philosophy of Care". During 2005/06 it became apparent that there was a need for a cultural shift in attitudes and practices at all levels within the Trust organisation if the Social inclusion agenda was to roll out as a seamless service within the Trust's core business and through partnerships and collaborative working with Stakeholders outside the NHS and DoH.

BDCT collaborative working with Job Centre Plus (JCP) has shown a positive outcome but after two years remains under-resourced to fully develop service user centred staged progression towards work related activity beyond creating pathways for employment opportunities within the Trust itself. This work is commended and it is recognised that the process will be prolonged.

Something undefined in previous years has been missing in the Trust's Learning Curve of organisational development since inception in 2002/03. During three further meetings with the Medical director during 2007 the term "What's the What" was adopted as a code for this undefined missing entity within the Philosophy of Care which the Trust Board had signed up to.

BDC Patients' Forum prepared an extensive working document in May 2006, which, amongst other things, identified the fundamental elements which underpinned the "What" but without specifically defining the "What" in terms of delivery mechanisms to achieve outcomes.

Throughout a process of speaking with service users and carers the "What" was repeatedly defined as not just an attitude or culture within service provider organisations or even an extension of choice and undefined quality improvements (though "quality" is one facet under the "what").

If you would like any copies of Bradford District Care Patient & Public Involvement in Health Forum reports and submissions please contact Emmerson Walgrove on 01274 408735 or ew.walgrove@googlemail.com



Emmerson Walgrove
Chairman

DEFINING WHAT THE "WHAT"

Person Centred

Relevant to the individual service user's cultural values, beliefs and where the clinical care, social care and citizenship mentoring service provider staff listen and act on what the individual has expressed as their preferences and aspirations. Where the individual lacks capacity to make an informed choice, then another person who is their holder of hope (relative, friend or someone else named in an advance statement) would be authorised to give consent.

Psychiatric interventions

These including prescription medication are administered with reference to the service users preferences, particularly when medical side effects are not acceptable. The onus is placed on the clinical practitioner to believe what the individual is saying about side effects and then to adopt alternative interventions even if less efficacious in the short term.

Reasons

The principal reason for mental health services is to achieve measurable outcomes in both quality of life and mental well-being. Stabilisation of symptoms is not sufficient. Services must deliver health improvements to a level which permanent or recurring onset of mental illness determines the course, direction, level of attainment and sustainability of the individual service user's Recovery.

The ethos for the commissioning framework for mental health services must be predicated on outcomes towards Recovery of mental and physical well-being.

Quality

Delivery of services can be measured against performance indicator targets. However measurement of the excellence of the people who are responsible for achieving the performance targets is dependent not simply on the amount of exposure to training and relearning but through continuous monitoring of mental health practitioners and all service provider staff and middle management throughout their working careers.

The pathway of continual self improvement is the true test of the value of the Quality standard targets and within the NHS there are well established protocols and mechanisms to ensure continuing personal development.

However the process can be improved. The fear of retribution remains a key driver of the climate of fear to "whistleblow". The Complaints procedure could be compromised within a controlled culture where bad practice could be covered up when it suits a purpose. The service user becomes the scapegoat if facts are buried when the service user is disbelieved and evidence is falsified in conjunction with the culture of non-responsibility.

The importance of reaching targets is the overriding purpose for service provider staff and management. BDCT claims to be a quality service provider but its treatment performance and quality assurance is not driven by the Market demands of patients' needs.

Patient Need

The Trust board have yet to convince the Forum that What the Patients Need is the driving energy of the Trust Board's agenda.

This is not a reflection of the competence of the Board Members. It is a sad reflection on organisational culture of NHS bureaucracy embedded in the principle that Professional Clinicians and Professional Managers hold different expectations for their responsibilities, which might be better realised without the inconvenience of patients' who perpetuate the chief problem for the NHS.

The principal constraint within the service provider sector to making a radical change to the way in which service users' quality of life expectations can be enhanced, lies in the predominant reliance on the Medical Model of provision.

The alternative Social Model while perhaps being less medically efficacious provides a more comfortable life sustained on welfare benefit.

What the Government Wants

This is a model of service delivery which imbues the individual service user with a (qualified) sense of self-dependency through Social Inclusion. This approach requires that healthcare, particularly psychiatry and medication together with Social Care, play the supporting role to assist the service user's Recovery Journey.

Commissioning

Much has been achieved to integrate Social Care with Mental Healthcare. The methodology for commissioning the two facets of care independently from each other has proved ineffectual and financially unsustainable.

Even when the Commissioning Framework for mental well-being and social care becomes fully evolved by 2015 unless there is a culture shift within service provider organisations and between

Stakeholders little real progress to improve the lives of mental health and Learning Difficulty service users will be evidenced.

At the heart of the culture change will be the shift from commissioning for targets and the management of symptoms towards commissioning for recovery.

Recovery in this sense does not necessarily mean "Cure" but is more than just "stabilisation" in expectation that there may be recurrence of symptoms.

The term "Recovery" might not be deemed suitable for use in connection with learning Difficulty Service Users. However the principles of service users' free will is no less applicable to MH or LD service users than too any other Citizen.

The Journey of Recovery

At first, for the service user the prospect of changing an outlook on life appears to be insurmountably daunting. Like the child on its first day at school unknowing and unaware of the riches of knowledge and understanding to be garnered.

Recovery is not so much a journey from one place to another but it is an approach to gaining degrees of self confidence, esteem, pride and self dependency through learning.

BDCT established itself at the outset to be a Learning Organisation. Within limitations of its inability to be self critical without the attending blame culture, personal development pathways for employees at all levels is underpinned by the NHS ethos of skills and knowledge development throughout the individual's career.

However BDCT does not see that it's Duty of Care towards service users should extend to directly assisting their personal growth through rehabilitation during the Journey of Recovery. Learning is an extra curriculum activity for those individuals who express a preference.

Learning is one of the fundamental cornerstones on which the journey of Recovery is entirely dependent. Yet it is one of the essential requirements of service provision which is not regarded within BDCT as anything other than an optional under the syllabus catered for by Occupational Therapy. Medication remains the core curriculum agenda which acts as a barrier to learning.

BDCT as a Care Academy

The vision that BDCT might become a Care Service Provider where "students" graduate in a manner akin to an educational establishment could be designed into the future commissioning Framework.

Since 2006 when this vision was first put to Social Inclusion Group, BDCT has embedded the mindset that Learning is another service provider's responsibility; that Learning is a cultural activity which at least passes the service users' days in a constructive activity to no particular purpose but, at best, might lead the individual into becoming a tax paying citizen. The Care Trust's role in this is limited to signposting the individual service user towards an outcome required by the State.

The Road Less Travelled

In order for the individual to commence and progress the journey of Recovery, the first step is for someone or something to be the Holder of Hope for and of that person and to mentor the person to rekindle self belief in that sense of hope. Without Hope no amount of medication and psychiatry can possibly help the individual to recover their lost sense of self worth to themselves or in society. Hope nurtures Self Belief which reinforces self discipline, confidence, self esteem Purposefulness, love of self and love for others.

Following on from this uplifting state of recovering mental well-being the individual continues with Personal Growth through acquired learned thought and behaviour which challenges the predetermination of their cognition influenced by mental illness.

The recovered mental health service survivor might still have continuing or recurrent mental health and social care needs but has through the acquisition of new knowledge to attain a new level of competence and personal fulfilment - not measured against comparative targets judged against others with different competences and aspirations; not measured against criteria which judge the individual to have passed or failed some external criteria; but measured against what the individual aspires to be, given support and encouragement and the opportunity to learn at their own pace.

Learning Mentors: the new opportunity for Support, Time and Recovery Workers

Learning is not a concept to be subcontracted out to an educational establishment which is signposted through Job Centre Plus. It must be embedded in the foundation of the individual user's Care Plan and carried through each and every care pathway.

Education and Training come later in preparation for Work but Learning is the key starting point towards mental well-being and the Journey of recovery is in fact an experience of self discover and personal attainment achieved by taking positive risks and learning from mistakes.

Challenging Stigma and Discrimination

Changing society's prejudices might never be achievable. Initiatives which challenge discrimination in families, communities and workplaces might bear positive results in time to come.

By imbuing the service user with Learned Behaviours which elevate confidence and esteem, the individual can rise above the hatred and lack of compassion in society towards mental illness and even though the individual might continue to experience discrimination their inner sense of self worth can carry all but the most vulnerably mentally ill person living a socially included life in their local community.

The Philosophy of Care

What it is that BDCT should be doing to measurably improve the quality of life for all service users. Adoption throughout every artery and sinew of the Care Trust organisation of the culture of learning should be the bedrock of the purpose of service provision.

The Bradford District Care Patients' Forum "What's the What" Activity

Throughout 2006-2007 the Forum has discussed ways to influence the Care Trust to recognise the elements which define the "what" that is what could, should and must be done in order to radically improve the lives of present and future generations of service users.

But as BDCT prepares itself for foundation Trust status, it appears the Board has little time to consider what its Mission and Values mean in reality against the entrenched doctrine of the medical model of mental healthcare.

THE FUTURE

The legacy the patients' Forum passes on to the new era of Local Involvement Networks, (LINKs) is signposted in the messages which define the "What".

It will be for Bradford LINK to participate in the development of the Commissioning Framework in order to influence to reshaping of mental health service provision to be driven by outcomes for mental well-being and social

inclusion. Re-branding the Care Trust as a Foundation Trust will not redeem an organisation which has yet to achieve what it so confidently aspired to become from the outset by its inability to listen to, believe and act on through engagement with its service users.

Bradford District Care Patient & Public Involvement in Health Forum recommends to Bradford Metropolitan District Council and the LINK host that there should be two separate sub groups, one group for Mental Health and one group for Learning Disabilities both are required to be separate sub groups within the Bradford's Local Involvement Network, and we believe that there's important sub groups needs to be set up as soon as possible.

Bradford District Care PPI Forum Documents

(To download the documents - just click on the links below)

[**2007 - 08 Annual Health Declaration**](#)

[**Annual Report 2007 - 08**](#)

[**2006 - 07 Annual Health Check Declaration**](#)

[**Annual Report 2006 - 07**](#)

[**2005 - 06 Annual Health Check Declaration**](#)

[**Annual Report 2005 - 06**](#)

[**Annual Report 2004 - 05**](#)