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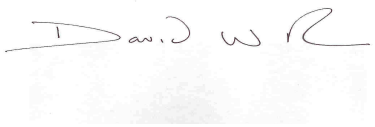
HALTON BOROUGH COUNCIL

Statutory Joint Scrutiny Committee

Thursday, 19 October 2006 4.00 p.m.
Civic Suite, Town Hall, Runcorn



Chief Executive

COMMITTEE MEMBERSHIP

Councillor Ellen Cargill (Chairman)
Councillor Diane Inch
Councillor Kath Loftus
Councillor Bowden
Councillor McGuire
Councillor Topping
Councillor Banner
Councillor Hoyle
Councillor Johnson

Please contact Caroline Halpin on 0151 471 7394 or e-mail caroline.halpin@halton.gov.uk for further information.

ITEMS TO BE DEALT WITH
IN THE PRESENCE OF THE PRESS AND PUBLIC

Part I

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.

Agenda Item 1

St.Helens Council

HALTON BOROUGH COUNCIL

Warrington Borough Council

Town Hall, St. Helens, Merseyside, WA10 1HP
Telephone 01744 456110 (Tina Molyneux)

Agenda

STATUTORY JOINT SCRUTINY COMMITTEE 5 BOROUGHS PARTNERSHIP NHS TRUST

Proposals Relating to Improving Services for Adults with Mental Health Needs in Halton, St. Helens and Warrington

Date: Thursday, 19 October 2006 Time: 4.00 p.m. Venue: Civic Suite, Runcorn Town Hall, Hall Heath Road Runcorn, Cheshire WA7 5TN

Membership

Halton	**3**	**Councillors**	**Cargill (Chairman), Inch and Loftus**
St. Helens	**3**	**Councillors**	**Bowden (Vice Chairman), McGuire and Stephanie Topping Ronan (Substitute for Councillor McGuire)**
Warrington	**3**	**Councillors**	**Banner, Hoyle and Johnson**

STATUTORY JOINT SCRUTINY COMMITTEE

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5 BOROUGHS PARTNERSHIP NHS TRUST PROPOSALS RELATING TO IMPROVING SERVICES FOR ADULTS WITH MENTAL HEALTH NEEDS IN HALTON, ST. HELENS AND WARRINGTON

Minutes of the meeting of this Committee held on
7 September 2006

(Members Present)

Halton Council

Councillors Cargill and Loftus

St. Helens Council

Councillors Bowden, McGuire and Stephanie Topping

Warrington Council

Councillors Hoyle, Johnson and Wright

(Not Present)

Halton Council

Councillor Inch

Warrington Council

Councillor Banner

(Also Present)

Halton Council

Dwayne Johnson, Strategic Director, Health and Community
Audrey Williamson, Operational Director Adults of Working Age

St. Helens Council

Carole Swift, Service Manager Carers and Scrutiny
Mike Wyatt, Assistant Director, Performance and Business Support

Warrington Council

Alison Williams, Overview and Scrutiny Officer
Helen Sumner, Strategic Director, Community Services

Tina Molyneux, (Clerk to the Committee),
Senior Democratic Services Officer, St. Helens Council

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19 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Banner and Inch. Councillor Wright attended as substitute for Councillor Banner.

20 MINUTES

* **Resolved that the minutes of the meeting held on 24 August, 2006 be approved and signed.**

21 **DECLARATIONS OF INTEREST FROM MEMBERS**

No Declarations of Interest from Members were made.

22 **RESPONSE TO PUBLIC CONSULTATION (MENTAL HEALTH STRATEGIES REPORT)**

A report was submitted which informed Members of the Response to the Public Consultation (Mental Health Strategies Report).

Carole Swift, Service Manager Carers and Scrutiny outlined the report.

The report detailed the following:

- Executive Summary
- Introduction
- Methods
- Raw Data Collection for Public Consultations
  - Public Consultation Introduction
  - Public Consultation Process
  - Staffing Table
  - Resources Table
  - Communication Table
  - Accessibility Table
  - Services Table
  - Overall Public Comments Chart
- Raw Data Collection for Staff/Internal Consultations
  - Staff/Internal Consultation Introduction
  - Staff/Internal Consultation Process
  - Staffing Table
  - Resources Table
  - Communication Table
  - Accessibility Table
  - Services Table
  - Overall Public Comments Chart
- Common Issues across Public and Staff Consultations
- Raw Data Collection from all other Correspondence
- Summary and Overarching Issues
- Area for Consideration

Members discussed the report.

* **Resolved that the report be noted.**

23 **FEEDBACK FROM VISIT TO NORFOLK**

A report was tabled which detailed the findings of the Visit to Norfolk Mental Health Services on 29-31 August 2006.

The report provided stakeholders information in relation to the visit to Mental Health Services in Norfolk and made recommendations as to how local Mental Health Services may learn from the 'Norfolk' experience.

* **Resolved that the report be noted.**

24 **FINANCIAL INFORMATION FROM THE 5 BOROUGHS PARTNERSHIP NHS TRUST**

It was reported that the 5 Boroughs Partnership NHS Trust had neither provided any general financial information or the specific financial information requested by the Statutory Joint Scrutiny Committee in time for consideration by the Statutory Joint Scrutiny Committee.

General financial information had however been sent to the Chief Executive's of each authority.

* **Resolved that the Committee express their disappointment to the 5 Boroughs Partnership NHS Trust at the lack of financial information.**

25 **STATUTORY JOINT SCRUTINY COMMITTEE - DRAFT REPORT**

A draft report was submitted which set out the findings of the Statutory Joint Scrutiny Committee established by Halton Borough Council, St Helens Council and Warrington Borough Council to consider the 5 Boroughs Partnerships NHS Trust's Proposals to Improve Services for Adults with Mental health problems (summarised in the document "Change for the Better"). The report set out the background to the consultation process, the methodology employed by the Committee and the Committee's findings in relation to various aspects of the proposals. The report closes with a conclusion and recommendations for the 5 Boroughs Partnership NHS Trust.

The Committee formally thanked all those who had contributed to the scrutiny process, and provided information for the Committee, which had helped in its deliberations. The Committee acknowledge that much of the information had been provided to demanding timescales, and would like to thank respondents for the efforts that they have made.

The draft report was outlined through each point and Members made comments as follows.

- A letter had been received by the Chairman which explained that Knowsley did not wish to participate as they decided that the proposal did not constitute a substantial variation
- Following the visit to Norfolk and Waveney it be noted that separate provision was made for older people in Norfolk and not treated as adult inpatient wards
- Carers - the Committee believed their needs should have been explicitly addressed

- The Committee wished to express their disappointment that they did not receive any detailed financial information
- The comparison with Norfolk and Waveney was flawed from a financial basis as the model was implemented in Norfolk to modernise services with a substantial level of investment rather than to achieve financial balance
- The availability of Specialist Workers linked to GP Surgeries in Norfolk and Waveney was perceived as one of the benefits of the model
- In Norfolk and Waveney separate inpatient facilities were provided for adults and older people
- Consultation process appeared to be in accordance with minimum requirements
- The Committee felt that in the consultation report it made a recommendation that "the general direction and framework of the new proposed model be adopted by the Trust with due consideration" and that the focus should have been on the outcome of consultation rather than making recommendations
- The Committee were unable to identify whether a risk assessment of the proposals had been carried out and whether effective risk management arrangements were in place
- Concerns were expressed about proposals relating to Thorn Road Day Centre
- The Committee supported the view reported in the analysis of public and internal consultation that the Hollins Park site is stigmatising and isolating and that the Gatehouse service offered a more appropriate venue
- There appeared to be a lack of agreement between Warrington Primary Care Trust and the 5 Boroughs Partnership NHS Trust as to the proposed levels of investment to support the model of care. This left the Committee with grave concerns about the future safety and viability of the service
- The lack of clarity about staffing proposals and appropriate workforce planning
- The Committee felt recommendations 1 and 2 should be merged

Recommendation 2 to read that:

- The 5 Boroughs Partnership NHS Trust and the relevant primary care Trusts should work closely to ensure that the necessary investment and range of community services are available to support the implementation of any model of care

- Halton and St Helens Primary Care Trusts, and Warrington Primary Care Trust, should review spend on mental health services in the boroughs to ensure that it is brought more closely in to line with national average, and that it properly meets the needs of residents of the boroughs.

Recommendation 3 to read:

- The 5 Boroughs Partnership NHS Trust should respond in writing to the Committee about the issues raised in the report and the recommendations within 28 days of its receipt.

The Committee unanimously agreed the report.

STATUTORY JOINT SCRUTINY COMMITTEE

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The Committee thanked all officers involved in the Statutory Joint Scrutiny Committee for their diligent work throughout the process.

* **Resolved that:**

(1) the report be noted;

(2) the amendments be made to the report as requested by the Committee;

(3) there be delegated to the Chair, Councillor Cargill, Vice Chair, Councillor Bowden and representative Member from Warrington, Councillor Hoyle to agree the final report;

(4) the final report be forwarded to the 5 Boroughs Partnership NHS Trust; and

(5) The Committee thanked all officers involved in the Statutory Joint Scrutiny Committee for their diligent work throughout the process.

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Statutory Joint Scrutiny Committee

5 Boroughs Partnership NHS Trust

Proposals Relating to Improving Services for Adults with Mental Health Needs

In Halton, St Helens and Warrington

1. Introduction

This report sets out the findings of the Joint Scrutiny Committee established by Halton Borough Council, St Helens Council and Warrington Borough Council to consider the 5 Boroughs Partnership NHS Trust's Proposals to Improve Services for Adults with Mental Health Problems (summarised in the document "Change for the Better"). The report sets out the background to the consultation process, the methodology employed by the committee and the committee's findings in relation to various aspects of the proposals. The report closes with a conclusion and recommendations for the 5 Boroughs Partnership NHS Trust.

The committee would like to formally thank all those who have contributed to the scrutiny process, and provided information for the committee, which has helped in its deliberations. The committee acknowledge that much of the information has been provided to demanding timescales, and would like to thank respondents for the efforts that they have made.

2. Background

On 1 June 2006 the 5 Boroughs Partnership NHS Trust launched a consultation document "Change for the Better – Improving Services for Adults with Mental Health Needs". The consultation document proposed changes to mental health services for adults in the four boroughs of Halton, Knowsley, St Helens and Warrington. The date initially identified for the end of the statutory consultation process was 24 August.

Three of the four local authorities – Halton, St Helens and Warrington – considered that the issues identified in the proposals would represent a substantial variation in the provision of health services in their area. An agreement was reached to form a Statutory Joint Scrutiny Committee. Knowsley were invited to join the committee but did not participate having decided that the proposal did not constitute a substantial variation.

The committee met on 20 July, 10 August, 24 August and 7 September. The committee was later informed that the timescale for response for statutory agencies, including the committee, was extended to 15 September.

3. Methodology

The committee was established in accordance with the "Local Authority (Overview and Scrutiny Committee Health Scrutiny Functions) Regulations 2002". The committee comprised of three elected members from each of the local authorities

involved, and the decision was made by each local authority to waive political proportionality.

The committee agreed the following terms of reference:-

- To establish a statutory joint committee to scrutinise proposals from the 5 Boroughs Partnership NHS Trust to improve services for people with mental health needs in the boroughs of Halton, St Helens and Warrington.

- To undertake the scrutiny of proposals in accordance with the Local Authority (Overview and Scrutiny Committee Health Scrutiny Functions) Regulations 2002, and the Directions to Local Authority (Overview and Scrutiny Committee, Health Scrutiny Functions) July 2003.

- To complete a report outlining the statutory committee's views of the proposals and to make recommendations to the 5 Boroughs Partnership NHS Trust where relevant.

- To monitor the Trust's responses to the report, and agree mechanisms for the ongoing monitoring of future changes to mental health services.

The committee agreed protocols and methodology for its working practices. Having read copies of the consultation document "Change for the Better" (attached as Appendix 1), the committee identified key issues and established an outline work programme, taking into account the tight timescales for the work.

The committee identified a list of key issues and wrote to the 5 Boroughs Partnership NHS Trust and invited them to attend the meeting and respond to these issues. A copy of the 5 Boroughs Trust response is attached as Appendix 2.

Similarly, the committee identified key issues for PCT commissioners in each of the boroughs, and wrote to them with a list of key issues. The PCT's response is attached as Appendix 3.

A press release was issued in each of the three boroughs, and written responses to this were considered by the committee. The committee also considered a range of other information including:-

- A financial report presented by the 5 Boroughs Partnership NHS Trust.

- A report of public consultation undertaken by Mental Health Strategies working in association with the 5 Boroughs Partnership NHS Trust.

- Reports of visits by officers and some service users to Norfolk and Waveney to see the model in operation.

4. Findings of the Committee

4.1 Impact on Service Users

4.1.1 General

The committee welcomes the aspirations of the model to see fewer people admitted to hospital and more people provided with services in the community. The committee also supports the model's intention of ensuring stays in hospital are as short as possible, and only those requiring hospital admission are admitted.

The committee is concerned, however, that the proposals in their present form do not satisfactorily explain how these aspirations will be achieved. The committee's concerns are outlined in this report, and explained below. The committee is concerned that deficiencies in the document and proposals, may actually lead to a decrease in support and services for vulnerable adults with mental health problems, particularly those living in the community.

4.1.2 Particular Client Groups

The committee notes that the document aims to improve services for adults with mental health needs, and in section 1.3 of the consultation paper it explains a number of service areas which are excluded from the process. The committee were not able, therefore, to formally examine these services, but it has become clear during the scrutiny process that there are many linkages between all these services, and whilst acknowledging that work is being carried out in a number of areas, the committee would still wish to make the following comments about a number of groups which are not properly dealt with in the proposals.

- *Dual Diagnosis* – the committee are not satisfied with the arrangements for service users with a dual diagnosis of mental health problems and alcohol and/or drug problems. However, they do acknowledge the 5 Boroughs Partnership NHS Trust's commitment in Section 2.3 ii of Appendix 2 assuring that this group will be given a high priority.

- *Adults in secure environments and psychiatric intensive care units* – the committee understands that adults in these environments are being dealt with separately. However, the proposals do seem to have some linkages with these inpatient services and the committee are disappointed that these have not been properly considered.

- *Personality Disorder* – the committee feel that more attention should have been paid to adults with a personality disorder as this is likely to impact on community services.

- *Young People* – the committee welcomed the high priority afforded to this in section 2.3 appendix 2, but are concerned that the issue of young people being admitted to adult wards is not being satisfactorily addressed, and the reduction in in-patient beds may have some impact on young people over the age of 16.

- *Older People* – the committee is particularly concerned that the proposals do not effectively meet the needs of older people, and do not link effectively with the Older People's Commissioning Strategy for the three boroughs. The committee note and support the comments about ensuring that people are not discriminated against in terms of their age, however, they believe that this does not properly reflect the complex needs of older people, particularly those older people requiring inpatient services. The committee continue to have concerns about the proposals to have older people and

younger adults on the same inpatient wards. Although the proposed model is based on that developed in Norfolk and Waveney, the committee noted that separate provision is made for older people in Norfolk and they are not treated on adult inpatient wards.

The committee acknowledged the 5 Boroughs Partnership NHS Trust's comments relating to developing a Commissioning Strategy for Older People with Mental Health Needs, but feel that this should have been properly considered and factored in to the proposals before they were published.

The committee feel that the issue of older people requires much more detailed attention, particularly in relation to inpatient settings.

- *Carers* – the committee note the view put forward by the 5 Boroughs Partnership NHS Trust that carers issues are implicit in the model. However, the committee believes their needs should have been explicitly addressed.

4.2 Financial Implications

The committee acknowledged that the 5 Boroughs Partnership NHS Trust need to ensure financial balance, and would wish to support the Trust in achieving this.

The committee have not been provided with thorough and detailed financial information about the present and proposed services. Whilst acknowledging some of the complexities of these issues, the committee is surprised that the financial information is "continuing to be finessed" at such a late stage in the consultation process. The committee are very disappointed that they did not receive any detailed financial information and this is a serious deficiency in the model. Some very general financial information was received on 7 September and this is attached as Appendix 4.

The Committee is aware that the overall level of investment in Mental Health Services is significantly below the national average in Halton and St. Helens. Although investment is close to the national average in Warrington, Warrington has significant ongoing commitments to ex-Winwick Hospital residents who still live in the Borough. In the light of this overall situation the proposals contained in the Model of Care to significantly reduce expenditure on services and to dramatically reduce the number of inpatient beds, is in the Committee's view, likely to be impossible to achieve.

The committee has made the following findings in relation to the financial implications based on the information it had access to :-

- There is no detailed financial information in relation to the savings which are to be achieved from back office functions (£1m) and the cost releasing efficiencies savings (CRES) of £2.6m. It is not clear how these savings will impact on adult mental health and other relevant service areas.

- The model of care proposals rely heavily on capital investment. The committee support concerns about the inadequacy of present facilities in the three boroughs, and welcome the confirmation that capital funding for

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some of the developments has been achieved, but the fact that other capital funding is still subject to bids at this late stage in the consultation processes causes concern. The committee note that there do not appear to be effective contingencies in place if the capital funding is not secured.

- Transitional resources – the committee feel that the issue of transitional resources has not been properly addressed. Such a significant change would require major investment, and the committee is not assured that appropriate resources have been identified and/or put in place.

- The comparison with Norfolk and Waveney is flawed from a financial basis as the model was implemented in Norfolk to modernise services with a sustained level of investment rather than to achieve financial balance. Norfolk and Waveney also had high levels of investment in community services to support the development of the model.

- Ashton, Leigh & Wigan – the situation relating to Ashton, Leigh and Wigan is difficult for the committee to understand. The committee understands from various professional that the situation is complex, but again, the committee feels that this should have been resolved prior to the finalising of the proposals and the consultation process. The Committee is concerned that the savings targets appear to be allocated to only four of the five boroughs served by the Trust as Ashton, Leigh and Wigan have been excluded.

- Out of Area Placements – the committee feels that the large reduction in inpatient beds may actually have implications for both Primary Care Trusts, and Social Care Services, in financing additional out of area placements. The committee is not satisfied with the 5 Boroughs Partnership NHS Trust's response that alternative services will be in place, particularly in the early years of the model.

- The committee is confused about the issue of indirect costs which need to be apportioned across different boroughs. Again, the committee felt that this should have been addressed as part of the planning process, and before the consultation stage was reached.

The limited financial information available to the committee indicates significant disinvestment in each of the three boroughs. These shifts in expenditure are likely to have a significant impact on services in the borough. When this is set against the relatively low spend on mental health services which the 5 Boroughs Partnership NHS Trust refers to, the committee has difficulty in seeing how the model can lead to improved services for service users and carers.

4.3 Access to Services

The committee supports the view that community based services normally offer better outcomes for service users and carers. However, the committee have strong concerns about the fact that the reduction in inpatient beds, coupled with a significant decrease in funding proposed, will see a tightening of eligibility criteria which will impact on people's access to mental health services. It seems clear that if the

following factors are combined:-

- A reduction in the number of inpatient beds,
- An increase in the number of people receiving services in the community,
- An overall decrease in staffing,
- An increase in staffing in inpatient services,
- An overall significant decrease in budgets,

that this will lead to a greater rationing of services. It is difficult to see how this fits with the promotion of early intervention and community based services.

The committee also have concerns about proposals to have access and advice centres in each borough. The committee is pleased that this issue is being actively considered by the Trust, but is disappointed about the lack of detail in the response, as it believes single points of access may actually serve to exclude some service users, and that other models of access i.e. through primary care, may actually do more to promote the types of services being proposed in the model. The availability of specialist workers linked to GP surgeries in Norfolk and Waveney is perceived as one of the benefits of the model.

4.4. Inpatient Services

The committee understands that if community services are enhanced, and inappropriate admissions are avoided, then the number of inpatient beds will decrease. However, the committee has serious concerns about the proposed reduction in inpatient beds. The committee has the following concerns:-

- There does not appear to be any phasing of the reduction and the assumption leads to dramatic reductions in Warrington and Halton, with the number of beds in Halton reducing to 38 from 60, and in Warrington to 32 from 60.

- The committee notes that the number of beds is the lowest level recommended by the Royal College of Psychiatrists, as stated by the 5 Boroughs Partnership NHS Trust, but the committee feels that achieving these lower level figures may not be realistic in the three boroughs.

- The 5 Boroughs Trust acknowledge in Appendix 2, Section 2.1 ii that this level of beds is only recommended when the appropriate level of community services is in place. The committee is not satisfied that these services are in place in the three boroughs, and is concerned that the proposals will reduce Community Services further.

- The recommended figures apply to the number of beds for adults under 65. As the 5 Boroughs Partnership NHS Trust are presently proposing to include inpatient beds for older people in the numbers, then it would appear that the actual number of beds available to adults (excluding older people) would fall below the minimum.

- In Section 2.1 ii of Appendix 2, the Trust states that many of the community services are "already in place". If this is the case, then the committee is uncertain why inpatient facilities are presently experiencing levels of over-occupancy, and how these community based services will manage when the

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number of inpatient beds have significantly decreased. The Committee believe that current bed usage should be demonstrably reduced before further bed reductions can be safely achieved.

- The committee note the intention to combine inpatient services for adults and older people, and acknowledge 5 Boroughs Partnership NHS Trust statements about age discrimination. However, the committee's view is that this over-simplifies the complexities of caring for adults and older people with mental health needs in the same inpatient settings. The committee notes that in Norfolk and Waveney where the model is said to be operating effectively, separate inpatient facilities are provided for adults and older people.

- The committee has concerns about the need for young people to be admitted to adult inpatient services, and whilst acknowledging that this is not part of the consultation process, the committee believes that some issues do need to be factored in to the proposals.

- The committee are pleased that the 5 Boroughs Partnership NHS Trust are proposing an increase in staffing in the inpatient units, coupled with the reduction in the numbers of beds, as this should lead to better services for those inpatient residents. However, the committee has concerns about the impact that this will have on community based services, as it would appear to be likely to increase the staffing reductions in these areas.

- The committee is concerned that there is a lack of clear information and apparent analysis to demonstrate the impact of reduction in beds on community services, and how this will be managed.

4.5 Resource and Recovery Centres (RRC)

The committee broadly welcomed the proposals to have resource and recovery centres in each of the boroughs, and believe that the model of multi-agency services offers the best outcomes for service users and carers. However, the committee have a number of concerns about the proposals:-

- Capital funding for the development of the centres has yet to be secured in a number of cases, and there does not appear to be a clear contingency plan should this funding not be available.

- The significant drop in the number of beds does not seem to be realistic or achievable.

- Staffing issues are not clear, and the increasing of staff in resource and recovery centres is likely to have a negative impact on Community Services.

- The mixing of older people and younger adults in inpatient settings does not seem to have been properly thought through.

- The committee has concerns about the capacity of the resource and recovery centres, particularly to provide community based services.

4.6 Assertive Outreach

The committee have noted Appendix 2, section 5, the comparison of assertive outreach services. The committee notes the 5 Boroughs Partnership NHS Trust's comments that services are being provided at higher levels of input than that for which funding has been obtained. However, the committee is concerned that in Warrington and St Helens the model does not allow for any increase in assertive outreach, with the number on caseload remaining the same. The committee would have expected that with the reduction in inpatient beds, more pressures might have been placed on assertive outreach, and that further resources would need to be identified.

4.7 Community Mental Health Teams

The committee acknowledges the commissioning strategies see the need for "a team of multi-disciplinary practitioners providing ongoing care and support to people with serious mental health problems". The committee is surprised that the role of such a team has not been more clearly thought out prior to the publication of the model, and disappointed with the response from the 5 Boroughs Partnership NHS Trust that "detailed operational issues will be progressed locally with LA and Trust staff." This may lead to an inconsistency in approach across the three boroughs and this appears to be one of the issues which the model was seeking to address.

4.8 Impact on Other Mental Health Services

The committee acknowledged that other aspects of mental health services are not part of the consultation process, but feel that the proposals contain issues which will have clear implications for other services, particularly through the cost releasing efficiencies savings and back office savings, and the committee believes that these may have impact on a number of relevant services including:-

- Services for people with a duel diagnosis,
- Child and Adolescent Mental Health Services,
- Psychiatric intensive care services,
- Secure services.

4.9 Impact on Council and Other Health Services

As the model states that it aims to ensure closer working relationships with partner agencies such as "PCTs, Social Services, Housing Departments, voluntary agencies and others", then the committee are surprised that very little consideration seems to have been given to the impact of the model on those services. In their response to the committee, the 5 Boroughs Partnership NHS Trust 6.1 Appendix 2 do not provide any detailed information about the impact on Council services, and the committee has similar concerns for other Health agencies. The committee's concerns can be summarised as follows:-

- There is possible impact in relation to out of area placements.

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- The tightening of eligibility criteria is likely to lead to increased pressures on social care services and increased demands on Primary Care services.

- The increase in community services may well lead to implications for housing providers.

- The impact on Local Authority staff seconded to, or working closely with, the 5 Boroughs Partnership NHS Trust have not been properly considered.

4.10 Staffing

It is clear to the committee that the proposals have significant staffing implications. The committee were anxious that there seemed to be a lack of clarity about the number and nature of posts to be deleted to secure the savings across front line services and support service staff. Although pleased with the proposals to increase staffing in inpatient settings to improve the quality of therapeutic work, the committee believes that there is an inconsistency in that any increase in staffing in inpatient services will lead to a greater decrease in staffing in community based services. It is therefore difficult to see how community services could be improved, and can manage more cases.

The committee also believed that a change such as this needs to be accompanied by a significant investment in staff development and training, and they have not been able to identify clear plans for this.

4.11 Partnership Working

The Committee's view is that the proposals appear to have been developed by the 5 Boroughs Partnership NHS Trust in isolation of the wider primary care and social care community. The key requirement of the Commissioning Strategy for the three boroughs concerned is to redesign services on a Whole Systems basis. The Committee is surprised that the model does not appear to have been developed in an effective partnership, particularly as developing a recovery and social inclusion approach clearly requires full partnership with local authority and other health services.

5. Consultation Process

The committee acknowledged that the consultation process appears to be in accordance with the minimum requirements of legislation relating to consultation. The committee would, however, support the view of the PCTs (Section 8 Appendix 3) that the application of the statutory minimum 12 week consultation period, in this case, has generated "undue haste".

The committee's view is that this weakness has been compounded by the lack of robust and accessible information to support the consultation process.

The committee has had sight of the analysis of public and internal consultations "Change for the Better" published by Mental Health Strategies and the 5 Boroughs Partnership NHS Trust. The committee note the findings of the consultation and were surprised that the consultation report makes a principal recommendation that

"the general direction and framework of the new proposed model be adopted by the Trust with due consideration". The committee would have expected that the report should focus on reporting the outcome of the consultation, rather than making recommendations about the developments of services.

6. Implementation of Proposals

The committee feel that the timescales for the implementation of the proposals require further, more detailed consideration. The committee were informed by the 5 Boroughs Partnership NHS Trust that the original start date of October would be delayed until early in the next year, and they were later informed by the Primary Care Trust (Appendix 3 Section 8) that this would now be delayed until April 2007. The committee welcomes the review of timescales but feels that the targets for implementation are particularly challenging, and in the light of the issues identified in this report, timescales need to be more carefully considered and a model developed for the phased and effective implementation across all three boroughs.

The committee was also of the view that proposals represent a significant variation in services, and they have not been able to identify clear plans to resource and implement the changes. The committee were not able to identify whether a risk assessment of the proposals had been carried out and whether effective risk management arrangements were in place. In the light of the proposed timescale for implementation, the committee are particularly concerned about this, and feel that the identification of additional resources from the Primary Care Trust of £0.5m to fund transitional work may not be sufficient. For a major service change like this, the committee would have expected detailed project plans to be put in place.

7. Borough Specific Issues

The committee identified a number of borough specific issues:-

7.1 Halton

There is confusion about an alcohol detoxification bed – the situation appears to be that a bed has been in existence although it has never been properly funded or commissioned. The bed is not contained in the proposals, and members of the committee are concerned about the impact on services.

The committee had concerns about the proposals relating to Thorn Road Day Centre.

The 5 Boroughs Partnership NHS Trust has also been providing services for Helsby and Frodsham, and there is a lack of clarity about how this will be resolved in the future, and the impact that this will have on Halton's services. Associated proposals would see the cost of a psychiatric intensive care bed being made to the borough of £100,000 per annum (shared with St Helens).

7.2 Warrington

The committee support the view reported in the analysis of public and internal consultation that the Hollins Park site is stigmatising and isolating and that the Gatehouse service offers a more appropriate venue.

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Associated proposals would see the cost of a psychiatric intensive care bed of £200,000 per annum for the borough. There is an issue of non-recurring financial support from the PCT which the committee feels needs to be clarified and addressed.

There appears to be a lack of agreement between Warrington Primary Care Trust and the 5 Boroughs Partnership NHS Trust as to the proposed levels of investment to support the model of care. This leaves the committee with grave concerns about the future safety and viability of the service.

7.3. St. Helens

The committee noted that the reduction in inpatient beds in St Helens had been minimised by the closure of a hospital ward shortly before the consultation process commenced.

An additional cost of £100,000 per annum has been identified for a psychiatric intensive care bed (shared with Halton)

8. Conclusion

In the time available, the joint committee has thoroughly scrutinised the proposals contained in the "Change for the Better" document.

The committee has found that the model in its present form has a number of deficiencies:-

- A potentially negative impact on many service users and carers; with fewer services available and a tighter rationing of those services.
- Potential negative impact on a number of associated client groups, particularly older people;
- Failure to properly consider the needs of carers;
- Lack of clear financial information and plans;
- Lack of clear sources of capital funding and contingency plans / alternative proposals if this is not secured;
- Significant reductions in investment and staffing across the three boroughs;
- Changes in arrangements to access to services which would be likely to lead to tighter rationing of services;
- Significant reductions in the number of inpatient beds, possibly below the minimum recommendations;
- The lack of community based services being in place to properly support the reduction of inpatient beds;
- The lack of clarity about the role of community mental health teams;

- The lack of clarity about the impact on other Local Authorities' services, and their ability to respond to changes;
- The lack of clarity in relation to other Health services, particularly Primary Care, and their ability to respond to changes;
- The impact which the model might have on other mental health services in the three boroughs;
- The lack of a clear risk assessment and evidence of effective arrangements for the management of risk;
- The lack of clarity about staffing proposals and appropriate workforce planning;
- The haste with which the consultation process has been conducted;
- The timescales for implementation of the proposals;
- The lack of clear implementation plans and resourcing for transition;
- The failure to properly consider other models of service.

Taking all of these issues into account, the committee has formed a view that the proposal in its present form would not be in the interests of the Health Services in the area of the three local authorities.

9. Recommendations

The Statutory Joint Scrutiny Committee makes the following recommendations to the 5 Boroughs Partnership NHS Trust:-

9.1. Recommendation 1

The model, in its present form, is not in the interest of Health services in Halton, St Helens and Warrington. The model should therefore not be implemented in its present form for the following reasons:-

- There is no clear financial information available, and the financial implications of the model are not properly understood.
- The model is heavily reliant on securing appropriate capital funding. This does not appear to be available, and there did not appear to be contingency plans in place.
- The model in its present form does not appear to offer the most appropriate access to service users and this is in need of review.
- Any reduction in inpatient services would need to be accompanied by corresponding increases in community based services. There is no evidence of an increase in community based services contained within the

model.

- There would appear to be a potentially negative impact on service users utilising mental health services in the three boroughs, and there is a particular need to properly consider the needs of a number of groups including:

    - Older people
    - People with a duel diagnosis
    - Young people
    - Carers
    - Adults in secure environments and psychiatric intensive units

- The role of community mental health teams in the model needs to be clarified.

- There is no clarity about the impact on other Council services, and no evidence of effective partnership working to agree them.

- The impact on other health services, notably Primary Care, requires further clarification before the model could be implemented.

- The impact on 5 Boroughs Partnership NHS Trust staffing and future workforce strategy needs to be clarified before the model can be agreed.

- The model has not been developed in full partnership with all interested parties, particularly local authorities.

- The proposals focus on recovery and social inclusion and yet demonstrate a poor level of understanding and recognition of the vital contribution made by local authority services within existing partnership arrangements to the achievement of these important objectives

- An implementation plan needs to be put in place, and appropriate infrastructure and resources must be made available to implement the proposed introduction of the model.

- There is no evidence of an effective risk assessment of the implications of introducing the model, and/or clarity surrounding risk management arrangements.

9.2 Recommendation 2

- The 5 Boroughs Partnership NHS Trust and the relevant Primary Care Trusts should work closely to ensure that the necessary investment and range of community services are available to support the implementation of any model of care.

- Halton and St Helens Primary Care Trust, and Warrington Primary Care Trust, should review spend on mental health services in the boroughs to ensure that it is brought more closely in to line with national average, and that it properly meets the needs of residents of the boroughs.

- The 5 Boroughs Partnership Trust, in partnership with the Primary Care Trusts and Local Authorities, should work on a revision of these proposals, which fully takes into account the above concerns.

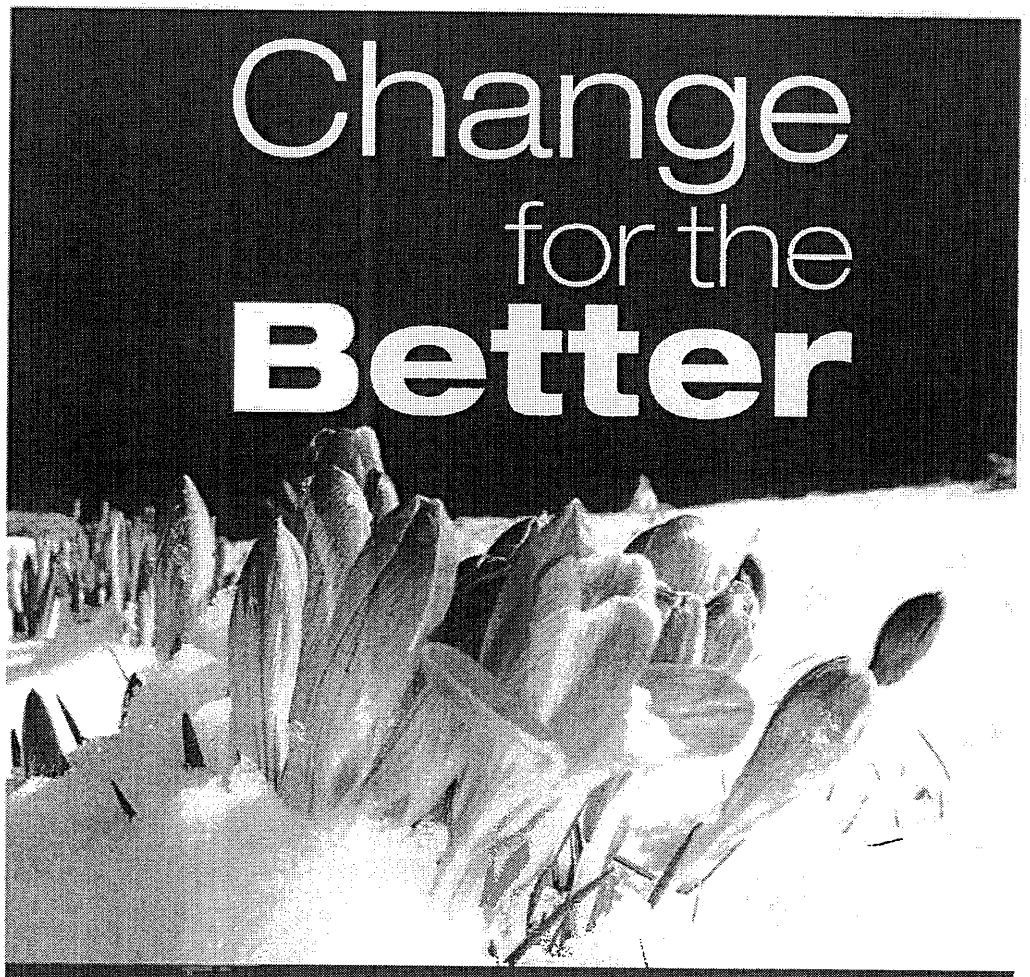
9.3 Recommendation 3

The 5 Boroughs Partnership NHS Trust should respond in writing to the Committee about the issues raised in the report and the recommendations within 28 days of its receipt.

The contact officer for this report is Mike Wyatt, Assistant Director, Performance and Business Support, St Helens Council, Adult Social Care and Health, Gamble Building, Victoria Square, St Helens WA10 1DY. Telephone 01744 456550.

5 Boroughs Partnership NHS
NHS Trust

Change for the Better



Improving services for adults with mental health needs

Public consultation document prepared in association with
Mental Health strategies

APPENDIX 1

4

Mental Health strategies

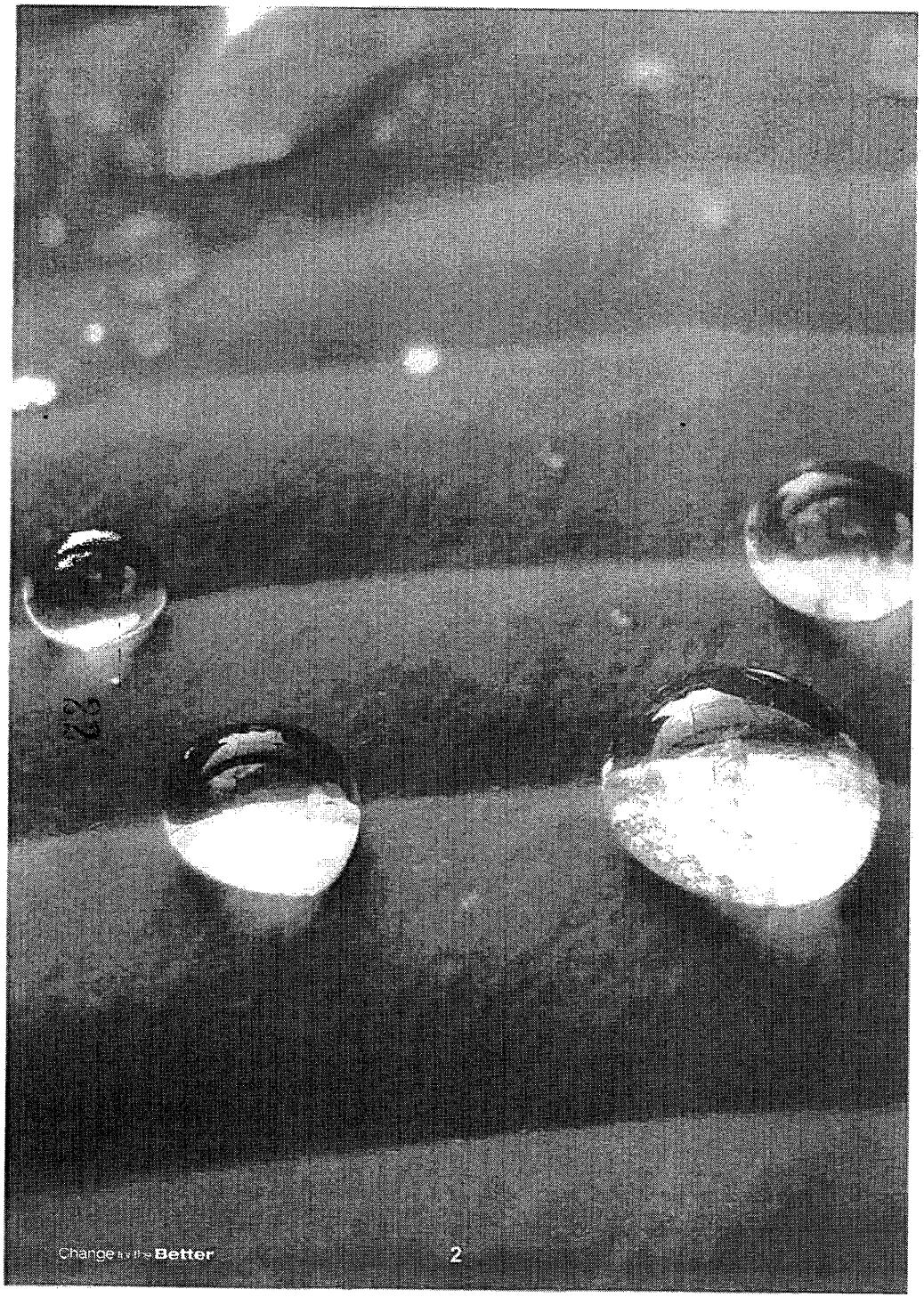
Mental Health Strategies
Emerson House
Albert Street
Eccles
Manchester
M30 0BG

Telephone 0161 785 1001
Website www.mentalhealthstrategies.co.uk

5 Boroughs Partnership NHS
NHS Trust

Trust Headquarters
Hollins Park House
Hollins Lane
Winwick
Warrington
WA2 8WA

Telephone 01925 664000
Mini com 01925 664094
Fax 01925 664052
Email hq@5boroughspartnership.nhs.uk
Website www.5boroughspartnership.nhs.uk



Contents

The Public Consultation will run from the 1st June 2006 until the 24th August 2006

It was Franklin who said that "without continual growth and progress, such words as improvement, achievement, and success have no meaning." The proposals set out in this document contain all these elements.

5 Boroughs Partnership NHS Trust currently provides mental health and allied services to the people of Halton, Knowsley, St Helens, Warrington and Wigan. We do this in an ever changing political and social environment, and we work together with users, carers, staff and other partners. It is part of our responsibility to provide what is needed today, but also to consider what will be needed tomorrow, and that is why this consultation is being undertaken.

There are many good things about the way we conduct ourselves. Feedback from users and carers and partners that comes in to our organisation regularly testifies to our ability to make positive changes. However feedback via complaints, user forums, or individual contacts leaves us in no doubt that there are things we could do better.

Thus we have worked on these proposals to change the way we work; to make our services more accessible, sustainable and effective. We are now at the stage where we want to share these ideas, and to hear what comments you have to make. We can then take account of your views as we develop our plans in more detail.

The image on the front cover is of croci pushing through the snow, and later images are of flowers in full bloom. That image of growth and development is one that inspires us to move forward.

We look forward to receiving your comments on our proposals.

Judith Holbrey
Chief Executive
May 2006

1 Introduction

We live in an ever-changing world. The NHS, like all services, needs to keep up with these changes to be able to provide what is needed, to the people who need it, when and where they need it. We at the 5 Boroughs Partnership NHS Trust plan to stay ahead of these challenges by improving the services we provide, to better meet the needs of the people of Halton, Knowsley, St Helens, Warrington and Wigan.

For the past two years we have been working with our Primary Care Trust (PCT) colleagues to identify the best way to commission (pay for) and provide the best mental health services that we can with the resources that we have been given. This document presents the combined vision that we, the 5 Boroughs NHS Partnership Trust and the affected PCTs, believe is the best way of improving how we provide high quality adult mental health services. We have already undertaken some discussions with our service users, their carers, staff groups and their representatives.

1.1 Listening to you

Since we were created in 2002 we have listened to both the people who receive services from the Trust and those who work for the Trust. As a result service users and their carers have told us they want to receive high quality services, local to their homes, that are easy to understand and access. They want to have more control over what happens to them and be fully involved in all decisions regarding their care. Staff members have told us they want to work in environments that are modern and help them do their jobs, they want access to training that supports their roles, and time and resources to be freed up to enable them to do the tasks they were employed to do. We have listened to these comments and agree with them.

1.2 About this document

This document will outline what we want to do as a result of listening to service users, carers and staff. It will explain to you,

- *what* we want to do
- *where* we want to do it
- *when* we want to do it
- *how* we want to do it, and above all
- *why* we want to do it.

Once we have explained our proposals, ***we again want to find out your views regarding our plans.***

1.3 What this document covers

The services that we are talking about in this document are a very important part of what we do, but it should be remembered that they amount to about one quarter of our total budget – there is a lot more that we do! The graph below illustrates this and identifies other services not affected by the proposals outlined in this document.

The focus of this document will ***only*** be on adults (aged over eighteen) who have mental health needs that are usually met by mainstream mental health services. For example, these include people who have common mental health conditions such as depression and anxiety, and serious and enduring mental illnesses such as schizophrenia and manic depression.

This document does not talk about other specialist services such as those for:

- adults with learning disabilities
- adults with alcohol and substance misuse needs
- older people with organic illnesses such as dementia
- children
- adult services that are prison based, and
- secure services.

We plan to treat every person accessing our services with respect for their individuality and needs. Therefore, we do not believe that just because people have a birthday and are 60 or 65 they become different people and should move to another - 'older persons' - service. Unless an individual has other specialist needs, such as dementia or some other organic condition, we will ensure they remain part of mainstream services.

WHERE'S ASHTON, LEIGH & WIGAN?

We believe the proposals within this document will benefit everybody within the boroughs of Halton, Knowsley, St Helens and Warrington, but the situation in Ashton, Leigh and Wigan is a little different.

Ashton, Leigh and Wigan PCT are currently preparing a new commissioning strategy that will be subject to further discussions regarding what services are needed and how they will be provided in their area.

The 5 Boroughs Partnership NHS Trust will respond to the new commissioning strategy once it is available.

1.4 What changes you might see

The biggest change you will notice will be fewer people being admitted to hospital as more and more people will receive the help they need either at home or within local resource centres. Many people who are currently admitted to hospital don't require a 'bed' but they do need important treatment. Skilled staff in the service users' own homes, or in local recovery centres, could better provide this treatment.

Similarly, many people who do need to be admitted to hospital have needlessly long stays there. Often after the early most distressing part of their admission has passed they could, and should, continue their recovery back to health in familiar home surroundings. For those who do need to be admitted to hospital to meet their needs we will continue to provide increasingly high levels of quality care for as long as they need it. We will also try to make their stay as short as possible so they can return to their normal lives because we know this is one of the most important and beneficial parts of their recovery.

The changes we plan to make will be implemented across the whole Trust. However this document does not include the Wigan Borough. This is because Ashton, Leigh and Wigan Primary Care Trust are working on a new commissioning strategy. For the remaining four Boroughs our preferred option would be for all sites to make these changes in the autumn of 2006 and completed by summer 2007. Across the Trust there will be a mix of substantial refurbishments to the existing properties, and if required, new buildings constructed.

1.5 Benefits of the new model

We believe the new way of working will have benefits for everybody concerned which include:

- Service users and carers will benefit as they will receive more effective, evidenced based services, from skilled staff who are working *with* them to enable their conditions to be better managed and treated in a way that fits into - rather than takes over - their lives. Services will be provided in more accessible and appropriate environments all of which promote the model of recovery for everyone in a shorter timescale as possible.
- Staff members will be enabled to work in positive environments that promote the view that people 'get better' rather than a view of merely 'maintaining' the current abilities of those people they work with. They will work in buildings that are fit for purpose and they will receive the training and support they need throughout the transition process.
- Partner agencies, such as PCTs, social services, housing departments, voluntary agencies and others will benefit from our proposals as we want to refocus our services to work even closer with them in the localities in which they also serve. Our view of recovery is not limited to treating any specific condition: it is about recovering and enhancing people's whole lives which will have to include employment, housing, education, benefits and financial planning. These proposals will only increase the work we do with our partners, not decrease it.
- Funders, be they our commissioning PCTs or the general public, who fund us via taxation, will benefit as the value of that investment will be greatly increased through improved quality services - fit for the needs of the 21st century.

2 Purpose of the document

This document provides you, the general public, with the **opportunity to find out what we are planning to do regarding** changes to how adults with mental health needs will have those needs met.

It will also outline the national and local issues that currently **influence mental health services. Following this it will then** outline our plans for reorganising adult services and ask for your views regarding the proposed changes.

We want to know what you think of our plans. We believe they are the best way forward to meet the needs of the people who access our services whilst providing value for money for the public funds that pay for them. If this is not the case we would like to know how they can be improved upon.

Even if you do not live, or receive services, in one of the first areas to experience these changes we would still like to hear your views on our plans.

Our plans have the full backing of our local commissioners, the people who are responsible for funding what we plan to deliver.

3 The national situation

3.1 The Government's view

Both the current and the previous Governments have sought to improve mental health services. Amongst the many initiatives the main pillars of these improvements have been through:

- **The National Service Framework for Mental Health** (NSF) 1999. The NSF established a ten year programme for reform, establishing quality standards that must be achieved by all mental health services.
- **The NHS Plan, 2000.** This document, and its many supporting documents and guidance, details how the **significant increase in funding of the NHS is to be used.**
- **Choice, and 'Choose and Book'.** Choice has become a big issue for all services. We all live in a world where we have almost unlimited choices of what to buy, when we buy it and where we buy it. The 'Choose and Book' initiative coupled with the new NHS technology provides the opportunity for service users to book, in advance, appointments with professionals at a time and a place that is convenient for them. In mental health services this choice is being extended beyond appointment times to include, where clinically appropriate, the types of treatments on offer, the environment where the service is provided and the gender of the person delivering the service. Our proposed model aims to increase service user's choices at every point of their treatment pathway.
- **Social Exclusion.** All services should be available to all of those people who need them regardless of issues such as their age, gender, economic status, religion or diagnosis. We know that people from Black and Minority Ethnic Groups (BME) have often been disadvantaged when coming into contact with mental health services. The "Mental Health and Social Exclusion[1]" report makes it clear that this can no longer be tolerated and every service must provide culturally appropriate services for all of the population. This report also highlights the need for all services beyond mental health services to recognise that there remains a stigma attached to a mental health diagnosis. Therefore all services have an added responsibility to provide services in an inclusive manner that does not exclude or disadvantage anyone.

[1] *Mental Health and Social Inclusion Report. June 2004. Published by the Department of the Deputy Prime Minister.*

- **Mental Health Law**, we now know that there will not be a new Mental Health Act in the near future. However the existing 1983 Act will be amended. It is anticipated that these amendments will seek to modernise mental health services by reducing the ambiguities within the 1983 Act, comply with the Human Rights Act, promote choice and to fit in with new ways of working included our proposed model.

3.2 Research findings

In 2004 a report[2] on the state of acute psychiatric care found that there were high levels of staff vacancies and use of bank or agency staff on inpatient wards. This amounted to more than 4 full-time staff per week per ward. This coupled with the findings that there were limited therapeutic treatments available on the ward and there was poor communication between ward and community based staff, clearly demonstrates that the current system isn't working properly.

Also, in 2004 the Department of Health published an evaluation of the NSF's first five years' effectiveness in improving mental health services[3]. This evaluation had a lot of positive things to say regarding the progress made in many areas of mental health provision. Nevertheless it also stated that there were areas where more work was required. For example the report stated there is a need for:

- new models of services, including in-patient services, to better meet the demands of those who use those services. These new models should include better systems for acute care, rehabilitation, crisis admission and specialist treatment
- improved integration with community mental health and social care services
- improved safety of patients, staff and others
- improved therapeutic skills among staff, and
- Improved recruitment, retention and morale of staff.

In respect of in-patient wards, the "Five Years On" paper said: *"In many mental health trusts, new in-patient units have been built and older ones refurbished, and the popular image of squalid mental health wards is outdated and unrepresentative. Nevertheless, there are in-patient wards in use that are not suited to the care of distressed people."*

[2] *"Acute Care 2004: A national survey of adult psychiatric wards in England." National Institute for Mental Health in England (NIMHE) and the Acute Inpatient Care Programme from the Sainsbury Centre for Mental Health (SCMH).*

[3] *"The National Service Framework for Mental Health – Five Years On" 2004. Department of Health*

Regrettably, we accept that some of our current inpatient facilities are no longer in suitable condition and need to be modernised (this is especially true of the Sherdley Unit, in Knowsley). Our proposals agree with the Government's view that new models of working are needed and new facilities need to be created to improve both what we do but also how we do it.

Our proposed new model of care is fully in line with the Department of Health's aims in improving the mental health for the whole community.

3.3 What we currently provide

Our current inpatient facilities for adults are situated at:

- The Sherdley Unit, based at Whiston Hospital (serving Knowsley and St Helens) has 67 beds and four wards as follows:

  T1 with 17 male beds (Knowsley)
  T2 with 16 female beds (Knowsley)
  T4 with 16 female beds (St Helens)
  T5 with 18 male beds (St Helens)

- The Brooker Unit, based at Halton General Hospital (serving Halton) has 40 beds split over two wards as follows:

  Weaver with 20 beds
  Bridge with 20 beds

- Hollins Park, Warrington (serving Warrington) has 46 beds split between two wards as follows:

  Austen with 22 male beds
  Sheridan with 24 female beds

3.4 Service User views

From our Trust's creation we prioritised listening to the views of those who use our services. There continues to be a number of Trust forums that also ensure the consultation is ongoing with users and carers.

Recent reviews undertaken by service users and their advocates have identified concerns about the quality and consistency of acute psychiatric services offered in some

parts of the Trust. For example an independent consultation exercise by *The Associates* - "Findings of User and Carer Consultation (St Helens) May 2004" - found consistent concerns regarding the way services were delivered within the Sherdley Unit and questioned the building's fitness for purpose.

Also, an analysis of service user complaints and recommendations from clinical governance reports into serious untoward incidents identify the following themes:

- poor environment and buildings
- little or no therapeutic interventions due to shortage or inconsistency of staff leading to excessive use of agency and locum staff
- high levels of actual or threats of violence
- lack of suitable admission and discharge arrangements with poor links with community services

Service users and carers generally appreciated the community services being provided to them on a long-term basis. However they expressed a real need to move away from the clinical model to a recovery model that places community resources at the heart, instead of the edge of the care provided.

The *Associates* local consultation exercise offered suggestions for improvement as follows:

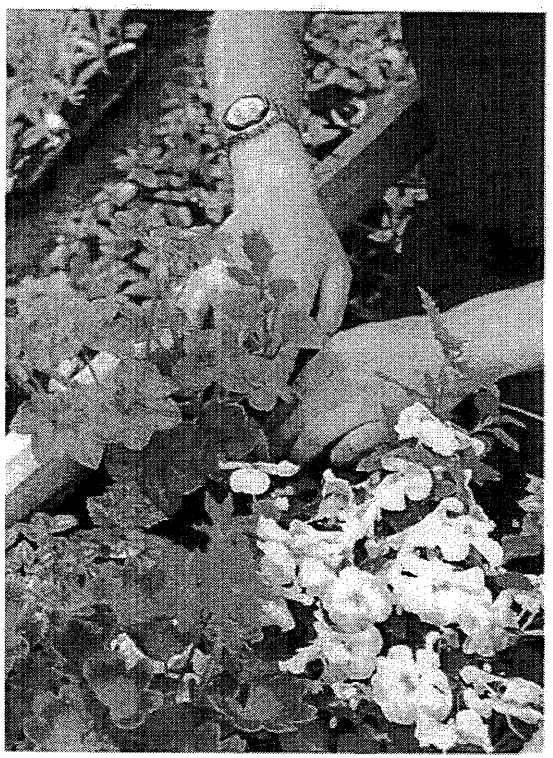
- support in dealing with the stigma of mental illness
- help to live independently
- getting out and about
- better information about mental health services
- improving access to mental health services
- improving buildings
- improving access to employment and education opportunities
- improving support for carers, and
- simpler and friendlier paperwork.

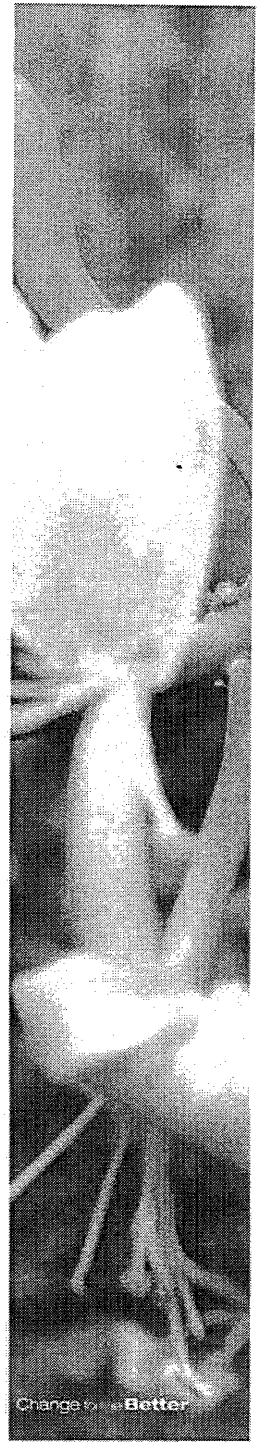
We believe this document demonstrates that we take these concerns very seriously and that our proposed model of care will significantly help in addressing the issues.

3.5 Trust performance

By working with our partners, we have consistently improved our services to the point that the Department of Health have awarded us the status of a 2-Star Trust. We want to continue to improve so that we will become an NHS Foundation Trust in 2008 subject to the appropriate authorisation.

We have also met the key Local Delivery Plan (LDP) targets in most of our boroughs by investing new money into services and redesigning others. We have met all of the Government's targets relating to waiting times, Agenda for Change and Choose and Book. In November 2004 we received a positive Heath Care Commission (HCC) review. In response to the Health Care Commission's review we simplified our management structure, which is now in place and working well.





4 The new model

4.1 What is the 'Recovery Model'?

When someone has an accident or an illness usually we expect him or her to recover. It may take time and they may need a lot of treatment but most people, most of the time, 'recover' and return to their previous life with little or no further problems. For other people their physical health conditions may be life long, such as diabetes, but with a few precautions and proper management of their condition they can continue with their normal lives as previously. Why should we consider mental health any different?

Most people who experience some kind of mental health breakdown return to their normal lives at a later date. However in the past some services have not helped in this process with some individuals feeling *"a mental health diagnosis is a sentence - not a word!"* We believe that this should no longer should this be the case.

Even those people who may have what is called a serious and enduring mental illness can continue on to have fulfilled and meaningful lives. We now know a lot more about people's conditions and as a result can provide better care that can enable them to better manage their illness and get on with their lives. This is the recovery model and we want all our services and staff to promote this view.

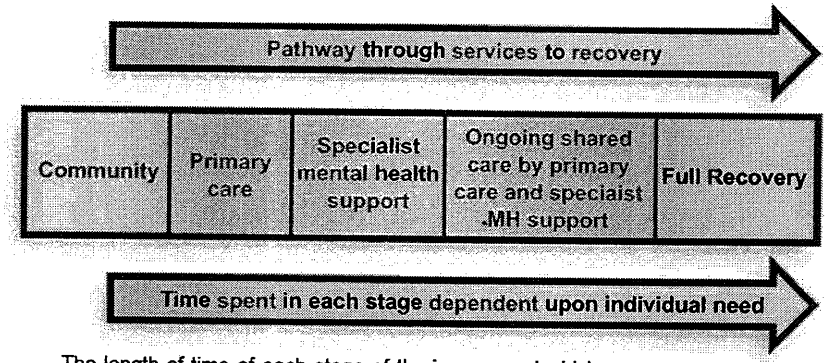
We see treatment as a journey that individuals take moving from health, through primary care and if required more specialist care before returning to primary care support and full recovery. This journey is represented in the diagrams below. An individual in full health living within the community is represented by yellow. This person then accesses primary care and if required specialist mental health services before returning to full recovery via joint specialist and primary care shared care support.

You will note that although there are points where one service ends and another begins the crossover points are deliberately blurred to show a seamless joint working service.

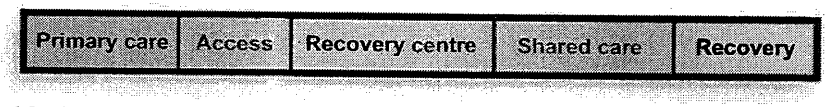
Key

- Healthy living within the community
- Person accessing primary care
- Specialist mental health services

The journey through treatment



The length of time of each stage of the journey and which specific services they access is dependent upon the needs of that person at that time. In the same way, a typical journey may include something like the stages below.



4.2 What are Recovery and Resource Centres?

In life generally, over recent decades our expectations of services have changed dramatically. We expect more, better and faster. For example, if we are car drivers we do not want our cars to break down; if they do we want them fixed as soon as possible – preferably at the roadside. Sometimes our cars have to be off the road for a short time, this can be very frustrating. We therefore want this time to be as short as possible. We do not want the car to have to go to the factory to be fixed, we want a local service station to fix it at a time that suits us - i.e., now.

People's expectations and needs of mental health services are similar. People rightfully want to be 'off the road' for as short a time as possible to enable them to get on with their lives as this aids their recovery. Recovery and Resource Centres are the 'local service centres' that will give you advice and will meet most of your needs. For most people their needs will be met either at the centre or within their own homes. Usually this will be during the daytime. However

some people may require around the clock support, again this could be provided either in their own homes or within the Recovery and Resource Centre where there will be a small number of beds for those who require them.

The staff will be NHS employees with at least the same levels of skills and qualifications as those who currently work for us now. In most instances they will be exactly the same staff, the only differences will be where they work and how they work. For those who require it, staff will also be given additional training to enable them to fulfil their new duties.

The Recovery and Resource Centres, like the garage example, are backed up by a whole range of more specialist staff away from the site that are better able to meet the needs of those individuals who require more specialist support.

In short, Recovery and Resource Centres are the bases from where most people will receive their services. They are not hospitals, but NHS and other professional staff, including doctors, nurses, psychologists, social workers, occupational therapists and various other related professionals, staff them.

For those who require it the Centres will provide support twenty-four hours a day every day of the year. However, most people will receive support during the core hours of 9am- 5pm Monday to Friday. We would like these core hours to be extended to include evenings and weekends but before we can do this we will require further discussions with our commissioners (the people who pay for our services).

Unless you are in the midst of a crisis and need immediate attention, you will able to book a day and time within the core hours to see someone that suits you and your circumstances best.

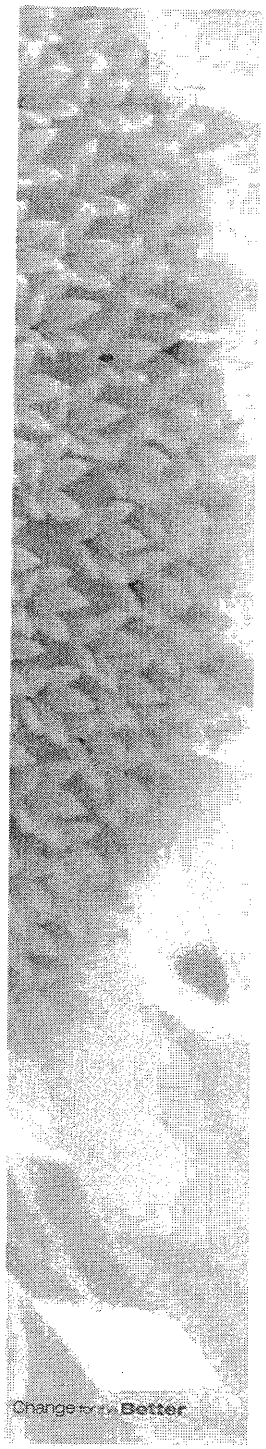
If you are experiencing a crisis and require more immediate attention the Recovery and Resource Centre's Crisis Resolution and Home Treatment Teams will be available to respond to your needs as required.

4.3 Tiers of support

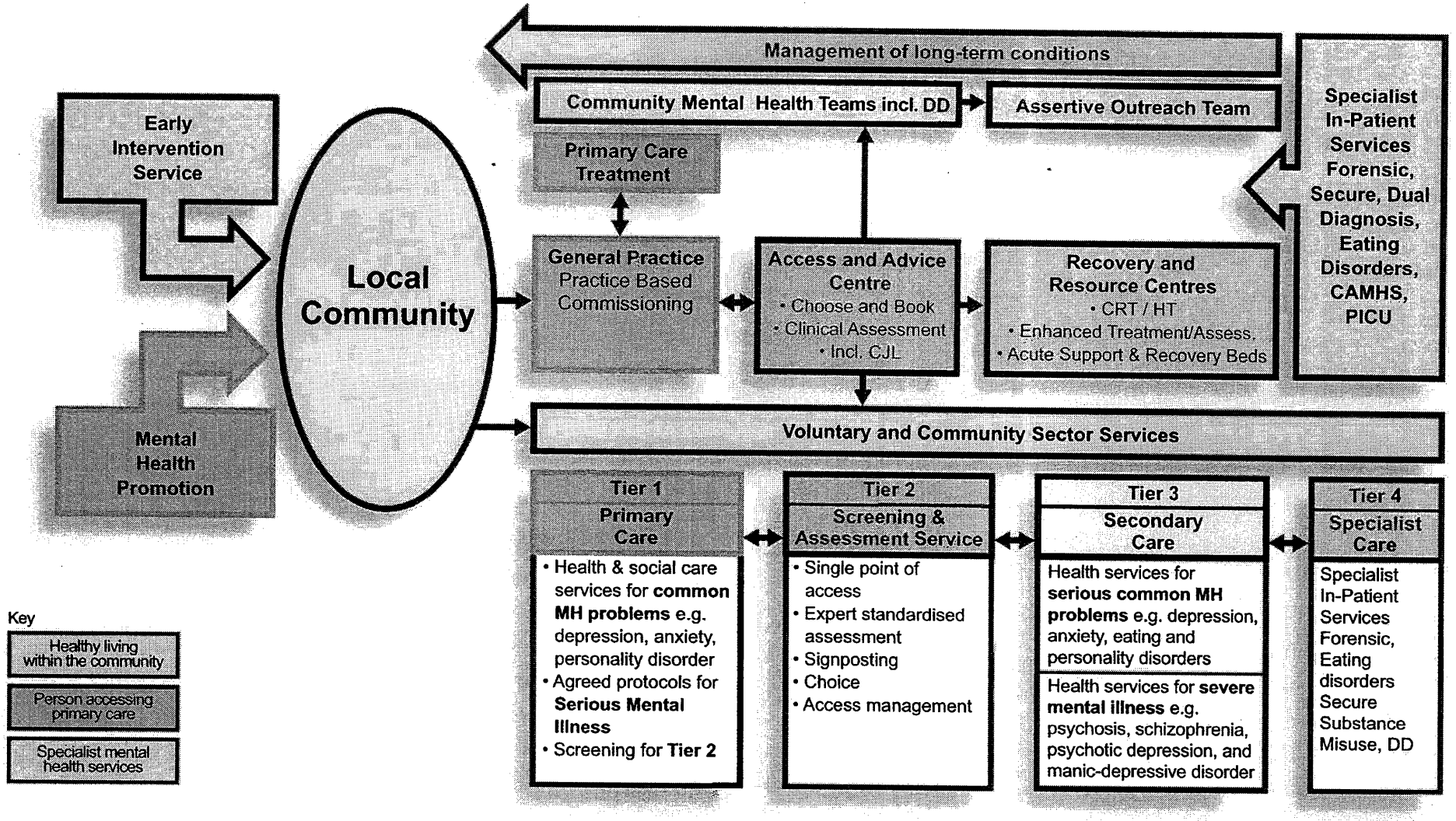
Increasingly you may have heard people talk about tiers of support. These refer to the 'whole system' of care – not just what we as a Trust provide. The new model that we are proposing to introduce builds on the tiered approach and fits into the local healthcare system as follows.

- Tier One - Primary Care. This is where most of your health and social care needs are met, often in your GP's surgery or community clinic.
- Tier Two – Screening and Assessment Service. This is the interface between primary care and specialist secondary care. This service will assess your needs and recommend which is the best service to meet your needs.
- Tier Three – Secondary Care. Traditionally this tier has been hospital-based services led by hospital based medical consultants. In the new models secondary care will be provided from locally based Recovery and Resource Centres that will support people in their homes, in community settings, or for a smaller number within the centre itself as an inpatient. These services are for those people whose needs are serious but we know enough about them to be able to treat them from within mainstream local services, typically these services would be for people with conditions such as depression, anxiety, eating disorders, personality disorders and mental illnesses like schizophrenia and manic depression.
- Tier Four – Specialist Care. These services are for those individual's whose needs are such that they required more specialist inpatient facilities, including forensic services, detoxification services, severe eating disorder services and specialist dementia services.

The diagram on the next page shows how these tiers fit into the new model and existing services. It also shows the two main areas for improvement that we want to improve, i.e., the interface between primary and secondary care at tier two and the increased provision of more locally based services (rather than within hospital settings) at Tier three. It should also be noted that not all services at Tier Three and Four will be provided by The 5 Borough's Partnership NHS Trust; increasingly commissioners are encouraging other providers to take on some of these roles if they can demonstrate they better able to provide these services, such as eating disorder services.



Our new service pathways



4.4 Recovery and Resource Centre structure

4.4.1 Leadership

Ensuring effective leadership is the key to the models success and it is proposed to establish a leadership team fit for purpose to ensure the centre's success. The team will consist of:

- Crisis Resolution Team Manager
  This role will ensure the appropriate patient flows though the service, working closely with medical staff to ensure appropriate admissions and discharge.
- Consultant Psychiatrist
  Together with a Staff grade psychiatrist, this role will offer medical leadership to treatment and care planning.
- Consultant Psychologist
  This role will offer leadership to ensure effective assessment and treatment is delivered by the Enhanced Treatment / Assessment service.
- Modern Matron
  This role will deliver the management functions of the centre.

4.4.2 The Functions

The Recovery and Resource Centre would deliver three core clinical functions:

1) **Crisis Resolution/Home Treatment Teams**. These teams will be based within the centre and will provide support to service users and carers in their own homes and within other community settings.

2) **Acute Support and Recovery Beds**. Just as it is now, nursing staff will support these beds but the unit will be much smaller and staff will be encouraged to work with service users before and after their admission to the unit.

3) **Enhanced Assessment/Treatment Teams**. These teams will provide a range of treatments including 'talking therapies', psychology services, medical staff and occupational therapy. Access to this service will be via pre-scheduled appointments set at times to best suit the most convenient time of the service users and their carers.

We also intend that the Recovery and Resource Centres will be an advice and information centre for its users. Examples of these other agencies include housing, employment, training and welfare rights agencies as well as targeted physical health checks for higher risk groups (i.e., diabetes, weight loss, smoking cessation groups, and so on).

Wherever possible most people will receive their specialist mental health care needs met either within their own homes or from within Recovery and Resource Centres. This will eliminate the need for all hospital based outpatient appointments, as this support will also be provided from within the Centre.

4.4.3 Access and Advice Teams

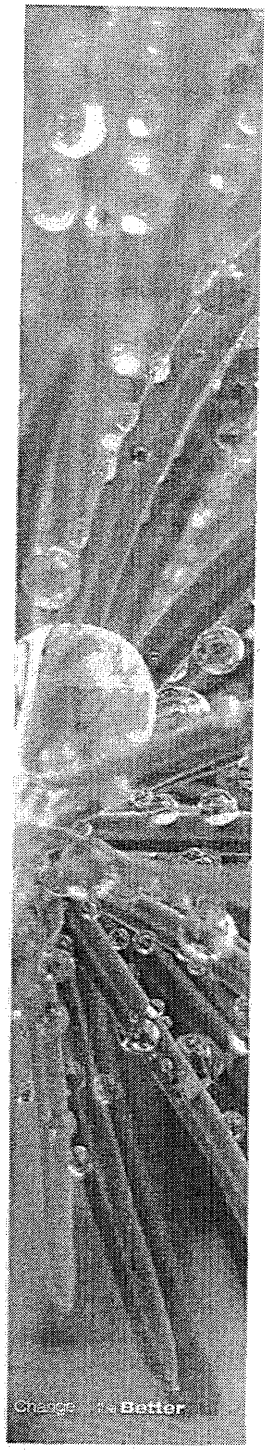
The 'gateway' for all of our services will be via the Access and Advice Teams. These teams will take all referrals and enquires and will manage the referral process – be that either to the Recovery and Resource Centres, specialist care, social care or signposting to other appropriate agencies and groups. The Access and Advice Teams will be located within the Recovery and Resource Centres. Whenever an assessment is undertaken it would be in line with the Government's standards of a "Clinical Assessment Service" as described in the "Choose and Book" initiative.

A range of health care professionals will conduct assessments and it is proposed that each Access and Advice Centre will have a Criminal Justice Liaison practitioner working within the team.

4.5 Early Intervention Service

We know that the sooner people who experience mental distress receive support, the better their chances of a full recovery. This is especially true in relation to people who may be starting with a mental illness. Therefore our Early Intervention Service will increasingly target younger people and people who appear to be experiencing a 'first episode' of illness to treat their needs sooner.

Although this is a service staffed by specialist secondary care professionals we strongly believe its 'location' should be in the community as much as possible. Staff will use two Recovery and Resource Centres as their bases but the vast majority of their work will be in home or community based environments.



We aim for the Early Intervention Service to support approximately 150 new people per year and have an ongoing total caseload of approximately 450 people.

4.6 Community Mental Health Teams (CMHT)

The current function of Community Mental Health Teams (CMHTs) will be further developed.

The CMHTs will provide a service that enables people with longer-term needs to return to mainstream services and society as soon as they are able. CMHT staff will co-ordinate the care they provide through a robust case management framework that ensures all aspects of the service user's life and needs are addressed, enabling the opportunity for recovery, social inclusion and greater independence.

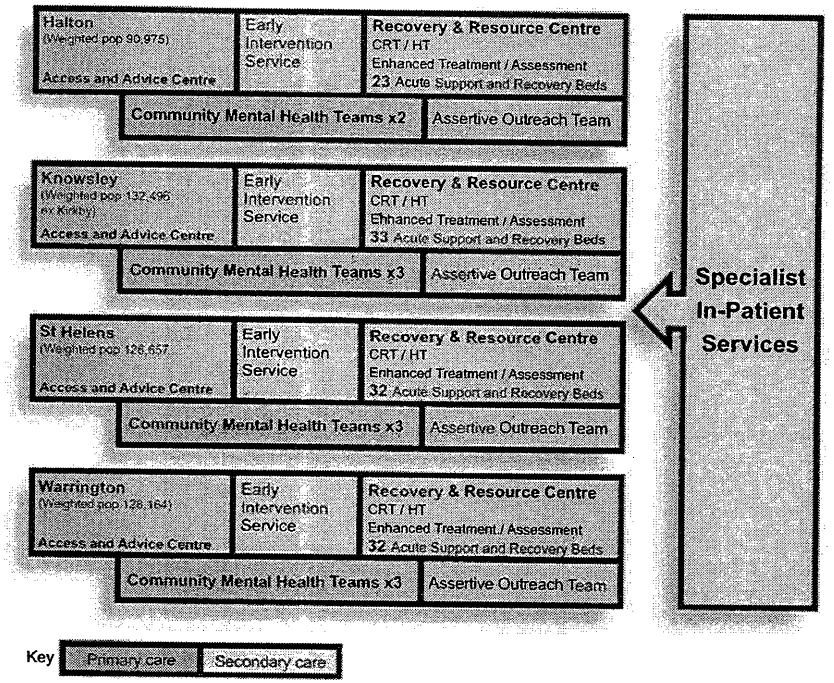
4.7 Assertive Outreach Teams (AOT)

The Assertive Outreach Teams will work closely with the Community Recovery and Support Teams and they will be based within community settings. They will work with the small number of people who for whatever reason are reluctant to work with services but clearly have mental health needs. Again the very nature of this service is one where the emphasis is on community-based provision that best meets the needs and choices of those who receive the service.

4.8 What we plan to do in your area

The chart below builds on the model detailed in section 4 and gives you more information about what we plan to do in your area. Again on the left hand side the green shade represents primary care and its interface with, the blue, secondary care services. You will note that this shading is deliberately blurred, as we want our services to be 'seamless', to the point that people who use them cannot see any partition – merely quality services.

How services will look in your local area



4.9 Halton

Halton's Recovery and Resource Centre will be based in the refurbished Brooker Centre. It will have 23 beds for individuals who require short-term inpatient support. However the emphasis of our new Recovery and Resource Centre will be placed upon supporting people either in their own home or within the centre on an appointment basis.

4.10 Knowsley

Knowsley's Recovery and Resource Centre is planned to be based in a new building to be constructed in the Knowsley district. In the meantime until the new premises are ready the services will continue to be provided from the Sherdley Unit. It will have 33 beds for individuals who require short-term inpatient support. However the emphasis of our new Recovery and Resource Centre will be placed upon supporting people either in their own home or within the centre on an appointment basis.

4.11 St Helens

St Helen's Recovery and Resource Centre will be based in the refurbished and extended Peasley Cross Court site. It will have 32 beds for individuals who require short term inpatient support. However the emphasis of our new Recovery and Resource Centre will be placed upon supporting people either in their own home or within the centre on an appointment basis.

4.12 Warrington

Warrington's Recovery and Resource Centre will be based in refurbished buildings on the Hollins Park site. It will have 32 beds for individuals who require short-term inpatient support. However the emphasis of our new Recovery and Resource Centre will be placed upon supporting people either in their own home or within the centre on an appointment basis.

5 Other options we considered

Over the past two years we, along with our health and social care partners, have looked at a number of different options of how best to provide our services in the future. The criteria we used to assess these options were that any new service model must:

1) Meet the identified needs of local people

2) Be in line with the best practice both in the UK and the rest of the world, and,

3) Be financially sustainable in the long term, ie, to live within our budget

In the end we were left with only three workable options. The first was to do nothing and continue as we are now. This option was rejected because we know our services are good but they could be a lot better. Also if we carried on as we are doing, over time we would have to close a lot of services as we would go more and more into debt.

The second option was to close some of our current inpatient units and centralise them in fewer locations. By doing this we would be able to save the money that we need to and this would stop us going into debt in the future. We rejected this option because we know this is not what local people want and there is a lot of research that tells us that for most people, most of the time, the best services are local and based in their community.

The third option is the new model of care that we are proposing. This option is in line both with what we know local people want, it is backed by best practice research and is affordable in the long term.

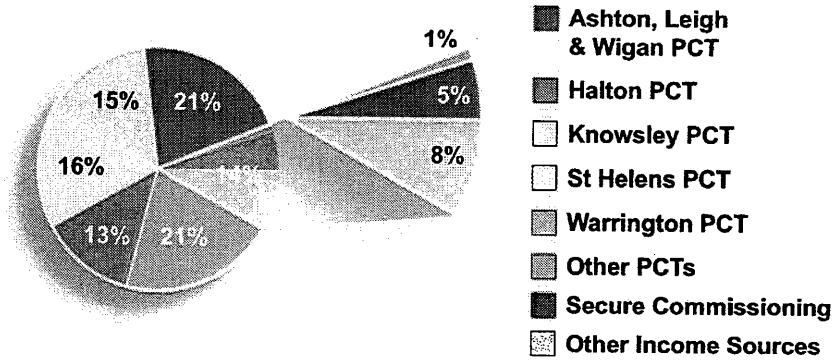
A summary of the options along with the reasons for selection is shown in the chart below.

Potential Options	Meets the Local Needs?	Best Practice?	Financially Sustainable?
1) Do nothing	Only partially	No	No
2) Centralise and close other units	No	No	Yes
3) The new model	Yes	Yes	Yes

6 Who will pay for the new model?

Like all mental health provider Trusts, the money that we receive comes from PCTs who commission (pay for) our services. For the 5 Boroughs Partnership NHS Trust, 86% of the funding we receive comes from the five local PCTs: Ashton, Leigh & Wigan, Halton, Knowsley, St Helens and Warrington.

The chart below shows where all our funding comes from proportionate to each PCT. The total income for 2006-7 is £95 Million.



In addition to gaining your approval for our proposals we will also seek the approval of our commissioning partners within each of the PCTs above. Indeed we cannot make these changes unless the PCTs are satisfied that our proposals are appropriate to the needs of the area and they provide value for the money the PCTs invest.

The current level of spending on the Trust's adult mental health services is higher than the money it receives. If we carry on like this we will go into great debt. The new model will bring the funding into the correct balance and will also be sustainable in the long term – as well as improving the quality of the services we provide.

6.1 How much will it cost?

The new model of working will cost £21 million per year, which with the on costs will amount to around 30% of the Trust's total budget.

The future running costs are forecast to be:

Anticipated Future Levels of Investment	£
Halton	3,348,611
St Helens	5,469,974
Knowsley	5,060,223
Warrington	5,437,044
Total	19,405,851
Estimated Drugs and Other Non-Pay Costs	1,400,000
Total	20,805,851

4

7 What do you think?

This document contains lots of information. For some people it may have too much to take in, for others it may not have enough information and you want to ask more questions. Whichever position you are in we want to hear what you think.

For a range of reasons some people may also be nervous about expressing a view or asking a question that may identify them. To ensure that you are able to speak freely about this document we have invited Mental Health Strategies an independent healthcare consultancy to receive your comments. You can speak to them and be assured that, if you so choose, your comments can be forwarded to us without your name being passed on.

You can send comments and questions to Mental Health Strategies via:

- **Writing**

  The 5 Borough's Public Consultation
  Mental Health Strategies
  9th Floor, Emerson House
  Albert Street
  Eccles
  Manchester
  M30 0BG

- **E-mailing**

  consultation@5boroughspublicconsultation.co.uk

  Please put the words '5 Boroughs' in the subject box.

- **Telephoning**

  0161 785 1001 and ask for Andrew Keefe or Lynne Stafford (if you are asking a question rather than leaving a comment you may have to leave contact details so the answer may be given later).

- **Faxing:**

  0161 785 1009

  Additional copies of this document can be supplied from the Mental Health Strategies office (details above), or a downloadable version can be accessed at

  www.5boroughspublicconsultation.co.uk

8 What happens next?

The formal public consultation will run from 1st June 2006 until the 24th August 2006.

All comments received will be published on the ***www.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.

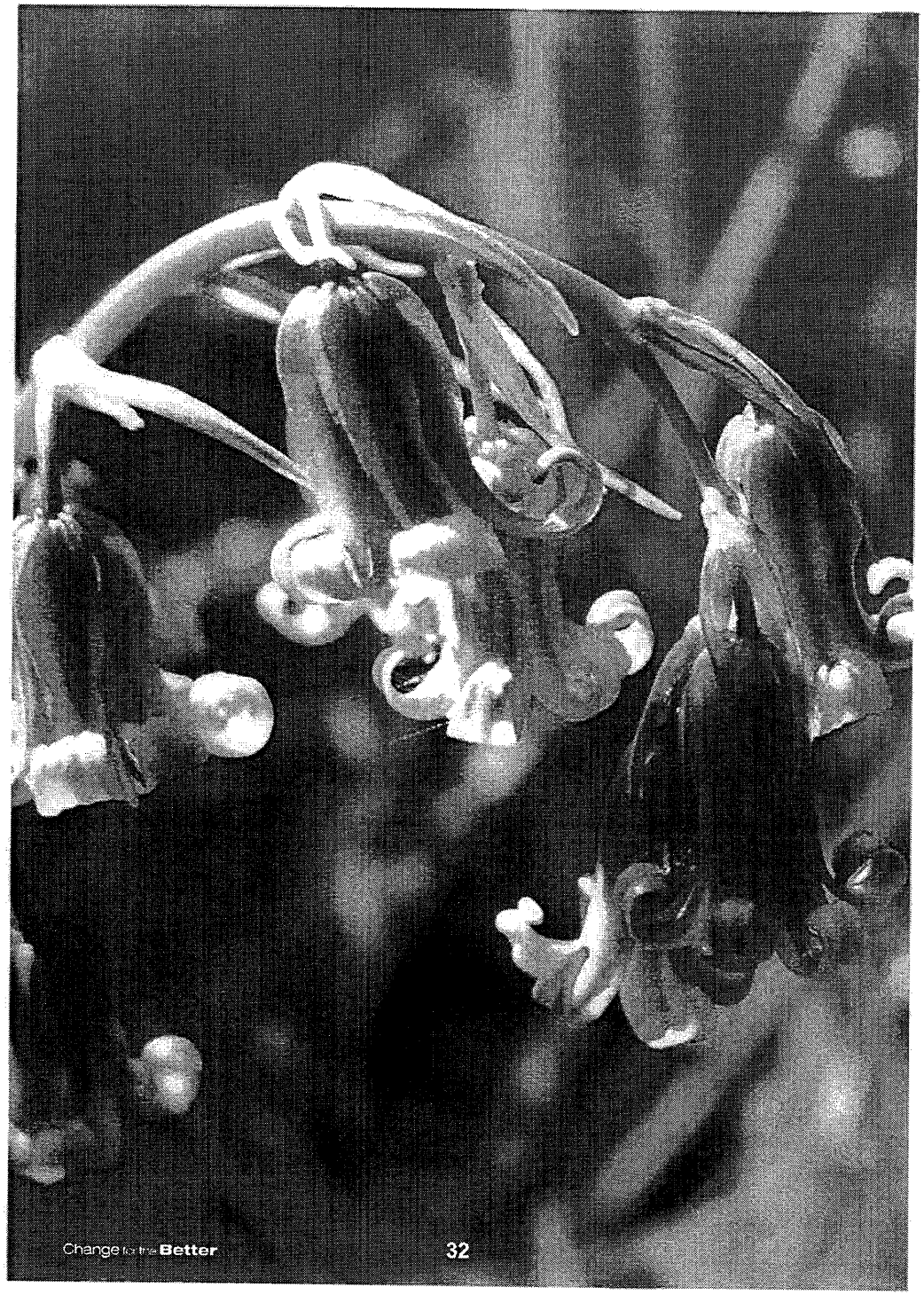
To discuss the changes in your area, public meetings will be held on*:

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***
03.08.06	2pm	CVS ***St Helens***
08.08.06	1pm	Gateway Centre ***Warrington***
17.08.06	6pm	Osprey Room Kirby Suite ***Knowsley***
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.

** Further public meetings may be added to this list.*

For up to date information, please see our web site at www.5boroughspublicconsultation.co.uk



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Feedback sheet

(Please use additional sheets as required)

I have read the 'Change For The Better' document regarding the proposed changes to the provision of adult mental health services and would like to say . . .

Please return comments to Mental Health Strategies (contact details on page 30) by 5pm on 24th August 2006. Alternatively you can submit your comments at any of the Public Consultation events detailed on page 31.

If you have any questions or comments about this document, or you wish to have it translated into your language, call 01925 664074. State the name of your language three times, together with your telephone number. We will arrange for a telephone interpreter to call you back.

English

اس دستاویز کے متعلق اگر آپ کوئی رائے دینا، سوالات پوچھنا یا اپنی زبان میں اس کا ترجمہ چاہتے ہیں تو براہ کرم 01925664074 پر فون کیجئے۔ اپنے ٹیلیفون نمبر کے ساتھ اپنی زبان کا نام تین مرتبہ بیان کیجئے۔ ہم ٹیلیفون مترجم کا بندوبست کریں گے اور وہ آپ کو واپس فون کریں گے۔

Urdu

اذا كانت لديك أي أسئلة أو تعاليق بخصوص هذه الوثيقة أو تود أن تترجم بلغتك، اتصل برقم الهاتف 01925 664074. اعطي اسم لغتك ثلاث مرات مع رقم هاتفك. سنتخذ تدابير كي يتصل بك مترجما.

Arabic

আপনার যদি এই দলিলটি সম্পর্কে কোনো প্রশ্ন বা মন্তব্য থাকে, অথবা আপনি যদি এটি আপনার ভাষায় অনুবাদ হিসেবে চান, 01925 664074 এই নম্বরে টেলিফোন করুন। আপনার ভাষার নামটি তিনবার বলবেন, সাথে আপনার টেলিফোন নম্বরটি দেবেন। আমরা টেলিফোনে একজন দোভাষীর ব্যবস্থা করবো যিনি আপনাকে আবার টেলিফোন করবেন।

Bangla

આપ આ દસ્તાવેજનો અનુવાદ કરાવવા ઇચ્છતા હોય તો કૃપા કરી. 01619584074 નંબર પર અમારો સંપર્ક સાધો. આપનું નામ અને ટેલિફોન નંબર તેમજ આપ કઈ ભાષા બોલો છો તે અમને જણાવો. અમે વિના વિલંબે આપનો સંપર્ક સાધીશું.

Gujarati

यदि आप इस दस्तावेज पर अपनी कोई राय देना और कोई प्रश्न पूछना चाहते हैं या आप इस दस्तावेज का अनुवाद हिन्दी भाषा में चाहते हैं तो कृपया 01925 664074 नम्बर पर फोन कीजिए कृपया अपनी मातृभाषा का नाम तीन बार बोलिए और अपना टेलिफोन नम्बर भी दीजिए। हम एक अनुवादक का प्रबन्ध करेंगे जो टेलिफोन करके आपको इस दस्तावेज के बारे में हिन्दी भाषा में जानकारी देगा।

Hindi

ਜੇ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਸਵਾਲ ਪੁੱਛਣੇ ਚਾਹੁੰਦੇ ਜਾਂ ਵਿਚਾਰ ਦੇਣੇ ਚਾਹੁੰਦੇ ਹੋ, ਜਾਂ ਤੁਸੀਂ ਇਸ ਦਾ ਪੰਜਾਬੀ ਵਿਚ ਤਰਜਮਾ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਟੈਲ 01925664074 ਤੇ ਫੋਨ ਕਰੋ। ਆਪਣੀ ਭਾਸ਼ਾ ਦਾ ਨਾਮ ਤਿੰਨ ਬਾਰ ਦੱਸੋ, ਇਸ ਦੇ ਨਾਲ ਆਪਣਾ ਟੈਲੀਫੋਨ ਨੰਬਰ। ਅਸੀਂ ਤੁਹਾਡੇ ਨਾਲ ਟੈਲੀਫੋਨ ਤੇ ਗੱਲ ਕਰਨ ਲਈ ਤਰਜਮਾਕਾਰ ਦਾ ਇੰਤਜ਼ਾਮ ਕਰਾਂਗੇ।

Punjabi

Haddii aad leedahay wax su'aalooyin ama faalo oo ku saabsan dokumentigan, ama aad jeclaan lahayd inaad hesho iyadoo luqad kale loo tarjumay, wac 01925 664074. Sheeg magaca luqadaada iyo telefoonkaaga saddex jeer. Waxaynu kuu hagaajin doonaa tarjumaan inuu ku soo waco mar dambe.

Somali

閣下如對這文件有任何問題或評語，或希望將之翻譯成你的語言，可致電 01925 664074。請清楚地說出三次閣下語言的名稱，連同你的電話號碼。我們便會安排一名電話傳譯員回電話給你。

Chinese

ئەگەر هەر پرسیارێك یان تێبینیەكت هەیە لەبارەی ئەم دۆكیومێنتەوە (بڵێوكراوەیە)، یان حەز دەكەیت وەربگێردرێت بە زمانەكەی خۆت، ئەوا تەلەفۆن بكە بۆ ئەم ژمارەیە 01925 664074 . سێ جار ناوی زمانەكەت بڵێ لەگەڵ ژمارەی تەلەفۆنەكەت. ئێمە رێكی دەخەین بە تەلەفۆن كە زمان وەرگێرێك تەلەفۆنت بۆ بكاتەوە.

Kurdish

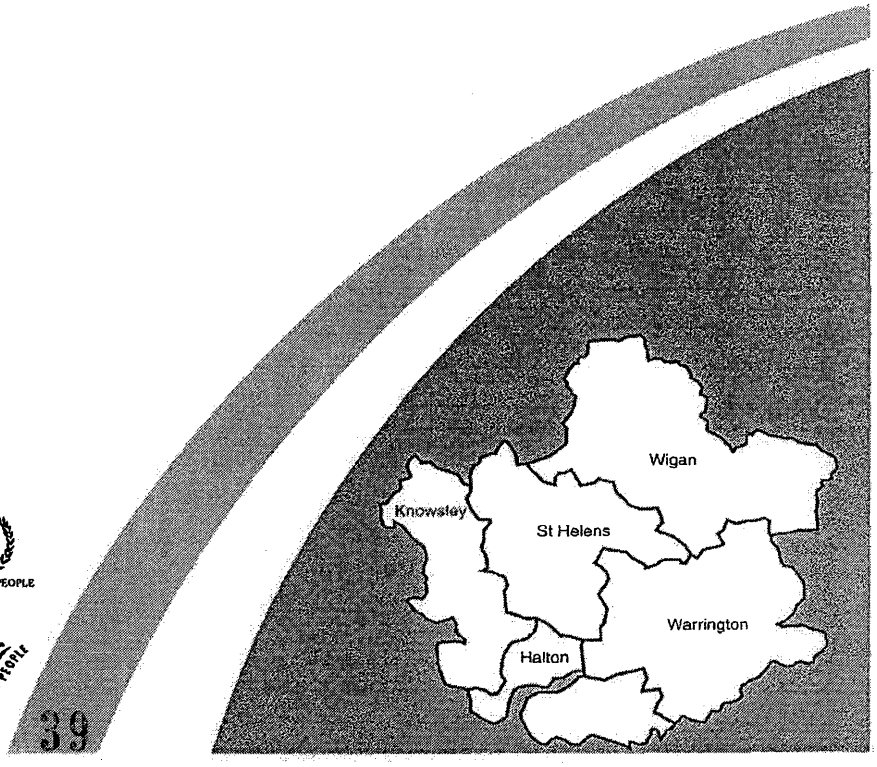
APPENDIX 2 4.

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



INVESTOR IN PEOPLE

POSITIVE ABOUT DISABLED PEOPLE

4

5 Boroughs Partnership NHS
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*'.

4

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.

[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.

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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.

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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.

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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.

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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

Appendix 1
Re: Issues for Joint Overview & Scrutiny 10.08.06

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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Appendix 1
Re: Issues for Joint Overview & Scrutiny 10.08.06

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

Appendix 1
Re: Issues for Joint Overview & Scrutiny 10.08.06

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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Re: Issues for Joint Overview & Scrutiny 10.08.06

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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Re: Issues for Joint Overview & Scrutiny 10.08.06

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

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Re: Issues for Joint Overview & Scrutiny 10.08.06

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	

APPENDIX 3

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JOINT OVERVIEW AND SCRUTINY COMMITTEE

KEY ISSUES FOR MEETING WITH PCT's 24th AUGUST 2006

1. IMPACT ON SERVICE USERS AND CARERS

Are the PCT's satisfied that the plans are based upon the needs and wishes of service users and carer ?

All 4 boroughs have ratified the 4 Boroughs Commissioning Strategy, which contained a significant body of needs analysis and intelligence in relation to feedback from service users and carers. In broad terms this information translated into a possible direction of travel, which included Resource and Recovery Centres to transform in-patient environments.

Individual boroughs have also demonstrated a range of engagements both on-going and specific to inform service planning and redesign. Therefore, a continuous process is operating to ensure service users and carers are involved in the construction of local services. This would complement systems and processes operating within other organisations.

At issue for service users and carers, as for the key partner organisations to 5BPT is the level of detail that is available and when information was made available.

Warrington's Mental Health Partnership Board convened an extraordinary meeting to receive a "Change for the Better" presentation. There were many concerns raised by service users and carers alike which the 5 Boroughs have endeavoured to consider.

2. FINANCIAL IMPLICATIONS

2.1 Can the PCT's assure members that the financial implications of the proposed model of care are robust ?

The PCT's have available financial information as contained with DRAFT reports leading up to the final version of Models of Care 12B and financial reports provided by 5BPT at subsequent Borough specific meetings. The PCT's await further detail and clarifications from 5BPT's in relation to the movements of funds from current to proposed service configurations.

It is though recognised that a disproportionate position will operate in relation to the savings sought against each borough.

HEADLINE COMMENT

HALTON

The following is apparent within the proposed changes presented by 5BPT.

- The level of planned beds (from 69 to 38) could increase the use of Out of Borough placements at cost to the PCT.

- The removal of the alcohol detoxification bed will potentially impact upon costs (recognition exists that 5BPT assert that such a facility was never funded and was based upon bed availability).

- The transfer of a substantial number of patients out of Specialist mental health service i.e. CMHT's down from 2912 (contracts) to 350 (cases) and the planned closure of day units (prescribing activity) will have a significant impact for primary care and there is at this stage no planned investments into Primary Care Mental Health capability and capacity.

- The proposed model does not include Psychiatric Intensive Care Provision (PICU) and this is a parallel Business Case at a potential cost to the PCT of £100K (shared bed with St. Helens).

- The proposed model has been costed for Halton without Early Intervention Service (EIS) which is a component of Resource and Recovery and a national requirement. 5BPT have identified additional cost of £186K to delivery EIS.

- The overall financial context and achieving financial balance will lead to the highest disinvestments within Halton i.e. £1,899,123 down from £5,811,958 to £3,975,723.

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ST. HELENS

Further discussions and subsequent information afforded by 5BPT would indicate either a small increase in investment (+£404K) or a small decrease (-£250K). The lack of clarify is due to accounting practices within 5BPT and the continued apportionment of full service costs to either St. Helens or Knowsley for shared services i.e. In-Patient environments, In-patient Rehabilitation Services (now closed) and Psychological Therapy Services.

- As with Halton the planned reduction in CMHT's activity from 1280 to 525 will have an impact upon primary care and again at this stage no additional investment has been identified to increase capability and capacity within Primary Care Mental Health Services.

- RRC based at Peasley Cross will require substantial capital funding and whilst an indication of securement has been given by 5BPT, this needs to be formalised.

- As already indicated, in relation to Halton, the shared PICU cost to St. Helens would be £100K.

WARRINGTON

The decrease in in-patient beds from 60 to 32 could increase the need for out of area placements, at extra cost to the PCT, if the calculations are not accurate.

The impact the model may have on Primary Mental Health Care Services may be significant. At this point, there is no plan for investment into this area.

As indicated in St. Helens and Halton, there is a separate funding request from 5BPT to fund a PICU bed at a cost of £200k to the PCT.

The PCT is awaiting confirmation of understanding that the non-recurrent financial support of £250K is to cover double running-costs, project management and dissolution costs.

In conclusion it is evident that further detailed financial work is required to inform understanding and decision making.

2.2. Are the PCT's in a position to provide detailed costings to implement and support the strategy including transitional costs where relevant ?

The PCT's are not able to provide detailed costings to implement and support the proposed changes, as these are yet to be agreed and would be the subject of further work. The PCT's have indicated that they would make available funds to assist with transitional work. The PCT's have identified

£0.5M additional ONE OFF funds to assist with transition and the establishment of a Project Team.

2.3.	In terms of the 5BPT recovery plan, why are the savings being financed solely from Adult Mental Health and only 4 of the relevant Boroughs ?

This question may require further clarification from 5 Boroughs Partnership NHS Trust, but the PCT's would consider that this is partly presentational. In that the 5BPT have parcelled together the financial pressures for 2006 / 2007 which are a combination of over-trading and Cost Releasing Efficiency Savings (CRES). Together this amounts to a projected over commitment of £7M.

The 5BPT Recovery Plan seeks to address this by :

- Reducing back office costs by £1M, applicable to all 5 Boroughs.
- Achieve CRES to the tune of £2.6M, equally applicable to all boroughs.
- Generate the balance through Models of Care, which is in line with the recently agreed 4 Boroughs Commissioning Strategy.

Adult Mental Health Services is the core business of 5 Boroughs Partnership NHS Trust and is considered the area requiring further modernisation and redesign. As indicated "back office" costs and CRES will be applied across all services and boroughs.

2.4.	Does the recovery plan have any implications for CAMHS or Older Peoples Mental Health Services. ?

The proposed changes will not directly impact upon contributions from PCT's to 5BPT in relation to the Commissioning of Child and Adolescent Mental Health Services. Clearly 5BPT may apportion back-office costs and CRES to this service area, but they have indicated no reduction of investment.

With regard to Older Adults, the model does incorporate older adults with functional mental health needs. 5BPT have indicated that such needs will be met within Resource and Recovery Centres, that access to Enhanced Day Programmes and Crisis Resolution / Home Treatment will be available.

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However, the PCT's have received no information in relation to the capacity assumptions made to enable this change to be implemented.

There are concerns that the RCP recommendations for the number of beds, which has been set at the lower end for adults, does not include consideration of old age. This in the light of an ageing population does generate real concerns.

Equally discussions have identified a clear difference allied to inclusion of Older Adults within Resource and Recovery Centres and the appropriateness of this.

It should be noted that changes and redesign are ongoing in older persons mental health services which need to be dovetailed at implementation.

Proposed changes will impact upon Older Adults. Such changes have been planned more in line with the Adult Mental Health 4 Boroughs Commissioning Strategy as opposed to the Older Adults Strategy. The dovetailing of these two positions requires further work.

2.5. The models of care aims to deliver cost reductions of £7M; approximately £4.4M from staffing and associated costs, with a further £2.5M from general efficiency savings. Is this a sustainable solution ?

As explained in 2.1 to 2.4., the 5 Boroughs Partnership NHS Trust have parcelled together cost reductions from Models of Care, back-office cost savings and CRES to achieve the overall position of £7M. This is within the context that whilst acknowledging the underlying financial problem, 5BPT did achieve a balanced financial position at year end 05 / 06.

Given the available information provided, it is difficult to judge sustainability without further work. Important will be transitional planning, agreed timelines for implementation and the actual management and implementation of the change,

2.6. In a presentation, the 5 Boroughs Partnership NHS Trust stated that the proposed model would work, providing there was no disinvestments from the PCT's. Can you confirm that this is the case? Can the PCT's guarantee that they are able to sustain this level of investment in future years ?

The PCT's are not planning to remove investments from 5BPT as a consequence of the proposed new Models of Care.

Warrington PCT is assured by the 5BPT that post implementation, it will be investing at a lower level than it is now. There are current redesign projects and proposals which are currently underway. These will need to be

completed and the cost implications considered separately to the Model of Care.

However, PCT's retain the right as commissioners to explore whether services can and should be provided by another provider. For example the proposed Access and Advice Centre does not have to be located within specialist mental health services and this could sit in Primary Care. This would involve either a partnership with 5BPT to deploy staff or staff being employed by the PCT's.

The proposed service changes will not lead to PCT's disinvesting in mental health services. To the contrary PCT's will maintain the current levels of investment to enable 5BPT to work differently and achieve greater efficiency and effectiveness allied to current investments. 5BPT are seeking to reconcile activity to the current investment levels. This explains the dual objectives of service improvements and financial balance.

As with all statutory organisations, the PCT's are not able to guarantee investments at a particular level for always. However confidence exists that PCT investments into mental health services will rise to both keep pace with pay and prices, but also afford service enhancements. The question will be the timeframe and level of growth.

2.7. In the 5BPT presentation it was identified that overall investments by PCT's in mental health services was significantly below the regional and national average. Will the PCT's not only sustain current investments but look to increase, if to a reasonable average, so that community services are not put at risk because of bed closures ?

The PCT's accept the below average spend per head of population on mental health services that has built up over many years and that will take time to address. However PCT's are firstly seeking to ensure that current investments are deployed efficiently and effectively to progress positive outcomes for service users and carers. Equally that the configuration of services across the whole system is safe, sound and supportive. PCT's have invested within mental health services and will continue to do so.

It is acknowledged that Warrington PCT invest at a higher rate (statistics / evidence). To this effect, the PCT would be looking to disinvest to enable investment elsewhere.

The PCT's accept that in-patient services can only be reduced with corresponding enhancements to community service infrastructures. To-date a shift has been taking place, as required by the Department of Health, away from in-patient services to supporting individuals at home and within community locations. This explains the development of Assertive Outreach,

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Crisis Resolution / Home Treatment and Early Intervention Services, together with Gateway and Graduate Workers to support primary care.

The Resource and Recovery Centre approach is seeking to re-balance existing resources to promote the shift away from a reliance upon in-patient services.

3. BED REDUCTIONS

3.1 Are the PCT' satisfied that the actual and proposed reduction in in-patient beds is realistic and sustainable ?

The PCT's would make the following overarching comments in relation to the planned, in-patient bed reductions within each borough, as this is differentially applied. The following arises :

- The reduction of in-patient bed environments is in line with national policy and a target of 30%. This is directly related to the establishment of Crisis Resolution / Home Treatment Services and the switching of resources away from in-patient services towards community. This position is further supported by Early Intervention Services, which will identify and intervene to prevent undetected psychosis and Assertive Outreach Services which will work intensively with those who are difficult to engage and were previously characterised by frequent admissions to hospital.

- 5BPT are not though seeking to adhere to the national position but seeking to achieve greater in-patient reductions, in line with the minimum recommended population figures identified by the Royal College of Psychiatrists.

- The proposed in-patient bed reductions is further complicated by the inclusion by 5BPT of current in-patient beds for Older Adults with functional mental health needs. At present there are no recommended bed numbers per population for Older Adults with such needs. The Royal College of Psychiatrists are currently working to provide advice in relation to this matter.

- 5BPT have therefore used the Royal College of Psychiatrists minimum figure for Adults, but in-patient provision within each borough will respond to both Adult and Older Adult needs.

- In-patient bed reductions can only be achieved, in a safe, sound and supportive manner, if a comprehensive, complementary and integrated community infrastructure exists across the whole spectrum of services and service providers. This is therefore central to any proposed reconfigurations of services. In essence the balancing of resources to assure unintended impacts do not occur elsewhere.

- The consideration of both Adults and Older Adults within the same ward environments, even with the proposed high staff to patient ratio's will present challenges. This has been the subject of further discussion and the importance of age appropriateness in service terms. For St. Helens, the proposed move to Peasley Cross will continue current practice of mixed environments, for Halton and Warrington the proposed change will move from separate environments to mixed.

HALTON

The context of Halton Borough is such that Crisis Resolution / Home Treatment Services have only recently been operationalised and that Early Intervention Services still are not provided. The PCT accepts as commissioners responsibility for this.

As indicated what is proposed by 5BPT is greater than the national 30% target. 5BPT will seek to reduce in-patient beds from 60 to 38 by the closure of two wards, ONE for Adults (which would achieve the 30% i.e. 17 adult beds) and ONE for Older Adults with functional mental health needs, an additional 14 beds.

At issue with this approach is the Intention to exceed the national target, without the proposals assuring community infrastructures (i.e. EIS not costed in) and to add older adult in-patient facility into the reduction. In essence the proposed Resource and Recovery Centre for Halton will operate at 38 in-patient beds for both adults and older adults.

WARRINGTON

As for Halton, what is being proposed by 5BPT is in excess of the 30% target. The proposals for the reduction in in-patient beds is from 60 to 32, with the complete closure of the older persons functional illness ward. The PCT have concerns about the number of beds, the lack of robust community infrastructure and the ability to manage the two client groups safely in the same environment.

The proposed reconfiguration of in-patient services, in the absence of a comprehensive community infrastructure, will involve significant risks to PCT's and partners. Such a position is further compounded by the proposed timeframe for change i.e. Halton will be the first borough to implement the Resource and Recovery Centre Models.

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3.2. Given that bed occupancy is currently in excess of 100%, are the PCT's confident in the Trusts ability to quickly achieve up to 50% bed reductions, given that there is no sign that the new NHS Teams which are now largely in place, have had any impact on bed usage by the Trust so far ?

This question reflects both the paucity and reliability of information provided by 5BBT in that it was the case, and could still be applicable in certain boroughs, that with the existing in-patient numbers, occupancy levels have exceeded over 100%. This is though equally related to the introduction or otherwise of the new services. PCT's acknowledge that Assertive Outreach, Crisis Resolution / Home Treatment and Early Intervention Services are either consolidated, still developing or not in place. As such the proposed changes will achieve consistency of establishments for all boroughs.

Consequently boroughs continue to operate differentially and this correlates to varying levels of in-patient occupancy.

We therefore require from 5BPT's actual performance in relation to in-patient occupancy levels and projected trends. National evidence would support the Crisis Resolution / Home Treatment target of 30% reduction in in-patient services.

As indicated earlier the complicating factor remains that 5BPT have imported Older Adults in-patient facilities into over bed reductions. This explains the proposed position within Halton and whether the number suggested is sustainable i.e. the national CRT / HT position is for Adults only.

4. COMMISSIONING STRATEGY

4.1. Are the PCT's satisfied with the proposed model of care and does it fit with the relevant commissioning strategies ?

The proposed reconfiguration of services provided by the 5BPT is focussed upon ADULTS of WORKING AGE and OLDER ADULTS with functional mental health needs.

The proposed model does not therefore address other service areas provided by the 5BPT, notably :

- Children and Young People (CAMHS)
- Older Adults with organic Mental Health needs.

- Adults with Learning Disabilities
- Substance Misuse Services

The model is evidence based and modelled upon service changes within NORFOLK and WAVENEY.

(Warrington PCT has some concerns that this is the only model that the 5 Borough Partnership appear to have considered. It has only been in place for 8 months so has it been fully evaluated ? The model took 18 months to implement, much longer than what the 5 Boroughs are anticipating.)

Early indications within this service indicates :

- Reduced in-patient length of stay
- Decreasing emergency admissions
- Positive staff commitment.

Such a position is balanced by operational change less than 12 months and emerging feedback from primary care of increasing referral rates. It is planned for a team of officers to visit representatives within NORFOLK and WAVENEY.

The concept of a RESOURCE and RECOVERY CENTRE, supported by complementary community services does therefore provide a sound platform to modernise mental health services. The key though remains transition and implementation recognising that "the devil is in the detail".

With regard to the recently agreed 4 Boroughs Commissioning Strategies (Adults of Working Age, Older Aged Adults and CAMHS) a direction of travel towards New Models of Care was indicated. However, this was within a whole systems context and a tiered approach to mental health services.

It is the case that 5BPT are seeking to work differently without fully considering the implications for the whole systems of support and service provision. The PCT's would therefore endorse in principle but seek efficient and effective transition planning to assure implementation.

4.2. Are the PCT's satisfied that the proposed model is clinically robust ?

The model as proposed by the 5BPT is considered to be clinically robust. In that it is seeking to comply with the National Policy Implementation Guide for the Complementary specialisms i.e. CRT / HT , AOT and EIS, it is based upon evidence in practice elsewhere i.e. NORFOLK and WAVENEY Mental Health

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Trust and will progress the standards recommended by the National Institute for Excellence (NICE). Equally the reconfiguration of in-patient services will comply with Safety First and Safer Services in the levels of patient to staff ratio's, fit for purpose physical environments and workforce development to embrace the proposed service models.

The PCT would seek advice from the specialist provider "as the expert" in relation to overall clinical governance.

The Warrington PCT Board have requested evidence of the clinical governance impact assessment to ensure patient safety, risk management and business continuity.

4.3. How does the proposed model of Care, and the recovery plan, relate to emerging developments in practice based commissioning ?

It is at this stage too early to give a definitive position in relation to the emerging Practice Based Commissioning Consortia within each of the Boroughs. Presentations by 5BPT's to the Professional Executive Committees and Primary Care Trust Boards has identified a need for further engagement with Primary Care.

Primary Care is supportive of the move from in-patient provision to enhanced community infrastructures. This change would be in line with the imperatives for Practice Based Commissioning to further develop primary care capability and capacity.

As indicated already, such a position recognises a tiered approach to service provision and advances STANDARDS TWO and THREE of the National Service Framework i.e. Primary Care and Access.

All of the above though is set within a financial context of constrained resources across health economies.

5. CONSULTATION PROCESS

5.1. The PCT's believe that there has been effective consultation with staff working in the 5 Boroughs Trust and allied professionals, for example GP's ?

With the progress of the formal consultation and direct meetings held within the specific boroughs, 5BPT have provided reassurance that staff consultations have been undertaken. This is a continuous process and both

internal and publically held meetings have afforded staff consultation. The 5BPT have also actively engaged with Unions and professional bodies.

Presentations to the Professional Executive Committees of PCT's and PCT Boards has identified a need for engagement with G.P's and Primary Care. Whilst supportive of the shift away from in-patient services, further discussion is required given the movement of patients.

5.2. Do the PCT's have confidence in the 5 Boroughs Partnership NHS Trust to deliver the proposals as described safely and in full and that appropriate consultation with all stakeholders will have been undertaken ?

The PCT's are at this stage not able to reach conclusions in relation to the delivery of the proposals to change services. This reflects the on-going nature of the consultation process, a developing body of information and a focus, now acknowledged by 5BPT, that agreement in principle is the first stage of the proposed change programme. As such engagement with 5BPT is building and more information has been provided to inform decision making as to the appropriateness of the model.

However, the PCT's are clear that if agreed in principle, critical to the change programme would be transitional planning, involving all partners and stakeholders and a robust programme of implementation, that is realistic and achievable within appropriate timelines. A measured approach, incremental in nature, is required to assure services are safe.

The PCT's do accept that the proposed change programme, within a context of financial imbalance, will challenge the capability and capacity of the organisation.

5BPT are endeavouring to learn fro the consultations and respond to partners enquiries in a meaningful manner. The proposals are significant and will require organisational leadership, workforce developments, strong communication processes and capacity to project manage the change programme. To-date 5 Boroughs have no experience of change within services on the proposed scale.

The PCT's are endeavouring to work with 5BPT and partners to ensure that the proposed changes, if agreed, are implemented in a robust manner.

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6. ELIGIBILITY CRITERIA

6.1. Who is responsible for defining eligibility criteria for Mental Health Services in the boroughs.

A combination of factors, interdependent in nature apply in relation to service accessibility and eligibility. A different position operates in part for health and social care organisations, but recognises the need for organisations to manage demand for services, within finite resources. In broad terms the statutory bodies are responsible for demand management and the use of eligibility criteria.

- For health eligibility is a clinical activity and access to services will reflect resources deployed. Health will manage demand through waiting lists.
- In the case of Local Authorities Fair Access to Care Services (FACS) is applied.
- Integrated services will seek to weld these two positions to discharge the respective responsibilities and duties of each organisation within available resources.

The key is patient appropriate care pathways affording progression of an individuals needs and circumstances.

6.2. The PCT have any analysis of how the tightening of eligibility criteria will impact on the range of community health services including G.P's. Are the PCT's intending to allocate additional resources to G.P's and other community services to cover any gap in services currently provided by 5BPT?

The PCT's are engaged with Local Authority Commissioners and Providers to complete Whole Systems Impact Assessments. Such Assessments will seek to identify the potential impacts given the planned reduction to in-patient services and changes to community services currently provided by 5BPT. Such a position recognises that services other than those provided by 5BPT are constrained and in some cases under-developed. As a consequence the proposed movement of people away from specialist mental health services will create pressures elsewhere within the local health and social care systems.

As already indicated at this stage, the PCT's have identified no additional investments to absorb the potential implications flowing from the proposed New Models of Care.

7. IMPACT ON SOCIAL CARE SERVICES

7.1 Are the PCT's satisfied that the Trusts claim that there will be little or no impact on social care services and costs following bed closures is correct ?

The PCT's are not able to endorse such a position because the partners are still seeking to scope whole systems impacts allied to the proposed change. The new Models of Care has been progressed largely in isolation and is focused upon 5BPT working differently. There is therefore little evidence to suggest that 5BPT have considered other implications.

The PCT's are therefore not able to confirm the assertion by 5PT that there will be no cost consequences to partners. On the contrary the outcome is likely to be additional costs for both the PCT's and Local Authority partners. The New Models of Care will not release resources for reinvestment. Additionality will be achieved, if at all, through a rebalancing of services.

7.2. Do the PCT's consider that additional pump-priming monies over an extended period are needed to fund additional community health and social care services, so that closures can be done safely ?

As already indicated, the PCT's recognise that in-patient services can only be reduced safely with corresponding enhancements to community services. The 5BPT are indicating that proposed service model will provide complementary community services to sustain the proposed levels of in-patient services.

For St. Helens, as now presented, this has been achieved and 5BPT will only seek to reduce the RRC by one additional bed. In contrast within Halton, the PCT is not assured that the planned level of RRV in-patient service is sustainable. This is because the proposal, as presented will not deliver Early Intervention Services and involves the loss of ONE Older Adult Ward for those with functional mental health needs. Equally partners have reported that the wider community service infrastructure is constrained.

WARRINGTON

Warrington PCT will only be pump-priming, on a non-recurrent basis, £250K, to facilitate the transition of services – project management, double-running costs and dissolution costs.

Again, there are concerns about the range and robustness of community services.

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Therefore a mixed picture prevails across the three boroughs requiring further discussions before a resolution of the way forward can be achieved.

7.3. Given that Mental Health Services are provided on a very integrated basis between the Trust and the LA's and are closely interdependent, are the PCT's satisfied with the low level of recognition by the Trust within its process of Consultation and its published document as to the importance of Local Authority Social Care Services is achieving bed reductions, social inclusion and recovery ?

This is, in many ways, the most fundamental of all the questions, in raising the nature of current relationships and whether partnership is real. It is the case, that despite formal and informal partnerships to assure integration, co-location and professionals working together, that the 5 Boroughs Partnership NHS Trust is a health organisation.

It is therefore difficult to evidence proactivity allied to social inclusion, recovery or the social model of mental health. This remains a challenge for 5BPT.

Such a position was evidenced in the earlier drafts of Models of Care, which reconfigured and provided services with health only establishments. The absence of social care was apparent but reflects both the core Service Level Agreements i.e., PCT's and the original remit from PCT Chief Executives allied to the Department of Health policy to achieve financial balance.

It could therefore be considered that in the current integrated service situations, that Local Authority Social Care establishments will be additional to the proposed Models of Service as presented by 5BPT. Again this matter requires further discussion.

8. TIMESCALES

In the PCT's views, are the revised timescales for the implementation of the proposals realistic and achievable ?

Given the scope of the proposed changes, and that partner organisations were not include in the pre-planning, then the statutory 12 weeks consultation period has generated undue haste. The danger exists that the condensed period of consultation will not enable a thorough exploration, given a relatively low starting point of available information.

This explains the 5BPT decision to extend for statutory partners the consultation period.

The reality now is such that there is a growing sense of mistrust on the part of partners. The timing and length of consultation is set against the financial context within which 5BPT is operating.

The PCT's are of the view that the concept and model proposed is appropriate and a sound basis for modernisation of services.

However, the scale of the proposed changes will require robust transitional planning and rigorous project management to enable implementation. The PCT's would therefore require evidence of joint impact assessments and transitional plans to inform decision-making before any service changes were implemented.

The original proposals were not realistic or achievable and it is noted that 5BPT will now reschedule the original plans to at least the commencement of financial year 07 / 08.

9. GENERAL

Are the PCT's satisfied with the out of hours arrangements proposed in the reports ?

The information as provided was confusing in relation to Resource and Recovery Centres and availability Monday to Friday 9.00 a.m. – 5.00 p.m. 5BPT have clarified that this is in relation to enhanced day therapies.

The Crisis Resolution / Home Treatment Team and in-patient services will operate on a 24 / 7 basis to provide appropriate responses to people in acute, emergency or crisis situations.

10. ASHTON, LEIGH AND WIGAN

Can the PCT's explain the position relating to Ashton, Leigh and Wigan. In particular the panel would like to know why Ashton, Leigh and Wigan are being excluded from the consultation when our understanding is that it still intends to utilise higher tier services from 5BPT. The Panel would also like clear understanding of what will happen to St. Helens residents who utilise Wigan Services, some of whom are registered with G.P's in Ashton, Leigh or Wigan ?

Ashton, Leigh and Wigan are not subject to the proposed New Models of Care and therefore the Consultation process, as they have commissioned a separate review of all mental health services. Ashton, Leigh and Wigan will

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explore a range of service configurations identified through this process to determine the future providers of mental health services. Ashton, Leigh and Wigan continue to commission services from 5BPT pending the conclusion of the options appraisal.

Equally Ashton, Leigh and Wigan were performance managed by Greater Manchester Strategic Health Authority whereas the other 4 Boroughs relate to Cheshire and Merseyside Strategic Health Authority.

11. ST. HELENS, HALTON AND WARRINGTON PCT SPECIFIC

11.1 Is the PCT satisfied that the actual and proposed reduction in in-patient beds in St. Helens is realistic and sustainable ?

ST. HELENS

Discussions with 5BPT has now clarified the current in-patient position. 5BPT have confirmed that with the additional investments provided by the PCT (£1.4M over three years), Crisis Resolution / Home Treatment, Assertive Outreach and Early Intervention Services are operational. This has enabled an incremental in-patient bed reduction from 50 down to the present position of 34. The proposed change to a Resource and Recovery Centre Model will only involve ONE further bed reduction.

HALTON

See Item 3

WARRINGTON

See Item 3.

11.2. The Panel would also like clear understanding of what will happen to St. Helens residents who utilise Wigan Services, some of whom are registered with G.P's in Ashton, Leigh or Wigan ?

PCT Responsible Commissioner Guidance is based upon G.P. registered populations and not ordinarily resident, as is the case of Local Authorities. This explains the ability of residents of one borough, registered with G.P.'s in another borough able to access health services within that borough. This position will remain unchanged.

HALTON SPECIFIC QUESTION

11.3. Can the PCT please clarify whether the funding in relation to Frodsham and Helsby patients has been resolved ?

This matter remains the subject of on-going discussions involving both 5 Boroughs Partnership NHS Trust Officers and Officers from Halton PCT. 5 Boroughs Partnership NHS Trust, as part of preparatory work for the proposed New Models of Care, have identified that the current activity exceeds the £130K p.a. received from West Cheshire PCT. 5BPT have quantified the value of such activity to be in excess of £1M.

However at this stage West Cheshire are not accepting the case made by 5BPT and this remains the subject of on-going negotiations. The reality is that costs incurred in the provision of services will not be recovered. The focus will be to determine the value of the Service Level Agreement for the remainder of this year and the future thereon.

Whilst this is an important issue, Halton PCT are focused upon the proposed reduction that is Halton specific i.e. £1,899,123. In that whatever the resolution is allied to West Cheshire, 5BPT are proposing reductions to the cost of Halton wide services.

APPENDIX 4

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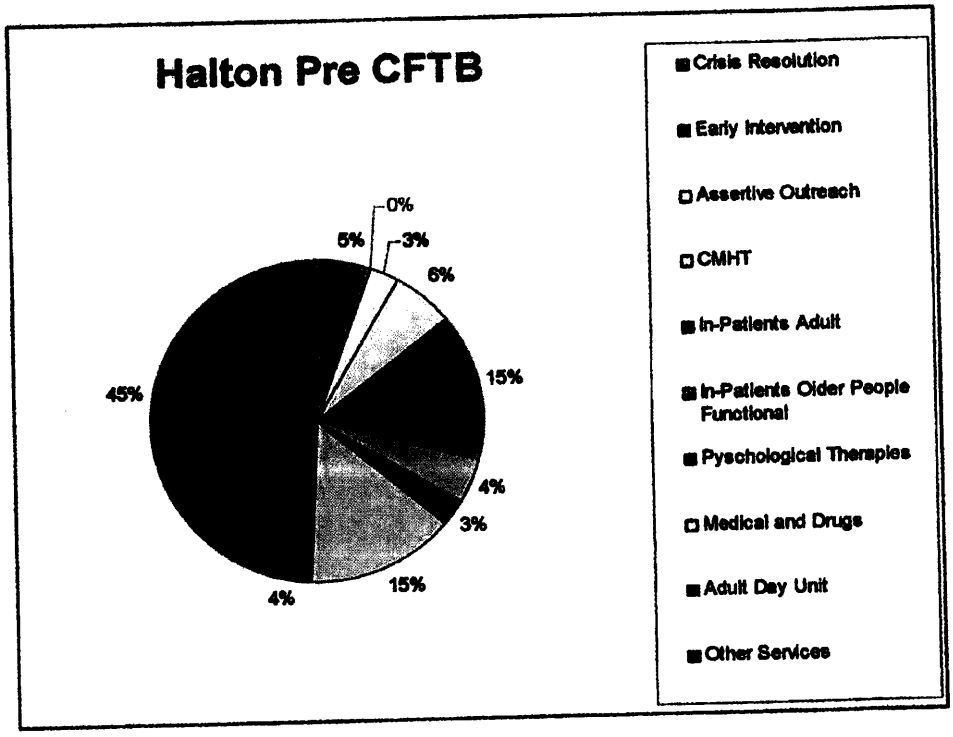

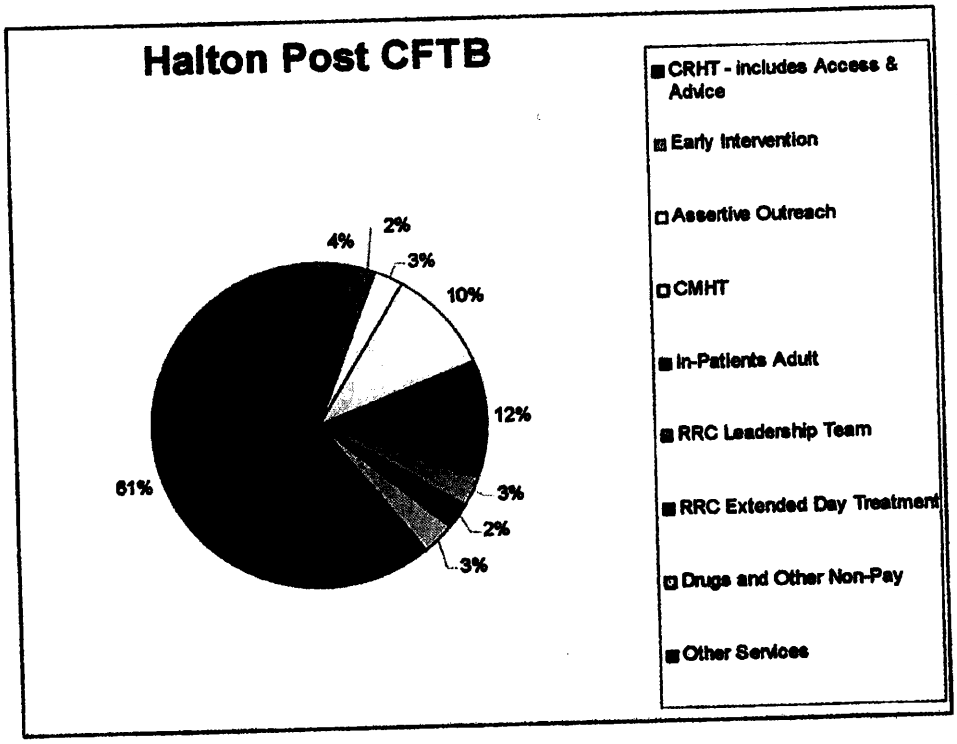

note: Pre Models of Care figures include Non-Pay costs within teams. Medical and Drugs are shown separately. Post Models of Care figures include Medical costs within teams but Drugs and Other Non-Pay are separate.

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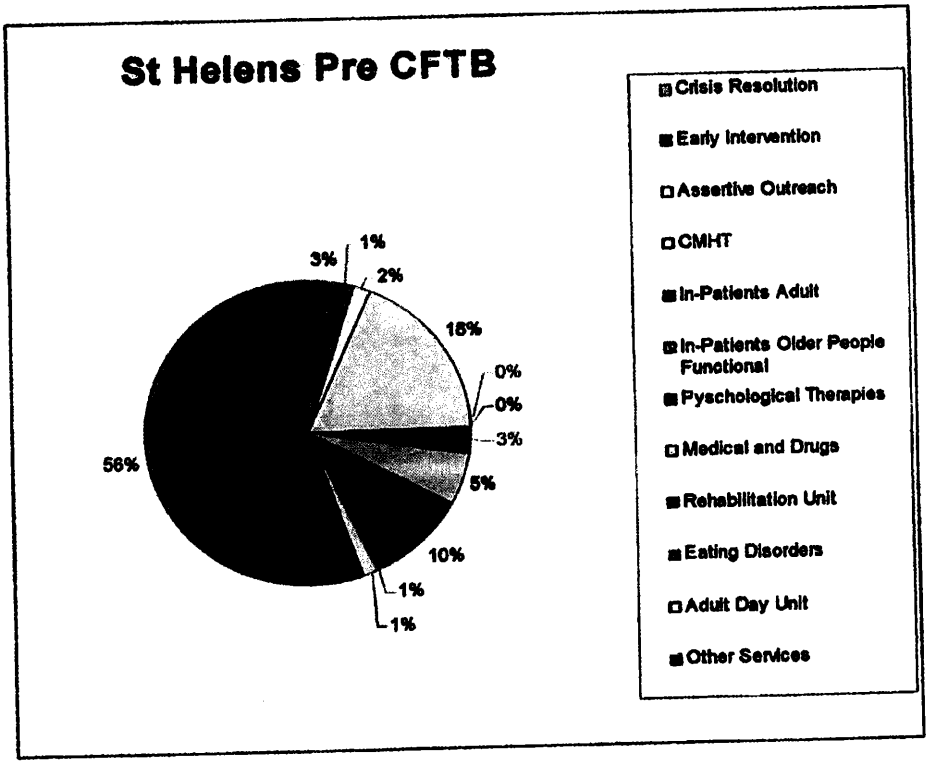

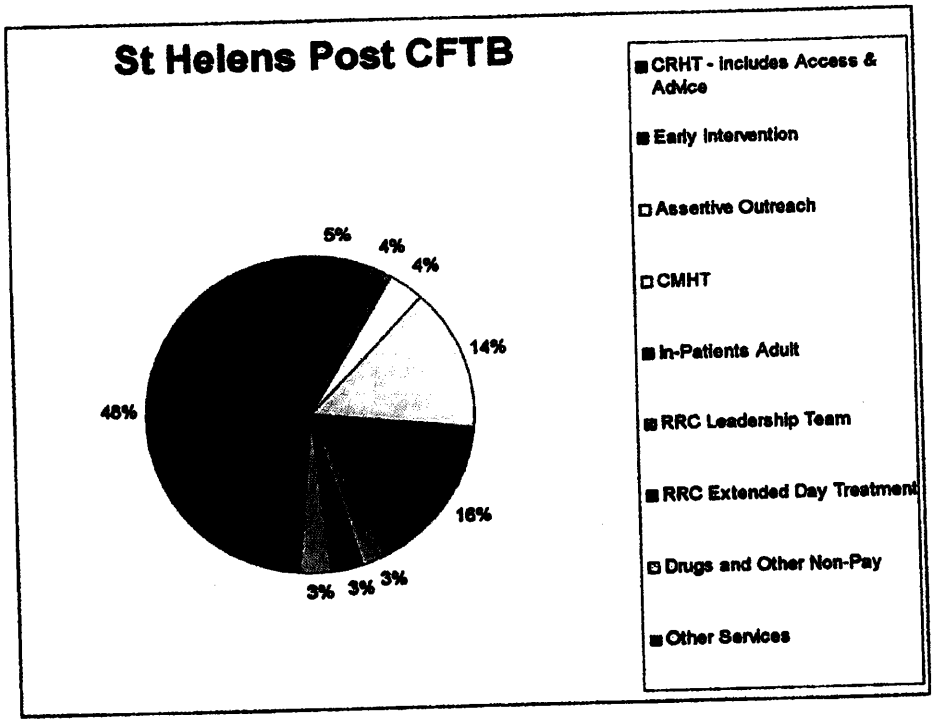

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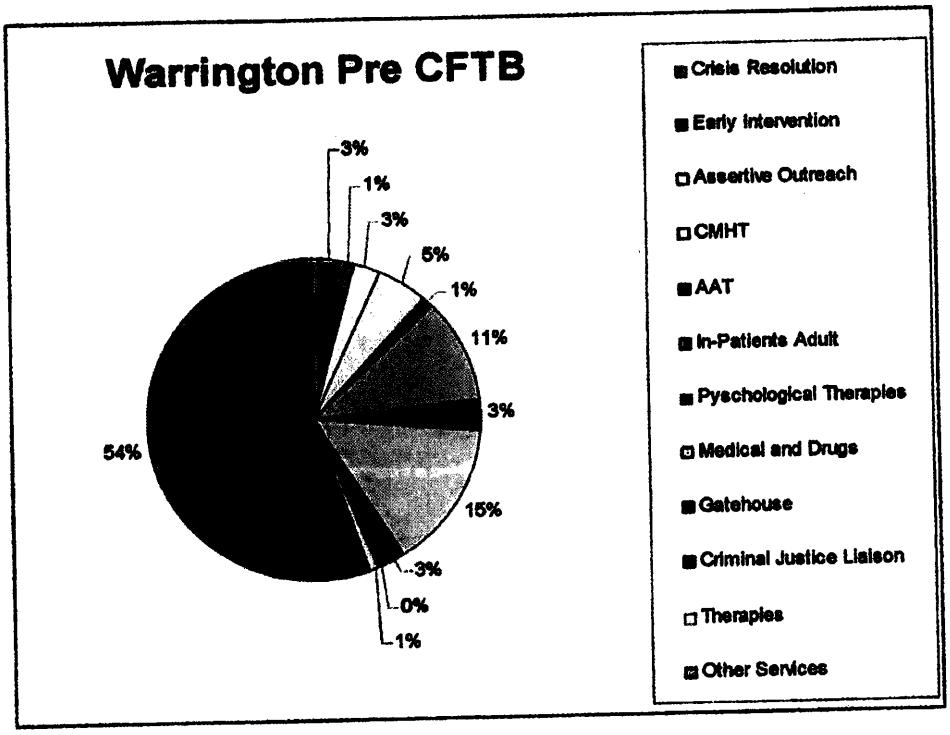

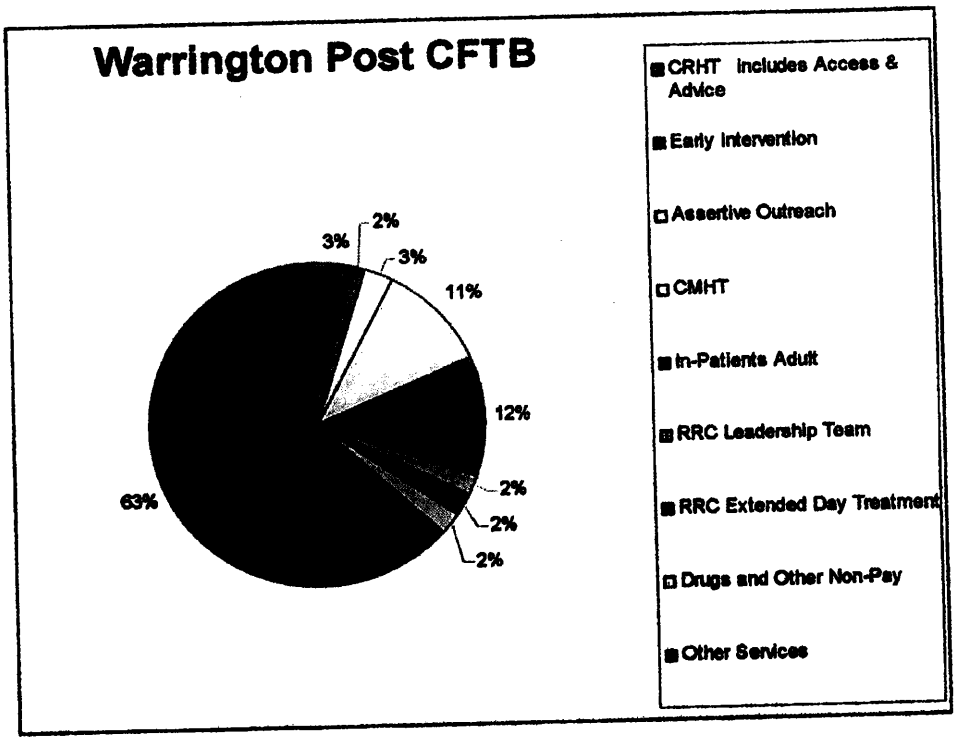

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