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The Cheshire and Wirral Councils' Joint Scrutiny Committee

Agenda

Date:	**Tuesday, 25th May, 2010**
Time:	**1.00 pm**
Venue:	**Middlewich Civic Hall - Middlewich Civic Centre, Civic Way Middlewich CW10 9AS**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the foot of each report.

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

2. **Appointment of Chairman**

   To appoint a Chairman of the Joint Committee.

3. **Appointment of Vice Chairman**

   To appoint a Vice Chairman of the Joint Committee.

4. **Notification of Spokesperson**

5. **Appointment of Secretary**

   To appoint a Secretary to the Joint Committee.

6. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any personal and/or prejudicial interests in any item on the agenda

7. **Minutes of Previous meeting** (Pages 1 - 4)

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To approve the minutes of the meeting of the Committee held on 12 April 2010.

8. **Jargon Buster** (Pages 5 - 6)

A "Jargon Buster" of frequently used acronyms and abbreviations is attached for the Committee's reference.

9. **Cheshire and Wirral Partnership NHS Foundation Trust - Quality Accounts** (Pages 7 - 34)

The draft Quality Account of the Cheshire and Wirral Partnership NHS Foundation Trust is attached for the Committee's consideration and comment. The draft document is currently undergoing a consultation period prior to the publication of the final document in June.

10. **Consultation on Substantial Developments or Variations in Service (SDV)** (Pages 35 - 126)

To consider reports from Cheshire and Wirral Partnership NHS Foundation Trust on the following 2 Substantial Developments or Variations in Service:

- Delivering high quality services through efficient design;
- Redesigning adult and older people's mental health services in Central and Eastern Cheshire

Agenda Item 7

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **The Cheshire and Wirral Councils' Joint Scrutiny Committee**
held on Monday, 12th April, 2010 at Council Chamber, Cheshire West and Chester Council, County Hall, Chester, CH1 1SF

PRESENT

Councillor Bridson (Chairman)
Councillor D Flude (Vice-Chairman)

Councillors Teggin, Grimshaw, Lott, Roberts, Thompson, Watt, G Baxendale, C Beard, C Andrew and Rachel Bailey

Apologies

Councillors Coates, Dawson, Smith and S Jones

30 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Cheshire East Councillor S Jones, Cheshire West and Chester Councillors A Dawson and P Donovan (substitute Councillor P Merrick) and Wirral Councillor I Coates.

31 **DECLARATIONS OF INTEREST**

RESOLVED: That the following declarations of interest be noted:

- Councillor D Flude Personal Interest on the grounds that she was a Member of the Alzheimers Society and Cheshire Independent Advocacy;
- Councillor P Lott, Personal Interest on the grounds that she was a Member of the Local Involvement Network; and
- Councillor D Roberts, Personal Interest on the grounds that her daughter was an employee of the Cheshire and Wirral Partnership NHS Foundation Trust.

32 **MINUTES OF PREVIOUS MEETING**

RESOLVED: That the minutes of the meeting of the Joint Scrutiny Committee held on 26 January be confirmed as a correct record subject to an amendment to Minute 24 to read “(Minute 23 refers)”.

33 **JARGON BUSTER**

The Jargon Buster was received and noted.

34 **PROCEDURAL MATTERS**

The Committee considered a report of the Cheshire East Borough Solicitor on procedural matters relating to co-option, meeting venues and the appointment of Chair, Vice Chair and Spokesperson for 2010 – 2011.

The Committee's Procedural Rules made provision for co-option as follows:

"The Joint Committee may choose to co-opt other appropriate individuals, in a non-voting capacity, to the Committee or for the duration of a particular review or scrutiny".

The Committee had previously resolved to co-opt one Local Involvement Network (LINk) representative from the LINks' Mental Health Sub Group. However, the mid point meeting had subsequently been made aware that, contrary to previous expectation, such a Sub Group was unlikely to be formed for some time. The mid point meeting had therefore reviewed the position and concluded that rather than formally co-opt a LINk representative onto the Committee, a representative from the relevant LINk should be invited to attend the Committee for consideration of specific items of business and/or onto any Task/Finish Groups where appropriate. Discussions were on-going with officers of the Cheshire and Wirral Partnership NHS Foundation Trust (CWP) regarding service user/carer contributions to the Committee.

The Committee noted that meeting dates had previously been agreed and discussed venues and start times. It was agreed that most meetings would commence at 2.30pm and venues would be rotated with further discussion at the mid point meeting of specific details.

The Procedural Rules provided that the Chair and Vice Chair should be appointed annually from the elected Members of the Committee and the Chair should be held by one authority and the Vice Chair from another, the Authority that did not hold either of these positions would elect a Spokesperson.

RESOLVED: That

(a) the previous decision of the Committee to offer one co-opted place to a representative of the LINks Mental Health Sub Group be not pursued on the basis that the Sub Group is not yet in being;

(b) as the Joint Committee meets in different venues, a representative of the relevant local LINk be invited to attend each meeting with the right to speak (and the Joint Committee's Procedural Rules be amended accordingly);

(c) all LINks be notified of the dates and venues for the forthcoming year's meetings, and be supplied with an electronic copy of the agenda for each meeting;

(d) the option to co-opt LINk representatives to Task and Finish Scrutiny Review Groups in a non-voting capacity be noted;

(e) further discussions take place with officers of CWP through the Mid Point meeting concerning Service Users and Carers representation;

(f) the venues for the Joint Committee's meetings for the forthcoming year be approved as follows:

- Monday 12 July, Capesthorne Room, Macclesfield Town Hall;
- Monday 4 October, Chester or Ellesmere Port;
- Monday 10 January, Winsford Lifestyle Centre;
- Monday 4 April, Committee Room 1, Wallasey Town Hall

with a start time of 2.30 pm subject to the Mid Point meeting considering an earlier start for the January meeting and agreeing the venue for the October meeting;

(g) the position concerning the appointment of Chair and Vice Chair and the notification of Spokesperson for the forthcoming year be noted.

35 CHIEF EXECUTIVE'S UPDATE

Sheena Cumiskey, Chief Executive of the Cheshire and Wirral Partnership NHS Foundation Trust, was welcomed to her first meeting of the Committee.

She explained that due to the election purdah period it would not be possible to brief the Committee on potential service changes or consultations.

However, Ms Cumiskey was pleased to report that for the current year contracts had been resolved with the majority of commissioners and the 5% reduction across all CWP commissioned services that had been anticipated from one commissioner had not been implemented.

Actions for the forthcoming year included to further reinforce partnership working; focus on preventative work such as early intervention work with dementia sufferers that was taking place on Wirral in partnership with the Borough Council; and looking at the wider determinants of well-being again through work with partners such as Councils in areas such as housing and work with employers generally in terms of mental health awareness raising (Mindful Employer) and challenging stigma and support to staff in the work place.

RESOLVED: That the update report be noted.

36 QUALITY ACCOUNT

Ursula Martin, Associate Director Quality, Compliance and Assurance, briefed the Committee on the process for submitting a Quality Account for Cheshire and Wirral Partnership NHS Foundation Trust (CWP).

All providers of NHS services were required to publish Quality Accounts – annual reports to the public on the quality of healthcare that they delivered. Prior to publication of the finalised Quality Account in June, providers were required to share their draft Account with the commissioning Primary Care Trust (or Strategic Health Authority), the Overview and Scrutiny Committee (OSC) and the Local Involvement Network (LINk).

Ursula Martin explained that part of the process of producing a Quality Account involved identifying Priorities for Improvement which had to include at least one priority relating to each of the following categories – Safety, Clinical Effectiveness and Patient Experience. CWP had identified:

- Under the Safety Priority- 2 priorities relating to monitoring trends from Serious Untoward Incident investigations and reducing preventable falls in inpatient areas;
- Under the Effectiveness Priority – 3 priorities were identified relating to implementing the Advancing Quality programme for schizophrenia and dementia; developing systems to help identify adherence to National Institute for Health and Clinical Excellence (NICE) guidance as part of an electronic care pathway and reviewing physical health for those with a mental illness;
- Under the Patient Experience – collecting real time patient experience data and ensure that patient experience of previous Assertive Outreach service users and carers is sought and continuously monitored during the merge of this function into Community Mental Health Teams.

CWP had reviewed the quality of its past performance and could demonstrate improvements in a number of areas including:

- Improved learning from patient safety incidents by increasing reporting by 3.1% - this upward trend was encouraging and in line with best practice which suggested that organisations where incident reporting by staff was high (incidents that were of low or no harm), were safer;
- Strengthen hand decontamination compliance – almost 2500 staff had attended hand decontamination training and audits had been carried out to measure compliance;
- Increase offer of psychological intervention to service users with schizophrenia – the target was 70% and a rate of 68% had been achieved;
- Diagnosis of dementia by a specialist – almost 95% of service users referred to the Trust were diagnosed and assessed within 13 weeks;
- Increased patient experience feedback – a target of 5% had been surpassed with patients' experience through comments, compliments, concerns and complaints increasing by over 7%.

CWP was also regulated by Monitor and the Care Quality Commission. The draft Quality Account would be submitted to a Special meeting of the Committee for consideration and comment prior to publication in June 2010.

RESOLVED: that the process of producing a Quality Account be noted and the CWP draft Quality Account be considered at a Special meeting of the Committee on Tuesday 25 May.

The meeting commenced at 2.30 pm and concluded at 4.00 pm

Councillor Bridson (Chairman)

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Jargon Buster

A4C	=	Agenda for Change
AHP	=	Allied Health Professionals
AMH	=	Adult Mental Health
BMA	=	British Medical Association
BOD	=	Board of Directors
C & EC	=	Central and Eastern Cheshire
CAMHS	=	Children and Adolescent Mental Health Services
CC	=	Care Co-ordinator
CDW	=	Community Development Worker
CEC	=	Cheshire East Council
CHAI	=	Commission for Healthcare Audit and Inspection
CHRT	=	Crisis Home Resolution Team
CMHT	=	Community Mental Health Team
CMN	=	Community Mental Health Nurse
COG	=	Council of Governors
CPA	=	Care Plan Approach
CPN	=	Community Psychiatric Nurse
CQC	=	Care Quality Commission
CRHTT	=	Crisis Resolution Home Treatment
CWP	=	Cheshire and Wirral Partnership NHS Trust
DAAT	=	Drug and Alcohol Action Team
DH/DoH	=	Department of Health
DPA	=	Data Protection Act
ECMHF	=	East Cheshire Mental Health Forum
EIT	=	Early Intervention Team
FOI	=	Freedom of Information
FTN	=	Foundation Trust Network
GMC	=	General Medical Council
HCA	=	Health Care Assistants
IAPT	=	Improving Access to Psychological Therapies
ICAS	=	Independent Complaints Advocacy Service
IM&T	=	Information Management and Technology
IR	=	Independent Review

IWL	=	Improving Working Lives
LD	=	Learning Disabilities
LINK	=	Local Involvement Network
LIT	=	Local Implementation teams
NEDs	=	Non-Executive Directors
NICE	=	National Institute for Clinical Excellence
NIMHE	=	National Institute for Mental Health in England
NSF	=	National Service Framework
OHS	=	Occupational health Service
OPS	=	Older People's Services
OSC	=	Overview and Scrutiny Committee
OT	=	Occupational Therapists
PALS	=	Patient Advice and Liaison Service
PAMS	=	Persons Allied to Medical Services
PCMHT	=	Psychiatric Community Mental Health Team
PCT	=	Primary Care Trust
PEAT	=	Patient Environment Action Teams
PER	=	Patient Experience Team
PICU	=	Psychiatric Intensive Care Unit
PPI	=	Patient and Public Involvement
R&D	=	Research and Development
RCN	=	Royal College of Nursing
SHA	=	Strategic Health Authority
SHO	=	Senior House Officer
SLA	=	Service Level Agreements
SLR	=	Service Line Reporting
SPR	=	Specialist Registrar
SU&C	=	Service Users and Carers
TUPE	=	Transfer of Undertakings (Protection of Employment)
WBC	=	Wirral Borough Council
WDC	=	Workforce Development Confederations
WHO	=	World Health Organisation

Cheshire and Wirral Partnership
NHS Foundation Trust

Cheshire and Wirral Partnership NHS Foundation Trust

Quality Accounts 2009/2010

Quality Accounts 1 April 2009 to 31 March 2010 – Contents

Part 1: Statement on Quality

1.1 Introduction and statement from the Chief Executive

I am pleased to present Cheshire and Wirral Partnership (CWP) NHS Foundation Trust's Quality Accounts, which provide information on the quality of care provided for 2009/2010.

An enormous amount of work is undertaken whereby clinicians and managers are routinely monitoring quality and driving improvements in clinical services. The information and data presented in this document represents a small proportion of this work.

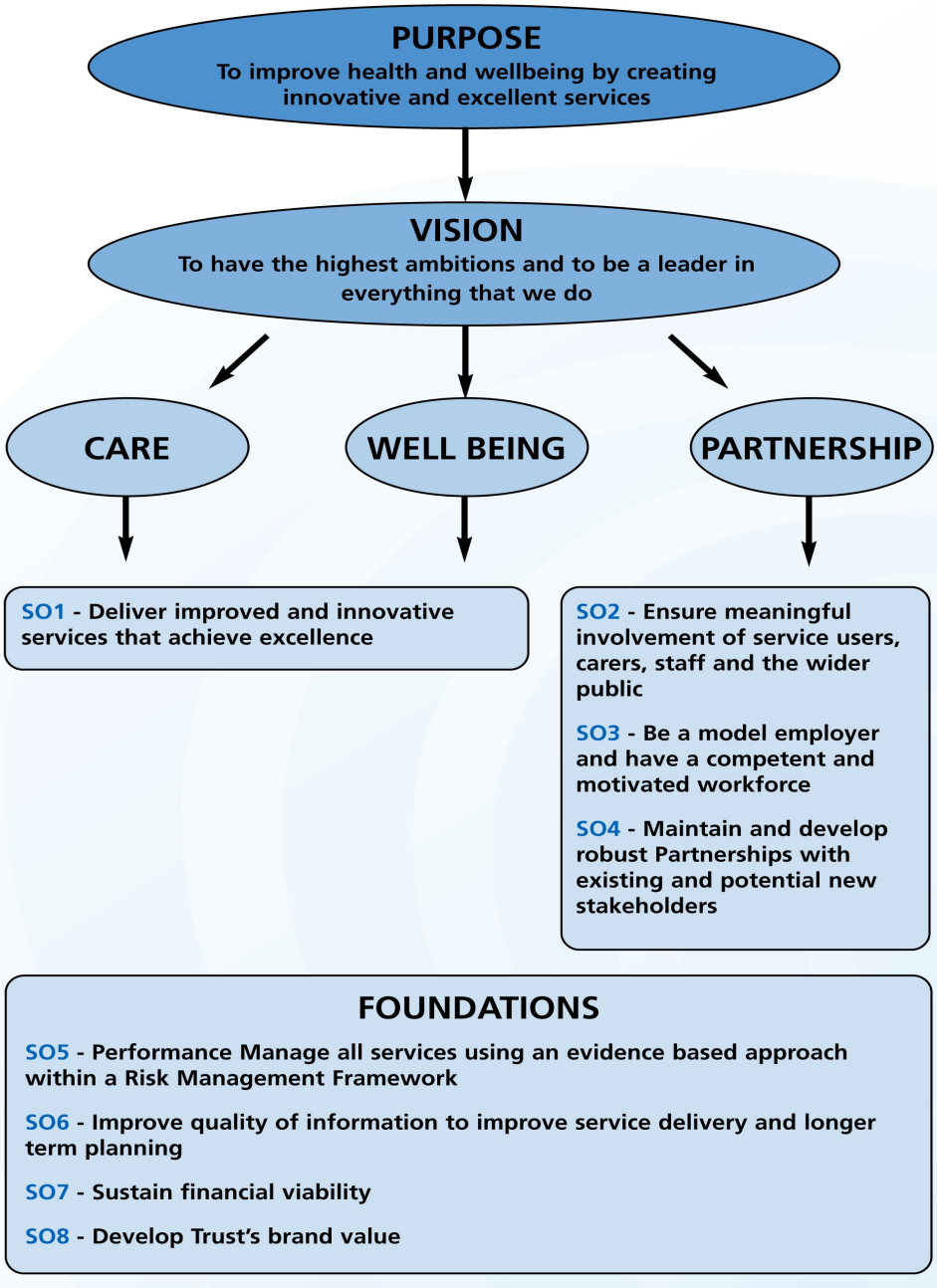
Quality is intrinsic to everything we do at Cheshire and Wirral Partnership, set out within our statement of purpose to 'improve health and well-being by creating innovative and excellent services'

The Board of Directors is totally committed to delivering high quality care and continually improving the quality of our services. We encourage and welcome feedback from service users, carers and the public so that we can learn and improve. It also gives us the opportunity to celebrate and commend staff who provide high quality services, meeting and often exceeding service user and carer expectations.

The Trust has always strived to provide quality services for the population that it serves, by ensuring that:

- the views of service users, carers, staff and the public are taken into account when planning services,
- the clinical care provided is the most up to date, aligned to best practice and current research;
- clinical audit and review of clinical services is conducted throughout the year to share learning and best practice, promoting safety and quality;
- the Trust works closely with partner organisations e.g. commissioners, voluntary organisations, local authority, Local Involvement Networks (LINks) etc. to ensure that we are responsive to the changing needs of the population.

These priorities are evident in our strategic vision, outlined below.



This ethos of striving to constantly maintain and improve quality has resulted in many achievements for the Trust, some of which are listed below.

81% of service users and 71% of carers would recommend CWP's services
Inpatient service user experience report/ Carer's audit, CWP, 2009

84% of in-patient service users rate the quality of CWP services as either 'Good' or 'Excellent'
Mental health acute inpatient service users survey, Care Quality Commission, 2009

Ranked in the top 20% of mental health trusts in England for patient care
National Patient Survey, Care Quality Commission, 2009

First mental health trust in the North of England to achieve foundation trust status
Monitor, 2007

First Trust in UK to achieve the 'Absolute Monty' award for implementing 75 ideas to improve the patient experience in all in-patient wards
Star Wards, 2009

First Trust in UK to achieve ward status level one for excellence in organic Acute *Inpatient Mental Health Services (AIMS)*
AIMS, 2009

First Trust to sign-up to the 'Time to Change' national challenging stigma campaign.
Time to Change, 2008

One of 15 mental health Trusts in the country to have achieved NHSLA level 2 accreditation
NHS Litigation Authority 2009

The Trust has an excellent culture of engagement with Patient and Public Involvement (PPI) representatives, Council of Governors, Foundation Trust members, Local Involvement Networks (LINks), commissioners and other key stakeholders. During 2010/11 we will be working very closely with these stakeholders ensuring that priorities for improvement outlined within this Quality Accounts are monitored and priorities are reviewed in year, to ensure a dynamic process.

Further information about the treatments provided by the Trust and its performance are available from either NHS Choices website (www.nhs.uk) or by accessing the Trust's website (www.cwp.nhs.uk).

Sheena Cuminsky, Chief Executive Cheshire and Wirral Partnership NHS Foundation Trust

1.2 Foreword from Dr Vimal Sharma- Medical Director, Executive Lead for Quality

High Quality Care for All, published in 2008 set the vision for quality, to be the guiding principal in the NHS. The challenge set out within this document was for all healthcare organizations to:

- Define what quality meant to their staff and service users;
- Understand where improvement is happening or is needed;
- Tell others what you are doing and what you are planning to do to improve quality;
- Recognize the role of clinicians as leaders and empower them to drive improvements in quality of care;
- Recognize and reward quality;
- Make sure essential standards are met;
- Make the best use of innovation and research and push forward, not back.

Lots of work has been achieved in 2009/10 to implement all of the above in Cheshire and Wirral Partnership Trust, some of which you will read within this document. Looking ahead for next year 2010/11, we will strive to maintain and improve quality of care.

We will continue to work with our service users, public, staff and commissioners to make sure we have a greater understanding of what quality means for them.

We will continue to engage our staff to improve quality, where it is required and reward best practice.

We will continue to develop our research and innovation agenda, so that the Trust is at the forefront of evidence-based practice in mental health, learning disability and drug and alcohol services.

This Quality Account document has been developed in partnership internally with clinicians, senior managers and service users. Externally the views of the Trust's commissioners, Overview and Scrutiny Committees and Local Involvement Networks have also been taken into account. I am assured that the information contained within this document, to the best of my knowledge, is accurate.

Dr Vimal Sharma, Medical Director Cheshire and Wirral Partnership NHS Foundation Trust

Part 2: Priorities for Improvement and Statement of Assurance from the Board

2.1 Priorities for Improvement

For 2010/11, the Trust has identified priorities to improve quality in line with its commissioners, staff, service user engagement groups and other key stakeholders. This are outlined within this section of the Quality Account, with the rationale for the priority, how it will be monitored and measured throughout the forthcoming year and how it will be reported.

The priorities are identified against the three principal areas of service quality:

1. Patient Safety
2. Clinical Effectiveness
3. Patient Experience

2.1.1 Patient Safety

Safety Priority 1: ***Improve safety by monitoring of trends from Serious Untoward Incident (SUI) investigations and development of systems to monitor reduction of repeatable themes***

Rationale for priority: Applying lessons learned from SUIs is a key measure of safety within any organisation. The Trust has always strived to ensure that any outcomes and recommendations resulting from investigations are shared and applied across the Trust. This is an area that the Trust is also being asked to consider as part of the Quality Schedule of the Trust's contract with its commissioners.
How improvement will be measured and monitored: The current incident system will be improved to capture details of themes highlighted from SUI investigations, as well as actions taken and monitoring of outcomes. The Trust will aim to provide evidence that we have reduced repeatable themes from SUIs.
How improvement will be reported: Repeatable themes from SUI investigations will be reported to the Board and commissioners as part of the quarterly incidents, complaints and claims report and reported internally to clinical services via a 'Lessons Learned' publication.

Safety Priority 2*: Reduction of preventable falls in in-patient areas by at least 10% by end March 2011*

Rationale for priority: A patient falling is the most common patient safety incident reported to the National Reporting and Learning Service (NRLS) from inpatient services at a national, regional and Trust level.
How improvement will be measured and monitored: Each inpatient fall will be reviewed to determine whether the Trust falls policy was adhered to, in order to assess whether the fall may have been preventable. If it is found that the fall could have been prevented, actions taken will be reported and cascaded as learning to all inpatient teams.
How improvement will be reported: Falls incidents will be reported to the Board and commissioners as part of the quarterly incidents, complaints and claims report and reported internally to clinical services via a 'Lessons Learned' publication.

2.1.2 Clinical Effectiveness

Effectiveness Priority 1: ***Implementation of the Advancing Quality programme for schizophrenia and dementia (including development of Patient Reported Outcome Measures)***

Rationale for priority: This is a new regional priority for mental health services. 'Advancing Quality' measures clinical and patient reported outcomes to determine the level of care that patients have received, benchmarked against a set of agreed 'best practice' criteria. This has also been identified as a priority by the Trust's commissioners and is a Commissioning for Quality Improvement (CQUIN) scheme for 2010/11.
How improvement will be measured and monitored: The Trust has signed up to Advancing Quality and will be implementing the programme against timeframes outlined within an agreed regional project plan.
How improvement will be reported: Progress with Advancing Quality will be reported within a quarterly quality report that will be provided to the Trust Board of Directors and key stakeholders, such as commissioners.

Effectiveness Priority 2: ***Development of integrated care pathways in mental health***
Rationale for priority: It is important that integrated care pathways are further developed to promote interface with other services i.e. primary care. This has been highlighted as a priority with commissioners, staff within the Trust and also service users/carers, who would like to see seamless care between primary and secondary care.
How improvement will be measured and monitored: Integrated care pathways will be developed for specific areas in mental health within the clinical framework of integrated care.
How improvement will be reported: Progress will be reported within a quarterly quality report that will be provided to the Trust Board of Directors and key stakeholders.

Effectiveness Priority 3: ***Review of physical healthcare for Trust service users.***
Rationale for priority: Research has indicated that people with mental health problems have an increased likelihood of physical health problems and are at risk of dying prematurely. In recognition that CWP service users may have complex physical health demands, which may be at risk of being neglected, it is important not only to detect physical health problems but also promote physical health and wellbeing. Performance in 2009/10 was monitored for inpatients as part of the quality reporting mechanisms and outlined in Chapter 3 of this Quality Account.
How improvement will be measured and monitored: The Trust has a physical health care pathway in place within the Trust for inpatient services, which will be reviewed. There will also be a review of physical healthcare in the community setting for the Trust's service users, working with General Practitioners.
How improvement will be reported: Progress will be reported within a quarterly quality report that will be provided to the Trust Board of Directors and key stakeholders.

2.1.3 Patient Experience

Patient Experience Priority 1: *Collection of real time patient experience data*
Rationale for priority: Patient experience has always been an important measure of quality within the Trust and feedback from service users and carers has been sought in a variety of different ways- surveys, clinical audit, PALS Talkback, focus groups etc. The Trust however has recognised the importance of collecting 'real time' patient experience data (which is about asking the views of patients and/or their carers/relatives during or immediately after their treatment), to allow service users and carers to give more accurate and timely feedback on their care, as a good patient experience is integral to quality of care and will affect outcomes. This has also been identified as a priority by the Trust's commissioners and is a Commissioning for Quality Improvement (CQUIN) scheme for 2010/11.
How improvement will be measured and monitored: The Trust will use technology to collect real time patient experience, piloting in a number of areas (at least one in each commissioning area). This will be linked to the Advancing Quality programme for dementia and schizophrenia, in order to be able to review clinical outcome and patient experience data for these service users.
How improvement will be reported: Progress with patient experience will be reported within a quarterly quality report that will be provided to the Trust Board of Directors and key stakeholders.

Patient Experience Priority 2: *Ensure that patient experience of previous Assertive Outreach service users and carers is sought and continuously monitored during the merge of the Assertive Outreach function into Community Mental Health Teams (CMHTs).*

Rationale for priority: CWP have undertaken a recent review of the Assertive Outreach function, in conjunction with service users, carers, staff and partner organisations. It was agreed that the work of the Assertive Outreach Teams would be incorporated into Community Mental Health Teams (CMHTs), rather than being a stand alone function. The review was based on clinical research and also to ensure a more efficient service.
How improvement will be measured and monitored: We have planned to put a process in place for monitoring the implementation of the proposal to ensure that assertive outreach service users and their carers receive the level of care and support that they need. This will achieved by undertaking focus groups and a survey.
How improvement will be reported: There is an action plan in place, which outlines the reporting requirements. This includes regular internally reporting within the Trust's governance structure, but also regular external reporting to Overview and Scrutiny Committee, LINks and Commissioners.

The Trust will continuously monitor progress against these quality priorities and will report progress in 2010/11 Quality Accounts, but also throughout the year internally to service users, and carer groups and staff; and externally to commissioners and scrutiny groups.

2.2 Statements Relating to Quality of all NHS Services Provided

2.2.1. Review of services

During 2009/10 Cheshire and Wirral Partnership NHS Foundation Trust provided and/or sub contracted 37 NHS services, across West, Central and Eastern Cheshire and Wirral, as outlined within the Trust's contract with its commissioners.

The Trust has reviewed all the data available to them on the quality of care in ***all*** of these services as part of the CQC registration process and the ongoing internal and external clinical governance arrangements. In addition to the performance and quality data reviewed by the Board of Directors, the Trust implemented 'Patient Safety Walk Rounds' in the past year, which gives Board members the opportunity to talk to frontline staff, service users and carers, giving Board members firsthand knowledge of quality initiatives in practice (e.g. Star Wards, Brilliant Basics, Productive Ward and Productive Leader) and also any priorities for quality identified in partnership with frontline staff.

The income generated by the NHS services reviewed in 2009/10 represents 100% percent of the total income generated from the provision of NHS services by Cheshire and Wirral Partnership NHS Foundation Trust for the period 1st April 2009 to 31st March 2010.

2.2.2a. Participation in clinical audits

Clinical audit is a way of measuring the practice of healthcare professionals and the standards of care and treatment delivered to service users, so that any necessary improvements can be made or excellence in practice consolidated and shared.

During 2009/10, no national clinical audits covered NHS services that CWP provides, therefore it did not and was not eligible to participate in the National Clinical Audit Programme. However, as a matter of best practice, CWP considers the merits of its participation in other national audits that are not part of the formal National Clinical Audit Programme. During 2009/10, CWP participated in the National Health Promotion in Hospitals audit, was the only mental health trust in the region to participate in the original pilot, and was part of the steering group to develop the audit methodology so that the 2009/10 audit would generate quality data and outcomes for mental health inpatient wards to use.

A total of 77 clinical audits were registered with the Trust's Clinical Audit Team and completed during 2009/10. This included those projects registered by individual teams where they aimed to improve the quality of healthcare for specific aspects of the services they deliver, an audit conducted in partnership with other mental health trusts in the North West region, and those participated in by medical trainees. The Clinical Audit Team provides direct support to and reports on a priority number of local (Trustwide) audits each year as part of its clinical audit programme. The reports of 18 local (Trustwide) clinical audits were reviewed by CWP in 2009/10 as part of the Trust-wide clinical audit programme, and it intends to take the following actions to improve the quality of healthcare it provides:

1. Inpatient record keeping audit

CWP undertakes an annual Trustwide record keeping audit to ensure compliance with standards for good quality record keeping, facilitating delivery of high quality care and treatment. The audit recommendations have re-enforced the need to comply with all elements of the Trust's record keeping policy, including the use of standard assessment and risk assessment paperwork, and to ensure that discharge arrangements are recorded in records. Where appropriate, health records will be audited on a smaller scale on an ongoing basis to ensure standards are monitored and high standards sustained, with any decrease in compliance actioned promptly.

2. Medical devices audit

CWP undertook this audit to provide quality information about the numbers and types of medical devices that are in use within the Trust and to assure service users, carers and the wider public with regard to the processes in place for the safe use of medical devices within the Trust. Learning from the audit has informed the following improvements:

- Introduction of an electronic dissemination system for medical device alerts;
- Development of an inventory checklist to teams and wards accompanied by a list of possible medical devices, to remind staff about medical devices that are used on an irregular basis so that they are taken into account when assessed by the nominated Medical Devices Co-ordinator;
- Learning and Development Services will incorporate staff responsibilities relating to medical devices as per Trust policy into staff appraisal training.

3. Carers audit

CWP recognises the need to support carers in terms of knowledge, guidance and understanding of their needs. Carers should be satisfied with the amount of support given to them by CWP to help them carry out their caring role. Carers should also be given adequate information about the services that are provided for them and for the person they care for/support. This audit recommended the following actions to improve the quality of this support further:

- To ensure the Trust supports older age carers with the appropriate level of support and guidance;
- To put programmes in place to strengthen links with all ages of carers;
- To communicate the availability of out of hours support;
- To support and encourage more carers from other services to participate in future carers audits by:
  - Providing more information and developing a standardised approach, working with voluntary sector to deliver this;
  - Working closer with care co-ordinators and 'carer links';
  - Presenting more information to carers.

4. Therapeutic observation audit

Within inpatients areas, it is vital that there is a clear process for therapeutic observation of services users to ensure the delivery of safe and effective care. As a consequence of the findings of a clinical audit of compliance with the Trust's therapeutic observation policy, CWP intends to share the learning from the audit with inpatient staff to ensure that actions are taken to:

- Record in all cases of observation the time of initiation of the current level of observation;
- Document in the case notes daily entry the current level of observation;

- Document complementary current risk assessments with current level of observation;
- Record the conversation assessing mood and behavior in the case notes at least once per shift for patients being observed,
- Complete an intervention plan for all patients on levels 1 and 2 of observation within 72 hours;
- Document in the observation care plan how often the patient should be checked at observation levels 1, 2 and 3;
- Complete a full or partial risk assessment tool at every observation level change;
- Document in the case notes when an observation level is reduced;
- Give patients verbal information about their current observation level;
- Give patients a leaflet containing written information regarding their current observation level.

5. Care Programme Approach audit

The Care Programme Approach is used in mental health services to assess, plan and deliver care, and aims to promote effective liaison and communication between agencies, carers and service users, thereby managing risk and meeting the individual needs of those service users in contact with the Trust so that it enhances their social recovery. As a consequence of the findings of a clinical audit of the use of the Care Programme Approach, CWP will share the learning from the audit with all clinical staff and will ensure the following actions are taken:

- Team managers raise any individual performance issues with staff as part of supervision;
- Staff awareness training is provided to ensure that the benefits of the Care Programme Approach are communicated to service users and carers and that they are aware of the need to inform service users that they can bring a relative or friend to care review meetings;
- All carers are offered a carer's assessment and those who accept should then receive a copy;
- Carers information packs are provided, recorded and monitored.

6 - 7. Safeguarding adults and children audits

Abuse and mistreatment of vulnerable adults and children and the need for a systematic approach when working with those who may be at risk is central to CWP's approach to safeguarding. CWP has undertaken clinical audits around these processes, and the learning has been shared with all Trust staff to ensure that team leaders and ward managers lead on safeguarding adults and children issues within their teams, so that each team and ward has an identified lead for safeguarding issues. CWP will also ensure that awareness is promoted of how to access safeguarding policies.

8. Slips, trips and falls

The Trust is aware of its responsibilities for managing the risk associated with slips, trips and falls, for service users, staff and others, and aims to ensure, via appropriate risk assessment, that staff, patients and others are protected from accidents and a safe environment is facilitated in which high quality clinical care can be provided. As a consequence of the findings of a clinical audit of slips, trips and falls, CWP will ensure that:

- All service users who are assessed and are at risk of falling within community teams are referred to the relevant Primary Care Trust falls prevention service;
- All service users who are assessed and are at risk of falling have a falls intervention care plan and it must be reviewed when applicable;

- All service users who are assessed as not at risk of falling are given a falls information leaflet. The falls information leaflet must be contained within the admission information pack given to each service user.

9 - 10. Medicines management audits

CWP aims to ensure the safe and secure handling of medicines at all stages of the medicine process within ward/inpatient and community/team settings and in doing so minimise the incidents of harm caused by medication errors. CWP undertakes an annual audit regarding medicines management to constantly improve the safe use of medicines, listed below are some examples of learning from the most recent audit and an additional audit of the medicines management policy. CWP will ensure that the following actions are taken:

- Staff distribute medicine leaflets to service users and record advice and monitoring of side effects in their notes;
- When prescribing, staff record the indication for prescribing medication on an 'as required' basis, and that this is relayed in junior doctor training;
- When prescribing, staff record the name of medication to be prescribed off-label and the treatment plan in the case notes;
- Systems and procedures where they have been identified as requiring review are updated and/or standardised;
- There are improvements to the training programme regarding controlled drugs.

11. Audit of NICE guideline: Anxiety

Compliance with National Institute of Health and Clinical Excellence guidance for anxiety has been assessed via a clinical audit and actions have been identified to ensure that:

- Staff distribute medicine leaflets to service users and record advice and monitoring of side effects in their notes;
- If one type of intervention does not work, the service user is re-assessed and consideration given to trying another type of intervention;
- If there has been two interventions provided [any combination of psychological intervention, medication, or bibliotherapy] and the service user still has significant symptoms, then referral to specialist mental health services should be offered.

12. Audit of NICE guideline: Schizophrenia

Compliance with National Institute of Health and Clinical Excellence guidance for schizophrenia has been assessed via a clinical audit and actions have been identified to ensure that:

- Service users with schizophrenia receive a comprehensive multidisciplinary assessment, including a psychiatric, psychological and physical health assessment;
- There are improvements to the number of service users who are given a copy of their care plan;
- There is an increase in the number of service users with schizophrenia offered cognitive behavioural therapy and family therapy;
- There is improved recording of indications/benefits/risks of medication.

13. Strategies to reduce missing patients audit

"Strategies to reduce missing patients" is a workbook designed to provide acute mental health staff with key strategies, illustrated with positive practice examples, to reduce the number of patients who go missing from acute wards. The learning from the self-assessment tool that was used in this clinical audit aims has resulted in the following actions:

- Ensuring the generic service user information pack is available throughout the trust, with use of this promoted;
- All areas should have a daily patient meeting;
- Modern Matrons should liaise with the lead Occupational Therapists for their areas to look at the provision of patient activities and collaborative working.

14. Self harm audit

The aim of this audit was to assess CWP's liaison psychiatry teams' compliance with the National Institute for Health and Clinical Excellence guidelines for self harm. Learning from the audit has resulted in the following actions:

- The Crewe, Chester and Macclesfield liaison teams will invite service user, carer, PCT and ambulance trust representatives to the meeting they currently have in place with the acute trusts;
- An email will be distributed amongst all liaison psychiatry team members to draw their attention to the legal services available to them for advice on the care of their patients;
- Information for staff on how to access legal services will be added to the local induction policy;
- All liaison psychiatry team managers will link with their respective emergency departments to jointly develop training programmes where this is not currently in place.

15 - 17. Resuscitation equipment audits

CWP aims to ensure the optimum management of adult and child cardio-respiratory arrests, should they arise, and a policy is in place to guide and support staff. A number of clinical audits have been undertaken throughout the year to measure compliance with the standards contained within the policy, and the learning from the most recent audit has resulted in the following actions:

- 'Availability of a ligature knife' field should be added to existing daily checklists; this is a recommendation nationally to ensure staff can react promptly to any ligature incidents that occur in inpatient areas;
- Assurance should be sought regarding access via the fob systems employed on clinic room doors. This will ensure that all staff, including bank and locums, are able to access ward clinic rooms in which resuscitation equipment is held;
- Further guidance regarding the acceptable/recommended volume of oxygen gas to be maintained within ward cylinders for use in a resuscitation capacity should be developed.

18. Ward audit

CWP undertakes an annual audit of compliance with clinical standards that are in place across all inpatient areas of the Trust. This year's clinical audit has informed the following actions to improve the quality of care:

- All wards to review at least annually their documentation to ensure they are using the current versions as per Trust policy;
- Staff must be reminded that the admission checklist must be fully completed and filed in the casenotes;
- Staff must be reminded that nutrition screening tools should be fully completed;
- Ensure that all staff are aware of and follow the CWP resuscitation policy;
- Ensure that all medicine fridges are kept locked, have external digital thermometers and there is evidence to demonstrate daily temperature checks;
- All wards should ensure that they have a folder to file National Patient Safety Agency and medicine alerts;

- All wards should ensure they have a Health and Safety poster;
- Risk assess and where possible remove waste bins with liners;
- Ensure a 'Welcome Pack' is available to all service users admitted to the ward;
- Ensure that all staff access line management supervision.

All service line clinical audit reports are reviewed and reported by service line clinical audit leads to frontline staff. Trustwide audits are reported to the Clinical Standards Sub Committee, a delegated sub committee of the Board of Directors, chaired by the Medical Director. The Trust Board also reviews audit data as part of its annual reporting processes but also will review risk based information, gauged from clinical audit, as part of the risk management processes.

The Trust also undertakes a series of infection control, cleaning and spot checks audits, which are undertaken by the Infection Prevention and Control nurses, reported to service line managers and through to the Board of Directors via the Director of Infection Control's quarterly Infection Prevention and Control report.

2.2.2.b. Participation in national confidential enquiries

There are a number of national confidential enquiries, all of which are overseen by the National Patient Safety Agency. The aim of these projects is to improve NHS services by gathering information about trends and developing recommendations to improve the safety of NHS services for the future. The current studies and enquiry programmes of all national confidential enquiries are considered by CWP for applicability to NHS services that CWP provides.

During 2009/10, one national confidential enquiry covered NHS services that CWP provides. During that period CWP participated in this national confidential enquiry. This was the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

The data collection that was completed during 2009/10 is listed below, alongside the number of cases submitted to each category of the national confidential enquiry that CWP was eligible to participate in, as a percentage of the registered cases required by the terms of the enquiry:

Number of cases	Categories of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	Percentage of registered cases
2	Sudden unexplained death in psychiatric inpatients	100%
50	Suicide	100%
1	Homicide	100%
1	Victims of homicide	100%

The table above demonstrates that the Trust fulfilled all requirements of participation in the National Confidential Enquiry programme.

2.2.3. Research

The numbers of patients receiving NHS services provided or sub contracted by CWP in 2009/10 that were recruited during that period to participate in research approved by a

research ethics committee was 558 patients, 17 carers, 5 staff members and 8 teams/wards. This is an increase from 2008/09 figures of 201 patients, 41 carers, 73 staff members and 3 teams/wards.

This level of participation in clinical research demonstrates the Trust's commitment to improving the quality of care that we provide but also making our contribution to the wider health economy. For details of the current research studies being undertaken at CWP, please access the following URL:

http://www.cwp.nhs.uk/AboutCWP/Pages/Researchprojects.aspx

The Trust was involved in conducting 51 clinical research studies. 94% of these studies were completed as designed within the agreed time and to the agreed recruitment target.

CWP used national systems to manage the studies in proportion to the risk. Of the 51 clinical research studies given permission to start in 2009/10, 100% were given permission by an authorised person less then 30 days from receipt of a valid complete application. Of the 51 studies, 2 were Clinical Trials of an Investigational Medicinal Products (CTIMPS), 100% of which were established and managed under national model agreements.

100% of the 51 eligible research involved using the Research Passport System.

In 2009/10 the National Institute for Health Research (NIHR) supported 25 studies through its research networks.

In the last three years 2007 to April 2010, 79 publications have resulted from our involvement in NIHR research, additionally a further 65 research related publications by Trust staff over this period, helping to improve patient outcomes both within the Trust and experience across the NHS.

2.2.4. Goals agreed with commissioners

A proportion of Cheshire and Wirral Partnership NHS Foundation Trust's income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed by the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. This equated to £338,175.

In 2009/10, the Trust achieved all its CQUINs with the commissioners. These were as follows:

- Review of inpatient assessment and treatment units within Learning Disabilities (LD), in line with key department of Health policy documents and most up to date guidance;
- The production and implementation of a recovery strategy for Black and Ethnic Minority service users within CWP;
- To improve access and reduce waiting times for children accessing 0-16 specialist Child and Adolescent Mental Health Services (CAMHS);
- Development of an alcohol pathway to promote the use of brief interventions in Adult and Older Peoples' Mental Health services

- Provision of a mechanism to communicate medication changes for mental health patients to general Practice;
- Regional CQUIN on quality to help measure, monitor and benchmark quality across the North West.

In 2010/11 the CQUIN schemes agreed with the Trust's commissioners are as follows.

- To promote quality for patients with learning disabilities accessing mainstream mental health services through application of the 'Green light Toolkit';
- Implementation of the regional 'Advancing Quality' programme for Schizophrenia and Dementia;
- Promote collection of real time patient experience data;
- Review the dementia pathway within the Trust, working with partner organizations, in line with the National dementia Strategy;
- Development of an alcohol pathway in CAMHS (16-19)/LD to support the use of brief interventions;
- To develop a strategy for improving services for those individuals with Challenging Behaviour.

There are also a number of specialist CQUINS for Secure Commissioning. The total CQUIN monies in 2010/11 equates to £1,246,093

Further details of the agreed goals for 2009/10 and for the following 12-month period are available on request from the Trust's Clinical Governance Department at the Trust Board Offices http://www.cwp.nhs.uk/1/Pages/contactus.aspx

2.2.5. What others say about the Provider

The Trust had to register its services with the Care Quality Commission (CQC), as part of the new registration standards applicable to all NHS Trusts.

The Trust provides the following types of services (as categorised by the Care Quality Commission):

- Hospital services for people with mental health needs, learning disabilities and problems with substance misuse, including liaison psychiatry;
- Rehabilitation services;
- Community based services for people with mental health needs;
- Community based services for people with a learning disability;
- Community based services for people who misuse substances.

CWP provide services to the following service users (as categorised by the Care Quality Commission):

- Learning disabilities or autistic spectrum disorder;
- Older people;
- Adults;
- Children 0-3 years;
- Children 4-12 years;
- Children 13-18 years;
- Mental health;

- Dementia;
- People detained under the MHA 1983;
- People who misuse drugs and alcohol;
- People with an eating disorder.

The Trust has had ***no conditions*** placed on its registration and the Care Quality Commission has not taken enforcement action against the Trust during 2009/10.

CWP is subject to periodic reviews by the Care Quality Commission, (please refer to the following link for more information).
http://healthdirectory.cqc.org.uk/findcareservices/informationabouthealthcareservices/summaryinformation/searchfororganisation.cfm?cit_id=RXAandwidCall1=customWidgets.content_view_1

The last review the CQC undertook with the Trust was in October 2009 and was a *'Visit to monitor the care of people whose rights are restricted under the Mental Health Act'.*

The Care Quality Commission visits all places where patients are detained under the Mental Health Act 1983. The Commissioner linked to the Trust monitors the Trust's operation of the Mental Health Act and visits and meets with detained patients, throughout the year, to monitor the care of people whose rights are restricted under the Mental Health Act. A feedback summary with recommendations is given to the Trust following each visit and, where necessary, action is taken and fed back to the Commission. At the end of the year, the Commissioner then produces an annual statement.

The Care Quality Commission's annual statement, dated October 2009, has provided an overview of the main findings and outcomes from visits to wards/units throughout CWP during the period August 2008 - September 2009.

The CQC made three recommendations for CWP to consider:

1. Section 58

The Commissioner has found a lack of evidence of Clinicians in Charge of treatment following the Code of Practice in the following areas:

- Information given to in relation to treatment and how this is recorded for each service user;
- Seeking and recording consent of those service users where the Mental Health Act permits some medical treatment for mental disorder without consent. In these instances, the individual's consent or refusal should be recorded in their notes, as should the treating clinician's assessment of the patient's capacity to consent, including those being treated under the three month rule as per Section 63 of the Mental Health Act.
- The compliance of Responsible Clinicians with their requirement to record the conversation they have with a detained patient following the visit of a Second Opinion Appointed Doctor [SOAD].

Trust Response to this recommendation

To reinforce the importance of compliance by Responsible Clinicians/Clinicians in charge of treatment with the requirements of the Code of Practice as outlined above. An internal audit will be carried out to ensure ongoing compliance with the issues raised.

2. Statutory Consultees

Compliance by Statutory Consultees with the requirements of the Code of Practice needs to improve.

Trust Response to this recommendation

To remind staff acting as Statutory Consultees of their obligations as outlined in the Code of Practice. An internal audit will be carried out to ensure ongoing compliance with the issues raised.

3. Section 17

Since the Trust's last audit, there is a much improved level of compliance. However, there are still issues relating to risk assessment and service users signing the section 17 proforma. The Commissioner has suggested that where a patient refuses or is unable to sign the leave form that this is recorded. Also staff are not always making a note in the case notes as to how leave has progressed and the impact on the patients Mental Health.

Trust Response to this recommendation

To remind ward staff of the need to consistently record the outcome of leave for daily leave of longer periods and escorted or unescorted.

CWP has made the following progress by 31 March 2010 in taking such action:

1. Section 58

A Trust-wide Section 58 audit is currently being undertaken by the Mental Health Act Team. Findings, recommendations and an action plan will be discussed at the Mental Health Act Strategy Group. The action plan will also be provided to the Care Quality Commission in April 2010. The Code of Practice's guiding principles continue to be highlighted at the Trustwide mandatory training sessions for application of the Mental Health Act.

2. Statutory Consultees

The Trust has a guidance note in place, as well as a reminder system regarding obligations placed on Consultees, as outlined by the Code of Practice. The obligation of Statutory Consultees is also highlighted in the Trust's mandatory Mental Health Act training. An audit will be undertaken in due course. In the interim, as an immediate action, the Mental Health Act Team Manager has reminded all staff in writing that their duties as Statutory Consultees [recording their consultation with the Second Opinion Appointed Doctor (SOAD)] are fulfilled.

3. Section 17

A reminder to all staff has been completed as an immediate action. Plans are in place to highlight the need for recording outcomes of leave in the Trust-wide mandatory Mental Health Act training. The section 17 leave form is in the process of being reviewed.

The CQC also highlights areas of good practice to which each Trust should be aspiring, as well as recommendations regarding matters that require further attention:

- The interface between the Mental Health Act and the Mental Capacity Act;
- Deprivation of Liberty Safeguards;
- The Guiding Principles of the Code of Practice;
- With regard to lone females on wards, the Trust should ensure that it is not acceptable under any circumstances for there to be a lone female on ward or unit and the Commission would like to see this closely monitored. The Code of Practice is clear about this;

- The Trust to monitor the use of Independent Mental Health Advocates.

Progress as at 31 March 2010 in taking action against these five areas has been to schedule a discussion at CWP's Mental Health Act Strategy Group in May 2010 with a view to producing an action plan to promote compliance with best practice.

Cheshire and Wirral Partnership has not participated in any special reviews or investigations by the CQC during the period April 2009 to March 2010. The Trust will be participating in the special review 'Meeting the Physical Health Needs of Those with Mental Health Needs and Learning Disabilities', which is due to be completed by October 2010.

2.2.6. Data Quality

CWP submitted records during 2009/10 to the Secondary Uses System (SUS) for inclusion in the Hospital Episode statistics, which are included in the latest published data. The number of records submitted was as follows:

- Inpatient: 2,860
- Outpatient: 43,468

The percentage of records in the published data which included the patient's valid NHS number was:

- 98.78% for admitted patient care
- 99.94% for outpatient care

The above data shows a high percentage of records within the Trust having the NHS number recorded. This is considered to be an important measure of patient safety as national evidence shows that recording a valid NHS number can reduce incidents involving patient misidentification.

The percentage of records in the published data which included the patient's valid General Medical Practice code was:

- 99.27% for admitted patient care
- 99.99% for outpatient care

The above data shows a high percentage of records within the Trust having a valid General Medical Practice code. This is considered to be an important measure of patient safety as having a valid GP practice logged can enable transfer of clinical information about service users from the Trust back to their GP.

CWP's score for 2009/10 for information quality and records management, assessed using the Information Governance Toolkit, was 88%.

CWP was **not** subject to the Payment by Results clinical coding audit during 2009/10 by the Audit Commission, as this is not applicable to Mental Health Trusts.

Part 3: Review of Quality Performance

3.1 Looking back at quality improvement

Cheshire and Wirral Partnership has been a Foundation Trust since July 2007. Prior to that, it had been an NHS Trust since 2002. The Trust currently serves a population of approximately 1 million people across its traditional area of Cheshire and Wirral although it does provide services on a regional footprint in some cases. Its principal activities have always been to provide primary and specialist mental health, learning disabilities, child and adolescent mental health, and drug and alcohol services - as well as a range of specialist services such as eating disorders services and occupational health.

Within 2009/10, there has been a specific amount of work undertaken to improve the quality of our services, as prioritised within our annual plan. This has included

Adult mental health

- NHS Wirral and CWP invested £2.8 million this year to co-locate all of its adult and older people's services on a single site with improved facilities at Springview hospital in Wirral. All of the older people's wards at Springview have now been completely refurbished and feature single bedrooms with en-suite facilities. In addition, service users have access to a healing environment garden and fully equipped gym.
- Refurbishment of Crewe Mental Health resource centre, enabling clinical and administrative staff to be co-located, promoting more effective working across the team;
- New front entrance and reception area in Millbrook Unit in Macclesfield, promoting a better welcoming and therapeutic environment;
- Establishment of three health facilitator posts in mental health services, to support the public health and health promotion agenda within mental health, working with partner organisations and service users to improve physical and mental well being;
- Establishment of the Intensive Re-enablement Team in Wirral to proactively support clients with complex needs in the community and reduce inpatient admissions;
- CWP's criminal justice liaison service in central and eastern Cheshire has provided mental health awareness training to over 200 police officers and 400 probation workers to ensure that people experiencing mental health problems receive the appropriate approach and care;
- CWP also joined forces with the Royal College of Psychiatrists to pilot a new programme in the North West to drive up standards in memory services. CWP developed two new practitioner roles to help access and diagnose local people with dementia. The Trust was subsequently accredited for its high quality care in memory services by the Royal College of Psychiatrists.

Child and adolescent mental health

- Maple Ward, a new 10-bedded emergency service for young people aged between 13 and 18, opened in Chester in September 2009, funded by CWP. It takes admissions from across Cheshire and Merseyside which means in-patient mental health care for young people experiencing serious mental health problems is now available 24 hours a day;

- Development of Multi-systemic team in Wirral in partnership with the Children and Young People's Department youth offending service, with joint investment from Wirral PCT;
- Development of Tier 2 services for primary mental health worker following investment from Wirral PCT;
- Development of psychology post to enable effective use of the alcohol pathway for children and young people admitted to A and E at Arrowe Park Hospital in Wirral
- Achieving the CQUIN target of 13 weeks access to CAMHS across CWP footprint;
- West 16 – 19 Service have completed the relevant process for meeting the You're Welcome Programme (A national programme for all Children's Services); the team are currently awaiting verification of this achievement. Wirral CAMHS working towards completion of same;
- Achievement of Level 4 across all 6 CQC standards.

Learning disabilities

- Greenways, the new £3.3 million state of the art assessment and treatment unit funded by CWP for adults with learning disabilities, opened in Macclesfield in February 2010. New design features include single en-suite rooms, additional lounges for privacy, a dedicated patient kitchen, computer suite, sensory room, and dedicated spaces for education and learning.
- Successfully part of the secure services framework, following competitive tender by specialist commissioners;
- Refurbishment of Mary Dendy Unit, Macclesfield, promoting a safer, more therapeutic environment;
- CWP continues to be at the forefront of the development of easy read materials, spearheaded by its learning disability services staff. A highlight of this work in the last year was partnership working with NHS Wirral to produce easy read leaflets for people with learning disabilities during the swine flu pandemic, including the symptoms and anti-viral medication. The leaflet was disseminated nationally as best practice.

Drug and alcohol

- Successful in being awarded the contract for provision of drug services in Trafford in partnership with Addiction Dependency Solutions (ADS);
- Wirral drug service has received national praise for its work on recovery and hosted a recovery event.
- New drug service navigator roles have been established to reduce the emphasis on long-term treatment.

CWP was also successful in its bid to become the new provider of the following services this year:

- A community eating disorder service for adults and young people in Warrington and Halton;
- A drug service, in partnership with Addiction Dependency Solutions, in Trafford;
- A learning disability service in Trafford.

3.2 Seeking Your Views

The Trust has a strong culture of Patient and Public Involvement and engagement with key stakeholders, such as commissioners, local businesses, voluntary agencies and partners in health and social care.

In 2009/10, the following activities were undertaken in relation to seeking and responding to views to improve quality:

- As well as participating in the national survey programme, the Trust conducted its own inpatient survey and a survey of carers. The inpatient survey was conducted by service users asking other service users their views of the wards, treatment and staff;
- During the last year CWP has hosted the Mindful Employer North West network, including a series of events with partners across the region to promote well-being at work. One event featured keynote speaker Dame Carol Black, the government's National Director of Health and Work;
- A 'jobs pledge' aimed at developing job opportunities for local people has been signed by the Trust and Jobcentre Plus. Local Employment Partnerships represent a new and innovative approach where employers pledge jobs for long term unemployed people and those at a disadvantage in the labour market;
- The Trust held a family day and annual members' meeting, which took place on World Mental Health Day as part of the national Time to Change "Get Moving" campaign in October 2009, and was attended by around 300 members and the general public. Activities included dance, drama, sports and art; and members also had the opportunity to find out about a wide range of CWP services;
- Three annual planning engagement events took place during November 2009. These events allowed members of the Trust to meet staff from across the Trust, find out more about CWP's latest plans, and to have their say on the longer term direction of the Trust;
- Members were invited to join governors and CWP staff at seven 'Meet the Service Events' which took part in different settings across the Trust. These events have proven to be hugely successful with members, and a further three local meetings along these lines have been planned for the coming year. Governors are also planning a number of local meetings with members living within their area.

3.3 Learning and Improving

Sharing learning is key to ensuring that safety is maintained and that action can be taken to prevent recurrence of similar issues. The following demonstrates improvements and learning as a result in 2009/10:

- The Trust developed information leaflets and training for staff on the safe use of bed rails following an incident;
- Incidents regarding GPs not being aware in changes to medication when service users were admitted for an in-patient episode have resulted in a 'change of medication' communications form being developed. This form is completed and faxed to a safe haven fax in the GPs surgery when medication is changed, improving safety for the patient;

- Following on from a complaint, Trust Liaison Psychiatry staff have reviewed the self-harm pathway with AandE staff to ensure adherence to NICE guidance and consistent application for all service users;
- Learning from a complaint has also demonstrated that there have been some occasions when carers have not been informed of a change in an individual's care plan. This has resulted in an alert being put on the Trust's Electronic Patient Record Systems (Carenotes) to remind staff to consult with carers on any significant changes in care or treatment decisions. This is also monitored through the Trust's carers survey.

3.4 Performance against key National Priorities and National Core Standards

Regulatory Body/Accountable Organisation	Target Title	Required Performance	Actual Performance
Patient Related			
Monitor	Admissions to inpatient services had access to crisis resolution home treatment teams	90%	100%
Monitor, also a Care Quality Commission indicator	100% Enhanced Care Programme Approach (CPA) patients receiving follow up contact within seven days of discharge from hospital	95%	98%
Monitor	Minimising delayed transfers of care	>=7.5%	2.16%
Monitor	Maintain level of crisis resolution teams set in 03/06 planning round (or subsequently contracted with PCT)	4	4
Care Quality Commission	Quality of Services	Not nationally determined	Good
Care Quality Commission (National Treatment Agency)	Number of drug users in effective treatment	Threshold not yet published	89%
Non Patient Related			
Care Quality Commission	Management of Resources	Not nationally determined	Excellent
Monitor	Financial Risk Rating	4 in last two quarters	3 in quarter Looking like 4 in quarter 4
Care Quality Commission (Connecting for Health)	Information Governance Toolkit	Not nationally determined	88%
Internal	Reduce overall sickness levels of staff	5%	5.15%

Some of these targets use external sources of data to assess performance. For more information contact the Trust at information@cwp.nhs.uk

The Trust reports performance to the Board of Directors and to regulators throughout the year. Actions to address any areas of under performance are in place.

In November 2009, the Trust made its mid-year declaration in respect of the core standards for the full year of 2009/10. The Trust declared full compliance with all core standards.

3.5 Review of Quality Accounts Performance Target 2009/10

CWP set itself some ambitious quality improvement targets in its inaugural Quality Report in 2008/09, which featured in last year's annual report and accounts. These comprised of three targets in each of the three domains of quality, defined in the 2008 Department of Health publication *High Quality Care For All* as **patient safety**, **clinical effectiveness**, and **patient experience**. There was robust stakeholder engagement in defining the targets, with the aim of supporting the delivery of high quality care by frontline staff. Below are CWP's achievement against these targets:

Patient Safety

1. **Improve learning from patient safety incidents by increasing reporting by 3%**
   The reporting of patient safety incidents over the past year increased by 3.1%, an upward trend that is encouraging and in line with best practice. This increase was assisted by the introduction of the online reporting of incidents across the Trust. A commitment to reporting demonstrates a commitment to patients and their safety by promoting the ability to learn from each patient safety incident that is reported. This is consistent with the national evidence from the National Patient Safety Agency (NPSA), which indicates that a good safety culture within any Trust is evident from a higher reporting of incidents and near misses, with the majority of incidents resulting in 'no' or 'low' harm. This is the case in CWP.

2. **Create a better safety culture by achieving NHSLA Level 2**
   CWP achieved compliance with Level 2 the NHS Litigation Authority's [NHSLA] risk management standards for mental health and learning disability trusts in November 2009. This independent assessment against national patient safety priorities verifies CWP's ongoing work in developing a better safety culture. There are only 16 mental health Trusts nationally that have achieved this level of accreditation.

3. **Strengthen hand decontamination procedure compliance**
   Almost 2,500 staff have attended hand decontamination training during the year, and almost 50 audits undertaken to measure hand decontamination practice. Equipping staff with the skills to undertake effective hand decontamination minimises the risk of cross infection to service users and staff whilst the additional audits that have been undertaken have ensured that areas requiring improvement have been acted on. This has been highlighted nationally by the Care Quality Commission and Department of Health. The Trust is due to receive a routine Infection, Prevention and Control inspection from the Care Quality Commission in 2010, the results of which will be published on the Trust's website.

Clinical Effectiveness

1. **Increase offer of psychological intervention for service users with schizophrenia**
   CWP set itself an ambitious goal of offering psychological intervention to 70% of service users with schizophrenia. During the year we developed the data collection method across all areas of the Trust for this target. As at January 2010, the Trust demonstrated that psychological intervention was offered to over 68% of service users, a significant improvement on 50% demonstrated by the most recently available clinical audit data. This improvement assists in addressing service users' identified needs more holistically via

their care plan, as stated within national evidence based practice and National Institute of Clinical Excellence (NICE) guidance. This will continue to be monitored as part of the 'Advancing Quality' programme for Schizophrenia in 2010/11.

2. **Diagnosis of dementia by a specialist**
   CWP has contributed to raising the profile of dementia, for example by developing care pathways through its dementia clinical network, and linking with the PCT-led National Dementia Strategy, to ensure that service users are referred, assessed and treated in a timely manner. Almost 95% of service users referred to the Trust were diagnosed and assessed within 13 weeks, which is national best practice. This will continue to be monitored as part of the 'Advancing Quality' programme for Dementia in 2010/11.

3. **Physical health checks for all in-patient service users (including Body Mass Index)**
   CWP contributes to promoting healthy lifestyles as part of its 'Choosing Health' work programme, aims to ensure that all service users who are admitted have an annual physical assessment including Body Mass Index [BMI] measurement as part of this assessment, and facilitates GP access for service users in the community. The importance of physical healthcare in patients who have mental illness has been highlighted via research and also within evidence based practice NICE guidance. Clinical audit data in 2009, showed that 79% of inpatients were receiving a physical health exam, with 83% of these individuals having had their BMI measured. The Trust has an action plan in place to increase this further and will be monitoring this in year as part of the prioritised work on physical healthcare for 2010/11 (which will focus on developing robust systems of monitoring this target), as outlined in section 2.1.2.

Patient Experience

1. **Increase patient experience feedback by 5%**
   CWP is committed to providing high quality services and does everything possible to promote patient experience feedback to help develop the services it provides. CWP surpassed its goal, with feedback obtained from patient experience by over 39% this year. This was broken down by the following:

Type of feedback	2008/2009	2009/2010
PALS (including concerns and comments)	311	743
Complaints	233	216
Compliments	884	1023
Total	1428	1982

   The Trust is pleased to see the downward trend in complaints received by the Trust and the increase in PALS contacts/compliments received, which is in accordance with the Department of Health's implementation guidance on 'Making Experiences Count'.

2. **Measure patient service satisfaction levels**
   Local and trust-wide patient survey activity to capture patient service satisfaction levels has been increased throughout the year. In addition to the national survey work, we said that we would increase local and Trustwide survey and engagement activity. In 2009/10, we undertook a Trustwide inpatient survey and survey of carers. We also organised a number of engagement events, such as 'Meet the Service' Events, 'Annual Planning and

Consultation' events and 'Open Space' events. This is in accordance with our Patient and Public Involvement and Membership strategies, which outlines our duty under the Health and Social Act, 2001.

3. **Improvement of complaints management and investigation processes**
   Last year, CWP introduced quality assurance reviews into its complaints management and investigation processes to support the implementation of the new complaints regulations. This involved a quality assurance check on responses to some of the more complex complaints, overseen by Non Executive Directors and Executive Directors of the Board, senior clinicians and managers, which is in accordance with the Department of Health's implementation guidance on 'Making Experiences Count'. The goal of 12 quality assurance reviews has been met.

The rationale for setting these targets was laid out in our quality report targets for 2009/10, a section within our Annual Report 2008/09, which is available in the reports section of the Trust website (www.cwp.nhs.uk)

3.6.1 An explanation of who we have involved

We have involved the following groups and bodies when developing these Quality Accounts

Internally

- Senior Clinicians and Managers;
- Patient and Public Involvement Representatives;
- Council of Governors.

Externally

- Commissioners;
- Joint Overview and Scrutiny Committee for Cheshire and Wirral;
- Local Involvement Networks

We will continue to work with the above groups to monitor these Quality Accounts throughout 2010/11.

3.6.2 Statements from Local Involvement Networks, Overview and Scrutiny Committees and Primary Care Trusts

Pending

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Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Report

Title of Meeting	Board of Directors
Date of Meeting	May 26th
Agenda item number	

Title of Report	Report on the independent analysis of response to the consultation 'Delivering High Quality Services Through Efficient Design'		
Presented by	Ian Davidson, Medical Director/ Deputy Chief Executive		
Author(s)	Natalie Park, Associate Director, Service Innovation and Development		
Purpose of the report	To appraise the Board on the outcome of the consultation exercise		
Related to strategic goals	SO1	Deliver improved and innovative services that achieve excellence	X
	SO2	Ensure meaningful involvement of service users, carers, staff and the wider public	X
	SO3	Be a model employer and have a competent and motivated workforce	X
	SO4	Maintain and develop robust Partnerships with existing and potential new stakeholders	
	SO5	Performance Manage all services using an evidence based approach within a Risk Management Framework	
	SO6	Improve quality of information to improve service delivery and longer term planning	
	SO7	Sustain financial viability	X
	SO8	Develop Trust's brand value	
Financial and legal implications			
Patient and public implications	CWP will prepare report informing the public on the outcome of the consultation exercise		
Staff implications	CWP will prepare report informing staff on the outcome of the consultation exercise		
Partner organisation implications	CWP will prepare report informing partner agencies on the outcome of the consultation exercise		
Equality issues			
Risk score and assurance rating			
Action required	To receive		x
	To review		
Recommendations	To approve		

	To confirm	x

Document History

Revision History

Version	Date Revision	Change by	Brief Summary of Change/Sections Changed
1			

Distribution

Version	Name/Group	Date Issued
1	Trust Board	17th May 2010

Executive director sign-off

	Executive director	Date signed-off
Version distributed to Board of Directors signed off by (state name):		

Document Owner Contact Details

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Report on the Independent Analysis of Responses to the Consultation 'Delivering High Quality Services Through Efficient Design'

CONTENTS

1. EXECUTIVE SUMMARY

This report appraises the Board on the independent analysis of the consultation exercise 'Delivering High Quality Services Through Efficient Design'.

The independent analysis was undertaken by the Faculty of Health and Social Care at the University of Chester. A copy of the draft report is attached to this document as Appendix 2. (The final copy is awaited. The reasons for this not being currently available are given below).

The overall conclusion of the report was that there were a small number of respondents to the questionnaire contained within the consultation document (32), and a significant majority supported the position of CWP in terms of the necessity to redesign mental health services to deliver greater efficiency. There was a general view that the main impetus for the development of mental health services was underpinned by a reduction in inpatient beds, which, in turn, pivots on fiscal concerns in the current financial climate. Some concerns were raised regarding access to inpatient services and poor public transport facilities. There was general support for the development of small specialist units across the Trusts' geographical areas and a request for an improvement in communication of information.

No significant issues were raised that would suggest that, from a consultation point of view, the Trust needs to reconsider the general direction of future service delivery. However local implementation and communication plans should be developed to underpin service changes that take into account comments and feedback from the consultation process.

2. INTRODUCTION

The Trust undertook a public consultation between 1st December 2009 and 9th March 2010 on its plans to deliver high quality services through efficient design. This consultation was managed in parallel with a consultation on redesigning inpatient services in Central and Eastern Cheshire. It was agreed prior to the consultation that Chester University, which had provided an independent analysis on a previous consultation exercise, should be approached to provide this service again. All responses were therefore sent directly to the University using a Freepost service.

A summary of the communications and engagement process for the consultation is attached as Appendix 1.

The first draft of the consultation report from the University was received at the beginning of April. Two changes to the text have been requested (as well as a number of typing corrections). However the author of the report has been on an extended holiday and then delayed overseas due to airline difficulties and the corrected final report has not yet been returned.

The two suggested changes are;

In the first paragraph refers to the 'consultation …..undertaken by Chester University', rather than stating clearly that the consultation was undertaken by CWP, and the independent analysis was provided by the University.

Throughout the document, responses provided by Trust Members have been abbreviated to 'Trust' as opposed to 'Member'. Within the context of the report this implies that a member of staff submitted the response.

It is not considered that these changes significantly affect the sense of the report which is attached at Appendix 2.

3. DISCUSSION

3.1 The Report

The report provides an analysis of, from whom and from where, the responses to the consultation questionnaire were received. It then provides an analysis of the responses to each question contained within the consultation document.

A total of 32 completed questionnaires were received plus four letters from service user and carer groups and forums. (Three of these were identical)

A total of eight questions were included in the questionnaire at the end of the consultation document with some key themes highlighted below.

1. The first question referred to removing age discrimination by providing services based on need. While 88% of people supported this there were a number of qualifying comments included across three areas -: Still a need for wide range of services, mixing of individuals with different clinical conditions, perception that choice is being reduced.

2. The second question asked about developing community services effectively and efficiently that may mean changes to care pathways. Again a high number of people (85%) supported this while raising some concerns in relation to increased pressure on clinical staff, reduction in inpatient beds and the need to further develop crisis support services.

3. The third question referred to the need to reduce inefficiencies in inpatient services due to large numbers of empty beds. 66% of people supported this however concerns were raised regarding possible lack of access in an emergency and access, location and transport to services. Many people also commented that communication of information should be improved particularly bed occupancy statistics.

4. Question four asked people if they agreed that CWP should develop specialist inpatient services eg. Eating Disorders. 93% of people agreed and many offered suggestions for services which should be developed eg. Dementia, Drug and Alcohol, Autism

5. The fifth question asked about making best use of specialist staff with an example given relating to specialist dementia wards. 69% of people agreed with support for reducing staff travel between sites balanced against need for access for service users and carers. Other comments related to the need to develop some staff and skills in different areas eg rehabilitation.

6. Question 6 was concerned with the need to use CWP buildings flexibly. 86% of people agreed with this but many complained that the question was too vague for them to give a proper response.

7. Question 7 asked for views on reporting back to governors and members and people were asked to tick events, meetings, newsletters or a combination of all three. Most (but not significant) responders voted for newsletters but requested a mixture of communication strategies.

8. The last question asked for suggestions for further improving services or ideas for services we should or shouldn't be providing. Six major themes emerged which include, environmental standards, support groups, community services, service delivery, communication and information. There was awareness by many respondents that CWP provide excellent services but only in certain areas and improvements in poorer quality services should be made.

The report ends with an overall conclusion that the majority of respondents answered yes to the questions but with certain qualifications regarding their answers. A major issue was the number of comments requesting further information on facts and figures

4. CONCLUSION

There was, despite a publicity campaign and seven public meetings, very few responses to the consultation exercise. The majority of respondents did support the Trust plans to deliver high quality services more efficiently and the depth of responses and the number of qualifying comments will need to be incorporated into the Trust response to stakeholders on the outcome of the consultation exercise.
The Trust report will provide a response to the individual comments made within questionnaires and will also summarise and provide responses to the questions raised at each of the public meetings which were recorded for this purpose.

No significant issues were raised that would suggest that, from a consultation point of view, the Trust needs to reconsider the general direction of future service delivery however local implementation and communication plans should be developed to underpin service changes that take into account comments and feedback from the consultation process.

5. RECOMMENDATIONS

It is recommended that the Board of Directors;

- Note the content of this report and the University of Chester independent report on the outcome of the consultation exercise
- Commissions the preparation of a report to stakeholders on the outcome of the consultation exercise

APPENDIX 1

Summary of communications and engagement for both consultations

A communications and engagement strategy for the inpatient reprovision project was in place via the Programme Board and Project Group from April 2009. The efficient design consultation joined together with the inpatient reprovision comms and engagement plan in October 2009, and both were managed through a task and finish group. The task and finish group included membership from the service innovation and development team, communications team, patient experience team, company secretary, and learning disabilities communications officer. It met throughout the period to ensure a comprehensive, joined-up approach.

The engagement process

The consultation documents themselves were produced as part of a much wider process of engaging with stakeholder views. The documents were the mechanism for capturing responses; however they were clearly placed within the wider context of support materials to help people understand the issues involved[1] . This included the public meetings, frequently asked questions, examples of successful service redesigns, and the freephone helpline.

A clear communications/engagement process was in place for the consultation, supported by a task and finish group including the expertise of the patient experience team and communications team. They advised on content within materials, including reducing/ explaining jargon (eg. footnotes explaining who the OSC is, what 'contracts' means, who Lord Darzi is, what a 'surplus' is).

This included real Trust examples being given for all of the factors that were being considered as part of the consultation and for the proposals in the 'way forward' section. Additionally these were cross-referenced in the 'your views' section to make it clear what each question referred to. The freephone helpline was advertised for any questions relating to the document, as were the public meetings – and the additional information and links on the website provided further background on key terms such as 'surplus' and 'best practice'.

Advertising and promotion

External stakeholder direct mail exercise

The January edition of CWP Engage newsletter featured full details of the public meetings and other ways to respond to the consultation. This was sent to all 12,000 of the Trust's members, as well as external stakeholder groups and voluntary organisations. We also sent a cover letter and copies of the consultation documents to MPs and governors. In addition, during the consultation we responded to a further 25 requests for copies of the consultation documents from organisations, individuals and staff.

Patient representative groups and PPI representatives

We wrote to over 200 representative groups across Cheshire and Wirral to raise awareness of the consultation process, ways to get involved and the public meetings – those groups were listed on our website and we encouraged people to contact us if any groups were missing from the list. We also sent copies of the consultation documents directly to all PPI representatives.

Staff, site signage/ direct patient comms

The consultation documents and ways to respond were promoted to staff through the weekly e-newsletter, via the intranet, and the November and February editions of the staff newspaper. In addition, we issued posters to main reception areas and encouraged staff to share the information with service users and carer groups that they worked with.

[1] Page 3 of efficient design document: "The document should be read together with additional information available on our website including frequently asked questions and more information..we would encourage you to attend one of our public events"

Website
A dedicated feature was published on the Trust website (with link from staff intranet) on 1st December. It featured:

- interactive pdf versions of both consultation documents;
- audio message from Ian Davidson encouraging people to 'have their say';
- frequently asked questions;
- service redesign achievements;
- lists of organisations the documents had been sent to;
- contacts for further information.

Public meetings/other meetings
Seven public meetings were held from 22nd January to 5th February across Cheshire and Wirral covering the two consultations, with about 150 attendees. In addition, Trust personnel attended local meetings to further raise awareness of the issues including West Cheshire Mental Health Forum, Central and Eastern Cheshire LINKS and GP leads meetings. A dedicated response to a series of queries was provided to Family Tree. We also covered the topic of efficient design in the three annual planning events held in November.

Advertising
We paid for the following advertising in newspapers covering the Cheshire and Wirral area:
Chester Chronicle/Chronicle website
Chronicle Xtra (free paper)
Wirral Newsgroup (range of titles)
Ellesmere Port Pioneer
Mid Cheshire Buy Sell (Tarvin, Tarporley, Middlewich, Winsford, Frodsham, Helsby)
Crewe Chronicle Series (Crewe, Sandbach, Nantwich)
Crewe Xtra (free paper)
Congleton Chronicle (Congleton, Sandbach, Biddulph)
Macclesfield Express

Media relations
We issued press releases to all local media and achieved coverage in the following:
Crewe chronicle
Macclesfield Express
Chronicle (Sandbach edition)
Nantwich Chronicle

Freephone helpline
We publicised the 0800 freephone helpline number on all documentation relating to the consultations and it received 15 direct enquiries during this period, most enquiries related to requests for hard copies of the consultation document.

APPENDIX 2

University of Chester report on the responses to the Consultation Questionnaire 'Delivering High Quality Services Through Efficient Design'

N:\SERVICE INNOVATION AND DE

Delivering High Quality Services Through Efficient Design

Report of the Responses to the CWP Questionnaire

Professor Tom Mason
Head of Mental Health & Learning Disabilities
Faculty of Health and Social Care
University of Chester

Kathryn Melling
Research Officer
Faculty of Health and Social Care
University of Chester

Contents **Page No.**

Executive Summary

1. Introduction

This report relates to the analysis of the CWP public consultation document questionnaire pertaining to the 'Delivering High Quality Services Through Efficient Design' undertaken by the University of Chester.

2. Questionnaire

The central themes of both the consultation document and the questionnaire relates to the delivery of services involving anti-discriminatory practices, efficiency and the development of specialist facilities. Within the questionnaire there were opportunities for quantitative responses as well as qualitative written commentary in relation to the questions posed.

3. Analysis

3.1. Demographics – A total of 32 questionnaires were received.

- 3.1.1. Section A – The majority of responses were from service users, carers and voluntary groups (n= 29, 67.4%).
- 3.1.2. Section B – There were more responses from community services (n= 4) than inpatient services (n= 2).
- 3.1.3. Section C – Responders in this section were from Adult Mental Health services (n= 5) and Other sources (n= 5).
- 3.1.4. Section D – The majority of responses were from Central and Eastern Cheshire (n= 16, 57.1%).
- 3.1.5. Section E – The source material accessed were predominantly from the Consultation Document and the Website.
- 3.1.6. Contact Details – From the 32 questionnaires received 29 provided contact details.

3.2. Question One (referring to age discrimination and changes to services) – There were 28 responses to 'yes' (87.5%) with 4 responses to 'no' (12.5%). The main suggestion was that there is a requirement for a wide range of services across age ranges, diagnostic categories and service types.

3.3. Question Two (referring to effective and efficient community services) – The majority of responses were 'yes' (n= 27, 84.3%) with the main comments referring to concerns regarding the increased pressure on clinical staff, the reduction in inpatient beds and community services being under resourced. The main suggestions were themed as (a) develop crisis support teams, (b) improve communications and (c) equality of services across districts.

3.4. Question Three (referring to reduction in inefficiencies) – The majority of responders answered 'yes'(n= 21, 65.6%) to this question with the main commentary themes being disparate views about the accuracy of bed occupancy, lack of access in an emergency, communication of information and access, location and transport to services.

3.5. Question Four (referring to the development of specialist inpatient services) – There was a majority of responses indicating 'yes'(n= 26,

92.8%) to this question with comments regarding (a) there should be a range of services developed, (b) peripatetic specialist staff should be made available and (c) that there should be access across boundaries.

3.6. Question Five (referring to making best use of specialist staff) – The majority of responders answered 'yes' (n= 20, 68.9%) to this question with the main concerns being transport to services, services for dementia sufferers a priority and the need to develop other specialist areas.

3.7. Question Six (referring to the use of buildings effectively) – The majority of responders answered 'yes' (n= 25, 86.2%) to this question and indicated that the main issues were a range of specialist services need to be developed, these should be developed across a wide geographical area and a lack of available information resulted in responders unable to make informed decisions.

3.8. Question Seven (referring to reporting procedures) – Most responders voted for newsletters but requested a mixture of communicative strategies and offered many suggestions.

3.9. Question Eight (referring to suggestions on improvement of services) – Six main themes emerged from question eight in relation to suggestions for improvement of mental health services, environmental standards, support groups, community services, service delivery, communication and information.

4. Correspondence

There were four letters of correspondence with three identical ones from service user and carer groups/forums and one from an individual.

5. Overall Conclusion

The overall conclusion to this questionnaire is that the majority of respondents answered 'yes' to the questions but with certain qualifications regarding their answers. The first major issue is that there were a number of comments requesting further information regarding the facts and figures of such items as number of beds available, uptake of services, admission rates, etc. There was a general view that the main impetus for the development of mental health services was underpinned by a reduction in inpatient beds, which, in turn, pivots on fiscal concerns in the current financial climate. The respondents generally felt that this would result in problems of isolation caused by inability to access inpatient services with large distances having to be travelled and poor public transport facilities. There was general support for the development of small specialist units across the Trusts' geographical areas and a request for an improvement in communication of information.

1. Introduction
The Cheshire and Wirral Partnership NHS Foundation Trust (CWP) undertook a public consultation exercise between 1st December 2009 and 9th March 2010 to establish the views of various stakeholders regarding 'Delivering High Quality Services Through Efficient Design'.

The gathering of public and professional views regarding this was felt to be of major importance given that there are no additional development funds currently available. The public consultation took numerous forms including the production of a consultation document containing a questionnaire, the establishment of a series of public meetings, a website, frequently asked questions and a freephone helpline. This report, undertaken by the University of Chester as an independent reviewer, relates to the responses to the questionnaire only.

2. Questionnaire
The questionnaire was designed by CWP and contains two parts.

Part A
The first part captures some demographic data pertaining to (a) personal details as to who the respondent is, (b) the areas in which the respondent might work, (c) further details about the areas of employment, (d) the geographical site of the respondent, (e) the type of consultation material accessed and (f) the provision of name and address for validation purposes (to be treated in confidence).

Part B
The second part contains eight questions with the first four relating to (1) age discrimination and services based on needs and problems with a 'yes'/'no' tick box response in support or not and further opportunity for written commentary, (2) the development of effective and efficient community services requiring a tick box response in the form of 'yes'/'no' with further opportunity for written commentary, (3) support for the need to take action to reduce inefficiencies with a 'yes'/'no' response required and space for written commentary and (4) an agreement for development of specialist services requiring a 'yes'/'no' response and room for written commentary. The remaining four questions relate to (5) the making of the best use of highly specialist staff with a 'yes'/'no' response required and further opportunity for written commentary, (6) the support for the need to use buildings flexibly and service delivery with a 'yes'/'no' response required and room for written commentary, (7) a four choice tick box relating to dissemination of information and room for written suggestions and (8) opportunity for expressing any other suggestions.

3. Analysis

3.1 Demographics

A total of thirty two (n= 32) questionnaires were received and 4 letters of correspondence from service user and carer groups and forums. There is no information available regarding response rates.

In analysing the demographic data the following Key of responders was identified from the questionnaire:

User = I am a CWP Service User
Carer = I am a carer for a person who receives CWP services
Voluntary = I am from a mental health forum/voluntary organisation
Trust = I am a Foundation Trust member of CWP
Governor = I am a Governor
Staff = I am a member of staff
Rep = I am a staffside representative
Other = Other (please specify)

3.1.1 Section A. Personal Demographics

From the 32 questionnaires returned the respondent had indicated the 'person' that they were representing in answering the questions, with some ticking more than one response. The following table shows that the majority of responders were from the User, Carer and Voluntary sectors with a total of 29 (67.4%) entries.

See table one in response to the questionnaire prompt 'Before you answer the questions below we would be grateful if you could tell us a bit about yourself (you can tick more than one box)'.

Table 1: Personal Demographics (numbers greater than total as items not mutually exclusive)

Participant	Number
User	5
Carer	14
Voluntary	10
Trust	7
Governor	1
Staff	2
Rep	-
Other	4
Total	**43**

3.1.2 Section B. Place of Work

The questionnaire requested information regarding employment and from the request 'Questions B and C are for staff only. Please select which of the following areas you work in' the following responses were reported. See Table 2 and Figure 1.

Table 2: Place of Work (Item not relevant to some responders)

Participant	Inpatient	Community	Other	Totals
User	-	1	-	1
Carer	-	-	-	-
Voluntary	-	2	-	2
Trust	1	-	-	1
Governor	-	-	-	-
Staff	1	1	-	2
Rep	-	-	-	-
Other	-	-	-	-
Totals	**2**	**4**	**0**	**6**

Figure 1: Place of Work

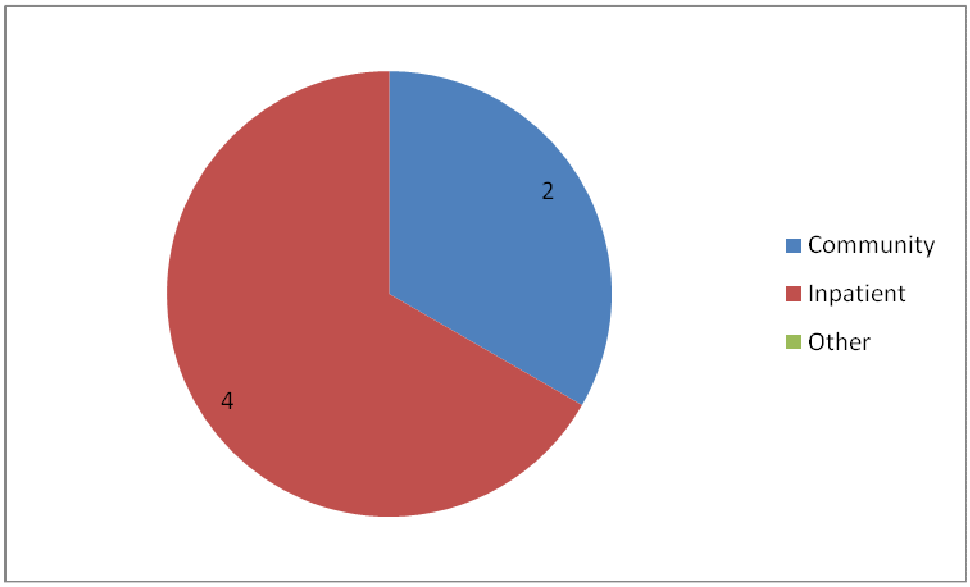


Table 2 indicates that there were two from the inpatient area and four from the community, with none responding with other. There was one User, two Voluntary and one staff responders indicating that they considered themselves to be employed in the community. The low numbers reflecting that the majority of responders were from the User, Carer and Voluntary sectors.

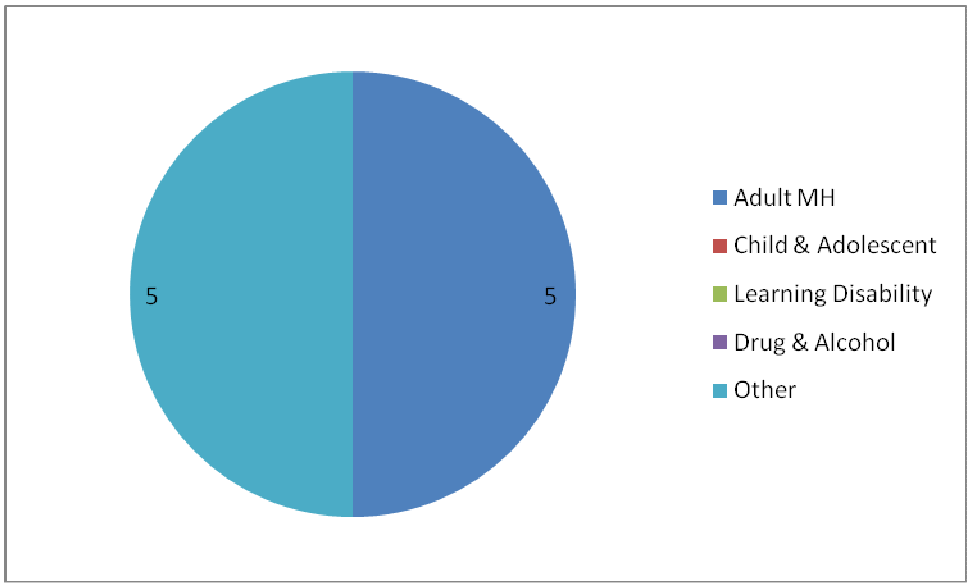
3.1.3 Section C. Work Areas

From the questionnaire request 'Please select which of the following areas you work in' it can be noted that there were a total of 10 responses, with 5 being from Adult Mental Health and 5 from other sources. The other sources were specified as 'carer at home' and 'community group promoting health and well being'. There were no responses from Child & Adolescent, Learning Disability and Drug & Alcohol areas. See Table 3 and Figure 2.

Table 3: Work Areas (Item not relevant to some respondents)

Participant	Adult MH	Child & Adolescent	Learning Disability	Drug & Alcohol	Other	Totals
User	1	-	-	-	1	2
Carer	-	-	-	-	-	-
Voluntary	2	-	-	-	2	4
Trust	1	-	-	-	1	2
Governor	-	-	-	-	-	-
Staff	1	-	-	-	1	2
Rep	-	-	-	-	-	-
Other	-	-	-	-	-	-
Totals	**5**	**-**	**-**	**-**	**5**	**10**

Figure 2: Work Areas



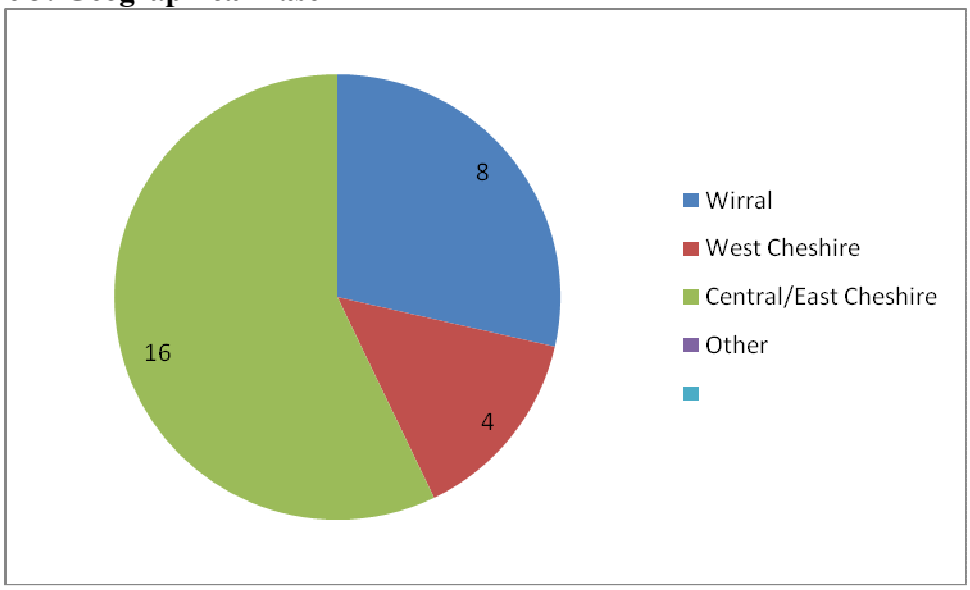
3.1.4 Section D. Geographical Base

The geographical area of responders was requested in Section D with the following results noted (see table 4). It can be seen in Table 4 and Figure 3 that the vast majority of responders were from Central & Eastern Cheshire (n= 16, 57.1%) and were from User, Carer and Voluntary groups (n=19, 67.8%). It should be noted that this section was not completed by 4 (12.5%) respondents.

Table 4: Geographical Base (Not completed by 4 respondents)

Participant	Wirral	West Cheshire	Central/ East Cheshire	Other	Totals
User	-	2	3	-	5
Carer	5	-	4	-	9
Voluntary	-	1	4	-	5
Trust	2	1	1	-	4
Governor	1	-	-	-	1
Staff	-	-	1	-	1
Rep	-	-	-	-	-
Other	-	-	3	-	3
Totals	**8**	**4**	**16**	**0**	**28**

Figure 3: Geographical Base



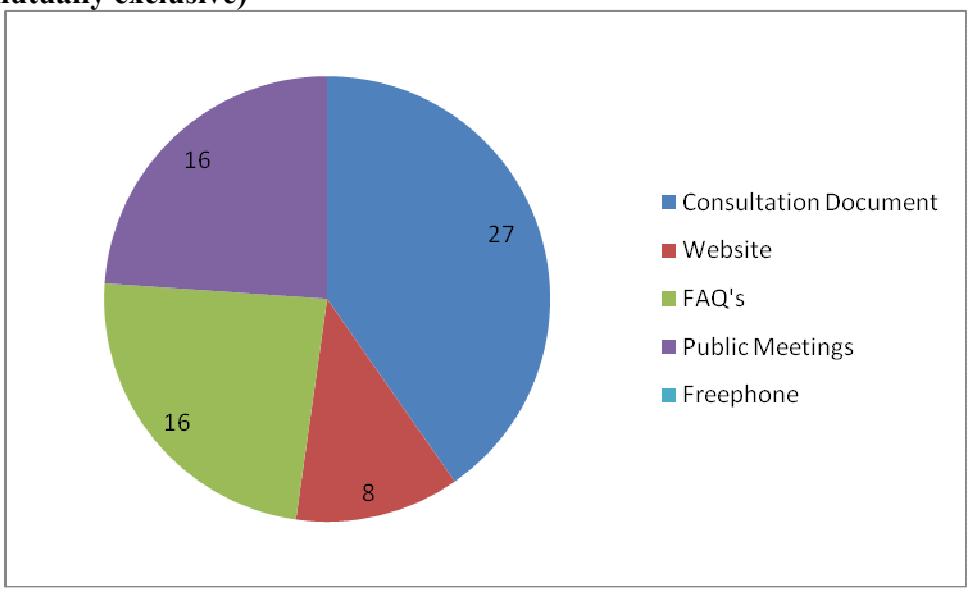
3.1.5 Section E. Consultation Material

The penultimate section to the preliminary information requested on the questionnaire referred to the consultation material that the responders were able to consider. The results can be seen in Table 5 and Figure 4.

Table 5: Consultation Material Considered (numbers greater than total as items not mutually exclusive)

Participant	Consultation Document	Website	FAQ's	Public Meetings	Freephone	Totals
User	5	1	2	2	-	10
Carer	7	-	-	7	-	14
Voluntary	5	2	5	3	-	15
Trust	4	2	4	2	-	12
Governor	1	1	-	1	-	3
Staff	1	-	1	-	-	2
Rep	-	-	-	-	-	-
Other	4	2	4	1	-	11
Totals	**27**	**8**	**16**	**16**	**0**	**67**

Figure 5: Consultation Material Considered (numbers greater than total as items not mutually exclusive)



It can be seen in Table 5 that the main source of consultation material was via the document containing the questionnaire from Cheshire and Wirral Partnership (CWP).

3.1.6 Contact Details

The final section (section F) in the questionnaire preliminary information requested personal contact details and these are confidential. The information was requested as follows: 'F. Please provide your name and address for validation purposes only (this information will not be provided to CWP by the independent reviewer of responses, Chester University. Chester University will treat your personal data in accordance with the data protection act and will not use the information for any other purpose'

It can be reported that 30 of the 32 responders provided their contact details.

Question 1. We think it's important to remove age discrimination by providing services based on assessment of a person's needs, problems and strengths – not simply their particular age in years. This will mean changes to community as well as inpatient services. Do you support this?

Table 6: Responses to Proposal

Participants	Yes	No	Totals
User	5	-	5
Carer	11	1	12
Voluntary	5	-	5
Trust	3	1	4
Governor	-	1	1
Staff	-	1	1
Rep	-	-	-
Other	4	-	4
Totals	**28**	**4**	**32**

Figure 5: Responses to Proposal

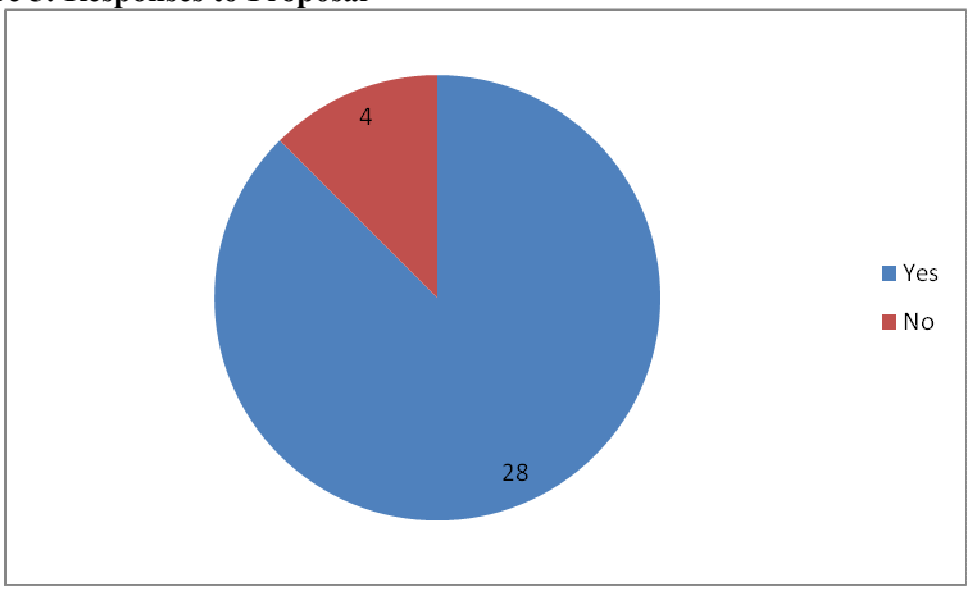


Table 6 and Figure 5 indicate that the majority of the responders answered 'yes' (n=28, 87.5%) to this question with only 4 (12.5%) answering 'no'. The greatest number of responses were from the User, Carer and Voluntary groups (n= 22, 68.75%) with 21 (95.4% of this group) answering 'yes' and 1 (4.5% of this group) answering 'no'. (Percentages may not add up to 100% due to rounding).

The questionnaire prompted further comments by requesting 'If yes, do you have any suggestions for which services we should prioritise and how we can make best use of resources to address differing needs?' and the following text entries are examples of this.

Users –

> **'Adult mental health – primary and secondary care. Older people's services'.**

'Using the JSNA to influence service decisions. Using mental health strategy for Western Cheshire. Focus on recovery and early interventions. Prevention'.

'The use of a crisis team for all (including over 65's) would be beneficial and potentially free up acute beds'.

'Alcoholism support services may be required by under 18s, who often have problems accessing these services'.

Carers –

'Assessed needs lead services'. 'Mental health'. 'Older folks seem to get a better community service at present. Despite not having dementia/alzheimers type conditions. Without facts and figures how can an informed opinion be given'.

'I don't know – you are the experts on how to deliver services and where the greatest need lies. You don't publish data which allows me to make an informed comment. My concern is not 'how' you deliver services but 'where' you deliver them'.

'Specialist teams should visit various sites to avoid people having to travel long distances for help'.

'The Wirral Link and West Cheshire Mental Forum have recommended that CWP should consider the Lancaster best practice model for a mental health intermediate care team as noted in issue 089 Mental Health News'.

'At present family support workers do not work with older people with mental health problems – only adults.

Voluntary –

'Target service user age 60-70 first to avoid disruption in their care. Many service users have been receiving excellent care age 64, then suddenly they turn 65 and it all stops'.

'Less about priorities (an institutional reaction) and more about choice; an 80 year old with depression may clinically be suitable for an acute ward – she may feel safer in an older person's environment – which may not have to be a hospital. It is unreasonable for CWP to impose nil choice on e.g. acquired brain injury, under 65 early onset dementia within an acute ward with highly disturbed acutely ill patients'.

'There must be transport to attend specialist clinics'.

Trust –

'I think that dementia, drug/alcohol and eating disorder services should be prioritised for all age groups. The Trust must work with all other relevant agencies to hopefully avoid duplicating services and therefore wasting resources that could perhaps be put to better use'.

Other –

'Alzheimer's, dementia etc. Young people's psychosis, alcohol related problems'. 'Accept some people can be offered help but refuse to change life style whereas others will try and want to improve their life'.

The questionnaire requested further commentary from the prompt 'If no, please can you explain what your concerns are and how we might address them' and the following are examples of responses.

Carers –

'Not entirely; elderly and physically infirm people should not be placed in dementia wards and the young (e.g. with depression, anorexia etc.) should be placed with older patients but housed and treated separately. Also men and women should not have to share bathrooms and toilets or even wards'.

Trust –

'This is a loaded question. Of course I'm against age discrimination. But in general different services are required by young, first-time, inpatients compared with older patients who have been in and out of hospital a number of times. The horror story, told to me directly by the young person, is of a first-time service-user being put in the same ward with a very psychotic rapist. Even in the community, a service devised solely around "a person's needs, problems, strengths", leaves out other major considerations such as whether the (young) person is living at home or elsewhere'.

Governors –

'Different age groups have some different needs and concerns. Day care for dementia patient to help families to look after them at home with periods of respite and to give patients (illegible) to help slow down cognitive decline'.

Staff –

'Current model is working well. This could be improved but no need to abolish this model. No need for change anything just for the sake of changing'.

Analysis

Although the majority of respondents indicated a positive response to the question the commentary from the wider data set shows that there are several concerns that accompany the answer 'yes'. First, there is a general view that service delivery should indeed be based on individual needs and problems and there are several references to the requirement for a wide range of services from young person's to older people's and including early interventions, bi-polar, depression, drug/alcohol, eating disorders and dementia. Second, there was concern that patients with differing diagnostic conditions would be inappropriately mixed, which may create vulnerability in some and unsafe practice in others. It was also felt that ultimately it may hinder rehabilitation and delay progress. The third concern revolved around the notion of choice. It was reported that there is a tendency to move towards choice reduction in the proposal and that this will affect services both in terms of access and location.

There are reports in the literature that reflect this problem (White, 2008). The main example of this was the need for inpatient, community and day care services.

On a positive note there were responses which suggested that the current model of service delivery is working well, although improvements could be made, and there were suggestions relating to how this could be achieved. For example, reference to the Lancaster Best Practice Model was made and stronger links to Service User and Carer groups.

Conclusion to Question 1

In conclusion to question one we can note that whilst the majority of responders indicated 'yes' this was qualified in relation to three major themes:

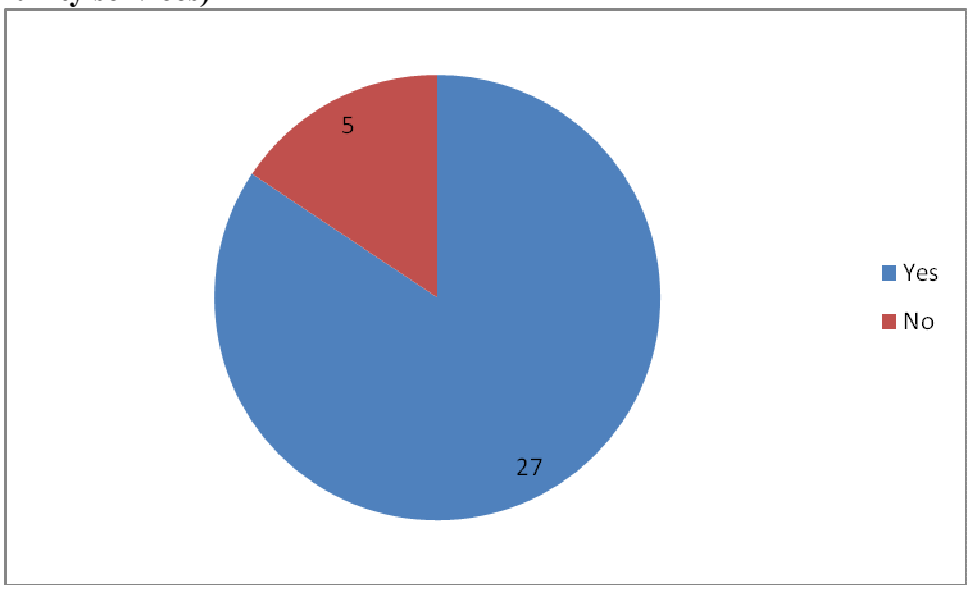
- A wide range of services are required across age ranges, diagnostic categories and service types.
- The mixing of individuals with differing clinical conditions was a concern.
- There was a perception that choice is being reduced which was perceived negatively.
- There were some positive suggestions as to improvements to the mental health services.

Question 2. We believe we need to continue to develop effective and efficient community services which may mean changes to the way care pathways are delivered within the community. Do you support this?

Table 7: Responses to Question 2 (Development of effective and efficient community services)

Participants	Yes	No	Totals
User	5	-	5
Carer	10	2	12
Voluntary	5	-	5
Trust	3	1	4
Governor	1	-	1
Staff	-	1	1
Rep	-	-	-
Other	3	1	4
Totals	**27**	**5**	**32**

Figure 6: Responses to Question 2 (Development of effective and efficient community services)



The major response to this question was 'yes' with twenty seven (n= 27, 84.3%) responders indicating this and only 5 (15.6%) reporting 'no'. Again, the highest group of responders was from the Users, Carers and Voluntary groups (n= 22, 68.7%) with 20 (90.9% of this group) voting 'yes' and 2 (9.1% of this group) voting 'no'. (Percentages may not add up to 100% due to rounding).

In response to the request 'If yes, do you have any specific suggestions for how we should do this?' the following are examples of the written evidence.

Users –

> **'As stated above, a crisis team for all age groups and more day care are needed within the community'.**

'Commissioners and providers need to understand the whole system outcome in order to identify indicators which attribute to this, in order to identify required pathway and service development'.

'However, by continually removing services/merging, you are putting too much pressure on staff (eg CPNs), who already have high patient load, and also reducing patients' access to their CPN/Social Worker. If more staff are needed, employ them'.

'Expansion of community mental health services'.

Carers –

'More crisis resolution and alcohol support teams are required. To whom are these teams responsible to'?

'Good things in Chester, poor in Wirral. Take the best in different areas. Take the best in each area. List to the carers the emergency number to carers and take actions'.

'CWP should consider how to simply how people can contact and get care in a crisis particularly for those who do not meet criteria or do not understand current system and pathway'.

'Need for much greater communication and clarification to service users and their families. They need to be involved in pathways, discussions and decisions – most do not know what a care pathway is! – including me. Many patients are 'static' – need help to move on and meet new challenges not just work'.

'Crisis needs to be available 24/7 without gaps and currently gaps between 4.30pm to 6.30pm'.

Voluntary –

'But with the least disruption to service users. Just give them a better service'.

'CAUTION. Better pathways almost certainly mean better attention to the complexity of a patients needs and a holistic approach; viz it becomes more time consuming and may be more efficient in terms of meeting patients needs – but more lengthy, more planning, smaller caseloads, more staff. Attention to physical and psychiatric needs, holism'.

'Public transport again a necessity'.

Trust –

'To be effective and efficient, community services must be adequately resourced and funded'.

'When listing the five drivers of change on page 5 of the consultation, a very significant one has been omitted, namely the move toward a less

medically-orientated model of service provision towards a more holistic model. This omission has coloured the consultation document and the way that the questions have been framed. Sections 2 & 3, indeed almost the entire document, makes no reference to carers. To think that the Trust can write a piece about "effective and efficient community services" without reference to support services required by carers beggars belief. Equally indicative of the way this document has been constructed is that there are no references to "recovery" services, nor of the desire by service users to have supported "self-help"'.

Other –

'Ensure dialogue so people given opportunity to engage and they know how to make their views known'.

'How are you physically showing this in drugs and especially alcohol'.

For those who indicated the negative response written commentary was produced following the request 'If no, please provide an alternative suggestion for how we should do this' and the following comments are examples of this.

Carers –

'I can not stress enough the importance of a proper crisis team to respond to an emergency call. At present the (Home Treatment) crisis team do not respond to an emergency'.

'No if by efficiency you mean cutting acute admission beds or dementia respite care/beds/ This places impossible burden on carers (who may need to work outside the home). As in community care (illegible) inadequate to current needs and you have come down from 75 to 20 and acute beds having lost ward and so it goes. Be more realistic and honest and spend less on management and more on clinical staff'.

Trust –

'This will lead to a reduction to inpatient facilities – no evidence to support this proposal. Increase significantly inpatient facilities'.

Staff –

'Again strengthening current model. Keep it simple, use common sense. Don't use fancy jargon and not deliver. Keep it simple and deliver'.

Other –

'I don't agree with closing down beds which give 24 hour care for patients and their families, in favour of skimpy time limited community care'.

Analysis

The majority of responses to this question indicated 'yes' but, again, with some qualifications. The major concerns are (a) the increased pressure on clinical staff, (b) the reduction in inpatient beds without adequate evidence for the need for this (c) the under resourced community services and (d) the lack of support for carers, particularly in times of crisis. The suggestions identified in the commentary can be

grouped under the following themes. First, crisis support – there were numerous comments regarding the pressure that builds on carers, especially in times of emergencies that occur outside of 'office' hours and the lack of support and access to services. The main suggestion being that in developing community services there should be resources for crisis resolution teams to be available across the 24-hour period. This is also linked into the views by responders who indicated 'no' and provided comments regarding the fact that inpatient services provide 24-hour care whilst community services do no. Thus, if inpatient beds are reduced then community services must be improved. Second, improvements in communication - there appear to be an urgent need to develop communicative strategies in relation to two-way information. Service users and carers, generally, feel that they not only need information from the Trusts but also have something to offer in relation to advising policy developments. Third, parity of service delivery – there were concerns that whilst mental health services are good in certain areas they were considered poor in others and this produces feelings of injustice for those suffering from mental health problems. There was an awareness that decisions regarding the delivery of mental health services are difficult ones to make (Hunter, 2008).

Conclusion to Question 2

In conclusion whilst the majority of responders indicated a 'yes' response to this question there were some concerns raised in relation to:

- The increased pressure on clinical staff.
- The reduction in inpatient beds.
- Community services under resourced.

The main suggestions are themed as:

- Develop crisis support teams.
- Improve communications.
- Equality of services across districts.

Question 3. Do you support the need to take action to reduce inefficiencies where we have large numbers of empty beds across our inpatient wards, which will mean fewer acute admission wards, to make better use of resources?

Table 8: Responses to Question 3 (Reducing inefficiencies)

Participants	Yes	No	Totals
User	5	-	5
Carer	7	5	12
Voluntary	4	1	5
Trust	1	3	4
Governor	1	-	1
Staff	-	1	1
Rep	-	-	-
Other	3	1	4
Totals	**21**	**11**	**32**

Figure 7: Responses to Question 3 (Reducing inefficiencies)

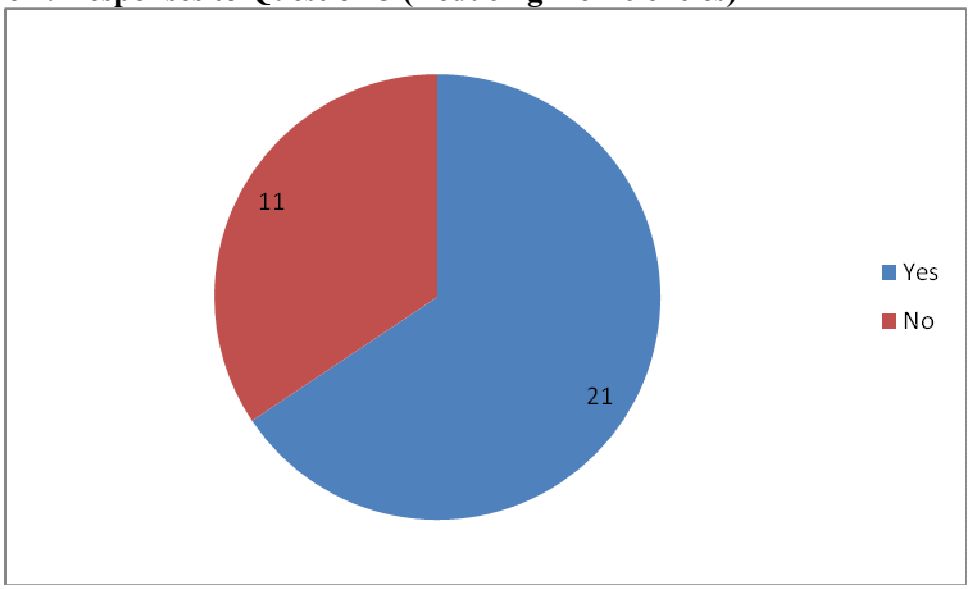


Table 8 and Figure 7 indicate that 21 (65.6%) responders reported 'yes' to this question with 11 (34.3%) answering 'no'. The majority (n= 22, 68.7%) of respondents were from the User, Carer and Voluntary groups with 16 (72.7% of this group) voting 'yes' and 6 (27.2% of this group) voting 'no'. (Percentages may not add up to 100% due to rounding).

The questionnaire stated the following 'If yes, what safeguards would you wish to see, to ensure that people requiring admission get prompt admission, to the ward most suited to their needs – and how best to support their carers and families?' and the following are examples of the responders comments.

Users –

> **'If beds are to be cut, there must be a relative expansion of community services'.**

'This is appropriate, however, figures for Western Cheshire do not reflect an under occupancy. Could you please clarify where this information has come from'.

'That's basic common sense but I don't know enough about the budget, etc'. 'More awareness of underlying medical conditions, for example, a dementia patient needs to be cared for in a particular way and this needs to be addressed on admission'.

'Ensure people are not made to travel long distances if wards are to be reduced. Downsize wards as opposed to removing them from certain hospitals'.

Carers –

'<u>Listen</u> more to the carer and take their concerns seriously. If its just 3 empty beds on each ward that seems acceptable'.

'Large numbers of single or two patient rooms rather than larger multi-bed wards. This would allow more flexibility of accommodation and so ease admission of emergencies. This would also allow more flexible visiting for carers and families without undue effect on patient care requirements'.

'This is a tricky question, there will always be the need for crisis beds, and these should be available to back up the 'Care in the Community Model'. Having an assessment in the home by a qualified nurse or health worker/doctor'.

'The impression of bed surpluses given by CWP is misleading since the empty beds are consistent with their stated 85% bed occupancy target and are nor real surplus over and above this target. Also serious concern that CWP have not yet provided information on the proportion of sectioned patients'.

'A very biased question – no one wants inefficiencies but many service users and carers do not want fewer acute admission wards. It can be very difficult to get prompt admission – particularly via the out of hours service in Wirral'.

Voluntary –

'Make sure there are enough beds – don't remove so many to cut costs, to find that later, there aren't enough to cope with a crisis'.

'Need to ensure public transport is available to any acute admission ward/unit'.

'There is a need for adequate transport provision for carers to visit patients wherever they been'.

'But patients need to be near enough to family and community to facilitate return to their community at the end of treatment. The costs in

time and resources of day visits etc., can be very expensive – just passing it to social service budgets is not the answer'.

Trust –

'Some beds must always be left empty to accommodate emergency admissions such as people being 'sectioned'.

'Carers and families must be provided with a contact phone number for them to use in an emergency and the Trust must ensure that a professional, suitably qualified person is always available to answer emergency phone calls immediately'.

Other –

'I was under the impression it was usually no free beds available'.

'As budgets become tighter people must accept they cannot be handled with kid gloves and to get the best from the service they must adapt life style choices'.

If responders answered 'no' then the following request was made 'If no, please provide an alternative suggestion for how we do this' and examples of these suggestions can be seen below.

Carers –

'Re-open closed wards, stop axing essential beds, employ more nurses and many fewer, highly paid administrators, stop this infernal system of files which exist within these trusts and departments, in aid of endless 'targets'. Possibly start by getting rid of the Trusts. This is much too vague, you are asking for an open ended licence to make whatever cuts you choose'.

'Reduce numbers of managers. We need to ensure that smaller numbers onwards – Sep. Male/Female wards – ensure good patient to nurse ratios i.e. less patients per nurse'.

'Your statement 'large numbers of empty beds' does not sit easily with the statement 'because of bed pressures, consultants often admit to wards on both sites' (page 3, Professor Craig's report 10/09/09). Which is correct?'

Voluntary –

'You cannot have it all ways – about 0.3% severe m.i. incidence; about 3-400K population, excluding incidence of increasing dementia – quick admission 'to wards most suited', you cannot mean it. Wards are generally full now! Evidence of significant empty beds?'

Trust –

'Not evidence based. More not less acute wards are required'.

'Another loaded question. Why hasn't the Trust set out the various points of view that are currently being expressed about this issue "behind scenes"? At one level the answer to this Question 3 depends upon what is

meant by "large". At a deeper level, the argument is related to the staff:bed ratio. One consequence of the unintended improvement in staff:patient ratios is that service users, much to their satisfaction, are getting more one-to-one time (so I understand from those that have studied the Clatterbridge situation). "Inefficiencies" are leading to better "recovery". Question 3 hides from us consultees that fewer acute wards means a return to a lower staff:patient ratio, with fewer staff running around near-full wards. The proportion of inpatients who are "sectioned" will also be higher undoubtedly. There is a balance to be struck here, but the loaded question with a yes/no answer doesn't even attempt to tease out what the public/ the service users/ the carers might regard as an appropriate use of those resources freed up by a ward closure'.

Governors –

'Figures could be very misleading. Empty beds often are those of patients having a trial at home. This happened to one family. There must be local beds for prompt admissions. When we had close contact with the service a few years ago patients had sometime to go to Clatterbridge when acutely ill'.

Staff –

'Acute care model is a failed model nationwide. You will have empty beds on some days but other days you will be full and sending patients elsewhere'.

Other –

'I think care in the community should be small residential units dotted across the area to provide proper medical help and reassurance to the community as a whole'.

Analysis

The majority of responders answered 'yes' to this question but, again, there were several concerns regarding the underlying issues. The issues of concern are (a) the differences in views regarding bed occupancies, (b) removing beds would lead to lack of access in an emergency (c) communication of information and (d) access, location and transport to services. As regards the different views regarding bed occupancy there were suggestions that it was the experience of some responders that beds were usually reported as full, some that small bed vacancies were usually related to some users having trials at home and others that there was not evidence that there were empty beds as figures had not been released. Removing beds altogether, it was argued, would lead to these facilities never being offered again in the future and the main suggestions revolved around reducing the bed numbers but not removing them altogether. There is some evidence in the literature to show that whilst reducing bed occupancy does not tend to alter the general patient profile it does create increasing demands on community services (Ward, 2008). There were also suggestions regarding the need for an increase in beds, particularly in relation to smaller two-bed rooms. Communication of information again featured significantly in the commentary as well as access, location and transport to services.

Conclusion to Question 3

In conclusion, whilst the majority of responders answered ‘yes’ there were significant concerns raised in relation to:

- Disparate views about the accuracy of bed occupancy.
- Lack of access in an emergency.
- Communication of information.
- Access, location and transport to services.

Question 4. Do you agree that we should develop specialist inpatient services to improve access by people from Cheshire and Wirral to these types of services e.g. Intensive Rehabilitation, Eating Disorders and Adolescent services?

Table 9: Responses to Question 4 (Development of specialist inpatient services) (There were 4 non-responders to this question)

Participants	Yes	No	Totals
User	5	-	5
Carer	8	1	9
Voluntary	4	-	4
Trust	3	1	4
Governor	1	-	1
Staff	1	-	1
Rep	-	-	-
Other	4	-	4
Totals	**26**	**2**	**28**

Figure 8: Responses to Question 4 (Development of specialist inpatient services)

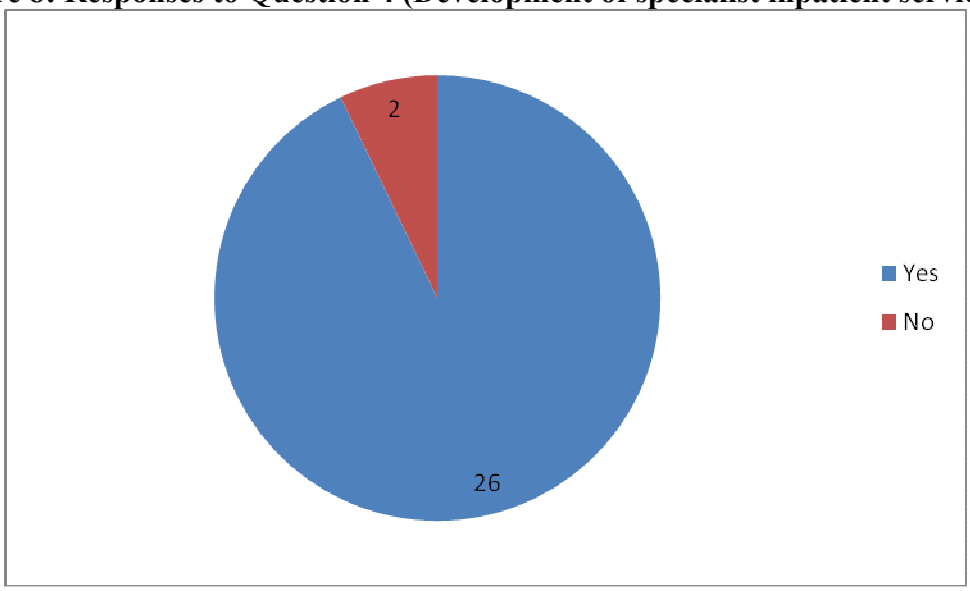


Table 9 and Figure 8 show that 26 (92.8%) responders answered 'yes' to this question with only 2 (7.1%) indicating 'no'. The majority of respondents were from the Users, Carers and Voluntary groups (n= 18, 64.2%) with 17 (94.4% of this group) answering 'yes' and 1 (5.5%) answering 'no'. It should be noted that four (n=4, 12.5%) responders did not answer this question. (Percentages may not add up to 100% due to rounding).

The questionnaire made the request 'If yes, do you have any suggestions for which services we should prioritise?' and the following comments are examples of the responses.

Users –

'Estimated prevalence of some disorders increasing such as dementia need to be given more attention, without ignoring adolescent disorders, both young and old need equal attention'.

'If too many inpatient beds, as in previous question, why not just have specialist staff who can travel where needed to offer these services and use these 'spare' beds for this purpose'.

'Specialist services for drug and alcohol'.

Carers –

'I think eating disorders should have a specialist service and should not be put in the main wards. Specialist services if not available in the Trust should be paid for privately'.

'But not to use age discrimination when providing services like emergency care, which at present can be accessed by some groups'.

'CWP deserves credit for all their innovative work in this area and should be encouraged to continue it'.

'Already have/or have detailed plans for eating disorders and adolescents. Great need for those with dual diagnosis, autism, personality disorders'.

'As there are no numbers available for any of these 'specialist groups' how can I comment'.

'We need to know relative number to be able to answer this. If I had a family member who had any one of these problems I'd practice it. It's stupid to answer No to this question without supportive information to assess it properly'.

'I have insufficient information to comment. The best practice in the three titles in the question number 4 should be available for everyone in the areas, with teams visiting local venues'.

Voluntary –

'Should all be given same priority'.

'Not necessarily inpatient but residential detox and rehab – alcohol services? Medium secure and very secure units. Some parts of some services may be better provided by smaller specialised units via SLAs. They are not either/or, patients needs should dictate provision – it is our responsibility to address the needs and for the organisation to provide. Public safety first; patient safety second; family breakdown third – irrespective of condition; degree of dysfunction/illness/distress/aggression, fourth, irrespective of condition'.

'Transport required to cover geographical area'.

Trust –

'But only if core inpatient services are not affected'.

'Eating disorders and Adolescent Services (Drug/Alcohol related problems'.

Staff –

'By all means, but not at the cost of other services'.

Other –

'But in more than just 3 areas across the Trust'.

'Intensive rehabilitation'.

'Don't be bogged down with committees, invite a cross section of people onto decision boards'.

Examples of the responses for those who answered in the negative from the prompt 'If no, please can you explain what your concerns are and how we might address them' can be seen below.

Carers –

'You must steal from Peter to pay Paul'.

Trust –

'My view on "specialist services" depends upon the numbers predicted for that specialism from within Cheshire and Wirral. If the numbers don't justify specialist units within CWP then either patients will need to be enticed from neighbouring Trust areas (with consequent travel problems for their carers/visitors) or CWP would be best advised to use neighbouring specialist services. It may be for instance that, for many in Wirral, travel to Liverpool is easier than travel to say mid-Cheshire. So the answer to the question about specialist services might be No to all specialisms, or Yes to some but not others; but the question is posed in a way that only allows a generalised yes or no. Anyway, what happened to "patient choice" (particularly where they are a voluntary patient and/or have made an Advanced Statement)? It gets no mention'.

Analysis

The majority (n=26) of responders answered 'yes' to this question with only 2 answering 'no'. It should be noted that not all responders answered this question. A number of commentary categories were noted. First, there were numerous suggestions regarding the development of services other than those identified in the question and included, drug and alcohol, learning disabilities, personality disorders, dual diagnoses, autism, dementia, detox, and medium security services. Second, peripatetic specialist staff should be available, particularly if CWP does reduce inpatient beds and there will be an increased need for community service developments. Third, access across boundaries was a concern, which refers to the suggestion that if local in-Trust services are not available then users and carers may need to be encouraged to access via other Trusts. For example it was suggested that Wirral users may be encouraged to access

Merseyside. These concerns are not specific to CWP but reflect a national picture (Glover, 2007).

Conclusion to Question 4

In conclusion this question raised a number of issues relating to:

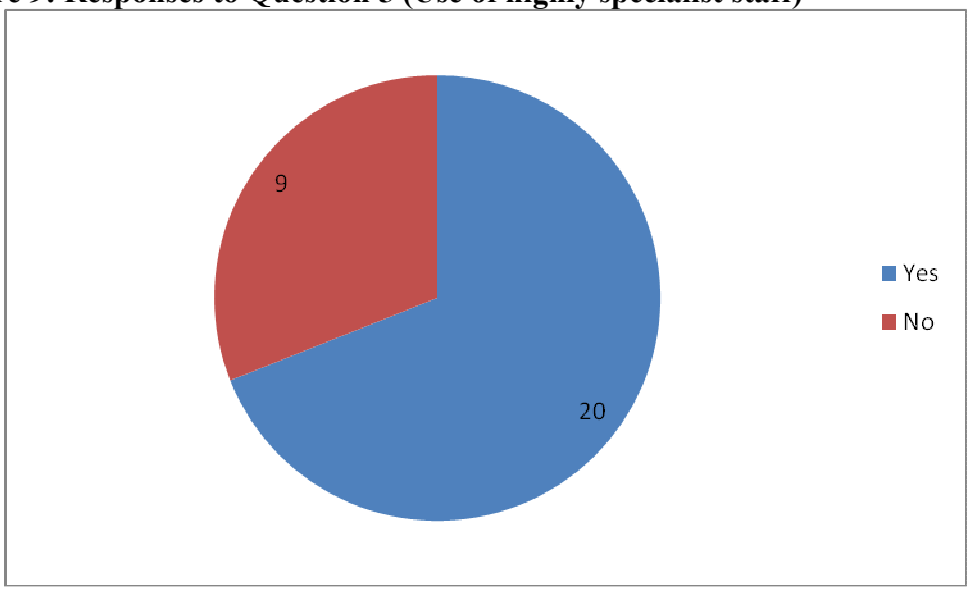
- There should be a range of services developed.
- Peripatetic specialist staff should be made available.
- Access across boundaries.

Question 5. Do you agree that we should be making best use of highly specialist staff to improve quality by bringing dispersed inpatient services such as intensive assessment and treatment wards for people with severe dementia to a reduced number of sites?

Table 10: Responses to Question 5 (Use of highly specialist staff) (There were 3 non-responders to this question)

Participants	Yes	No	Totals
User	3	2	5
Carer	8	3	11
Voluntary	3	-	3
Trust	3	1	4
Governor	1	-	1
Staff	-	1	1
Rep	-	-	-
Other	2	2	4
Totals	**20**	**9**	**29**

Figure 9: Responses to Question 5 (Use of highly specialist staff)



Again, the highest number of responses agreed with this question with 20 (68.9%) responses and 9 (31.0%) indicating the negative. The majority (n=19, 65.5%) of responses were from the User, Carer and Voluntary groups with fourteen (n=14, 73.6% of this group) voting 'yes' and 5 (26.3% of this group) voting 'no'. It should be noted that three (n=3, 9.3%) responders did not answer this question. (Percentages may not add up to 100% due to rounding).

To the request 'If yes, do you have any suggestions where we can improve quality of inpatient services?' the following examples are given.

Users –

'But needs to be aware that dementia sufferers with medical conditions need to be in non-distressful environment. So this would work best on a single site not on multiple locations'.

Carers –

'Reducing ineffective travelling time of skilled staff is desirable where possible. But ease of travelling and access by service users and carers/visitors must be a serious consideration when planning locations and services'.

'There are benefits in concentrating resources for greater effectiveness'.

'Maybe not a yes/no situation. Depends on how reduced are the site numbers and where – should not be too far from families'.

'The second part of the question cannot be answered unless we have more information than is provided'.

'More nurses with smaller case load. More research into dementia. Travel for carers/visitors should be reasonable journey'.

Voluntary –

'Ensure that carers are able to visit them – that transport is not an issue perhaps provide transport for carers'.

'Transport required'.

'This is duplicitous. Yes to specialist staff, No to reduced number of sites. Close proximity to physical medicine. Space sufficient to respond to agitation. Good OT and physio support of prime need. Adequate time out for staff. Proper support for relatives. Proper integration of a properly funded branch of Alzheimers Society and other organisations'.

Trust –

'Carers and relatives of the older age group have significant difficulties with visiting if inpatient facility is not local'.

'But – consideration must be given to providing people with easy transport/access to these wards'.

'Should be adequate patient/staff ratios at all times to ensure that patients always receive adequate care and attention and don't feel neglected. Occupational therapy and psychotherapy sessions when appropriate'.

Governors –

'Cognitive therapies, occupational therapy, exercise, rehabilitation, attention to diet and lifestyle. Improved staffing to enable patients to go out for walks, etc.'

Other –

‘Increase number of beds in a specialist unit’.

‘I am a single person who has lived all their life alone. There is an increasing number of people who do not have family to help and will need to make own care decisions’.

To the request ‘If no, please explain what your concerns are and how we might address them’ the following comments provide evidence.

Users –

‘Specialised services must be based on locality and need’.

‘Not if patients/family have to travel long distances to access treatment’.

Carers –

‘The number of sites for treating people with severe dementia should not be reduced as with an aging population the need will increase’.

‘Reducing access is not an answer. Many inpatients (not all) need contact with friends, family, carers to aid rehabilitation. Good access by car and public transport is crucial’.

‘It would make the lives of carers even more difficult to have to travel further, especially as it has always resulted in fewer respite beds which is what is really essential to help carers cope ‘in the community’’.

Trust –

‘It depends upon what is meant by "severe". If it means so severe that the service user is hospitalised, then maybe the answer is "yes", but if "severe" includes people still living at home (as many carers believe) then CWP should be developing higher quality outreach services, so that the highly specialist staff cover a greatly increased number of sites e.g. those people's homes’.

Staff –

‘Give equal priority to all the services’.

Other –

‘Treatment of good quality is a growing need and should be available to all who need it, not just those in the few beds that will be available to a massive population’.

‘Reduced services means these people with more needs have further to travel adding complications to accessing services’.

Analysis

Not all responders answered this question but of those that did the majority answered ‘yes’ but with certain qualifications. The first major issue to emerge from the written commentary was the notion of transport to services. It was generally felt that this is going to be an important aspect for users, carers and family members alike. There

were also suggestions that transport may need to be provided by CWP if public transport was not available. The second issue involves the need to focus on the provision of services for dementia sufferers and that given the national picture of an increase in the aging population then there is likely to be an increase in need in inpatient services. The development of services for dementia patients should also include the support of further research into this condition. The third issue was the need to develop other services, which included occupational therapy, psychotherapy, cognitive therapies, exercise sessions and rehabilitation. These were viewed as specialist staff requiring specialist training, and services that ought to be developed. This was viewed as not an easy balance to achieve (Firth, Hanily & Garratt, 2008).

Conclusion to Question 5

In conclusion the majority of responders answered 'yes' to this question but raised a number of concerns relating to:

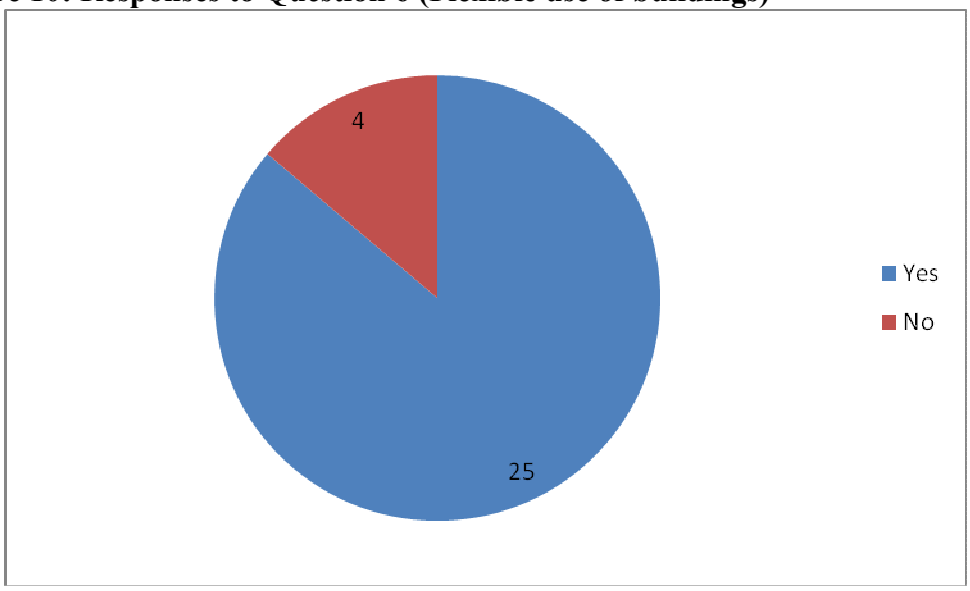
- Transport to services.
- Services for dementia sufferers a priority.
- The need to develop other specialist areas.

Question 6. Do you support the need to use our building flexibly to enable us to respond to emerging demand to further develop, or establish, a wider range of specialist services.

Table 11: Responses to Question 6 (Flexible use of buildings) (There were 3 respondents who did not answer this question)

Participants	Yes	No	Totals
User	5	-	5
Carer	10	1	11
Voluntary	3	-	3
Trust	3	1	4
Governor	1	-	1
Staff	-	1	1
Rep	-	-	-
Other	3	1	4
Total	**25**	**4**	**29**

Figure 10: Responses to Question 6 (Flexible use of buildings)



In Table 11 and Figure 10 it can be seen that twenty five (n= 25, 86.2%) responders answered 'yes' and only 4 (13.7%) indicated 'no'. The majority (n=19, 65.5%) of responses were from the User, Carer and Voluntary groups with eighteen (n= 18, 94.7% of this group) voting 'yes' and only 1 (5.3%) voting 'no'. Again, a small number of responders did not answer this question (n=3, 9.3%).(Percentages may not add up to 100% due to rounding).

From the prompt 'If yes, do you have any specific suggestions for how we should do this?' the following comments are provided as examples.

Users –

> **'Need to know if authority proposes to develop services in partnership with a private sector company to free up additional funds potentially'.**

'Mental health clinics should be based in the locality and where services closed can best access them'.

Carers –

'Some kind of rehab/recovery place to give sessions for people with mental health problems who are now released from hospital often too quickly – this results in carer stress/pos homicide/suicide/revolving door syndrome'. 'The growing elderly people mean the likelihood of developing dementia is great and will continue growing, so make sure there are sufficient services in place'.

'Ensure sufficient space for in-patients. Acutely ill persons at different stages of their illness need to be able to 'escape' from others. Need enclosed outdoor area too – for (illegible) movement'.

'How could anyone answer 'No to this question''?

'The Bowmere Unit/Chester has got flexible accommodation. Similar facility could replace existing older accommodation in Central and East Cheshire'.

'Do you really think we are in a position to answer this? I don't. I suggest even members of staff need much more information to be able to answer this. Yet, you expect us to come up with solutions from a nil information level'.

Voluntary –

'Over complex sentence. Does this make sense? Why is it not possible to have flexibility that can cater for a wider range of specialist services? The person(s) drafting this has no experience of phrasing a proper question!'

Trust –

'Adequate available space to enable changes to be introduced and implemented quickly when necessary without detriment to other essential services'.

'But not to continue to close wards/reduce bed numbers'.

'Have purpose built units, with single en-suite facilities, with structure that can be altered to changing demands'.

Other –

'Though I do not know what your exact plans are. This and other questions are so broad that you can interpret the results to suit yourselves'.

'Specialist unit for people with dementia'.

'Be pragmatic and approachable'.

For those who answered in the negative, the request 'If no, please can you explain what your concerns are and how we might address them' produced the following comments as examples.

Carers –

> **'Another platitudinous statement which is vague deliberately to enable administrators to axe whatever services and staff they choose. Have the decency and the courage to consult the public properly and do them the courtesy of inviting them to opt in instead of falling back on the trick of leaving it to them to write and opt out if they disagree. Vagueness is suspicious to carers who are well aware of the proposed asset stripping put forward by the council'.**

Trust –

> *'I am answering No to this question on the precautionary principle that I should not agree to something where the intention is so unclear'.*

Staff –

> **'Again, use common sense and don't make it difficult and unpleasant for staff to worry. Most of them spend their mentor time in the week at their work so make it comfortable'.**

Other –

> *'Too confusing for some people'.*

Analysis

The majority of responders answered 'yes' to this question with 3 responders failing to provide any response. From the written commentary a number of issues emerged. First, the development of specialist services is important and rehab, recovery, bi-polar, dementia and community services were mentioned. There were also comments regarding the need to develop small units across a wide geographical area. Second, the lack of information in some responders' comments indicated that they could not make a decision. In not having information regarding the future direction of CWP plans a number of responders felt that they could not comment.

Conclusion to Question 6

In conclusion the majority of responders answered 'yes' to this question with the following concerns being raised:

- A range of specialist services need to be developed.
- These should be developed across a wide geographical area.
- A lack of available information resulted in responders unable to make informed decisions.

Question 7. We will be reporting to our members and their representative governors on progress in developing quality, efficiency and effectiveness – do you have any views as to how this is best done?

Table 12: Responses to Question 7 (Reporting arrangements)

Participant	Events	Meetings	Newsletters	Totals
User	4	3	4	11
Carer	5	4	9	18
Voluntary	3	3	4	10
Trust	2	2	1	5
Governor	-	1	1	2
Staff	1	1	1	3
Rep	-	-	-	-
Other	2	2	2	6
Totals	**17**	**16**	**22**	**55**

Figure 11: Responses to Question 7 (Reporting arrangements)

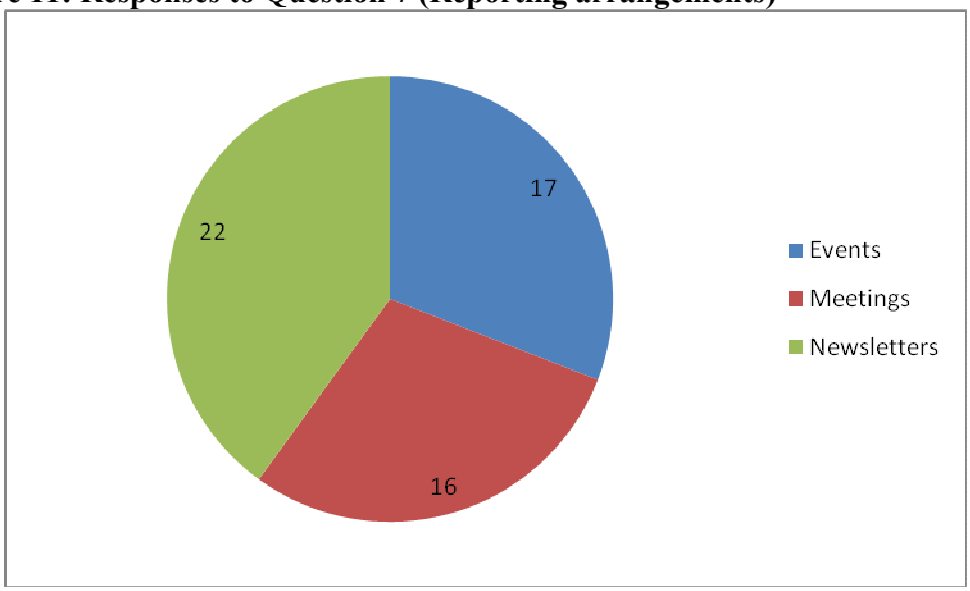


Table 12 and Figure 11 indicate the responses regarding reporting arrangements and the use of 'Newsletters' was the most popular, closely followed by 'Events' and 'Meetings'. This clearly shows that an array of reporting mechanisms are preferred rather than a focus on just one.

The questionnaire requested 'Other suggestions:' and the following examples are given.

Users –

'E-mail updates similar to or using the MHIP'.

'Website, Local and National Newspapers'.

Carers –

'I think a mixture of events and newsletters. Also sending information to the people in charge of the societies so it can be passed on'.

'Make your annual reports more widely available'.

'Publish you KPIs on your website. It will enhance your credibility no end and enable us to answer your questions more effectively'.

'Use existing meetings and newsletters and occasional events for major changes and also keep CWP website updated and encourage feedback'.

'The very poor attendance at a number of the formal consultations for this report shows that more effort must be made to communicate with service users and carers. Most areas have support groups for service users and separate ones for carers. CWP should be going to these groups instead of expecting 'clients' to go to 'their' i.e. CWP held meetings'.

Voluntary –

'All ways and means necessary. Question and answer sessions are very useful'.

'Low cost and simplicity are key: therefore newsletters are probably best'.

'Use of website. Use of local media'.

Governors –

'Information leaflets handed out at clinics and primary care centres (not just left around for people to pile up). Via existing care groups, support groups etc. Meeting (llegible) newspapers, local (illegible) networking sites, feedback. The public consultation exercise have been very poorly attended'.

Trust –

'By making available the full report of the conclusions reached by Chester University and making available facilities for the viewing of all of the consultative submissions (anonymised and redacted where appropriate)'.

Other –

'Don't waste money on events/meetings use post and e-mail'.

'To notice boards at all hospitals, GP surgeries, clinics, libraries, Town Halls, Council Offices etc, across the area'.

'Local media – newspaper, radio, tv'.

Analysis

More responders requested feedback in the form of newsletters but there was a general agreement for a mixed method approach to communication with events and

meetings also appearing important. There were other suggestions which included website, occasional events, e-mails, local media, information leaflets, networking sites, notice boards, GP surgeries, clinics, libraries, Town Halls, Council Offices and the publication of this report. A number of comments were noted regarding the need to keep expenses to a minimum but also emphasising the importance of communication.

Conclusion to Question 7
In conclusion, most responders voted for newsletters but requested a mixture of communicative strategies.

Question 8. Do you have any other suggestions on how we can further improve our mental health, learning disability and drug/alcohol services, or ideas for services that you think we should or shouldn't be providing?

Suggestions	Notes
Environmental Standards	Need for privacy, dignity and safety. Relaxed, bright atmosphere. Occupational therapy, psychological services. Recovery work.
Support Groups	Family support. Financial advice. Older people's support group.
Community Services	Expansion needed. Crisis teams. Balance between Acute Beds and Community Services. 24 hours services. Weekend cover. Access to services.
Service Delivery	Small units needed. New builds. Access. Location.
Communication	Carers involved in decisions. Liaise with service users. Improve consultation. Educate the public.
Information	Maintain statistics. Admissions, referrals, types of disorders.

Table 13: Main Suggestions Regarding Service Improvement

Table thirteen highlights six major themes that emerged from the written commentary from this question. It should be noted that it is not listed in order of priority. There is concern within the written commentary that services are delivered according to fiscal and organisational requirements rather than in relation to service users' and carers' needs. There is a call for an improvement in existing facilities (environmental standards) with an expansion of a supportive framework (support groups) and development of community services, particularly in relation to crisis teams, 24-hour access and location of units. Although there is an understanding of fiscal restraints the responders felt that new, smaller units, are needed to provide a comprehensive mental health service. Communication was a major concern and there were numerous requests for this to be improved and it was felt that the responsibility for this falls to CWP. Communication was seen in two main aspects, first, as information being made available from the Trusts regarding facts and figures and, second, in relation to informing the public about mental health issues to reduce stigma, discrimination and prejudice.

The following comments are examples from the written commentary to this question.

Users –

> **'Appreciate need to upgrade environmental standards to ensure privacy, dignity and safety. More day care for dementia sufferers needs to be provided and is a priority when assessing community care services'.**
>
> *'There is a desperate need for support groups for people with mental health needs, especially in Chester. Support networks are vital for coping with illness*

and rehabilitation, as well as providing safe opportunities for socialising. Can the NHS set one up'?

'(1) There must be an expansion in community services to cope with those people living at home in the community. (2) There is a need for one 'new build' unit in East Cheshire, but with the opinions of the families. (3) With more older people in East Cheshire in the future, there must be a plan to expand older people's services effectively. (4) Clinics (for depot and blood tests) must be maintained in the localities. (5) With 'cuts' in the money anticipated over the next few years it is vital to maintain front-line services. If 'cuts' are made then trim 'middle' management'!

Carers –

'You must provide a service whereby when all emergency crises, usually evenings and weekends, there has to be a service that you can tap into (i.e. telephone number) for help. This team would come out and visit the carer and service user to assess the situation. If they do not feel they can do anything positive at the time then they should be able to contact the appropriate service provider'. 'The crisis teams should be available on request and help or advice should be immediate. A carer should not have to resort to the police for help when a service user is obviously seriously disturbed and mentally ill. Support workers should keep their appointments. Carers observations should not be dismissed out of hand and common sense should prevail. So more crisis resolutions are required and well educated support workers are a necessity'.

'Carers of people with mental health problems often suffer distress by not being properly involved in discharges. Some carers suffered badly over the xmas holiday. Many patients are often still unwell when discharged. Crisis team needs to be larger and responsive. A single 24 hour phone service for emergencies needs to be set up that is separate to out of hours available at present'.

'Speaking from the view of Alzheimers, I think that this should be seen as a physical illness like Parkinsons, as far as financial help is concerned and that the general public be made more aware of what exactly dementia is. Not just something that 'old people' get. Early diagnosis is essential to give the patient the best possible chance of slowing the symptoms down. It would help if we could have a designated person e.g. social worker assigned to each dementia patient so that the carer has someone they can contact if they have any concerns'.

Voluntary –

'This document is an insult. There are about 54 positive words or statements stating the excellence of CWP; it implicitly shapes the unwary respondent. If CWP does not get a single site there will, allegedly, be no release of funds for better services – how dare you try and make me give a carte blanche for your re-organisation when it is contrived (if it was such a good idea, why did it depend on the DGH giving you notice and forcing your hand?). We are all adults and want to support an organisation that treats us as adults, not be manipulated. An absence of economic analysis,

even provisional at this stage, is ridiculous. At a meeting of members of different vol. orgs. There was despair at the dishonest, cynicism that decisions had been made, and we (none of us) would be listened to. For example, page 5, para 4; No one would argue 'and admitting people into acute beds just to keep wards full' this is a betrayal of rational thought, it puts words into mouths (whose?) and then criticises it. How can professional staff write such nonsense? It is debateable whether questions 3-6 apply to this consultation or better placed in the other one. The OSC was misguided in suggesting that a consultation like this was required – a largely complete waste of time – it does no favours to CWP'.

'If acute beds are reduced then community services must be increased to compensate. Care services must be improved to provide wellbeing and holistic care. Despite fiscal restraints front line services must be maintained'.

Trust –

'1. I am concerned that when a service user becomes an inpatient, the role of the carer changes from being 'near full-time' to being 'not wanted'. Ward managers and ward-based practitioners can be very possessive of 'their' patients. A much fuller role should be designed for the carer. I would surmise that the patient turn-around will be even quicker, thus achieving efficiency. 2. As services become more community-based, the role of the service user in their own recovery and role of carers in providing basic, holistic, non-medical, support and sustenance, both increase. This process is creamed full with efficiencies as neither service users nor carers are paid to do this. I would like however to see more thought being given to how this process can be supported by the statutory agencies using the efficiency savings. An obvious 'starter for one' is the provision of more Family Support Workers.3. One West Cheshire councillor has reportedly described this consultation as an 'exercise in obtaining acquiescence'.

Staff –

'Use simple common sense. Imagine yourselves as mental health patients. Check and see what sort of services you will expect realistically. This is not any Rocket Science'.

Other –

'I think CBT services are good but the ability of those delivering the services is very varied. I learnt so much from my first course at Macclesfield 2004-2006 that I could have taught the person I had in 2009 in (name removed). I think some services are self indulgent and people need to "get real" about the need for budget cuts. So many people abuse the system. If you truly need the services you offer you will seek out the help. We are in danger of mollycoddling people. I would really like to get involved in the practical aspects of these proposals'.

'This survey has not been sufficiently advertised. There are patients and staff who are not aware of its happening or of its significance. I think you should stop paying people to support the Trust. You could send your management

teams to meet and discuss their ideas and needs for mental health care and their service experiences instead of paying management teams to fulfil government paper chases and meeting merry-go-rounds'.

Analysis
Question eight is an open invitation to offer comments regarding the improvement of mental health services by CWP and there were many comments provided. The main suggestions revolve around the need to establish smaller units, with specialist foci across the geographical area covered by CWP. This, the comments indicate, will address the main issues of location and access by service users, carers and families. There is awareness by many respondents that excellent services do exist but only in certain areas and the disparity between these and other areas in which services are considered of poorer quality should be improved. There was a strong call for more information regarding statistics on mental health services, particularly in relation to bed occupancy, uptake of services, admissions, and so on. This was a consistent reference throughout the questionnaire.

Conclusion to Question 8
In conclusion, six main themes emerged from question eight in relation to suggestions for improvement of mental health services.

- Environmental standards.
- Support groups.
- Community services.
- Service delivery.
- Communication.
- Information.

4. Correspondence
There were four letters of correspondence received, three identical responses from three user and carer groups/forums (see appendix 1) and one from a named individual (see appendix 2). The correspondence is largely positive in their responses but with qualifications and requests for further information before committing their views. There was some considerable criticism regarding the wording of the questions on the questionnaire with many comments suggesting that they were 'loaded' and biased to elicit the responses that CWP requires. Numerous respondents felt that they could not answer these questions in the form in which they were set and others answered 'yes' but with many qualifications.

5. Overall Conclusion
The overall conclusion to this questionnaire is that the majority of respondents answered 'yes' to the questions but with certain qualifications regarding their answers. The first major issue is that there were a number of comments requesting further information regarding the facts and figures of such items as number of beds available, uptake of services, admission rates, etc. There was a general view that the main impetus for the development of mental health services was underpinned by a reduction in inpatient beds, which, in turn, pivots on fiscal concerns in the current financial climate. The respondents generally felt that this would result in problems of isolation caused by inability to access inpatient services with large distances having to be travelled and poor public transport facilities. There was general support for the

development of small specialist units across the Trusts' geographical areas and a request for an improvement in communication of information.

6. References

Firth, M., Hanily, F. & Garratt, P. (2008) Initial assessment and eligibility for secondary care mental health services: not a simple equation. *Journal of Integrated Care.* 16 (6): 41-48.

Glover, G. (2007) Adult mental health care in England. *European Archives of Psychiatry and Clinical Neuroscience.* 257 (2): 71-82.

Hunter, D.J. (2008) Coping with uncertainty: decisions and resources within health authorities. *Sociology of Health and Illness.* 1 (1): 40-68.

Ward, M. (2008) Evaluating the impact of in-patient bed reduction and community nurse increases in one English Mental Healthcare Trust. *Journal of Advanced Nursing.* 26 (5): 937-45.

White, J. (2008) CBT and the challenge of primary care: developing effective, efficient, equitable, acceptable and accessible services for common mental health problems. *Journal of Public Mental Health.* 7 (1): 32-41.

Appendix 1 Letter from User groups/forums
All of the first six consultation questions can be answered 'yes' in principle, but they all largely hinge on being funded by savings from fewer acute admission wards. However, CWP have not yet fully answered queries to clarify Question 3 such as:

- What is the number of beds in CWP now compared with three years ago?
- What is the level of bed occupancy in CWP now compared with three years ago?
- What is the proportion of in-patients in CWP who are sectioned now compared with three years ago?

Q1. Yes.
Both the (user group/forum) have recommended that CWP and its commissioners should consider the Lancaster best practice model for a Mental Health Intermediate Care Team as summarised in Issue 089 of NHS North West's Mental Health News.

Q2. Yes

Q3. Yes **But**
The impression of bed surpluses given by CWP to date is **seriously misleading** since 50 empty beds in 350 only just meets their stated 85% bed occupancy target and is not a real surplus over and above this target. Unless CWP can **prove** that their Acute Care Model leads to a major reduction in the number of people sectioned, ward closures will increase this proportion and will risk leading to greater staff stress and burnout, **to the detriment of patient care.** Further bed closures and shorter in-patient stays will put further pressure on resources for 'care in the community', so there would then be a need for:

- Increased capacity for meaningful activities based on 'Recovery' principles.
- Simpler pathways for contacting care in a crisis, particularly for those who do not meet strict criteria or who do not understand current pathways.
- Greater availability of carer information packs and Family Support Workers.

Q4. Yes
CWP deserve great credit for much innovative work in this area already and should be encouraged to continue it.

Q5. Yes
There are benefits in concentrating resources for greater effectiveness.

Q6. Yes
The design of the new build Bowmere unit in Chester has lent itself to flexible adaptation. It is to be hoped that a similar facility could replace existing older accommodation in Central and East Cheshire.

Q7. Use existing meetings and newsletters and occasional events for major changes, but also keep the CWP website updated and encourage feedback on it.

Q8. Very many of the challenges for CWP in the future will be controlled more by commissioners, some of whom may not always have sufficient background or knowledge.
Names of organisations supplied.

Appendix 2 Letter from an Individual (name provided)

Question 1.
The answer is Yes but CWP must not assume that this gives them a licence to change community or in patient services in the future as a result of this consultation without specific and explicit further consultation about any significant change and without committing itself to monitoring and evaluating the impact of change on service users, their carers and the rest of the mental health service system. CWP has to ensure as it claims it will that it will always provide "appropriate alternatives'.

As I understand CWP's strategy it is committed to mainstreaming the need to improve and promote good mental health and well being for all. If this is the case then the further development of early intervention and prevention through enhanced community based services is urgently required. Additionally, ensuring improvements in the connections between primary, secondary and tertiary care and the system's relationships with local government, commissioners and the 3rd sector need further investment. Further efforts are also required to engage service users and carers in service wide decision making and the development, delivery and quality assurance of provision. The local mental health forum were briefed on 9 February about by the Lancashire best practice model of intermediate care for adults and were fully supportive of this initiative and would wish CWP and the PCT to seriously consider its introduction in West Cheshire (See issue 089 of Mental Health News). Developments in more community based services inevitably add to the responsibilities upon carers and even service users for their own recovery. CWP needs to satisfy itself that it is investing enough support in them so that they can make their contributions to improving mental health e.g. is there enough family or carer support?

Question 2.
The answer to this question is again 'Yes' given reference to improving community services above but at what cost or implications to other parts of the system? What changes to care pathways does CWP envisage? What elements of community services are ineffective and or inefficient? We will continue to need a balance range of inpatient and community services otherwise patient choice is not possible. If I am isolated and live at home on my own and feel that a hospital bed will give me the best chance to begin recovering and my clinician supports this surely I should be able to access in patient services? CWP also needs to reconsider how visible and accessible are its services and its pathways to the wider community.

Question 3.
Yes of course I want action to be taken to deal with any inefficiency and to make best use of available resources but how many beds are regularly empty and how much money could be reinvested? How sure is CWP that they have enough acute admission ward beds and they are currently being made best use of? In question 4 later in the consultation we are asked to agree the development of additional specialist inpatient services? Are these empty beds simply going to be used for these additional specialist services? If so where is the saving?

Question 4.
The answer to this question is possibly but I cannot be sure without knowing specifically what CWP is really talking about in relation to the 3 listed services?

Additionally, what other options would there be for further investment in the mental health care system? CWP needs to disclose on what basis it has arrived at the identification of the need for these 3 listed services? What level of need is there for them Trust wide and where would the funding come from? Would any existing services have to do with reducing funding as a cosequence?

Question 5
It really is impossible to answer this question at this time. All stakeholders are engaged in developing Dementia strategy for west Cheshire and Chester. Shouldn't the decision to reduce the number of sites await the strategy and the priorities for service developments that presumably will be made explicit? Which dispersed inpatient services does CWP have in mind? Once again clearly a level of analysis has been undertaken which has not been shared to inform this consultation. There is also a huge assumption that the best use of highly specialist staff will be achieved by reducing the number of sites. What other options are there to achieve this CWP?

Question 6
I cannot support this because CWP's intentions are so non specific.

Question 7
CWP has to report progress through all 3 options. In my view it also has to make available the full report of the outcomes of the consultation from the University of Chester and make clear itself and in a more effective evidence based way the decisions it has taken as a result of the consultation and not just to its members and governors but the wider community and all respondents to the consultation.

Question 8
The adult health and social care system is in fundamental transition at present at the worst possible time given the worsening public expenditure environment. CWP needs to ensure that it is a full and active participant in the development of emerging integrated commissioning arrangements in Cheshire West and Chester. It cannot make effective use of its resources without detailed and ongoing discussions with adult social care and the 3rd sector about its plans and priorities. It has to offer leadership and support the 3rd sector in its work if we are to see the development of a holistic and community wide public health approach to improving the mental health of our communities.

A medical model simply will no longer do. CWP should also lead efforts to develop a population wide mental health strategy which improves early recognition/intervention, promotion and prevention which targets groups of people with known risk factors for mental illness and whole population awareness raising, education and mental health and well being promotion. I expected to see an explicit commitment to a flexible and holistic approach to the design of services that will intentionally seek to deliver quality of life outcomes to restore and enrich the lives of all adults who experience mental health distress. This consultation has been a missed opportunity in my view.

The consultation has been crafted to secure the answers CWP wants. If this was an attempt to produce an easily accessible consultation document it should not have assumed a level of knowledge and understanding of the existing mental health service

system. CWP needs to look more carefully at the use of its language in any future consultation and also ensure it gives the reader enough information to make an informed decision.

Name supplied.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Report

Title of Meeting	Board of Directors
Date of Meeting	May 26th
Agenda item number	

Title of Report	Report on the independent analysis of response to the consultation 'Redesigning adult and older people's mental health services in Central and Eastern Cheshire'		
Presented by	Ian Davidson		
Author(s)	John Loughlin		
Purpose of the report	To appraise the Board on the outcome of the consultation exercise		
Related to strategic goals	SO1	Deliver improved and innovative services that achieve excellence	X
	SO2	Ensure meaningful involvement of service users, carers, staff and the wider public	X
	SO3	Be a model employer and have a competent and motivated workforce	X
	SO4	Maintain and develop robust Partnerships with existing and potential new stakeholders	
	SO5	Performance Manage all services using an evidence based approach within a Risk Management Framework	
	SO6	Improve quality of information to improve service delivery and longer term planning	
	SO7	Sustain financial viability	X
	SO8	Develop Trust's brand value	
Financial and legal implications			
Patient and public implications	CWP will prepare report informing the public on the outcome of the consultation exercise		
Staff implications	CWP will prepare report informing staff on the outcome of the consultation exercise		
Partner organisation implications	CWP will prepare report informing partner agencies on the outcome of the consultation exercise		
Equality issues			
Risk score and assurance rating			
Action required	To receive		x
	To review		

Recommendations	To approve	
	To confirm	

Document History

Revision History

Version	Date Revision	Change by	Brief Summary of Change/Sections Changed
1			

Distribution

Version	Name/Group	Date Issued
1	Ian Davidson (Executive sign off)	13th May 2010
2	Ian Davidson (second approval following corrections)	17th May 2010.
3	Avril Devaney	17th May 2010.
4	Trust Board (reformatted into standard format	17th May 2010

Executive director sign-off

	Executive director	Date signed-off
Version distributed to Board of Directors signed off by (state name):		

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Report on the Independent Analysis of Responses to the Consultation 'Redesigning adult and older people's mental health services in Central and Eastern Cheshire'

CONTENTS

1. EXECUTIVE SUMMARY

This report appraises the Board on independent analysis of the consultation exercise 'Redesigning adult and older people's mental health services in Central and Eastern Cheshire'.

The independent analysis was undertaken by the Faculty of Health and Social Care at the University of Chester. A copy of the draft report is attached to this document. (The final copy is awaited. The reasons for this not being currently available are given below).

The overall conclusion of the report was that while there were a small number of respondents to the questionnaire contained within the report, many accepted the position of CWP in terms of the necessity to redesign mental health services and understood the position regarding financial constraints. Concerns were expressed about the potential location of a single unit and access to it. However no significant issues were raised that would suggest that, from a consultation point of view, the Trust needs to reconsider or revise current intentions.

2. INTRODUCTION

The consultation was carried out by Cheshire and Wirral Partnership NHS Foundation Trust at the request of and on behalf of Central and Eastern Cheshire PCT (CECPCT). It was held between 1st December 2009 and 9th March 2010. It was agreed prior to the exercise that Chester University, which had provided an independent analysis on a previous consultation exercise, should be approached to provide this service again. All responses were therefore sent directly to the University using a Freepost service.

A report outlining the communications and engagement strategy for the consultation was submitted to a previous CWP Board meeting

The first draft of the report was received at the beginning of April. Two changes to the text have been requested (as well as a number of typing corrections). However the author of the report has been on an extended holiday and then delayed overseas due to airline difficulties and the corrected final report has not yet been returned.

The two suggested changes are;

In the first paragraph refers to the 'consultation …..undertaken by Chester University', rather than stating clearly that the consultation was undertaken by CWP on behalf of the PCT, and the independent analysis was provided by the University.

Throughout the document, responses provided by Trust Members have been abbreviated to 'Trust' as opposed to 'Member'. Within the context of the report this implies that a member of staff submitted the response.

The outcome of the consultation exercise needed to be submitted to the Board of the PCT in May. It is not considered that these changes significantly affect the sense of the report.

3. DISCUSSION

3.1 The Report

The report provides an analysis of from whom and from where the responses to the consultation questionnaire were received. It then provides an analysis of the responses to each question contained within the consultation document.

A total of 23 completed questionnaires were received plus one letter from a service user group who declined to use the questionnaire.

The first question referred to new ways of working which would see community based services further strengthened and as a consequence a reduced requirement for inpatient beds. The second referred to the provision of inpatient services from a single site. 69% of respondents said that they agreed with the Trust's proposals for both of these questions

The third question offered the opportunity for respondents to raise concerns they may have regarding the location of inpatient services. Predictably words like, 'access', 'hospital proximity,' 'transport' and 'centrality' were contained within 51 of the 55 issues raised.

The fourth question asked for other suggestions to improve mental health services. These have been summarised in the report under the following headings

- Management
- Education
- Communication
- Training
- Service review

The report ends with an overall conclusion that there is broad acceptance of the need to redesign services and operate within financial constraints.

3.2 The next steps

There was, despite a publicity campaign and four public meetings, very few responses to the consultation exercise. However the issues raised appear not to be so contentious as to cause negative reaction among stakeholders. There has been no single issue raised that would indicate that the Trust should reconsider or revise current proposals.

The University of Chester report will be presented to the CEC PCT Board meeting in May. Subject to the approval of the PCT, CWP can then move to the next stage which is determining how these proposals can be implemented. This will have to be

undertaken in the context of the challenging financial situation in the NHS both nationally and locally.

The Trust will also now have to prepare a report to stakeholders on the outcome of the consultation exercise. This will provide a response to the individual comments made within questionnaires. This will also summarise and provide responses to the questions raised at each of the consultation events which were recorded for this purpose. Reference will also be made to the review of the implementation of the Acute Care Model which offers the evidence of decreased requirement for inpatient beds that was referred to at these events.

4. CONCLUSION

While there were few responses to the questionnaire, no significant issues were raised during the consultation that indicates that the Trust should reconsider or revise current plans. This allows the Inpatient Project team to be reconvened and the planning of service redesign to recommence.

5. RECOMMENDATIONS

It is recommended that;

- CWP notes the content of this report and the University of Chester report on the outcome of the consultation exercise
- Subject to the comments of the CEC PCT Board, reconvene the inpatient reprovision project team
- Commissions the preparation of report to stakeholders on the outcome of the consultation exercise.

Appendix 1

University of Chester report on the responses to the Consultation Questionnaire ‘Redesigning Adult and Older People’s Mental Health Services in Central and Eastern Cheshire’

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APPENDIX 1

University of Chester

Redesigning Adult and Older People's Mental Health Services in Central and Eastern Cheshire

Report of the Responses to the CWP Questionnaire

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Contents **Page No.**

Executive Summary

1. Introduction

This report relates to the CWP public consultation document questionnaire pertaining to the 'Redesigning Adult and Older People's Mental Health Services in Central and Eastern Cheshire' undertaken by the University of Chester.

2. Questionnaire

The central theme of both the consultation document and the questionnaire relates to the reduction of inpatient services to a single site facility accompanied by an expansion of community resources. Within the questionnaire there were opportunities for quantitative responses as well as qualitative written commentary in relation to the questions posed.

3. Analysis

3.1. Demographics – A total of 23 questionnaires were received.

- 3.1.1. Section A – The majority of responses were from users, carers and voluntary groups (n= 13, 56.5%).
- 3.1.2. Section B – There were more responses from community services (n= 5) than inpatient sources (n= 1).
- 3.1.3. Section C – Responders in this section were from Adult Mental Health (n= 6) and Other (n=3) with none from Child & Adolescent, Learning Disability and Drug & Alcohol.
- 3.1.4. Section D – The majority of responses were from Central/Eastern Cheshire (n=20).
- 3.1.5. Section E – The source material accessed were predominantly from the Consultation Document and the Website.
- 3.1.6. Contact Details – From the 23 questionnaires received 21 provided contact details.

3.2. Question One (referring to reduction in beds and strengthening of community services) – There were over twice as many responses to 'Yes' (n= 16, 69.5%) than 'No' (n= 7, 30.5%) but with a number of qualifications noted.

3.3. Question Two (referring to single site for adult/older people's services) – There were over twice as many responses to 'Yes' (n= 16, 69.5%) than 'No' (n=7, 30.5%) and a number of points were raised within the written commentary.

3.4. Question Three (referring to issues relating to location of inpatient services) – Access is the major concern with close proximity to General Hospital facilities being regarded as a priority. Transport to single site was also raised as an issue.

3.5. Question Four (referring to other suggestions for improvement of services) – The main suggestions involved issues of management, education, communication, training and service review.

4. Correspondence

One letter of correspondence was received from a Service User group providing minor criticism of the questionnaire and the language used in the consultation document. The letter also outlined some suggestions (appendix one).

5. Overall Conclusion

The majority of responders accepted the position of CWP in terms of the necessity to redesign mental health services and understood the position regarding fiscal restraints. However, the main concern involved the location of a single site service and ease of access to it. The major anxieties were that the community services would be overloaded and that ultimately users and carers would be worse off, particularly in relation to sufferers of dementia.

1. Introduction
The Cheshire and Wirral Partnership NHS Foundation Trust (CWP) undertook a public consultation exercise between 1st December 2009 and 9th March 2010 to establish the views of various stakeholders regarding the redesigning of the adult and older people's mental health services in Central and Eastern Cheshire. The geographical area that CWP encompasses is large and redesigning the mental health services to a single site provision would be problematic. Therefore, the gathering of public and professional views regarding this was felt to be of major importance given that there are no additional development funds currently available. The public consultation took several forms including the production of a consultation document containing a questionnaire, the establishment of a series of public meetings, a website, frequently asked questions and a freephone helpline. This report, undertaken by the University of Chester as an independent reviewer, relates to the responses to the questionnaire only.

2. Questionnaire
The questionnaire was designed by CWP and contains two parts:

Part One
The first part captures some demographic data pertaining to (a) personal details as to who the respondent is, (b) the areas in which the respondent might work, (c) further details about the areas of employment, (d) the geographical site of the respondent, e) the type of consultation material accessed and (f) the provision of name and address for validation purposes (to be treated in confidence).

Part Two
The second part contains four questions which relate to (1) agreement with the CWP proposal with a 'yes'/'no' tick box response and further opportunity for written commentary, (2) specific agreement with option three from the consultation document as a tick box response in the form of 'yes'/'no' with further opportunity for written commentary, (3) relating to a request for information on specific issues of importance for the responder and (4) a request for any further suggestions.

3. Analysis
3.1 Demographics
A total of 23 questionnaires were received and one letter of correspondence from a Service User group. There is no information available regarding response rates.

In analysing the demographic data the following Key of responders was identified from the questionnaire:

User = I am a CWP Service User
Carer = I am a carer for a person who receives CWP services
Voluntary = I am from a mental health forum/voluntary organisation
Trust = I am a Foundation Trust member of CWP
Governor = I am a Governor
Staff = I am a member of staff
Rep = I am a staffside representative
Other = Other (please specify)

3.1.1 Section A. Personal Demographics

From the 23 questionnaires returned the respondent had indicated the 'person' that they were representing in answering the questions, with some ticking more than one response. The following table shows that the majority of responders were service users, carers and representatives from voluntary organisations (n= 13, 56.5%), with only 9 (39.1%) responses from Trust and staff sources. See Table 1 in response to the questionnaire prompt 'Before you answer the questions below we would be grateful if you could tell us a bit about yourself (you can tick more than one box)'

Table 1: Personal Demographics (numbers greater than total as items not mutually exclusive)

Participant	Number
User	1
Carer	7
Voluntary	5
Trust	4
Governor	-
Staff	5
Rep	-
Other	5
Total	**27**

3.1.2 Section B. Place of Work

The questionnaire requested information regarding employment and from the request 'Questions B and C are for staff only. Please select which of the following areas you work in' the following responses were reported. See Table 2 and Figure 1.

Table 2. Place of Work (Item not relevant to some respondents)

Participant	Impatient	Community	Other	Totals
User	-	1	-	1
Carer	-	-	-	-
Voluntary	-	1	-	1
Trust	-	-	-	-
Governor	-	-	-	-
Staff	2	2	1	5
Rep	-	-	-	-
Other	-	1	0	1
Totals	**2**	**5**	**1**	**8**

Figure 1.

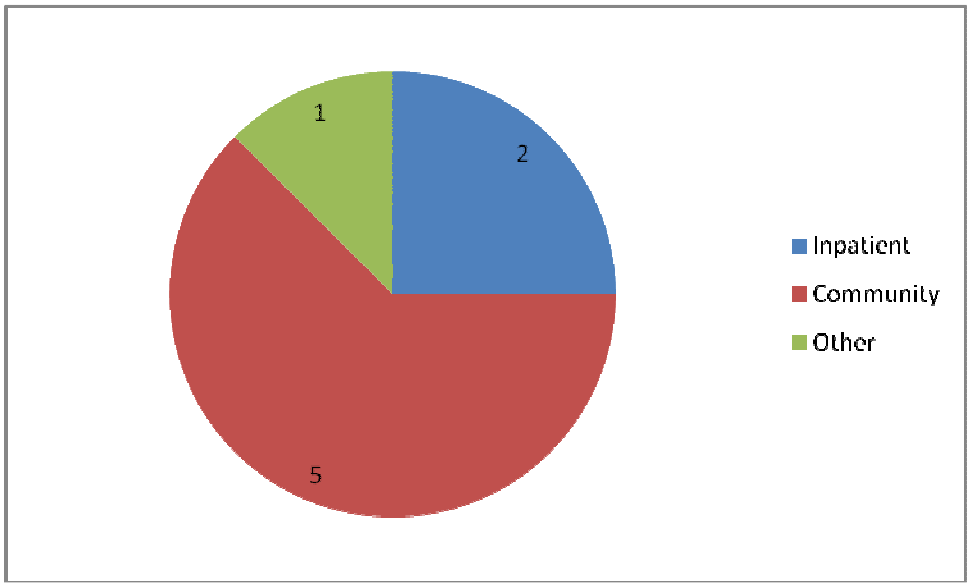


Table 2 and Figure 1 indicate that there were 2 staff from the inpatient area and 5 from the community, with 1 staff responding with other. One User responder and one Voluntary responder indicated that they considered themselves to be employed in this area.

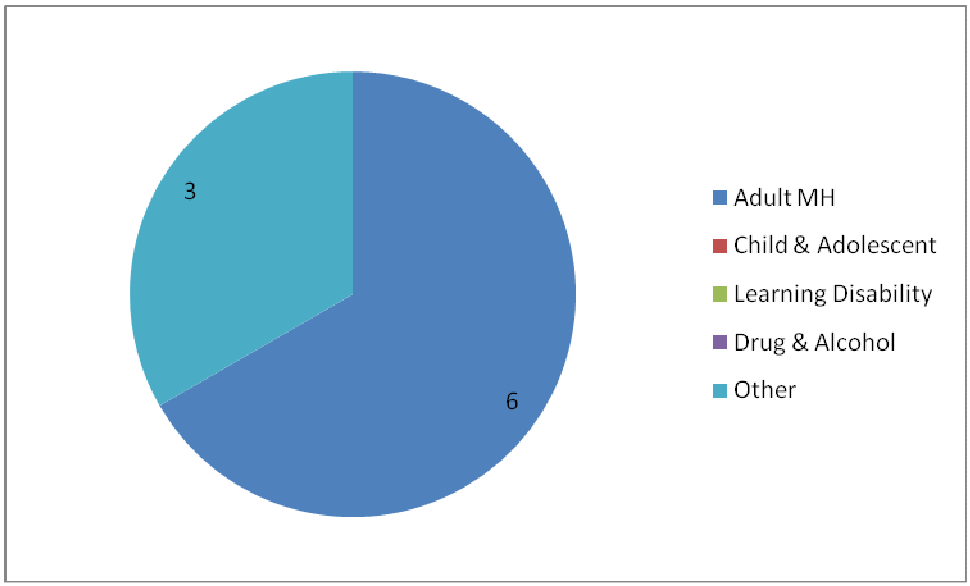
3.1.3 Section C. Work Areas

From the questionnaire request 'Please select which of the following areas you work in' it can be noted that there were a total of 9 responses, with 6 being from Adult Mental Health and 3 from other sources. The other sources were specified as 'carer at home' and 'community group promoting health and well being'. There were no responses from Child & Adolescent, Learning Disability and Drug & Alcohol areas. See Table 3 and Figure 2.

Table 3: Work Areas (Item not relevant to many respondents)

Participant	Adult MH	Child & Adolescent	Learning Disability	Drug & Alcohol	Other	Totals
User	1	-	-	-	-	1
Carer	-	-	-	-	1	1
Voluntary	1	-	-	-	-	1
Trust	-	-	-	-	-	-
Governor	-	-	-	-	-	-
Staff	4	-	-	-	1	5
Rep	-	-	-	-	-	-
Other	-	-	-	-	1	1
Totals	**6**	**-**	**-**	**-**	**3**	**9**

Figure 2. Work Areas



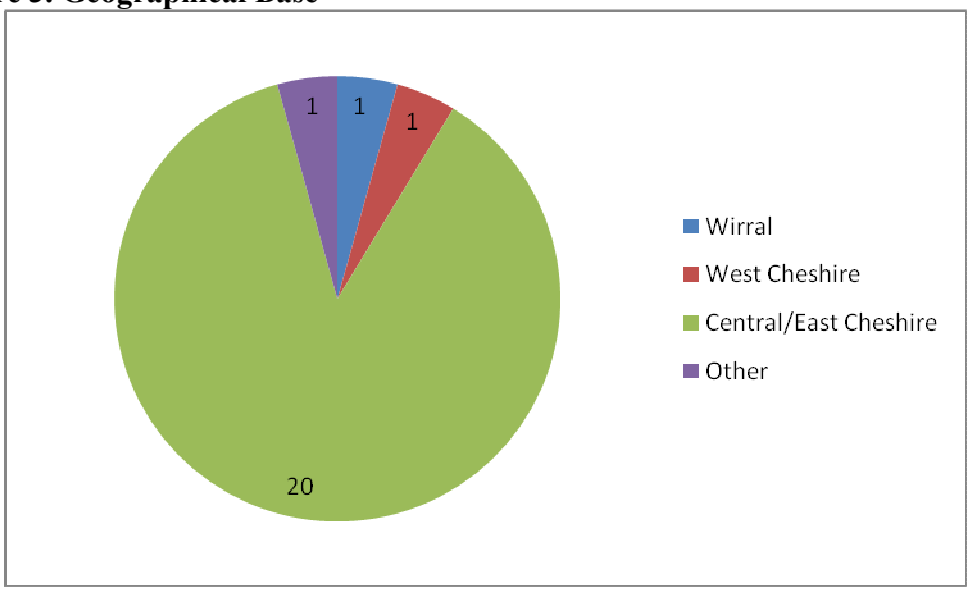
3.1.4 Section D. Geographical Base

The geographical area of responders was requested in Section D with the following results noted (see Table 4). It can be seen in Table 4 that the vast majority of responders were from Central & Eastern Cheshire and were from user, carer and voluntary groups.

Table 4: Geographical Base

Participant	Wirral	West Cheshire	Central/ East Cheshire	Other	Totals
User	1	-	1	-	2
Carer	-	-	7	-	7
Voluntary	-	-	4	-	4
Trust	-	1	-	-	1
Governor	-	-	-	-	-
Staff	-	-	4	1	5
Rep	-	-	-	-	-
Other	-	-	4	-	4
Totals	**1**	**1**	**20**	**1**	**23**

Figure 3. Geographical Base



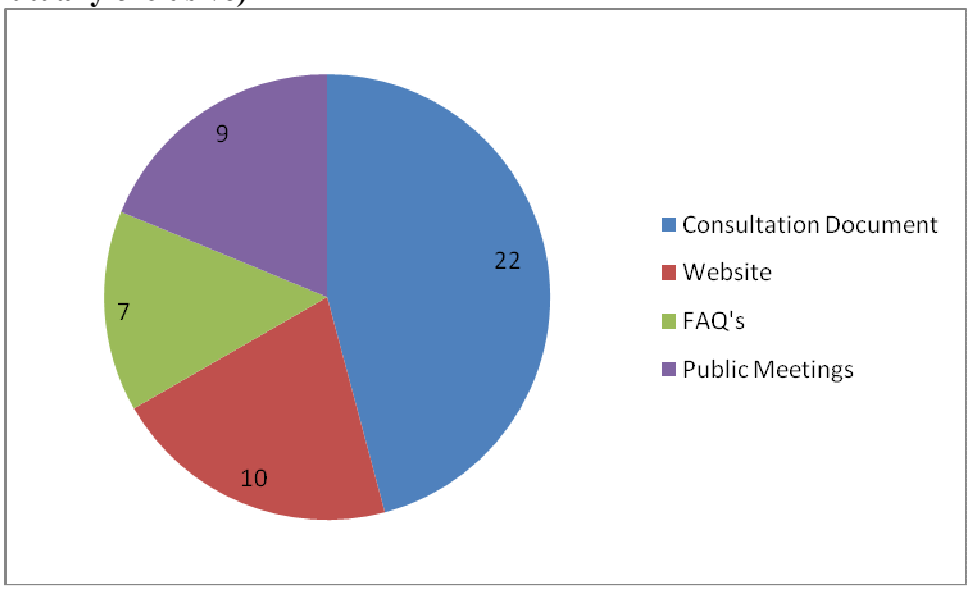
3.1.5 Section E. Consultation Material

The penultimate section to the preliminary information requested on the questionnaire referred to the consultation material that the responders were able to consider. The results can be seen in Table 5 and Figure 4.

Table 5: Consultation Material Considered (numbers greater than total as items not mutually exclusive)

Participant	Consultation Document	Website	FAQ's	Public Meetings	Freephone	Totals
Users	1	-	1	1	-	3
Carers	7	1	1	3	-	12
Voluntary	4	2	2	3	-	11
Trust	1	-	-	-	-	1
Governor	-	-	-	-	-	-
Staff	5	4	3	1	-	13
Rep	-	-	-	-	-	-
Other	4	3	-	1	-	8
Totals	**22**	**10**	**7**	**9**	**-**	**48**

Figure 4. Consultation Material Considered (numbers greater than total as items not mutually exclusive)



It can be seen in Table 5 and Figure 4 that the main source of consultation material was via the document containing the questionnaire from Cheshire and Wirral Partnership (CWP). However, the website was also a popular response and source of information.

3.1.6 Contact Details

The final section (section F) in the questionnaire preliminary information requested personal contact details and these are confidential. The information was requested as follows: 'F. Please provide your name and address for validation purposes only (this information will not be provided to CWP by the independent reviewer of responses, Chester University. Chester University will treat your personal data in accordance with the data protection act and will not use the information for any other purpose'

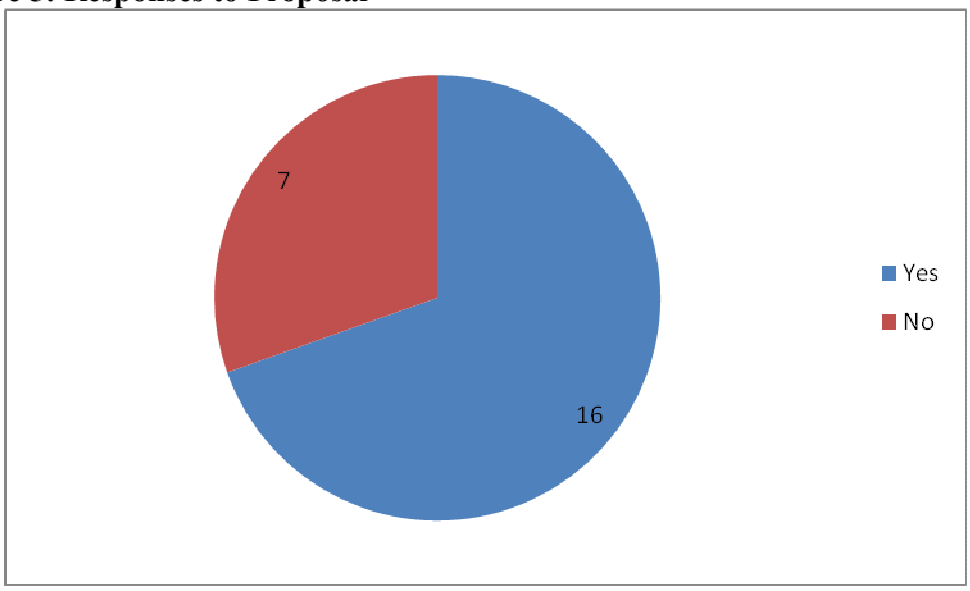
It can be reported that 21 of the 23 responders provided their contact details.

3.2. Question 1.
Do you agree with the proposal to continue to introduce new ways of working which will see community based services further strengthened and as a consequence a reduced requirement for inpatient beds?

Table 6: Responses to Proposal

Participants	Yes	No	Totals
User	2	-	2
Carer	4	3	7
Voluntary	3	1	4
Trust	-	1	1
Governor	-	-	-
Staff	4	1	5
Rep	-	-	-
Other	3	1	4
Totals	**16**	**7**	**23**

Figure 5: Responses to Proposal



It can be seen in Table 6 that there were more responders indicating 'Yes' (n= 16, 69.5%) than 'No' (n= 7, 30.4%) and that there were slightly more from User, Carer and Voluntary groups (n= 13, 56.5%).

In response from the questionnaire request 'If yes, please indicate what safeguards you would like to see put in place to ensure that this has been done effectively' the following examples of commentary are reported:

Users –

'Even with financial limitations there must be a protection of front-line services'.

'Fair treatment for all age groups. Currently crisis team is discriminating against dementia patients and this team should apply to anyone regardless of age'.

Carers –

'It is essential to improve care in the community, especially for dementia sufferers'.

'Random case reviews by CPN or Social Worker. Review to include discussion with carer to assess progress and plan ongoing care where appropriate'.

'No age discrimination. Importance confused elderly are not located with e.g. young potentially violent mental health patients'.

Voluntary –

'Fair access to beds – a push on reduction of beds implies people e may be deterred from being admitted, but if this is the best care for them, more beds should be made available'.

'Case loads for community staff must not be increased so that staff are not time constrained when visiting patients'.

Staff –

'I am concerned that even with the current provision patients often have to be admitted to other trust sites – Clatterbridge or Leighton because of insufficient beds at Macclesfield. This, in spite of daily interventions being offered where needed by the crises teams and CMHT's. Community resources have recently been reduced with the withdrawal of AO teams and the opportunity to change the role of staff in alternative community posts was not taken up'.

'CRHT would need to be strengthened. CMHT will need to be able to focus on severe and enduring mental illness. Primary care service s need to be increased in Vale Royal'.

'The modern mental health unit should reflect modern society and therefore should be easily accessible for all service users with good links to road networks. It should contain a library, IT services, further education access, private meeting rooms, single sex quiet areas, dedicated OT areas integrated onto the wards and separate, gym facilities and safe care rooms. Observation should be paramount whilst privacy and dignity should be maintained'.

'Safe numbers of staff working together such that staffing levels don't become too low that risk will occur'.

Other –

'That the single base has access easily available. Mental health can strike anyone. I was a high profile career person yet I felt isolated and suicidal very quickly, access to help is crucial'. 'Community services need to be available round the clock, 7 days per week, to be able to provide more than two brief visits per day to really provide an alternative to admission'.

'Patients need to be as near as possible to their home and families to facilitate contact and also to facilitate arrangements for home visits etc. in the run-up to discharge'.

Example commentary from the questionnaire request 'If no, please say what alternative policy you think should be adopted' are given as follows:

Carers –

'Community based services are overloaded. Where are the extra staff going to come from? The figure of 70% occupancy of beds might be very, very misleading. Patients having a trial at home are not in their hospital beds'.

'You have provided no evidence that 'new ways of working' will in practice reduce the requirement for inpatient beds'.

'The reduction of EMI facilities in favour of increased provision for self-inflicted conditions is neither fair nor practical given an increasingly aged population'.

Voluntary –

'Present evidence of reduced need for inpatient beds. Present a cost/benefit analysis – even if provisional. The question is faux, it is duplicitous. Of course we want to see better community based team irrespective of unproved "reduced requirement for inpatient beds". It is deceitful to make it either/or'.

Trust –

'Most solutions require access to acute services not community. Increase the number of inpatient beds'.

Staff –

'There is a need for inpatient units due to complex needs of service users, but community services need to be strengthened also'.

Other –

'They are based on administrative and financial purposes only and have not considered patient (carer) family needs thoroughly enough'.

Analysis
It can be seen from the foregoing that the responses to this question are predominantly positive in relation to the 'yes/no' tick-box, however, the commentary reveals a degree of qualification. There was some concern regarding the commitment to community service enhancement despite the comment in the questionnaire regarding the reduction in inpatient beds. Such re-configuration of services has a history of concerns with some being realised whilst others have not. For example, there have been reports of increased stress in community teams with added role functions (Lucas, 2009) and concerns regarding the potential increase in suicides (Hawton & Saunders, 2009). Furthermore, there are questions relating to the 'value for money' in redirecting services from inpatient to community settings with reports of some monies being well spent whilst others have been wasted (Godlberg, 2008). What was noted in the responses to this questionnaire was a growing concern that current community staff should not be overloaded with extra work without further resources being committed. The central concern was the staff-patient ratio and the need for community staff to have time to spend with their clients. Finally, from the 'No' group responders the major concerns related to the accuracy of the figures produced by CWP in relation to bed-occupancy and the requirement of inpatient beds in times of crises.

Conclusion to Question One
In conclusion to this question the following is noted:

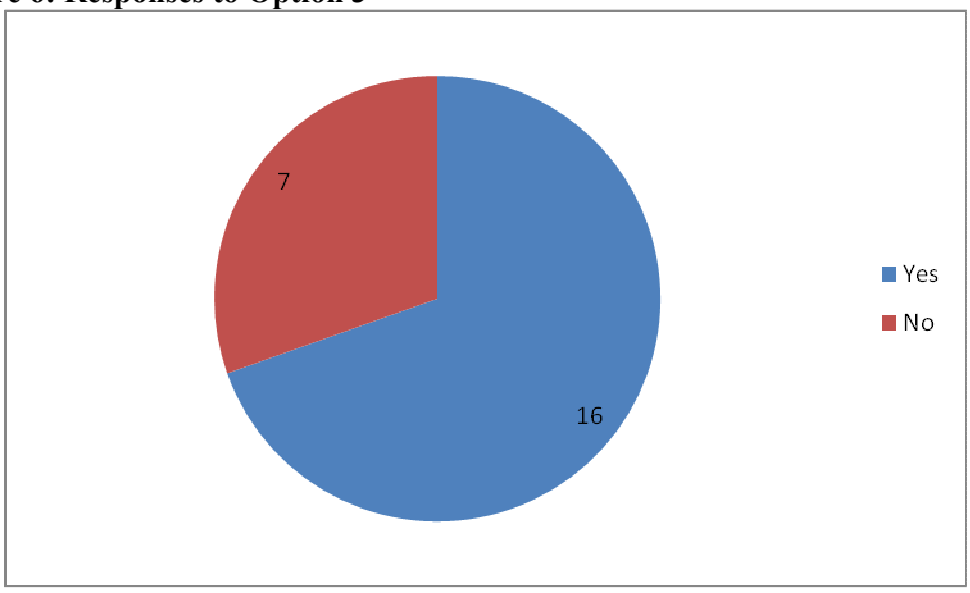
- The responses to 'yes' equalled 16 (69.5%).
- Many of the 'yes' responses were qualified in relation to (a) communication with service users and carers, (b) discrimination against dementia patients and (c) staff overload in the community.
- The responses to 'no' equalled 7 (30.5%).
- The major concerns were (a) accuracy of figures reported, (b) community staff overload and (c) ongoing need for inpatient beds.

3.3 Question 2.
Do you agree with option 3 (page 5) that all adult and older people's inpatient services be provided from a single site?

Table 7: Responses to Option 3

Participants	Yes	No	Totals
User	2	-	2
Carer	4	3	7
Voluntary	3	1	4
Trust	-	1	1
Governor	-	-	-
Staff	4	1	5
Rep	-	-	-
Other	3	1	4
Totals	**16**	**7**	**23**

Figure 6: Responses to Option 3



It can be seen from Table 7 that, again, the majority of responses were for 'yes' (n=16, 69.5%) rather than 'no' (n= 7, 30.4%) with Users, Carers and Voluntary groups also being in the majority (n= 13, 56.5%).

There were numerous commentary responses to this question and from the questionnaire request 'If yes, please state what you think should be included within a single site to ensure it meets your expectations of a modern mental health service' the following examples are given.

Users –

> ***'I have already submitted a 'shopping list' of user needs (e.g. single sex wards and en-suite bedrooms)'.***
>
> *'Individual en-suite rooms are needed, as are dementia – specific areas so to not disturb or be disturbed by any other users e.g. alcohol and drug services'.*

Carers –

'That there should be a 24 hr service to help with dementia patients if a problem arises for the carer'.

'Provide accessible across the county for staff, patients and their visitors. Move community based services i.e. crisis resolution, made available to over 60s'. 21S,

'This depends very much on where the site is. It needs to be easily accessible to clients and their carers by public transport. Most of our users do not have cars'.

'Separate facilities/accommodation for different types of care e.g. bi-polar, dementia and learning difficulties/autism. To be accommodated with dementia patients can adversely affect sufferers of bi-polar or autism/LD'.

Voluntary –

'Specialist wards for different types of mental health issues e.g. dementia. Better access and information for relatives/carers – where they can get supportive carer links on site'.

'Privacy and dignity, access to internet, provision for smokers'.

'Our shopping list would include practice and facilities based on world class commissioning and reduction in the carbon footprint'.

Staff –

'The fundamental aspect to mental health services as first highlighted through the NSF and the NHS plan should be that care is local to individuals and easy to access. Our NHS Our Future'

Review initiated by Lord Darzi and the touch stones indicated in the consultation support this notion. It is my view that any new build should be sited in between Macclesfield and Crewe to promote a fairer system of access. This will ensure that mental health is not impacted negatively through social isolation and other factors. The location should also reflect modern attitudes to health and social integration providing access to all the services that one would expect if in the community'.

'Access to a coffee bar, exercise facilities, open green space, sufficient care parking for staff & visitors, pharmacy team office. Occupational health office, meeting rooms, interview rooms'.

'Resource centre; activity centre; inpatient unit – older persons functional, older persons organic, adult acute, picu or low stimulus environment, day hospital, crisis beds'.

Other –

'Yes, but people must be able to access the service in person or via technology. There is still stigma that physical illness such as a broken leg is visible but mental health is not visible and still carries a veneer of embarrassment.

'Adequate physical health care facilities. Close to good public transport facilities including bus and rail for visitors and staff. Intensive psychiatric care – not transfer to Chester/Clatterbridge'.

'But with major proviso. Key issues will be the provision of transport services, suitable discussions with council and providers'.

'Self contained unit within the hospital grounds'.

From the questionnaire request ' If no, please say what alternative approach you think the Trust should adopt' the following commentary examples are reported:

Carers –

'Keep Macclesfield's Millbrook Unit – can use facilities of Macclesfield DGH. Build another unit (if Leighton really has to close its unit) further West.

'You must maintain acute facilities in Macclesfield and Crewe. If you can't, acute patients should be admitted to Greater Manchester and the Potteries (respectively). In this event there is no longer a need for CWP (Chester services can be provided by Merseyside) and then there will be no need for CWP central admin and more resources for patient care'.

'Cheshire is too big to expect families and carers to travel unreasonable distances'.

Voluntary –

'As I have previously argued, smaller, local units including local "crash pads" as used to exist in Crewe (if Alternative Futures can provide a single [NHS paid] ward unit in Winsford, CWP can). No assessment of unexpected consequences of a single site unit'.

Trust –

'Every effort should be expended to continue being hosted on a DGH site that will provide access to <u>all</u> medical/clinical services (dual)'.

Staff –

'The proposal for a single modern site sounds attractive and, reading the proposals, it sounds like the decision has already been made. Patients who have been hospitalised out of area do complain about the inaccessibility of units for family and friends, which often adds to the trauma of admission. Patients who are admitted to current specialist services out of area such as mother and baby units find their admission to a unit out of area adds to a sense of fear and isolation about the admission'.

Other –

'Improve efficiencies in terms of management staff rather than patients. Adopt Macc. Premises instead of shelving them. More day placements should be provided for the vulnerable and needy who are abandoned by hospital closures and bed reductions'.

Analysis

Similar to question one the responses to 'yes' were sixteen and the responses to 'no' were 7 in this second question relating to the provision of services on one site. There was some degree of resignation within the commentaries produced from this question in that there was an understanding that fiscal requirements would drive the decision to base services on one site. This is supported in the literature when reorganisation takes place for 'political' reasons and the motivation for change is felt to be change for change's sake (Hunter, 2008). From the commentary in the positive responses ('yes') it was noted that the main concerns of single site services from service users and carers was a matter of improvement of facilities with numerous statements regarding material aspects such as en-suite provision and policy developments that deal with mixing patients with differing conditions together on wards. On the other hand, the staff group were concerned with accessibility and location. The main concerns from the responders' comments within the negative ('no') group were the geographical location of the single site, the ease of access to it and the degree of travel involved for patients, families and friends. If great distances needed to be travelled, they argued, this could lead to family and social support dysfunction leading to further isolation. The main suggestions emanating from this question revolved around building smaller units with more geographical ease of access and the distribution of patients into other geographical areas such as the Potteries and Greater Manchester, which may be politically unacceptable.

Conclusion to Question Two

The main conclusions from this question are:

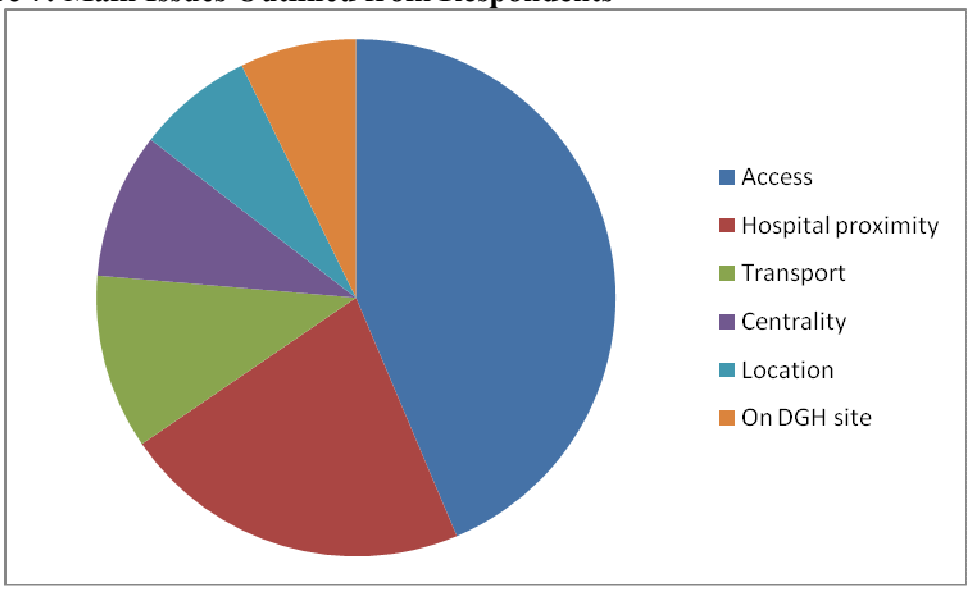
- The responses to 'yes' equalled sixteen (69.5%).
- The main points raised in the commentary were (a) improvement of inpatient services (b) access and (c) long term deterioration of family relationships.
- The responses to 'no' equalled 7 (30.5%).
- The main points raised in the commentary were (a) build smaller units, (b) ease of access and (c) patients who are some distance from a CWP service to cross boundaries and access other Trust facilities.

3.4. Question 3.
What issues matter to you regarding the location of inpatient services? We believe that access is one issue. Is this correct? What other issues matter to you?

Table 8: Main Issues Outlined from Respondents

Issues	Number of times indicated
Access	24
Hospital proximity	12
Transport	6
Centrality	5
Location	4
On DGH site	4
Total	**55**

Figure 7: Main Issues Outlined from Respondents



This thematic analysis emerged from the written commentary in regard to question three and the following examples are reported.

Users –

'Transport availability. Central access. A modern hospital with all relevant care and modern nursing facilities'.

'Access is an issue, as is where funding is going to come from to create a single site service. All parties have to be considered e.g. carers, nurses'.

Carers –

'Definitely the problem of access'. 'Access – especially for family and friends. Links with General Hospital – many patients arrive via A&E. Support facilities are local e.g. GP for follow up, the more distant the inpatient care the greater the opportunity for breakdown in

communications'.
'Access – Access – Access and sufficient inpatient beds to cater for 98% of acute admissions. Close proximity to A&E given the number of referrals. Stop re-organising so that patients have continuity of staff relationships'.

'Safety, local and readily available'.

'Accessibility very important. No age discrimination against elderly dementia patients. 'Ease of access by public transport for patients and visitors. Non-appearance of visitors can impact on patients progress'.

'Increasing provision is required'.

Voluntary –

'Yes access and transport issues are most important. Also minimise *change and disruption to service users'.*

'Divorce from local community – a reminder of asylums – and all that implies. Relative easy access to a DGH – important for older people, liaison psychiatry, better integration of mental and general medicine, better joint training. Access can be improved via community car schemes, local churches, Dial-a-Ride for older relatives, etc. (Ask Crewe and antwich Open Minds for ideas).

'Location of site must be central to C&E Cheshire to ensure access is fair'.

'Location of new unit must be central to East and Central Cheshire to ensure access is fair'.

Trust –

'Access to both patients and public. Avoid isolation from other services. Integrate/host with partners/NHS acute DGH'.

Staff –

'Needs to be accessible to service users, carers, visitors and as importantly to staff – by all forms of transport'. 'I think there are advantages to sharing a site with facilities for physical health in that it helps to reduce stigma, also for some patients, interventions from both facilities are needed'.

'Yes, location is very important. I think access to A&E and general hospital facilities would also be preferable. Physical health issues are often overlooked in psychiatric patients'.

'Access is valuable as it needs to be somewhere which is easily accessed by those on public transport. The relocation of the pharmacy team from existing premises into the new inpatient facility is important so that the team can work with the multidisciplinary team reviewing medicine treatments and service users have sufficient access to members of the pharmacy team'.

Other –

'It should be located on a general hospital site to allow access to cardiac arrest team, ease of input from medical/surgical specialities and investigations e.g. x-ray. Our patients have increased physical morbidity and mortality'.

'Access for families and carers. Patients can be disconnected in day/care if they are a long way from home. Distance from home makes rehabilitation visits very time consuming and demanding on resources and liaison with family is more difficult if patients are a long way from home'.

'That access is geared to individual needs. I wanted help from a highly trained professional which I achieved but I know less educated people who need help geared to them. Not a 'one-fit all remedy'.

'Access – good parking'.

'Transport for patients and visitors. Quality. Usefulness of inpatient treatment regimes'.

Analysis

It would appear that the vast majority of the responders agreed with the questionnaire in relation to the main issue being 'access' with twenty four references to this noted in the comments. This issue appeared to dominate the responses and is the major concern. Access is a complicated area in the responses and included the patients', families' and friends' accessibility to services but also included the mental health services accessibility of General Medical services. This was noted in the twelve comments regarding the location of a single site mental health service needing to be in the locale of a District General Hospital for referral to specialist services there. This was the second major issue. Some responders appeared to appreciate that any single site provision would, by necessity, be located away from other areas due to the large geographical land mass the CWP encompasses, which raised the issue of transport facilities being provided. If the single site is not easily accessible by public transport then there were some suggestions that CWP should provide the facilities or work with local organisations to put a transport facility system in place.

Conclusion to Question Three

In conclusion to question three the following can be stated:

- Access is the major concern.
- On-site District General Hospital or in close proximity to a DGH was the second major concern.
- Transport facilities to and from the single site mental health service was the third main concern.

3.5. Question 4.
Do you have any other suggestions about how we can further improve our mental health services?

Suggestions	Notes
Management Issues	This referred to the management of staff as well as the management of services.
Better Education	This referred to the education of the public in relation to mental health issues.
Communication	The respondents felt that communication was important in service delivery in relation to facts and figures published on website as well as discussions relating to future plans.
Training	There was some element of disquiet regarding the diverse range of skills in clinical staff with some positive and some negative.
Service Review	This referred to the need for service delivery to be reviewed and discussed with service users.

Table 9: Main Suggestions Regarding Service Improvement

The major themes emerged from the commentary relating to question four and examples of this are now offered:

Users –

'Consider demographics – such as the estimated increase in dementia sufferers – how is this going to affect the mental health service and has it being took into consideration?'

Carers –

'That there should be an adequate affordable day care service'.

'Keep change to a minimum so your key staff and consultants don't move elsewhere as happened a few years ago. There needs to be stability of provision'.

'You need to review how you manage your staff'.

'Achieving' 6% sickness absence implies low morale. You don't publish your staff turnover. It's probably equally concerning'.

'Research, care and training'.

'Involve carers when drawing up care and recovery plans. These people are the primary source of contact and information when service user suffers a crisis. Their knowledge and capabilities should be taken into account'.

'Better training at GP level is requested to allow an effective interface with MHS at hospital level. Current situation is unacceptable!!'

'More care in the community. Dignity and safety issues to be addressed, also privacy'.

Voluntary –

'Institute what CWP significantly fails to do (1) choice, as in general medicine (2) talk to critical friends like us honestly – stop the hype and manipulation (3) perfect one improvement – like acute care model – before you move on to the next and (4) stop ignoring voluntary sector in preference to your reliance on LINK'.

'To ensure that people with enduring problems have adequate access to supported work and social activities'.

'(1) Provision of new build. Adequate community care provision. (2) Sufficient manpower and skill mix to respond to need. (3) Practical activities for all patients'. 'Better communication with carers'.

Trust –

'Stop wasting funds on none service provision'.

Staff –

'Involve staff at a grass roots level more before decisions are made. Plus, the case presented for a single site mental health facility is well put but does not present both sides of the argument clearly. People who were unaware of other factors, which are not presented in the document, could easily be swayed to agree with the proposal'.

'A local perinatal psychiatry service so mothers who need admitting don't need to go miles away'.

'More awareness. Better education re: mental health issues'.

'Single sex accommodation. Gym and exercise equipment during inpatient stay. Nurses who have more time to talk to patients rather than paper work. Better morale throughout all staff'.

'Making more information available on services, be it voluntary or NHS via the internet & information points in waiting areas/reception areas in the facilities provided by CWP'.

Other –

'Yes without appearing to (illegible) an attitude of people very in need – they do. I have had CBT from 2 people, one who was on my wave length and one who spoke to me as an idiot who I could have run rings round. I would like to be on a working party'.

'Listen constructively to local patients/carers and families.
Take less notice of those who regard targets, guidelines etc.
as more important than people'.

Analysis
There were many issues in the responses obtained, with some being dispassionately listed and others appearing more passionate in their prose, as can be seen in the above raw data examples. However, for the purposes of this exercise we can categorise the issues under the broader headings in Table 9. The first theme involves a collection of management issues and these include management of staff as well as the services. There was concern regarding the management of facts and figures relating to mental health service provision, the management of change and the management of personnel. The second category was the education of the public in relation to mental health problems to assist in the reduction of stigma, prejudice and discrimination. Whilst it was noted that some work had gone on in this area it was felt that there was still some way to go. The third category relates to communication and there were many comments referring to the production of facts and figures which they claimed were not easily accessed via the websites and there was strong representation that this source of information should be made available. Communication also involved service developments, future plans and the soliciting of ideas from external groups, for example, service user and carer forums. Training was the fourth category and involved increasing the parity of clinical skills delivery as it was felt that some clinicians were better than others in certain areas. Suggestions were made for an increase in training across a number of health care professions. The final category to emerge was a service review. There were a number of statements regarding the need for a review of services and these referred to the future planned provision and the current service structure.

Conclusion to Question Four
We can conclude that the issues raised in question four can be categorised under the five categories as seen in Table 9. However, it should be noted that there are areas of overlap between them. The main categories identified are:

- Management
- Education
- Communication
- Training
- Service review

4. Correspondence.
There was some minor criticism relating to the construction of the questionnaire from a Service User group in a letter of correspondence (see appendix one) to the author of this report and some disapproval of the language used in the documentation. This group felt that there should have been more information provided and that the questions were leading. However, the group offered their views, bypassing the questionnaire, through their letter of correspondence.

5. Overall Conclusion

Whilst the overall number of questionnaires returned was small there was rich data in relation to the written comments from the responders. The main responders were from service users, carers and voluntary groups and individuals and the overall conclusion was of support but with qualifications. Many accepted the position of CWP in terms of the necessity to redesign mental health services and understood the position regarding fiscal restraints. However, there was some disquiet in terms of the location of a single site service and ease of access to it. The major concerns were that the community services would be overloaded and that ultimately users and carers would be worse off, particularly in relation to sufferers of dementia. There was a strong call for a further review of service delivery and an investment of smaller purpose built units which are geographically and strategically located.

6. References

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Appendix 1.
Further Correspondence

1. **A service user group letter.**

'The (name of group) are a mental health service users group who have taken an interest in the consultation you are undertaking in light of the need to vacate the mental health unit at Leighton Hospital. We have read all of the published literature and attended various meetings to discuss the documents but when it came to answering the associated questions we were stumped – to us they weren't designed to draw out opinion they were designed to lead responders to your preferred option hence we have decided to respond to the consultation bypassing the given questions.

The language used in the consultation is very (overly) positive and yet gives little actual information necessary for answering the questions; for instance there is no projection of bed requirements.

A key concern has involved identifying a suitable location for the new unit – a not inconsiderable task – what locations are being considered, will it be central and easily accessible to patients and visitors across the patch? How do you propose to eliminate the NIMBY arguments bearing in mind the aim to reduce stigma and discrimination?

Clearly there is a compelling case for change however time is marching on with little evidence that progress is being made or monies being available. We have had three options outlined with the warning that "failure to make a decision at the end of the consultation process would make it very unlikely that suitable facilities could be available by 2012". Two of the Options aren't options at all hence Option 3 – your preferred option – is the only option. This smacks of an ultimatum rather than a consultation.

Is the money available to provide a new single site mental health unit or are we to lose Leighton hospital's facilities and then patients in central Cheshire to be shared amongst existing facilities? If this is the case what choices will patients have available to them?

Name supplied

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