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Statutory Joint Scrutiny Committee

Thursday, 10 August 2006 4.00 p.m.
Town Hall, Runcorn

AGENDA

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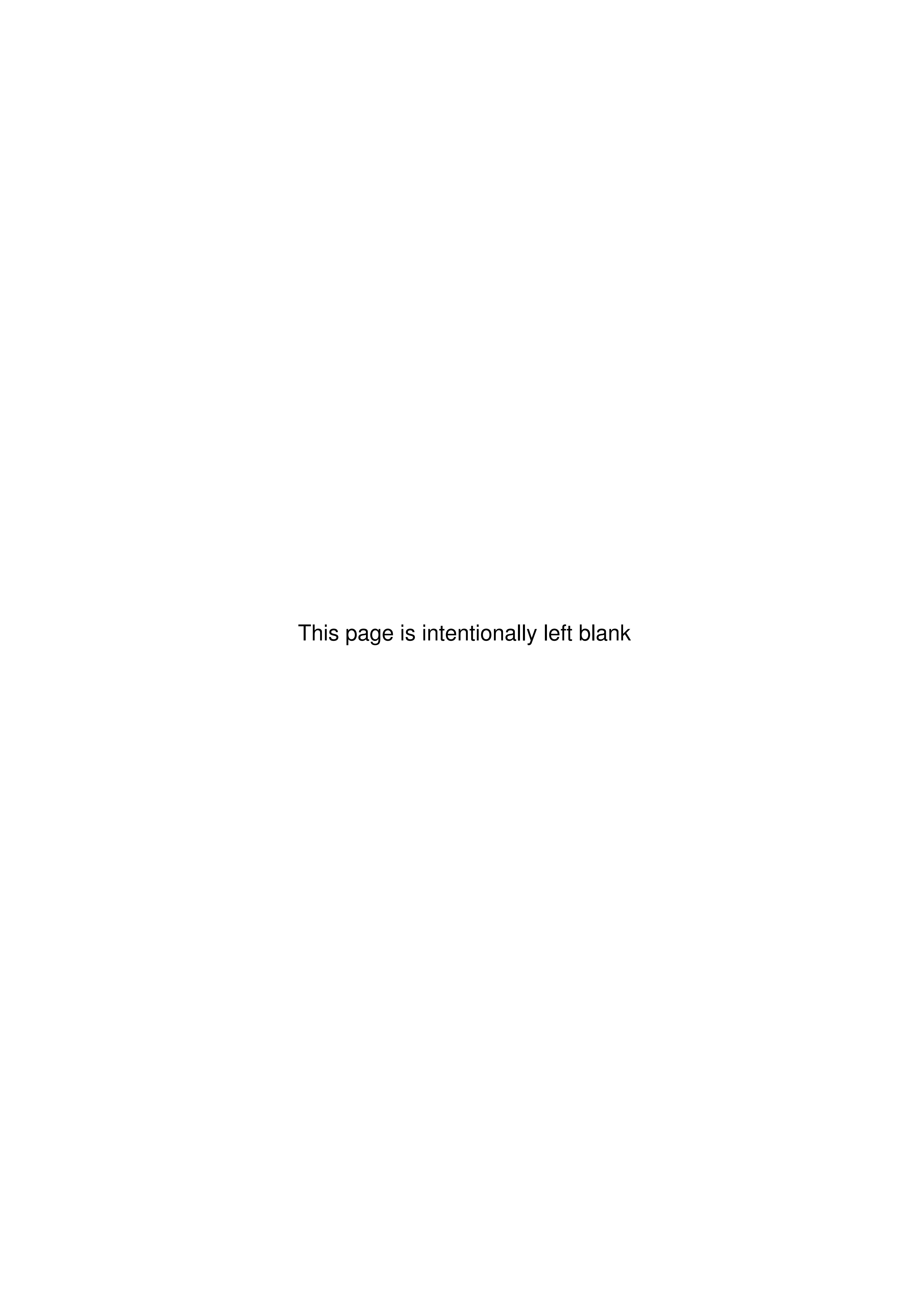
1. AGENDA	**1 - 90**

In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.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Statutory Joint Scrutiny Committee
5 Boroughs Partnership NHS Trust - Proposals Relating to Improving Mental Health Services in Halton, St. Helens and Warrington
10 August 2006

PROTOCOL

INTRODUCTION

This protocol is intended as guidance and seeks to facilitate the conduct of the Statutory Joint Scrutiny Committee meeting for all involved.

AGENDA

Agendas will be published five clear days in advance of meetings, placed on St. Helens Councils website and each Council should follow their normal procedures for publication.

MINUTES

Following the normal procedures for publication, the minutes of the meetings will be published within five days of the meeting and placed on the website of each participating Council.

PRESS RELEASE

Each local authority to issue a press release giving dates of meeting and details of the scrutiny process. Also local authorities to include the Statutory Joint Scrutiny Committee in their normal notification of formal Council meetings.

DECLARATIONS OF INTEREST FROM MEMBERS

All Members will have an opportunity at each meeting of the Statutory Joint Scrutiny Committee to declare an interest regarding issues to be considered at the meeting.

WHO CAN SPEAK AT MEEINGS

In order to support the effective running and management of the meeting and to ensure fairness and consistency, Members of the public who attend the meetings will not be able to speak, but are welcome to attend as observers. Individuals or groups who approach any of our Councils Members or Officers, expressing an interest in speaking at the Committees should be asked to make their request in writing. It will then be considered by the Chair and/or Vice Chair who will make a decision about whether the individual should be called as a witness to the Committee. Any written requests should be referred to the Clerk to the Committee, who will discuss them with the Chair and/or Vice Chair. The decision of the Chair/Vice Chair as to who will be invited to speak will be final.

Statutory Joint Scrutiny Committee
5 Boroughs Partnership NHS Trust - Proposals Relating to Improving Mental Health Services in Halton, St. Helens and Warrington

Those who would be able to speak at the Committee:

- The Elected Members who are Members of the Committee.
- Identified Officers supporting the process (3 nominated in advance from each local authority)

<u>Warrington</u>

1. Helen Sumner, Strategic Director, Community Services
2. Roger Millns, Head of Service Mental Health, Learning Disabilities and Corporate Social Services
3. Brian Magan, Overview and scrutiny Co-ordinator

<u>St. Helens</u>

1. Peter Hughes, Head of Policy
2. Carole Swift, Service Manager, Carers and Scrutiny
3. Mike Wyatt, Assistant Director, Performance and Business Support

<u>Halton</u>

1. Audrey Williamson, Operational Director, Adults of a Working Age
2. Dwayne Johnson, Strategic Director, Health and Community
3. Lindsay Smith, Divisional Manager, Mental Health, Health and Community

Rob Vickers, Joint Commissioning Manager, St. Helens and Halton PCT

- The Clerk to the Committee.

Tina Molyneux, Senior Democratic Services Officer, St. Helens Council

- Witnesses who have been invited to attend at the Panel to present can speak with the permission of the Chair / Vice Chair.

HOW DO I REGISTER MY WISH TO SPEAK AT THE MEETING?

Any person wishing to speak at the Committee must notify the

Clerk to the Committee

(Miss Tina Molyneux)

St. Helens Council

Town Hall

Victoria Square

St. Helens

WA10 1HP

(01744) 456110

by the following deadlines

Requests submitted by:	Date of Committee
14 August 2006	24 August 2006
25 August 2006	7 September 2006

QUORUM

The quorum for the Statutory Joint Scrutiny Committee will be one quarter of the whole number of Members, rounded up where appropriate. During the meeting if the Chairman counts the number of Members present and declares there is not a quorum present, then the meeting will adjourn immediately. Remaining business will be considered at a time and date fixed by the Chairman. If he/she does not fix a date, the remaining business will be considered at the next ordinary meeting

SUBSTITUTES

As agreed at the meeting of the Committee held on 20 July 2006 there should be two named nominated substitutes from each authority as follows:

Halton Council

1. Councillor Jones
2. To be advised

St. Helens Council

1. Councillor Sheldon
2. Councillor Ronan

Warrington Council

1. Councillor Bromley
2. To be advised

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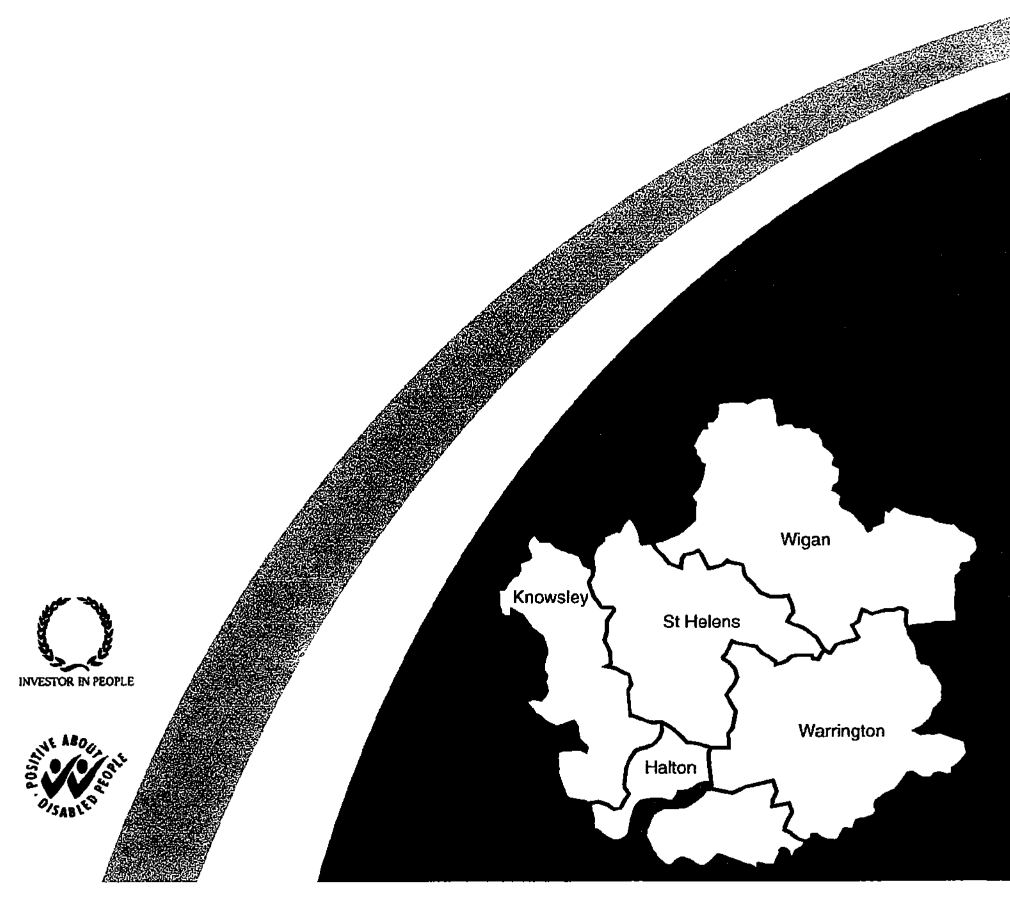
5 Boroughs Partnership NHS
NHS Trust

Consultation Information Pack

Re:

'Change for the Better'

Consultation on a New Model of Care



St Helen's
Coalition for Disabled People

On behalf of:

Modernisation and Redesign of Mental Health Services

Findings of Service User and Carer Consultation

May 2004

Prepared by:

The Associates
21 Victoria Road
Manchester
M16 8GP
0779 156 164
mail@theassociates.as

Summary

Over a two-month period between April and May 2004, there has been an intensive consultation exercise with over 150 mental health service users and carers in an attempt to engage them in the modernisation and redesign of mental health services in St Helen's.

The consensus was that service users and carers were generally very happy with the services being provided to them. However, there is a real need to move away from the clinical model to a recovery model that places community solutions at the heart, instead of the periphery of services.

This report attempts to capture the qualitative and quantitative responses and suggestions for improvement and identifies nine key themes for improvement:

- Deal with the stigma of mental illness
- Help to live independently
- Getting out and about
- Better information about mental health services
- Improving access to mental health services
- Improving buildings
- Improving access to employment and education opportunities
- Improving support for carers
- Simpler and friendlier paperwork

In addition to this the report identifies six beacon projects that if actioned will demonstrate a very real commitment to modernisation:

- One stop shop/s
- Helpline
- Mental health services within the Millennium Centre
- Leaflets/newsletter
- Mad Pride/celebration event
- Free bus passes for service users

The report also makes recommendations for delivering the actions and the ongoing monitoring and evaluation of the consultation process.

1 Background

1.1 There is a Modernisation and Redesign Group with representatives from St Helen's Primary Care Trust (PCT), the Five Boroughs Partnership NHS Trust and the Mental Health Forum. This group commissioned the St Helen's Coalition for Disabled People (CDP) to consult with service users and carers of mental health services to find out what they wanted from the modernisation process by seeing things through the patients eyes, asking if there are better ways of doing things and identifying the small steps and big leaps that would demonstrate that mental health services have heard and are responding to what people say.

1.2 CDP embarked on a publicity campaign to promote the consultation, ensuring that flyers and adverts inviting people to come or contribute to the process were widely distributed.

1.3 CDP and St Helen's Carers Centre (St HCC) held nine focus groups with service users and carers where people were asked about their experiences of mental health services, their hopes for future services and ideas for improving services. The focus groups were moderated by either a CDP or St HCC member of staff and a member of the St Helen's PCT was invited to participate and take notes.

1.4 The CDP appointed the Associates to: analyse the information from the focus groups; run a consultation day to test out the findings; deliver a follow-up feedback session to fill any gaps and get people to buy into the process and write this report.

1.5 An average of eighty service users and carers participated in the nine focus groups, three of which were with carers and six with service users held in the following venues:

- Heath Park Lodge
- Abbey House
- Peasley Cross Court
- Sherdley Unit
- Birch Day Unit
- Market Chambers Social Group

1.6 Almost eighty people came to the one-day consultation event. Some of these had been involved in the focus groups but, interestingly, many were new to both the CDP and St HCC. At this event people explored in some detail the six key themes that came out of the analysis of the focus groups. Everyone also had the opportunity to express their priorities for the future by reflecting and adding to the wishes people made in the focus groups and then voting on them. A brief report of the event was circulated prior to the feedback event.

1.7 Almost forty people attended the feedback event – about a third of which hadn't been involved in the consultation day. Here the group explored in some depth three further issues that came out of the analysis of peoples votes at the consultation event. The group also considered how they wanted to be kept informed of progress to achieving the changes.

1.8 All in all, approximately 150 people were involved in this consultation process. The methods used made sure that the process was a democratic as possible, enabled everyone to communicate their priorities and most important of all, we listened to what people said and created opportunities for people to get to know one another, share information and socialise.

2 Findings - Specific

2.1 There were nine improvement themes that came from the consultation process. During the process people were specifically asked to describe the current position, the big leaps that will need to be made and the little steps that will demonstrate the commitment to change for each of these themes. The results have been complied into a draft action plan template for each theme (see Appendix 1).

2.2 Most of the themes are interlinked i.e. it is not possible to separate difficulties in getting suitable housing or the ability to freely socialise from the stigma of mental illness.

Theme 1 - Deal with the Stigma of Mental Illness

2.3 The overriding message from the consultation process was to educate the general public about mental illness so that mental health service users could achieve acceptance where they live, work, learn, play or heal.

2.4 People said that they would like to see a training programme in place for GPs and other health professionals to raise awareness of mental illness and help providers to identify ways of improving access to quality mental health care. Alongside this, people said that they wanted to see a comprehensive public awareness campaign and an outreach programme that involves service users and carers and is targeted at educational and community settings.

2.5 In keeping with the above, when asked for the 'small steps' those consulted identified a number of schemes such as a local positive mental health award, mad pride event and greater use of the existing media group.

Theme 2 - Help to Live Independently

2.6 This theme received the second highest support from those consulted. The only conclusion that can be reached is that there is insufficient support in the community for getting people housed appropriately. There is a lack of (and at times no) coordination between professionals, meaning that people are often very vulnerable. The inability to get people housed in the community, which is what the consultation found was needed, is proving extremely costly to the primary and secondary care health services.

2.7 Ideally people want to see a range of housing solutions i.e. sheltered, single person, families, shared, residential, nursing home and accommodation with support being available across the Borough. But it is not just the physical accommodation – it is also about staff working together across a number of agencies having the appropriate attitudes, who are willing and able to make appropriate housing allocations.

2.8 People in hospital should have their discharge accommodation dealt with as part of their care plan and there should be evidence of practical help and support following discharge from hospital.

Theme 3 – Getting Out and About

2.9 People said that having too much time on their hands, needing friendship and relationships and not getting out all contributed to feeling isolated, lonely and a reduction in self esteem and confidence. This makes people unwell. Whilst there are a number of opportunities available for social activities, it was felt that not enough information or publicity about them was available and that there needed to be more, particularly on evenings and weekends when people feel more vulnerable.

2.10 The biggest obstacles to people getting out and about (therefore the big leaps) include making free bus passes available, having a drop-in centre and more funds for social activities that would prevent people from becoming ill. Ultimately if mainstream spaces were more aware of mental illness and were welcoming and supportive, people could envisage a time when separate activities weren't necessary.

2.11 Some of the smaller steps identified included better advertising, information packs giving ideas for activities developed for self help groups, allotment scheme, better advertising of activities and non-segregated trips out for people living in supported/residential accommodation.

Theme 4 – Better information about mental health services

2.12 Every focus group and workshop concluded that more effort was needed to ensure better information about mental health services and most people found out what was available by accident or word of mouth. There were three categories of information asked for:

- Information about diagnosis, medication and recovery
- Regularly updated contact details of health and voluntary sector providers
- Information on services and support available for service users and carers

Having access to good and accurate information means that service users and carers can understand what is happening and who can help them when they need it.

2.13 Ideally people want to see a one-stop-shop established that is supported by a 24-hour help line and regular events such as Mad Pride to raise awareness of what is available. In the meantime, good quality, widely distributed leaflets and a newsletter with contacts and reading lists would be useful as would having a mental health presence in the Millennium Centre.

Theme 5 – Improving access to mental health services

2.14 This is probably the biggest area requiring modernisation and redesign. There is a belief that hospital staff don't understand or care about social issues and see them as 'community' problems. People want redesigned services that will stop A&E being a route for people with mental health illness i.e. more and better primary care services at places and times when they are needed. People emphasised the importance of continuity of care and reducing waiting times.

2.15 There was a clear call for mental health services to be open to and embrace modern communication technologies to enable people to access them e.g. internet, phone lines, text etc.

2.16 Services need to be supported by more visiting, befriending and mentoring schemes to make people feel important and increase their confidence and self esteem.

Theme 6 – Improving buildings

2.17 The people consulted were most passionate about and united in their call for Sherdley Unit to be dealt with. It is not fit for purpose and there is a general perception that it is used to hold people rather than to treat people.

2.18 What is needed instead is a range of community based facilities that specialise in different areas e.g. younger people, alcohol dependent, single sex and units. Space for meeting with people, family and children's spaces and spaces for agencies supporting discharge should all be provided.

2.19 There could be the opportunity to bolt on one stop shop services as called for in several other themes that will also assist partnership working with the voluntary and community sector.

Theme 7 – Improve access to education and employment opportunities

2.20 Being in education or employment is really important for confidence, self esteem, socialising and making friends. The reality is that people with mental health problems find it difficult to access these opportunities and the benefits system is really hard to deal with. People would like to think that employers and education establishments have and implement equal opportunities policies that specifically deal with mental health, so that people can be honest when applying for jobs/places.

2.21 The big leaps needed include: support for people to make sense of the benefits system, particularly with regard to therapeutic earnings; making Job Centre Plus provision more accessible, relevant and sympathetic to mental health service users and an expansion of provision such as Making Space and The Shaw Trust with clear progression routes.

2.22 In the meantime people would be encouraged to see further education providers to identify someone to support people into learning; a campaign to get people with mental health problems engaged with volunteering and a mentoring scheme to support people through their pathway to employment or education.

Theme 8 – Improve support for carers

2.23 Carers demands for the modernisation of mental health services were very clear – the service user is part of a family, however family is defined, and carers can feel excluded from mental health provision. They want to see information, communication, accommodation, medication and isolation being dealt with. Carers say 'when it works, it is because understanding professionals communicate clearly with carers'.

2.24 The big leaps identified by carers include a change in staff attitudes so that they share information with, involve and listen to carers. They would like to see more

sensitivity to carers from GPs and all professionals to be able to tell carers where they can get support and an increase in respite care.

2.25 Their small steps fit under other themes and included a child friendly room at the hospital, involving carers in designing information and dealing with the stigma of mental health.

Theme 9 – Simpler and friendlier paperwork

2.26 Too much bureaucracy and red tape was an ongoing theme from the focus groups. Particularly when the volume of complicated paperwork is increased when people are ill and failure to deal with it properly can even cause people to be admitted to hospital. Some of the problems are because paperwork and forms are devised nationally but local health care is picking up the implications and cost of these failings – and not communicating the problems.

2.27 What people would like to see is support available at a one-stop-shop for helping to fill in forms. They said that a 24-hour helpline would also help stop worrying and refer to the one stop shop.

2.28 In terms of locally generated paperwork – keep it simple and jargon free and use tick boxes; enclose a leaflet telling people where they can get help in understanding information or filling in forms; make appointment letters more friendly and train CAB workers to work with mental health service users and carers.

Beacon Projects

2.29 There are some actions that are duplicated across the nine themes, specifically:

- One stop shop/s
- Helpline
- Mental health services within the Millennium Centre
- Leaflets/newsletter
- Mad Pride/celebration event

2.30 For the purposes of this report, we have left these cross cutting actions duplicated in the action plans. It is recommended that the Modernisation and Redesign Group identify where they best sit and amend the action plans accordingly. However, it would seem that from the number of times these actions were identified, that these could also be agreed as the five beacon projects that if actioned will demonstrate a very real commitment to modernisation.

2.31 Because of the impact it would have on all themes and because of the sheer demand for it, we would suggest adding a sixth Beacon Project – getting free bus passes for mental health service users.

3 Findings - General

3.1 There were a number of issues that came from this process that don't fit neatly into the nine themes but warrant a mention.

See things through the patients eyes

3.2 The methods used enabled a minimum of 150 service users and carers to get engaged in the modernisation process and those responsible should be commended. The original idea was to get mental health service staff involved throughout and this worked well except that the frontline staff didn't participate in all of the focus groups. This was a lost opportunity for raising awareness and helping people to 'see things through the patients eyes'.

Social group a model of good practice

3.3 The consultants were very impressed with the quality of responses from the focus groups and the consultation and feedback events. We were particularly impressed with the responses from the Market Chambers Social Group. Despite some feedback that they felt a bit isolated and lacked continuity from staff members, this s clearly a model of community based solutions working in practice and their progress should be documented and their advice sought in setting up similar initiatives.

A mandate for the Mental Health Forum

3.4 The Mental Health Forum (MHF) should also see the findings and themes arising from this report as a clear mandate from its constituent group in the months ahead. The MHF is in the process of developing and agreeing its strategy and it should ensure that the strategy reflects the needs identified here.

Gender segregation

3.5 There was a contradiction in approach to gender that needs to be ironed out. In buildings and services there is a view that segregation is required, yet in terms of getting out and about to socialise, make friends and develop relationships there was a clear call to stop segregation.

Compliments

3.6 Throughout the consultation process a number of mental health services came in for praise, specifically: dual diagnosis workers, crisis resolution teams, community psychiatric nurses, Mental Health Advocacy Workers, MIND, the Carers Centre, the Coalition for Disabled People and Making Space.

Use service users and carers

3.7 Sometimes agencies are reluctant to engage with service users because they believe that people will come up with unrealistic ideas and suggestions. This process has shown that service users and carers have their feet firmly on the ground and are more than capable of identifying solutions. The Monitoring and Review Group should take account of this and wherever possible should engage with service users and carers to get their input into designing or testing information and services.

Work in partnership

3.8 The action plan templates found in appendix 1 of this report require a named person to be identified as a lead and the identification of partner agencies. Many of these actions cannot be dealt with unless partnership approaches are sought e.g.

free bus passes. Partnership working takes longer and the Monitoring and Review Group should bear this in mind when it starts timetabling actions.

Say why things can't be done

3.9 Some actions may not be feasible. It is important that the Monitoring and Review Group documents the reasons why something is not possible and engages with relevant service users and carers to explain this. When people understand why something is not possible, it can be closed. If you take the risk of not doing anything, you risk losing people's faith.

Communicate what is already happening

3.10 Some of the actions may require nothing because they are already being done. Two things – firstly the Monitoring and Review Group need to tell people because they are only here because people don't know what is already happening. Secondly there is the opportunity to draw existing provision into the modernisation process, improve it and brand it under the umbrella of modernisation.

Tell people what you have heard and what you have done about it

3.11 During the consultation we asked how people want to be kept informed about progress on the actions identified. A number of ways were suggested that the Monitoring and Review Group should take on board:

- Newsletter
- Word of mouth
- Internet
- Local media via the PCT media lead
- Get together in a year's time to reflect

Participatory monitoring

3.12 We would recommend that in addition to the Mental Health Forum monitoring progress, the Monitoring and Review Group considers using the Coalition for Disabled People to work with some service users and carers to do some participatory monitoring and evaluation work over the coming year or so.

Chronology – Meetings and communications re: MoC Consultations pre-formal Consultation Process

Ref No.	Date	Meeting/Event/ Communication	Decision/agreement
1.	10.02.06	Strategic Commissioning Plan Programme Board	JK and JE presented draft 1 of Improving Value for Transformation (IVTT) paper (pre-cursor paper to Models of Care to members seeking comment. Agreed action: to arrange meeting with LASS colleagues to go through the paper and proposals.
2.	03.03.06	Meeting with ADs of LASS – representatives of Warrington, St Helens and Knowsley present, apols from Halton.	IVTT paper and proposals for model reviewed and amendments agreed and made
3.	26.03.06	JK attended ST H MH Forum and presented outline proposals contained in IVTT.	Obtained service user comment on the proposals to date.
4.	29.03.06 and 03.04.06	Email from A Cooke, CE Warrington to CEs Halton, St Helens PCTs and 5BPT and response from J Holbrey	Informing of discussions and decisions at SCP Prog Brd meeting of 24th March. 1. Impact assessment for each boro. 2. PCTs to indicate 'ownership' of the model thro' their Boards 3. To identify whether clinical staff are supportive to the model. 4. Establish Council member engagement 5. Share MoC with OSCs 6. Mental Health Strategies to assist in issues doc for PCTs. 7. Compilation of a simpler user friendly version of MoC doc.
5.	04.04.06	Email from J East to OSC leads – 4 boroughs	Seeking views of OSC leads on Joint OSC committee, giving an indication of expectation (at that time) of Consultation commencing in May '06 led by PCTs.
6.	26.04.06	Briefing to Council Executive and Adult Social Care and Health OSC – St Helens	Consequent to Vote of No Confidence – Closed meeting. Agreed impact assessment to be completed.
7.	27.04.06	JK Impact Assessment meeting with St Helens	

Ref No.	Date	Meeting/Event/ Communication	Decision/agreement
		LA	
8.	03.05.06	JK Impact Assessment meeting with Halton	
9.	05.05.06	JK meeting with R Vickers, St Helens MH Commissioner/SS Asst Dir	
10.	05.05.06 a.m.	Strategic Commissioning Plan Prog. Brd Verbal feedback from J Holbrey to J East and later to EMT	That the MoC business case paper be submitted to a joint OSC panel as work in progress for their consideration of a) whether formal consultation is required; b) whether a shortened consultation would be acceptable or not c) whether there were any particular issues relating to the service proposals for their local residents that they saw as a problem and for which they may wish to make recommendations.
11.	05.05.06	JK Impact Assessment Meeting with Halton	
12.	05.05.06	Email from A Cooke, CE Warrington PCT.	Confirming decisions of the SCP Prog. Brd. To R Burke-Sharples and colleagues.
13.	05.05.06 p.m.	Meeting of LA Directors of Social Care and Health	Decision/agreement of the morning meeting overturned. D Johnson advised JH of change
14.	08.05.06	Email from D Johnson's office	Advising of LAs view that Borough based OSC review is preferred and that St Helens and Halton supported this approach.
15.	09.05.06	JK attendance at Knowsley - briefing	
16.	10.05.06	Email resp to D Johnson by J Holbrey	Expressing disappointment of change of decision and plan as agreed on 05.05.06
17.	10.05.06	Email resp to J Holbrey from D Johnson	Confirming intent to address the issue of review as quickly as possible, but advising that an OSC Joint Panel will only review a formal Consultation Doc (I.e having been through PCTs) and suggesting individual OSC presentations of business case as a working document.
18.	18.05.06	JK Impact Assessment	

Ref No.	Date	Meeting/Event/ Communication	Decision/agreement
		meeting with Knowsley LA/PCT	
19.	18.05.06	EMT meeting with advisors from CM SHA and Solicitors re: H&SC Act consultation process	Advice obtained that 5BPT is able to undertake its own consultation. Agree to seek Trust Board Approval for commencement of Consultation on 1st June 06.
20.	22.05.06	JK attending Special meeting of Health Policy and Performance Board at Halton	
21.	01.06.06	Extraordinary Trust Board meeting	Launch of the Trust's formal consultation period 1st June 06 – 24th August '06

Dates of PCT Board meetings and deadlines for papers:

Borough PCT	Date of Brd Meeting	Time	Venue	Deadline for papers
Warrington	7th June	1.00 – 5.00 p.m.	Trg Room, Warrington Wolves	26th May
	5th July	"	Boardroom, Birchwood	23rd June
St Helens	7th June	9.30 a.m.	Board Room, Cowley Hill	Not stated – assume 26th May
	5th July	"	"	Not stated – Assume 23rd June
Halton	24th May	9.30 a.m.	Runcorn Town Hall	Not stated – assume 15th May
	28th June (Informal)			
	26th July	9.30 a.m.	River Suite, Halton Stadium	Not stated – assume 17th July
Knowsley	1st June	9.30 a.m.	KCVS Boardroom. Nutgrove Villa	22nd May
	6th July	"	"	26th June

DATES OF CONSULTATION MEETINGS WITH STAFF

Staff may attend any meeting. All meetings last for an hour and a half		
Date	**Time**	**Venue**
29.03.06	2.00pm	Training Room 3 - Hollins Park
04.04.06	2.00pm	Pine Day Unit - Brooker Centre
04.04.06	5.00pm	Training Room 3 - Hollins Park
05.04.06	2.00pm	Eccleston Centre - St Helens Hospital
06.04.06	2.00pm	Avenue Day Hospital - Leigh Infirmary
06.04.06	5.00pm	Postgraduate Centre - Whiston Hospital
10.04.06	9.30am	Training Room 3 - Hollins Park
10.04.06	1.30pm	Therapy Room - Sherdley Unit
11.04.06	2.00pm	Postgraduate Centre - Halton Hospital
12.04.06	1.00pm	Postgraduate Centre - Whiston Hospital
13.04.06	9.00am	Avenue Day Hospital - Leigh Infirmary
18.04.06	9.00am	Postgraduate Centre - Halton Hospital
18.04.06	2.00pm	Training Room 3 - Hollins Park
19.04.06	9.30am	Therapy Room - Sherdley Unit
20.04.06	2.00pm	Postgraduate Centre - Leigh Infirmary
24.04.06	2.00pm	Training Room 3 - Hollins Park
25.04.06	5.00pm	Postgraduate Centre - Whiston Hospital
26.04.06	5.00pm	Postgraduate Centre - Halton Hospital
27.04.06	9.30am	Therapy Room - Sherdley Unit
Any queries about the meetings - telephone 01925 664400		

Dates for Public Consultation Re: *Change for the Better*

The formal public consultation will run from 1st June 2006 until the 24th August 2006. All comments received will be published on the ***ww.5boroughspublicconsultation.co.uk*** website and hard copies will be available from Mental Health Strategies. Comments will be considered by the Trust's Executive Team and Trust Board at a meeting in September.

To discuss the changes in your area, public meetings will be held on*:

Date	Start Time	Venue
09.06.06	11am	Gateway Centre ***Warrington***
16.06.06	10am	Castlefields Community, Centre ***Halton***
21.06.06	6pm	Town Hall Room 8 ***St Helens***
30.06.06	11am	Gallery at Huyton Suite, Civic Way ***Knowsley***
06.07.06	10am	CVS ***St Helens***
11.07.06	6pm	Town Hall Council, Chambers ***Warrington***
18.07.06	6pm	Stadium Widnes ***Halton***
25.07.06	2pm	Osprey Room, Kirby Suite ***Knowsley*** (This venue had to be changed)
03.08.06	2pm	CVS ***St Helens***
08.08.06	1pm	Gateway Centre ***Warrington***
17.08.06	6pm	Osprey Room, Kirby Suite ***Knowsley*** (Thus venue had to be changed)
22.08.06	1pm	Stadium ***Halton***

All meetings will be facilitated by Mental Health Strategies. Senior Managers from the Trust who are responsible for Adult Mental Health Services will also be present to answer your questions. Meetings will be as informal as possible.

Last updated 09/08/2006

Consultation Matrix
Change for the Better

	Date	Consultee Group	Venue	Time	MHS Rep	5BP Rep	Status	Approved
1	09.06.06	Public	Gateway Centre Warrington	11.00am – 1.00pm	Andrew Keefe Lynne Stafford Steve Stanley	John Kelly Nick Pym	Planned	Yes
2	13.06.06	Internal	Training Room 3 Hollins Park House	9.30 – 11.30	Lynne Stafford	Neil Matthewman Nick Pym Gail Briers	Planned	Yes
3	15.06.06	Internal	Pine Day Unit Lounge Halton	9.00 – 11.00am	Lynne Stafford	Roger Wilson Nick Pym	Planned	Yes
4	16.06.06	Public	Castlefields Community Centre Halton	10.00 – 1.00	Steve Stanley Lynne Stafford	Roger Wilson Nick Pym	Planned	Yes
5	21.06.06	Public	St Helens Town Hall – Room 8	6.00 – 9.00pm	Andrew Keefe Steve Stanley	John Kelly Nick Pym	Planned	Yes
6	27.06.06	Internal	Lecture Theatre Whiston Post Grad	9.00 – 12.00	Lynne Stafford	Sam Oliver Nick Pym	Planned	Yes
7	27.06.06	Knowsley OSC	Council HQ Huyton	6.00pm	None	Ray Walker Roger Wilson John Kelly	Requested	Yes
8	28.06.06	Warrington OSC		6.30pm	None	Neil Matthewman Chris Hedley John Kelly	Requested	Yes
9	30.06.06	Public	Gallery at Huyton	11.00 –	Andrew Keefe	John Kelly	Planned	Yes

Last updated 09/08/2006

			Suite Civic Way Knowsley	2.00	Lynne Stafford	Nick Pym		
10	04.07.06	Internal	Lecture Theatre Post Grad Halton	2.00 – 5.00pm	Lynne Stafford	Roger Wilson Nick Pym Gail Briers	Planned	Yes
11	05.07.06	St Helens PCT Board Meeting	Boardroom Cowley Hill	9.30am	None	John Kelly	Requested	Yes
12	06.07.06	Public	St Helens CVS	10.00 – 1.00pm	Andrew Keefe Lynne Stafford	Nick Pym Gail Briers Maria Gaskell	Planned	Yes
13	10.07.06	Health Policy & Performance Board	Runcorn Town Hall	6.00pm	None	John Kelly Chris Hedley Roger Wilson	Requested	Yes
14	11.07.06	Public	Town Hall Council Chambers Warrington	6.00 – 9.00pm	Lynne Stafford Steve Stanley	Chris Hedley Nick Pym	Planned	Yes
15	12.07.06	St Helens MH Partership Board	Boardroom Cowley Hill	1.30pm	None	John Kelly	Requested	Yes
16	13.07.06	Internal	Training Room 3 Hollins Park House	5.00 – 7.00pm	Lynne Stafford	Gail Briers Nick Pym	Planned	Yes
17	18.07.06	Public	Halton Stadium Widnes	6.00 – 9.00pm	Lynne Stafford Steve Stanley	Roger Wilson Sam Oliver	Planned	Yes
18	19.07.06	St Helens PEC	Boardroom Cowley Hill	1.30pm	None	Ray Walker John Kelly	Requested	Yes
19	21.07.06	Internal	Lecture Theatre Whiston Post Grad	2.30 – 5.00pm	Lynne Stafford	Ray Walker	Planned	Yes
20	24.07.06	North Cheshire	Halton Post Grad	1.30 –	Not required	Neil Matthewman	Requested	Yes

Last updated 09/08/2006

		Hospitals Trust Board	Centre	2.00pm		Roger Wilson		
21	25.07.06	Public	Arncliffe Centre Halewood	2.00 – 5.00pm	Lynne Stafford	Gail Briers	Planned	Yes
22	26.07.06	St Helens Coalition of Disabled People	PCT Boardroom Cowley Hill St Helens	10.00 – 11.00am	None	Sam Oliver Maria Gaskell	Requested	Yes
23	26.07.06	Halton PCT	River Suite Halton Stadium	9.30am	None	John Kelly	Requested	Yes
24	03.08.06	Public	St Helens CVS	2.00 – 5.00pm	Lynne Stafford	Judith Holbrey Gail Briers	Planned	Yes
25	08.08.06	Public	Gateway Centre Warrington	1.00 – 4.00pm	Andrew Keefe	Neil Matthewman Gail Briers	Planned	Yes
26	08.08.06	Internal	Lecture Theatre Post Grad Halton	4.00 – 6.00pm	Lynne Stafford	Roger Wilson Bruce Moore	Planned	Yes
27	10.08.06	Internal	Post Grad Whiston	4.30 – 6.30	Lynne Stafford	Roger Wilson Gail Briers	Planned	Yes
28	15.08.06	Internal	Training Room 3 Hollins Park	2.00 – 5.00pm	Lynne Stafford	Neil Matthewman Gail Briers	Planned	Yes
29	17.08.06	Public	Prescot Suite Prescot	6.00 – 9.00pm	Lynne Stafford	John Kelly Nick Pym	Planned	Yes
30	22.08.06	Public	Halton Stadium Widnes	1.00 – 4.00pm	Steve Stanley	Roger Wilson Nick Pym Gail Briers	Planned	Yes
31	19.07.06	Warrington	Warrington Day	7.00pm	None	John Kelly	Requested	Yes

Last updated 09/08/2006

	Mental Health Forum	Centre			Colin Rimmer		

Requested awaiting approval
Cover required
New date for Director's diary

"Change for the Better"

A New Model of Care

"Making the Promise a Reality"

Clarification and Responses to Queries

for the Joint Overview & Scrutiny Committee

5 Boroughs Partnership NHS
NHS Trust

A Quote from the Comprehensive Mental Health and Social Care Commissioning Strategy for Halton, Knowsley, St Helens and Warrington

'.. services need to be fundamentally reorganised so that acute care, alongside most support and treatment, is provided at home rather than in hospital, except in the most extreme of circumstances, where the risk indicates no alternative to hospital admission.'

2

Query 2.1.i):
The reports referred to would seem to indicate a tightening of eligibility criteria across mental health services?

- The Comprehensive Commissioning Strategy advises the development of clear and robust eligibility criteria (Ref: p3). Admission to a bed will be based on assessed need, not as a substitute for something more appropriate.

- A Point Prevalence audit showed **between 15 and 40%** of people who are admitted to an in-patient bed, do not need to be there.

- Different LAs have different eligibility criteria for social care access and provision – joint work is required.

- Key task – provide appropriate level of services in the least restrictive environment and to ensure that those most in need of services get access to them

3

Query 2.1.ii)

This (stricter eligibility criteria) is likely to be as a result of the decrease in in-patient beds.

Drivers for decrease of beds are:

- National Directive to reduce beds by 30%
- Royal College of Psychiatrist advises lower bed No.s.
- Commissioning Strategy states over-supply (ref. p.46)
- The 10 High Impact Changes for mental health – I.e. treatment at home to become the norm.
- Commissioning Strategy intention for 'clear and robust specifications' (refs. pp.15 & 46)

4

Query 2.1.ii)
Continued

- Community service enhancement will allow the existing criteria to be properly applied.
- 'Change for the Better' proposals ensure all localities have community services in place which meet the best practice standard.
  (i.e. Policy Implementation Guide Compliant).

5

Query 2.1.iii)
The model is not clear about the impact that this will have for service users and carers in the Boroughs.

- Service users will not be admitted unless it is appropriate to their assessed needs.
- In-pts' views = in-pt units can be threatening, feel unsafe, don't have enough staff leading to poor levels of pt:staff interaction. RRCs will have better staff:pt ratios and will have improved environments.
- Carers want a clear point of contact and assistance -the Access and Advice service will improve this. (Ref. p.63 - Single point of access described in Commissioning Strategy).
- People who do not need admission will be directed to other, more appropriate service(s) by expert assessment and the gate-keeping function. (Commissioning Strategy Ref. as above)

6

Query. 2.1.iv).
The model is unclear about any arrangements to ensure the safety and effective risk management of issues relating to individuals through the transition of services

- The delivery of safe services is a key priority for the Trust.
- Intention to develop joint protocols with our partner organisations pending outcome of the consultation.
- Trust's Risk Assurance Framework has been externally audited as providing significant assurance.
- Detailed project planning to be undertaken for the phased transition.
- The risks presented for and by individuals will be assessed as part of clinical risk management.

7

Question 2.2:
There are concerns about the possible impact on other aspects of 5 Boroughs work, notably the Child and Adolescent Mental Health Services, where there is no clarity in the proposals outlined.

- 'Change for the Better' is about services for adult and older persons with functional mental ill health .
- 'Change for the Better' neither enhances nor negatively impacts on CAMHS services.
- 'Change for the Better' does not affect current arrangements for transition between adult and children's services.

8

Query 2.3:
The Committee is concerned that the proposals do not properly meet the needs of a number of specific groups including:-

i) Older people with functional mental health needs

- Many services not previously accessible to older people will become so eliminating discrimination on age e.g. Crisis Resolution and Home Treatment, Psychological Therapies.
- The issue of older people on adult wards – vulnerability is not just an issue of older age. In-pt design is key to providing safe care for vulnerable people of all ages.
- A piece of work is commissioned to review the issue of vulnerability, its assessment and management – to be considered at the end of the consultation period.

9

ii) *People with dual diagnosis i.e. drug and/or alcohol and mental health problems.*

- Services will be accessible (as they are now) to people with a dual diagnosis I.e. people identified to have a mental health problem requiring treatment who also have co-morbidity of substance misuse.

  NB: The Model of Care also proposes a Dual Diagnosis worker per CMHT.

- Treatment and support interventions for people **without** mental health problems who have a drug or alcohol problem are provided via separate services.
- There is need for further dialogue with commissioners regarding service developments

10

iii) People presently living in secure environments

- Services for people who require secure services are not part of the model of care proposals or this consultation

11

iv) People with personality disorders

- People with a mental illness and a personality disorder will continue to access treatment as they do now.
- People with personality disorders present a real challenge for all the health and social care community and require consistent response.
- Most people with a personality disorder will not require the skills of a specialist Mental Health Trust.
  [Changes in legislation may alter this position]
- The 5 BPT is not commissioned to provide services to people with a pure personality disorder with no mental illness.

12

v) Young people aged 16-17 years.

- Transition arrangements between child and adult services are unaltered by the proposals.
- The current deficits in service provision need to be addressed through the implementation of the recently approved CAMHs Commissioning Strategy, which identifies services for 16-19 year olds as an area of service shortfall.
- The Trust agrees that this is an area of high priority for development and is committed to working with commissioners and other partners to develop services for young people

13

Query 2.4.i):
There are concerns about the proposals to mix in-patient settings for older people and younger adults. The Committee believes this is contrary to good practice.

- This is currently the position in 2 of 4 Boroughs for older people, in accordance with locally commissioned service patterns.
- The Trust is committed to ensuring vulnerable people are risk assessed and that current environments are remodelled to provide separate areas for vulnerable people.
- The model provides enhanced staffing in in-patient areas, which will allow 1-1 observation when required.

14

Query 2.4.i):
Continued

We are continuing to review the guidance and liaise with advisors of the Strategic Health Authority. If there is further guidance that we have not considered, then we would be happy to consider it.

15

Query 2.4.ii):
The Committee is also concerned that people under the age of 18 may be admitted to adult wards.

- Young people currently get admitted on to adult wards. Their vulnerability is assessed and the Mental Health Act Commission informed. One to one nursing is often required.
- CAMHs commissioning in relation to the new Commissioning Strategy needs to take account of in-patient provision for young people.
- The development of Early Intervention in Psychosis Services (EIS) will assist but not in the short term (services take up to three years to become operating at capacity).
- Not all Boroughs have a funded and established EIS, in 'Change for the Better' proposals this will be resolved.

16

Query 2.5:
There are concerns about the impact on alcohol services for adults and older people; the proposals contain a reduction of allocated beds for alcohol detoxification.

- Currently, no funded bed exists for alcohol detoxification, nor will there or should there be in the new model – this is not compliant with best practice.
- All but the most highly complex alcohol detoxification is carried out in the community.
- Complex alcohol detoxification often requires proximity to and the back-up of general medical care and intervention.

17

Queries raised in section 3 of the:

'Issues for Consideration by the Statutory Joint Scrutiny Committee'

will be addressed by the Director of Finance

18

5 Boroughs Partnership NHS
NHS Trust

Change for the Better

- **Financial Update**
- **9 August 2006**

19

5 Boroughs Partnership NHS
NHS Trust

Financial Overview

- Currently overtrading giving rise to an underlying financial problem of c £4m if left unchecked.
- DoH efficiency targets set at 2.5% pa which is deducted from Trust income.
- Trust must "consume own smoke" for any in year cost pressures.
- Trust must respond to above from a service perspective in line with commissioning intentions.
- DoH/SHA/Monitor requirements for financial sustainability – not negotiable
- No disinvestment by PCTs

20

5 Boroughs Partnership NHS
NHS Trust

A Service Response

- Manage down cost of overtrading by delivering to contract and ensuring appropriateness of admissions & discharges
- Maximise the benefits of the MH NSF by dealing with people in the most appropriate care environment that ensures social inclusion.
- More responsive services at community front end rather than reactive inpatient approach to care.
- Above service response is efficient and therefore delivers efficiency savings in cash terms too.
- No disinvestment by PCTs

21

5 Boroughs Partnership NHS
NHS Trust

How Do We Get There?

- Utilise Trust annual Capital Resource Limits to make available funds to provide for Resource Centres
- Utilise agreed funds from PCTs to protect existing NHS services through the process of transition.
- Tightly project manage the process as facilitated by agreed PCT & SHA funds.
- After consultation agree the detail behind asset enhancement, transitional processes & project management protocols.

22

5 Boroughs Partnership NHS
NHS Trust

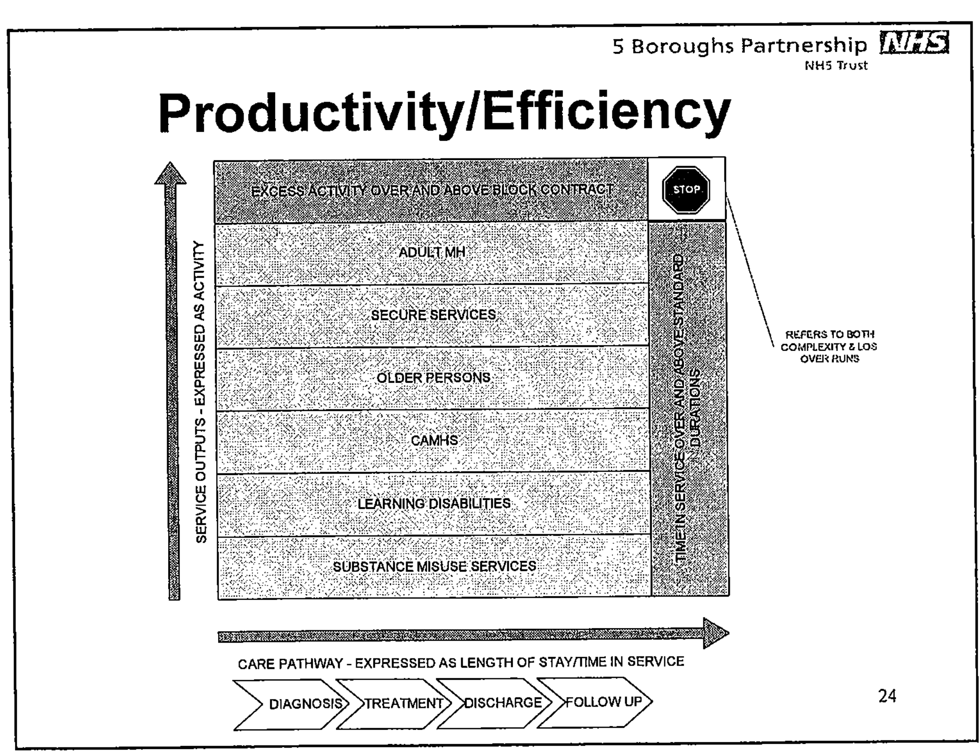
Further Work

- Service response to commissioning strategies for all our other services, including, old age & children's services is required.
- Cost efficiencies for 2007/08 & 2008/09 need to be identified.
- Equitable process of delivering efficiencies across all localities and services is paramount.

23

5 Boroughs Partnership NHS
NHS Trust

Productivity/Efficiency



24

Query 4.1:
There is some confusion in the various documents about the number of in-patient beds. The Committee has concerns about the level of service for people who would have been utilising these in-patient beds, particularly in the light of the described over occupancy.

- The Commissioning Strategy refers to the ample evidence that an effective range of community services reduces demand for in-patient bed use (ref. p55) e.g. Newcastle and North Birmingham models.
- The proposed bed numbers are as stated in the consultation document.
- The numbers reflect the Royal College of Psychiatrists norms – lower end – as the boroughs are starting from a better community infrastructure baseline than many of the exemplar models.
- Calculations of bed occupancy are complicated by information systems counting people who are on home leave, plus patients who have been admitted from other boroughs.

25

Query 4.2:
The Committee were concerned that the proposals relating to in-patient beds do not include psychiatric intensive care.

- Currently the only PICU beds within the 5 boroughs are in Wigan borough.
- The Commissioning Strategy states the need for at least one PICU (accessible to the four boroughs) that provides higher levels of security (ref. p.49).
- These beds are additional to and separate from those referred to in the Model and are funded separately. A new Unit is to be developed on the Warrington site. Local Commissioning of access is not confirmed as yet.
- A local PICU should reduce Out of Area commissioning of such facilities, thus reducing PCT costs (approximately 1% of OATS expenditure - ref. p.48 of Commissioning Strategy).

26

Query 4.3:
The impact on Council services, particularly the impact on the infrastructure currently in place and the type of accommodation required in each Local Authority given the planned bed reduction.

- Most people with mental health problems live at home and the model aims to maintain that position wherever possible.
- People should be able to access their local mainstream services though they may need support in doing so.
- The approved Commissioning Strategy advises that a range of supported accommodation is required, with modernised day provision in the community rather than institutional settings – flexible to the needs of individuals (ref. pp.66.67)
- The numbers of people who require a degree of special accommodation will not increase as an outcome of bed reduction, and as now, they will require planned care packages.

27

Query 5.1:
The Committee is concerned about proposals to develop access and advice centres within each borough, as a single gateway to specialist mental health services. Based on the information provided, the Committee believes that further thought should be given to access to mental health services being from within Primary Care and other tier 2 services.

- Access and Advice Centres (referred to as single points of access (SAP) in the Commissioning Strategy) are an important part of the model. Where they 'sit' is not vital, however, as the gatekeeper to specialist services, close relationship with the RRCs is vital.
- The Trust will consider the comment on this arising from the consultation.

28

Query 5.2:
The Committee are disappointed that the RRC model seems mainly focussed on 9.00 a.m. to 5.00 p.m. services and the details of other out of office hours services are sparse. The Committee would welcome further information about staffing levels and implications for Council services out of hours.

- RRCs operate on a 24 hour basis in respect of Crisis Resolution and Home Treatment and provision of in-patient care. Access and Advice service also needs to operate on a 24 hours basis.
- Currently enhanced therapy provision is indicated as 9-5, however, as service becomes established the available capacity will be more flexibly targeted. Service user feedback will inform this.

29

Query 5.3:
The committee would like a comparison of Assertive Outreach Services – what currently exists and what will be required.

	Current Investment * £000s	Current Caseload	Future Investment £000s	Future caseload
Halton	£201	84	£426	84
St Helens	£412	72	£393	72
Warrington	£303	24	£303	60

* Some services are being provided at higher levels of input than that for which funding has been obtained through commissioning

30

Query 6.1:
The Model of Care refers to the impact on Council services including social care, however, the Committee were concerned that detailed information was not available.

- New services such as Assertive Outreach, Crisis Resolution, Early Intervention in Psychosis and the addition of Access and Advice have and will provide positive impact for service users and carers.
- To address the issue of stigma, it is important that people with mental health problems and their carers should be able to access every day mainstream services.

31

Query 6.1:
Continued

- Treating people in their own homes - maintains their informal and formal support networks. Thus - results in less breakdown of these mechanisms and lower levels of complex care packages.
- The delivery of integrated community services as described in the Commissioning Strategy requires joint agency work by implementation teams if the model is supported.

32

Query 6.2:
The committee are unclear as to the future functioning of community mental health teams and how they will operate under the proposed model of care.

- The Commissioning Strategy states that there will continue to be need for MDTs of practitioners providing ongoing support and care to people with serious and enduring mental health problems – focusing on promoting recovery, social inclusion and support of carers (ref. pp65-66). The Model proposed targets this group and incorporates these functions.
- Details of operation will be progressed locally in each borough with Local Authorities should the model be supported.

33

Query 6.3:
The committee are concerned about the impact on Council day services given the proposal to close day units.

- The commissioning strategy suggests that day centre requirement will 'melt away' overtime (ref. pp.66-67) as non-stigmatising community based alternatives develop.
- Some Councils have already de-commissioned day services as it is recognised as not being the most effective way to deliver modern mental health services.
- The Trust has offered to commission work to look at day service provision if this is considered to be useful to all agencies.

34

Query 7.1:
The committee are concerned that there was some evidence that the consultation processes did not appear to be thorough and adequate.

- The Models of Care proposals were shared with the Strategic Commissioning Plan Programme Board on 10th February '06.
- As described in the handout notes – the Trust has followed Cabinet Office Guidance on consultation and used an external company that has previous experience in managing consultations to manage the process.
- Prior to the formal consultation, service user feedback and consultation has been undertaken through formal and informal means over the last two years e.g. through Acute Care Forum, meetings of PPIF, Local service user and carer groups.
  A pack is available providing further information

35

Consultation Processes - Continued

- In addition the model has been presented to and debated at:

  - Local Implementation Teams/Health Partnership Boards,
  - Professional Executive Committees of PCTs,
  - PCT Boards
  - Overview and Scrutiny Committees of all boroughs
  - Executive Officers of Local Authorities

36

Query 7.2:
The panel appreciate the extension of the timescale in relation to the Statutory Joint Scrutiny Committee, but feel that the timescales for the public consultation and the fact that they will still end on 24 August did not allow proper time for the full and proper involvement of service users, carers and staff.

The Committee will be assured to be advised of examples of timescale and extent of consultation:

- Initial consultation with service users and carers of St Helens borough in respect of local services – March 2004.
- 19 meetings undertaken with staff between 29th March and 25th April '06 pre-commencement of formal section 11 consultation.
- Meetings with service user groups commenced in March '06.

37

Consultation Process Information - Continued

- Meeting with Patient and Public Involvement Forum (PPIF) held on 5th May '06.
- 31 meetings with staff, public, service user forums and the borough O & S Cs have taken place since 1st June '06
- Consultation in accordance with Section 11 of Health & Social Care Act '01 commenced 1st June '06 for a period of 12 weeks.
- Consultation with O & S Cs under Section 7 commenced at the same time.

38

Query 7.3:
The committee are concerned that publicity relating to the consultation process did not appear to be thorough and adequate, and there seemed to be a general lack of awareness amongst key professional groups and the public about the consultation process.

- The Trust is only aware of one instance of problem where publicity posters did not reach a Council within the first days of the consultation. This was speedily addressed. The Trust would be pleased to receive evidence of any problems.
- Press advertisements were placed in all local newspapers in each of the 4 boroughs.
- Consultation documents were issued to a stakeholder list of 190 people and organisations.

39

Query 7.3:
Continued

- Staff meetings - held as noted previously plus separate meetings held for some staff groups e.g. medical staff.
- Poster and leaflets were available in all mental health services.
- A group of service user representatives has been accompanied to visit the Norfolk and Waveney services and a feedback report obtained.

40

Query 7.4:
The committee felt that some of the language used in the consultation events made it difficult for people to properly understand the issues.

- This has not been raised during the consultation meetings. It is useful feedback that has been fed-back to Mental Health Strategies when first received.

41

Query 8.1
The Committee felt that some general points were worthy of further consideration. These include:
i) The lack of clear links with existing commissioning strategies for adults of working age and older people

- Uncertain of basis for statement - The Model of Care has been based upon the approved Comprehensive Mental Health and Social Care Commissioning Strategy for adults, which includes provision relating to older people with functional mental health problems to provide non-age discriminating services.
  NB: Cross-references to the document have been noted in the slides.

- Additionally, reference has been taken from mental health best-practice evidence.

- The Commissioning Strategy for older people was not completed at the time of compiling the model, but it concurs with delivery of non-age discriminating service access. Some dovetailing of the model with the recently approved strategy may be required.

42

ii) The proposed Model of Care does not cover all recommendations of the scrutiny exercise "scrutiny of hospital discharge services for St Helens residents with mental health problems".

- A joint health and social care action plan is in process. Recommendations primarily relate to care processes rather than model of delivery. Changes implemented from the action plan will carry forward into the new model as practice.
- The St Helens Overview and Scrutiny Panel for Adult Social Care and Health have been informed of the above (June 06).

43

iii) The focus on carers within the proposed Model of Care seems weak and carers issues do not appear to have been properly addressed.

- Action for carers is implicit in the way that Effective Care Co-ordination operates (ECC). However, this point was picked up as an issue early in the consultation meetings and more explicit emphasis of this work needs to be incorporated into the model post-consultation.
- The Trust is committed to working with all partner agencies to ensure that carers' issues are addressed within services.

44

iv) The need for a clear and robust training programme for staff at all levels to support the proposed changes.

- This is well recognised by the Trust and early work has commenced for planning this work, since skill and practice changes are required irrespective of the model of service delivery.
- An existing Assistant Director is being seconded as of 14th August to focus on staff development and training in new ways of working.
- The increased staff establishments proposed in the model will enable staff to be gradually released to undertake required training.

45

Query 8.2:
Governance and accountability arrangements – how will the new model fit with current agreements?

- Internally – The Governance arrangements of the Trust will continue, subject as now to external audit for compliance to standards.
- Locally - Currently Partnership Agreements are either being negotiated and finalised or subject to annual review. Continuance of integrated service delivery is a vital ingredient of provision of mental health care in its widest sense , whatever the model of delivery.
- Externally - The future Service Level Agreements with PCTs for commissioned services will be far more detailed and related to performance, which will include governance.

46

Query 8.3:
Relationship with West Cheshire PCT - currently Halton provides a service to residents in Helsby and Frodsham. The committee requires further details about how this will be managed and financed in the future.

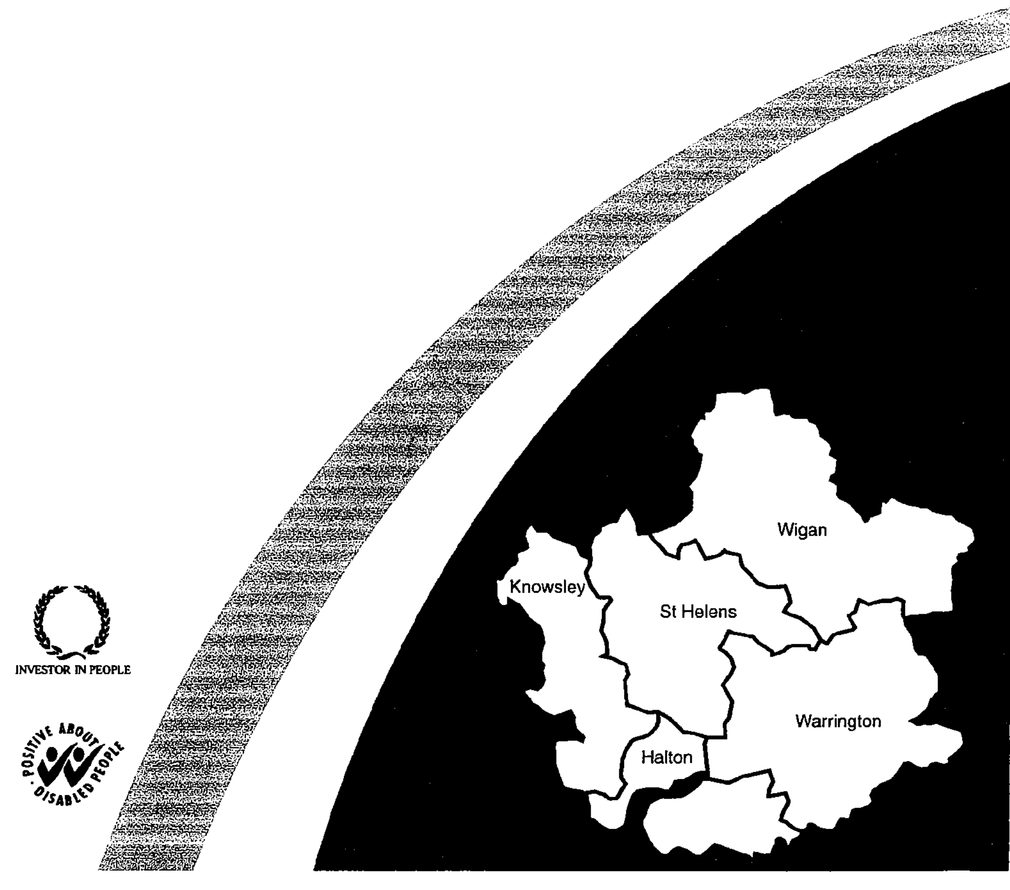
- The Trust will provide services where and at what level they are commissioned and funded through more detailed Service Level Agreements.
- The detailed work being undertaken to desegregate funding obtained via block contracts will provide the information to determine the extent of funding and deficit.
- The Trust is in discussion with Cheshire West PCT regarding its service commissioning.

47

5 Boroughs Partnership NHS
NHS Trust

Point Prevalence Study Of In-patients in Acute Mental Illness Beds

July 2006



5 Boroughs Partnership NHS
NHS Trust

In-Patient Review July 2006

Adult Services

Ward/Department/Unit	Number of Beds	Number of Functional Inpatients	Number of inappropriate Inpatients
T1 Knowsley	17	12	1 **(8%)**
T2 Knowsley	16	16	4 **(25%)**
T4 St Helens'	16	14	9 **(64%)**
T5 St Helens'	18	18	2 **(11%)**
Bridge Ward Halton	20	16	2 **(13%)**
Weaver Ward Halton	20	20	3 **(15%)**
Womens Mental Health Unit, Wigan	25	25	3 **(12%)**
Makerfield Unit, Wigan	25	30	13 **(43%)**
Austen Ward, Warrington	22	22	10 **(45%)**
Sheridan Ward, Warrington	26	24	7 **(29%)**

Older People

Ward/Department/Unit	Number of Beds	Number of Functional Inpatients	Number of inappropriate Inpatients
T3 Knowsley	19	0	0
Heath Ward, Halton	14	13	3 **(23%)**
Holdenbrook Unit, Wigan	25	21	3 **(14%)**
Byron Ward, Warrington	14	10	1 **(10%)**
Stretton Ward, Warrington	19	2	0

Learning Disabilities

Ward/Department/Unit	Number of Beds	Number of Functional Inpatients	Number of inappropriate Inpatients
Willis House, St Helens'	8	8	3 **(38%)**
Fourways, Warrington	7	7	3 **(43%)**
Fairhaven, Warrington	9	6	2 **(33%)**
Auden Unit, Warrington	15	14	1 **(7%)**

Overall figures

	Number/percentage inappropriate inpatients		
Borough	**Adult Services**	**Older People's Services**	**Learning Disabilities**
Knowsley	5 **(18%)**	0	N/A
St Helens'	11 **(34%)**	N/A	3 **(38%)**
Halton	5 **(14%)**	3 **(23%)**	N/A
Wigan	16 **(29%)**	3 **(14%)**	N/A
Warrington	17 **(37%)**	1 **(8%)**	6 **(22%)**

Reasons why patients in hospital inappropriately

Knowsley Adult Services

Comment	**Number of patients**
1. Inappropriate admission:	
Not a mental health problem, admitted due to alcohol misuse; not a Knowsley patient (Halton patient)	1
More appropriate long-term care required, lack of community resources	1
Should have been managed in community	2
2. Unable to go home:	
Domestic issue	1
Total	**5**

St Helens' Adult Services

Comment	**Number of patients**
1. Inappropriate admission:	
Admitted in crisis with substance misuse, sent on leave the following day instead of discharge	2
2. Delayed Discharge:	
Patient from another area – difficulties organising discharge with patient's own team	1
Patient refusing home treatment, consultant won't discharge	2
Patient threatening self harm if discharged	1
3. Lack of appropriate placement:	
Waiting for special care residential place (funding available)	3
Carers wanted rehab place – waited 1 month for a placement	1
Awaiting decoration (2 weeks)	1
Total	**11**

Halton Adult Services

Comment	Number of patients
1. Inappropriate admission:	
Could have been treated in community; threatening behaviour if discharged	2
Transferred from elderly unit	1
2. Unable to go home:	
Doesn't want to go home, needs intense care in community	2
Total	**5**

Wigan Adult Services

Comment	Number of patients
1. Unable to go home:	
Relative fraudulent with patient's benefits	1
2. Delayed discharge:	
Placement found but patient refuses to leave	1
Reluctant to discharge due to self harm	1
Drug problems & associated behaviours	1
3. Lack of appropriate placement:	
Homeless	4
Parents unable to cope with problems	2
Concerns from relatives re: finding a placement; needs all male environment	1
Trafford refuse to take him back	1
Has binge drinking problem	1
Behavioural problems – refused placements	1
Awaiting placement	1
Arguments over who takes patient (areas, St Helens', Knowsley, Liverpool)	1
Total	**16**

Warrington Adult Services

Comment	Number of patients
1. Inappropriate admission	
Homeless - no mental health problems	1
No mental health problems	3
Respite care	1
Does not comply with treatment	1
Too old for acute ward; awaiting suitable placement due to behavioural problems	1
2. Delays in treatment/discharge:	
Delay in assessment & treatment (violent behaviour)	1
Cautious management by care team	2
3. Lack of appropriate placement	
Awaiting placement	3
Placement found unsuitable	1
Turned down by many places due to behavioural problems	2
Argument between PCT & secure commission who will take patient	1
Total	**17**

Halton Older People's Services

Comment	Number of patients
1. Unable to go home:	
Lack of social care (no support workers)	3
Total	**3**

Wigan Older People's Services

Comment	Number of patients
1. Inappropriate admission:	
No mental health problems, admitted due to aggressive behaviour	1
2. Delays in discharge:	
Patient refusing to go back to nursing home	1
Consultant reluctant to discharge as patient has court case pending	1
Total	**3**

Warrington Older People's Services

Comment	Number of patients
1. Unable to go home:	
Suffered assault when discharged previously, alternative placement sought	1
Total	**1**

St Helens' Learning Disabilities Services

Comment	Number of patients
1. Lack of appropriate placement:	
Homeless	3
Total	**3**

Warrington Learning Disabilities Services

Comment	Number of patients
1. Inappropriate admission:	
Not LD patient, delays assessing and placing with adult mental health services	1
2. Lack of appropriate placement:	
Family did not like original placement	1
Original placement could not be adapted	1
Homeless awaiting placement	3
Total	**6**

In-patient Review July 2006
Adult Services
5 Boroughs Partnership NHS Trust

Name of Ward / Department / Unit..

Name of person being interviewed..

Position of person being interviewed..

Number of beds available....................No of beds in use...........

In your opinion how many of the current in-patients should not be in

hospital?..

please given reasons why not? And numbers for each reason

Reason	Numbers	Comments
Inappropriate admission (Give reasons)		
Unable to go home due to other reasons (please give reasons if not in list below)		

Non compliance with treatment (give details)	**Numbers**	**Comments**
Care co-ordinator unallocated (reasons)		
Homeless / no accommodation (what is being put in place, what problems encountered)		
Lack of appropriate day care		

Any other reasons please give examples	**Numbers**	**Comments**
Any delayed discharges? Please give reasons if not listed below		
Social worker role not allocated (give reasons)		
CPN not allocated (give reasons)		

Concerns from family and carers	**Numbers**	**Comments**
Have there been any unnecessary delays in treatment? (Give details)		
Delay in receiving ECT? (Give details)		
Delay in receiving Clozaril ? (Give details)		

Have there been any delays in discharge? If yes how many? What reasons if not listed below?	**Numbers**	**Comments**
Cautious management by Care team (i.e. risk of self harm, suicide, harm to others) (Give details)		
Inability of crisis team / home treatment to support service user (Give details)		
Inability of Assertive Outreach team to support service user (Give details)		

Lack of appropriate placement (give details)	**Numbers**	**Comments**
Lack of funding for placement (give details)		

Name of person conducting interview..

Signature.......................................

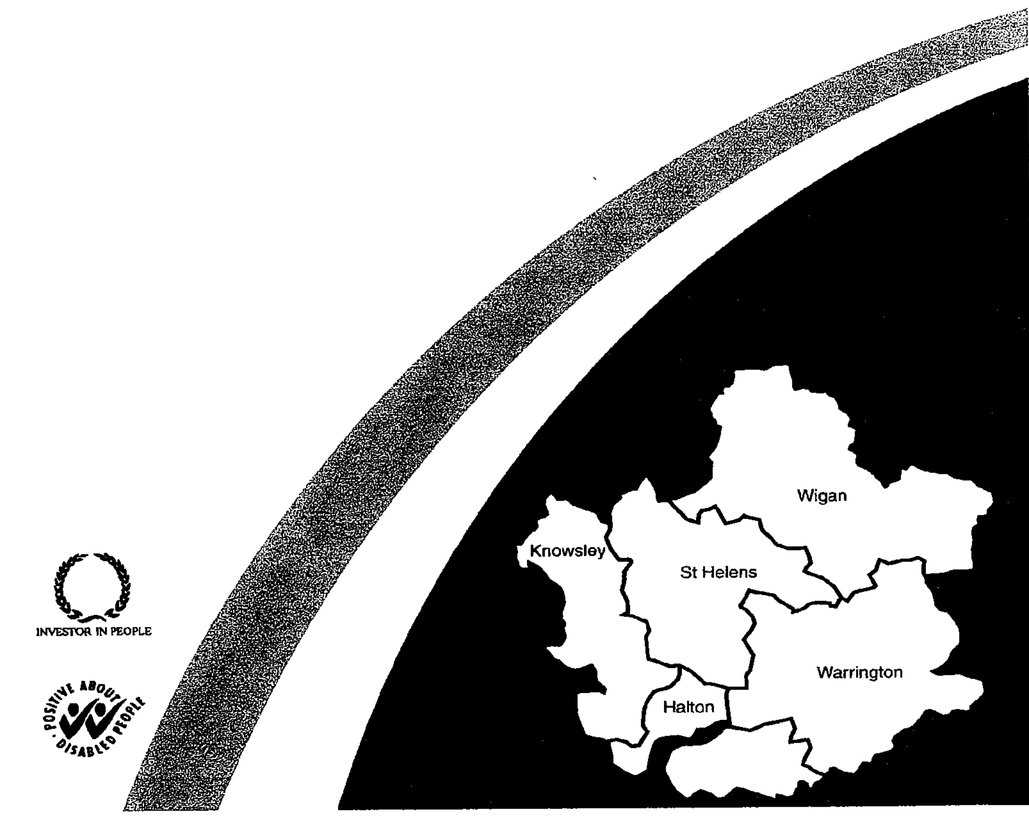
Date ..../July 2006

5 Boroughs Partnership NHS
NHS Trust

Responses to Queries for the Joint Overview and Scrutiny Committee

Re: 'Change for the Better'

A Consultation on proposals for delivering a New Model of Care for Adults and Older People with Functional Mental Health Problems



NHS Trust

Issues for Consideration by the Statutory Joint Overview and Scrutiny Committee

Re: Improving Services for Adults with Mental Health Needs

5 Boroughs Partnership NHS Trust

1. Introduction to Response:

The Trust thanks the borough Overview and Scrutiny Committees for convening a Joint Committee and for the opportunity to provide more information and responses to queries in respect of the 'Change for the Better' consultation on the proposals for a new model of care.

We must be mindful that the model relates only to adults of working age and older people with functional mental health problems, though review of other elements of the Trust's services in relation to the latest Commissioning Strategies for Children and Older People will need to be undertaken in the future.

The Trust would also wish to remind Committee members that the proposals provide a model framework for service delivery, the details for implementation of which require to be developed with partner agencies in each of the boroughs. The proposals provide a consistent and cohesive network for the provision of effective and non-post-code discriminated services for the benefit of service users.

The impetus and direction of the proposed changes has been stimulated and led by comments that service users and their families have been making to the Trust through various forums since 2004. This feedback and consultation has been obtained through both informal and formal mechanisms and it must be recognised that some of the issues raised present real challenges to professional groups and to current ways of working.

Similarly, the development and subsequent approval of the Comprehensive Mental Health and Social Care Commissioning Strategy for Adults of Working Age for Halton, Knowsley, St Helens and Warrington provided the basis for the development of the model and referred to the evidence of effective service delivery. The Model was developed alongside the commissioning project group work and the first draft was presented to the Strategic Commissioning Programme Board, comprising of PCT Chief Executives and Directors of Social Care, at its meeting on 10th February 2006.

The presentation to be given today is specifically related to the queries received from the Committee via Mr Mike Wyatt dated 26th July 2006 and the slides follow the format of that paper, of which we are assuming that you will have received prior copy.

Whilst aware that the functions of the Overview and Scrutiny committee is to scrutinise and comment upon the proposals with regard to the adequacy of consultation and whether the proposals would not be in the interests of the health service in the three boroughs, the Trust has sought to provide wider information in this response. The presentation is thus quite lengthy and there are supplementary items of information that are provided for the benefit of reference by committee members. However, should there be need for any further reference material, please advise.

2. Impact on Service Users and Carers

Q. 2.1. i) The reports referred to would seem to indicate a tightening of eligibility criteria across mental health services.

The proposals contained in 'Change for the Better' respond to the content of the Comprehensive Mental Health and Social Care Commissioning Strategy for Adults in Halton, Knowsley, St Helens and Warrington. (See also separate paper relating the Commissioning intent with the proposed model).

People are currently accessing beds when they do not need to. A recent audit showed that **between 15 and 40%** of people admitted to an in-patient bed, do not need to be there (Point Prevalence Audit July 2006).

We are aware of differences in Eligibility Criteria in different Local Authorities for services and also for the health provision of Community Mental Health Teams (CMHTs) in some boroughs. Service eligibility criteria within the proposed model are to be subject to joint work with health commissioners and Local Authorities in respect of in-patient admission and the Effective Care Co-ordination policy respectively. This work to be undertaken post-consultation on the outline model.

The proposed model is about ensuring service users receive the most appropriate level of services in the least restrictive environment and to ensure that those most in need of services get access to them.

In some of our localities service users would be best served by specialist mental health community services. Currently not all service users are able to access these services for a number of reasons, for example service not currently funded or service provided for working aged adults only.

Q.2.1.ii) This is likely to be as a result of the decrease in in-patient beds.

The reduction in in-patient beds reflects National Policy and best practice of providing treatment and care in the least restrictive manner. The provision of effective 'front-end' access services and effective alternatives to admission will result in the current criteria for admission to acute care to be properly applied. This has not been possible due the community infrastructure not being fully complete and cohesively integrated. The Commissioning Strategy notes that the *'amount of in-patient provision required more often depends on, and is a function of, the range of other services available locally'.*

The Commissioning Strategy also notes the relative over-supply of beds in the boroughs.

The Royal College of Psychiatrists has provided advice and recommendations for the numbers of beds required per head of population, and the lower level is that which is appropriate when the community services are developed and in place to provide appropriate alternatives.

The approach taken by the model is also being championed in the recently published 10 NHS High Impact Changes for Mental Health Service. (Ref: Number 1 of the 10 Key High Impact Changes[1])

It will always be the case that some service users will require a stay in hospital (sometimes compulsorily) however all efforts should be made to ensure that alternatives to in-patient hospital care are not more appropriate.

The Commissioning Strategy also advises of the need to have and apply clear and robust specifications for eligibility criteria to operate at all levels of service. (Ref. Page 15, Para 11 of Commissioning Strategy) in addition the Strategy describes the criteria for use of Psychiatric Intensive Care Unit beds as distinct from acute care beds (Ref. Page 46).

In support of this the NHS has invested significantly in community-based services since the introduction of the Mental Health NSF. Many of the community-based services are already in place for example Crisis Resolution and Home Treatment, Assertive Outreach, Early Intervention in Psychosis.

Community Mental Health Teams have been in place for a number of years.

'Change for the Better' will ensure all localities have community services in place which meet the best practice standard (i.e. Policy Implementation Guide Compliant)

Q. 2.1. iii). The model is not clear about the impact that this will have for service users and carers in the Boroughs.

For many service users there is currently no alternative to a hospital admission, resulting in a period away from the families, friends and work, which may have been avoidable. Patient surveys (locally and nationally) indicate that some patients find psychiatric hospitals threatening and unsafe environments with poor staffing levels and thus poor levels of service user staff interaction. This model will reduce the need for admission and, for many people, actually shorten the amount of time that they will remain as an in-patient. The increased staffing levels will help improve the time available for staff to engage in therapeutic interactions.

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[1] Care Services Improvement Partnership, *10 High Impact Changes for Mental Health*, 20th June 2006. An Executive Summary is also available.

The new model proposes the full development and establishment of crisis teams in all boroughs who will work with service users and carers in an alternative environment to an in-patient setting, this may be the person's own home or at another location.

For carers, the main theme has been about how to negotiate their way through the various health and social care systems. The introduction of Access and Advice services (referred to as Single Points of Access (SPAs) in the Commissioning Strategy, page 63) should improve this. These services provide expertise in assessment, gate-keeping and 'sign-posting'. Proposals to establish a Resource and Recovery Centres (ref. Page 15, section3, para. 12 of Commissioning Strategy) have been welcomed by service users, carers and staff alike.

Some carers and service users have expressed dissatisfaction with the location of Hollins Park for services and have asked that consideration be given to locating the Warrington RRC in the centre of the Town.

Q. 2.1 iv). The model is also unclear about any arrangements to ensure the safety and effective risk management of issues relating to individuals through the transition of services.

The delivery of safe services is a key priority for the Trust now and will continue to be so in the future. We will continue to develop joint protocols for admission and discharge and develop care pathways with our partner organisations.

As with any of the services provided by the Trust, the risks of service delivery are assessed as part of the Trust's Risk Assurance Framework and through its risk management systems. All of which have been subject to external scrutiny and audit and evaluated as providing significant assurance.

Additionally, partners and service users will be involved in the detailed planning and implementation of services. The Trust will continue its acknowledged high level of general involvement of its services users in its activities.

The assessment of risks for an individual service user will continue to be undertaken within the clinical process of Effective Care Co-ordination.

Q.2.2. There are concerns about the possible impact on other aspects of 5 Boroughs work, notably the Child and Adolescent Mental Health Services, where there is no clarity in the proposals outlined.

'Change for the Better' is about services for adults and older people who have functional mental health problems and was developed at a time when there was no agreed or cohesive CAMHS Commissioning Strategy. The proposals neither enhance nor detract from the provision of CAMHS services. Arrangements from transition of individuals from CAMHS to Adult services will continue as now.

Commissioners across the four boroughs of Halton, Knowsley, St Helens and Warrington have very recently developed a CAMHS strategy. The recently appointed Director of CAMHS and Psychological Therapy Services will be meeting with each of the Local Authority Directors with responsibility for Children's Services to develop a response to the commissioning strategy. Notwithstanding this, the issues that face CAMHS service continue to be progressed.

Q. 2.3. The Committee is concerned that the proposals do not properly meet the needs of a number of specific groups including:-

i) Older people with functional mental health needs

Many of the services not previously accessible to older people will be accessible to them in the new model e.g. Crisis Resolution and Home Treatment, and psychological therapies via enhanced day therapy provision. We have reviewed the various policy guidance documents and have not found anything that contradicts our position in respect of providing appropriate care and environments for people who are vulnerable of whatever age. We take the issue of caring for vulnerable people very seriously.

ii) People with dual diagnosis i.e. drug and/or alcohol and mental health problems.

The presentations have all clearly stated that the services will be accessible, as they are now, to people with a dual diagnosis much in the same way that services are for people with Schizophrenia. The services for people without mental health problems who have a drug or alcohol problem are managed through a separate service, which is not part of the consultation - indeed some of these services are currently being put out to tender by commissioners.

There is a need for further dialogue with commissioners on the delivery model for substance misuse services.

iii) People presently living in secure environments

Services for people who require secure services are not part of the model proposals or this consultation. These are specialist services and are commissioned by the specialist commissioning team and are provided in a number of locations across the North West (eg the Scott Clinic, John Denmark Unit and Ashworth Hospital) and Nationally (e.g. Learning Disability at Rampton Hospital and the unit for Dangerous People with a Severe Personality Disorder at Rampton and Broadmoor) Hospital). Those secure services provided on the Hollins Park site are also commissioned by the specialist commissioners and are not included in the proposals for change.

iv) People with personality disorders

This is a real challenge for all the health and social care community. Some estimates indicate as many as 1 in 20 people have a personality disorder. Most people with a personality disorder will not require the skills of specialist Mental Health Trusts, though changes in legislation may alter this position. Services are not currently commissioned from the 5 Boroughs Partnership for those people with a pure personality disorder and no mental illness. In the new model, people with a mental illness and a personality disorder will continue to be able to access treatment.

v) *Young people aged 16-17 years.*

The position re: transition arrangements is unaltered by these proposals and is currently being addressed through the Children's Strategic Commissioning and planning route. The CAMHs Commissioning Strategy identifies the deficit of services for young people of 16-19 years. This continues to be actively addressed by Health and Social Care.

The current deficits in service provision for young people need to be addressed through the implementation of the CAMHs Commissioning Strategy with commissioners pursuing the development of strong and seamless services for young people via whichever provider(s) they choose.

The Trust agrees that this is an area of high priority and is committed to working with commissioners and other partners to develop a range of services for young people

Q. 2.4.i). The Committee also has concerns about the proposals to mix in-patient settings for older people and younger adults. The Committee believes that this is contrary to acknowledged good practice.

This is currently the position in two out of the four Boroughs for older people (Knowsley and St Helens), and has been for some time, in accordance with locally commissioned service patterns.

All adult services, on occasions, have children aged 16-17 admitted, and more occasionally, children under the age of 16 have to be admitted as a last resort due to there being no alternatives other than paediatric wards. Neither of these options is satisfactory. (See also 2.4.ii)

The model is intended to reduce the risk for vulnerable people, of whatever age, in in-patient settings. We are committed to ensuring all vulnerable people are risk assessed and that the current environments are remodelled to provide separate areas within wards. The model also provides enhanced staffing in in-patient areas, which will allow 1-1 observation when required.

The Trust does not believe the proposals are contrary to current best practice guidance and have written to Local Authorities seeking clarification as to the Policy Guidance that it is thought that this approach breeches. To date we have not received any specific information. However, we are continuing to review the guidance and liaise with advisors of the Strategic Health Authority on this, and if there is further guidance that we have not considered then we would be happy to consider that guidance.

Q. 2.4.ii) .The Committee is also concerned that people under the age of 18 may be admitted to adult wards.

As noted earlier, the model will not alter the current position in the short term and requires consideration and action by health service commissioners regarding shortfalls of in-patient provision for young people.

Currently, young people under 18 are admitted to our in-patient wards, the alternative is, on occasion, a paediatric ward, neither of which is ideal. When a child is admitted to an in-patient ward all our staff have access to support from our Full-time Child Protection Specialist and access to the Mental Health Act Commission as described previously.

The Trust notifies the Mental Health Act Commission of every admission of a minor (under 16 years) into an adult in-patient bed. A visit is then made by the Commission to scrutinise the arrangements made to make care as appropriate as possible. A one to one nurse to patient ratio tends to be required. There have been 30+ admissions of young persons under the age of 17 years onto adult wards in the last year.

Cheshire and Merseyside have one of the lowest numbers of Tier 4 beds for this age group in the country, though agreement has been reached to provide more beds in the future. Very young children are admitted to Alder Hey provision and adolescents to a unit in Chester.

The development of Early Intervention Services (EIS) will help this position but not in the short term (services take up to three years to become operating at capacity). Not all Boroughs have a funded established EIS, in 'Change for the Better' this will be resolved

Q.2.5. There are concerns about the impact on alcohol services for adults and older people; the proposals contain a reduction of allocated beds for alcohol detoxification.

Currently, no funded bed exists for alcohol detoxification, nor will there or should there be in the new model. All but the most highly complex alcohol detoxification is carried out in the community. Complex alcohol detoxification often requires proximity to and the back-up of general medical care and intervention.

3. Financial Information

Q. 3.1. The proposals in the plan are not supported by robust financial data. It is not possible to identify the financial impact on services in the 3 Boroughs and the Committee believes that until this issue is addressed it will not be possible to complete the scrutiny exercise.

The financial data continues to be finessed and we have shared that financial detail available at the moment through individual iterative Borough meetings with both Health and Local Authority partners. This position is historically complex but we have committed to share further information. There is currently in train a process (Foundation Trust (FT) Diagnostic), which will result in a transparent position regarding funding being agreed between the PCT and the Trust. This information will be available before the close of consultation for the statutory agencies. The model is predicated upon the current level of investment by each PCT continuing at its current level.

Q. 3.2. There are a number of concerns in relation to financial issues, which are not clear in the proposals, including details of the impact of the £1m savings identified from back office functions and the £2.6m savings from cost releasing efficiency savings, which are not clearly stated in the proposals.

Currently funding is identified to manage the implementation of the new model; this budget is required for consultation, staff training and development. As part of our cost-efficiency action back office functions are expected to contribute to the reduction of the over-spend. The £2.6m relates to 'Gershon' action requirements, which is also applicable to Local Authorities. The £1m corporate contribution will limit the impact on front-line services and the Trust will manage this.

Q. 3.3. The model of care seems heavily reliant on significant capital investments in the Resource and Recovery Centres (RRCs). There is no clarity about the likelihood of this funding or contingency plans should the funding not materialise.

The funding is from our capital funding and it is available now for the minor (less than £200k) alterations. Funding has also been identified from the Trust's capital programme for work required in Peasley Cross Court.

The redevelopment of the Sherdley unit in the long term is subject to a Strategic Outline Business Case (SOBC).

A number of people have expressed the view that the in-patient services at Hollins Park should be relocated to central Warrington. We are not opposed to this idea, however, the proposals to develop in-patient services in Warrington does not form part of the current proposals, and would be subject to an SOBC.

Q.3.4 There is no clarity in relation to transitional resources. A significant shift in the type of services provided is likely to lead to the need for transitional resources to be invested, which will facilitate shifts in services.

The "Transitional" resources in fact have been invested over the last three years and equate to several £million (i.e. see previous details of community service developments). Additional resource has been allocated to the Trust to manage the latter stages of implementation of the model of circa £0.5million.

Q. 3.5. There are concerns about the workforce implications and, in particular, the impact on recruitment and the basis for decisions about filling posts.

The Trust is currently holding a significant number of vacancies at present, **around 10% of total. The model sees an overall reduction in staff numbers, although through re-deployment, enhanced staffing will be available for some services, e.g. in-patient facilities in RRCs**. It is anticipated that existing staff will fill the vast majority of posts identified in the new model.

The process for this will follow agreed best HR practice for Trust staff, **which was developed and agreed with staff side representatives.**

The Director of Workforce and Development in the Trust will be working with his equivalents in Local Authorities to ensure the implications of the various HR policies are understood and any action required is agreed with the Local Authority.

These issues will need to formally agreed as part of the Partnership Agreements most of which are in the process of being formally negotiated

Q. 3.6. The Committee is particularly concerned that Ashton, Leigh and Wigan do not appear to be properly factored in to the recovery plans. The Committee acknowledge a statement that they are not included in the process but feels that there is a lack of clarity about the financial impact of this.

Wigan services have to contribute to any Cash Release Efficieny Savings (CRES). In addition, Ashton, Wigan and Leigh PCT isactually wanting to continue to increase the PCT investment in Mental Health.

The FT diagnostic will provide transparent and agreed data for all.

Q. 3.7. The committee would like to know what the budget is for atypical drugs and a comparison of spends in each borough.

The previous figures that were made available were from third party provider organisations and had not been validated by the Trust, **and they showed significant variation that requires further review.**

We are keen to have accurate information regarding prescribing and expenditure and have commissioned a member of the Medical team to conduct an Audit in August. The issue is as much a governance issue as a financial one and the Trust would expect adherence to best practice guidelines by all parties

The developing SLA will cover the governance arrangements costs and practices associated with the prescribing of atypical anti-psychotic medications.

Q.3.8. There are concerns about the impact on out of borough placements. What are the current arrangements for joint placement?

The model proposes no changes to Health funded out of area treatments, the costs for which are currently met by the PCT.

Social Care out of borough **placements** will clearly remain the responsibility of the Local Authority and are not expected to be subject to, or impacted by, the proposal of 'Change for the Better'.

Q.3.9. Project management - funding for this and process. Will partners have a place on the project board?

Subject to conclusion of Consultation we would wish to establish local implementation teams (many based on existing multi agency structures). It is envisaged we will establish a Programme Board for the implementation of 'Change for the Better' and we would hope that Local Authority officers would be part of the Project Board.

Q. 3.10. Future funding priorities - given the pace of Government change we may have to look at a different model in the future. How can we resolve this?

We can only work with existing policy **and** it would be inappropriate to agree finances on unconfirmed policy. The proposed model is not only based on evidence it is also congruent with national policy. Both health and social care policy is subject to change continually in association with national policy direction and ongoing research into practice.

Q. 3.11. The Committee would like reassurance that finance invested by individual Boroughs remains within that Borough and is not used to subsidise other boroughs.

In respect of PCT investment this will be the case should the option for 4 RRC be approved. Clearly a number of indirect costs are apportioned across all of the five boroughs, e.g. Child Protection, Mental Health Act Managers, and Control of Infection.

It is possible that the impact of Patient Choice may affect this in the longer term, however, we estimate this will be marginal.

However, if a two-centre more centralised model is adopted, the money will follow patients as this service may be provided from 2 boroughs (i.e. on 2 sites not four. We hope this is not the case but this remains an option within the consultation.

4. In-Patient Beds

Q.4.1. There is some confusion in the various documents about the number of in-patient beds. The Committee has concerns about the level of service for people who would have been utilising these in-patient beds, particularly in the light of the described over occupancy.

The proposed bed numbers reflect the Royal College of Psychiatrists recommended lower level figures and are based on evidence nationally and locally. The numbers are as per the consultation document. The picture is slightly complicate due to the way occupancy is calculated i.e. figures include people who are on home leave and people from another borough. The model is based on future service delivery and configuration not the present i.e. the demand for beds in the future will be different than it is today because of the community service infrastructure.

It should be noted that the four boroughs have the benefit of a better developed community infrastructure to build upon as a starting point for further development than has been the case in some of the exemplar areas.

Q.4.2. The Committee were concerned that the proposals relating to in-patient beds do not include psychiatric intensive care.

Currently, only Wigan borough has a Psychiatric Intensive Care unit (PICU). Admission to a bed from another borough has been difficult at times.

These beds, and those new beds for which capital funds have been recently obtained, are additional to the numbers of beds proposed within the model. Funding for this service is outside of, and additional to, the current funding arrangements and remains so in the future model. It is a commissioning decision to fund or not to fund these beds.

The Commissioning Strategy states the need for at least one PICU with higher levels of security. We will have a service available before the end of the year, based on the Hollins Park site, that other Trusts are purchasing and would hope that local negotiations with PCTs will conclude shortly.

The availability of local beds will reduce Out of Area Expenditure by PCTs on such provision. The longer-term impact of effective community services in admissions for intensive care will need to be evaluated.

Q.4.3. The impact on Council services, particularly the impact on the infrastructure currently in place and the type of accommodation required in each Local Authority given the planned bed reduction.

Most people with metal health problems live at home and the model aims to ensure that this continues to be the case wherever possible.

It is important that people with mental health problems and their carers should be able to access mainstream services, though some may need support to do so. In many respects the Councils' planning will have addressed this, as capacity for services would have been designed to cater for all people irrespective of their disability. It is recognised that some of those services are currently not available to people at present in some boroughs.

The Commissioning Strategy refers to a range of supported accommodation being required with modernised day provision, not in institutional settings.

The numbers of people who require some form of special accommodation is not going to increase as an outcome of reducing the number of in-patient beds, but they will continue to require care packages to be planned. People who are currently likely to lose their homes or tenancies due to their illness and associated behaviours, would be provided with more support by community services and thus prevented from reaching that position

5. Access to Services

Q.5.1. The Committee is concerned about proposals to develop access and advice centres within each borough, as a single gateway to specialist mental health services. Based on the information provided, the Committee believes that further thought should be given to access to mental health services being from within Primary Care and other tier 2 services.

Access and Advice centres are an important part of the model. The Commissioning Strategy refers to such services as Single Points of Access (SAP) (Ref: p.63). The consultation is clear about what it proposes i.e. that these services are based in local RRCs. It is critical that such a service exists in a borough; it is less critical where it 'sits'. The Trust is actively considering a number of themes that have emerged from the consultation so far; this is one of those themes.

Q. 5.2. The Committee are disappointed that the RRC model seems mainly focussed on 9.00 a.m. to 5.00 p.m. services and the details of other out of office hours services are sparse. The Committee would welcome further information about staffing levels and implications for Council services out of hours.

The RRC is a 24-hour operation in terms of Crisis Resolution and Home Treatment and In-patient Beds. Assertive Outreach will be PIG complaint 8am to 8pm. Access and Advice services will also need to be operating 24/7.

The Enhanced Therapy sessions are indicated as 9-5 and from a resource perspective that reflects the "quantity" of time available. As the service becomes established we believe there will be opportunities to be more flexible about the times the resource is made available. The trust will trial different patterns of provision by spreading the available capacity over different hours and will respond to feedback from service users.

Q. The committee would like a comparison of Assertive Outreach Services – what currently exists and what will be required.

Investment in Assertive Outreach Services

	Current Investment* 000s	**Current Caseload**	**Future Investment**	**Future Caseload** 000s
Halton	£201	84	£426	84
St Helens	£412	72	£393	72
Warrington	£303	24	£303	60

*** Services are being provided at higher levels of input than that for which funding has been obtained through commissioning. The re-deployment of resources from in-patient provision will allow these services to be fully funded. In addition, working practices will be standardised to effect efficient delivery in all the teams**

The levels of Assertive Outreach will be Policy Implementation Guide (PIG) compliant and be sufficient to meet the anticipated demand. The table above reflects services from pre-PIG, currently and in the future

6. Impact on Council Services

Q. 6.1. The Model of Care refers to the impact on Council services including social care, however, the Committee were concerned that detailed information was not available.

The impact of new services, Assertive Outreach, Crisis Resolution, Early Intervention in Psychosis, and Access and Advice, have and will provide a positive impact for service users and carers.

In tackling the issue of stigma and prevention it is important that people with mental health problems and their carers should be able to access mainstream services.

In many respects, the Councils' planning will have addressed this, as capacity for services would have been designed to cater for all people irrespective of their disability to help ensure that people with a mental health problem are able to recover and resume their lives in mainstream society. This is inherent in social inclusion policies

Delivering care in people's own homes assists in the maintenance of the existing family and friend support mechanisms and networks. These are very often lost when a person is admitted to hospital, particularly for what may be a lengthy period currently. This would be expected to have the positive impact of reducing the levels of complex care packages.

The Trust is committed to the further development and agreement of detail with its partners for the delivery of integrated community services in support of the model, should it be supported.

Q. 6.2. The committee are unclear as to the future functioning of community mental health teams and how they will operate under the proposed model of care.

In response to the Comprehensive Health and Social Care Commissioning Strategy for Adults the NHS will target its resources on those with the greatest need (Enhanced CPA). The Strategy identifies the continuing need for a team of multi-disciplinary practitioner providing ongoing care and support to people with serious mental health problems.

Detailed operational issues will be progressed locally with Local authority and Trust staff.

Q. 6.3 The committee are concerned about the impact on Council day services given the proposal to close day units.

The Commissioning Strategy suggests that the need for day services as currently provided will 'melt away'. (Ref: pp 66-67). Many Local Authorities have already decommissioned day services. It is recognised that day services are not the most effective way to deliver modern mental health services, nor the most socially inclusive.

The Trust have offered to fund an independent assessment in respect of day services, however Local Authority officers have indicated they have the capacity to undertake this internally, discussions are ongoing on how best to progress this.

7. Consultation Processes

Q. 7.1. The committee are concerned that there was some evidence that the consultation processes did not appear to be thorough and adequate.

This Consultation reflects the Cabinet Office's code of practice for written consultations in addition to the Overview and Scrutiny of Health Guidance document. The six main criteria of the code are as stated below:

- Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.
- Be clear about what your proposals are, who may be affected, what questions are being asked and the time-scale for responses.
- Ensure that your consultation is clear, concise and widely accessible.

- Give feedback regarding the responses received and how the consultation process influenced the policy.

(**NB**: the formal consultation process has not yet reached this stage, as the public consultation does not conclude until 24th August, and the response date for statutory agencies has been extended until 15th September)

- Monitor the Trust's effectiveness at consultation, including through the use of a designated consultation co-ordinator.

(**NB**: This is being managed by an external company)

- Ensure your consultation follows better regulation best practice, including carrying out a regulatory Impact Assessment if appropriate.

(**NB**: This is in process)

The Trust has followed these guidelines and has obtained advice from the Strategic Health Authority and the Trust's solicitors.

The Trust expects to receive a Report of the Consultation on 30th August and intends to issue copy to partners thereafter.

Directors of the Trust have also attended Impact Assessment meetings with Local Authority Colleagues during April and May 06.

An information pack on the consultations is available.

Q. 7.2. The panel appreciate the extension of the timescale in relation to the Statutory Joint Scrutiny Committee, but feel that the timescales for the public consultation and the fact that they will still end on 24 August did not allow proper time for the full and proper involvement of service users, carers and staff.

Please refer also to the response above.

It should also be noted that the Trust has had the benefit of feedback and consultation with service users and carers regarding service provision, both informally and formally, over the last two years. E.g. via - The Acute Care Forum, the Patient and Public Involvement Forum (PPIF) (15th May '06) and local service user and carer groups. A formal consultation event, funded by St Helens PCT in 2004 as part of a review of local services, identified service user concerns and desires for changes in services, that have been further informed and confirmed since that time.

A series of 19 meetings were held with staff during the period 29th March and 25th April with more than 500 staff attending these.

In addition to the planned public consultation events, presentations have been

given to:
Local Implementation Teams/Mental Health Partnership Boards
Professional Executive Committees of PCTs
PCT Boards
Overview and Scrutiny Committees in all boroughs
Executive Officers of Local Authorities

A total of 12 planned public meetings and 19 other events have been held since 1st June 2006.

The formal Section 11 public consultation period of 12 weeks commenced on 1st June '06 and Section 7 consultation commenced at the same time.

Q. 7.3. The committee are concerned that publicity relating to the consultation process did not appear to be thorough and adequate, and there seemed to be a general lack of awareness amongst key professional groups and the public about the consultation process.

There was an issue initially in St Helens when advertising posters had not been delivered. This was identified early in the period, and was immediately addressed. We are not aware of any significant issues since then.

Two rounds of advertisements of consultation events have been placed in local press in each borough.

Consultation documents were issued to 190 people and representatives of organisations and all mental health service areas had documents and summary leaflets available for patients/clients and visitors.

As noted above, 19 meetings were held with staff in the services affected by the proposals. In addition, separate meetings have been and continue to be held for some groups of staff.

In addition to the public consultation meetings, there have been many borough-based meetings for many groups as referred to previously e.g.
Service User groups
Carers' groups
Primary Care Trusts
Professional Executive Committees of PCTs
Overview and Scrutiny Committees
Local Implementation Teams for the National Service Framework/ Mental Health Partnership Boards.
Voluntary organisations.

Arrangements were made for a group of service users to travel to Norfolk and Waveny Mental Health Trust to visit the services provided there.

Q. 7.4 The committee felt that some of the language used in the consultation events made it difficult for people to properly understand the issues.

This is helpful feedback, we have not received this comment before, though we recognise the issues are complex. We have given feedback to the presenters regarding the language used and apologise if this was not right on all occasions.

8. General Points

Q. 8.1. The committee felt that some general points were worthy of further consideration. These include:-

Q 8.1.i) The lack of clear links with existing commissioning strategies for adults of working age and older people:

The Trust is uncertain of the basis of this comment as the proposed model is based on the Comprehensive Commissioning Strategy. The older people's Commissioning Strategy was still in the process of development and finalising at the time that the new model was being considered around the boroughs. It is recognised, however, that there will be a need to dovetail service changes with the recently approved commissioning strategy for older people.

To assist in the cross-referencing of the proposals to the Commissioning Strategy, page references are noted on presentation slides and a separate reference paper has been compiled for the Joint Overview and Scrutiny Committee. (Appendix 1)

Q. 8.1.ii) The proposed Model of Care does not cover all recommendations of the scrutiny exercise "scrutiny of hospital discharge services for St Helens residents with mental health problems".

A joint health and social service action plan and response to the recommendations is in process and a report is to be provided to the Overview and Scrutiny Panel as previously advise by Jan East to Mike Wyatt on 8th June 2006. Changes made consequent to the action plan will carry forward into the new model.

Q. 8.1.iii). *The focus on carers within the proposed Model of Care seems weak and carers issues do not appear to have been properly addressed.*

This was highlighted early in the consultation period and action for carers could have been made more explicit in the Model of Care. However, the issue has been discussed at many of the public meetings and carer's needs are implicit in the model and in how we deliver all our services and use Effective Care Co-ordination. We have also been meeting with carers' representatives and carers' groups in different boroughs.

The Trust is committed to working with all partners to ensure that carers' issues are addressed.

A list of all the consultation events that have taken place is compiled and being updated regularly. The most recent update is available as an additional item of information for the Joint Overview and Scrutiny Committee.

Q. 8.1.iv) The need for a clear and robust training programme for staff at all levels to support the proposed changes.

This is well recognised by the Trust, thus an existing Assistant Director is to be seconded, from the 14th of August, to the post of Assistant Director Staff Development. His role will be to focus on and support the development of the workforce as required to support the model.

The additional staffing for in-patient areas will facilitate the ability to release staff for training

Q. 8.2. Governance and accountability arrangements – how will the new model fit with current agreements?

Internal to the Trust, its governance arrangements will continue, subject as now to external scrutiny for compliance against standards.

Locally in boroughs, these will continue to be agreed and exercised through the Partnership Agreements. The provision of integrated services has been a strong feature and benefit of local services and its continuation is an integral element of service delivery, whatever the model.

Externally, the future commissioning by PCTs will be through detailed Service Level Agreements rather than block purchasing. This will benefit the Trust and PCTs in greater clarity of what is funded and what is provided. This will enable improved governance to be applied.

Q. 8.3. Relationship with West Cheshire PCT - currently Halton provides a service to residents in Helsby and Frodsham. The committee requires further details about how this will be managed and financed in the future.

We will only in the future provide services for which the Trust is funded. We will be happy to provide services if they are funded.

Discussions are ongoing to this effect and we expect this issue to be resolved as part of the refining of financial allocations through the FT Diagnostic Process.

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5 Boroughs Partnership NHS
NHS Trust

Extracts from Commissioning Strategy for Adults
Illustrating Basis for the Proposals of Models of Care/Change for the Better

Element of Model	Comprehensive Commissioning Strategy	Page Reference
Direction of Change	'… services need to be fundamentally reorganised so that acute care, alongside most support and treatment, is provided at home rather than in hospital, except in the most of extreme circumstances, where the risk indicates no alternative to hospital admission. Despite the fact that the least restrictive alternative was enshrined as a principle in the 1983 Mental Health Act, hospital admission is too often the first response. Practitioners in the field often point out that there is sometimes no alternative to admission, hence local inpatient units running at over 100% bed occupancy. This situation is clearly not sustainable in the medium to long term. It places intolerable pressure on inpatient services, it constitutes a disproportionate drain on resources, and it serves to maximise the disruption, which an episode of mental illness has on service users and their carers. All of these factors fly in the face of the modernisation agenda, but are often cited as reasons why the shifts cannot take place.	Page 62
Resource and Recovery Centres (RRCs)	New mental health resource and recovery centres should be commissioned in each borough, capable of delivering effective evidence-based care and management of clients with serious and/or enduring mental disorders. Future bed provision for each locality should be based on current Royal College of Psychiatrists projections, which assumes full provision of comprehensive community services. Resource centres will operate within the recovery model philosophy and continuum.	Page 15. Section 3 para.12
Eligibility Criteria	Development of clear and robust specifications, care pathways, contracts and eligibility criteria for all services operating at all Tiers.	Page 15. Section 3 para.11

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Element of Model	Comprehensive Commissioning Strategy	Page Reference
Recovery Model	Over the next five years two fundamental shifts need to take place to transform mental health services across the four boroughs. Firstly, clinicians and support services should join together to develop a model of care and treatment based on recovery principles, to maximise ordinary life chances of service users and their carers, to ensure social inclusion.	Page 62
RRCs and Workforce Training and New Ways of Working	Workforce development and configuration should ensure that the full potential of all professions is realised in the development of resource and recovery centres. The potential of new roles such as Nurse Consultants, Support Time and Recovery workers and the Social care workforce should be maximised.	Page 15. Section 3 para.13
Non-age discriminating service access	An end to the current age-related demarcation lines and transfer of mental health care between working age and older people's services.	Page 5. Section 1
Principles of service configuration	'… elements and principles of service configuration, which need to be in place across the area: • A multi-agency network of recovery focused services. • An end to the current age-related demarcation lines and transfer of mental health care between working age and older people's services. • A service, which supports vulnerable people appropriately and safely. • A focus on community-based provision, which offers more choice, as close to home as possible. • Support to families and carers according to need, with assistance to help maintain contact with service users receiving care in services provided outside their immediate home district'	Page 5. Section1

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Element of Model	Comprehensive Commissioning Strategy	Page Reference
- **Bed Reduction** - **Alternative of Crisis Resolution and Home Treatment** - **Shift of resource deployment from in-patient provision to community** - **Evidence of effectiveness of community network on in-pt bed use**	' … the four boroughs experience a relative over-supply of acute psychiatric inpatient beds per head of population compared with other nearby areas.' • Recent guidance suggests that the amount of inpatient provision required more often depends on, and is a function of, the range of other services available locally • Home Treatment services for acutely ill people should be the main source of support • Acute in-patient services should be provided as near to a person's home as possible with a minimum of travel for families to visit and remain involved in their care and treatment. • If the in-patient stay is in hospital, a range of treatment, therapy, and recreational activities should be offered to ensure that people are supported to return home promptly	Page 46, Section 7
	(Referring to the idiosyncratic development and post-code lottery of service developments) 'This pattern is compounded by long-term, chronic under investment in services which has led to **an emphasis on in-patient provision at the expense of a range of community based support and treatment**. A vicious circle arises wherein in-patient services are over-used in the absence of community alternatives maximising the disruption to service users ordinary lives. Despite all this it is universally acknowledged that there should be a shift of emphasis towards developing a spectrum of community services of sufficient diversity to meet local needs. There is **ample evidence (such as in North Birmingham and Newcastle) that such developments reduce the demand on in-patient facilities.'**	Page 55

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Element of Model	Comprehensive Commissioning Strategy	Page Reference
	Some of the current in patient units will require refurbishment to ensure that these units meet acceptable standards. Although this strategy seeks to reduce the number of these beds, this will not happen overnight and currently the poor quality of these environments has a negative impact on the therapeutic milieu and well-being of the people using these services.	Page 77
Requirement for improved in-patient environments and, creation of integrated community services network to support RRC	• Community facilities are inadequate and lack co-ordination between agencies. They do not fully support the recovery model. • Whilst none of the acute inpatient units is ideal, some have to be acknowledged as worse than others	Page 47
Crisis Resolution and Home Treatment	These services will be the key drivers for transformational change. There needs to be a clearly understood demarcation between the two components of the service. Crisis resolution bears down on the specific components of a mental health crisis, offering intensive support to minimise further harm and restore the service user and their carers to an acceptable level of personal functioning. Crises are often triggered suddenly by a hazardous event for a previously vulnerable person. This requires a rapid response to avoid further harm or deterioration. Home treatment may be delivered before or after a crisis, or in unrelated circumstances, where an appropriate level of care and treatment is provided at home. This may previously have been provided in hospital. Both services are characterised by a flexible approach to risk taking and management, with the primary goal of improving the future functioning of the service user. Both also require the capacity to provide highly intense support. CRHT teams must deliver a real alternative to hospital based care.	Page 65

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Element of Model	Comprehensive Commissioning Strategy	Page Reference
Access to PICU beds with level of security	The cost of PICU placements constitutes approximately 1% of OATs budgets and is significant high cost expenditure *(Ryan et al 2005)* to PCTs.	Page 48
	Purchase of acute psychiatric bed activity, including PICU beds from the private sector, should be eliminated within the first year of the provision of (CRHT)(financial year 2006-7). The money released should be used to further enhance local community mental health infrastructure. • To manage such cases, at least one PICU in the 5 Borough NHS Trust should be able to provide higher levels of security. • The Trust will ensure that it has common policies across all services to ensure a consistent approach.	Page 49
CMHTs	The twin pillars of contemporary public policy, service modernisation and community regeneration, pose particular challenges for community mental health services. The new specialist services, such as Assertive Outreach, question the continuing role and function of established CMHTs. It is important therefore to develop a strategic overview of how services fit together and collaborate to deliver a spectrum of care reflecting local needs. The modernisation agenda has also challenged traditional resource rather than needs-led service delivery.	Page 53

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Element of Model	Comprehensive Commissioning Strategy	Page Reference
Clinical Leadership **Continuation of integrated provision/Partnership Agreements**	The move away from generic CMHTs towards increasingly functional services offers the chance to develop a range of community teams which more appropriately reflect a service user's needs along their support and care pathway. These functionalised teams should be fully professionally integrated with clinical and managerial leadership. They should be the primary focus and working environment of all practitioners. The workforce should be representative of the communities, which they serve including service users. A successful Community Service will also require integrated single line management across health and social care, with or without organisational integration. The teams should provide parallel services for carers.	Page 62-63
	The introduction of functionalised teams undoubtedly serves to question the future role and function of generic CMHTs. However it is clear that there will continue to be a need for geographically based multi-disciplinary teams to provide ongoing support and care to those with serious and enduring mental health problems. These teams will refocus on promoting recovery and social inclusion, and the provision of support to carers. They will also be best placed to develop relationships with local communities and lead the promotion of good mental health for all. Furthermore they will develop the micro-commissioning capacity of the system through recovery care planning.	Pages 65-66
Cessation of traditional day services	For example, the "one size fits all" day centre is no longer adequate to meet the expectations generated by Effective Care Co-ordination through individualised care planning.	Page 53

Element of Model	Comprehensive Commissioning Strategy	Page Reference
	A range of cost effective initiatives can be launched by local mental health services in order to integrate them in local communities including: • Delivering of care and treatment in community settings, rather than specialist facilities such as day centres • Establishing a consistent presence on community forums • Organising mental health promotion programmes • Developing a collaborative approach with other service providers, sharing information and resources • Engaging in community safety initiatives Initiatives such as these require staff to do things differently rather than doing extra, and will reveal their cost effectiveness through prevention and the economies of partnership.	Page 54
Development of consistency of integrated community network of services across boroughs	The absence of a single strategic vision across the four boroughs meant that services developed haphazardly, often driven only by the commitment and enthusiasm of local clinicians and managers. As a result there may be no obvious relationship between local provision and local need, as in the availability of psychological treatments. This is equally true in the relationship between needs and expenditure. A post-code lottery continues to exist in the prevalence of mental health services across the area.	Page 55
	The four key elements of integrated community support services are: - • A broad spectrum of supported accommodation: service users and carers frequently cite appropriate accommodation as one of their top requirements. Clinicians and practitioners share this view and often point to the absence of suitable accommodation as contributing to relapse, hospitalisation and problems with timely discharge. Because	Pages 66-67

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Element of Model	Comprehensive Commissioning Strategy	Page Reference
	of the diversity of accommodation needs amongst service users, a spectrum of options should be available so that service users are not placed where there is a vacancy, rather where their needs are best met. • Modernised day services delivered in community rather than institutional settings with a focus on employment, education and training. Local services need to become much more flexible to the needs of individuals and groups of service users which are mediated through Care Co-Ordination. This will involve doing new things and doing things differently, as well as exploiting the capacity of mainstream community services through the use of resources and joint initiatives. Over time the requirement to have day centres will melt away as services are increasingly provided in non-stigmatising community based venues. One measure of the success of this initiative will be the extent to which currently excluded groups, such as minority ethnic groups, are engaged by services. • Accessible therapies: Service users frequently point to the lack of available therapies, where and when they need them. Commissioners must consider how current psychological therapies could be delivered in more cost effective formats in more accessible locations e.g. Primary Care and Community Based Settings. • Support, Time and Recovery (STaR) Teams: The Department of Health's recent initiative to develop non-professionally affiliated staff into STaR workers presents the local health economy with an important opportunity to develop existing resources. This programme offers staff the opportunity to develop new skills in the promotion of recovery and social inclusion, which will supplement and support the work of the functionalised teams. This programme is also appropriate for support staff in day services and accommodation schemes, across health, social care and the Independent Sectors.	

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Element of Model	Comprehensive Commissioning Strategy	Page Reference
Access and Advice Services (Single Points of Access – SAP) **Clinical Leadership**	A single point of access for all referrals to specialist mental health services should be located at the interface with Primary Care, using Graduate Primary Care and Gateway staff. This part of the service will provide support to Primary Care teams as well as an assessment and sign-posting function. It will also regulate the flow of work into specialist services. The SPA will be the gateway into specialist services; it will perform an ambassadorial function and will therefore place a heavy emphasis on customer care. They provide expertise in assessment and gate keeping, and can accumulate a wealth of knowledge about services and resources to assist in effective signposting towards appropriate assistance for service users. These teams should be multi-professional and include clinical leadership, to enrich initial contact with services and facilitate speedy assessment.	Page 63
Early Intervention in Psychosis Service enhancement and close relationship required with Access and Advice service – both proposed to be sited in RRCs	Currently these staffs are deployed in individual CMHTs. In order to harness this expertise, and ensure that the whole system retains ownership of the principles of early interventions, it may be appropriate to locate these staff together at the interface with Primary Care in the Single Point of Access Service. In order to ensure consistency of performance, and conformity to Service Governance, these services should be supported and managed from a central point in the 5 Boroughs Partnership Trust.	Page 64
Assertive Outreach services	Good progress has been made throughout the four boroughs in achieving targets related to introducing Assertive Outreach Teams. However, it is vitally important for the transformation of services that the integrity of the model is preserved, particularly where there may be a temptation to use AO Teams to supplement the work of overloaded CMHTs. This is important because AO has the potential to be a significant change agent for local systems in general. If these teams are successful in engaging those service users who are the most reluctant, alienated or excluded, then lessons on	Page 64

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Element of Model	Comprehensive Commissioning Strategy	Page Reference
	how this is done can be learned by other areas of service. Furthermore, AO can be a creative and imaginative service element, if it is prepared to manage risks whilst doing things differently. This will stimulate the development of the whole system. Currently AO services exist as a bolt on to community services rather than a lever for modernisation of community services, particularly CMHTs. No benefit is realised in current service provision from the economies of scale that a pan-borough trust could provide for specialist team configuration and provision	

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