# MENTAL HEALTH PCBC
# FEEDBACK AND RESPONSE TRACKER

**October 2019**
**Version 1.2**

| Item ref | Feedback source | Feedback | Our response |
|---|---|---|---|
| 1 | Clinical Senate | It was noted that a timeline for the delivery of the community model aligned with proposed changes to inpatient services would help give confidence that pathways were joined up to prevent crisis". | We have covered this (crisis cafes) and on in the timeline. See pages 50 and 90 |
| 2 | Clinical Senate | It was noted that there should be greater clarity to describe the different teams in the community, in particular the crisis team which will need to be staffed to be available when people are mostly likely to present and with a clear 24/7 offer to help reduce admissions. | We have included a table “Increase in staff numbers to support the Community Workforce Model” together with narrative describing different community teams and the provision of crisis cafes (see page 50)<br><br>We have also expanded on MDT teams in bullet 3 (page 49) |
| 3 | Clinical Senate | The Community Model should be updated to include level zero prevention | The model has been updated in two instances in the PCBC |
| 4 | Clinical Senate | The benefit of potential training opportunities resulting from the model should be emphasised and multi-disciplinary roles also fully described, to include the use of Occupational Therapy input to wards. | The MDT staffing mix and overall care model will remain the same on the relocated located ward as aligned to Safer Staffing requirements. However, there is an expectation that there will be an expansion in the range of AHPs working in the community model and this has been included in the PCBC. There is also |

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| | | | recognition that co-location of staff teams will enhance training opportunities. |
| 5 | Clinical Senate | The CRP commented that there could be greater clarity regarding the plan for an enhanced community mental health provision in the Wells area | We have included a table “Increase in staff numbers to support the Community Workforce Model” together with narrative describing different community teams and the provision of crisis cafes near Wells – Mendip and North Sedgemoor (see page 50) |
| 6 | Clinical Senate | An enhanced community model will be drawing from the existing workforce and this should be considered in the workforce planning for the community model implementation. | We have strengthened the PCBC in terms of providing a table describing the community workforce increases, and updated the timeline to include implementation of the Community Workforce Model |
| 7 | Clinical Senate | The CRP was satisfied that Taunton as a site for the combined beds had been appropriately discarded for clinical outcome reasons | Updated table 17 option 4 "This also would be in danger creating a ‘campus’ site which would be counter to National policy" |
| 8 | Clinical Senate | The CRP noted that there was a strong argument for not co-locating beds at Wells, in particular the lack of a S136 suite. | Updated table 17 option 4 "This also would be in danger creating a ‘campus’ site which would be counter to National policy" |
| 9 | Clinical Senate | Expand on social care and recovery partners | We have referenced peer support in the PCBC |
| 10 | | Clearer around crisis model and response | We have referenced crisis cafes as an |

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| | | | element of the CWM and the expansion of Home treatment team provision and Core 24 Psychiatric Liaison |
| 11 | Clinical Senate | Need to be clear about enhancing wells service | We have referenced crisis cafes as an element of the CWM and the expansion of Home treatment team provision and Core 24 Psychiatric Liaison |
| 12 | Clinical Senate | Expand on AHP roles across all services | Comment acknowledged – addressed where appropriate. |
| 13 | Clinical Senate | Expand on benefits of training across all roles not just medical staff, impact of critical mass | Comment acknowledged – addressed where appropriate. |
| 14 | Clinical Senate | The CRP suggested that a refurbishment of the existing ward at Yeovil could be undertaken as soon as possible, potentially using bid monies highlighted to the panel. The development of a space to facilitate this could create an emergency decant ward and clinical space of use to the wider system. This would have the added benefit of speeding up co-location of mental health inpatient beds if and when approved so that facilities are not a rate limiting step post consultation. | Addressing this in MHSE S2 presentation |