A case for change by NHS Cambridgeshire, NHS Peterborough and Cambridgeshire and Peterborough NHS Foundation Trust

Proposed Re-Design of Mental Health Services across Cambridgeshire and Peterborough

Contents

Foreword

NHS Cambridgeshire, NHS Peterborough and the Cambridgeshire and Peterborough NHS Foundation Trust are consulting on a range of proposed changes to how mental health services are provided locally. These are services for people with needs greater than those that can usually be met by their GP during normal surgery appointments.

NHS Cambridgeshire (NHSC) and NHS Peterborough (NHSP) are responsible for commissioning these services for their respective populations and the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) is the main provider of NHS mental health services across the county.

There are three main components to these proposals, and we are proposing these changes for three main reasons:-

- **Improved Access and Responsiveness:** Although the great majority of people using local services express satisfaction with the care that is provided, we do receive feedback from both patients and local GPs that access to services could be made easier. We also believe that by offering patients and GPs quicker access to support, advice and information at an earlier stage in their illness, including making greater use of modern technology, we would often help to prevent deterioration in an individual's mental health at a later stage, thereby avoiding the need for further and lengthier contact with local services.

  We would therefore like to replace the many current ways of accessing local services with a single point of access via a proposed "**Advice and Brief Interventions Centre**". This Centre would also allow easier access for previous service users back into services should their mental health deteriorate.

  The work of this proposed Advice and Brief Interventions Centre would be complemented and supported by a new age-inclusive "**Primary Care Mental Health Service**", aligned with local surgeries, maintaining the current gateway worker function and offering a choice of treatment options in accessible community settings.

- **Modern and Purpose-Built Facilities:** We wish to ensure that all local people who require an in-patient admission are cared for in modern, purpose-built facilities, that meet today's enhanced standards of patient privacy and dignity, and where they could access the full range of available therapeutic interventions.

  We would therefore like to consolidate all our wards onto just two sites in Cambridge (at Fulbourn Hospital) and Peterborough (at the Cavell Centre).

  We wish to merge the two wards for older people in Cambridge - James Ward at Addenbrookes Hospital and David Clarke House at Fulbourn - into a single refurbished ward for older people with functional mental health problems within the current David Clarke House building.

  The Cobwebs adult rehabilitation facility in Cambridge would also close if our proposals are approved, and patients who could not be supported safely to remain in the community would be looked after at the Cedars Rehabilitation Unit at Fulbourn.

The Acer acute adult in-patient ward in Huntingdon would also close and its beds be re-provided at the Cavell Centre in Peterborough.

Overall, the number of adult acute beds locally would remain unchanged but the number of beds for adult rehabilitation and for older people with functional mental health problems beds would be significantly reduced. We know that we have significantly more of these beds than other comparable areas. We have set out to demonstrate in this document how we would deliver modernised services in more appropriate settings so that these beds would no longer be required.

- **More Efficient Services:** In common with the rest of the NHS, all three organisations leading this consultation face significant challenges to deliver cash-releasing efficiency savings during the next three years. It is anticipated that - as a minimum requirement - all NHS providers will need to deliver savings of 4 per cent annually for each of the next three years, and for a range of reasons, the actual level of efficiency saving required will be greater than this.

  These proposals would deliver those savings. Our ideas to achieve this include greater use of modern technology to deliver appropriate care, greater use of self-help materials, prompter signposting to other community resources, new ways of working to promote "recovery" in the community rather than on a hospital ward, a different skill mix in our services, and supporting people with more serious mental health problems who have been stable for a long period to be looked after in primary care with guidance from specialist mental health services

  We also believe that our focus on earlier intervention and increased primary care support available for patients with less complex needs will reduce demand upon secondary care and in turn improve throughput and efficiency throughout local services.

This combination of the improvements that we wish to make, together with the scale of the efficiency challenges we face over the next three years, has lead us to develop these proposals for a radical re-design of local care pathways.

It is important to note that, subject to the outcome of the this public consultation, we propose to consolidate all local in-patient wards into modern facilities within three months of a decision by the PCT Boards to support these proposals. This will enable us to release staff to provide service in the community. The proposals for the Advice and Brief Interventions Centre and the Primary Care Mental Health Service will be designed and implemented over a longer period of time. We anticipate it will take at least twelve months to design and fully implement the proposed Advice and Brief Interventions Centre, and Primary Care Mental Health Services.

We recognise that - to achieve the improvements in access and responsiveness and ultimately patient experience that we seek - we need to work closely with local service users, carers, voluntary organisations and the local social care and children's authorities (Cambridgeshire County Council and Peterborough City Council) as well as local GPs during the next few months to design the details of how these innovations would best work for local service users. This will take time, and we would like to "pilot" new ways of working in individual localities to identify potential problems, before we fully implement this model across Cambridgeshire and Peterborough.

Local GPs and senior clinicians from CPFT have worked in partnership to develop these proposals. Their priorities throughout have been to:-

- ensure that there is a patient focused approach with strong partnerships links to the local authority and other community and third sector organisations;
- ensure mental health services meet the needs of both patients and primary and secondary care professionals;
- ensuring mental health services commissioned are evidence need based and value for money;
- seek ways to provide “more for less” whilst maintaining the quality of care provided;

We do believe that if these proposals are adopted then local mental health services will be improved, and more people will receive the care that they need promptly and in the most appropriate setting.

The National Clinical Advisory Team have recently visited local services and strongly endorsed our proposals as reflecting the latest best practice and ensuring that services remain clinically safe in the future.

In this consultation document, we have set out in turn:-

1. **Why We Have Developed These Proposals**, including the national policy background, the local background and circumstances of the mental health services that we currently provide, the access and responsiveness issues fed back locally that we wish to address, and the scale of the efficiency savings that we are required to make during the next three years.

2. **How We Have Prepared These Proposals**, identifying the principles and priorities we have established to help guide us to develop these proposals, and describing in particular the extensive partnership working there has been between local GPs and senior clinicians working in local mental health services to plan the proposed new service models.

3. **What The Proposals Consist Of**, including the future service model or “vision” that we have developed, the most significant changes to local services that we propose to make, and the timescales for implementing these changes during the next three years.

4. **What The Impact Would Be** upon patient pathways and the care received by people with mental health problems throughout Cambridgeshire and Peterborough, if our proposals were to be implemented after this public consultation. We have included in this section a series of individual patient “vignettes” comparing the current experience of a range of “typical” service users with what would be the case if these proposals were implemented.

5. At the end of the document there are two **Appendices** setting out current local care pathways for mental health services and the timetable for implementing these proposed changes should that be the outcome of this public consultation.

We have also prepared separately a more detailed “**Frequently Asked Questions”** leaflet seeking to answer the questions that have already been raised with us during the pre-consultation period whilst we were developing these proposals.

We have also produced a shorter version of this document to support the public consultation process. This seeks to help those members of the public with less knowledge or personal experience of this area to understand more clearly the most important features of the changes that we are proposing.

We would also be pleased to provide a translation of this document into another language on request.

The purpose of this consultation is to seek your views about:-

- the vision for local mental health services that we are describing;
- your ideas on how the proposed new “Advice and Brief Interventions Centre” and Primary Care Mental Health Service” could best be designed to enhance access and user experience
- our proposals to consolidate in-patient facilities on two sites in Cambridge and Peterborough including, if these proposals were to be implemented, how we might best mitigate the possible impact upon access for people living in other parts of Cambridgeshire;
- any other ideas as to how the service model that we are proposing can be further enhanced to provide the prompt and responsive services that local people experiencing mental health problems rightfully expect;

We encourage anyone with an interest to take the time to read either or both of these documents and to contribute to the consultation by either:-

- completing the questionnaire at the end of each document; or
- contacting us to arrange a meeting at which we would be happy to discuss any aspect of the proposals in more detail and answer specific questions that people may have;

Sushil Jathanna, Chief Executive, NHS Cambridgeshire and NHS Peterborough

Jenny Raine, Chief Executive, Cambridgeshire and Peterborough NHS Foundation Trust

Dr Simon Hambling, Chair of NHS Cambridgeshire Senate and GP Cluster Lead for Mental Health, Borderline Commissioning Group

Dr. Caroline Lea-Cox, NHS Cambridgeshire Senate Lead GP for Mental Health and mental health lead for the local commissioning group Cambridge Association to Commission Health (CATCH)

Dr Mike Caskey, Chair of NHS Peterborough GP Board Sub-Committee

Dr. Sohrab Panday, NHS Peterborough GP Board Sub-Committee Mental Health Lead GP

Dr David Irwin, GP mental health lead for the local commissioning group, Hunts Care Partners

Dr Dee McCormack, GP mental health lead for the local commissioning group, Isle of Ely

Dr John Richmond, GP mental health lead for the local commissioning group, Hunts Health

Dr Emma Tiffin, GP mental health lead for Older People’s Mental Health, NHS Cambridgeshire

Dr Ray Webb, GP mental health lead for the local commissioning group, Wisbech

1. Why We Have Developed These Proposals

National Policy Background and Context

Improving mental health services for adults has been a priority of successive recent governments. The National Service Framework (NSF) in 1999 set out a ten-year programme to deliver more services in the community rather than in-patient settings, and introduced a number of specialist community-based services such as assertive outreach (for people disengaged from services), crisis resolution / home treatment (for people at risk of an imminent hospital admission) and early intervention (for young adults experiencing a first episode of psychosis).

The NSF also established new roles for the delivery of services within primary care for people with mild to moderate mental health problems such as anxiety and depression. Traditionally, the only referral option available to GPs for such patients had been either counselling or a range of services offered by local voluntary organisations.

In 2008, the "Improving Access to Psychological Therapies (IAPT)" programme - for which Cambridgeshire was a first-wave pilot site - further expanded the range of services available within primary care for adults with common mental health problems. The IAPT programme itself focussed in particular upon specific types of psychological therapy and employment support. There will be more focus in the future to also offer IAPT-style primary care services to people with long term conditions such as diabetes and asthma.

In the past few years, local mental health services have increasingly adopted as a core value the concept of "**recovery**". Recovery is about a person's right to build a meaningful life for themselves, whether they have mental health symptoms or not. Recovery does not mean a cure (clinical recovery). Recovery is about life beyond illness (social recovery) and is about a person's own personal experience of living with mental health problems. So it is possible to 'recover' life without necessarily 'recovering from' illness.

In July 2010, the Government announced a number of reforms to the NHS in its White Paper, "Equity and Excellence: Liberating the NHS". This set out plans for local GPs to take control of the commissioning of health care for their patients. The commissioning of health services will transfer between now and April 2013 to newly-established "Clinical Commissioning Groups".

These "Clinical Commissioning Groups" will lead the local commissioning of mental health services in future. At present, the local configuration of Clinical Commissioning Groups and their commissioning support arrangements have still to be determined. The emerging Clinical Commissioning Groups across Cambridgeshire and Peterborough have however participated actively in the preparation of these proposals and confirmed their commitment to equity of access to mental health services for service users throughout the county.

Local Clinical Commissioning Groups have also already highlighted the need for greater partnership working locally in order to deliver seamless and integrated services for local patients. Key partnerships in the future will include those between:-

- Clinicians working in primary care (GPs, practice nurses, etc.) and those working in specialist mental health services (consultants, psychologists, psychiatric nurses, etc.)
- Local commissioners of NHS (health) and local authority (social care and housing) services;
- NHS and voluntary sector providers of mental health services;

Local Service Developments

Reflecting the national policy drivers set out above, in recent years community services for people with mental health needs have developed significantly across Cambridgeshire and Peterborough. There is now a far greater range of services available locally for people of all ages than there was in the past.

In addition to the expanded primary care services described above, there are now crisis resolution (for adults) and intermediate care (for older people) teams providing intensive support to people at home rather than in hospital. There are also other more specialist services, such as rehabilitation and recovery teams, eating disorders and personality disorders. The benefit of these developments has been that fewer people require admission to an in-patient ward to receive the care that they need and that very few local people now have to travel outside Cambridgeshire to receive appropriate treatment.

Nowadays, we are able to support many more people in their own homes or in the community generally. This has been a success story, but one consequence is that those people who do require an in-patient admission are likely to be more acutely ill and require greater skilled care from a wider range of clinical practitioners and in a more secure environment than was the case previously.

In 2007 a major and innovative programme - known locally as “Transformation” - modernised local mental health services into a suite of care pathways. Individual patients are assessed and assigned to the most appropriate pathway which will meet their needs. Within each pathway there are a range of treatments available, and there are time periods that patients would typically remain within that pathway. The current local pathways are set out at the end of this document.

Local Investment in Mental Health Services

The resources currently invested in local mental health services are relatively low in Cambridgeshire compared to other similar counties. The data and methodology used in benchmarking exercises is variable, but the most recent data from the Office of National Statistics (ONS), relating to the 2009/10 financial year, shows that the expenditure by NHS Cambridgeshire on mental health services is approx 5 per cent lower than in comparable counties across southern England.

This gap has been narrowing in recent years. This is mainly due we believe to other counties now implementing modernisation programmes for mental health services similar to those that we have been doing locally since 2007. The amount spent by NHS Cambridgeshire on out-of-area placements is also now very much lower than other counties because we have developed local services to enable more people with complex specialist needs to receive treatment locally.

The benchmarking data for NHS Peterborough compares its investment levels with other “new towns” and does not indicate significant over- or under-investment by that PCT. However, the data is less reliable as a comparison, because other “new towns” do not

have the same demography as Peterborough, in particular the comparisons may not fully reflect the relatively high forensic morbidity and large ethnic minority populations in Peterborough.

Resource Outlook and Efficiency Savings Requirements

It is also clear that the resource environment will inevitably be very challenging for the NHS during the next three years. The NHS has an efficiency savings target of £20 Billion during the four years 2011/12 to 2014/15 and local mental health services have - like the rest of the NHS - to seek to identify ways in which care pathways can be improved whilst also demonstrating that they are as efficient as possible and provide excellent value-for-money.

The NHS National Operating Framework for the 2011/12 financial year required all service providers to deliver a 4 per cent annual efficiency saving as a minimum requirement. We anticipate that this scale of efficiency saving will again be required in each of the next two financial years. In practice, and for a number of reasons including the current relatively high level of inflation and demographic pressures (i.e. an ageing population) throughout the NHS, the level of efficiency saving required from current services in the current financial year is even greater than this.

Almost all local NHS mental health services in Cambridgeshire and Peterborough are provided by the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). The table below sets out the implications of the efficiency requirements summarised above for the local mental health services currently delivered by the Trust and how we plan to achieve them.

	11/12	12/13	13/14	Total
CPFT Income from NHS Commissioners	£97.153m	£97.403m	£98.310m	
Annual Required Efficiency Saving - %	6.3%	4.3%	4%	14.6%
Annual Required Efficiency Saving - £	£6.100m	£4.153m	£3.929m	£14.182m
To be achieved by:-				
- re-design of primary care and community teams	£3.234m	£1.320m	£2.132m	£6.686m
- consolidation of in-patient wards	£1.587m	£2.291m	-	£3.878m
- corporate and support services savings	£0.541m	£0.221m	£0.209m	£0.971m
- other savings	-	-	£0.300m	-
Total Efficiency Savings	**£5.362m**	**£3.832m**	**£2.641m**	**£11.835m**
Business Developments and Income Growth	£0.738m	£0.321m	£1.288m	£2.347m
Total Savings/Income Plan	**£6.100**	**£4.153**	**£3.929**	**£14.182**

All NHS providers are required by the National Operating Framework to make efficiency savings as set out in the table above. However, in recognition of the relatively low local investment in mental health services, both NHS Cambridgeshire and NHS Peterborough have not sought to make any additional reduction in our investment in mental health services during 2011/12. All other major local NHS service providers are being asked to deliver significant additional efficiency savings this year in excess of the NHS Operating Framework requirement.

2. How We Have Prepared These Proposals

Local Clinical Commissioning Groups and these Re-Design Proposals

As part of the current NHS changes, new "Clinical Commissioning Groups" are increasingly leading the local commissioning of mental health and other NHS services. Local GPs have been grouping into smaller local "clusters" of practices that will combine t9o form larger "Clinical Commissioning Groups". A local network of eight GP mental health leads with a representative from each local cluster has been given the mandate to commission mental health services across Cambridgeshire and Peterborough in future.

The proposals for service re-design in this document have been developed over several months by these GP mental health leads in partnership with senior clinicians from the Cambridgeshire and Peterborough Foundation Trust. They have sought to incorporate in these proposals the regular feedback they receive from patients about service access and responsiveness, the choice of treatments they are offered, and the settings in which they have received treatment. There is also a clear commitment to continue and strengthen the integrated commissioning of health and social care services with local authority partners.

In this document, we have not proposed a series of alternative options for consultation. This is because we have examined alternative ways to meet the challenges that we face, but have concluded that they would either be clinically unsafe, and/or result in unacceptable reductions in service provision for some groups of people, especially those receiving treatment in primary care or the community.

It is the consensus of local GPs and CPFT clinicians that the model proposed is the best option to enable us to maintain our progress during the past ten years in treating greater numbers of people in primary care and the community, and at an earlier stage of their illness.

The Process for Developing These Proposals

There has been much work done locally, over a period of almost a year, to develop these proposed service changes. Throughout this time we have been anxious to ensure that there is a patient focussed approach to our planning and we have continued to strengthen our already strong partnerships links with local authorities, local voluntary sector providers of mental health services and other community organisations.

We have also continued to develop our Service User Network (SUN) so that we are able to receive feedback from a representative group of service users across the county.

In order to develop new service models, a number of workshops and other events have been held with key local stakeholders since July 2010. These have included 'listening events' which were held during February and March 2011 across Cambridgeshire and Peterborough and which over 200 people attended including local GPs, service users, carers, representatives of local authorities, patients, carers, commissioners of local services, local voluntary organisations, and many staff who actually work to deliver local mental health services.

Joint Working Between Local GPs and Specialist Clinicians

Since January 2011, there have been a series of workshop-style meetings between representatives of the local GP mental health leads network, the local PCT mental health commissioning team which now supports both NHS Cambridgeshire and NHS Peterborough, and senior executives of the Cambridgeshire and Peterborough NHS Foundation Trust, including the five Clinical Directors of each of its operating divisions which provide local services for adults, older people, children and adolescents, primary care and specialist mental health services.

Their strategic objective throughout this work have been:-

- address the issues of responsiveness, prompt access and communications that have been raised in recent surveys
- ensure that people who require an in-patient admission can be accommodated in modern, purpose-built and safe facilities
- deliver the efficiency savings that we will be required to make during the next three years

Whilst also maintaining the long-standing local and national strategic objective of enabling as many people as possible to receive their treatments at home, in primary care, or elsewhere in the community.

Key Principles

A consensus quickly emerged from these meetings concerning the key principles that should underpin future service redesign locally:-

- Service user engagement both in terms of involvement in design and through to implementation of new services and pathways.

- When considering new service models, we must focus on the individual patient's experience and outcomes achieved.

- For patients needing to access specialist help or advice there must be as few steps or stages as possible.

- "Core" services for people with severe and enduring mental illness should be the absolute priority and with no compromise on safety.

- We will continue to rigorously monitor the safety of local services through our existing clinical governance mechanisms.

  There will be a pathway facilitating prompt re-access to services for people experiencing relapse.

- There need to be sufficient acute beds retained so that all local patients requiring an in-patient admission will be cared for locally.

- Greater emphasis throughout services upon prevention, early intervention, support and self management.

- Single point of access for health professionals for advice on management and referral options from a mental health professional who is of the appropriate seniority

- Prompt access for GPs to obtain advice and effective help for patients presenting at surgeries in distress or “crisis”.

- Partnership working across local service providers (including the voluntary sector) in order that patients receive an integrated and seamless service across all interfaces.

- Quality and “value for money” will be integral to all services delivered.

- The “stepped care” model will be embedded throughout the redesign process to ensure that patients can be seen and receive appropriate care and treatment in the least restrictive setting that is appropriate to their needs.

Our Use of Benchmarking Information

In November 2010, the East of England Strategic Health Authority commissioned from the Audit Commission a “benchmarking” exercise, which compared data from all of the NHS providers of mental health services in the East of England. This followed a national study by the Audit Commission, which identified major variations in care pathways, in particular the relative use made of in-patient beds and community-based services between areas. This variation could not be reasonably explained by differences in local population characteristics such as levels of deprivation.

The purpose of the regional exercise was to provide comparative data about the impact of different service models across the region and in turn identify potential areas for improvement.

The work involved an extensive programme of data collection and validation in order that each local area could then be provided with information of sufficient detail to identify allow them to identify specific areas where productivity could be improved without impacting on patient experience or outcomes.

Use of mental health service data has limitations, for example diagnosis is not always useful as an indicator for appropriate treatment setting or resource need.

However, the study did reach some important conclusions about mental health services in Cambridgeshire and Peterborough which we have used to formulate the ideas for change set out in this consultation document:-

- The number of acute bed admissions is relatively high locally, and there are in particular a high number of “short-stay” admissions - that is, patients who remain on the ward for less than three days before being discharged again.

  In response we have developed ideas for new care pathways for these patients, including ways to enable more of this group to be treated in the community and achieve the same outcomes without the need for an admission at all. A joint staff team working in both the wards and the local community will offer rapid support to patients at risk of admission. This would allow us to make more efficient use of the acute beds we have.

- The number of rehabilitation beds locally is more than double the national average. This reflects a number of factors including historic models of service provision for people with mental health problems and local availability of accommodation for longer-stay patients. The occupancy of some of these beds has reduced during

recent years as we have developed community services so that more patients can be rehabilitated in community settings.

In response and in order that we can safely reduce the number of local rehabilitation beds towards regional and national averages, we have developed proposals to change the way that we work with patients requiring rehabilitation. The focus will be much more on a "recovery" model, working with patients to prepare and support them to return to living in the community.

We have visited other areas where lengths-of-stay in rehabilitation wards are much shorter than in Cambridgeshire and Peterborough. We are already making progress on this. During the first five months of 2011/12, the average length of stay on local adult rehabilitation wards was 26 days, compared with 35 days during the same period of 2010/11.

- Overall, lengths of stay are about average although more detailed analysis shows that the high number of short-stay admissions and a relatively small number of long-stay rehabilitation patients distort the interpretation of this average figure.

  As described above, in response we have developed new ways of working to enable patients to safely return sooner to their local community. This is more challenging for the longer-stay patients and we recognise the need for more additional community resources, for example more supported housing in some areas would provide an additional choice for a small number of people unable to return to their own homes.

- The amount spent locally on community-based mental health services as a percentage of our relatively low total investment in mental health services is relatively high. This is a good thing and reflects our efforts over many years to enable as many people as possible to receive treatment in the community. However, the data also indicates that local community services are less productive than in other areas. This may be because of under-recording of activity, but the data does suggest that reviewing and re-designing community services locally could lead to the achievement of significant efficiency savings.

  In response we have developed proposals to make more efficient use of the community-based service capacity that we have locally. These efficiencies would be realised by reviewing the skill mix of local teams, ways of working, using peer support, better use of IT, maximising the use of other community resources, and discharging stable patients back to primary care. We also believe there are opportunities to improve efficiency via closer working with local authority partners to strengthen integration with local social care services.

3. What Our Proposals Consist Of

Summary of Our Proposals

As already described in this document, local Mental Health Lead GPs and senior clinicians from CPFT have worked in partnership during the past nine months to develop and refine these proposals.

The three main components of our proposals are:-

1. Most mental health prevention work, including specialist advice for GPs, self-management, signposting and triage would be provided via an **"Advice and Brief Intervention Centre".**

2. Most treatments currently delivered in primary care or community settings to people with mild to moderate mental health problems would be provided by a community-based **"Primary Care Mental Health Service".**

3. Local in-patient wards would be consolidated onto two sites at **Fulbourn (Cambridge)** and the **Cavell Centre (Peterborough)** where the accommodation meets modern standards and where the full range of therapeutic interventions can be easily accessed by patients.

   Specifically, we are proposing the following ward closures or relocations:-

   The Acer acute adult in-patient ward in Huntingdon would close and its beds be re-provided at the Cavell Centre in Peterborough.

   The Cobwebs adult rehabilitation facility in Cambridge would also close, and patients who could not be supported safely in the community would be looked after at the Cedars Rehabilitation Unit in Fulbourn.

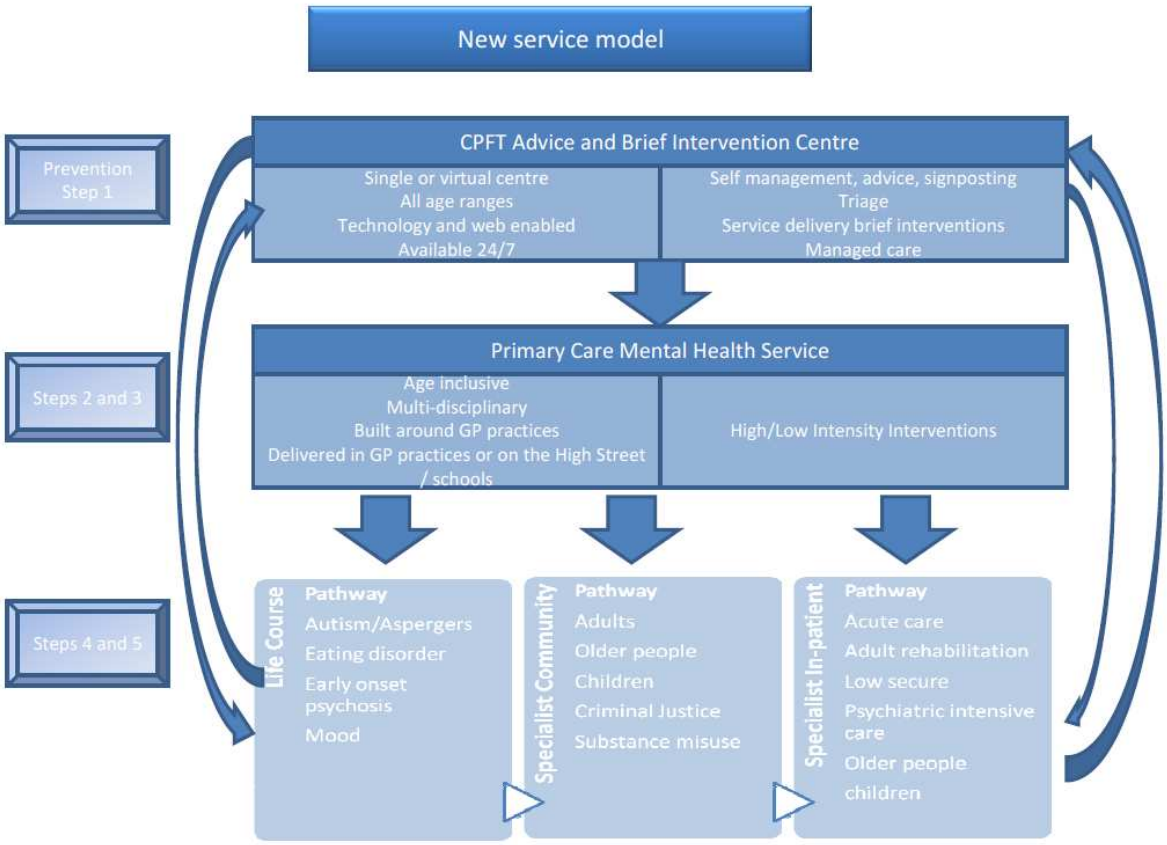
   The two wards for older people in Cambridge - James Ward at Addenbrookes Hospital and David Clarke House at Fulbourn - would be combined into a single newly-refurbished ward for older people within the current David Clarke House building.

It is again important to note that, although we are proposing to consolidate all local in-patient beds into modern facilities within the next few months, we expect to take up to a year to design and longer to fully implement the proposed "Advice and Brief Intervention Centre" and "Primary Care Mental Health Service".

We already have some excellent examples of innovative good practice locally, for example the St Ives Older People's Primary Care Mental Health Service pilot which is now being rolled out across Cambridgeshire. This has been warmly received by local GPs and service users. We will ensure that the new service models incorporate these examples of good practice.

During the next few years, we also have to implement a number of major nationally-developed service improvements - for example the National Dementia Strategy. Again, the proposed new service models must not jeopardise local delivery of these national priorities.

The diagram illustrates how all three major components of the proposed new service model would link together.



The following pages describe each of our three main proposals in more detail.

Our plans envisage that this new service model would be designed, piloted and implemented initially for **adult** mental health services. We have described our emerging ideas for community-based older peoples and child and adolescent mental health services later in this section.

1. Proposed Advice and Brief Intervention Centre

This Centre would be an entirely new concept designed primarily to streamline access to local mental health services for all age groups whilst also seeking to give GPs, other local practitioners, patients and carers better support, advice and information as promptly and as early in the development of their illness as possible.

There is evidence from elsewhere that a Centre of this nature has the potential to improve both patient and referrer experience of local mental health services. There are currently 34 different points of access to local NHS mental health services, and a significant amount of clinical time is occupied by referral management issues. The arrangements can also be confusing for local GPs, other referrers, patients and their carers.

The Centre would:-

- Be staffed 24 hours a day, 365 days a year by a range of specialist clinicians with the specialist skills needed to give prompt advice to GPs and other practitioners locally involved in providing care for people with mental health problems;
- "Sign post" or direct people to the most effective intervention to meet their needs, or provide advice, information and guidance to referrers to enable increased self management by the patient of common mental health conditions;
- Manage and triage all referrals to local NHS mental health services;
- Deliver "low-intensity" psychological interventions such as telephone support;
- Offer 'fast track' access back into services for patients with more serious mental illness who have been previously 'stepped down' from local mental health services.

There would be a dedicated helpline for current service users and their carers to access promptly specialist advice whenever needed.

This Centre would initially provide this service for adults but we plan to progressively expand its work to cover all age groups. It would incorporate a number of initiatives to improve responsiveness, increase productivity and make greater use of other community resources so that more people will be able to receive help.

This proposed Advice and Brief Intervention Centre is innovative and we would wish to finalise the details of how it would work in partnership with service users, carers, local voluntary and independent sector organisations, and local authorities. For example, we do not yet have a proposed location or locations for it. We acknowledge the importance of retaining local knowledge and sensitivity alongside easy access for service users and referring GPs. The use of the most up to date information technology will also be critical to its success.

2. Proposed Primary Care Mental Health Service

This Service would include a range of age-inclusive teams offering access - based on an individual patient's particular needs - to specialist advice and treatment both to people with moderate to more complex common mental health needs and also people with more severe and enduring illness but who do not require continuing access to more specialist mental health services.

This Service would also initially provide services for adults but over time would be expanded to serve all age groups

The teams would be aligned with local groups of surgeries in order to develop stronger relationships with local GPs and others involved in providing care for people with mental health problems.

Our initial ideas, based on feedback received during the preparation of these proposals, are that the Primary Care Mental Health Service would:-

- include named senior clinicians able to provide local advice to GPs and other referrers;
- deliver "high-intensity" evidence-based psychological interventions for people typically requiring help over a period of several months;
- work in partnership with other local service providers such as employment support to deliver a seamless service for patients;
- retain within the overall service individual teams such as the older peoples primary care service that have been introduced in recent years and has been well-received by local GPs, service users and carers;

- deliver, a range of psychiatric and psychological interventions such as mental health/carers assessments, neuropsychological assessment, and medication management, which are currently provided by the Intake and Treatment Pathway for people typically engaged with mental health services for up to three years;

As with the proposed Advice and Brief Intervention Centre, we would wish to finalise the details of how the local Primary Care Mental Health Service would work in discussion with local GPs, service users, voluntary and independent sector providers, and local authorities. We especially recognise the importance of these teams retaining locality expertise and being able to offer continuity of care and advice to local patients, carers and their GPs.

3. Proposed Consolidation of In-Patient Wards

In preparation for this consultation, we have conducted a detailed review of our local acute and rehabilitation bed capacity. Both local GP commissioners and senior CPFT clinicians agree that it is essential that there are sufficient beds available locally to accommodate anybody who requires an admission to an inpatient ward.

We have "benchmarked" local services against those provided in similar areas to provide an indication of how many beds we have locally compared to other areas. This work identified that we have significantly more rehabilitation beds locally than other areas. Further, modern best practice in mental health services and especially the "recovery" model of service delivery requires increasingly that people should be supported to rehabilitate in the community, rather than on a ward. We also know that there are a small number of local people who have been in rehabilitation beds for several years, but would be more appropriately placed (provided appropriate support is in place) in supported housing or other accommodation options within the local community.

In addition, nowadays, inpatient mental health wards must also rightly meet much higher standards of privacy and dignity, be fit for purpose and meet stringent infection control, health and safety standards. If these proposals were adopted, we would be able to ensure that all local people who required an inpatient admission would be cared for in a modern purpose built ward.

Adult Wards:-

We propose to consolidate the local in-patient acute and rehab bed capacity for **adults** of working age from eight to six sites as set out in the table below:-

Ward	Location	Function	Current Beds	Proposed Beds
Acute Beds:-				
Oak 1 Ward	Peterborough	Female Acute Admission	22	22
Oak 2 Ward	Peterborough	Male Acute Admission	22	22
Acer Ward	Huntingdon	Acute Admission	16	0
Lucille van Geest Centre	Peterborough	Acute Admission	0	16
Friends Ward	Cambridge	Acute Admission	24	24
Adrian Ward	Cambridge	Acute Admission	24	24
Total Acute Beds			**108**	**108**
Total Sub Acute Beds				
Springbank Ward	Cambridge	Sub-Acute	0	8
Total Sub Acute Beds			**0**	**8**
Rehab Beds:-				
Cobwebs	Cambridge	Rehabilitation	12	0

Cedars Recovery Unit	Cambridge	Rehabilitation	16	16
Lucille van Geest Centre	Peterborough	Rehabilitation	16	0
Total Rehab Beds			**44**	**16**

Acute Beds

Oak 1 and 2 Wards comprise a 44 bedded modern purpose built unit situated at The Edith Cavell campus in Peterborough. The unit currently accommodates patients primarily from the Peterborough and Fenland localities. The wards are single sex and provide 24 hour acute inpatient care, including a wide range of treatment interventions such as medicines management, occupational therapy, psychological support, physical exercise programmes, and other brief interventions as appropriate to individual needs to support recovery.

The beds in these two wards, together with those in the Lucille van Geest Ccentre described below, would in future if these proposals were adopted provide the inpatient bed facilities for patients requiring acute admission from the Peterborough, Fenland and Huntingdonshire localities.

The beds in these two wards, together with those in the Lucille van Geest Centre described below, would in future if these proposals were adopted provide the acute bed facilities for patients requiring acute admission from the Peterborough, Fenland and Huntingdonshire localities.

Acer Ward is a 16 bedded ward situated on the Hinchingbrooke hospital site in Huntingdon. Built originally in 1994, and upgraded since then, the ward no longer meets important accommodation standards, for example it still has “dormitory style” bedrooms. As the only mental health ward on the Hinchingbrooke site Acer is also relatively isolated and unable to offer the full range of support and interventions that are available to patients accommodated in Cambridge or Peterborough acute inpatient wards.

Acer Ward is currently temporarily closed, pending the outcome of this consultation. The National Clinical Advisory Team who visited recently recommended that the ward should be closed, and local community services strengthened, on the grounds of clinical safety.

We are mindful that this proposed change will increase travel times for family, carers and friends of Huntingdonshire residents who require admission to an acute ward. Should the outcome of this consultation be the permanent closure of Acer Ward we will, as was the case last year when the neighbouring Hawthorn Ward closed, work with local authority partners to develop a travel strategy to assist the carers, family and friends of people admitted for whom the increased distance to travel is problematic.

Lucille van Geest Centre (LVG) is currently a rehabilitation and recovery ward with16 beds. It receives patients primarily from the Peterborough and Fenland localities and from a range of local pathways, including the acute wards and patients returning from out-of-area placement for long-term rehabilitative care.

During recent months, as the working practices on the ward have changed in line with the “recovery” model of care, and an increased emphasis placed upon supporting people in their own homes rather than a hospital ward, both the numbers of patients in the ward and lengths-of-stay have reduced significantly. The average length-of-stay on the wards during the five months April to August 2011 was 21 days compared to 40 days during the same period of 2010.

Our proposal is that in future all patients from Cambridgeshire and Peterborough who

require admission to a specialist rehabilitation ward would be accommodated at the Cedars Recovery Unit in Cambridge. This would ensure all local patients had equitable access to the wider range of therapeutic interventions and support that a single dedicated unit of this type would be able to provide.

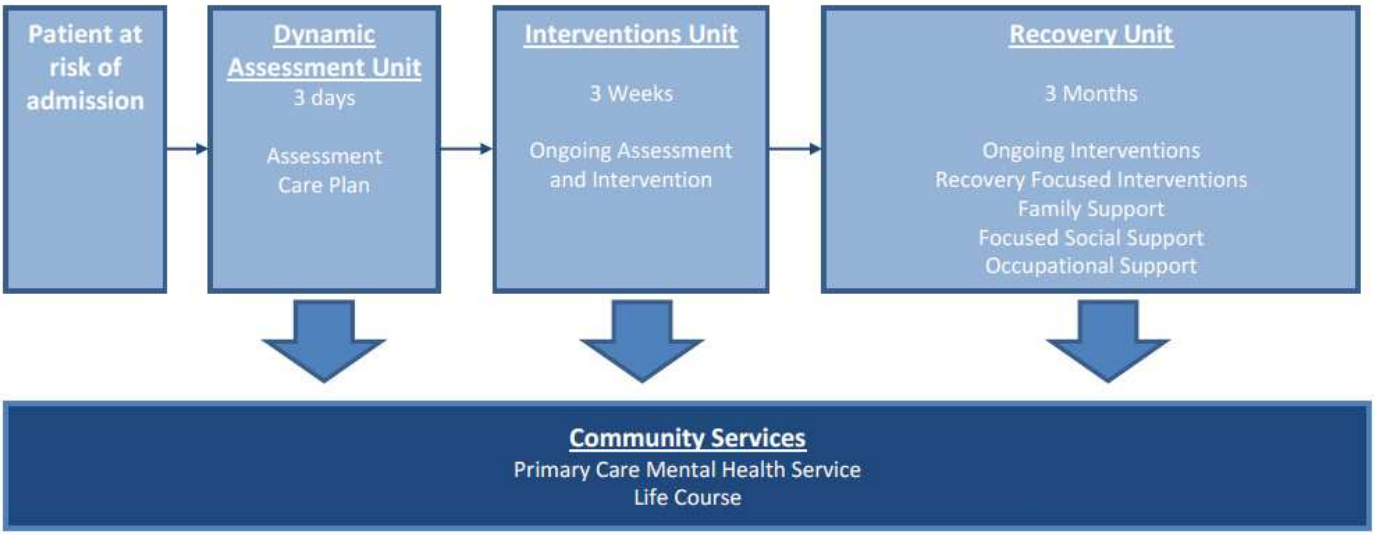
We are also planning new ways of working, based on experience of other areas, within the wards in Peterborough to ensure that we make best use of the available capacity in Peterborough and reduce the number of people who would require access to the specialist rehabilitation facility we are planning at the Cedars Recovery Unit in Cambridge.

Specifically, we propose to divide the available capacity into three components or pathway stages:-

1. A "Dynamic Assessment Unit" with a typical length-of-stay of three days. The focus during a patient's stay in this unit would be that this unit operates and is managed by the community-based crisis resolution team. The aim will be to (a) provide a safe environment, (b) enable a thorough assessment of mental health, risk and treatment needs in a focus and robust way, and (c) ascertain if the patient can safely be discharged back to the care of the community-based crisis team or alternatively requires transfer to the "Interventions Unit" as described below.

2. An "Interventions Unit" with a typical length-of-stay of three weeks. The focus during a patient's stay in this unit will continue to be on-going assessment but also upon treatment, care and recovery and preparing for discharge. We would expect most patients to be safely discharged back into the community from this unit.

3. A "Recovery Unit" for people with more complex needs with a typical length-of-stay of three months. The focus during a patient's stay in this unit would be upon the patient's recovery using a recovery based approach to meet their needs. Based on our success in recent months n reducing lengths-of-stay, we would expect that most local patients in Peterborough will require an in-patient stay of three months or less as part of their "recovery" before they could be safely discharged back to community-based services. Most patients would therefore stay in Peterborough for the duration of their treatment.



Based on the experience of other areas where this new way of working has been adopted, the required number of specialist beds for people with more complex rehabilitation needs likely to require an in-patient stay of more than three months would be insufficient to justify

more than one specialist rehabilitation unit to meet the needs of a population the size of Cambridgeshire and Peterborough combined.

Friends Ward and Adrian House provide 24-hour acute in-patient care on the Fulbourn Hospital site for patients aged 18 to 65, primarily for patients from the Cambridge City, South Cambridgeshire and East Cambridgeshire localities. We are not proposing any changes to these wards as part of this consultation exercise.

Rehabilitation Beds

Cobwebs is a 12-bedroom converted house in Cambridge city centre. It provides 24-hour nursed inpatient rehabilitation care for adults aged 18-65 years, primarily from the Cambridge locality. The unit itself is not fit for purpose and does not meet modern accommodation standards.

The occupancy of Cobwebs has been steadily reducing in recent years as the focus of local rehabilitation services has moved towards community settings. At present there are only a small number of residents. An almost empty unit of this nature is not an appropriate setting in which to provide rehabilitative care. We therefore plan to temporarily close the Cobwebs Unit, pending the outcome of this consultation, at the end of October. All patients from the south of the county requiring admission to a rehabilitation ward will then be accommodated at the Cedars Recovery Unit.

Cedars Recovery Unit (CRU) is an assessment and treatment ward with 16 beds, co-located with other mental health inpatient units at Fulbourn Hospital. It admits clients aged 18-65 years, primarily from the Cambridge City, South Cambridgeshire and East Cambridgeshire localities, from a range of local pathways including the acute wards, and also patients returning from out of area placement for long term rehabilitative care

If our proposals were adopted, the Cedars Recovery Unit would accommodate all patients from Cambridgeshire and Peterborough who required admission to a rehabilitation ward, other than those for whom an admission to nearby Springbank Ward would be appropriate.

Springbank Ward was refurbished early in 2011 and contains eight beds commissioned by NHS Cambridgeshire and NHS Peterborough primarily for people with personality disorders. Some patients currently in local acute and rehabilitation wards either locally or out-of-area would receive specialist care more appropriate to their needs if they were accommodated in this new unit.

The map and patient vignettes contained in the next section of this document provide more details about what the impact of all these proposed changes might be for individual patients.

We are also planning during the next 2-3 years to develop another new facility on the Cavell Centre site in Peterborough. This would enable us to relocate all of the beds currently at the Lucille van Geest Centre to the Cavell Centre, so that all wards serving the north of the county are co-located at a single site.

Older Peoples Wards:-

We propose to consolidate the local in-patient capacity for **older people** from five to four sites as set out in the table below:-

Ward	Location	Function	Current Beds	Proposed Beds
Denbigh Ward	Cambridge	Dementia care	18	18

Maple 1	Peterborough	Dementia care	16	16
Total Dementia Beds			**34**	**34**
James Ward	Cambridge	Acute functional illness**	22	0
Maple 2	Peterborough	Acute functional illness**	26	26
David Clark House	Cambridge	Rehabilitation and recovery	22	0
New Unit (in current David Clarke House building)	Cambridge	Acute functional illness** (acute and recovery)	0	22
Total Functional Beds			**70**	**48**

** - acute functional illnesses are those mental health illnesses other than dementia. These include depression, anxiety, psychosis, bi-polar disorder.

We are not proposing in this consultation any changes to our local wards for people with dementia. There would also be no change to the Maple 2 ward in Peterborough for people with functional illness. We are however proposing to merge James Ward and David Clarke House (DCH) into one refurbished ward that would occupy the current DCH building. Both wards primarily care for patients from the Cambridge City, South Cambridgeshire and East Cambridgeshire localities

James Ward is based on the Addenbrookes Hospital site. It is currently a mixed gender 22 bed ward providing care and treatment to older people with "functional" illnesses such as depression, anxiety, and bi-polar disorder. The environment surrounding James Ward has changed significantly in recent years, as Addenbrookes hospital has developed. It has become completely enclosed by other buildings, and therefore has little natural light or open space for patients to access with any privacy. Internally the ward has become out-dated and no longer meets modern standards of privacy and dignity.

David Clark House (DCH) has 22 beds and is based on the Fulbourn hospital site. It provides rehabilitation and recovery to older people - male and female - with longer term mental health problems.

We are proposing that James Ward and David Clarke House combine into a new refurbished ward for older people, using the current David Clarke House building. This new ward would provide acute care and rehabilitation & recovery for older people with longer term mental health needs. The new ward will have 22 beds and be based on the Fulbourn hospital site. David Clarke House is currently closed for a major refurbishment programme that will bring it up to modern standards of privacy and dignity.

The overall effect of these proposals would be a reduction of 22 beds for older people in Cambridge, so that the numbers of beds serving the north and south of the county would become proportionate to the numbers of older people in the respective localities that they serve.

The introduction in recent years of community based Intermediate Care Teams has steadily reduced our requirement for in patient beds for older people. Other initiatives such as "re-ablement", and the expansion of day therapy services, have also reduced the requirement for specialist mental health beds for older people. There are also many fewer older in-patients who have been cared for in wards for many years. The expanded community services have also enabled us to reduce lengths of stay.

Older Peoples Community-Based Services:-

Older people's community services are currently reviewing how best they are structured and operate to meet the needs of the local population, whilst sustaining a responsive service to patients and local GPs, and also ensuring local implementation of the National Dementia Strategy.

Key components of the re-design emerging from this review are:

- Improved memory services providing a consistent service to people with mild memory problems across Cambridgeshire and Peterborough that meets standards set out by the National Institute for Clinical Excellence (NICE).
- A New Primary Mental Health Care service for older people in Cambridgeshire providing access, support and guidance to people with mild mental health problems. This follows a successful 18-month pilot in St Ives and very positive feedback from local patients, carers and GPs. We envisage in time this service will become an important part of the proposed new age-inclusive Primary Care Mental Health Service.
- Review and improvement of the seven care pathways currently available locally for older people (as set out in Appendix A) with mental health needs to reflect changing best practice.
- Strengthened Intermediate Care Teams providing intensive support to people at home who are in crisis and at risk of admission to hospital.

Child and Adolescent Mental Health Services:-

We are not proposing any changes to local in-patient services for children and adolescents.

For community-based **child and adolescent** mental health services, we have developed a service redesign programme to look at all aspects of the current services - from community-based services through to specialist inpatient and intensive crisis support provision. This redesign work is still at an early stage but all key local stakeholders are engaged in developing the proposals. There are three key work streams:-

- Cambridgeshire Children and Young People's Transformation Project
- CAMHS Specialist and Intensive Support Services Re-design
- Peterborough Integrated Children's Services Project (CPFT also provide children's services alongside CAMH services in Peterborough)

All three work streams share the same key principles as the other proposals for service re-design already set out in this document, aiming to maximise local opportunities to improve the health and well-being of children and young people and providing good support for their families and carers, work in closer partnership with other organisations, and make the best use of the available resources.

Reflecting our future vision for all local mental health services, our early ideas envisage:-

- The merger of a number of current CAMH services into Primary Care Teams that in turn would form part of the age-inclusive Primary Care Mental Health Service described above. These teams will support localities, GPs and schools and child health services in identifying children with mental health problems and delivering IAPT-style interventions to improve their well-being.

- A continued "core" CAMH pathway, providing a broad range of psychological services, including medication where indicated for children with mental health

problems. We have applied to be a pilot site for "young IAPT" services for children which will enhance the range of services we will be able to offer.

- A continued neuro-developmental pathway to ensure that there is appropriate assessment of developmental disorders for children with behavioural problems, and coordinating interventions for those with and without a developmental disorder diagnosis.. The team will also be able to offer specialist groups for children diagnosed with ADHD and Autistic Spectrum Disorders.

As with our services for adults and older people, we will provide regular updates as our ideas for child and adolescent mental health services develop and are finalised with local GPs and other key stakeholders.

"Specialist" Mental Health Services:-

In this context, the term "specialist" means services to which people typically with more severe but relatively uncommon mental health problems are referred by local services to access the specialist care that they need. We are not proposing any changes to local specialist services such as eating disorders, personality disorders as part of this consultation.

We are developing ideas for "life course pathways" for some specialist conditions such as eating disorders, and neuro-developmental disorders such as autism. These would cross and traditional age transition points between services and ensure seamless services for local patients with these conditions throughout their lifetime. .

We also plan during the next two years to:-

- integrate the adolescent and adult services that we currently commission for eating disorders;
- extend the early-onset psychosis service (CAMEO) that we currently commission for adults from 18 years old to treat school age children from aged 14 onwards;

A local "life-course pathway" for neuro-developmental disorders such as autism would meet the requirements of the recent legislation to provide assessment, diagnosis and follow-up for people with autistic spectrum conditions and also address an acknowledged local gap in services for these patients. We are currently working with local Learning Disability Partnerships in both Cambridgeshire and Peterborough to map local services for these groups in order to identify key gaps and develop an appropriate local pathway.

4. What The Impact Would Be

In this section we have set out the main changes that local service users would experience should these proposals be implemented.

We believe that the main benefits for patients if these proposals are implemented will be:-

- patients presenting to their GP with a mental health problem that requires additional care beyond that routinely provided during a GP consultation will be able to access and receive appropriate specialist advice and help more quickly and in the most appropriate setting for their needs
- primary care and community services will become “age-inclusive” - i.e. patients will be signposted to the most appropriate service for their needs irrespective of age and there will be fewer transition points between services
- all patients requiring an inpatient admission will receive treatment in modern purpose built facilities
- there will be equitable access to services and a consistent standard of accommodation throughout Cambridgeshire and Peterborough
- the current community services in Huntingdonshire will be strengthened using some of the resources released by this consolidation

There will however be additional travelling for patients and their carers from some localities who require an inpatient admission and we recognise the need to provide additional support in these circumstances.

We believe the best way to illustrate how local care pathways would change (or not) is by describing a set of individual patient journeys at present and in the future should these proposals be approved.

A - A patient from any locality with mild to moderate needs who is referred to the Advice and Brief Intervention Centre and then either provided with self-help materials, signposted elsewhere maybe local voluntary sector, receive a brief intervention, or if necessary escalated to the Primary Mental Health Service

Current service: patients are referred to mental health services through GP surgeries. Following referral the patient will then be seen by the Intake and Treatment Team for an assessment, where self help materials will be provided to the patient and a plan for their care will be agreed. This can take up to two weeks

Proposed new service:, the referral will be assessed initially at the proposed new Advice and Brief Intervention Centre. Self help materials will be available on the Cambridge and Peterborough NHS Foundation Trust website, and the patient can be directed to the material at their initial referral. After initial assessment, the patient will be referred onto the appropriate voluntary sector organisation or to the proposed new Primary Care Mental Health Service, for further clinical treatment. This will all take up to 48 hours.

B - An adult in Huntingdon needing an in-patient admission and how they would now go to Peterborough or be supported by the enhanced crisis team

Current service: the patient is seen by Crisis Resolution Home Treatment team (CRHT) in the Huntingdon area, where an assessment is carried out and the patient will continue to

remain at home with the support of the CRHT who will see the patient regularly for ongoing assessment and treatment. The patient continues to deteriorate and so requires an admission to Acer Ward at Hinchingbrooke Hospital. When admitted, a further assessment is carried out and the patient is put onto the ward which is dormitory style with other patients. In this scenario, the patient finds the facilities intimidating with other patients in the room and remains unsettled. The patient is seen regularly by the team and after a week of assessment by the team, a clear plan of care is agreed with the patient and their family. The patient remains on the unit for two weeks and is discharged home to be reviewed by the CRHT. The CRHT follow up regularly.

Proposed new service: the patient is assessed in their home by the enhanced CRHT covering Huntingdon and initially is followed up in the home daily by the team. However, the patient continues to deteriorate and is not responding to the additional clinical treatment and medication, and so requires an admission to the new Dynamic Assessment Unit at the Cavell Centre in Peterborough They are taken there by their family where the assessment and treatment that has already started, will be continued within this unit. A thorough assessment is carried out within the safe, modern unit including an assessment of the risk of self harm or harm to others with input from the family. After two days, the patient is transferred to the Interventions Unit at Lucille van Geest where brief psychological interventions, support and advice on medication are provided. After one week this leads to early discharge of the patient back to their home with a specific care plan offering support and advice for the family from the enhanced CRHT Team.

C - A rehab patient in Peterborough and their new pathway including local housing

Current service: A patient is admitted to Lucille van Geest and will be on the unit for nine months, during which time they will receive a number of psychological and social interventions using a very traditional model of rehabilitation care. The patient does not have appropriate accommodation so will need supported accommodation. The ward team at Lucille van Geest will liaise with the appropriate agencies/providers to help organise this. The patient is discharged from Lucille van Geest after five months, however due to challenges in providing supported accommodation and delays in the system, the patient remains at LVG for a further month, whilst accommodation is arranged.

Proposed new service: The patient will be admitted to the Dynamic Assessment Unit at Cavell Centre initially and then be transferred through the system, which will end in a three month recovery unit which will deliver innovative rehabilitation and recovery treatment, thus improving the quality of the patients' treatment. Discharge planning will have started when the patient was first admitted to the Dynamic Assessment Unit, with the appropriate supported accommodation identified early on in order to reduce the length of stay on the Unit.

D - An older person in James or DCH in Cambridge and their new pathway including enhanced community support

Current service: A patient is admitted to Willow Ward (new combined ward at James/David Clarke House ward in Cambridge) after suffering acute depressive illness. The patient was seen by their GP who felt that urgent admission was necessary.
On Willow Ward, the patient responds well to the psychological treatment and support the ward team provide. The patient begins to recover on the ward and after 6-8 weeks is well enough to try living back at home independently. The patient returns home for a weekend, then returns to the ward. The patient then returns home for five days and then returns to the ward. Whilst at home the patient is visited each day by a community mental health nurse (CMHN) who checks that the patient is coping. After 14 weeks on the ward the patient is finally discharged with follow-up support from a CMHN and a psychiatrist.

Proposed new service: the same patient is admitted to Willow Ward. On the ward the patient responds well to the psychological treatment and support the ward team provide. The patient regains their confidence and abilities to self-care and takes more control over their medication. As the patient begins to recover on Willow Ward over the next 2-3 weeks, the older people's mental health Intermediate Care Team (ICT) engage with the patient to plan their discharge with the patient and the ward team. The patient is discharged home after 5 weeks on the ward with the intensive support of the ICT visiting the patient 3 times per day to ensure that the patient feels supported and is able to sustain living well and independently again. Over the next 6 weeks the patient's confidence and well-being continues to improve and as part of regular reviews with the patient of their care plan, the ICT reduces their contact with the patient. The patient attends out-patients clinics where they are reviewed by a psychiatrist and community mental health nurse.

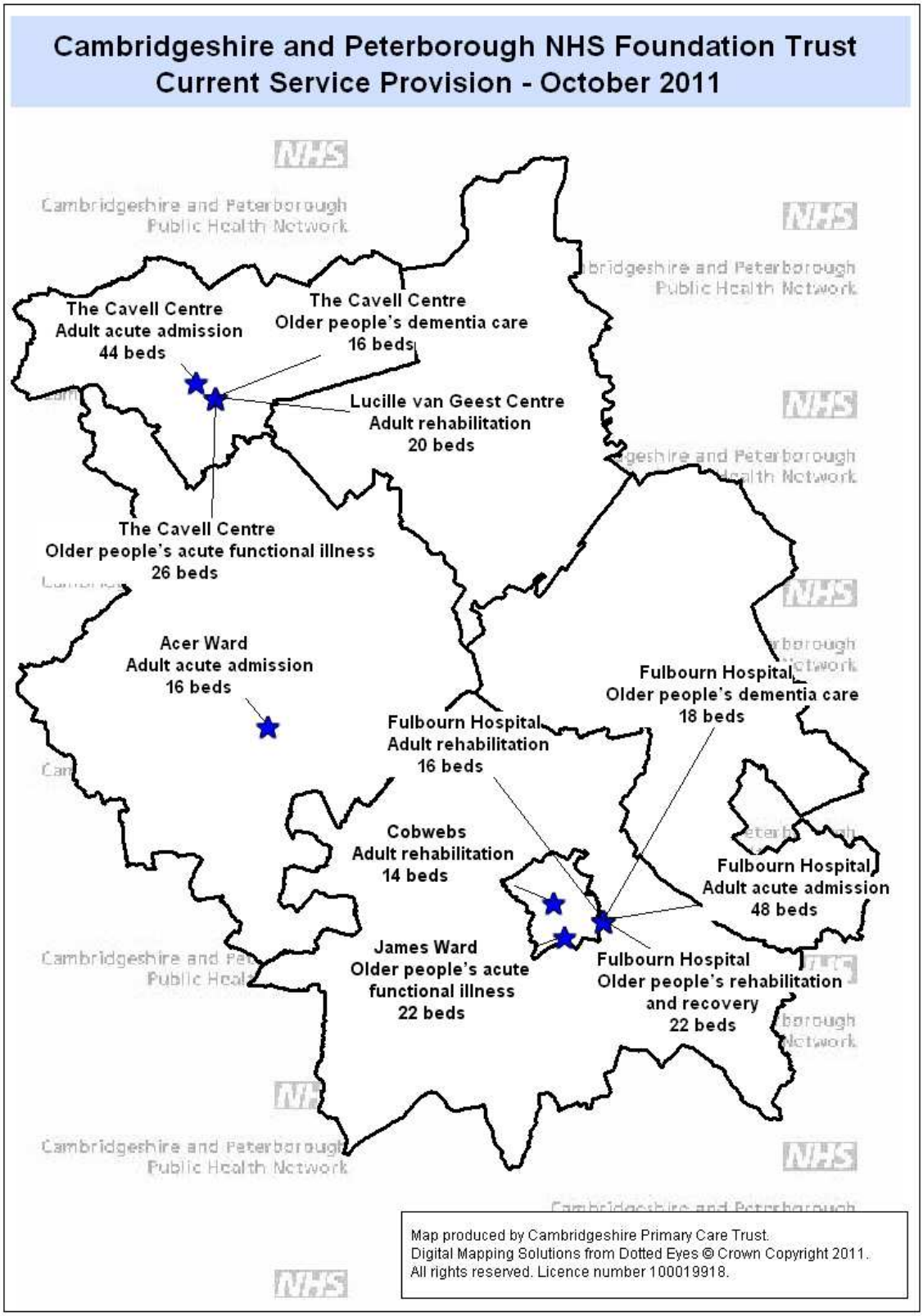
E - Possibly an older person in current community services and how their pathway might change with proposed Advice and Brief Intervention Centre and Primary Care Mental Health Service

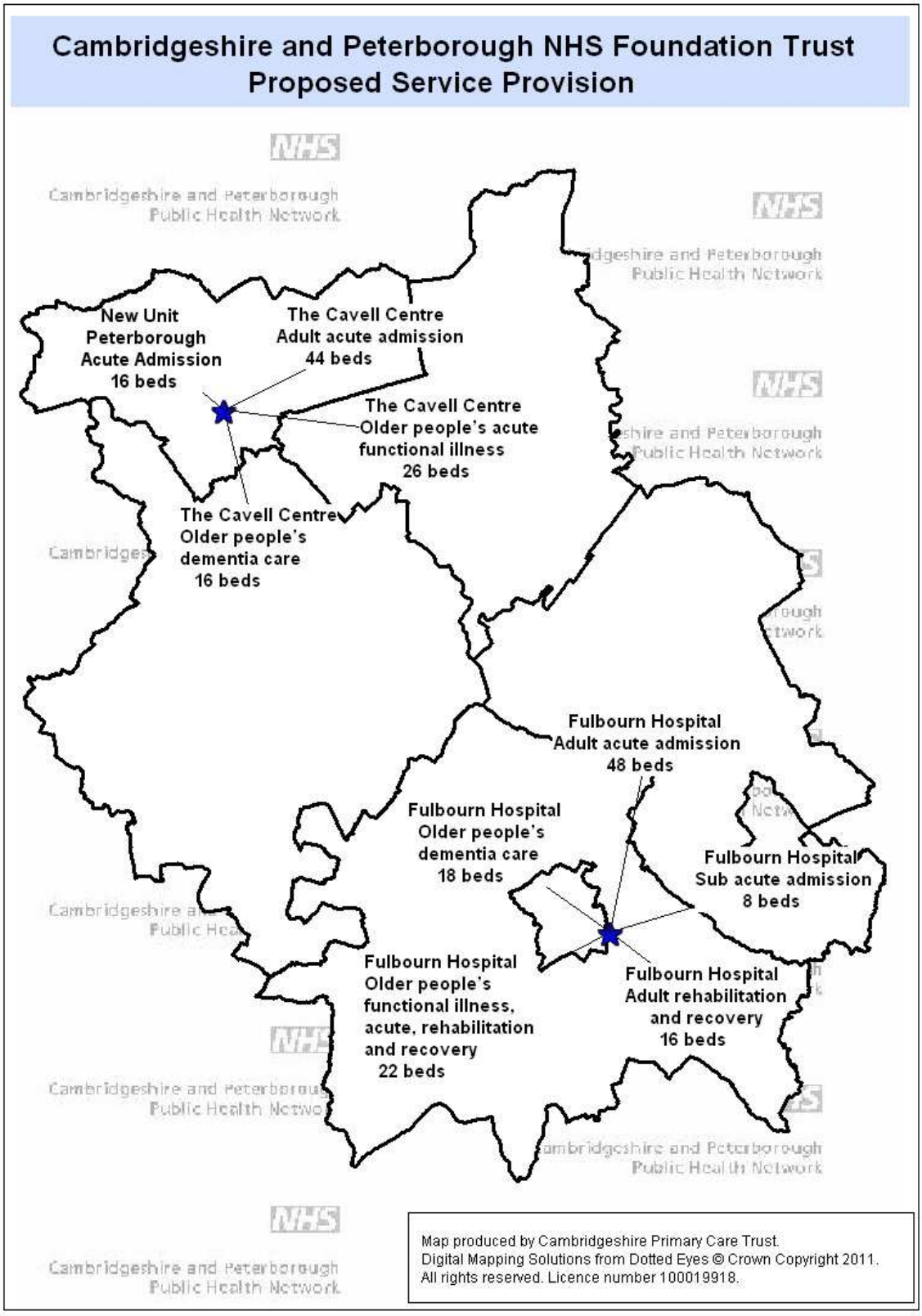
Current service: An 82 year old person visits their GP struggling to cope after the death of their partner, but is not assessed as having needs serious enough to warrant referral to the local mental health services. The GP prescribes some medication and talks with the patient about what services might help them, such as local groups which could provide the patient with appropriate support.

Proposed new service: the same person visits their GP who then refers them by phone to the Advice and Brief Intervention Centre. The referral is reviewed immediately. The patient's local older people's primary mental heath care team (PMHC) contacts the patient the next day to arrange a convenient time for a primary mental health care practitioner to visit them at home. The patient and practitioner talk about the patient's situation and what the patient feels might be of help to them. The practitioner is able to tell the patient of local services and groups that could help and leaves information about these with the patient to think about. The practitioner and patient meet again a couple of days later and the patient decides that they would like to attend a local group for people who have suffered bereavement. Through this group the patient felt support and not alone in learning to adapt to living alone. An older people's primary mental health support worker keeps in touch with the patient and their GP to check the patient is making progress. This continues until the patient feels they no longer need PMHC support.

The two maps below set out where the current inpatient facilities are locally at the moment and where they would be if these proposals were adopted. It is important to note that the maps only illustrate the location of in-patient facilities. A very high proportion of mental health service users receive their services at home, in primary care, or elsewhere in the community.

Cambridgeshire and Peterborough NHS Foundation Trust
Current Service Provision - October 2011




Cambridgeshire and Peterborough NHS Foundation Trust
Proposed Service Provision
New Unit
Peterborough
Acute Admission
16 beds
The Cavell Centre
Adult acute admission
44 beds
The Cavell Centre
Older people's acute
functional illness
26 beds
The Cavell Centre
Older people's
dementia care
16 beds
Fulbourn Hospital
Adult acute admission
48 beds
Fulbourn Hospital
Older people's
dementia care
18 beds
Fulbourn Hospital
Sub acute admission
8 beds
Fulbourn Hospital
Older people's
functional illness,
acute, rehabilitation
and recovery
22 beds
Fulbourn Hospital
Adult rehabilitation
and recovery
16 beds
Map produced by Cambridgeshire Primary Care Trust.
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APPENDIX A:

Current Local Care Pathways:-

(more details about the treatments offered and anticipated time spent in each pathway is available on the CPFT website www.cpft.nhs.uk)

Primary care and liaison

- Primary care pathway

Child and adolescent mental health

- Early intervention - tier 2
- Choice and partnership approach - care pathway (core pathway) - tier 3
- Neurodevelopment pathway
  - Neuro-Attention Deficit Hyperactivity Disorder sub-pathway - tier 3
  - Neuro-Asperger's Syndrome Disorder sub-pathway - tier 3
- Children with learning disabilities - tier 3
- Tier 4 pathway
  - Complex eating disorders (Phoenix)
  - Complex adolescent mental health (Darwin)
  - Complex child development problems (Croft)

Adult mental health

- Intake and treatment care pathway
- Early intervention care pathway
- Acute care pathway
  - Acute care sub-pathway Psychiatric Intensive Care Unit (PICU)
- Rehabilitation and recovery care pathway
- Eating disorders care pathway
- Personality disorders care pathway

Older people's mental health

- Community pathway
  - Community functional care - sub-pathway
  - Community dementia - moderate and severe care sub-pathway
  - Community dementia - diagnosis and stabilisation care sub-pathway
- Intermediate care pathway
- In-patient treatment care pathway
- Young onset dementia care pathway
- Day therapies care pathway

Specialist services

- Learning disabilities acute care pathway
- Learning disabilities rehabilitation care pathway
- Supported living and complex care packages
- Low-secure care pathway
- Substance misuse care pathway
- Prison in-reach care pathway

APPENDIX B:

***Timeline*:-**

Project		2012/13				2013/14			
	Jan-Mar	April-June	July-Sept	Oct-Dec	Jan-Mar	April-June	July-Sept	Oct-Dec	Jan-Mar
Advice and Brief Intervention Centre Development									
Primary Care Mental Health Service									
Consolidation of Inpatient Facilities									
Acer Ward Closure									
Lucille van Geest new way of working									
Cobwebs Closure									
Closure of David Clarke House & Relocation of James Ward									
Relocation of Lucille van Geest to Cavell Centre Site									