NHS Cambridgeshire and NHS Peterborough
working in partnership

MEETING: **NHS CAMBRIDGESHIRE AND NHS PETERBOROUGH BOARD MEETING IN PUBLIC**

AGENDA ITEM: **4.2** **SECTION: STRATEGY AND REVIEW**

DATE: **28 MARCH 2012**

TITLE: **PROPOSED RE-DESIGN OF MENTAL HEALTH SERVICES ACROSS CAMBRIDGESHIRE AND PETERBOROUGH**

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FOR: **APPROVAL**

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1 ISSUE

The purpose of this report is to provide Board members with information on the public consultation process undertaken in respect of proposals to reconfigure mental health services across Cambridgeshire and Peterborough, and to set out the feedback from stakeholders and members of the public in order to inform the Board's decision.

2 CORPORATE OBJECTIVE AND BOARD ASSURANCE FRAMEWORK LINK

- NHS Cambridgeshire BAF06 Patient and public expectations outstrip our ability to resource and deliver.
- NHS Peterborough BAF 15 Public and patients not engaged in service configuration proposals.

NHS Cambridgeshire and NHS Peterborough cluster Corporate Objectives:

- Corporate Objective One Quality *(maintaining and improving quality in the services that we commission)*
- Corporate Objective Three Finance and QIPP *(achieving financial balance and delivery on the QIPP and Reform Plan for 2011-2012*)
- Corporate Objective Five Transformation (*for better service delivery*)

3 KEY POINTS

3.1 Working together with Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), we are proposing a radical re-design of local care pathways during the next three years. These proposals would radically change the way we provide mental health services, further strengthening the focus of service delivery in the community rather than hospital services, emphasising preventative services, early intervention and simplifying pathways that are currently complicated. There is evidence from patient feedback, local GP experience and the results of recent external inspections that current pathways may not be addressing local needs as responsively as they might. We do believe that if these proposals are adopted then local services will improve.

3.2 The proposals consulted upon seek to deliver three key strategic objectives:-

- **A more accessible and responsive local mental health service, the headline innovation being an 'Advice and Brief Interventions Centre'** (now being renamed as the Advice and Referral Centre, ARC). This would provide a single access point available 24/7 for all ages and for local GPs, service users, carers, Social Services, local voluntary organisations, and people working in other services. The Centre would provide information about common mental health conditions, personal advice, and access to more specialist local care pathways if required. They would also manage a patient's progress through local services to ensure they do not 'slip through the net' or become 'lost in the system'. The service would not provide telephone 'diagnosis'.

- Ensuring that any patient who requires admission to an in-patient ward receives their care in a **modern and purpose-built setting that meets today's much higher standards of environment and privacy and dignity**. We are proposing the closure of the Acer adult acute ward on the Hinchingbrooke Hospital site, James older peoples acute ward on the Addenbrooke's Hospital site and reductions in the number of adult rehabilitation beds from 44 to 16 beds, by closing Cobwebs in Cambridge and reducing the number of rehabilitation beds at the Lucille van Geest Centre in Peterborough. A benchmarking exercise had identified that we had more of these beds than comparable areas, and modern "recovery-based" mental health service models favour community-based support for service users whenever possible. **There are no reductions proposed overall in the numbers of beds for acute admissions** (additional beds were opened in Peterborough to offset the reduction in Huntingdon) or in the number of beds available for people with dementia. The national trend is for a reduction in these bed numbers too, but we have decided to retain the current number as part of our planning for population growth.

- Acknowledging the financial challenges facing the NHS but wishing to ensure quality of service provision, the objective is to deliver the anticipated minimum efficiency savings requirement for local mental health services for each of the next three years. Our planning assumption is that the CPFT contract baseline will reduce by 1.5 per cent annually in each of 2011/12, 2012/13, and 2013/14. This in practice

requires an efficiency improvement of approx 14-15 per cent during this three-year period due to the additional pressure of inflation.

3.3 The NHS clearly faces significant financial challenges at the present time. We are proposing these changes as the logical next step in our long-term strategic direction of providing as much care as possible in community settings where appropriate (including peoples' own homes) rather than in hospital wards, even if we did not have to make efficiency savings. Our aim is always to deliver "the most appropriate care in the most appropriate setting".

4 DEVELOPMENT OF THE PROPOSALS

4.1 The proposals were developed in partnership by Local Commissioning Group GP mental health leads, Dr Simon Hambling (Borderline LCG), Dr David Irwin (Hunts Care Partners LCG), Dr Caroline Lea-Cox (CATCH and representing Cam Health), Dr Dee McCormack (Isle of Ely LCG), Dr Sohrab Panday (Peterborough LCG), Dr John Richmond (Hunts Health LCG), Dr Emma Tiffin (OPMH Lead for Cambridgeshire) and Dr Ray Webb (Wisbech LCG) and CPFT senior clinicians from January to September 2011.

4.2 There was also an extensive programme of pre-consultation preparations to finalise the proposals, including staff workshops, regular dialogue with Local Commissioning Groups, and briefings for a number of key stakeholder forums locally.

4.3 A review of the clinical case for change of the proposals was undertaken by the National Clinical Advisory Team (NCAT), to provide clinical assurance. The NCAT review team visited the Cavell Centre in Peterborough and Acer Ward at Hinchingbrooke Hospital in Huntingdon. NCAT supported the clinical case for change of the proposals, and also recommended immediate closure of Acer Ward on the Hinchingbrooke site and relocation of the beds to Peterborough.

4.4 Based on safety and environmental grounds. Cambridgeshire and Peterborough NHS Foundation Trust therefore closed Acer Ward immediately following this recommendation, which meant that Acer Ward was closed before consultation launch.

4.5 An Office of Government Commerce (OGC) Gateway 0 Review was also carried out. This was a Strategic Assessment. Gateway reviews are mandatory for all projects and programmes in NHS organisations which are assessed as high risk and should also be used for those assessed medium risk. A Gateway review is also required prior to public consultation when any service reconfiguration is proposed. Gateway uses a "peer review" approach; it is not an audit or inspection and the process is undertaken in partnership with the project. Gateway reviews provide a valuable perspective on the issues facing the internal project team, and an external challenge to the robustness of plans and processes.
The clinical NCAT review and Gateway review can be found at **Appendix 1.**

5 CONSULTATION PROCESS

5.1 NHS Cambridgeshire and NHS Peterborough Cluster PCT has a statutory duty to involve and consult local people in relation to health service planning and delivery. In order to fulfil this duty in relation to proposed changes, a formal public consultation was undertaken to seek the public's views on the proposed redesign of mental health services across Cambridgeshire and Peterborough.

5.2 The consultation was run jointly by NHS Cambridgeshire and NHS Peterborough Cluster PCT, and the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). It ran for 90 days from 17th October 2011 to 16th January 2012. The consultation document was disseminated by email and posted to a range of stakeholders, members of the public and all GP surgeries across Cambridgeshire and Peterborough. A distribution list can be found at **Appendix 2.** The consultation document was also made available on the NHS Cambridgeshire and NHS Peterborough websites. An easy read version of the document was also provided on the websites, as were translations of the document to Lithuanian, Portuguese, Urdu and Polish. Hard copies of these were sent out on request.

5.3 The launch of the consultation was proactively advertised in the local media. There was a high level of public interest in the proposals and a number of radio interviews were given, as well as a television interview.

5.4 NHS Cambridgeshire and NHS Peterborough offered through the consultation document to attend groups or meetings to present the proposals and receive feedback. We were invited to present and discuss the proposals at a number of meetings, which included a range of local stakeholder groups. We met with the following groups:

- 24 November 2011 - NHS Peterborough Public Consultation Forum
- 6 December 2011- Police
- 7 December 2011 – Cogwheel
- 12 December 2011 – MDF Cambridge, Arts and Minds, Friends of Fulbourn Hospital, Age UK, Lifecraft, Cam MIND, Rethink
- 21 December 2011 - Friends and family of people with Borderline Personality Disorder support group
- 3 January 2012 - Patient Participation Group representatives
- 9 January 2012 - Adult Attention Deficit Hyperactivity Disorder group
- 10 January 2012 – Richmond Fellowship
- 8 February 2012 - St Ives Town Council. This meeting took place after the consultation had closed, but it was thought important that councillors were able to be briefed in detail and have some concerns addressed.
- We met three times (two formal and one informal meeting) with the Huntingdonshire District Council Overview and Scrutiny Committee (Social Wellbeing), to discuss the proposals.

The minutes of all these meetings can be found at **Appendix 3.**

5.5 In addition to the meetings listed above, we hosted five open public meetings across Cambridgeshire and Peterborough. These meetings were open to anyone who wished to attend, and gave members of the public the opportunity to find about the proposals in detail, discuss these, raise concerns and ask questions. The meetings provided NHS Cambridgeshire and NHS Peterborough with the opportunity to gain useful insight into service users', carer's and local peoples' views and concerns about the proposals, as well as their current experience of mental health services in Cambridgeshire and Peterborough.

The dates and times of these meetings are listed below and were provided on the NHS Cambridgeshire and NHS Peterborough websites, as well as being proactively advertised in the local media:

- 11 November 2011 – Meadows Community Centre, Cambridge 12.00-14.00
- 30 November 2011 – March Town Hall, March 18.00-20.00
- 7 December 2011 – Oak Tree Centre, Huntingdon 18.00-20.00
- 8 December 2011 – Cavell Centre, Peterborough, 14.00-16.00
- 4 January 2012 – Oak Tree Centre, Huntingdon, 18.00-20.00

Minutes from these meetings highlighting the questions and concerns raised, can be found at **Appendix 4.**

5.6 We also offered a number of specific times when members of the public could book private appointments, to discuss the proposals. Appointments were provided across Cambridgeshire and Peterborough. This offered members of the public the opportunity to discuss the proposals in private. These times were provided in the consultation document and on the NHS Cambridgeshire and NHS Peterborough websites:

- 27 October 2011 10.00-13.00 – Peterborough
- 3 November 2011 14.00-17.00 – Cambridge
- 8 November 2011 12.00-14.00 – Huntingdon
- 11 November 2011 14.00-16.00 – Cambridge
- 18 November 2011 10.00-13.00 – Fenland
- 24 November 2011 12.00-14.00 – East Cambridgeshire
- 7 December 2011 11.00-13.00 – Huntingdon
- 8 December 2011 12.00-14.00 – Peterborough

A number of appointments took place, the minutes of which can be found at **Appendix 5.**

5.7 We hosted two further events for voluntary organisations involved in the provision of mental health services, and for service users to take part. These meetings gave the opportunity for in depth discussion of the proposals with service users and representatives of voluntary organisations. These both took place on 14 November 2011, with the voluntary organisation event taking place from 10.30-12.30, and the Service User event from 13.30-15.30.

5.8 There was an exceptional level of public interest in the proposals. In total, the PCT mental health commissioning team attended 45 meetings during the consultation period.

5.9 The Health and Overview Scrutiny Committees of Cambridgeshire County Council and Peterborough City Council formed a Joint Committee to scrutinise the proposals. We worked closely with members both before and during the public consultation itself, providing briefings, gathering helpful feedback on the consultation document, organising visits, and providing additional information as their work progressed. The Joint Committee held public meetings in both Cambridge and Peterborough. A number of meetings were held with the joint Adult Health Overview and Scrutiny Committee. We also met twice with Huntingdonshire District Council's Overview and Scrutiny Panel (Social Well-Being).

5.10 During the consultation period, NHS Cambridgeshire provided Freephone and landline telephone numbers for the public to call for further information, to request a meeting, or to request further copies of the consultation document.

6 RESPONSE TO THE CONSULTATION

6.1 21 formal responses from organisations were received to the consultation. These were from the following organisations:

Little Paxton Parish Council	The Cambridge and the Peterborough and Fenland Rethink Carers Group
Cambridgeshire Older People's Enterprise	St Ives Town Council
Holywell-cum-Needingworth Parish Council	Her Majesty's Court Service
Papworth Trust	Hinchingbrooke Healthcare Trust
ADDventure Within	Lifecraft & Lifeline
Peterborough City Council	Huntingdonshire District Council Overview and Scrutiny Panel (Social Well-being)
Making Space	Cambridgeshire and Peterborough Joint Overview and Scrutiny Committee
Cambridgeshire County Council Children and Young People's Services	Cambridgeshire County Council Adult Services Directorate
Support Group for Family and Friends of People with Borderline Personality Disorder	Cambridgeshire Service User Network (SUN)
Peterborough Community Services	Cambridge and District Citizens Advice Bureau
Cambridge Mental Health Stakeholders	Cambridgeshire LINk and Peterborough LINk

A summary of these responses can be found at **Appendix 6.**

6.2 A questionnaire for completion was provided at the end of the consultation document. An online version of the questionnaire was made available on the NHS Cambridgeshire and NHS Peterborough websites, enabling people to complete the questionnaire online. In total, 107 questionnaires were completed. 36 were completed online and 71 postal questionnaires were returned. The responses were independently analysed by MRUK Research. The report of MRUK's analysis and a copy of the questionnaire can be found at **Appendix 7.** 10 postal responses were received after the consultation closed, which repeated concerns already raised.

- 59% of respondents to questionnaires agreed with the proposals to open a new 24/7 Advice and Brief Intervention Centre, with 30% disagreeing and 11% saying they do not know.
- 56% of respondents were in favour of setting up a new Primary Care Mental Health Service to support the Advice and Brief Intervention Centre, with 20% disagreeing and 24% saying they do not know.

- 55% of respondents do not agree with proposals to combine a number of inpatient wards for adults, with 23% agreeing with the proposals and a further 23% saying they do not know.
- 45% of respondents do not agree with combining a number of inpatient wards for older people, with 17% agreeing with the proposed change and 38% saying they do not know.

6.3 11 formal letters were received from members of the public, responding to the consultation. A summary of these can be found at **Appendix 8.**

6.4 Three petitions against the closure of Acer Ward at Hinchingbrooke Hospital were received:

- One petition received by post, entitled 'Re-open Acer Ward', contained 8 names and signatures. Town names were given but no full addresses.
- An online petition was received, protesting against the closure of Acer Ward. The petition contained 110 names supporting the petition. No postal addresses were provided, only email addresses and full names.
- A further petition against the closure of Acer Ward was received by post, which contained 501 names and signatures in support of the petition. Some full addresses provided and where full addresses were not provided, town names were. A cover letter accompanied this petition, setting out the main points of concern, which can be found at **Appendix 8.**

6.5 What people told us and what we have done to respond to their concerns

A number of common themes became apparent both in the consultation responses from members of the public and stakeholder organisations, and at the consultation meetings. The main themes that emerged consistently during the consultation process were:

- **Support for Advice and Brief Intervention Centre (ABIC) to be renamed ARC**

What people told us: There was much support for the concept of the ABIC amongst responses from both members of the public and stakeholder organisations. The principle of improving access and responsiveness with a single point of access to services was widely supported. However, many questions and requests for more detail about the practical implementation arrangements for the ABIC were raised.

There was consistent support for the proposal that services be age inclusive.

Some nervousness was expressed by local voluntary organisations as to how the ABIC will operate and a proactive programme to ensure their engagement (and also that of service users) in the design process has been set up.

What we did: The Local Commissioning Groups GP mental health leads have been meeting with senior CPFT clinicians to ensure this is designed in a workable manner that will meet the needs of primary care, key stakeholders and service users. A "walk through" workshop was held on 1st February 2012, and agreed some key features of the design and first stages of the implementation process. These meetings continue on a regular basis. It is planned to implement the first phase of the ABIC in Peterborough in early July, with a countywide roll-out in the autumn. The initial phase will focus first on referral management from and provision of prompt advice and support to GPs, and then a direct

access point for service users and carers. Other features will be added once there is confidence the necessary capacity and systems are in place to manage these safely.

What people told us: Service users, carers and local voluntary organisations sought reassurance that they would be genuinely involved in the design of the new services, and especially the proposed ABIC.

What we did: In response to this a series of events will be set up for key stakeholders to ensure their views are incorporated into the design. A further workshop has already been held with local voluntary sector organisations.

- **Earlier intervention supported**

What people told us: The focus of the proposed model on earlier intervention, ensuring that people receive help to treat their mental health problem as soon as possible, and on the "recovery" model – i.e. supporting people to manage their condition and live as rewarding a life as possible within the community, rather than spending long periods in "rehabilitation" wards, were strongly supported by all stakeholders, and especially service users and carers.

- **Consolidation of wards**

What people told us: There was concern raised over the consolidation of inpatient wards. Concern has been raised that this does not take into account the projected population growth of the county. Assurance has been sought that there will remain sufficient beds to ensure that everybody who requires an in-patient admission will be able to do so locally

What we did: The number of acute beds is not being reduced, and a number of innovations in patient and ward management have been introduced to improve patient experience and make better use of the capacity/occupancy that we do have.

- **Acer ward closure**

What people told us: There have been many concerns raised about the proposed closure of the Acer ward in Huntingdon. Concerns expressed were mainly the loss of a valued local facility, where many people had received an excellent service; fears that people in crisis would not be able to access local community-based services, or that those services would not be able to respond promptly; the difficulties of travel for Huntingdonshire patients and their carers admitted to a ward in Peterborough or Cambridge; reduced specialist mental health input into Hinchingbrooke Hospital.

What we did: In response to these concerns, we have pro-actively engaged with the local media (including highlighting of local GP support for the proposals) and the District Council to explain in more detail the clinical reasons why the closure of this ward has been proposed. These are essentially:-

- With the development of more community-based services in recent years, the requirement for acute beds has reduced. There are now typically approximately 10 people from the Huntingdonshire area requiring an acute bed at any one

time. This number includes some people who for clinical reasons, would have been admitted to a ward in Peterborough for clinical reasons even when Acer Ward was open. Lengths-of-stay are also much shorter nowadays than was previously the case

- A modern "recovery-based" service aims to offer patients admitted a range of interventions to enable them to return to the community as soon as is safely possible. This range of interventions cannot be provided to such a small patient group on a relatively isolated site.

- The acuity of those patients admitted is much more severe than historically was the case, and these patients cannot be safely looked after in Acer Ward even if there was a substantial refurbishment. There also needs to be sufficient trained medical staff available to respond promptly should a psychiatric emergency arise, and this is not possible at an isolated unit;

- NHS Cambridgeshire and NHS Peterborough Cluster PCT does recognise the concerns raised by service users and carers about the lack of sufficient local capacity in Huntingdonshire, to enable people in crisis to receive help promptly. There have subsequently been further discussions and the proposals have been revised so that the capacity of the Huntingdon-based crisis team will be increased by the equivalent of 5.3 wte staff to 17.33 full-time staff, an increase of 44% , which is in line with the recommended levels of team capacity recommended in national guidance on crisis resolution / home treatment teams.

- **Crisis Resolution Home Treatment Team in Huntingdon**

What people told us: Criticism and concern was expressed particularly by service users in Huntingdonshire of the Crisis Team being relocated to Peterborough from Huntingdon when Acer Ward temporarily closed. Some stakeholder organisations expressed concern for the capacity of the team and some service users' experience of this service was reported to have deteriorated with the move of the Team to Peterborough, with difficulty found in being able to speak to members of the team on the phone for advice and support, and long waits for home visits.

Concerns were also raised that the specialist mental health support to the A+E department at Hinchingbrooke Hospital would be less responsive if there was no longer an acute ward on the site.

What we did: In response to these concerns, from 1 February 2012, the Crisis Resolution Home Treatment Team moved back to Huntingdon, based at the Newtown Centre.

The expansion of the crisis resolution team will also help to ensure a responsive service is maintained to the A+E department at Hinchingbrooke hospital. We have also initiated discussions with the hospital about the establishment there during the next year of a specialist "liaison psychiatry" service that would provide mental health support to patients throughout the hospital and not only in the A+E department.

- **Transport**

What people told us: Transport has been an area of particular concern for patients, their families and carers. This has been of particular concern in relation to Huntingdonshire residents and the proposed closure of Acer Ward, which means that patients would be treated in either Peterborough or Cambridge. Concerns regard difficulties travelling to visit relatives at Peterborough in particular from the Huntingdonshire area, particularly from rural locations, and the associated costs of this. The logistics of using public transport was also a concern for service users, their families and carers with a lack of direct and regular bus routes from certain areas to Peterborough in particular, and Cambridge. This was also of concern in terms of possible implications to patients taking home leave and also the potential of having fewer visitors with facilities being located further away from Huntingdonshire.

What we did: In response to the transport issues raised, NHS Cambridgeshire and NHS Peterborough is working with Cambridgeshire County Council and CPFT and have identified the catchment area of the ward and are looking at community transport schemes and public transport routes in these areas. We are going to be providing a specific fund for transport and will be contacting service users and families who have used the Acer Ward in the past. We are also looking at visiting hours on the wards and what public transportation is available around these times, as late visiting hours at Peterborough for those in rural areas can mean they are unable to get a bus home. In addition to this we are aware that day release from an acute ward in Peterborough for a Cambridgeshire resident can be very difficult due to lengths of travel time of public transport. We would look to use this fund to support service users to return home to their family and friends for the day in the easiest way possible. If the Board approves these proposals, this will be put in place as part of the implementation plan.

- **Capacity and quality of community based services**

What people told us: Concerns were raised during the consultation about the capacity and quality of local community-based services, especially those providing treatment and care for people with severe and enduring illness.

What we did: In response to this and also the recent CQC inspection the Local Commissioning Group GP mental health leads have agreed to review with CPFT how quality monitoring of community-based services can best be undertaken in future by the new CCG. We are developing ideas around service user ‘inspectors’. CQC inspections historically have focussed upon buildings-based services in Mental Health.

- **Life course pathways**

What people told us: This was an aspirational component of our proposals and the consultation further highlighted the lack of local pathways or support for adults with life-long conditions such as autism or ADHD.

What we did: NHS Cambridgeshire and NHS Peterborough are currently finalising proposals to provide better access to diagnosis and some training to enable staff working in mental health services to improve their support for people with these conditions as part of our contract negotiations for 2012/13.

- **Closure of Cobwebs**

What people told us: The closure of Cobwebs in Cambridge was criticised. Reasons given against the closure of the facility are that it is ideally situated in the community, in the heart of Cambridge City, allowing for social inclusion as residents could easily mingle with the community and access voluntary work if they wanted to.

What we did: Cobwebs had reduced occupancy throughout the consultation and in December 2011 the numbers fell to a level at which patient experience was impacted and therefore the ward was temporarily closed pending the final outcome of the consultation. Many attendees of public meetings expressed concern and regret at the closure of Cobwebs and expressed a wish for it to be reopened. Unfortunately, the building does not meet modern standards of accommodation and service users are now accommodated in a range of alternative housing locally.

- **Criticism of the consultation:**

What people told us: The consultation was criticised as people perceived that proposals were being taken forward before the close of the consultation period. This was seen as undermining the consultation process and related to the early temporary closure of both Acer Ward and Cobwebs.

What we did: An unforeseen complication that arose prior to the start of the public consultation was that the National Clinical Advisory Team advised that Acer Ward in Huntingdon be closed temporarily on safety and environmental grounds, prior to the start of the consultation. This recommendation was implemented. This was inevitably interpreted by some parties as pre-judging the consultation process. In addition to these temporary closures of Acer Ward and Cobwebs, David Clark House was also temporarily closed due to environmental concerns. The temporary closure has enabled full refurbishment of the facilities. David Clark House has now reopened and is receiving patients.

7 RECOMMENDATION

The Board is asked to:-

- Note the consultation responses which were gathered following good engagement with patients, carers, the public, stakeholders and local clinicians throughout the process.

- Endorse proposals to set up an Advice and Brief Intervention Centre (ARC), subject to the PCT Cluster Executive Team ensuring there is robust engagement with local GPs, service users and carers, voluntary organisations and other key stakeholders during the design process.

- Endorse proposals to set up a Primary Care Mental Health Service.

- Endorse proposals to consolidate inpatient wards for adults, subject to ensuring plans are put in place to support patients, their carers and families

with transportation to and from mental health services in Cambridge and Peterborough, for those who need it. Furthermore, to ensure that the Crisis Resolution Home Treatment Team continue to have a base in Huntingdon and that community support is enhanced to ensure there is sufficient capacity to provide a responsive service to patients being treated/supported in the community.

- Endorse proposals to consolidate inpatient wards for older people.

- Endorse the changes made to the model in response to consultation and monitor the progress of changes in six months time.

8 REASON FOR RECOMMENDATION

The proposals once implemented will deliver the next stage of our long-term strategic objective of a local mental health service based on modern best-practice, in particular:

- Prompt and easy access to effective help as soon as a problem emerges;
- Service delivery in community settings whenever clinically appropriate;
- Accommodation in modern purpose-built settings that meet all modern standards of privacy and dignity for those patients who do require a ward admission;
- A service based on 'recovery' principles, i.e supporting people to manage their condition in the community and to continue to lead as fulfilling a life as possible.

9 IMPACT ASSESSMENT

- Financial: The proposals will ensure we can provide a safe service locally based on modern best-practice, within the available resources;
- Performance: We will continue to performance-manage both the implementation of these proposals and the subsequent service delivery, including an enhanced emphasis upon monitoring the quality of community-based services;
- Governance: We will continue to regularly update Local Commissioning Groups, the Cluster Executive Team and the Board on the progress of implementation;
- Patient Experience: By simplifying access to services and strengthening the emphasis upon early intervention and support, we believe these proposals if implemented will enhance patient experience of local services;
- Standards for Better Health: We will continue to monitor compliance with these standards through our routine quality monitoring processes;
- Travel: Patients from the Huntingdonshire area and their carers who might previously have been admitted to Acer Ward, would now have to travel to Cambridge or Peterborough.
- Equality and Diversity: An Equality Impact Assessment was undertaken as part of the Gateway Review. Stakeholder mapping including vulnerable groups, ensured views were fed into the proposals. We will be working with service users to develop the Advice and Brief Intervention Centre (ARC).

10 TIMELINES

If the Board supports all of the above recommendations, below is a high level summary of our proposed timelines for implementation. A more robust plan will be developed once the Board has made their decision:

Set up implementation group to meet monthly	April 2012
Set up of travel fund and strategy	May 2012
Move from Temporary to Permanent Ward Closures	May 2012
Phase 1 of ARC-Peterborough referrers	July 2012
Primary Care Teams	July 2012
ARC fully operational across Cambridgeshire and Peterborough	March 2014

11 CONCLUSION

These proposals were designed to continue the progress we have made in recent years towards a modern local mental health service based upon early intervention, the 'recovery' model, and services delivered in the community as much as possible. During the consultation period we received a number of comments and suggestions to improve our proposals, and these have been incorporated into our revised recommendations.

March 2012

APPENDIX 1 – GATEWAY AND NCAT REVIEWS

NCAT visit report

To:

Cambridge and Peterborough FT

Date:

2/9/11

Venue(s)

1. Cavell Centre, Edith Cavell Healthcare Campus, Bretton Gate, Peterborough PE3 9GZ
2. Acer Ward, Hinchingbrooke Hospital, Hinchingbrooke Park, Huntingdon, Cambridgeshire, PE29 6NT

NCAT visitors:

Dr Pete Sudbury (Medical Director, Barnet, Enfield and Haringey MHT)
Prof. Tom Craig (Professor of Social Psychiatry, KCL; Consultant rehabilitation psychiatrist, SLAM)

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Introduction:

1. The review was commissioned by NHS Cambridgeshire and NHS Peterborough via the East of England SHA, and our visit was at the end of an extensive pre-consultation process.
2. The 3-month public consultation is planned to commence in October
3. Due to time constraints, our visit was restricted to the North of the patch (Peterborough and Huntingdon), where the changes are perhaps more contentious, but we understand that the issues in Cambridge are similar, as is the degree of engagement of stakeholders. Follow-up visits to the South of the patch could be arranged should that prove necessary.

Background to review

Case for change.

This is a second stage of reconfiguration of MH services in the area. The first stage developed (i) an effective and valued model of older people's healthcare, including home treatment; and (ii) the strengthening of links into primary care, using primary care MH workers and link workers. The Trust is acting, with support from commissioners, to implement known best practice in the delivery of community-based and in-patient MH services, reducing a current excessive dependence on in-patient care.

Proposals

The proposals, which have been developed through extensive consultation with GPs, patients and other stakeholders, with consultancy assistance from UnitedHealth UK involve changes to the organisation and delivery of most aspects of services. The major headlines are:

1. A shift in emphasis, in line with national policy and best practice, towards prevention, early intervention, self-help and patient driven care.
2. Reconfiguration of community MH services into local hubs ("service centres" or "Advice and Support centres"), with a genuine single point of access for all services, with accurate, timely triage to the appropriate level of care.
3. Implementation of a number of lifespan pathways: eating disorders, early intervention in psychosis and Aspergers / ADHD. The Trust representatives also spoke of their intention to develop similar pathways for personality and affective disorders.
4. A more assertive and outward-focused model of rehabilitation, with patients moving out of long stay rehabilitation units into more appropriate accommodation, usually not in the health sector.
5. Streamlining in-patient care for adults, through process changes including short-term admissions under the control of the HTT, admission wards focusing on the first 3 weeks of admission, and accompanying changes in the functioning of the wards.
6. Resulting from this, some closures or relocations of beds, and a proposed development of replacement acute in-patient capacity in Peterborough.
7. closure of some older people's beds due to overcapacity following successful previous implementation of community models of care
8. Reduction in the number of in-patient sites to improve safety and appropriateness of the in-patient facilities

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Expected outcome

These changes can be expected to produce

1. significant further improvements in links with primary care,

2. much greater ease of referral, and in the rapidity and appropriateness of response to it
3. improved co-ordination of care around the patient
4. significant reductions in the need for in-patient care, and consequent reductions in the associated overhead costs.
5. improvements to in-patient patient safety, privacy and dignity
6. stronger, more effective community care
7. savings totalling £11.2m over 3 years (including £3.9m from ward reconfigurations; £6.7m from community reconfiguration)

There are transitional problems particularly around the management of Acer Ward and its associated HTT. On the basis of the evidence we have gathered, we are of the opinion that there is unacceptable clinical risk in the current arrangements, due to the ward and attached HTT having 14 vacancies from a complement of 33, which they have been unable to fill. Such recruitment and retention problems are not uncommon as details of proposed reconfigurations emerge. The associated clinical risk is particularly around the effective functioning of the HTT, and we are of the opinion that having both ward and HTT functioning suboptimally for a significant period of time is not acceptable. **We therefore strongly recommend that the move of Acer ward to the Cavel Centre, with associated strengthening of the HTT, should be implemented as rapidly as possible, this being the only feasible mitigation for that risk**.

Documents reviewed

CPFT service redesign consultation document 2011-12 v9
NHS Peterborough cluster leads CPFT contract and redesign briefing paper
Letter to GPs about consultation
Senate 15/3/11 mental health commissioning
MH consultation steering group terms of reference
CPFT inpatient redesign - comms and engagement plan June n2011
Project Risk Log
NHSC CPFT 11 12 Memo of understanding
JSNA 2010
MHD Consultant steering group terms of reference
CPFT consultation document v2 final
Pathways booklet Jan 2010 final
Final data C&P all
Final data C&P EoE
C+P presentation 26 Apr
Acute care pathway Cams and Peterborough
Redesign financial background
Commissioning strategy for older people
Locality structure

People seen / interviewed

Commissioners: Claire Warner, John Ellis
Trust senior managers: Keith Spencer (Director), Mick Simpson (General maanger), Jill Hudson Senior manager quality and innovation),
Clinicians:
Dr Manaan Kar Ray (clinical director),
Dr Zahoor Syed, Dr Dell'Erba (consultant psychiatrists)
Rena Hughes, Elaine Young, Denise Hone (modern matrons).
Maxine Coppard (ward manager)

LINk and OSC Cambridgeshire:
Bernie Gold, Jane Belman, Cllrs Sails, Kenny, West, Reynolds.
OSC Peterborough:
Cllr Rush
GP MH lead:
Dr Caroline Lea-Cox (telephone conference)

Discussion & analysis

Quality check

Patient safety

These proposals, properly implemented, will have a positive impact on patient safety.

1. Barriers to (re)entry to specialist MH services will be reduced, and waiting times for triage and assessment minimised
2. Improved links with primary care, which result in "upskilling" up GPs, impact positively on the healthcare of the 90%+ of patients with MH problems who are dealt with entirely in primary care.
3. Recovery-focused models of care, concentrating on enablement of patients, improve safety in the long term, by improving self management.

Patient related / clin outcomes

Patient experience

1. The experience of in-patients will be very significantly improved by moving from substandard accommodation in Acer ward, which is isolated, to the excellent Cavell centre in Peterborough.
2. Closing long-stay rehabilitation units, and moving patients to appropriate accommodation, with appropriate assistance, in the community, will improve the life experience of those patients.
3. The improvement in HTTs in the north of the county will allow more patients to be better managed at home and in the community: home treatment is generally preferred by both patients and carers to in-patient admission.
4. The development of "lifespan" rather than age boundaried services improves continuity of care and seamless transition through age boundaries that are arbitrary and have no significance in the development or time-course of mental health conditions.
5. There are no clear plans for involvement of other providers in the delivery of services, even those such as rehabilitation and recovery, where non-statutory organisations may well be better qualified to help patients develop their independence, although discussions have taken place. The Trust is highly successful in employing "experts by experience" to deliver care within teams, and the addition of such partnerships would further enhance the range of options available to patients (also meeting the Lansley "choice" criterion).

Wider issues

Trust management and planning

The Trust is well-led, open to change and has a good track record of change management. The proposed changes are significant in both scope and scale, but the evidence around the planning and engagement process so far, from the previous

reconfiguration and from the detailed plans, suggests that they and their partners can confidently be expected successfully to deliver the proposed models of care.

Future state modelling:

The Trust and commissioners may need to revisit or make more widely known their capacity modelling in 2 areas: around community bases, and especially around in-patient bed numbers.

Community hubs:

The effective functioning of the community hubs underpins the clinical strategy, and the Trust and commissioners need to clarify and publicise the assumptions underlying the working of these, at a basic level for the consultation (where case vignettes, indicative numbers of expected referrals and their disposal should be sufficient), and in greater detail as the implementation process rolls forward.

In-patient bed numbers.

Current state: Over the last 3 years, the Trust has reduced out of area placements by 60 beds, and reduced adult in-patient beds by 25, a very significant and sustained trajectory of reduction in overall bed use. Benchmarking supplied to us puts the Trust in or on the upper quartile for admissions and occupied bed days per weighted head of adult population. Benchmarked against East of England, the best performer uses just over half the occupied bed days per weighted head of population compared to CPFT. CPFT shows high admissions and bed use particularly in affective, neurotic and somatoform disorders: reducing these to the lowest quartile would halve the bed usage associated with these disorders and reduce overall admissions by over a third. Even within the Trust area, there is wide variation in in-patient bed use, with areas further from hospitals, particularly Fenland, using fewer beds than expected considering their population and level of deprivation.

The current reconfiguration plan envisages implementing a number of measures with proven significant impact on bed usage, including

- use of “assertive inreach” by HTTs, and their access to short-term beds,
- implementation of admission wards,
- use of “lean” methodology in the running of in-patient areas,
- strengthening of HTTs
- more preemptive models of community care.

However, the current plan has acute beds remaining at 108 (including reprovision of 16 in a new-build facility), whilst the bed reduction is entirely in rehabilitation beds, where the Trust is also an outlier in terms of the number in use.

Clinicians and managers pointed to (i) current high levels of bed occupancy, (ii) concerns about knock-on effects of rehab bed closures on ability to discharge patients from acute care (iii) a larger in-patient catchment area (500k WAP, compared to 400k population of Cambridgeshire) as justification for their cautious approach to bed numbers.

(i) The first reflects a tendency for those working in clinical systems to be “constrained by the present” when envisaging future service use, and reflects an underlying (and understandable) unwillingness to anticipate the possibility of success of clinical innovations that have not yet been introduced. This lack of confidence is not justified either by the track record of the Trust or the clarity and ambition of its vision for service development.

(ii) The second, whilst a possibility in the short-term, is no justification for a planned capital investment, or for implicitly expecting the Trust to remain in the upper

quartile for bed use for the foreseeable future, compared to other organisations that do not have rehabilitation beds in such numbers.

(iii) A 20% difference in catchment is not sufficient to explain the variation, nor does it explain the internal variation in admission rates

The Trust needs to rework its modelling along a range of assumptions, up to and including achievement of lower quartile (at minimum) or "best in class" bed use. This can be supported by examining variation between areas within the Trust catchment.

This modelling should also cover bed provision for older people, where there is a larger national variation, but where the Trust should also anticipate its ability to perform in the bottom quartile, given that service changes introduced last year have already reduced bed use, and may be expected to continue to do so.

The combination of these may indicate a significant risk of the Trust being left with excess estate in the short to medium term (2-5 years), especially should the proposed new build go ahead. This remodelling does not need to be done in any detail for the consultation to proceed successfully, though it would be sensible to include within the current consultation the possibility of future (potentially large) bed reductions if current and further plans are successful in reducing the need for in-patient care.

Overlaps between physical and mental health

We are concerned at the weakness of liaison services in the general hospitals in Peterborough and Huntingdon, which is a potential source of uncontrolled and poorly-triaged mental health admissions to both acute and MH providers. The cost-effectiveness for acute providers of these services is beyond doubt, and it is surprising that neither acute hospital has sought to commission such services, which are clearly not within the core MH contract.

In addition, very large healthcare savings can be generated by effective treatment of comorbid MH problems in people with physical long-term conditions reducing healthcare costs for those individuals by up to 2/3. Commissioners can encourage such cross-silo working by integrated pathway commissioning for LTCs.

Contingencies

Clinical IT: The stated dependency for the community hub developments on the implementation of a clinical IT system may cause serious problems for the Trust if left unchallenged. The current timeframes may well not be sufficient to allow for procurement, implementation and comprehensive roll-out of a full EPR. The Trust may need to develop contingency plans for use of paper and low-tech information transfer systems, such as fax or e-mail, in the eventuality that clinical IT does not materialise at the required rate.

Community placements and accommodation. There is a clear problem with the availability of suitable community accommodation for patients discharged from acute and rehabilitative care. This is particularly the case in Peterborough. The development of these and other community (non-health) recovery-oriented services will be important in ensuring the sustainability of this clinical model.

Stakeholder engagement and agreement

The evidence suggests a well-conducted, extensive and inclusive pre-consultation and engagement of important stakeholders in the pre-consultation. The pivotal and catalytic role played by emerging GP commissioners was acknowledged widely, and the positive and knowledgeable engagement of the LINk and OSCs was obvious and welcome. Although we did not meet with patients, there is evidence of their significant input into the plans as they have been developed.

Impact on populations

Health inequalities

The OSC expressed concern around access to MH care, especially in Fenland. These plans in general improve access for patients seen in primary care or by other referral agencies, but the Trust and its partners may need to consider specifically how access is improved for those who are geographically and perhaps socially isolated, and who may not seek health advice at all.

Health of population

Interventions that have shown improvement in general population mental health are generally based in primary care, and this is a compelling supporting argument for the Trust strategy of developing close links with primary care clinicians and services.

Conclusions

1. These are an excellent set of clinical proposals, which reflect international best practice and undoubtedly meet the criterion for a sound clinical case for change.
2. There is every indication that the Trust management and leadership is of high quality, and is able successfully to deliver this well-planned project.
3. The degree of collaboration between Trust, commissioners and GPs, and active engagement of other stakeholders is exemplary.
4. The plans would benefit, and patient choice be increased, by inclusion of other, particularly non-statutory, providers within the pathways, particularly those appertaining to recovery and rehabilitation.
5. The general hospital liaison function of crisis teams should be developed and marketed by the MHT to the acute Trusts, with support from commissioners.
6. Following a review of modelling assumptions, the consultation should include the possibility of future reductions in the bed base, which are highly likely to result from successful implementation of this strategy.
7. The move towards lifespan rather than age-boundaried services is to be encouraged, as it is likely to improve early intervention, seamless and consistent care throughout the age range. This may require commissioners to work outside their traditional age-boundaried commissioning silos.

Recommendations

1. Subject to the above, this case is ready to go to full public consultation.
2. The closure of Acer ward, strengthening of the local HTT, and relocation of the beds to the Cavell Centre should be expedited on the grounds of clinical safety, and should not await the consultation.

Document history:

1st Draft: 2nd September
Factual accuracy comments from commissioners and provider: 5-8th September
Final version: 8th Sept

Pete Sudbury

Version number: Final

Date of issue to SRO: 30/09/2011

SRO: Cathy Mitchell

Organisation: NHS Cambridgeshire, NHS Peterborough

Health Gateway Review dates: 28/09/2011 to 30/09/2011

Health Gateway Review Team Leader:
Paul Passemard

Health Gateway Review Team Members:
Michael Biddle
Pam Coen
Stephanie Finch

Background

The aims of the Programme:

NHS Cambridgeshire (NHSC), NHS Peterborough (NHSP) and the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) are planning to consult on a range of proposed changes to the ways in which adult and older people's mental health services are provided locally.

A radical re-design or ''transformation'' of local care pathways during the next three years is proposed. The proposals will radically change the way mental health services are provided, bringing the focus on community rather than hospital services, an emphasis on early intervention and simplification of pathways that are currently complicated, as well as ensuring all services work to the highest standards.

The driving force for the programme:

There is evidence from patient feedback, local GP experience and the results of recent external inspections that current pathways may not be addressing local needs as responsively as they might.

Furthermore, in common with the rest of the NHS, all three organisations face significant challenges to deliver efficiency savings during the next three years.

Benchmarking exercises carried out by the East of England Strategic Health Authority in 2010 showed:-

- 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.
- The number of rehabilitation beds locally is more than double the national average.
- 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.
- The amount spent locally on community-based mental health services is relatively high.

Current position regarding Health Gateway Reviews:

This is the first Gateway Review of this programme.

Purposes and conduct of the Health Gateway Review

The primary purpose of this Health Gateway Review 0: Strategic Assessment is to assess the readiness of the programme to proceed to public consultation and the robustness of the arrangements to manage this.
Appendix A gives the additional and full purposes statement for a Health Gateway Review 0.

This Health Gateway Review was carried out from 28/09/2011 to 30/09/2011 in Peterborough and Cambridge. The team members are listed on the front cover.
The people interviewed are listed in Appendix B.
The Review Team would like to thank the Programme Team and everyone they met during the course of the review for their support and openness, which contributed to the review team's understanding of the programme and the outcome of this review.

Delivery Confidence Assessment

Our Delivery Confidence Assessment for the ability of NHSC and NHSP to produce a timely, robust and persuasive consultation is **Amber/Green**
We consider that the draft consultation document seen by the Review Team and the other preparations described to us for the consultation require limited further work in order to achieve a successful outcome.
Remaining actions proposed include some editing of the document and briefing of the individuals responsible for fronting the public consultation.
The delivery confidence assessment status should use the definitions below.

Colour	Criteria Description
G	Successful delivery of the project/programme appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery significantly
A G	Successful delivery appears likely. However attention will be needed to ensure risks do not materialise into major issues threatening delivery
A	Successful delivery appears feasible but issues require management attention. The issues appear resolvable at this stage of the programme/project if addressed promptly.
A R	Successful delivery of the project/programme is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed.
R	Successful delivery of the project/programme appears to be unachievable. There are major issues on project/programme definition, schedule, budget, required quality or benefits delivery, which at this stage do not appear to be manageable or resolvable. The project/ programme may need re-base lining and/or overall viability re-assessed

A summary of recommendations can be found in Appendix C.

Findings and Recommendations

1: Policy and business context / business case and stakeholders

The drivers for this Programme include the local need for mental health services to work more effectively, to meet projected demand and the national imperative for CPFT to make £14m of QIPP savings over the next three years. The proposals are generally in line with the national context and guidance. The National Clinical Advisory Team [NCAT] have reviewed the services and proposals in Peterborough and endorsed the strategic and clinical direction planned.
CPFT has two main commissioners, which some stakeholders perceived raised issues of equity and access between the two areas. Recently the NHSC and NHSP have been working closely on this programme, which is a positive development. The two areas have GPs who are actively involved in commissioning, and there is good GP leadership for both adult and older people's mental health.

Business Case and Stakeholders

While the above drivers and the overall proposals were well understood by the stakeholders we interviewed, they are less well reflected in the documentation we were given. The Joint Commissioning Strategies for both adults and older people are being reviewed and therefore there is no over-arching strategy within which these proposals fit. We understand that this work is planned and we would support completion as soon as possible. Additionally, there is no programme initiation document (PID) or business case for this programme; however we recognise that the proposals form part of the wider QIPP savings programme.
The only documents provided to us, setting out the changes, were the drafts of the full and shortened consultation documents. In the absence of a business case, we found it initially difficult to get a picture of the affordability of the proposals but the Foundation Trust was able to articulate for us the development of the proposals and the projected costings. The aim is to save £14m. Savings will come from various areas, including estate costs, reductions in posts, and changes in skill mix.
CPFT is confident that the savings are achievable and that the costs of the re-designed services are affordable. There is a belief that CPFT can deliver the savings required but some stakeholders do need to be re-assured that while significant savings have to be made and posts lost, the promised improvements to services in the community can also be delivered. This is particularly critical for the consultation. While the detail of how the savings break down might not need to be included in the consultation document, the key people presenting the proposals need to speak confidently about how costs have been arrived at and that they will fund the improvements proposed.
Engagement with the Overview and Scrutiny Committees has been strong and positive and there are plans to have joint working with the two committees on this mental health service change. .

In terms of further stakeholder engagement, there is scope to more strongly engage the Third Sector, as they have the potential to make a real contribution both to the consultation and the provision of services.
There is a draft communications and engagement plan with key stakeholders mapped and an impressive list of pre-engagement consultation activities. We noted that the mapping segments stakeholders into groups, including those who will be informed but not consulted. This mapping needs to be confirmed as there appear to be some anomalies.

2: Management of intended outcomes / programme and project management arrangements

The consultation for the redesign of the mental health services is led by NHSP and NHSC, as the commissioners and statutory bodies responsible for public consultation on health service change proposals. CPFT, as provider of the services, has worked up the detail of the proposals and is providing support to the commissioning bodies.
Overall programme management arrangements for co-ordination between the organisations are generally informal and dependent on a few key individuals. Those working across Cambridgeshire and Peterborough face, a particularly heavy workload in the final run up to the start of consultation and there would be merit in using more of the resources that appear to be available in CPFT to support this work.
A number of fora, across and within the three organisations, including a Mental Health Consultation Steering Group, the GP Mental Health Leads Meeting, the NHS Cambridgeshire GP Senate, NHS Peterborough GP Sub Committee, as well as various project boards and the statutory governance boards, all have an overview of progress of the programme. While this plethora of bodies has promoted engagement, communication and buy-in, the decision making processes for progressing the consultation are unclear. There would be benefit in clarifying the roles, responsibilities and interfaces between the various bodies in a single document. There may well be opportunities for streamlining /reducing the number of bodies and the amount of time demanded from attendees at their meetings.
Project and programme management arrangements within CPFT appear more structured and able to satisfactorily support the preparations for consultation, the consultation itself and the subsequent delivery and realisation of the benefits of the proposed changes.

Recommendation 1:
The programme should review and clarify the governance arrangements.

The programme has recently developed a draft risk register for the consultation and the subsequent delivery phase. As it currently stands the risk register only identifies some of the risks that could affect the programme and the risk mitigation and management process does not appear to be robust.
The risks that affect each and all three organisations need to be identified and the interfaces and dependencies between them need to be defined and managed.

Recommendation 2:
The programme should ensure that all three organisations implement a robust risk management process covering the consultation process and implementation of the changes.

3: Review of current phase / readiness to go to consultation

The NHSP and NHSC as a result of their pre-consultation process have two well-developed versions of their consultation document; one describing the detail of the proposed changes to the affected services and one at a higher level for more general consumption.
There has been an NCAT review of the proposals which was very supportive and recommends some limited further work which needs to be finalised.
There was a general concern amongst stakeholders that the consultation document does not provide convincing evidence that there will be sufficient resources in the community to deliver improvements to the pathways for both the acute and older people's services in the context of a planned reduction of c.£7m in community services.
For older people's services we were told that the proposed bed closures have already been undertaken, albeit on a temporary basis. It was reported that as part of the response

to the National Dementia Strategy the changes to the clinical pathway in community settings have been put in place, in conjunction with General Practice, and are working. This should be verified and included in the consultation document.
We were also told that in relation to the adult acute services there are proposals to restructure and improve both the efficiency and service delivery of the clinical pathway. It is proposed that the staffing resources released from the bed reductions will be redeployed to improve the staffing levels in the Assessment Team and the Crisis Team. This will streamline the assessment process and improve the Home Treatment Service. In addition we were advised that it is planned to bolster the staffing levels on the wards and reduce the number of patients on the wards to improve therapeutic activity and reduce average length of stay. Again this needs to be verified and included as the context to the bed reductions and financial savings in the consultation document.
Currently the draft starts with significant financial savings and goes on to talk about the patient improvements; it may benefit from some re-ordering.
It may also be appropriate to include the role of the Local Authorities in achieving the changes.
There was no universal understanding of what response was expected from stakeholders and the public. This needs to be clear in the final document.

We believe that inclusion of the above and some re-ordering of the detail would improve the flow of the document and allay the concerns of stakeholders. When this has been done, the programme should take a view on whether the currently planned consultation start date can be achieved.

Recommendation3:
The Programme should review and edit the draft consultation documents to include the proposed pathway changes as a context to the bed reductions and the financial implications.

We did not find clarity on the scope of the consultation, for example, the title covers the whole of mental health service and yet there is only a limited section on children's services and nothing on other elements of the service. We feel that this limited, apparent extension to the scope may well confuse the prime thrust of the consultation, which in the main relates to services for adults and older people.

Recommendation 4:
Review the scope of the consultation and consider revising its title to make it explicit and remove superfluous material.

4: Readiness for the next phase/running the consultation and implementation

In preparation for signing off the final consultation document there is now a requirement to plan for the consultation process. We heard that this will involve a series of stakeholder meetings and events throughout the area and this will need to be captured in a detailed communications plan.
There is now also a requirement to ensure clarity on the key corporate messages and to prepare the relevant leaders to deliver them effectively. Although commissioning leads can clearly articulate the vision and benefits of the new model of care, they were less able to explain where the savings would be made, particularly how c.£7m will be saved from community services. It will be important to ensure that this is addressed and to explain where there is scope for efficiencies in the current system e.g. too many beds, too many

people with stable conditions retained long term by mental health teams and increasing the effectiveness of crisis teams etc.
We strongly support the plans to articulate the key corporate messages and brief staff to deliver them effectively.
NHSC & NHSP have successfully supported the development of GP mental health commissioning capability and there are arrangements in place across the patch, with identified mental health leads and a specialist area lead for the main patient groups. There is evidence of excellent team working coordinated through the GP Senate.

As well as making significant financial savings, the programme aims to achieve an improved, high quality patient-focused service. Although there is little doubt that CPFT will deliver the savings required there would be benefits in the new Commissioners strengthening performance management to ensure that the changes are delivered in accordance with their requirements. Commissioners should identify some simple metrics (key performance indicators) for gaining assurance on the programme linked to CPFT's programme plan and consider the mechanisms for performance management. One such mechanism for this would be the development and use of a benefits realisation plan. This would enable Commissioners to focus on the achievement of quality outcomes rather than mainly numerical and financial savings.

Recommendation 5:
NHSC and NHSP to confirm KPIs and a benefits realisation plan, with measurable milestones, for the delivery of the transformation programme and the structure for managing performance.

The programme should consider the benefits of a Gateway Review, in early 2012, after completion of the consultation process, to assess the robustness of the delivery arrangements.

APPENDIX A

Purposes of Health Gateway Project Review 0: Strategic assessment

- Review the outcomes and objectives for the programme (and the way they fit together) and confirm that they make the necessary contribution to the overall strategy of the organisation and its senior management.
- Ensure that the programme is supported by key stakeholders.
- Confirm that the programme's potential to succeed has been considered in the wider context of the organisation's delivery plans and change programmes, and any interdependencies with other programmes or projects in the organisation's portfolio and, where relevant, those of other organisations.
- Review the arrangements for leading, managing and monitoring the programme as a whole and the links to individual parts of it (e.g. to any existing projects in the programme's portfolio).

- Review the arrangements for identifying and managing the main programme risks (and the individual project risks), including external risks such as changing business priorities.
- Check that provision for financial and other resources has been made for the programme (initially identified at programme initiation and committed later) and that plans for the work to be done through to the next stage are realistic, properly resourced with sufficient people of appropriate experience, and authorised.
- After the initial review, check progress against plans and the expected achievement of outcomes.
- Check that there is engagement with the market as appropriate on the feasibility of achieving the required outcome.
- Where relevant, check that the programme takes account of joining up with other programmes, internal and external.

APPENDIX B

Interviewees

Name	Role
John Ellis	Head of Mental Health Commissioning
Adele McCormack	Service User Engagement Worker Cambridgeshire
Dr Asif Zia	Clinical Director, Specialist Services
Dr Sohrab Panday	GP Mental Health Lead
Dr Mike Caskey	NHS Peterborough Board
Claire Rintoul	Chief Executive, Peterborough and Fenland MIND
Barbara Cork	Peterborough LINK
Dense Radley	Director of Adult Social Services, NHS Peterborough and Peterborough City Council
Cllr Brian Rush	Chair of Peterborough CC Health Scrutiny Committee
Cathy Mitchell	Director of Integrated Commissioning, NHS Cambridge and NHS Peterborough and SRO
Sue Last	Assistant Director of Patient Experience and Public Engagement, NHS C and NHS P
Dr Emma Tiffin	GP Mental Health Lead
Annette Newton	Director of Operations CPFT
Elaine Bailey	Associate Director, People Services, CPFT
Keith Spencer	Director of People and Business

	Development, CPFT
Jane Belman,	Scrutiny and Improvement Officer, Cambridgeshire County Council
Cllr Kevin Reynolds, Cllr Gail Kenny	Cambridgeshire County Council
Janet Feary,	Cambridgeshire LinK
Dr Caroline Lea Cox	GP Mental Health Lead, CATCH
Dr Susan Welsh	Clinical Director, Older People, CPFT
Dr Manaan Kar-Ray	Clinical Director, Adults, CPFT
Dr Krishna Singh	Clinical Director, Primary Care Services. CPFT
Jenny Raine	Chief Executive, CPFT
David Frampton	Mental health Commissioning Manager, CCC
Paul Millard	Clinical Director, Children's Services, CPFT
Dr Tom Dening	Medical Director, CPFT

APPENDIX C

Summary of recommendations

The suggested timing for implementation of recommendations is as follows:-

Do Now – **To increase the likelihood of a successful outcome it is of the greatest importance that the programme/project should take action immediately.**

Do By – To increase the likelihood of a successful outcome the programme/project should take action by the date defined.

Ref. No.	**Recommendation**	**Timing**
1.	The programme should review and clarify the governance arrangements.	Do by end 2011
2.	The programme should ensure that all three organisations implement a robust risk management process covering the consultation process and implementation of the changes.	Do now
3.	The programme should review and edit the draft consultation documents to include the proposed pathway changes as a context to the bed reductions and the financial implications.	Do now
4.	Review the scope of the consultation and consider revising its title to make it explicit and remove superfluous material.	Do now

5.	NHSC and NHSP to confirm KPIs and a benefits realisation plan, with measurable milestones, for the delivery of the transformation programme and the structure for managing performance.	Do by end 2011

APPENDIX 2 – DISTRIBUTION LIST

The consultation document was distributed to the following organisations and individuals:

Organisation	Method
MPS	
Andrew Lansley CBE MP	Email
James Paice MP	Email
Shailesh Vara MP	Email
Stephen Barclay MP	Email
Julian Huppert	Email
District Councils	Email
Cambridgeshire County Council Chairman of the Council	Email
Cambridgeshire County Council Vice Chairman of Council	Email
South Cambs Council Chairman	Email
South Cambs Council Leader	Email
South Cambs Vice Chairman	Email
Huntingdonshire District Council Executive Leader	Email
Hunts District Council Deputy Leader of the Council	Email
Hunts District Council Chairman	Email
Hunts District Council Vice Chairman	Email
Fenland District Council Vice Chairman	Email
Fenland District Council Chairman	Email
Fenland District Council Leader of the Council	Email
Fenland District Council Dept Leader	Email
Peterborough City Council Leader	Email
Hunts District Council Exec leader	Email
Hunts Dept Leader of the Council	Email
Hunts District Council Chairman	Email
Cambridgeshire County Council CE	Email
Cambridgeshire and Peterborough Overview and Scrutiny Committees	Email
Cambridgeshire and Peterborough Local Involvement Networks	Email

Cambs ACRE	Email
Vol orgs	Email
Huntingdon CVS	Email
Cambridge CVS	Email
St Neots Volunteer Bureau	Email
Ramsey and Warboys volunteer bureau	Email
C3sa	Email
Other orgs	Email
MENTER (ethnic minorities)	Email and post
CECF - Cambridge Ethnic Community Forum	Email and post
COPRG	Email
Care Network	Email
Hunts Patients Congress	Email
COPE Cambridgeshire	Email
Diversity Forum Huntingdonshire	Email
Care Network	Email
West Anglia Crossroads - Caring for Carers	Email
Crossroads Care Cambridgeshire	Email
The Carers Support Manager	Email
The Carers Support Manager	Email
PEC	Email
Borderline Patients Forum	Email
Borderline Commissioning Cluster	Email
Hunts Care Partners	Email
Hunts Health	Email
LMC	Email
Age UK	Email
Age Concern Cambridgeshire	Email
Cambridgeshire County Council Carers Support Team	Email
CPFT and their members	Email
East of England Ambulance Trust	Post
All Cambridgeshire and Peterborough GP Practices	Post and email
All Cambridgeshire and Peterborough public libraries	Post
All Cambridgeshire and Peterborough Parish Councils	Email

NHS Cambridgeshire Customer panel mailing list	Email
NHS Peterborough Consultation Forum	Email and post
Hinchingbrooke Healthcare NHS Trust	Post
Cambridge University Hospital NHS Foundation Trust	Post
Cambridgeshire and Peterborough NHS Foundation Trust	E-mail
SHA	E-mail
Probation	E-mail
Cambridgeshire Community Services	E-mail
All local mental health groups (full list available on request)	E-mail
Addenbrookes	E-mail
Hinchingbrooke	E-mail
PSHFT	E-mail
Cambridgeshire Service User Network	E-mail
Peterborough Public Consultation Forum	E-mail
CPFT Associate Commissioners (full list available on request)	E-mail
Neighbouring NHS Organisations (full list available on request)	E-mail
Voluntary Organisations	
Hunts MIND	E-mail
Cam MIND	E-mail
CIAS	E-mail
Peterborough and Fenland MIND	E-mail
Lifecraft	E-mail
Age Concern	E-mail
Alzheimer's Society	E-mail
CVS- Hunts	E-mail
CVS- Fenland	E-mail
Peterborough CVS	E-mail
Cambridge ethnic community forum	E-mail
Diversity Forum Huntingdonshire	E-mail
Rethink	E-mail
Making Space	E-mail
Carers Project Group	E-mail

APPENDIX 3 – MINUTES OF MEETINGS WITH GROUPS AND ORGANISATIONS

Meeting with representatives from Family and Friends of people with BPD Friday 11 November 2011 Meadows Community Centre, Cambridge	
Comment/Issue/Question	**Response**
People feel crisis handling is not good	
Importance of easy access back into secondary care if a crisis occurs	
Will there be sufficient seniority and decision making at the BIAC	BIAC will be staffed by existing professionals who are currently staffing the 59 current access points to the service
Issue of how you stay attached to the service for as long as you've got BPD (20-30yrs or life). How you come back into the service if you haven't needed it for a while, such as at a time of crisis	
What other support will there be when carers support is absent	
Pathway for someone with BPD presenting in the run up to a crisis	At the moment it is the GP who'd refer on. With the redesigned service, you'd phone the BIAC. Focus would be to prevent an admission.
Experiences with Huntingdonshire crisis team is bad because they're short staffed	
Cambridge Crisis Team decision making is short sighted, they talk to the patient and not the carer.	
There is a gap – there needs to be something to get someone over a crisis for longer than their currently is.	
Better training in PD is needed for community teams	
Ongoing support. Preventative ongoing therapeutic support is needed after crisis.	The primary care mental health team has been doing some work on this.
Concern over transition from acute service to supported accommodation. Community support teams are unable to support those as their needs are so great. There is no specialist follow up support which leads to people ending up back in the acute service.	
Comment: difficulty accessing the service. GPs are blocking access to the service as they don't recognise symptoms. GP practice is quite uneven with some GPs better than others. Need GPs to undertake training in PD.	The BIAC will be an extra resource. A GP can call them and the BIAC will pick up symptoms as will Primary Care Mental Health teams aligned with surgeries

Meeting with Police
6th December 2011, Chord Business Park, Godmanchester

Comment/Issue/Question

Key elements which need to be considered in the mental health consultation for the police service are as follows;

1. Creating links between the ABiC and the MARU (the design group to include the MARU and Custody inspector)
2. Access from custody suites and the ability for assessment
3. Access for front line staff to call the ABiC
4. Early diversion pathways
5. Strong links with probation
6. Input into risk assessments undertaken by the police

Support for officers when using MHA and MCA

Meeting with Cogwheel
7th December 2011, Tribunal Room, Newtown Centre

Key elements which need to be considered in the mental health consultation;

1. Cogwheel welcomed the opportunity to link closer with CPFT via the ABiC
2. More information on how to become an 'accredited' Provider for the ABiC would be welcomed.
3. Highlighted the needs of children and young people and the high risk nature of this population.

Stakeholder meeting
12th December 2011, Elizabeth House, Fulbourn
Attendees: MDF Cambridge, Arts and Minds, Friends of Fulbourn Hospital, Age UK, Lifecraft, Cam MIND, Rethink

Concerns/Questions/Issues

1. More information on the distribution of savings would be appreciated. There was more detail in the longer "case for change" document.
2. The consultation paper reads as if it is assumed that non-statutory services will expand in response to the reduction in NHS provision of mental health services even though there are no funding opportunities.

3. There appear to be a lot of people being discharged from secondary care services to their GPs without appropriate support in place. This is causing a lot of distress, there needs to be information provided about local services when this happens.
4. The concept of the ABIC is strongly supported however it needs to; a. Have prompt access for people who have been discharged from secondary care to their GP who have a crisis b. Strong engagement with voluntary organisations
5. Ideally there would be more staff, more training and more services; however there is understanding that local mental health services are “only” being asked to deliver the minimum savings required of all NHS service providers.
6. As voluntary organisations there is a need to protect us from similar cuts as we are unlike statutory organisations. No promised could be made about this given the overall PCT funding situation.
7. There needs to be transparency of service provision with clear access criteria and thresholds for different services. This will be reflected in revised service specifications for the new service models if these are implemented.
8. The document does not mention the impact of changes in local demography, has this been considered in these proposals? The proposals recognise the impact of population growth, but there are no additional resources available and in effect this is a further efficiency challenge for the local services.
9. CBT cannot be relied on for all service users and conditions. The need for a wider range of therapies and other interventions to be offered is acknowledged and the choice has widened in the years since IAPT was first implemented.

Meeting with Friends and Family of Borderline Personality Disorder (BPD) Support Group,
21 December 2011
Springbank Ward, Fulbourn Hospital
Number of attendees: 16

Comment/Issue/Question	**Response**
Supportive of the idea of a single point of access, however, if the system works well with referral though the single point of access you may be faced with significantly greater demand with people actually wanting to use the service.	
Will you have to deliver services with the same number of staff	Yes
Personality Disorder is not covered in the consultation document – it’s seen as part of the general system and unfortunately the general system has difficulty dealing with it.	This was an unintentional exclusion and any suggestions on how BPD could be better dealt with would be welcomed
Third sector needs to be developed to provide expertise and support for those having crisis. Transition of patient moving from inpatient care to home is when people come into difficulties and may fall into crisis and need to go back into hospital. Agencies such as local authorities are too risk averse and carers are currently fulfilling the role, but carers won’t be around forever (ageing parents etc). The Third Sector needs to grow and help fill this gap, so there is not so much reliance on carers. Good examples of	

this work are Cover and Pringles.	
The model is very good but outside of CPFT there is no support. Carers know the Third Sector don't have enough resource to provide the support and demand for support will grow as well.	
The 8 beds on Springbank ward are very welcome. How was the decision that 8 beds was enough, made and has whether 8 beds is now enough been assessed?	This is all done in line with national guidance – beds per capita of population
Experience of equality of service is not great – Springbank is 8 beds for women only but the attendee has a son with acute needs and is either treated on an acute ward where the experience is terrible or sent out of county which is also not ideal.	
Support from mental health services has not been great and interventions have been unhelpful as Borderline Personality Disorder (BPD) was not diagnosed from the outset. Raising awareness of BPD across the service would be cost effective, including more training for specialists and GPs. Time for diagnosis of BPD is very lengthy (a matter of years).	
Experience of psychiatric wards bad as they're not well equipped for dealing with Personality Disorder.	
A less clinical approach is needed when dealing with families and patients. Language used by staff is too clinical.	
Self-harm and suicide need to be taken into account for BPD patients, including when admitted to an acute ward. Approach to the threat of suicide on acute wards is not taken seriously and needs to be. This needs to apply to agency care stuff as well. Acute wards include all wards, not just mental health wards.	
Need to be able to gain access back into the service easily if you reach a crisis point, and be able to be blue lighted back into the service. Also need someone to be able to do something for you 24/7. Also need to click in with other services such as Police.	
Experience of rudeness from emergency services, accusing patients and families of being time wasting	
Need to give the carer more status	
Student carers find it hard to get placements with the NHS, which only seems to accept PHD level students. These other students could really bump up the workforce.	
How will members of the public be informed of the ABIC number?	Marketing/Communications campaign to advertise the service
Counselling services need to be increased – would help with diagnosis. GP could also speak to the councillor about the patient	Looking at options to increase counselling services to make them more equitable. The Advice and Brief Intervention Centre will help as a port of call for GPs to get advice.
A mechanism to help move the process on and get other people involved in discussions would be helpful – a trigger card for instance – if you answer 'yes' to something, this may alert services to something else e.g. if someone comes in suicidal, that raises an alert that someone could have PD	
When will the Advice and Brief Intervention Centre happen	1st phase June/July 2012 in Peterborough for referral management and then it'll be rolled out across the county over the year

Counsellors for carers need to be available for a longer period of time – currently only offered for 6 weeks.	
Need a central point of information (such as website for the Intervention Centre) so people can find out about all the services available – currently service users are very ill informed of what is available out there.	
Support for carers is needed. This is not provided within CPFT. Carers need information and support so they can care better. If this is given then perhaps the burden on the service will be less.	
Individual care planning is needed, during which the carer will be trained.	
It would be good if carers could go into treatment sessions with patients, so they can learn how to deal with them and situations.	
Carers need to be educated – perhaps a self-learning tool online or by dvd for example, which is made available to everyone.	
Staff at the Intervention Centre need to have sufficient expertise to be able to respond to a situation immediately. Seriousness of situations needs to be recognised and taken seriously – even experience of crisis teams is of them not dealing with actual crises well enough.	
Advice and Brief Intervention Centre needs to have lots of phone lines available so if you call it, the number is not engaged and you are not put on hold	
Very supportive of a single referral system, but this is a daunting task to implement	
Supportive of all principles, the only real worry is that BPD is not at the core of what we are doing and that it will continue to be treated as a specialist service.	
Other areas are looking at a BPD CWQUIN, has this been considered for Cambridgeshire	Not at present, and it is potentially too late for 11/12 but this could be looked at for 12/13.

Meeting with Patient Participation Group Representatives Lockton House 3 January 2012 18.00-19.30	
Comment/Issue/Question	**Response**
Who is going to be answering the phones at the Advice and Brief Intervention Centre?	It will be staffed by the current staff who deal with thousands of calls a week at 39 different access points. They will work on a rotational basis to cover 24/7
What sort of frontline help do you envisage to help people through the system. It would be a good idea at the launch of the service, to have plenty of information on how to use the system, sent out via mailshot and the media	Lots of information online to guide people through the services.
What type of phone number will it be?	Service users have said they want an 0800 number, so that is

	what it will be. People can get involved in developing the detail of how all this would work via an online forum, Huddle. (CW offered to invite all the attendees to join Huddle)
What mechanisms are in place to ensure the interface between the NHS and Councils works	Very close working relations with all the Councils to ensure that everything works and interfaces well, to ensure that the community elements, such as community housing, are in place.
What are the current occupancy rates of the wards?	These vary month on month. Occupancy rates have been reducing as people have been able to be supported in the community more. CW to circulate occupancy figures to the group.
What sort of feedback have you had from the voluntary and third sector?	They have a few concerns, such as that all calls may go to CPFT and they might not get any. Lots of discussions are going on at the moment between voluntary organisations and CPFT.
If more people will be treated in the community then the concern is there will be more demand on carers, which will lead to an increased need for respite care.	
Transport – looking for a real addressing of transport issues. It would be good to see support for travel.	We will look at lots of different options for support for travel, as was done with the Older People's Mental Health ward closures where money was put into community car schemes. Ideas would be very welcome.
Concern at emphasis on use of technology such as internet. This is good but the internet mustn't be relied upon as many do not use it and do not have access to it	Materials will be available in many different formats; we will not rely on the internet as we understand that this does not suit everyone.
With promotion of the Advice and Brief Intervention Centre, concern is that there will not be enough capacity to provide the support in the community. Would like to see appropriate community support, and the main area of development would be for transition.	
Outreach teams need to continue with on-going monitoring and be responsive to patients' or carers' calls.	
What provision is being made for those in the community with English as a second language?	Currently, if there is a language barrier we have a contract with Cintra for translation services. Some of our therapists speak other languages and are brought in where needed and where possible. This is an issue we have in particular in Peterborough, and we'll be looking at this closely with the Advice and Brief Intervention Centre
Need to think about how you alert people with a low command of English to the service available and how to provide reassurance when they make contact with the service.	

What happens when a patient acutely in danger of self-harm or harming others calls the service in crisis	For those known to the service they would be blue lighted directly into the service by the crisis team, or would have an acute admission. If they are not known to the service, mental health services would be informed and the crisis team would be taken to the individual or the individual would be taken to the Section 136 Unit at Fulbourn.
Why the 3:3:3 model?	It is based on other models which found 3:3:3 was the average length of stay. It's an idea to help shape service users' ideas, it's not a hard and fast rule set in stone and will be adjusted where appropriate.
Dementia is forecast to increase significantly over the next 10 years – concern about how demands will be met	Older People's Mental Health strategy is to be published soon, which explains how we intend to meet these demands. CW will be able to circulate this when published.
There is the expectation that patients will be accommodated in single rooms. This isn't the case on the Adrian House and Friends Ward at the moment	It should be the case and this will be looked into.
What happened to patients on Cobwebs?	They were moved to more appropriate wards at Fulbourn, or appropriately housed in community accommodation.
Comments received from attendee after the meeting	
Provision for adolescents is a worry. Provision for adolescents is still woeful. I don't have a developed view about integrating the teenage and adult eating disorders service, though in general teenagers do better with targeted services. I hope Centre 33 will continue to get funds for Mental Health outreach work. They had a very good service in Ely that was axed. Psychiatric support for the university and college counselling services seems much patchier now.	
The 'mild to moderate 'service has been skewed in a very unhelpful way by IAPT, pulling it into the currently preferred NHS –Nice guidelines CBT form, which suits anxiety and phobias very well and some depression but is really unhelpful for people with other more moderate to severe issues such as complicated grief, or who have issues of trust and early damage from abusive childhood experiences, for whom longer term or more intensive provision is important. In many areas of the country IAPT has included therapists of a variety of theoretical orientations, but I believe the Cambs and Peterborough services are CBT focused. The stepped care approach works best when a number of appropriate options are available. It also occurs to me that there was nothing about research / monitoring outcomes beyond the annual audit.	
Preventative work in general, and public health provision: There is nothing in the (consultation) document about parent -infant	

attachment services, for instance, which were being developed through the psychiatric services at Douglas house, I think, in liaison with health visitors and midwives, and have a dramatic preventative function.
I was concerned, and I saw you were aware of the issues, on the difficulty in the transition period of having the Advice and Brief intervention service not fully integrated and up and running till 2014. I know that's not your headache, but for users there will be hazards. Reliance on web technology, as you said is good for some genders and age groups and hopeless for others.
I am less in touch with inpatient services, but could see there are issues especially in managing transport for carers and users with proposed ward closures both to Fulbourn and from Huntingdon.

Probation Services meeting **4 January 2012, Godwin House, George Street, Huntingdon**
Comment/Issue/Question
ABIC a. Probation access to this service would be greatly appreciated when in contact with an individual who needs support due to public protection b. There would need to be robust information sharing protocols in place to support the service user which is signed up to by all key organisations in advance c. Training would be welcomed to the Probation service as to how best to use this service d. The advice needs to be clear and not bureaucratic, i.e. not just signposting e. A single assessment and discussion will be key
It would be helpful to have the new service mapped against the offender journey and what options are available at each stage as currently there is a gap in custody and court appearances. What would be required would be information, advice and assessment. This could be undertaken at the next Bradley Group (the multiagency stakeholder group tasked with implementing the National Bradley Report which aims to improve access to services for individuals in the criminal justice pathway with learning disabilities of mental health problems) with work looking at other areas and how these interventions are financed.
Access to mental health treatment requirements across the patch would benefit the team and service users
It would be helpful to have referral thresholds to be shared across agencies to understand who it is and is not appropriate to refer to mental health services

Could Improving Access to Psychological Therapies (IAPT) be widened to see individuals in the forensic pathway and in custody, or if Probation could just refer directly into IAPT?
There remains problems with clients with dual diagnosis, if this redesign could promote shared working that would be great
Currently there is no Multi Agency Public Protection Arrangements (MAPPA) 3 service, can these redesign proposals meet this need?

Meeting with Attention Deficit Hyperactivity Disorder (ADHD) Group **9th January 2012, Mount Pleasant House, Cambridge**
John Ellis presented the proposals, discussion and questions followed
Key elements which need to be considered in the mental health consultation for the service users with ADHD and Attention Deficit Disorder (ADD) are as follows;
There needs to be a clear and defined pathway for adults with ADHD with particular attention to the transition age between childhood to adulthood. a. A nurse led clinic could address some of these issues b. Potential for GPSIs
The document refers to life course pathways as being aspirational but more emphasis needs to be given to this as currently adults with ADHD and ADD have no service.
ABIC is a welcomed idea; a. It could potentially help in identifying the current unknown need for information, advice and services for adults with ADHD and ADD. b. It must hold accredited information about the whole life course of different conditions and not just be a signposting site. c. It would be great to develop documents on ‘what to expect as a patient’ d. Interactive Products is a set of Government approved guidelines to ensure services are compliant and accessible to

everyone; it would be good to use these to ensure the service does not exclude anyone. e. Alfred Alf and Your Life, Your Choice are great examples of websites and should be looked at when developing the ABIC f. The information on website needs to be accurate, the group would be happy to support the team in the development of information about ADHD and ADD.
GPs require training about adult ADHD and ADD as practice is inconsistent. The group would be very happy in helping facilitate this.
Acer Ward will cost a lot of money to renovate but why has it not been maintained so this renovation is not required. Answer: maintenance was undertaken however the CQC guidance changes constantly with new evidence, research and government guidelines and unfortunately the work we have undertaken has not been enough.
People in St Neots should be able to choose if they want to go to Peterborough or Cambridge for an acute admission, as Cambridge is closer and has better transportation routes.
IAPT should be accessible to adults with ADHD, but staff need to be trained in making CBT applicable to this client group. The group would be very happy to help with the development of this training.
Drug prescribing needs to be consistent and accessible, the Group has contacted the Joint Prescribing Group to understand the double red classification on of the ADHD drugs has been given but no response has been received. A FOI will be submitted.

Meeting with the Richmond Fellowship **10th January 2012, Richmond Fellowship Offices, Peterborough**
The main points raised during the presentation and discussion were:-
There needs to be prior discussions with agencies that the Advice and Brief Intervention Centre (ABIC) might refer clients on to in order to ensure they have the capacity to offer appropriate help promptly.
There need to be arrangements within the ABIC to monitor patients who don't neatly "fit" a single local pathway to ensure they don't just fall out of the system.
The ABIC needs to offer a menu or choice of options for service users.
The culture of the new service should be to dismantle barriers to access; this is better for the patient and more cost-effective for the

service longer-term. Services should treat the "whole person" in a holistic manner.
The earlier people can receive help with their problems the better.
It is essential that the ABIC is easily and directly accessible to service users.
A wider range of supported housing options is needed in Peterborough to enable the reduction in rehab beds to be safely implemented.
The new service model should seek to widen the range of opportunities and support for social inclusion of service users as part of the recovery model.
We would like to be invited to events organised to develop how the ABIC might operate.
We are pleased that carers and service users will be able to directly access help via the ABIC rather than having to go via their GP.
It will help improve physical health if more service users are managed in primary care.
The information in the ABIC needs to be properly validated and locally-sensitive.
Transport is a very difficult problem for carers in rural areas.

MINUTES RECORDED BY HUNTINGDONSHIRE DISTRICT COUNCIL OF THE 7 FEBRUARY HUNTINGDONSHIRE DISTRICT COUNCIL OVERVIEW AND SCRUTINY COMMITTEE (SOCIAL WELLBEING) MEETING:
MINUTES of the meeting of the OVERVIEW AND SCRUTINY PANEL (SOCIAL WELL-BEING) held in Civic Suite 0.1A, Pathfinder House, St Mary's Street, Huntingdon, PE29 3TN on Tuesday, 7 February 2012.
PRESENT: Councillor S J Criswell – Chairman. Councillors S Akthar, K M Baker, I C Bates, J J Dutton, S M Van De Kerkhove, Mrs D C Reynolds and R J West. Mrs M Nicholas – Co-opted Member. **APOLOGIES:** Apologies for absence from the meeting were submitted on behalf of Councillors Mrs J A Dew and Mrs P A Jordan and Mr R Coxhead.
90. MINUTES
The Minutes of the meeting of the Panel held on 3rd January 2012 were approved as a correct record and signed by the Chairman.
91. MEMBERS' INTERESTS

Councillor J J Dutton declared a personal interest in Minute No. 93 by virtue of being a Member of Cambridgeshire County Council.

92. LOCAL GOVERNMENT ACT 2000: FORWARD PLAN

The Panel considered and noted the current Forward Plan of Key Decisions (a copy of which is appended in the Minute Book) which had been prepared by the Executive Leader of the Council for the period 1st February to 31st May 2012.

93. NHS CONSULTATION: PROPOSED REDESIGN OF MENTAL HEALTH SERVICES ACROSS CAMBRIDGESHIRE AND PETERBOROUGH

(Ms A Newton, Director of Operations and Ms C Mitchell, Director of Integrated Commissioning for Cambridgeshire and Peterborough NHS Foundation Trust and Ms C Warner, Commissioning Service Improvement Manager for Mental Health, were in attendance for consideration of this item).

Pursuant to Minute No. 11/79, the Panel received a presentation from Ms A Newton and Ms C Mitchell, Director of Operations and Director of Integrated Commissioning for Cambridgeshire and Peterborough NHS Foundation Trust respectively, on the way the provision of mental health services had change in the last 30 years, the clinical rationale for the closure of Acer Ward, the availability of acute care services and the decision made by NHS Cambridgeshire to relocate the Crisis Resolution Home Team back in Huntingdon. Responses to each of the points made by the Panel in its first submission on the consultation on the Proposed Redesign of Mental Health Services across Cambridgeshire and Peterborough were also provided.

The Chairman reminded Members that since the previous meeting, NHS Cambridgeshire representatives had attended a briefing session for all Members on the proposals, which took place on 1st February 2012. He indicated that he had also met with Circle Healthcare, NHS Cambridgeshire representatives and the Executive Councillor for Healthy and Active Communities to discuss options to preserve the mental health facility at Hinchingbrooke Hospital. Circle had confirmed that they would be submitting their own response to the consultation but that this would have an operational orientation intended to ensure that robust arrangements would be in place at the Hospital to deal with mental health patients.

The Chairman reported that he had received feedback from patients who had utilised the mental health facility in Peterborough. He outlined the experiences which had been reported to him relating to the poor quality of food, the lack of continuity of care with staff and the fact that the ward accommodated both drug and alcohol abuse patients and patients diagnosed with clinical depression. The latter was of particular concern to Members in light of the fact that those requiring intense treatment often made other patients feel at unease thereby delaying their rehabilitation.

The Panel asked a number of questions and made a series of comments on the cost of improvement works at Acer Ward in comparison

to the projected cost of upgrading the Cambridge facility, the travel and associated cost implications of the proposals for patients and their families and friends, the need for clarity regarding the Hospital transportation system, the impact on the service of population projections for its entire catchment which included neighbouring Counties and the methods employed by NHS Cambridgeshire to deliver assurances to residents about the proposed changes. A suggestion was made that an acute unit should be co-located alongside the Crisis Resolution Home Team. Other matters that were discussed included whether transitional arrangements would be in place if the proposals were accepted by the NHS Board, the availability of supported housing and how outcomes would be monitored in the future.

On the basis of their discussions, the Panel unanimously expressed the view that the case for the closure of Acer Ward had not been justified. Members reiterated the view that an acute facility in Hinchingbrooke Hospital formed an integral part of the redesign of mental health services across Cambridgeshire and Peterborough. However, they expressed support for the proposals to strengthen and enhance the primary community services available to mental health patients, their carers and their families and, in particular, they welcomed the decision to relocate the Crisis Resolution Home Team back to Huntingdon. Should Acer Ward be formally closed, the Panel sought assurances that a budget would be established on an ongoing basis to assist patients travelling to and from alternative Wards.

Having been informed that NHS Cambridgeshire had offered the Panel an opportunity to submit further comments on the proposals which would be incorporated within the full consultation summary report due to be presented to the NHS Board meeting on 28th March 2012, the Panel

RESOLVED
that NHS Cambridgeshire be formally notified of the Panel's additional views on the Proposed Redesign of Mental Health Services Across Cambridgeshire and Peterborough.

MINUTES OF THE ST IVES TOWN COUNCIL MEETING 8 FEBRUARY 2012. PLEASE NOTE THAT THESE ARE DRAFT MINUTES, TO BE AGREED ON 16 MARCH 2012.
MINUTES RECORDED BY ST IVES TOWN COUNCIL

CONSULTATION ON PROPOSED REDESIGN OF MENTAL HEALTH SERVICES ACROSS CAMBRIDGESHIRE AND PETERBOROUGH

Representatives from NHS Cambridgeshire and Cambridgeshire and Peterborough NHS Trust gave a presentation on the Re-design of Mental Health Services and addressed the queries raised by Members before the meeting.
In response to a query regarding the Crisis Intervention team and public concern regarding levels of service, Members were advised that the team had been split back out to Huntingdon and Peterborough bases on 1 February, which was already showing improvement in services.
The efforts to make units feel 'homely' were described in balance with meeting standards of dignity, privacy and safety.
Access to services was a concern. Members were advised that a patient would be admitted to a unit based on clinical need and that as the home-based service had improved, threshold for admittance had risen. It was confirmed that the Newtown Centre would remain open and be used for patient appointments.
A concern was raised that there is a lack of continuity in who a patient sees in the service. When a patient would have a mix of people to visit and when they might have one consistent person was outlined.
The view was offered that Hinchingbrooke Hospital should be used as a hub for Huntingdonshire patients. It was commented that local GPs support Hinchingbrooke fully but that they also want the best level of care for their patients.
It was acknowledged and accepted that changes in mental health provision impacts on prisons and prisoners.

APPENDIX 4 – MINUTES OF PUBLIC MEETINGS

Public meeting at Meadow's Centre, Cambridge **Friday 11 November 2011** **Approx 15 members of the public** **John Ellis, Claire Warner, Victoria Wallace, Keith Spencer (CPFT)** **John Ellis delivered a presentation on the proposals and then invited questions and discussion**	
Comment/Question/Issue	**Response**
If you visit a GP during the day, they have very little knowledge of mental health and out of hours have no knowledge; therefore people end up presenting at A&E. What happens when you turn up at A&E at Hinchingbrooke	The Liaison Service at Hinchingbrooke will still operate. If a person needs an admission they will go to Peterborough. There is no reduction in professionals at Hinchingbrooke
Are you going to increase homecare crisis teams for Huntingdonshire?	The community team will be strengthened for Huntingdonshire. It has already been reinforced following the closure of Acer
The document suggests the onus will be on relatives to take patients to Fulbourn or Peterborough.	This is not correct, the ambulance would take the patient
There will not be enough beds at hospitals for those needing an admission.	We actually have some empty beds since closure of Acer Ward. This is the first in a long time.
Comment regarding table on page 10 of public consultation document – Beds on Springbank Ward started in June this year.	
Comment – Feel very strongly about Cobwebs – it is a normal house in the centre of Cambridge. Patients will get on much better there than in Fulbourn.	
Cobwebs has not been barely used as has been suggested. Cobwebs is very popular and people there feel they're a member of the community. Patients at Cobwebs can integrate into the community such as by working in charity shops for example. They tend not to regress back onto the acute ward. Disgraceful that it is closing down before the consultation ends.	
Reason for closing Cobwebs is financial – it's an expensive property in central Cambridge	This is not about money, it's about the right setting for patients with long term mental health needs. This is about how thinking has changed regarding treatment and recovery. Patients will not be moved to Fulbourn instead of Cobwebs, they'll be moved to supported housing.
Important that mental health patients are not alone. If they're in the community they need to be properly supported.	

This is a one size fits all solution	This is not one size fits all, it'll be using a range of different resource
Cobwebs is a very valuable asset. It's a tried and tested way and it works. People in the house learn how to integrate with other people. It's a setting more like what they'll be going to when they return home	We have a range of arrangements in Cambridgeshire and Peterborough where packages are tailored individually to patients' needs.
Main concern is about recovery. To recover, people need very good support. Quality of input that people get is a main concern. It's worrying that we still have lots of GPs who have very little knowledge of mental health. We should role out mental health first aid training for primary care staff.	
Concern there'll be a lag between cutting services and putting the support services in place.	
Comment on the reputation of supported housing providers having a very large waiting list for supported housing and high demand that's not being met.	The Council has been looking at this issue
Thought needs to be given to how people with communication difficulties, such as autism, access the Brief Advice Intervention Centre. Autistic Society would be interested in being involved in the design of the centre	The detail is still being worked on as to the operating of the centre. We would look for alternative access and training staff in learning disabilities
More support for carers needed at home. Are we going to be able to put additional support into homes to support carers if more people are being treated at home?	Crisis teams have been strengthened and our aspiration is that carers will be more supported.
Comment on reduction of older people's beds	The number of dementia beds is not being reduced. Older people redesign is not about dementia.
Is there scope to increase dementia beds?	There may be greater use of care homes
In terms of consultation, what capacity is there to change things? Can we stop Cobwebs closing and reopen Acer?	People can make representations about anything; everything will be fed into a report for the NHS Cambridgeshire Board, which will inform their final decision. You are not wasting your time by making representations, no decision has been made.
Emphasis in Government Policy on shared decision making between patient and GP. How can that happen if GPs aren't up to speed on mental health.	There is a lot of training which GPs must attend. GPs should be able to deal with the issues presented to them in an appointment. We don't have GPs with Special Interests (GPSI's) in mental health. Prompter access to specialist advice through the BIAC will help a lot. CPFT run a GP education programme. Development of primary care mental health teams will help as well as this will

	mean GPs can build relationships with mental health professionals.
Comment that with restructuring of pathways, continuity of care goes out the window. People with mental health issues don't like change. When pathways are restructured the people don't see the same consultants	
Brief Advice and Intervention Centre (BIAC) will cost a lot of money to set up. Worry it'll fail like the national IT system (Lorenzo) did.	CPFT decided to implement its own IT system rather than Lorenzo. There are currently 59 staffed access points to mental health services. With the BIAC we're reducing this to a single access point and the staff in place at the current 59 access points will move to the BIAC. It will therefore be staffed by mental health professionals who will book service users into the system. There is a high degree of sign up to this within the organisation. BIAC will be implemented in a phased approach – it'll be road tested and then rolled out if it works
Comment regarding patient confidentiality and the BIAC – don't want to hit a barrier of confidentiality if carer/wife/husband calls on the patient's behalf, want to be able to speak about them to someone	Our aspiration is to work in the interest of patients and not hide behind confidentiality
Not sure this is an honest consultation	We've been as transparent as we can be
Comment from OSC representative: feeling from GPs, consultants and psychiatrists thought this was an excellent proposals and in line with modern thinking	
James ward – Good thing is that it's not Fulbourn and therefore doesn't have the stigma of mental health associated with it	We should break down that stigma and perception. If you speak to staff, they are very positive about moving James Ward to Fulbourn. As Addenbrooke's has developed, conditions have got worse for patients in James Ward – lack of natural light and private space
Transportation issues to get to Peterborough for family and carers to visit. Community transport money hasn't been forthcoming.	

Meeting: Public meeting 14 November 2011, 10.30am

John Ellis introduced all the staff present and opened the meeting with a presentation about the proposals.
The public were then invited to ask questions and give their comments

Comment/Question/Issue	**Response**
I am broadly supportive of the work to improve Mental Health services, I have two points: 1. The new proposed advice and brief intervention centre, can you still fund this in the current climate? 2. What are the timescales for when it will open?	The short answer is yes, we will be redeploying staff to central locations, making better use of their time. We will make appropriate use of IT systems. Efficiencies come from using staff appropriately, and making more effective use of GP time. The timescales in Peterborough are for new facilities to open in April to June 2012, Countywide by the end of 2012.
Are there any representatives here from Cambridgeshire and Peterborough NHS Foundation Trust?	Yes, Mick Simpson, General Manager
I would like to raise an issue about inter-trust Governor communications. I was hoping to meet someone here today. Mike Farmiloe knew nothing about this. CPFT have not formally told their Governors about this.	CPFT Governors have been briefed about this consultation and the documents have been circulated to them.
Poor governance goes back a long way	CPFT Governance is not an area I am very familiar with however I can assure you that there has been a lot of internal communications around this consultation.
I attended the last two Governor meetings for CPFT as a member of the public and this consultation was discussed at both of those meetings, however Mike Farmiloe was not in attendance. LINk has also been involved in a joint Scrutiny meeting to discuss Mental Health redesign and there were two CPFT Governors at that meeting. This line of discussion continued.	
NHSC and NHSP have since been assured that:	

o A briefing meeting about the consultation was held with 3 CPFT Governors on the 11th October prior to the launch, Mr Michael Farmiloe was in attendance at this meeting o The documents were distributed to all governors on the 26th October 2011 including a list of public meetings and asking if people had any father comments or queries to get in touch**.** o The consultation is on the agenda for the Governors meeting on the 7th December 5-7pm Cambridge Central Library	
Another issue have is around the proposed savings to be made. Primary care Trusts are the commissioners while CPFT is the main provider. It appears to be a closed shop between the Primary care Trusts and CPFT. NHS reforms suggest an open market approach – how do you think this will marry with the Competition and Co-operation Panel? My final issue is around statistics from care Quality Commission. I have done some number crunching myself with these statistics. In the Care in the Community National Patient Survey from June 2011, January 2011 and the survey on inpatient care, CPFT came out as one of the worst performers. Are we going to see an improvement in standards in Cambridgeshire and Peterborough?	CPFT have done a whole raft of work around these issues, this is not something we are comfortable or complacent about. Actions plans have been put in place to address this. These will be robustly managed by the CPFT Board, Directors and Governors. Every Care Quality Commission recommendation is taken seriously, we are addressing this. GPs are working with us on this too.
We monitor the delivery of all services, GPs are very concerned with the quality of services they will be commissioning. I have a question; I can't see the role of carers standing out very clearly in this consultation. Can carers contact the access centre on behalf of people they care for?	Yes, they will be able to do that, not only service-users but carers and members of the public who have concerns about people will be able to contact the advice and brief intervention centre. It was mentioned at another public meeting that sometimes people feel they come up against a 'wall of confidentiality' we need to work out how primary carers can get through this wall
Will there be any new builds necessary?	Yes, at the Cavell Centre in Peterborough.
Where will the money come from?	Capital money
Could that be PFI (Private Finance Initiative) money?	It could be.
If Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT) are already hugely in debt by £38 million how can they afford any new builds?	This is CPFT money not PSHT. The money for any new build will come from capitol money not running costs money
With the new intervention programmes you propose will there be	This is a question we are asked a lot, especially by Scrutiny. We

enough staff – we need to talk about people – are there enough staff to manage these proposals?	need to make efficiency savings – this can be done through the use of technology, we believe there are effective systems for better use of technology out there. We know this is an area where we need more detail.
Is this the only meeting we have to discuss this?	No, there is another meeting planned in Peterborough on 8th December, and we can meet with you on a one to one basis if you prefer. We are also happy to attend any meetings you may have planned. At the end of the consultation all of the notes from the meetings as well as all of the responses that we receive will be collated, independently verified then will go the NHSC and NHSP Board for a decision.
You are talking about new ways of working at the Lucille van Geest Centre – what are they?	There will be a new system of inpatient care comprising of three elements: • Assessment • Treatment • Recovery The reality is that the NHS does not provide long-term residential care for Mental Health patients – they should be cared for in the community. The patient profile at the Lucille van Geest Centre will change and as it does so it will become isolated. The average length of stay now is less than 30 days
What happens to children and adolescents? They are mentioned in here at all. These cuts to services have been going on for years. I have worked for health trusts for years including CPFT. You talk about efficiencies, have been talking about efficiencies for years. Hardly anything is left now of the service I worked for. I now work for a voluntary organisation doing work that was once available on the NHS. Counselling services now can't be provided to young people as there is now no money in the voluntary sector	There is a separate consultation process going on to discuss services for children and young people as most of these services are linked to Local Authorities due to strong links with education services. That is a separate process but we do understand your concerns. Agree that efficiencies have been made. Cambridgeshire has been a low investor in mental health services. The Government requires 1.5% efficiencies. In Cambridgeshire

either.	we have to make the minimum savings that the government requires.
I used to work in a large team; this was gradually reduced; now the team doesn't exist due to efficiencies over the years. This will affect services.	I understand your views but do not accept that services will be affected. The NHS is facing difficult circumstances. We are making a minimum reduction in funding compared to other areas of service. We need to invest in childhood for example services for children with Autism, as this will save money later on in the system. A lot can be done by making efficiencies on services that people are not using.
I want to make a point about savings; I made this point at the recent Primary Care Trust consultation, now CPFT need to make savings. The Primary care Trust has a large Executive structure, Savings can be made there.	Savings are having to be made across all health services including within management at primary care trusts and this is being implemented as we speak. However this is a separate pot of money and cannot be used to meet the savings required for mental health.
I work for a voluntary organisation, many callers have Mental Health problems, they call out of hours, they are insecure. We are a 24 hour service. Would the access centre be able to sustain that level of service? We receive a grant from the Primary care Trust. Where will we apply for funding?	That would be a decision for the Clinical Commissioning Groups. We are moving into shadow arrangements after April 2013.
Will the access centre be open 24 hours and cope with the demands of the type of service we currently provide?	Yes there will be a 24hour service with weekend cover. We will be working in tandem and in partnership with some organisations in the room today, the key is getting people to the appropriate place, this centre is in no way meant as a replacement to the services offered expertly by the Samaritans. We are all on this together.
Can I address an issue? The invidiousness of CPFT being here today. I work for primary acre counselling services for Peterborough. Recently CPFT have deliberately severed links with us and they are competitors. I have a letter from gateway	I am aware that IAPT contracts are different across the area. Some we commission and some we provide. We are an organisation working in a changing environment – some of the issues you raise refer to people with dual diagnosis. New NICE

workers to say CPFT are no longer using our referral forms. I challenge the genuineness of whether you will work together with us.	guidance has been issued on this – it has been a challenge to develop working relationships with charities and voluntary organisations. We are constantly working to improve this.
The infrastructure for the advice and brief intervention centre is offered by CPFT rather than Primary Care Trusts. Can CPFT share information on how this infrastructure would work? Will there be one for Peterborough and one for Cambridgeshire or shared? Will this need premises and building projects?	A scoping exercise has been undertaken looking at IT infrastructure, numbers of staff, scoping around estates. We should be making savings in non-clinical areas such as estates wherever possible. We have 82 different sites; we need to reduce this where possible. There no definitive plans yet for where this will operate from. The first stage will be implemented in Peterborough next year using existing facilities. The triage system will use existing staff and resources, progress will be monitored.
Talking about better use of people, this is a very stressful environment to work in, special people do it. I left my role as the situation became unbearable, the stress and pressure. More demands, more things to do in the same time, I will be interested to see what happens with staff.	That is a very good point
You will have more staffing problems than service user problems. Staff have no support. Years ago we had a broader remit of clients, some difficult, some less so, this meant you had some relief and resolution as a member of staff. Now the work is emotionally and physically draining.	This is a very good point, but we need to ensure that only those who need to be in services are and then support staff in the appropriate way.
These are uncomfortable issues. CPFT arranged an event for all GPs some months ago, only 1 turned up. This reliance on GPs puts them under scrutiny. There is a cop out for GPs – easy referral system would get people off their books so this is not a priority for them. Do not assume all GPs will be supportive of the solution; they need to up their game as regards to Mental Health awareness.	Our GP Mental Health Leads network has been greatly involved in developing these proposals. The new Advice and brief intervention centre will enable those GPs with fewer skills in mental health to be able to access advice quickly for the service user.
My family have experience of mental health service. GPs recognise that they are not as well educated in this area as they	The Joint Scrutiny Committee also raised the issue of GP training to ensure consistent practice.

could be – but they do know that. We have an excellent mental health lead Dr Panday, they are not sitting around doing nothing about this. We are raising awareness and educating GPs.	

Public Meeting
14th November 2011
Service users x3

John Ellis introduced all the staff present and opened the meeting with a presentation about the proposals.
The public were then invited to ask questions and give their comments

Comment/Question/Issue	Response
The advice and information centre – is this a drop-in service? Where will it be located? It is these practical details of how it will work that I would like to hear.	It is all theoretical at the moment, several different models are being looked at. It will be a call centre / tele-medicine centre. Instead of lots of different referral routes into the service it will all come through one route. Mild to moderate mental health needs can be treated – or directed to the right services via this advice and brief intervention centre. It is hoped it will be age inclusive for all adults over the age of 18 and will link to local authority call centres. We have no answers on where it will be based. It could be anywhere in the county. There will be a core group of staff working within that system. They will link to other staff as necessary. The model is very dependent on a robust IT system. There will be triage systems within it. It must support information flow; we don't have full information on how that will happen yet. The information systems must be robust enough to support people who have had problems in the past, and also their families and carers, accessing the system again quickly and safely. This centre will streamline telephone referrals especially GP referrals. They won't necessarily have the capacity to accept 24 hour referrals, however they will be able to access advice and

	information 24 hours to give people the peace of mind that there is somewhere there that can help. The system should enable known formal carers to refer in and access information and advice.
When you talk about physiological therapies what do you mean?	We are referring to a range of services including all types of talking therapy, CBT, counselling etc., we are constantly looking at more efficient ways of delivering services.
I have been accessing some services, when I saw my patient notes it wasn't a true assessment of how I was feeling. This can be alarming for a new service user. I am in the process of changing my GP as I don't feel they are supportive. A more supportive GP would have made the journey into mental health services easier for me. Once I started my counselling I soon realised I needed more support than just the six weeks of counselling. You need to ensure that patients aren't left hanging when they need further support. At the end of my six weeks counselling I wasn't given any more support, this left me angry and frustrated and I realise I need more support for things that came to light during the counselling. GPs need more awareness so they can offer you more support. I was worried how much to say at my assessment as I was given a leaflet that said that my GP could section me. I now don't understand how to get the next level of support I feel I need from mental health services.	
My GP prescribed anti-depressants, I also had six weeks counselling. I have now stopped taking the anti-depressants as I don't like how they make me feel. I now feel as though I have been left. The six weeks counselling helped and I left spaces between the sessions to learn from each session, but now I feel I have been completely left.	It would be disingenuous to suggest that anything in these proposals would change the types of services you are discussing as longer term psychotherapy is not offered. However where things would improve is that GPs could more readily access information to support you to find other services or organisations offering support that may be of help to people who have completed their counselling sessions. We will include into the redesign proposals the need for non-stigmatising entry to mental health services. Re the experience with patient notes, these should be an accurate reflection of discussions and course of treatment/medicine taken.

	If this is not the case we would encourage you to speak to PALS.
I have experience of friends being transferred from Oak Ward to the Lucille Van Geest centre, they were given 10 minutes to gather their belongings. This hadn't been properly managed. No-one explained to her why she was being moved – this caused her a lot of distress.	That sounds like a badly managed bed management issue. They were at over capacity; they are now managing that capacity better. These proposals would alleviate those issues.
What happens to people with dual diagnosis? I currently work with homeless people, when they have to fill in assessment forms they always feel that if they have a drug or alcohol issue it is dealt with before any mental health issues, many explain that they have the drug or alcohol issues because they self-medicate their own mental health problems.	It is difficult when there is dual diagnosis. It is complicated to address as it is difficult to address mental health concerns when substance misuse is an additional factor. We need to have a collaborative approach to this.
Would service users who have accessed a support group or services be able to inform the advice centre? Would we be able to add to the information they hold?	We want to develop a collaborative way of working with other services and the voluntary sector. We would welcome as much information as possible on what support is available. However before we could give out that information we would need to be satisfied that the service or support was safe and appropriate.

Public meeting, March Town Hall, March
30 November 2011 18.00-20.00

NHS Cambridgehire & NHS Peterborough staff present: John Ellis, Claire Warner, Jessica Bawden
4 members of the public, including volunteer support worker, representative from Granta Housing and service users

Being pushed around because I don't fit the right pathway or because I need to go back to a service after I've been discharged. Will this address that?	Yes, it should do as you will be able to access the Advice & Brief (A&BIS) Intervention Service for help, rather than going back to your GP for referral.
People should be able to have access to care even if they are not accessing services regularly.	Yes, the A&BIS should make accessing services easier for people in this position.

Will there be a freephone no that will be free for mobile users?	There will be a freephone no, but we need to check about charges for mobile phone users.
Will the A&BIS be able to provide face to face meetings, because some people will not be comfortable with new media?	Yes they will be able to make an appointment for the service user with the primary care service.
Won't this lead to more people using services?	Yes, potentially, but the hope is that if people are seen earlier, they can be helped more quickly, leading to less severe illness.
There was a discussion about impact of the recession on mental health and it was agreed that commissioners and CPFT need to be aware of this and planning for growth.	
Where will the A&BIC be located?	No decision made. The information and advice will be virtual or by telephone, linking to local services where people can access more easily if necessary.
What about the out of hours services, how are they doing?	The feedback is mixed and some service users and carers are reporting they are finding it difficult to access services, which is where we hope that being able to call the service 24/7 will help.
What about services in rural areas? There was talk about a local drop in centre in Wisbech or Chatteris and how good it was.	These are really important, and these proposals are not looking at changing these types of services.
How will this impact on voluntary sector providers?	We want to involve the voluntary sector more in this new model. Their role is hugely important both in directing people to the right services and providing support.

Public meeting, Oak Tree Centre, Huntingdon
7 December 2011 18.00-20.00

Number of attendees: approximately 37
In attendance: John Ellis, Claire Warner, Annette Newton, Dr David Irwin, Victoria Wallace

John Ellis delivered a presentation on the proposals and then opened the floor up for discussion	
Comment/Question/Issue	**Response**
Huntingdon is a small town with a small service which is being taken away (Acer ward). Perhaps something could be taken away from Cambridge or Peterborough which have very big services	
Quoted in the case for change that Cambridgeshire spends 5% less than other counties in the South on mental health services. Feels like you congratulate yourselves for this, but it's not a good thing that less is spent on these services than elsewhere	We are low spenders. We would like to spend more, most people who work in mental health services would like us to spend more. The reduction to mental health services spending is the lowest of all health services in Cambridgeshire.
The Home Treatment Team (HTT) now in Peterborough, therefore has to travel more. Surely this costs money.	The Crisis Team is based in Peterborough, as one of their functions is to support people coming out of hospital in Peterborough. There are options for staff to use hot desks at the New Town Centre in Huntingdon
Home Treatment Service is reduced, meaning people get fewer sessions before they're left on their own	
Who decides how funding is allocated?	The clinicians
CPFT governor stated she wasn't briefed	
Why was Acer ward deemed unsafe and therefore closed?	The National Clinical Advisory Team visited Acer ward and after judging it to be unsafe, advised immediate closer. Staffing levels were making it unsafe. CPFT continued to recruit staff to posts and worked hard to maintain staffing levels on the ward. No cost savings were being made regarding staff at Acer, no staff reductions were envisaged, but staff were beginning to move on to other posts, therefore staffing levels became too low to maintain a safe service.
Why was Acer allowed to become unsafe?	It comes down to staffing levels
Comment from staff that there were lots of rumours that the ward was going to close, therefore the staff moved on and therefore the ward was deemed unsafe as staffing levels were low. The service at Acer was excellent and accredited, but it has been undermined by the rumours	We do not dispute that the service at Acer was very good, but the NCAT team deemed it to be unsafe when they visited, which meant we had to close it temporarily
A lot of very strong feeling at the closure of Acer Ward. By closing it the local service has been wrecked.	
Action has been taken on the consultation proposals already,	Definite decisions have not been made yet. The process with

which makes people very angry. Are these really proposals or has a decision already been made?	developing proposals is very lengthy (9-12 months), meanwhile the world doesn't stand still and circumstances change and sometimes mean things needed to be acted upon quickly.
The Advice and Intervention Centre will have a telephone based system. How will deaf people use this?	There needs to be special arrangements in place for lots of groups, including deaf people to access the service
People need face to face contact, not just a telephone service (Advice and Intervention Centre). How do you build up trust with someone on the phone, need face to face?	People who need to see someone face to face will be able to. A lot of people prefer the telephone, as they prefer the anonymity. There needs to be lots of ways to access the service. The consultation talks of the concept of the centre and comments from the consultation will feed into how the centre will function
The duty system has been cut at the New Town centre since Acer closed	
If someone has a crisis, where do they go?	Through the crisis team
People being shipped off to Peterborough for treatment does not help people's mental health	
Anger at finding out about Acer ward closing being in the paper. This has caused a lot of stress. Without Acer, families have to travel to Peterborough to visit relatives, which is a very long journey, particularly after a full day's work.	
Feeling that services are disappearing	A lot more people are accessing services that are more community based. Just because a physical building may no longer be there, does not mean the service has gone
Everything in the press says the closure of Acer ward is temporary, is it?	Everything is subject to consultation; it's not a permanent closure at this stage.
At what stage were proposals formulated?	Nearly 12 months. We have to plan proactively
The Service User Network is within NHS Cambridgeshire. How easy is it for service users on that panel to speak out against proposals	The SUN is not run by NHS Cambridgeshire, it is completely independent of the PCT. Hunts Mind run it. The groups on the SUN have not been silenced in any way.
Huntingdonshire is losing out with these proposals – again.	The proposals have come from looking at the best way forward under the current circumstances
Public transport is very bad in Huntingdonshire	
At what level have clinicians been consulted?	The main development of these proposals has been by the clinical directors of the mental health trust. Detailed discussions have been undertaken with mental health staff and with mental health lead GPs as well.
What are you doing to smooth the transfer while the changes happen	The community team has been strengthened

Beds at the Cavell Centre have been cut (Oak Ward)	All Peterborough beds are there, they have not been cut. Additional beds have been opened at Lucille van Geest as well. People are admitted to the Cavell centre instead of Acer and Acer ward staff are in place at the Cavell centre
There needs to be a trial period	Unfortunately we didn't have the option with Acer ward.
Why were so many acute beds put at the Cavell centre when there was Acer ward? Public transport wise it is much more convenient for people in Huntingdon to go to Cambridge rather than Peterborough. People from St Ives are going to Peterborough, but Cambridge is much closer and more convenient with transport links. Lots of people have said they feel very isolated at Peterborough.	
How is transport going to work for patients	Transport is a big issue for all areas of healthcare. Cambridgeshire County Council and NHS Cambridgeshire are working on transportation available across the county to strengthen transport links. We are hoping to have an update on transport at the next OSC meeting. It is a commitment from NHS Cambridgeshire and Cambridgeshire County Council. There is a general issue about access from rural areas for health and other public services.
Comment from attendee who had to visit their mother in Peterborough, travelling from St Neots by car every day. This journey is very stressful to make every day – it takes 50 minutes each way, which makes for a very long day after a full day at work. Astounded at the closure of Acer. It's like going back to the dark ages when people were sent away.	Accept the point on transport. We would love to have facilities in every town, but at this time we have to make choices. The number of people needing admissions these days is thankfully quite low.
Comment about Oak Ward, where the patient did not see a doctor for three weeks	
Due to the distance from home, a patient could not take home leave from Peterborough. The number of the patient's visitors fell sharply after they were moved from Acer to Peterborough	
Closing Acer ward is going back to the dark ages	Practice in mental health has changed significantly over the last 20 years. Community based care is now the model for recovery
Although the recovery model is based on community based provision, there's still a place for inpatient care.	
Comment that with these proposals, service users feel that they are being told they don't matter	These are our proposals on the best way forward
What are GPs doing in terms of mental health services	Every GP surgery has a mental health representative. We now have input in to the service. Agree we need to input more at a higher level of the service.

Frustration of family members and community teams with patients being in Peterborough. Community teams find it very difficult keeping in touch with their patients when they're in hospital in Peterborough. There has been a real dilution and change in the service with patients now being taken out of area to Peterborough	
If these proposals go ahead, can you give promises that things won't change again in a few years' time?	No, unfortunately. These are the savings to see us through the next three years, but we cannot guarantee we won't be asked to make more.
You say the number of admissions for mental health has decreased. Is that because the number of beds has been cut?	No, the number of beds has decreased over the number of years and that's because of the more care in the community and greater prevention etc.
You say you have to make all these savings but are you not still paying rent on Acer ward. How will you make these savings if you are still having to pay rent and are incurring the extra cost of having to have staff travelling much further to see their patients	There is a whole package of savings. There will be some additional costs initially in order to make these savings. These plans have been made robustly, with robust costings.
Staff are losing out financially with petrol rates once they have done over a certain number of miles.	
Staff are losing out on face to face time with their patients as they are having to spend more time in their cars travelling to patients	
Why not make Acer one big crisis centre	Surely the point here is that the crisis team is working throughout different areas, not just Huntingdon. Wherever you base a centre, there will always be issues for people travelling to it.
Will mental health be taking on autism?	Proposals are being developed to provide a specialist diagnostic service
Seems there'll be a strengthening for people with mild to moderate conditions but the changes will affect people with long term and severe mental illness	The focus is on earlier intervention to prevent conditions developing into severe and long term. There still however needs to be provision for people with more severe and long term conditions
Experience of having a fixed number of sessions with a professional and then being left to your own devices. This is not good, more support is needed.	
Experience of the service getting worse for people with severe and long term conditions in Huntingdonshire: • People feeling they're being discharged at an inappropriate stage. • Lack of long term support – 6 sessions and then you're left. • Discharging to GP.	
There needs to be better support for people going back to primary care	
The Home Treatment Team should be based in Huntingdon, with their existing patients. Comment that a patient does not feel the HTT is there for her when needed due them having to travel	

Huntingdon has lost Acer, so could we not have a Hunts based home treatment team to compensate for this?	We can look at it. There are advantages and disadvantages of being in Peterborough; A big disadvantage is the travel.
Will there be a psychiatric unit in Huntingdon?	It is all subject to the consultation, on which the PCT Board will base their decision
Comment that people feel very powerless in this situation. Feeling that everything is just going ahead without consideration to them.	
Is New Town going to close?	No, New Town is not part of this three year plan.
Audience requested another meeting at the start of January	
Can the consultation be extended?	
Very unhappy with the case study given of the patient in Acer ward in the consultation document. Inaccurate portrayal of Acer and want this corrected.	

Public Meeting **8th December 2011** **Cavell Centre Peterborough 2pm** John Ellis started the meeting with a presentation on the proposals.	
Comment/Question/Issue	**Response**
This seems like a very good plan, if you get consent what are the next steps? Will you set-up a board to affect implementation?	A project board system is already established. There will be a specific group that will manage the implementation of the advice and brief centre; they will manage any IT procurements for example. NHS Cambridgeshire and Peterborough Board, as well as the health Scrutiny Committees, will want to be kept updates as the implementation takes shape. The infrastructure to manage the implementation is ready to go.
This single point of access for referring into the service could cause a bottle neck.	We do appreciate that concern and to avoid this we propose a phased roll-out. We will start with GP referrals only, and then we will phase in the other service users. This will ensure that the

	service is fit for purpose, and the infrastructure can support the volume of calls.
I would like to know how you have prepared these proposals – the links to finance. I have completed my own benchmarking exercise to compare trusts against each other. Did the preparation of these proposals include benchmarking for quality?	There have been audits across the region; we can share that information with you. Quality is measured through the CPR process. These proposals seek to address service models – we want those proposed service models to be the best quality. We listen carefully to service user feedback about their experiences of how services work.
In my own benchmarking CPFT does not perform well. In the Case for Change document you state that CPFT plans to increase income by marketing some services elsewhere, can you tell me what services will they be able to market and in what areas?	Quality is an issue that is taken very seriously; it is at the top of every agenda. Work is going on to ensure that quality is good. Cambridgeshire is the centre for many services for example eating disorder services. Through setting up a specialist model and marketing this out of the area this could bring income back from private providers. This will be a continuation of this work
Are the figures quoted for business within the county?	No they are for specialist services offered to other areas such as Eating Disorder services and Personality Disorder services. They are currently offered to Bedfordshire, Hertfordshire, Essex, Suffolk and Norfolk. The numbers are currently small but projected to increase. Tier 4 personality disorder services are another example, they are contracted on an individual basis, cost per case basis, but hoping to increase this to bring in more income.
During some discussion I have had with people about this consultation, especially around the advice and brief centre, people have raised concerns that there may not be a personal; approach. Some people do not use the phone or computers and struggle to communicate. Will there be somewhere where people can see and talk to a human?	At the moment people contact individual teams, a lot of this is GPs referring people to various teams, this is not very efficient. Some of these referrals are not to the right teams or need to be referred again to another team, or person within thin the team. The first phase of the advice and brief centre is to improve GP referrals to the correct team, to have a more co-ordinated approach. Teams will still carry a case load and people will then still be able to

	contact those teams. However we have to improve out of hours access to services and access to people who may have left services and want to renew contact. We do appreciate that there are people who cannot communicate by telephone and we need to work on improving access for those people too. Having a phone service should free time for people who need face to face contact and home visits. We do appreciate that people do not want a system that endlessly says press '1' for this or press '2' for that. We are learning from other areas, we are trying to allay people's fears that it will be a faceless call centre. We are trying to prevent that from happening.
When we have contact with potential clients we can learn a lot from body language – you will lose that by having phone contact.	
Are you still planning to have a pilot advice and brief centre operating from the start of 2012?	We hope to have the pilot running from May/June 2012.
What are the staff requirements and structure for this?	We envisage needing 30-40 full-time staff across the county. This scoping exercise is still going on. We would need a 24 hour psychiatrist on call. We would outline the staffing model, starting smaller and phasing up. This would be a mix of clinical and administrative staff. We assume that a consultant psychiatrist would be at home on call throughout the night rather than being paid to sit in a call centre waiting for a potential call.
Are there any costing implications for this?	We are looking at consolidation of existing staff. At the moment there are 59 different referral pathways, access can be complicated. If this process is streamlined then there can be potential for efficiencies and staff consolidated to work in the advice and brief centre model.
To lend some support to your proposals it is worth noting that in Lincolnshire we are at the pre-consultation stage of exactly the same thing, the proposed models are the same. We are exploring the same issues, one point of access, and the same messages - that community services improvements will reduce the need for	We appreciate that – Essex is also looking at a similar model. We are not under estimating the risks, how will an advice and brief centre and community support teams offer support to people who would have been in inpatient beds? All services need to be connected

beds. We have the same issues in Skegness and Louth as you have in Huntingdonshire, we are looking at 6 beds for a 220 00 population in SW Lincolnshire, supported by a 24hour crisis support team.	
3 days, 3 weeks, 3 months. I challenge how you can make people better in this time.	It is more about support not making people better within a certain timeframe. Ensuring that the correct support is available, at the right time, and in the most appropriate setting for people. Patients benefit from more employment support, benefits advice – if that is appropriate. It is a holistic approach looking at the person's whole life not just the mental ill health.
Have you got any plans to strengthen community teams?	There aren't any more resources going in, as there are no more resources available. It is a different focus, for example cognitive behaviour therapy can be very effective, however some people need intensive support to reduce the amount of time they need to be within the service. We need to support staff to have the right mix of skills, and ensure they have the skills to do the job they need to do.
I understand this is also a consultation with staff and CPFT and you are having these difficult conversations. We appreciate that community support needs to be strengthened. Social inclusion is a large part of community support. Social and vocational inclusion teams were wiped out, this is a confusing contradiction.	All recovery, rehabilitation and community support staff need to be involved in social and vocational inclusion and trained to be able to support in this area. This is a genuine consultation and we appreciate your view and welcome this feedback.
Peterborough and Fenland MIND service have recently reduced the number of hours their drop-in service is open. With more people receiving treatment in the community will there be somewhere for them to go?	I am from MIND services and people do become dependent on services like drop-in services, when really they need to be integrated more in the wider community. Drop-in services have a valuable role to play but don't always fit into a recovery model. We are looking at how services can integrate into that model.
Please do feed all of those comments into the consultation. We are making notes from this meeting please do complete the consultation forms or write to us individually or as an organisation. We are mapping what services are out there to support people, either from individuals coming together or from the voluntary sector. We hope to make all of these services available to people through the advice and brief centre.	
Lincolnshire County Council has given some budget to Lincolnshire Mental Health Trust to support 3rd sector to set-up and develop support for people who need it, through drop-in services etc.	
I think this is brilliant – finally the criminal justice system and	Again we can't underestimate the challenge of all of that – but yes

support services all coming together. Previously it was difficult to make all of those links; it is great they are all working together more.	that is the intention and it is starting to come together.
In the case for change document you mention out of area beds – how far geographically are you prepared to go if necessary?	This has happened very rarely in the past 3-4 years. When we have had to go out of area we have gone to Northampton and Stevenage. If there is not a bed available and we need one we talk to local trusts and make the necessary arrangements.
People from Boston do come to Peterborough for out of area beds so this happens across trusts in the area not just Cambridgeshire and Peterborough.	We have improved how we manage beds especially at peak times. Although with a reduction in the number of beds we will have to manage this very carefully

Public meeting, Oak Tree Centre, Huntingdon
4 January 2012 18.00-20.00

Number of attendees: 30
In attendance: John Ellis(NHSC), Claire Warner(NHSC), Annette Newton(CPFT), Dr David Irwin, Dr John Richmond, Denise Hone (CPFT) Victoria Wallace (NHSC)

John Ellis delivered a presentation on the proposals and then opened the floor up for discussion

Comment/Question/Issue	Response
Fundamental issue is that there are not enough staff to do the jobs	
Crisis Team is too small to cover Peterborough and Cambridgeshire.	
Since Acer Ward closed, experience with the Crisis Team is that it isn't available and doesn't work. People can't get help when they need help. Since Acer has closed it is like the mental health service for Huntingdonshire has closed.	
People cannot get hold of the Crisis Team and if they do get hold of them on the phone, there is no one available to provide real advice and no one available to come out to the patient. Experience of the Crisis Team turning up very late for appointments – sometimes the day after they were due to visit.	
Transport to Fulbourn from the Huntingdon area is very difficult	
Closure of Acer Ward is causing problems at Hinchingbrooke's emergency unit	
Could someone in St Ives go through the Crisis Team in Cambridge, rather than Peterborough	Annette Newton will look into this

Former patients of Acer Ward feel safe there. It would be good if former patients of Acer could go and see the new ward at the Cavell Centre, so they can see what it is like.	
Description of experience at the Cavell Centre given on behalf of a patient: not homely unlike Acer Ward, felt stressed at the Cavell due to too much noise, it's too large. Feeling of being overlooked at all times. Springbank has had a suicide whereas Acer ward had no suicides.	
How many staff are there in the Crisis Team compared to before Acer closed?	Staff numbers have remained the same; there may have even been a slight increase.
Too much travelling for the Crisis Team now being based in Peterborough	
Acer is outdated – bad food, staff discussed patients openly so other patients could hear. Can see why closure of Acer is beneficial but there should still be a facility locally. This is an opportunity to redesign Acer Ward and have a local facility.	
Problems with contacting services at night. Hinchingbrooke has a very good out of hours doctor surgery. Is there any way this resource could be used for mental health as well so there's always someone to speak to?	
Closure of Acer ward looks like services for Huntingdonshire are being closed down. Since Acer has closed, experience has deteriorated – experience of Crisis Teams never turning up. This didn't happen when Acer Ward was open. The service at Peterborough is not working for local Huntingdonshire service users.	
If someone is in a crisis, with the current experience of the crisis team, they will go to A+E.	
First point of contact needs to be very calm and very informative and it needs to be ensured that whatever the person at the end of the phone says to the service user happens.	
Travel: St Ives bus service does not to go Fulbourn or the Cavell Centre, they go to Addenbrooke's and Hinchingbrooke which is where services are being moved away from. To get to Peterborough from St Ives you have to go on at least three buses and to go to Fulbourn you have to use at least two. This is not acceptable for patients in terms of the logistics, but also in terms of cost. The proposals are reliant on families taking people to hospital. Acer ward is within walking distance from 1 bus journey from St Ives.	
Feeling that Huntingdon and the surrounding area does not matter	
Must think about physical access to services	
People with mental health problems tend also to be on very low incomes, therefore can't afford the transportation costs to get to Fulbourn and Peterborough.	
Will GPs get further mental health training?	If GPs wish to receive more training then they will be able to get this
Dr Irwin said that local GPs were unhappy with Acer ward closing but that there was no choice but to close it for the safety of patients	
Were you thinking about closing Acer before the NCAT team visited?	The Clinical Director had suggested closing a month before the NCAT team visited due to the difficulty in maintaining staffing levels. However we wanted to avoid this.
GPs want to see home teams increased	

Very concerned about people who are on their own getting to the services, due to the transport issues.	
The mental health service needs more money.	
What is the timescale for the Crisis Team to come out now?	If you are already known to the service then there's a four hour response time
Hinchingbrooke Hospital is very precious as a District General Hospital and should have all the facilities of a DGH.	
The reason for closure of Acer Ward given in the consultation document is unfair and misleading – it is misleading to say that Acer has dormitory style bedrooms.	
Acer Ward should be reopened as a modern environment.	
Travel difficulties for people to get to Peterborough and Fulbourn from the Huntingdon area are enormous.	
If money is being put in to Fulbourn to upgrade the facilities there and get rid of the dormitories there, why can money not be put into Acer Ward.	
What are the reasons for centering all the Crisis Team in Peterborough. Why can the team not be split between Huntingdon and Peterborough?	At the moment there are some staff in the Newtown Centre
Advice and Brief Intervention Centre – there is lots of concern that people do not have someone to speak to at the moment. People do not want to be batted back and forth in a call centre.	
Would like to see comparable funding for mental health in other local authorities	This can be provided; Cambridgeshire is a low spender on mental health in comparison to other local authorities.
Would like to have seen Circle at the meeting	
If you had the funding, would you keep Acer Ward open?	Not necessarily, no. This is also about modern mental health care, not just funding.
What is going to happen with physical health care at the Cavell Centre – attendee spoke of bad experience of the handling of physical health problems by staff at the Cavell Centre.	
Transport: Acer has been closed because of safety issues. There are also safety issues about taking someone on a bus or by car to Peterborough or Fulbourn. Doctors will advise you should have at least two people in the car with a patient.	
Transportation and parking is very expensive	
More emphasis needs to be put on carers and their role. Carers are carrying the NHS Service.	
What support is there for people after they've left the ward – is there assisted living ie. People to come and check that people are taking their medication and are integrating in the community etc?	There are home treatment teams and supported accommodation. There's more need for this and we're working with District Councils and housing providers to get this.

APPENDIX 5 – CONCERNS, ISSUES AND QUESTIONS RAISED IN PRIVATE MEETINGS

All names of members of the public have been removed.

Friday 11 November 2011 **Meadows Community Centre, Cambridge** **John Ellis (NHSC)** **Victoria Wallace (NHSC)** **Two members of the public**
Comment/Issue/Question
Community support is very important. In supported housing will people have the 24/7 support that at times they need? Comment that their son was at Cobwebs for 15 months and he was the most stable there than he'd been in a long time and made great progress. He did not do as well in supported housing where he didn't have properly supervised administration of medication, which was a contributing factor to his relapse. The level of support he received was not sufficient after leaving Fulbourn.
Patients need continuing access to specialist mental health practitioners and support once they have left hospital – not just support provided by Healthcare Assistants. Their experience with Healthcare Assistants was that their son's medication was not sufficiently supervised.
Not clear why Cobwebs is being closed as it's not saving any money. The support people have is more important than modern accommodation.
As Cobwebs is in central Cambridge, patients can integrate into the community, which is very important to their recovery eg. Go to the pool, volunteer to work at charity shops etc. At Cedars they are further away from the community and have to rely on bus trips in to town. Places need to be accessible to the town centre to allow reintegration in the community. People need to be in accommodation where they have access to community facilities.
Comment that Cedars Ward staff are very good, caring and helpful, the location of the Ward is the problem and it's set away from the community and facilities.
Cobwebs staff said that the ward was fully occupied on 23 October when Mrs Heinemann phoned and spoke to them.

8th December 2011 **12.30-13.30, Cabinet Offices, Peterborough Town Hall** **Member of the public** **John Ellis (NHSC)** **Aidan Fallon (NHSP)** **Dr Sohrab Panday** **Claire Warner (NHSC)**
Comment/Issue/Question
The ABIC is a great idea and needs to be implemented as soon as possible but with attention to training required and the interoperability with the wider health and social care economy including joint working with voluntary organisations. Developing links with Neighbourhood Managers would be a great way to achieve this.
The delivery of these redesign proposals need to link closely with the Health and Wellbeing Board and help deliver government initiatives
The acute system needs to be closely linked with community services and discharges need to be carefully planned and prepared for.

1st December 2011, **13.00-14.00, Elizabeth House, Fulbourn** **John Ellis (NHSC)** **Claire Warner (NHSC)** **Member of the public**
Comment/Issue/Question
Individuals with mental health are very vulnerable and any change needs to be implemented with this in mind.
Family carers need to be central to all elements of the service, be taken seriously but at the same time not expected to pick up the slack which this redesign creates.
CPA is the bedrock of the whole service which is lacking in East City and South Cambs
Consistency of care, service users CPNs are changing constantly with no notice.
There are long waits for carer assessments and this needs to be resolved
There are long waits for counselling in Peterborough

High quality of care is needed for the floating support service
Mental health will need to be central to the health and wellbeing board
Health watch will need to cover mental health as part of the remit
With increasing petrol costs, the potential impacts of this on services available in the Fenlands needs to be prioritised
ABiC needs to be aware of the Rethink Carers Helpline and Lifeline 24/7
The benchmarking quoted in the consultation paper does not take into account elements such as absconsions and suicides, so although there may be less beds and less investment, this does not necessarily mean it is a good or safe service.
Cedars is the wrong place to relocate Cobwebs to as it is a silo
Ward staff need to spend more time in common rooms not in offices due to the amount of paperwork

15th December 2011, **Town Hall, Peterborough 9.30 – 10.45** **John Ellis (NHSC)** **Member of the public**
Comment/Issue/Question
The document does not emphasise clearly enough that the service must be “community-led”. This should be the fundamental “ethos“ of the service.
The proposals are “clinically-led” – this reinforces a “medical model” whereas mental health services should have a strong social and community-care led approach. .
Strongly support the proposed reduction in rehabilitation beds. It is difficult to “rehab” in a ward setting. The recovery process is individual to each user and shouldn’t be dependent on where you are on the clinical pathway.
The service in Huntingdonshire should return to be community-based as It was before Acer Ward was constructed. The priority should be to raise the quality of the community-based care that is provided.
The whole emphasis on the change should focus on improved outcomes for service users and to reflect local needs and priorities. There should be more data about service quality and outcomes collected. In my view there is an over reliance on national data and not enough reference to actual local activity
More use should be made of the JSNA and a commissioning strategy developed for Peterborough.
Voluntary organisations are better-placed to deliver some community services.
Mental health services should be based on individual needs rather than pathways, make better use of CPA documentation. The document should reflect the broader government shift into personalisation.

How will the proposed ABIC help people address social care issues such as housing?
The document does not clearly explain what is “primary” and what is “secondary” care, or which services would be best provided by NHS, voluntary sector or independent organisations? The Trust (or at least NHS staff) are the only people who can provide secondary and specialist services. They should concentrate their expertise in that area. A much broader range of people can provide primary care.
Why can’t emergency presentations in Peterborough be seen at the Cavell Centre rather than having to be assessed at A+E?
There should be a separate consultation process for proposed changes to old-age services.
The potential of the Health and Well-Being Board to promote joint working should have a greater prominence to emphasise the wider system links needed for successful mental health service delivery.

10th January 2012, **3.00-4.00pm** **Cambridge** **Claire Warner (NHSC)** **Victoria Wallace (NHSC)** **Member of the public**
Key elements which need to be considered in the mental health consultation for the service users with ADHD and ADD are as follows;
Commissioners and clinicians should be familiar with and use this toolkit in relation to any consideration of children’s and young people’s services ‘Developing Mental Health Services for Children and Adolescents with Learning Disabilities’ http://www.rcpsych.ac.uk/PDF/DevMHservCALDbk.pdf (free download; hard copy available from RCP Publications or from Amazon http://www.amazon.co.uk/Developing-Services-Children-Adolescents-Disabilities/dp/1904671616 .
Cuts are being considered to a service that already barely exists and is totally inadequate and undeveloped.
Commissioners should also maintain and improve access to assessment which may lead to diagnosis of autism both in pre-schoolers at the Child Development Centre in Cambridge and in children and young people of school age at Douglas House. At the moment unacceptably long waits are occurring.
Service providers including the County Council are all trying to push responsibility for providing a particular service onto another provider.

Re adult services: where are adults with long term mental health problems which seriously impact on their ability to work or sustain relationships (but who have not had psychotic episodes or problems with drug or alcohol abuse) supposed to get help? Social services do not help this group and mental health services appear to provide nothing either, once they have had a short course of CBT or similar. It is concerning that people's needs are not considered but that service models are designed around a "tick box" mentality and the overriding desire to obtain quick and easy results. This means that "difficult" cases don't get the help they need.
There is no children's partnership board for learning disabilities so it is very difficult to have a voice and to champion this area and for service users and their parents to be partners in policy making. This needs to be accessible to all parents, not just those of children who are high functioning.
Public transport is an issue from Cambridge to Fulbourn as there is only one long bus journey and if you have to travel to Cambridge first this can take a very long time
The document states very little about mental health services for children and young people and less for those with learning disabilities also.
Coordination of input needs to be improved to include all areas of the service users life e.g. school life, home life and social life
Assessments need to be holistic, looking at physical, sensory and behavioural, they should also look at whether the individual is in pain
Drug prescribing should be a last resort
PALS services need to include and advocacy role and be independent of the organisation which is being discussed.
A life course integrated pathway is needed for Autism.
All services should meet government guidelines and be based in evidence based practice
An IST team is needed in Cambridgeshire
Services need to be consistent across the whole of Cambridgeshire; a postcode lottery is not helpful.
Education for parents would be welcomed
Key improvements to children's services 1. Behavioural methods training 2. Educational psychology needs to be increased 3. Clinical psychology input needs to be increased 4. A regular LD Clinic 5. IAPT for individuals with LD 6. Statements need to be reassessed every 3 years.

7th December 2011 11.00-12.00 **Tribunal Room, Newtown Centre** **John Ellis (NHSC)** **Claire Warner (NHSC)** **Member of the public**
Key elements which need to be considered in the mental health consultation;
ABiC Is a great model and electronic services need to be optimised
Continuation of web support is a great way to support people in the community
The development of a social networking site for carers is a great opportunity for the ABiC
When the ABiC is implemented, the development of key workers for consistency is needed to avoid a call centre approach
Service user input into the design of the ABiC is crucial
When developing web resources there needs to be collaboration between agencies enabling seamless pathways
Any implementation of new services need to be evidenced based
More clarity is needed with regards the age inclusive primary care services

APPENDIX 6 – SUMMARY OF FORMAL CONSULTATION RESPONSES FROM STAKEHOLDER ORGANISATIONS

Little Paxton Parish Council consultation response, 7 November 2011

Comment/issue	Response
The Parish Council is against the redesign of the Mental Health services in Cambridgeshire and Peterborough.	
Although review and improvement are essential for progress within the mental health service, some of the proposals would not best serve the residents of Little Paxton	
Local easily accessible facilities were being polarised to 2 areas; Peterborough and Cambridge	
Distances to be travelled by patients' families and friends for visiting/consultations could be difficult via public transport and expensive. Patients may lose valuable support from friends and families as a result of difficult transport	NHS Cambridgeshire is aware of the travel issues that you raise, which may be caused by these proposals. NHS Cambridgeshire is working closely with Cambridgeshire County Council to address these issues, but would appreciate any ideas on how we can improve transport for residents in St Neots to feed into these conversations.
Moving the care for mental health patients to other districts may mean that local community support systems and their funding may go to other areas, thus losing expertise and because of a lack of funding	With regards to your concern about local community services, we would like to assure you that community support within Huntingdonshire will in fact be increased as a result any permanent closure of Acer Ward, and it is a priority of the GP Mental Health Leads to ensure local provision is not disaggregated.
There may be a poorer quality of service for what provision did remain within the community	

Cambridgeshire Older People's Enterprise consultation response, 31 October 2011

Comment/issue
Agree with providing a single point of contact/access to Mental Health Services
Experience of COPE members of less than ideal treatment from mental health services.
Acer Ward has been closed before the consultation concludes, COPE considers that this undermines people's trust in consultation processes
The reason given for closing wards appears to be, not that there is no need, but that statistically Cambridgeshire has better or more provision. Does Cambridgeshire need to match other areas, with perhaps inferior provision? The statement that 'modern best practice requires treatment at home' is disingenuous, especially in circumstances where the carer is elderly and can no longer cope with the behaviour of the patient. How can the balance of medication be checked at home, where proper supervision is not possible to ensure that correct dosages of medication are being taken by the patient?
In response to question 7 of the questionnaire ' do you have any views on how we could make mental health services more efficient', the answer to this question would be that better management would make this service more efficient.

Holywell-cum-Needingworth Parish Council
Consultation response by email 25 November 2011

Comment/Issue – transport
The Council requests due consideration is given to transport issues when considering centralisation of services. Transport in rural communities can have a major impact upon ability to attend appointments and cost implications for patients and authorities.

Papworth Trust's response to the proposed re-design of mental health services across Cambridgeshire and Peterborough 20 December 2011

Comment/issue – Employment support for patients with severe and enduring mental health conditions
Supportive in principle of the broad proposals but with support for the continuation of employment support for patients with severe and enduring mental health conditions within the intake and treatment team.
Role of the employment advisor embedded within clinical teams is vital, within the broad structure of the Individual Placement & Support (IPS) model of care for severe and enduring mental health patients. Not supportive of the proposal to scale down or remove the employment advisor and guidance service.

Wish to maintain and foster the relationship between the embedded employment advisor and Papworth Trusts management of the Work Programme to help support the recovery of patients by accessing the open employment market
People with severe and enduring mental health problems have one of the lowest employment rates in the UK. Yet it is clear that the vast majority want to work and with the right support many people can. It is acknowledged widely that people with mental health problems experience poverty and income inequality; consequently their needs are of concern to the Papworth Trust, agencies and individuals tackling poverty and disadvantage by promoting economic and personal growth. A contributing factor of this inequality is the difficulties experienced by people with mental health problems in finding and sustaining employment, and managing mental health issues whilst at work. This group now forms the largest proportion of people claiming inactive benefits, and there has been a steady increase in the absolute numbers of people with mental health issues claiming inactive benefits over the last five years.
Recently documented successes with the Individual Placement and Support (IPS) follow the belief that supported employment for the severe and enduring mentally ill, provides the possibility to reengage with supported employment to facilitate the recovery process. To successfully implement this, the employment advisor or employment specialist provides potentially the most pivotal role within the clinical teams.
It is clear from evidence that the dedicated advice, training and guidance to patients (provided by the employment advisor/specialist) toward supported employment may aid the recovery process for those that require supported employment.
The management of the patient's condition is mediated through the clinical teams, however the expertise and local knowledge of the employment advisor/specialist will maintain the focus upon the patients employment needs and help with the journey back toward sustainable and meaningful employment.
Proposed changes for employment services within the intake and treatment mental health teams, it is hoped that the wealth and breadth of evidence for employment specialists embedded within the clinical teams is essential to the functioning of supporting people back to work. The role is critical to the way that Papworth Trust's employment services can support both mentally ill and recovering patients obtain employment via the open job market. As a result we would urge the CPFT and mental health commissioning services to consider this reply to the recent proposal for dispensing with the employment specialist role within the intake and treatment teams; thus helping support mentally ill patients' recovery process back into sustained and fulfilling work with all the associated benefits to both the economy and the individual.

ADDventure Within consultation response, 23 December 2011 – Adult ADHD Action Campaign for Cambridgeshire and Peterborough

Comment/issue
Extremely concerned that there is no provision for support for newly diagnosed adults with ADHD or those that have received a diagnosis of ADHD in adulthood in the local area. Recent decisions by NHS Cambridgeshire, the Cambridge Clinical Priorities Forum (CCPF) and the Cambridgeshire Joint Prescribing Group (CJPG) have effectively denied access to treatment for these

individuals, which has a devastating impact for them, and their families
While we understand funding may be an issue with adult ADHD services, it is likely that the cost of untreated ADHD is much greater than the cost of diagnosing and treating the condition. Due to our experience with our own untreated ADHD or that of a family member, lack of recognition and support places a massive strain on every part of our life, and impact our jobs, finances and relationships.
Until recently, it was possible to receive both a diagnosis and treatment in this area. Since 2000, a specialised research clinic has been running a basic service at Addenbrookes Hospital, and from November 2009 to June 2011 the same professionals were running a monthly satellite clinic in Peterborough. This was the 2nd oldest adult ADHD clinic in the UK, with the potential to establish a high quality fully supportive service in this area. A business case to this effect was submitted to NHS Cambridgeshire in November 2010. No supportive response came from NHS Cambridgeshire. The professionals in the clinic have also twice developed programs to work with GPs to gain insight into the incidence and prevalence of adult ADHD in Cambridgeshire and Peterborough, and have received little to no response. Therefore, despite a lengthy waiting list, the service was forced to close in June 2011
We ask for your help and support in developing an effective service for adults with ADHD in the Cambridgeshire and Peterborough area. We were pleased to note in your consultation document that you state, “we would also like to develop a life course pathway for people with neurodevelopmental disorders.” Adult ADHD clearly falls within these parameters, and provision for these patients should be included in any redesign of mental health services as per NICE guidance.

Peterborough City Council consultation response, dated 19 December 2011

Comment/Issue
In summary, support proposed changes to Acute Ward configurations in Cambridge and Huntingdon and welcome the focus of modern adult mental health facilities for the north of Cambridgeshire and for Peterborough at the Cavell Centre.
Concerned that the proposals for the Advice and Brief Intervention Centre and for the Primary Care Mental Health Service have not yet been fully developed and consider that further consultation should take place on both these proposals before they are agreed and implemented.
Impact on community resources for mental health services of the changes to the way that Acute Wards operate has not yet been properly modelled and want assurance that these proposals will not impact on the resources available for community-based mental health resources available in Peterborough.
The proposals are intended to provide very significant cost savings and want assurance that such savings will not result in any cost-shunting to adult social care in Peterborough.
Major aspects of the proposals that we support:

- The reduction in rehabilitation beds is in line with modern professional practice and the relocation of the Lucille Van Geest beds to the Cavell Centre will ensure that the focus of the local rehabilitation beds is on individuals moving along the journey to recovery
- The closure of Acer Ward and the relocation to the Cavell Centre will avoid the difficulties of running an isolated facility and provide improved professional support.
- Allied to these two physical moves is the development of new ways of working within the acute wards at the Cavell Centre and at Fulbourn with the introduction of a new Dynamic Assessment Unit that will undertake assessments within 3 days when the patient is transferred to a Recovery Unit for 3 weeks before a planned discharge within 3 months.
- The continuing development of modern mental health facilities at the Cavell Centre is good news for Peterborough residents and for the City.

Other parts of the proposals where want to see more work carried out and where assurances are required about the future operation of the health funded elements of the mental health system. In particular:

The Advice and Brief Intervention Centre:

- It is not yet clear how this service will link with existing mental health services, including the social care elements, and how such a telephone system will link with existing services such as Peterborough Direct and the Emergency Duty Service.
- We also need to see evidence from elsewhere that the introduction of such a service can improve the patient experience and provide the necessary assurance to GPs, other clinicians and social care professionals that such a system provides safe and positive care.

The Primary Care Mental Health Service:

- The detail underpinning this proposal is lacking. We, together with local GPs will want to be assured that these new teams are adequately resourced and skilled in order to provide the support needed by individuals and to be able to provide support to the local community.

Changes to the way that Acute Wards operate:

- Whilst supporting the innovative approach to a recovery-based model with the introduction of the Dynamic Assessment Unit and the Recovery Unit, it is not clear how the anticipated increase in the number of people likely to be supported in the community can be achieved without increased resources within the community. There will be an increased need for community-based support and the availability of supported housing as a result of the quicker progress that individuals will make on their journey to recovery. It will be important for the City Council that it is recognised that where individuals resident in Cambridgeshire are admitted to an acute ward in the Cavell Centre and later return to live in the community, that the responsibility under Section 117 of the Mental Health Act on their on-going aftercare and support remains the responsibility of their originating authority.

The efficiency savings required:

- It is not clear how the costs involved in creating the Advice and Brief Intervention Centre and the new Primary Care teams

are to be afforded whilst at the same time achieving cost savings of £6.7m in primary care and community teams. There are similar questions over the financial impact of new ways of operating the Acute Wards on a community infrastructure

Making Space consultation response, 6 January 2012

Comment/Issue (the comments listed are a summary of conversations with carers and comments made regarding services from both carers and staff).
Carers have expressed concerns regarding the closure of Acer ward: extra time/cost involved with visiting. No local mental health ward in Huntingdonshire.
Leaving the Huntingdonshire area without a mental health ward seems 'a farce'. The area is expanding rapidly with St Neots being the largest town in Cambridgeshire, yet the nearest hospital is over 20 miles away
A&E: What happens if someone presents at A&E with mental health issues (overdose, psychosis etc). If there is no mental health provision at Hinchingbrooke does this mean someone will have to come from Peterborough or Cambridge to assess the patient. If so, will there be a separate waiting room where the carer and cared for person can sit quietly to wait rather than in a busy A&E department. If there is no consultant/mental health professional at Hinchingbrooke this will increase waiting time which is already lengthy. Also who do the other staff consult with (at A&E) if they are unsure about a patient exhibiting mental ill health.
Crisis service/home treatment – even though it is appreciated that CPFT need to save money if community based care is going to work, we need a local crisis service which is easily accessible and has knowledge of the area and teams/services available
The proposals rely on family to take service users to hospital - Family members may not have transport to take the service user to the Cavell Centre, or they may feel the person is too unstable to take in their car.
At present, family members are often not included in care planning or discharge even though they have a right to say what care they are prepared to offer and who lives in their home. How do you propose to ensure family members are included? This is already a requirement of the care programme, so what will change as it doesn't happen very often now?
Primary Care: Pathways to secondary services need to be clear to all
Primary Care: Will the Gateway worker service be increased and better advertised thereby understood by carers and service users
Primary Care: GP's often lack understanding of mental health issues/services. Will more emphasis be put on training/involving the carer/listening to carer
Primary Care: GP's need to understand the role of the third sector in supporting carers/service users and accept of at least listen to their professional judgement.
Advice and Brief Intervention service: The proposal for this is not until 2014, other changes including the change to primary care services are happening sooner. How do we know who to contact.

Advice and Brief Intervention service: If the brief intervention centre is run by CPFT will it be truly inclusive of all services and have information about a variety of services thereby giving patient choice. Staff training and involvement of the third sector from the start will be key to this.

Cambridgeshire County Council Children and Young People's Services

Comment/issue
Definition of mental health: We would like to see a definition of mental health services from your perspective, with regard to the new services, perhaps in the format 'Mental Health is…'. This…will make it clear…where the boundaries are in relation to other services for adults and children. For example, would problems stemming from ADHD, substance misuse, risk taking behaviour and son on fall under the remit of Mental Health in the redesigned services?
Children: We recognise that the Children's transformation is happening in tandem with the adult services redesign and as such has its own consultation(s). However we feel it needs to be made clear in the adult service redesign what the interface will be between children and adult services, as well as much more explicit recognition of the changes which are also happening in CAMH and how the two services will co-exist. Cambridgeshire County Council CYPS works with young people up to the age of 19 or sometimes up to 25 if they have additional needs, which leads to much crossover in terms of people still in receipt of our young people's services but who receive adult mental health services.
Children: Point 2, page 9 and also bullet 2 on page 14 helpfully explain plans for a new Primary Care Mental Health Service which will be expanded over time to include all age groups. Are there timescales for this and how this will interact with CAMH transformation? This has potential to remove many of the issues relating to differing upper age limits of services and transitions between child and adult services. Would the Primary Care Mental Health Service seek to replicate the boundaries that the CAMH transformation is seeking to with its model of service?
Transition (including CAF):
The consultation document makes no mention of transition arrangements from children's to adult's services at the age of 17. This is a time of disruption and change in many young people's lives as they have made the move from statutory education to further education, training and employment. It would make sense if a redesign of mental health services used the opportunity to make provision to make transition between services as worry free as possible for those young people already marked as the most vulnerable. The comment assessment framework can support this. We would be interested to know more about how the plan to 'extend the services for treating adults with early onset psychosis to also treat children from age 14' (page 19) will interact with other services and access points, being the only service which currently crosses age boundaries.
A Single Plan: On page 19 of the consultation document you mention a 'life course pathway' for people with neuro-developmental disorders. We would like to see in the service redesign a recognition of the above green paper (Government's green paper, 'Support and aspiration: A new approach to special educational needs and disability', published March 2011) and its

recommendations, and a commitment to working toward a single plan not just for specific disorder groups but for services users with complex needs, including mental health needs, in order to prevent the escalation of mental health needs often associated with Special Educational Needs.
Early Intervention and Partnership working with the Local Authority and others including PVI sectors: Page 2 of the consultation document states that local GPs and CPFT have worked in partnership to develop these proposals and that their priorities throughout have been to: 'ensure…strong partnership links to the local authority and other community and third sector organisations'. We welcome this recognition of the work we have been doing together and would like to see more evidence of this and work done with other health partners, statutory and community and third sector organisations throughout the development of these proposals and in consultations. Following on from point 3 above about use of CAF, we would welcome the proposals to include identification of early intervention measures which tie in with County Council priorities around prevention and escalation of need.
Young offenders: There is a clear link between the prison population and poor mental health. This needs early intervention from mental health services to prevent risk taking behaviour/behavioural disorders such as conduct disorder/oppositional defiant disorder/ADHD from escalating into criminal activity, subsequent incarceration and further mental health problems. Are there any early intervention plans both with young people in the transitional age and with adults? What is the pathway link with the YOS mental health for young people in criminal justice system after age 17?
Substance misuse: We would like to know how the link is made with substance misuse services, given the link between substance misuse and mental health problems.
Looked after children: How can we all work with families to decrease the number of children subject to a child protection plan/looked after? What is the provision for parents as inpatients to facilitate return of their children?
Looked after children: How can we protect young people in care when they are receiving mental health services from more disruption in their lives? What links are there with social care for LAC who may be supported by Social care until the age of 21?
Families and Mental Health: We would like to see recognition of the fact that mental health is a family issue in many cases. Parental mental health can have a profound effect on children, and potentially increase the LAC population, so how do you work with families to prevent this?
Families and Mental Health: Parental mental health such as post natal depression; when there are mental health issues pre pregnancy is there any preventative work or any planning done to prevent PND, which can contribute to attachment disorders which in turn are a precursor to problematic behaviour in adolescence? What provision is there for work with whole families, again showing the need to recognise in the proposal links with CAMH and to demonstrate more of a holistic and/or systems approach?
Access to Services (including hard to reach and families with multiple needs): In closure of the rehabilitation ward at Peterborough, some families will have to travel a long distance to see a parent/young person over 17. This may not be feasible with high fuel costs and limited public transport for the north of the County. Page 11 mentions recognition of the additional travel for patients and carers from Huntingdon to Peterborough for acute admissions and the need for 'additional support in these circumstances'. We would like more details on what sort of support would be offered to families for whom travel is a barrier to

maintaining positive, health relationships. We welcome the plan for more patients to be treated in the community as this will support families to stay together (page 19)
Access to Services (including hard to reach and families with multiple needs): Linked to the previous point, is there any scope for family assessment in families with multiple needs who access many services already? The mental health services according to this consultation document, and particularly given there is little mention of the children's transformation, seem to be acting very discretely to each other. We would welcome more joint approach which would contribute to early intervention.
Access to Services (including hard to reach and families with multiple needs): Is there any outreach provision for hard to reach families who may visit their GP or have an issue flagged by a health visitor or another professional but who are not able to access services, in order to prevent escalation of need and emerging needs in the children? Similarly models to improve access for adults, in line with children, does mention this use of community resource on page 6; will these be in line with the children's transformation? Clearly adults could not be seen in a school as children could but could children access the same locations as their parents do?
Access to Services (including hard to reach and families with multiple needs): Will services support residential settings and other health teams?
Access to Services (including hard to reach and families with multiple needs): Single point of access (page 6); how will this link with children's services? How will it be made clear to GPs and other professionals which single point of access is to be used in different scenarios? Similarly, the work of the Advice and Brief Intervention Centre (p8) must take account of CAF, especially given the intention to expand this work to cover all age groups.
Other points: Page 19:Children: Please include Locality Teams within your plan to make better use of resources and skills of staff by delivering more integrated care, as well as Social Care which is already included

Support Group for Family and Friends of People with Borderline Personality Disorder, 11 January 2012

Support	Supportive of the proposals and overarching aims
	Supportive of single point of access, speedier advice and intervention, quicker referrals, more structured therapeutic interventions and better crisis management.
Concerns regarding the proposals:	
Concerns	Two key reservations are firstly that our special interest of BPD may not fit quite so neatly into the proposals as we would all wish for reasons explained in our response
	Secondly, we appreciate that the redesign of services needs to start off considering the operational infrastructure, but successful implementation will depend far more on the softer issues of culture and staff training and development – it is in these areas that we feel that BPD sufferers have been let down

	in the past.
Need for training in Personality Disorder amongst mental health professionals	Worried that the service redesign will not produce desired improvements for Borderline Personality Disorder sufferers unless accompanied by a significant programme of training and development to raise awareness and understanding of Personality Disorder (PD) amongst mental health professionals. Our experience is that PD has been treated as peripheral to main mental health services or 'too difficult' even amongst professionals. Staff outside the specialist service at Complex Cases have not displayed the expertise needed and we strongly urge that this must change.
	The single point of access and redesigned community services will not be able to cope with Personality Disorder without a great deal more understanding and expertise than currently exists.
Increase in demand, raise in expectations of service users by proposals. Difficulty with current referral and assessment system	Improved access and referral will bring about a significant increase in demand for therapeutic services and positive interventions. The demand for these services is currently rationed very effectively, albeit inequitably, by the great difficulty which exists at present in getting through the multitude of referral systems to actual service provision. It is our experience that Borderline Personality Disorder sufferers often find the referral and assessment system insurmountable and hence never get effective services to help them. The majority of people with BPD are not engaged with Complex Cases and flounder without any suitable service. This increases demand for other NHS resources (such as A&E) whilst also increasing stress and anxiety for carers. We query whether the proposed redesign has fully considered the implications of raising expectations. Speedier access and referrals must be matched by suitable service provision. Certainly for people with BPD, there is currently a mismatch between demand for and supply of services which, bluntly, won't be reconciled with self-help advice and leaflets.
Specific comments on proposals:	
24/7 Advice and Brief Intervention Centre	The setting up of this centre is welcomed. It is vital that centre staff must have skills, knowledge and experience in dealing with Borderline Personality Disorder. This is to ensure that at times leading up to a crisis or immediately before a crisis happens, a decision can be made to affect an intervention that will prevent the crisis or divert it. Effective interventions can support family and friends in their quest to help alleviate stress on the BPD sufferer and prevent the NHS expending more resources than is needed. BPD is potentially a lifetime illness. Many sufferers need to move in and out of services as the acuteness of their illness demands. An efficient and effective intervention centre which allows patients to easily re-enter services at time of greatest need has the potential for being a very major improvement especially if the IT systems ensure full case notes are always readily available.
Primary Care Mental Health Service	Services for BPD sufferers are patchy or non-existent. The current Community Services do not offer an adequate service. We very much hope that the redesigned Primary Mental Health Service will examine the needs of BPD patients and make specific provision for those sufferers who do not have access to

	Complex Cases Service.
Primary Care Mental Health Service • **More knowledge of BPD needed amongst Home Treatment Teams** • **Blue light response back into system needed**	At present there is not an adequate crisis response arrangement for BPD sufferers in the community. This has meant that there is no effective intervention when needed, too often resulting in an emotional crisis developing into self-harming or attempted suicide. The knowledge within the Home Treatment Teams about effective interventions for BPD at crisis times seems very limited. The stress and resources expended by the patient, carers and the NHS can be mitigated if a range of 'tools' were available for these crisis interventions. Given the nature of BPD, such crises require the mental health equivalent of blue light response. Unfortunately our experience is that we are a very long way away from such a system and adequate arrangements need to be part of the redesign of services. The planned use of Continued Professional Development (CPD) to instil expertise of BPD during the set up of this service could be carried out at the same time as that of CPD for the Advice and Brief Intervention Centre.
The redesign of community services for people with severe and long lasting mental illness	This section makes no special reference to BPD patients and it should. BPD patients have extensive support needs, not just medical, but environmental ones that are critical to patients continued wellbeing. They need not be demanding on NHs resources. What is required is a specialist home-care framework staffed by professionals with a good understanding of mental health issues and ideally of BPD. At present there are too few specialist agencies/services available for the minority of BPD population whose support needs are the most complex. Agencies are risk averse about working with them. Social services are reluctant or do not have the resources to provide the necessary community support. It is likely that the paucity of community support will result in increased demand on NHS resources such as expensive in-patient treatment.
Consolidation of in-patient wards • **Not enough beds for BPD** • **Lack of knowledge of PD amongst professionals**	We warmly welcome the new in-patient facility for Personality Disorder at Springbank. This is a major step forward but it is extremely unlikely that 8 beds will be sufficient to cover the actual level of need for both long term and short term care of all BPD sufferers requiring in-patient services. It seems quite likely that BPD sufferers will have no choice but to continue to access in-patient facilities in non-specialist acute psychiatric wards. Our experiences in this respect have been profoundly unsatisfactory and we can cite many examples where the stay in hospital has been at least ineffective and at worst potentially dangerous. The reasons for this…come back to a lack of knowledge and expertise in dealing with Personality Disorder amongst even experienced mental health professionals. The problems are often further exacerbated by the extensive use of agency staff who lack appropriate training and skills
Services for Adult males and adolescents • **In-patient facilities for**	We would ask that you address the lack of in-patient facilities for adult males and for adolescents – categories of sufferers who are too often over looked since conventional wisdom has it that BPD is an illness suffered in the main by adult women. As diagnosis improves and the single access point becomes effective there may well be an increased proportion of male sufferers of BPD presenting.

these sufferers needed	Current professional thinking is that BPD cannot be diagnosed before the age of 18. This can mean effective interventions are not available despite sufferers experiencing all the traits of BPD
The role of carers – an omission from the consultation document	We feel that an opportunity is being missed in not tying in the work on a Carers' Strategy with the redesign of services. There are 3 aspects we would suggest you consider: 1. Carers need to be involved from the beginning of treatment and when developing therapeutic interventions. We have in depth knowledge of the patient and much to contribute, especially in implementing the coping strategies which BPD suffers need to develop. Patient confidentiality has become a barrier and all too often acts against the best interests of patients. 2. Carers and the wider family often need their own counselling support if they are to cope… 3. The age profile of many carers of sufferers of BPD is such that a fresh look needs to be taken at the long-term support needs for BPD sufferers. Aged carers cannot be expected to provide care forever; hence there will ultimately be an increased demand on NHS resources for this client group. With the forthcoming CPFT Carers Strategy, there needs to be a clear line of direction for the future.
Concluding comments: The Support Group is very supportive of the aims of the redesign of services. However we believe that changes to systems and processes must be backed up with effective staff development and continuous professional development if the service is to be truly effective for the increasing client group of BPD sufferers. We are particularly concerned that the current gap in expertise and knowledge about BPD must be filled; otherwise the gap will exacerbate the situation, particularly at this time of change. We recognise and fully support the efforts already being made to transfer the knowledge and expertise of CCS (Complex Cases) out to the wider mental health service. Such work needs to be a priority for the redesigned services to reflect the scale and intensity of BPD as an illness in the community and to remedy the neglect and misunderstanding of personality disorder amongst even mental health professionals as well as the wider health and care systems.	

The Cambridge and the Peterborough & Fenland Rethink Carers Group

Flawed consultation	Due to closure of Acer Ward and Cobwebs. This did not instil confidence in the process
Increase in staff in community	There will be a need for an increase in skilled and trained staff working in the community.
Reduction of rehab beds	The drastic reduction of rehabilitation beds (Cobwebs and Van Geest) will deny patients the chance of recovery and social inclusion.
	There is no question that outcomes, recovery and social inclusion could be much improved with the establishment of step up/step down houses.

Transition from secondary to primary care	Discharge of patients from Secondary to Primary Care can be extremely traumatic for the patient. The process is not always handled with the care of the patient in mind.
Crisis Resolution and Home Treatment Teams	Due to the constraints on staff numbers and the predominance of rural villages and towns in the CPFT area, there is an increase in the difficulties delivering continuity of consistent and safe community care by the Crisis Resolution and Home Treatment teams to those requiring a visit.
	The delivery of floating support is of great concern in most areas. There is an urgent need for a 'tightening up' of the conditions of the agreement and regular audits. In places and at times, we believe there have been incidences when patients have been at risk.
Accommodation - ghettos	Supported accommodation, independent living or group home – there will continue to be varying options. However there is a general opinion that 'ghettos' have been created in Cambridge and Peterborough in which vulnerable patients with mental illnesses have been placed and are pestered by drug dealers and, because they are lonely and lack any form of therapy often succumb to drugs and/or alcohol
Lack of continuity of staff involved in care	Patients and carers consider that, apart from the importance of building and retaining trust, the change of consultant, CPN, GP etc involving the repetition of the details of their illness to new (different) professionals is disturbing.
Medication	Medication treats the symptoms of mental health, not the causes. Carers are constantly consoling the ones they care for due to a high level of side effects experienced.
Training of health professionals in medication	Carers are concerned that there is insufficient training of GPs and psychiatrists in the effects of medication and that they do not adequately describe the side effects which the patient may experience. Carers believe that not sufficient time or thought is given in the suitability of specific medication to a specific patient.
Care Plans	Those responsible for the care of those with serious psychotic illnesses are failing to consistently provide a comprehensive Care plan/Care Programme Approach (CPA). The CPA is the bedrock of the whole service.
Supportive of Advice and Brief Intervention Centre	The potential of the Advice and Brief Intervention Centre should be good for the operation of mental health services
Staff shortages	There is a shortage of staff, particularly trained staff.
Training	Training should be mandatory, with annual refresher training
Health and Wellbeing Board	It is essential that mental health is central to the Health and Wellbeing Board. There must be direct and robust representation of patients and their carers on the Board. Mental health is too important to the overall health
Signposting to Careline	Rethink operate a 24/7 helpline – Careline – for the carers of those with severe and enduring mental

from Advice Centre	ill health. We trust that the Advice Centre will signpost this service to carers contacting the ABIC.

St Ives Town Council consultation response

Acer ward	Acer Ward should remain open long-term. In the short-term, members would encourage the re-opening of the ward with modifications to improve the facilities on offer. We would seek clarification on what makes the standard of accommodation 'out of date' – it is understood the ward comprises a number of ensuite single rooms.
Advice and Brief Intervention Centre	The lack of detail about the proposed point of access makes comment on it difficult
Savings targets	Concern at the level of total target savings to be made over 3 years.
Transport	Concern expressed at the proposed onus that would be put on families to get a patient to the Cavell Centre in Peterborough, and the health and safety issues raised by this.
Reduction in beds	Concern expressed at the proposed reduction in beds, when our area is undergoing a huge expansion in housing.

Her Majesty's Court Service consultation response.
Mr D Ratcliffe, Clerk to the Justices, Cambridgeshire
Peterborough Magistrates' Court, Bridge Street, Peterborough, PE1 1ED

Any changes to the provision of Mental Health services in Cambs allow the recommendations contained in the Bradley Review 2009 to be implemented at the earliest possible opportunity, specifically:
• A liaison and diversion service to be developed that can provide effective screening and identification of individuals with mental health problems or learning disabilities who are involved in the criminal justice system.
• A process to be developed whereby information can be provided to the police, solicitors and CPS to facilitate the earliest possible diversion of offenders with mental disorders from the criminal justice system and signposting to local health and social care services as appropriate
• A process to be developed whereby information can be provided to the courts and probation service to enable appropriate decisions to be made by the courts as to remands, fitness to plead and sentencing.
• A county-wide service level agreement to be put in place between HMCTS and NHS as to the provision of psychiatric reports/mental health assessments to the courts
• The provision of sufficient secure hospital places to be made available locally to enable courts to remand defendants to

hospital for assessment where appropriate

Hinchingbrooke Healthcare Trust consultation response

Community based services	Shift of emphasis towards community-based rather than ward-based services provides the opportunity for more responsive services for patients.
Crisis support team	The Trust is keen to ensure that a robust and responsive crisis support team is in place for those patients that present at A&E or are in our inpatient beds and require psychiatric assessment.
	Recently the responsiveness of the crisis support service has deteriorated and whether this is due to the recent closure of Acer Ward is not clear.
	Whilst work continues with CPFT to ensure patients receive a responsive service from the crisis support team, it is fair to say that we still do not yet have a signed agreement between the two organisations to ensure a responsive service and we would require NHSC to ensure this in place in order to give our support to the permanent closure of Acer Ward.
Acer Ward closure	If the outcome of consultation is permanent closure of Acer Ward, this has a financial implication for the Trust. We would welcome discussing whether the commissioners have any proposals for alternative use for this facility as part of the future commissioning intentions. We will of course continue to consider this as part of the Trust's wider estates strategy. Equally should the decision of the consultation be to retain the Acer Ward facility, we would be happy to discuss this option further with CPFT.

Lifecraft & Lifeline
Carole Morgan, Lifeline Coordinator, Dept Manager Lifecraft, The Bath House, Gwydir Street, Cambridge, CB1 2LW

Single point of access	Access to services is not clear presently, with so many different routes, therefore this needs to be improved for all.
	Important to be realistic about what you are offering. Consultation document says the centre would 'enable people to receive treatment and advice quickly' – in some cases users would receive treatment more quickly, if there was appropriate treatment available.
How would a service user like to access the	In a clear, straightforward way, being supported, treated with respect.

service?	
Primary Care mental health services	Our concern is that GPs will be expected to take on an extra workload for which the majority do not have the relevant training, expertise and may not have a strong level of professional interest. Also, do GPs have the capacity to absorb this potential extra work? In turn service users will not be getting the help and support they need as this cannot be provided in a 10 minute appointment by a GP who is under pressure to have time-limited, short sessions.
Combining in-patient wards for adults	As Cobwebs and Acer closed before the consultation process was complete, this can lead service users to mistrust the process.
Cobwebs	People who used Cobwebs found it worked for them and there is not the equivalent for them to move to. It is felt that the closure was not handled well and for the service-users for whom it was difficult to re-house felt this was about them and this didn't help their own mental health.
Acer ward - transport	Strong campaigning locally for the ward to re-open. Concerns from carers regard difficulties travelling to visit relatives at Peterborough and associated costs. Particular concerns raised if having to rely on public transport if living in villages.
Crisis Team	Feedback given at consultation meeting around issues with regards to Crisis team. Capacity of team an issue; it was reported they are not meeting demand. This needs to be addressed to keep patients save
How could the mental health services be made more efficient?	Over the years we have tried to feed back information where necessary to help improve services. Culture needs to change to become more open, by taking this information and using it
	It is also very clear that it is not just about services becoming more efficient. Funding for mental health services in Cambridgeshire is low and needs to be improved to enable services to be provided more efficiently.

Huntingdonshire District Council Overview and Scrutiny Panel (Social Well-being) consultation response

Closure of Acer Ward	Do not support closure of Acer Ward. The case for closure has not been satisfactorily justified.
	The Panel has not been presented with evidence that mental health facilities in Peterborough will produce better outcomes than could be achieved at Acer Ward. Panel recommends that before a decision is taken, such evidence should be sought. This should include undertaking

	analysis of the proposals' Community Impact Assessment and of the implications of the Public Health Joint Strategic Needs Assessment for the proposals. To further assist with this, it is also suggested that the Royal College of Psychiatry should be consulted.
Future population growth	The proposals do not demonstrate how the mental health service will cope with anticipated population growth projections in both Cambridgeshire and Peterborough. Members therefore question the future sustainability of the proposals
Travel	Members are not satisfied that sufficient consideration has been given to the travel implications of the proposals, both in terms of the adequacy of the hospital transportation system and public transportation links to both the Cambridge and Peterborough facilities together with the cost of travelling to and from these areas. Cost is of particular concern for both patients and their visitors as well as in terms of NHS and Ambulance Service resources. Detailed plans on the transport that would be provided to these facilities should be developed before a decision is taken.
Lack of information and misleading information provided on Acer Ward	Members had expected to see information on the services that were previously available at Acer Ward included within the consultation document. Consultation document was also misleading as it gave the impression that Acer Ward only had dormitory style bedrooms, when in fact many are not. Also expected information to be available on the costs and other implications of brining Acer Ward up to an acceptable operating standard. Concerned that the consultation has taken place without this work having been undertaken. This suggests the outcome was predetermined. This work should be completed to inform the decision
Acer Ward	State that Acer is isolated as it does not have the support structures that are available at larger sites. Seek clarification on what these support structures might be. Satisfactory response to these questions was not received at the meeting.
Closure of Acer Ward	Closure of Acer Ward could be detrimental to the health and well being of both patients and their visitors thereby impacting upon patient rehabilitation levels. The mentally ill often feel isolated and moving them to Peterborough would exacerbate this feeling. Evidence needs to be compiled on the potential effect of the proposals on existing patients.
Primary community services	Supportive of the proposals to strengthen and further enhance the primary community services available to mental health patients, their carers and their families.
Advice and Brief Intervention Centre	Concerned that this could lead to a flawed diagnosis given that some patients would not receive a face to face service. In addition, members have formed the view that the Centre could act as a potential barrier to acute services for those in urgent need of care.
Circle Healthcare	Panel is concerned over the lack of engagement by NHS Cambridgeshire with Circle Healthcare on the proposals. Owing to their wish to retain the facility at Hinchingbrooke

	Hospital, the Panel will be meeting with representatives of Circle to discuss with them the option of preserving the facility within the Hospital.
Joint appointment of physicians	As a possible means of retaining the service at Hinchingbrooke, the Panel has suggested that NHS Cambridgeshire should investigate making joint appointments of clinical physicians across Hospitals, for example they could operate at both Peterborough and Hinchingbrooke Hospitals
	The value of the service to Huntingdonshire has been recognised. Mental health services should be retained at Acer Ward. NHS Cambridgeshire should undertake a thorough exploration of all options through which mental health services might be retained in Huntingdonshire before a decision is taken on the future of Acer Ward.

Further comments from Huntingdonshire District Council Overview and Scrutiny Panel (Social Wellbeing), submitted 17 February 2012

Poor patient experience in Peterborough	Attention was drawn to the experiences of a patient at the mental health facility in Peterborough: poor quality of food, lack of continuity of care from staff, hospital ward accommodated patients suffering from drug and alcohol abuse as well as those diagnosed with clinical depression.
Acer Ward	Panel still not satisfied with the case for closing Acer Ward, still believe this is unjustified. An acute facility in Hinchingbrooke Hospital forms and integral part of the redesign of mental health facilities across Cambridgeshire and Peterborough.
Support for enhanced primary community services and relocation of Crisis Resolution Home Treatment Team	The Panel confirms support for the proposals to strengthen and enhance the primary community services available to mental health patients, their carers and families and welcome the decision to relocate the Crisis Resolution Home Treatment Team back to Huntingdon.
Travel	There needs to be clarity on the transport arrangement that will be introduced. Panel wants assurances that should Acer be closed, a budget will be established on an ongoing basis to assist patients travelling to and from alternative wards.
Costs to upgrade Acer Ward and the mental health facility located in Cambridge	The Panel is not satisfied the costings have been prepared on a consistent basis (£1million investment to upgrade Cambridge facilities and £1.7million to upgrade Acer Ward). Both facilities are located within dated buildings so they will need similar works to be undertaken.
Co-location of Crisis Resolution Home Treatment team with acute unit at	Suggest Crisis Resolution Home Treatment Team is co-located alongside an acute unit at Hinchingbrooke Hospital. NHS Cambridgeshire is requested to consider this

Hinchingbrooke.	suggestion.
Population growth of the area and surrounding areas	Proposals have not satisfactorily taken into account local population growth projections. The mental health service's catchment is not limited to Cambridgeshire and Peterborough, but also neighbouring counties such as Lincolnshire, which are also regarded as growth areas.
Community Impact Assessment	Whilst it is acknowledged that there is no legal requirement to complete a Community Impact Assessment, the Panel suggests this would be valuable and should be undertaken before any decision is reached.
Consultation with Royal College of Psychiatry	The Royal College of Psychiatry should be consulted upon the proposals.
Transitional arrangements	Transitional arrangements need to be clarified in detail. This includes the availability of supported housing and how outcomes will be monitored in the future.
Assurance for residents	Methods employed by NHS Cambridgeshire to deliver assurances to residents about the proposed changes need to be improved.

Cambridgeshire and Peterborough Joint Overview and Scrutiny Committee consultation response

OSC Recommendation	NHS response
1. NHS Cambridgeshire, NHS Peterborough and CPFT publish timescales for more details on the specific proposals to be made available to Overview and Scrutiny and the public.	The detailed Project Plan is being regularly updated in meetings with GP commissioning leads.
2. A detailed budget is agreed and spending closely monitored by CPFT, NHS Cambridgeshire, NHS Peterborough and the two local authority social care departments to ensure that any mismatches between spending and resources are identified and addressed Contingency arrangements are set up from the start to ensure that patient care is not compromised if the anticipated savings, or income generation targets, are not achieved.	This will be taken forward via the annual contract negotiation processes between all the organisations mentioned. This will be added to the relevant risk register(s).

3. In addition to ongoing monitoring, an in-depth review of the implementation of the changes, including the views of staff, patients, informal carers, and other stakeholders is conducted after 6 and after 12 months, with action taken on the issues identified. A particular concern is ensuring the right balance between inpatient and community capacity, particularly in the transitional period	We will use our Service User Engagement Worker and other local resources to conduct this work. The priority groups to monitor will be (a) former Acer ward patients and carers from Huntingdonshire now travelling to Peterborough and (b) former "Cobwebs) residents in Cambridge now living in the local community.
4. The transition plans explicitly address the above issues and include clear milestones, and that there is ongoing monitoring to identify and address any emerging service gaps at an early stage.	The Project Plan includes specific reference to transition arrangements, including the need for some "double-running" as new service models are implemented. We are also exploring the feasibility of establishing a "liaison psychiatry" service in both Peterborough and Hinchingbrooke Hospitals and strengthening that already in existence at Addenbrookes Hospital.
5. CPFT work with the local authorities, NHS Cambs and Peterborough, and mental health voluntary organisations to develop a training strategy that ensures that: • GPs, domiciliary care staff, and other staff working with people with mental health issues of all ages are appropriately trained • Relatives and friends who care for people with mental health issues have access to training that will enable them to better support the people that they care for. • Resources are clearly identified to achieve the above.	We will review the local training strategies of each of the organisations mentioned. The proposed Advice and Brief Intervention Centre will also be a valuable local resource for GPs, carers and other people working with individuals with mental health problems
6. NHS Cambridgeshire, NHS Peterborough, and CPFT work with Cambridgeshire County Council and Peterborough City Council as a matter of urgency to ensure that there are transport arrangements for patients and visitors, particularly Huntingdonshire residents with friends	The Committee received a presentation from the Cambridgeshire County Council transport lead during the consultation period. This work is ongoing. We also propose to maintain for a further 12 months the fund

and family in acute wards in Peterborough These arrangements are widely communicated to patients and family members, including previous Acer ward patients with long-term mental health problems who may need admission in the future.	established in 2011 to support patients and carers of the former older peoples wards in Huntingdon and Wisbech to travel to Peterborough.
7. CPFT and NHS Cambridgeshire and Peterborough build on the work being undertaken with the local authorities to address gaps in housing provision for patients throughout the area, with a particular emphasis on developing policies and practice in Peterborough	We acknowledge this is a priority issue in Peterborough, and this will be highlighted in the continuing work to develop new housing strategies in both local authority areas.
8. CPFT, with NHS Cambridgeshire and NHS Peterborough are proactive in communicating to current and former patients and family members what improved outcomes they envisage by closing the ward, what transport arrangements will be made, and what improvements will be made to the crisis and community mental health services.	The Communications Plan will be strengthened to ensure we are proactive in keeping those affected by these changes fully-informed
9. There is ongoing monitoring of the pressures on existing acute beds, with scope to increase the number if this is needed, particularly during the transitional period The number of acute beds is not reduced in future unless there is clear local evidence that this is appropriate.	We will continue to monitor the impact of the changes to the local acute system that were described in the consultation document and are currently being piloted in Peterborough. These are designed to increase the efficiency of our current bed management.

Cambridgeshire LINk, Peterborough LINk & Service User Network response to the Mental Health Re-Design Consultation

Comment/issue
Q1 Do you agree with the idea of a 24/7 Single Point of Access for mental health services?
Yes
The IT system is of concern, especially as NHS IT systems have historically been very problematic and ineffective. What is the cost implications for introducing the IT needed for the Brief Intervention Centre (BIC).
How will the BIC be staffed to ensure it can meet demand and be responsive to the average person in the street, and will it operate like NHS Direct, the concern here would be that for people in mental distress waiting for a ring back could add to their distress, will immediate support be available from the BIC?
Will service users be able to self refer, and will access be truly open to all? If so, how will it cope with potential demand and traffic from the street?
The BIC will need to be delivered by staff with the appropriate skills, knowledge and training; this will require specific skill sets and management.
Whilst signposting people is a positive aspect, will there be extra resources for voluntary and community organisations to be able to deal with the influx of increased demand on their services.
Q2
N/A
Q3 If you are a service user how would you like to access mental health services?
Choice and access are both important issues, as is GP understanding and options as to where and when you can access.
In regards to the BIC an information pack would be useful and it will also need to be widely publicised.
How will Clinical Commissioning impact, when GPs may end up having to pay for external referrals will they still have the patients best interest at heart?
With regards to the BIC any form of automated response would not be welcomed, staff training will be vital to ensure service is delivered appropriately to those who may use it.
Q4 Do you agree with our proposals to set up a new Primary Care Mental Health Service?
Yes
Staff will need to have the appropriate skills in working with complex needs, such as people with substance misuse, personality disorder, neuro-developmental disorders or learning difficulties alongside mental health problems. This may well require a cultural change within some services; staff will need to be supported and trained to ensure that these new responsibilities are recognised, understood and ultimately delivered to patients.

Will staff possibly become dis-satisfied at working in different ways, for example those doing BIC loosing face to face contact with patients. For patients in distress face to face contact is invaluable, telephone support obviously can't see or monitor body language.
Q5 Do you agree with our proposals to combine a number of inpatient wards for adults?
Yes
If people are using inpatient facilities in Peterborough how will their physical health needs be met if they would need to use Hinchingbrooke/Addenbrookes for example?
How will peoples accommodation be managed across different councils whilst they are receiving inpatient care, what is the strategy to manage housing?
Specialist rehabilitation services located at the Cedars in Cambridge will mean some Peterborough patients will be included. Will the same consideration of travel arrangements be made as suggested for Huntingdon residents?
Cost of refurbishment of David Clarke House – has this been accounted for?
Is it envisaged that less people will be admitted once the BIC is set up? Is there not a gap in service provision until it is up and running?
Will the savings of reducing beds be re-invested into other services, for example developing 'safe' houses for service users in crisis, who otherwise self harm or make suicide attempts to get access to safe spaces/support; prevention would be not only be financially cheaper but would also provide better outcomes and support.
Q6 Do you agree with our proposals to combine inpatient wards of inpatient wards for older people?
Yes
Demographics show that we have and will continue to have an ageing population, and we will continue to see an increase in the number of people living with Alzheimer's and Dementia; will there be sufficient in-patient beds to cope with demand.
Providing mental health liaison services in acute hospitals and care home can improve clinical outcomes while reducing the need for hospital admissions and GP consultations, we would like to suggest that patients with functional mental illness and dementia are supported separately.
What levels of support will be available, and has the skill mix at LVG unit with a change of usage been identified.
Q7 Do you have any views on how we could make mental health services more efficient?
An obvious area to begin is the large number of people with long term conditions and co morbid mental health problems. Research shows that by providing better support for their psychological needs, the costs related to treating people's physical illnesses can fall substantially, for example, by reducing unplanned hospital admissions.
Will mental health professionals have a place on the clinical commissioning board?
Q8 Please provide any further comments you may have regarding these proposals:
The starting point for commissioners should be to benchmark their use of inpatient beds against other areas. Knowing where you stand in this distribution can be a useful first step. In areas with high levels of bed use commissioners may understand the reasons lying behind

this and intervene as appropriate.
The savings envisaged will require an expansion in screening, development of collaborative care arrangements between primary care and mental health specialists, and provision of appropriate interventions, for example based on CBT. Improved access to psychological therapy services will also need to play an important role in this.
The paper has been designed to guide and encourage specific answers; ultimately the basis for services should be focused on: Accessibility, Consistency, User-Friendliness and Specialisms.
The focus is more on financial savings and not on quality, targets of success should be centred on the individual/personal experience.
Please describe how the skills of the voluntary sector can be used to support service users / carers and help improve their Quality of Life
Can the availability of relatives' sleeping quarters at the Cavell Centre for long distance travellers be promulgated better
Can help with transport or parking costs be provided to visitors who need it?
We would like to include some examples of good practice from other areas: • In Bradford, each psychiatric ward is led by a dedicated inpatient consultant. This fixed point of contact allows professionals in community mental health crisis resolution and home treatment teams to establish stronger relationships with inpatient teams, and makes it easier for nursing teams to organise discharge. The CMHT staff review patients with ward nurses daily; new technology for joint working between inpatient and community teams. Technology for joint working between inpatient and community teams, electronic patient records and progress notes give community professionals real time information on admitted service users, allowing them to update on developments; such as changes to care plans or risk assessments. • Norfolk and Waveney Mental Health Foundation Trust has introduced an innovative model for adult acute services in which each locality has an integrated team led by a consultant psychiatrist, the team aims to deliver a seamless service by providing home treatment, crisis resolution and inpatient care. • In Salford, the improving access to psychological therapies service has developed a new care pathway for people with diabetes and co morbid depression or anxiety. The service provides sessional input into the community diabetes clinic and has trained diabetes professionals in screening for mental health problems.

Cambridgeshire County Council Adult Services Directorate response

The Adult Services Directorate fully endorses the key reasons for change, namely: • Improved access and responsiveness

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Modern and purpose built facilities
More efficient services

These are largely in line with our strategic priorities and in the context of Intergrated Health and Social Care services, would be prerequisites of modern forward looking services. However it will be necessary for a large degree of detail to be developed in particular around Advice and Brief Intervention Centre; Primary Care Mental Health Service and the re-design of community services for people of all ages. There are areas where there is an absence of detail, in particular between the link between the financial challenges, which also include Adult Social Care, and the changes to mental health services.
</td></tr>
<tr><td></td><td>It is a matter of concern that there is an absence of the sense of integration between health and social care at an adult level throughout the consultation document</td></tr>
<tr><td></td><td>We endorse the response of the Joint Overview and Scrutiny Committee.</td></tr>
<tr><td>Advice and Brief Intervention Centre</td><td>We acknowledge that there is a significant amount of work to shape this proposal. We recognise that this has the potential to deliver significantly improved access to services and support the development of this approach. We would want assurance that this service would:

Have clear protocols regarding its relationship with other access points, mainly Cambridge First. This would include clarity around definitions such as mental illness and mental health, and would include clear protocols in relation to ‘life course pathways’
That there is broader approach that enables people to either directly refer themselves or for organisations to refer directly to the ABIC ie that there is an open access approach to referrals.
That in the final model there is a proper level of resource, staff, skill and technology support the service.
That the County Council would be involved in shaping the service, particularly if Social Care funded staff are inputting into this service.
That as services become more open, that there is clarity around the impact of confidentiality so that it does not become a barrier to accessing support, particularly for family and paid carers.
That the strength of local voluntary sector organisations is utilised and recognised in the establishment of this service.
</td></tr>
<tr><td>Primary Care mental health service</td><td>We do see prevention as a key element of any service. There is a clear link between this element of the consultation and the ABIC and do feel that further work is required to give a fuller sense of this proposal.</td></tr>
<tr><td>Inpatient wards for adults of working age</td><td>We do support the proposal to consolidate beds and deliver against best practice both in terms of interventions and the physical environment. This includes the move towards community based</td></tr>
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	rehabilitation. We would wish to seek reassurances in relation to: • The strengthening of community based teams in Huntingdon coupled with improved management of crisis teams to offset the loss of local beds • The impact of closures and the transfer of beds on the management of the AMHP service. Initial evidence is that there are problems around delays to admissions and access to Section 12 doctors. We would wish to see bed availability monitored given that the proposed changes have already occurred. • Establishing effective transport arrangements, particularly around enabling and maintaining social contact • We do endorse the OSC view in relation to the timing of the closure of Acer Ward • That pressures on beds do not result in an increased use of residential and nursing care thus shifting cost pressures across organisations.
Inpatient wards for older people	In line with the changes to adult beds, we are supportive of proposals to consolidate beds but want to ensure again that there is best use of resources
Community Services for people with severe and enduring mental illness	We support the intention to redesign community pathways, including 'life course pathways'. Significant detail is required to enable the impact of such changes on social care professionals within CPFT. Within this context it is recognised that there are significant issues around care planning, personalisation and skill mixes that require a level of detail that is not within the current proposals.

Cambridgeshire Service User Network (SUN)

Strengthening of community services in Huntingdon	Services should be user led particularly when it comes to decision making about care, not being 'pushed'. Service users should be empowered and services need to be empowering. Choices need to be given to service users. It was felt that volunteers could be used more effectively but there is a strong consensus that GPs need to have better knowledge about mental health with the ideal of being one GP per practice to take the lead in mental health. Services need to be 'user friendly' with better understanding from professionals about what service users are going through. There needs to be a greater emphasis on social inclusion and community schemes and more appropriate support particularly when being discharged. It was felt that services need to be strengthened county-wide. Services need to be face to face and consistent. More information needs to be given about what services are available to access. People would like to see the

	crisis team strengthened and all services should offer a choice of professional. There was also great emphasis that the services should be honest and promote integrity. *Some ideas raised* – There needs to be health checks making greater links between physical health and mental health. It was stressed also that within physical health there needs to be a better understanding of how physical issues can have an impact on mental well-being. More group support like recovery star groups would also be useful.
Set up a new primary care mental health service	People felt strongly that a preventative approach works best. This could be done by having easier and quicker access to the Home Treatment Team before there is a crisis, making more use of the information about each patient and sharing that information with appropriate people. Complete annual mental health checks perhaps having a questionnaire that the service user completes themselves to monitor their mental health and share that with the GP. Provide courses i.e. anxiety and anger management to give people more awareness and self help tips to manage their mental well-being. Some people felt that Acer ward was not big enough to cope with different needs. It was also stressed with high importance that people should not be discharged from services unless there was some back-up or discharge plan. CBT in surgeries felt beneficial but there needs to be better continuity of staff contact, sharing of care plans with service users and duty workers to be able to recognise ill-health. It was also mentioned to not have fixed periods of contracts with services, housing and police should be able to access the Advice and Brief information centre and that people who were having a wobble should be able to access the ABIC. It was felt that the ABIC would help 'blue zone' patients but that there needs to be face to face contact after the initial phone contact with the ABIC as face to face work is incredible important.
24/7 Advice and Brief information centre	Most people felt that there needs to be better knowledge of things and what services are offering. An example was given that lots of GPs do not know about Hunts Mind. People talked about how the ABIC could be used as a 'stepping down' tool when being discharged from services and that they would like to see telephone support being offered in intervals for this. It was felt that there needs to be better links between primary and secondary care and that it would be important that there were call logs of when people had called. Again it was mentioned about yearly mental health checks but there were concerns about the ABIC being able to identify emergency situations. People felt that the ABIC should be a 'bank account of information' that the mental health trust should be accountable for maintaining. It was also said as being important to being service user centred and that it would be better if the centre was localised.
Consolidate Inpatient wards for adults	There were lots of concerns that the closure of Acer ward meant the loss and demise of local services although some people felt that the state of facilities on Acer ward were poor. There was some value

	given to having and assessment unit, similar to that of MAU and offering more day service provision as an alternative to Acer Ward. People were worried that losing Acer Ward may mean that there are not enough beds and questions were raised about why Acer Ward was not being refurbished. It was mentioned that if things were that bad on Acer Ward, why had there been no deaths on there. Things that need to be considered are visiting times for friends and family, these need to be co-ordinated around public transport and busy times.
Concerns	Despite the intentions being of not closing Acer Ward until the outcome of the consultation, many service users reported being told by GPs, ward staff and psychiatrists that the ward was due to close in the autumn. It was stressed to the participants at this event that no one should have been told that information as the Board of CPFT would be making the decision depending on the outcome of the public consultation. It has been concluded that information about proposals was leaked. The leaking of information has undermined the process of public consultation as it has placed mistrust from service users in governing bodies and commissioners to properly consult. People have felt that this has been a 'tick box exercise'. People also reported that staff have been transferring their worries about ward closures onto the service user which is both unacceptable and ethically immoral. The leaking of information has made service users anxious and worried. Service users should not have to take on board staff anxieties, their concern should be only about the service they receive and the service they receive in the future. The Service User Network would like to see that this behaviour is addressed with the staff teams and any person found to have been leaking information to be held accountable. The Service User Network would also like to request that service users are able to come and view the inpatient wards at the Cavell centre so that the surroundings are familiar should they require future admissions.

Peterborough Community Services
Comments submitted by Chief Operating Officer, Alison Reid

Other than the logistics of where the inpatient beds will be, the plans are extremely positive.
Concern is the response or delay in response that is currently experienced when referring to Mental Health Services and the reluctance to support community services that are unable to meet the needs of individuals with complex mental health issues and in

addition, the reluctance to move individuals even when the person is at risk to themselves or others, and I am not sure how the proposal will address these issue.	
Advice and Brief Intervention Centre	A 24/7 service for support and advice is a positive move, but is has to ensure a timely response and appropriate input.
Advice and Brief Intervention Centre	Proposed single point of access to 24/7 support and access to brief intervention is a positive and important step in ensuring access to MH services is readily available and easy to access. The recognition that brief interventions can be effective and that services are being reconfigured to supply these interventions to save the need for greater use of MH services further down the line fits well with the social care preventative agenda.
Transport, lack of provision in Huntingdon	The map showing proposed services highlights a geographical "gap" in MH provision at Huntingdon (a significant sized commuter town). Expecting patients to travel to Peterborough or Cambridge may not be practical.

Cambridge and District Citizens Advice Bureau

We welcome an emphasis on a move from ward to community based services and the need to look at how "pathways" can be more responsive and we fully support the 3 reasons for change (Improved access and responsiveness; Modern and purpose built facilities; More efficient services)	
Advice and mental health	Disappointed that there is no mention of the impact that practical advice has upon people's mental health and wellbeing. As an example. There is now a wealth of evidence that debt is a major contributor of stress and other mental illness. Debt and other practical matters (e.g. housing), if not sorted out, can also seriously hinder any possibility of recovery. (National Mental Health Development Unit Toolkit for Commissioners Dec 2010 recognises that quality of life can be improved through interventions such as debt counselling, signposting to welfare advice, financial literacy and self help programmes. The Government's Strategy "No health without mental health" identifies potential cost savings from investing in Face to Face debt advice amounting of up to £950m) We would like to see added to this section, something about the need for practical advice to help people with mental health issues deal with every day issues such as coping with the costs of living in community based situations (proposal 5).

	We would welcome the opportunity of working with the Trust to help provide such a component of health care.
Advice and Brief Intervention Centre	Given its significance in the proposed changes and its potential impact on the advice landscape, we are concerned about the lack of detail about a single 24/7 Advice and Brief Intervention Centre. Will this be in one geographical location for the whole county? Is it intended that clients would visit the centre or access its services in other ways? Will it deal mainly with GPs or directly with end-users? How will carers be supported? How will patient referral work in this arrangement? There is much emphasis in the document on telephone and web-based services; how will the trust deal with access issues e.g. for people in a state of high distress?
Equality Act.	We are concerned that the only means of access to the 24/7 Centre appears to be by telephone. This would exclude the many service-users who feel unable to use telephone services by reason of their disability. We suggest that alternative means of access should be provided, including text messaging and email. We are piloting partnerships with local organisations to provide remote-access interviewing using video-cams for our advice work, and suggest that such plans should form part of the Trust's long-term strategy.
Primary Care Mental Health Service	We would emphasise again the importance of integrating access to practical advice and support in this service (see point 1 above), as a necessary part of treatment and recovery. Cooperation between CABx and GP surgeries has been found highly effective in some areas, such as [??] Cambridge CAB is about to launch a pilot project focusing on such work.
Consolidating wards/closing wards	Equality Act. Families and carers who themselves have physical or mental disabilities, including older carers, may be disproportionately affected by the increased distance from facilities, given their difficulty with accessing transport. We should be glad to see the result of any Equality Impact Assessment focusing on such questions. We need to know what consideration has been taken of the Equality Act concerning access for family and friends should patients have to be admitted to wards further away from current facilities.
Consolidating wards/closing wards	We note there is acknowledgement that you will need to work on a Travel Strategy and would welcome the opportunity to comment on this.
Consolidating wards/closing wards	Timescale: we note that the timescale for change starts before the end of the consultation which brings some scepticism as to how genuine this consultation is.
Care in the Community.	We fully support the view that people are generally better off cared for in their community.

	We also welcome the commitment to improved services for people with autistic-spectrum disorders, and hope that this will include better diagnosis of adults and improved access to services for those with long-undiagnosed conditions.
Care in the Community.	We are concerned to know: • What support/resource will be made to ensure adequate community support, given the long history of failure in this respect, with people and their carers being effectively 'dumped'? • Voluntary sector groups are highly cost-effective in this field, but we are concerned to know what provision is being made for proper partnership arrangements, taking into the account the costs involved to the sector. 'Voluntary' sector support is not cost-free. • What priority is being given to care of people with chronic and non-responsive conditions, and their carers? This is a matter of strong concern given existing weaknesses in this area. The proposal is currently incoherent, with reference (section 6) to people with non-responsive conditions being followed only by proposals for improved service for early-onset psychoses. • Given statutory requirements, understandably the consultation paper is most detailed on ward closures. We are concerned about the minimal discussion of other associated changes in community-based services in rehabilitation, recovery and social inclusion which will have a direct impact on our clients. • What provision is being made to ensure that discharge into the community really is the best solution for an individual? For some people being put back into their community is the most disruptive thing to do.
Funding	We appreciate that the proposed changes take place in the context of a difficult funding environment. However, we note that per capita spending in our area on mental health services is already relatively low both in comparison to mental health spend in other parts of the region and to physical health spending locally. We also note that recently both the Quality Care Commission and NHS Staff Survey have raised concerns about the current standard of service offered by the Trust. Our understanding is that the CPFT is only cutting corporate costs in line with frontline service costs. We would like reassurance that all alternative means of achieving savings have been explored including the potential of merging corporate functions with other trusts.
	There is on-going reference in the document to the merging of services for children and adults. This runs counter to the Kennedy Review on age appropriate services.

Cambridge Mental Health Stakeholders

Age UK Cambs, Alzheimer's Society, Arts & Minds, CAB, Cambridge MDF Bipolar Self Help Group, Cam-Mind, Corona House, Friends of Fulbourn, Lifecraft, Rethink, Winston House

Current impact on service users	We note the extent to which the reorganisation is already impacting on service users, who in many cases no longer know with clarity their named support workers. People are being told their cases are closed (Lifeline). A recent circular from the new CEO stated that 'service users have a named care coordinator who sees them regularly'. This is not always the case, and absences due to sickness are not being covered.
Insufficient community support	
Lack of community follow up and ongoing support	
Granta support	
Expectation of voluntary sector	The consultation paper seems to think the voluntary sector will pick up the pieces. We have no more money than the statutory providers and we understand there will be no money to commission voluntary sector support.
Advice and Brief Intervention Centre	

APPENDIX 7 – INDEPENDENT ANALYSIS BY MRUK RESEARCH, OF QUESTIONNAIRES COMPLETED AND RETURNED DURING THE CONSULTATION

1. Introduction

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

1. To open a new 24/7 Advice and Brief Intervention Centre
2. To set up a Primary Care Mental Health Service
3. To combine some inpatient wards for adults
4. To combine some inpatient wards for older people
5. To re-design community services for people of all ages.

NHS Cambridgeshire and NHS Peterborough issued the consultation document including questionnaires to help seek people's views on the proposed changes to mental health services in Cambridgeshire and Peterborough. The consultation also gathered views on how the proposed service model could be further improved, in order to provide the prompt and responsive services that local people experiencing mental health problems, and their families and carers expect. **mruk** research was commissioned to analyse the findings from the consultation.

This report details the main findings to emerge from the research. The consultation took place from 17th October 2011 to 16th January 2012. Following this consultation, the NHS Cambridgeshire and NHS Peterborough Boards will make a decision on the proposals. The self-completion questionnaire was designed and issued by NHS Cambridgeshire and NHS Peterborough as part of the consultation document. A copy of the questionnaire can be found in Appendix A.

In total 107 questionnaires were completed, 36 were completed online and 71 postal questionnaires were returned. Non-responses have been removed from the charts therefore base sizes for each question may vary. The actual numbers of responses are shown in brackets for sub group analysis due to the low base sizes. In some cases, question responses add up to more than 100%. In the case where figures are slightly over this total this is likely to be due to rounding, however larger totals are shown where respondents were able to respond to more than one option within a question – such as for Q9a.

The margin of error for the base size of 107 respondents is +9.5%. The expressed level of accuracy refers to the margin of error around any research result within which we can be 95% certain the true value would lie. For the sample size of 107, if 50% of respondents gave a particular survey response we can be confident (at the 95% confidence level) that the result lies between 40.5% and 59.5%, with the most likely response being 50% itself.
This work has been conducted in accordance with ISO 20252, the international standard for market and social research.

2. Executive Summary

NHS Cambridgeshire and NHS Peterborough issued respondents with the mental health services consultation document to seek their views on proposed changes to mental health services for the people of Cambridgeshire and Peterborough. 107 completed questionnaires were returned.

24/7 Single Point of Access for Mental Health Services

Over half of respondents (59%) agreed with the proposed change to open a new 24 hour/7 day a week Advice and Brief Intervention Centre for mental health service users.

Accessing Mental Health Services

GP's were asked unprompted how they would like to access services provided by the Mental Health Trust. Although only 10 GP's answered, 3 wanted to access Mental Health Trust services via a locally based team or through a local area consultant. Only 2 GP's thought access through a co-ordinated service would be beneficial while a further 2 wanted to be able to speedily access the right person. Other suggestions included email for non-urgent help, phone or fax for urgent referrals and access available from 8am to 8pm and weekends.

CPFT users wanted access to mental health services through their GP. They wanted services to be as quick and easy as possible to access.

Primary Care Mental Health Service

Over half of respondents (56%) were in favour to set up a new Primary Care Mental Health Service which would support the work of the Advice and Brief Intervention Centre.

Combining Adult Inpatient Ward

Slightly less than one in four respondents (23%) said they agreed with the proposal to combine some inpatient wards for adults of working age. Some 55% of respondents were not in favour of this proposal.

Combining Inpatient Wards for Older People

Less than a fifth of respondents (17%) were in favour of moving the David Clarke House at Fulbourn Hospital and the James Ward at Addenbrookes Hospital into a new unit at the David Clarke House site. Nearly two in five respondents (38%) were unsure about this proposed change (with a slightly higher proportion of health or social care professionals). Concerns included increased travel and travel costs for families.

Making Mental Health Services More Efficient

Approaching half of respondents (46%) did not have any comments about making mental health services more efficient. Those respondents who did make additional comments, ideas included centralising administration and information systems, making the service more localised and providing more help, information and support to families and carers

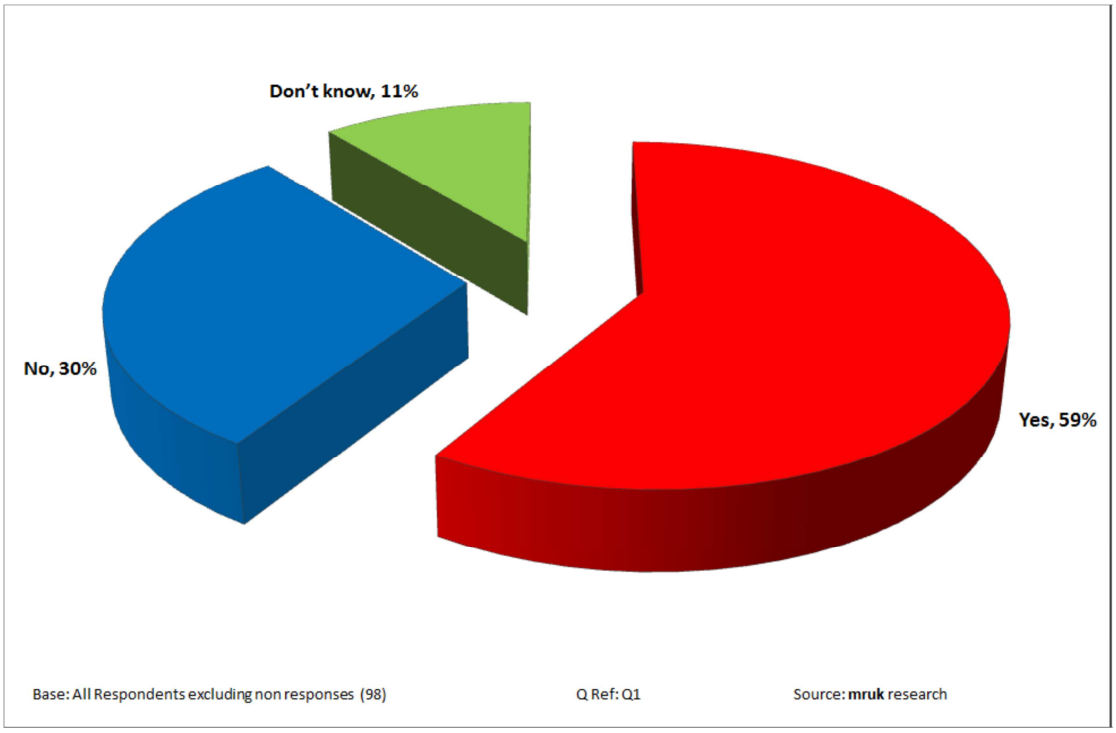
3. 24/7 Single Point of Access for Mental Health Services

The first proposed change to the mental health service is to open a new 24 hour/7 day a week Advice and Brief Intervention Centre. This service would:

- Offer a direct way into mental health services.
- Provide GPs, nurses, other local medical professionals and carers' with advice, support and information.
- Provide most of the specialist advice to GPs for mental health patients, directing to the right service for help, and the first assessment of patients.
- Have a 24 hour/7 day a week telephone advice help line. This would help more people to get treatment and advice quickly.

Figure 1: Do you agree with the idea of a 24/7 Single Point of Access for mental health services?

Over half of respondents (59%) agreed with the idea of a 24/7 single point of access for mental health services. Three in ten respondents (30%) did not agree with the single point of access centre and a further 11% were unsure.



Over half of respondents (59%) agreed with the idea of a 24/7 single point of access for mental health services. Three in ten respondents (30%) did not agree with the single point of access centre and a further 11% were unsure.
Although base sizes were low, findings indicate that 71% of health or social care professionals agreed with the 24/7 access centre (17 respondents) compared with just over half of members of the public (37 respondents equating to 51% of this group).

Respondents were asked for any additional comments they had about the idea of a new 24/7 single point of access centre for mental health. Overall three fifths of respondents made a comment (61% - 63 respondents). Comments which were given by 3 respondents or more are outlined below:

- It should be appropriately staffed with knowledgeable staff - (6 respondents)
- Needs to be where needed, not single point - (6 respondents)
- A telephone helpline alone is inappropriate / need to be face to face - (5 respondents)
- Seems okay on the surface / in principle - (4 respondents)
- Please keep Acer ward open / concerns over the future of Acer ward - (4 respondents)
- Travel distances would be difficult for everyone - (4 respondents)
- This would be ideal / excellent / better than current system - (4 respondents)
- Should make response time much quicker - (3 respondents)
- Would need to be run efficiently to avoid another layer of bureaucracy - (3 respondents)

4. Accessing Mental Health Services

GP's were then asked unprompted how they would like to access services provided by the Mental Health Trust. Only 10 respondents answered this question, responses are shown below:

- Named local area consultant / locally based teams – (3 respondents)
- Through a better co-ordinated service – (2 respondents)
- I want to be able to speedily access the right person – (2 respondents)
- E-mail might be useful for non-urgent help – (1 respondent)
- Dedicated phone / fax number for urgent referrals – (1 respondent)
- Access should be from 8am to 8pm, and weekends – (1 respondent)

Service users of CPFT or another mental health organisation were asked how they would like to access mental health services. 17 service users answered this question and also 19 non-service users. All responses have been analysed below as non-service users may include carers of service users and former service users.

- With GP contact / via GP – (14 respondents)
- As easy and quickly as possible – (11 respondents)
- Access a local centre where family and friends have reasonable travel distance – (4 respondents)
- Professional on the spot team – able to have knowledge of your mental health – (2 respondents)
- With a directory of services so I can choose my preference – (1 respondent)
- I did use the service for mental health – (1 respondent)
- Telephone – (1 respondent)
- Drop in centre – (1 respondent)
- Via a clearly defined pathway for adults with ADHD – (1 respondent)

5. Primary Care Mental Health Services

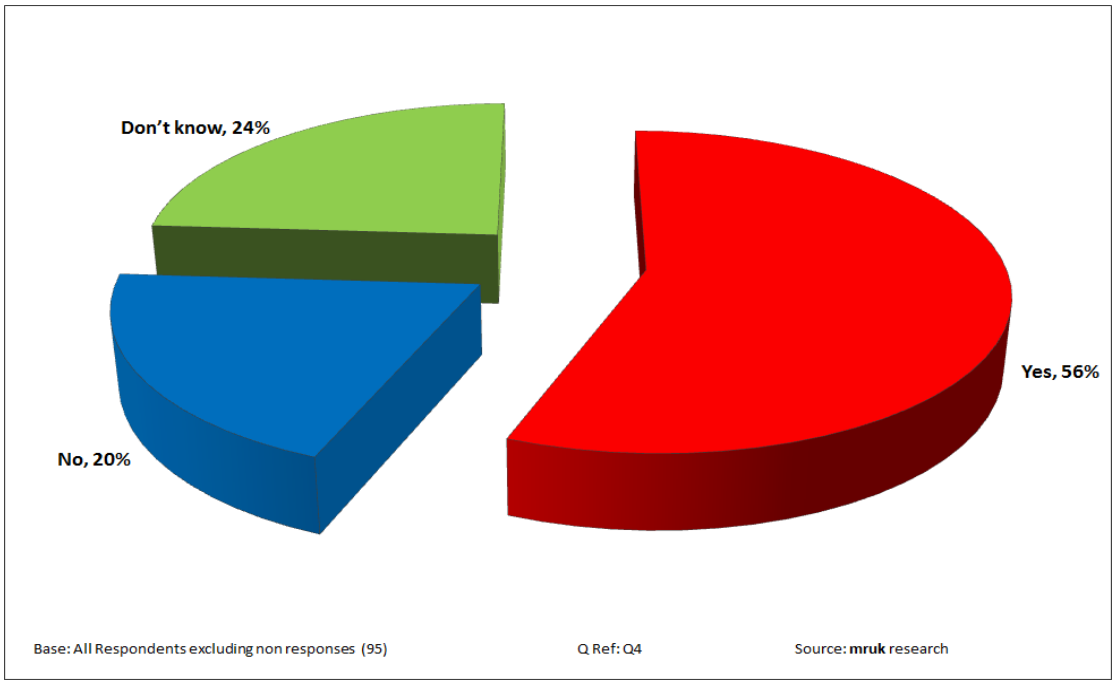
The second proposed change is to set up a Primary Care Mental Health Service. This service would support the work of the Advice and Brief Intervention Centre by:

- Having teams of mental health professionals who will provide specialist advice and treatment to people with mild to moderate mental health needs.

- Having the teams of mental health professionals provide treatment to people with more severe and long term mental health problems who have been alright for a long time.

The teams will work with local groups and GPs to build stronger relationships with those providing care for people with mental health problems.

Figure 2: Do you agree with our proposals to set up a new Primary Care Mental Health Service?



Over half of respondents (56%) agreed with the proposal to set up a new Primary Care Mental Health Service. A fifth of respondents specifically disagreed (20%) and a further 24% of respondents were unsure.

Although base sizes were low findings suggest that health or social care professionals were more likely to be in favour of the Primary Care Mental Health Service proposal than members of the public. Just over two thirds of health or social care professionals agreed with the proposal (67% - 16 respondents) and half of members of the public (50% - 35 respondents).

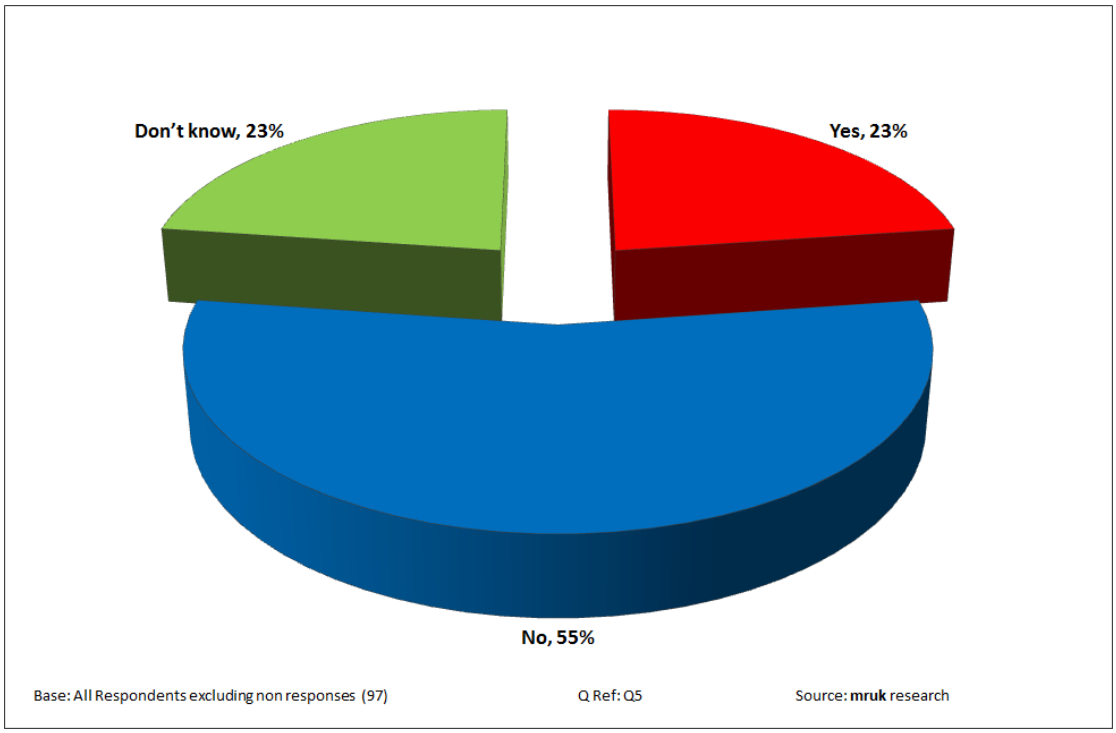
Just over half of respondents (51%) made an additional comment about the proposal for a new Primary Care Mental Health Service. Comments which were given by 3 respondents or more included:

- A better service to those really affected / patients – (8 respondents)
- Needs to say local / distance for family / friends could be a problem – (6 respondents)
- As long as it doesn't result in more limited care – (5 respondents)
- As long as it is properly resourced / sufficiently staffed – (4 respondents)
- Ensure joined up care to avoid patients under several different teams – (4 respondents)
- Need more information / lack of detail in the proposal – (4 respondents)

6. Combining Adult Inpatient Wards

Another proposal would bring together some inpatient wards for adults of working age. Two adult rehabilitation wards in Cambridge would be brought together to create one rehabilitation facility at Fulbourn Hospital in Cambridge.

Figure 3: Do you agree with our proposals to combine a number of inpatient wards for adults?



Slightly less than one in four respondents (23%) were in favour to combine a number of inpatient wards for adults. Over half of respondents (55%) did not agree with this proposal and a further 23% of respondents did not know.

Respondents were then asked if they had any additional comments about combining the adult inpatient wards. Just over three in five respondents (61%) made a comment, these included:

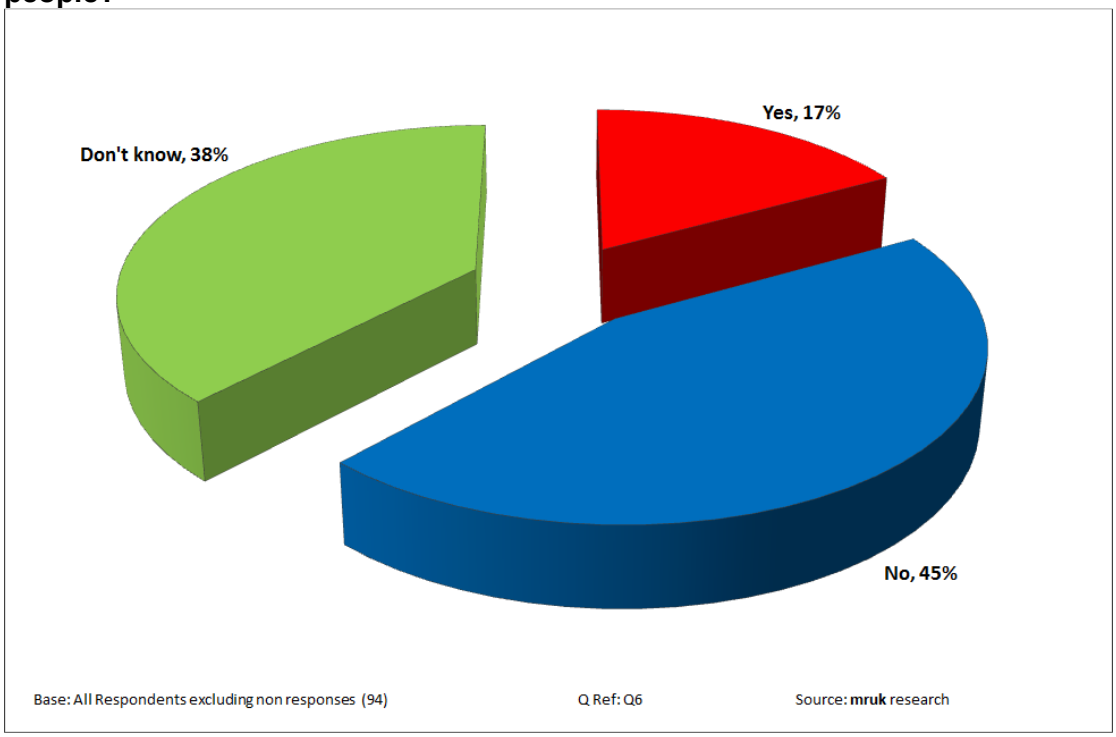
- Closing Acer ward is a mistake / I am concerned about the closure of Acer ward – (15 respondents)

- Putting patients and families at a geographical disadvantage will not help – (13 respondents)
- As long as standards / staffing levels do not drop – (6 respondents)
- As long as different patient needs are monitored – (5 respondents)
- People would be treated out of area / have to travel and additional expense – (4 respondents)
- Some clarification would be required – (3 respondents)
- It would provide less beds overall – (3 respondents)
- It seems patients will be unable to stay locally which causes a lot of issues / anxiety – (3 respondents)

7. Combining Inpatient Wards for Older People

Another of the proposed changes includes moving the David Clarke House at Fulbourn Hospital and the James Ward at Addenbrookes Hospital into a new unit at the David Clarke House site. This move would mean that there would be four instead of five wards. This new ward would provide specialist acute care and rehabilitation for older people with long term mental health needs.

Figure 4: Do you agree with our proposals to combine a number of inpatient wards for older people?



Less than a fifth of respondents to the survey agreed with the proposed change to combine inpatient wards for older people (17%). Some 45% of respondents said they did not agree with this and a further 38% were unsure.

A higher proportion of health or social care professionals (52% - 12 respondents) did not know if they agreed with this proposed change when compared to members of the public (37% - 26 respondents). Members of the public were most likely to disagree with the proposals to combine inpatient wards for older people (49% - 35 respondents) compared to health or social care professionals (35% - 8 respondents).

Additional comments about combining inpatient wards for older people reflected their concerns and explained why a high proportion were not in favour or uncertain of the proposal to combine inpatient wards for older people. Comments included:

- Will create transport issues / increase travel costs for family etc – (15 respondents)
- Elderly and Dementia patients have different needs – (6 respondents)
- Older people feel more secure when being treated locally – (4 respondents)
- We have a rapidly growing population of elderly people – (3 respondents)

8. Making Mental Health Services More Efficient

Respondents were then asked for their views on how to make mental health services more efficient. Approaching half of respondents (46%) did not have any comments about making mental health services more efficient. For those who did give their views, ideas included:

- Centralised administration / information system – (6 respondents)
- Making service localised – (6 respondents)
- Provide more help, information and support for carers / family – (4 respondents)
- Staff training / rotas / supervision should be closely monitored – (3 respondents)
- A clear need for greater financial provision – (3 respondents)
- Make waiting times shorter – (3 respondents)
- Continuity of staff – (3 respondents)

9. Additional Comments on the Proposals

Nearly two fifths of respondents (38%) did not have any additional comments regarding the proposals. Of those who did, comments included:

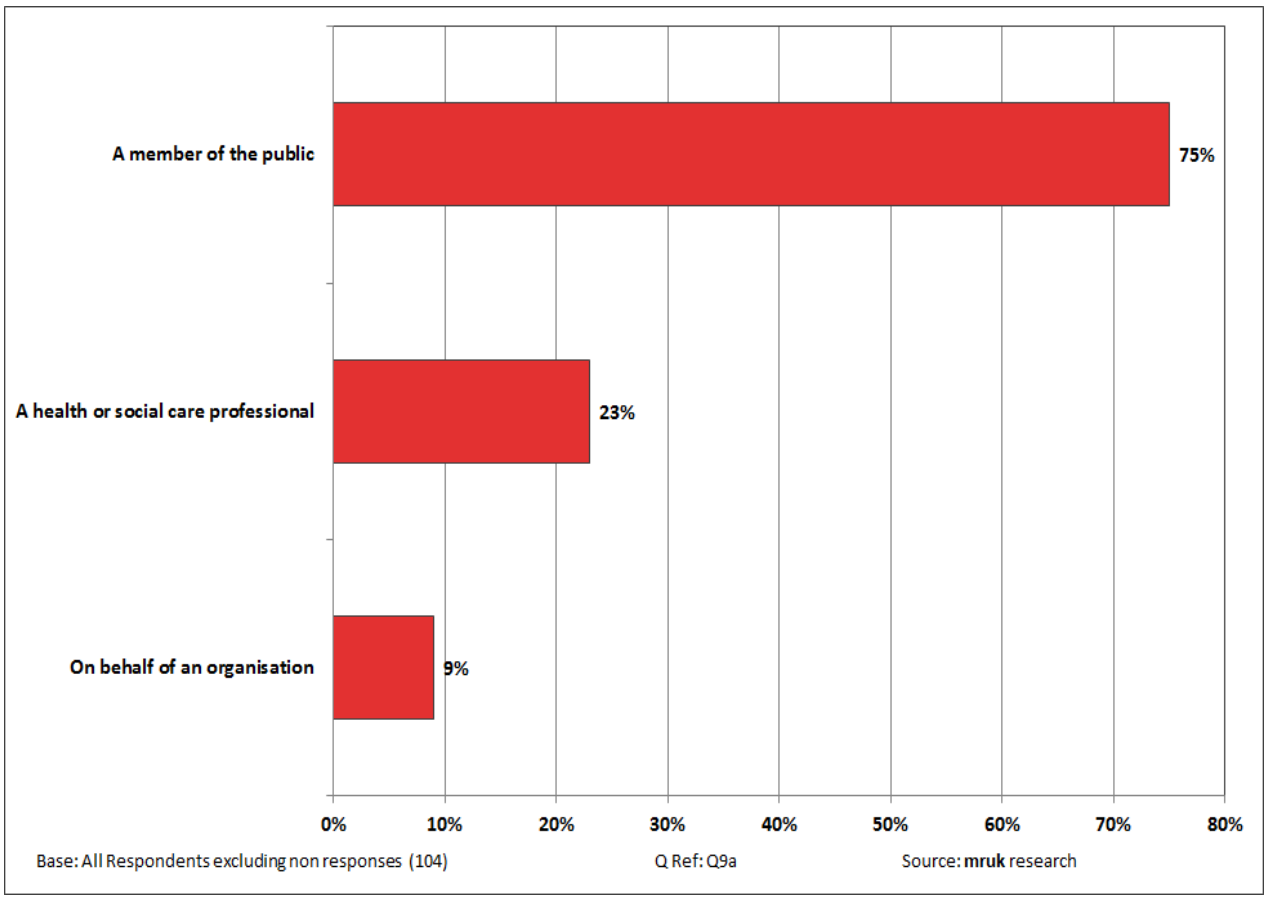
- Pre-emptive closure of Acer Ward prior to consultation is scandalous / a mistake – (15 respondents)
- Making sure every mental health patient gets the help and care they need – (8 respondents)
- Concerned about travel for service users / family – (6 respondents)
- Not sure the supposed savings in closing Acer Ward will work / Acer ward is important – (5 respondents)
- The changes will happen anyway / our views will not be taken into account – (4 respondents)
- Listen to patients thoughts on this matter / more research – (3 respondents)
- Proposals are vague in parts, needs to be more specific – (3 respondents)

10. Respondents Demographics

10.1 Responding As

Three quarters of respondents to the survey were responding as a member of the public. Just over a fifth (23%) said they were respondents as a health or social care professional and 9% were responding on behalf of an organisation as illustrated below.

Figure 5: Are you responding as:



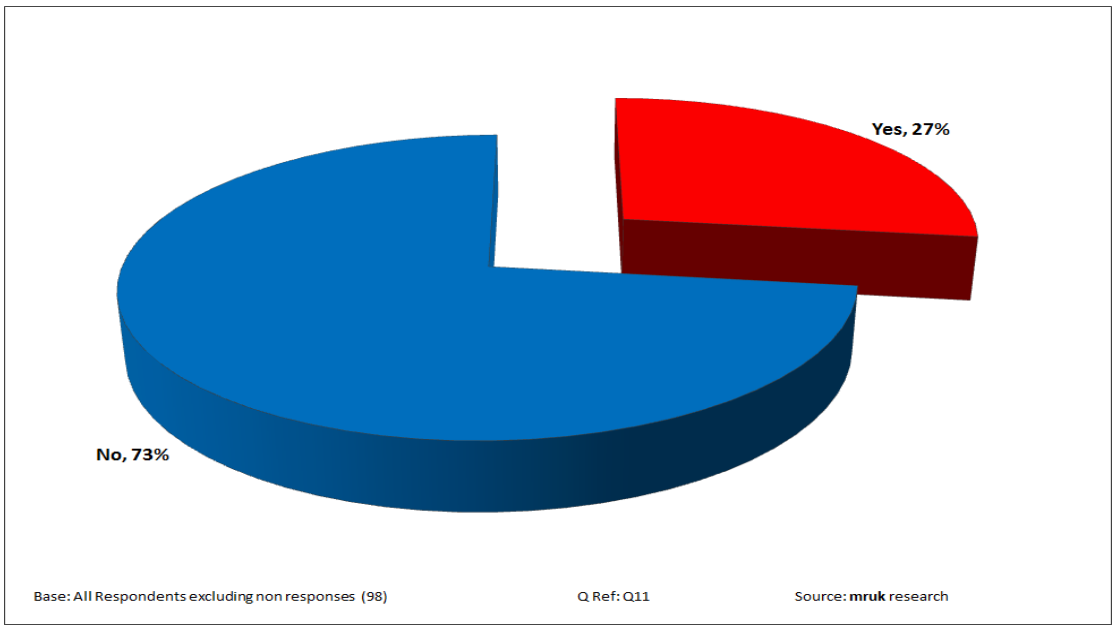
The vast majority of respondents (97%) said they were providing their own response, whilst 3% were providing a response for someone else.
The organisations respondents were responding on behalf of included:

- CPFT
- Richmond Fellowship Employment Services, Peterborough
- Peterborough Streets
- Cambridgeshire CC Children and Young Peoples Service (CYPC)
- Her Majesty's Courts & Tribunals Service
- The Adult ADHD Support Group, Cambridgeshire
- Cambridgeshire Drug and Alcohol Action Team
- The Live Wires Group

10.2 Service User of CPFT or Another Mental Health Organisation

Just over a quarter of respondents were CPFT service users or a user on another mental health organisation (27%).

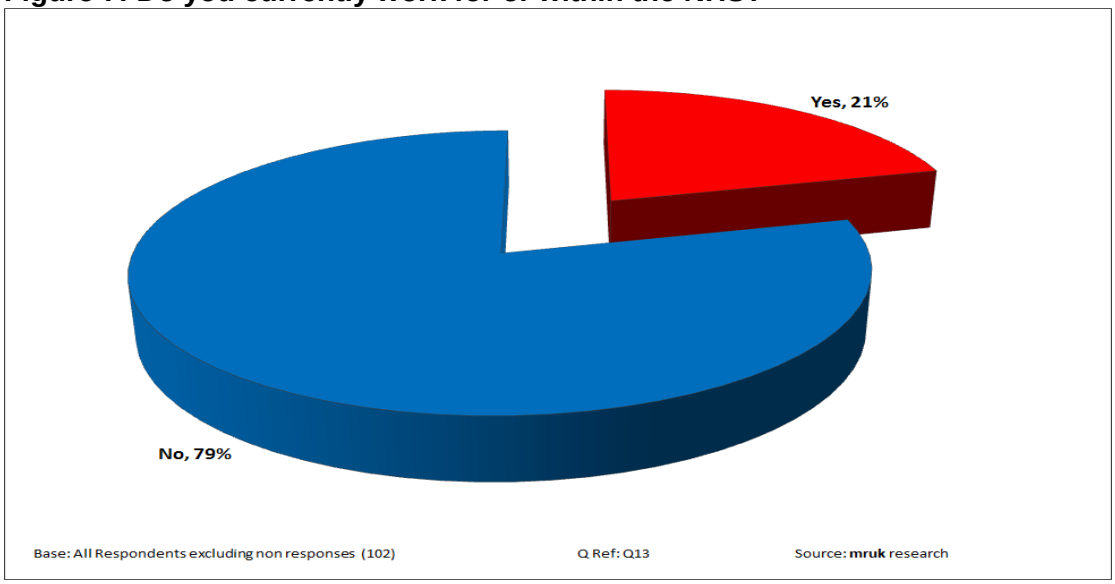
Figure 6: Are you currently a service user of CPFT or another mental health organisation?



10.3 Working for the NHS

Just over a fifth of respondents (21%) worked for or within the NHS as illustrated below.

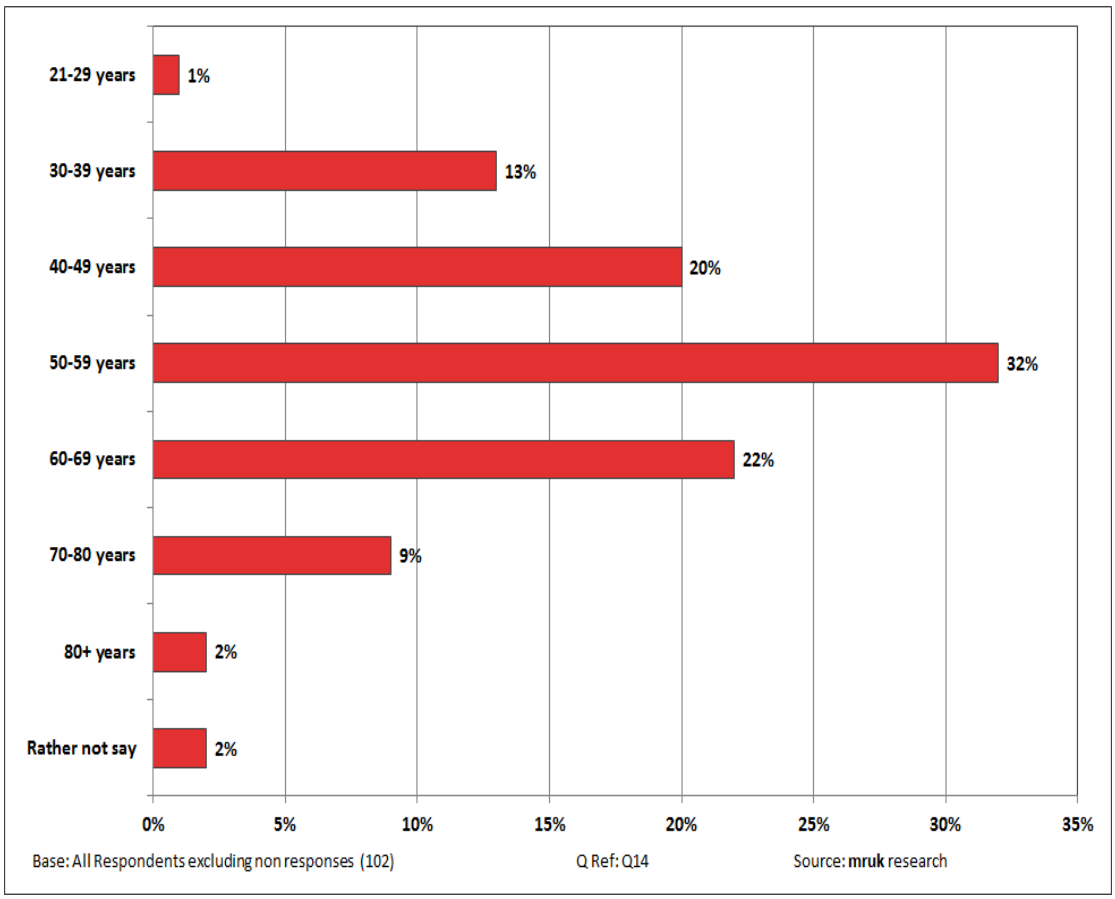
Figure 7: Do you currently work for or within the NHS?



10.4 Age

Only 1% of respondents were aged under 30 years, 13% were aged between 30 and 39 years and a fifth (20%) of respondents were between the ages of 40 and 49. Approaching a third of respondents (32%) were aged between 50 and 59 years, 22% were between the ages of 60 and 69 years and only 9% of respondents were aged between 70 and 80. Few respondents (only 2%) were aged over 80 and a further 2% did not give their age.

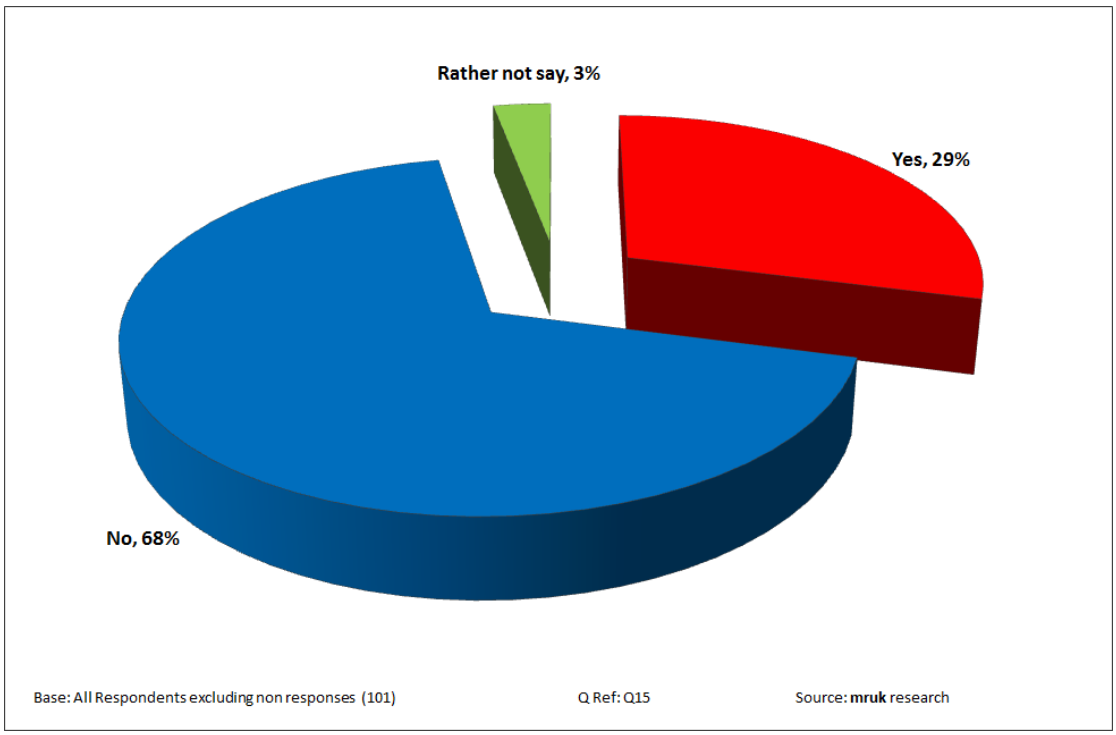
Figure 8: Age



10.5 Disability

Nearly three in ten respondents said they had a disability (29% - 28 respondents). Of those, 22 respondents had a long term mental health condition, 8 respondents had a physical impairment, 3 respondents had a sensory impairment, 1 respondent had a learning disability and 8 respondents had another long term health condition. Please note respondents may have had more than one disability type.

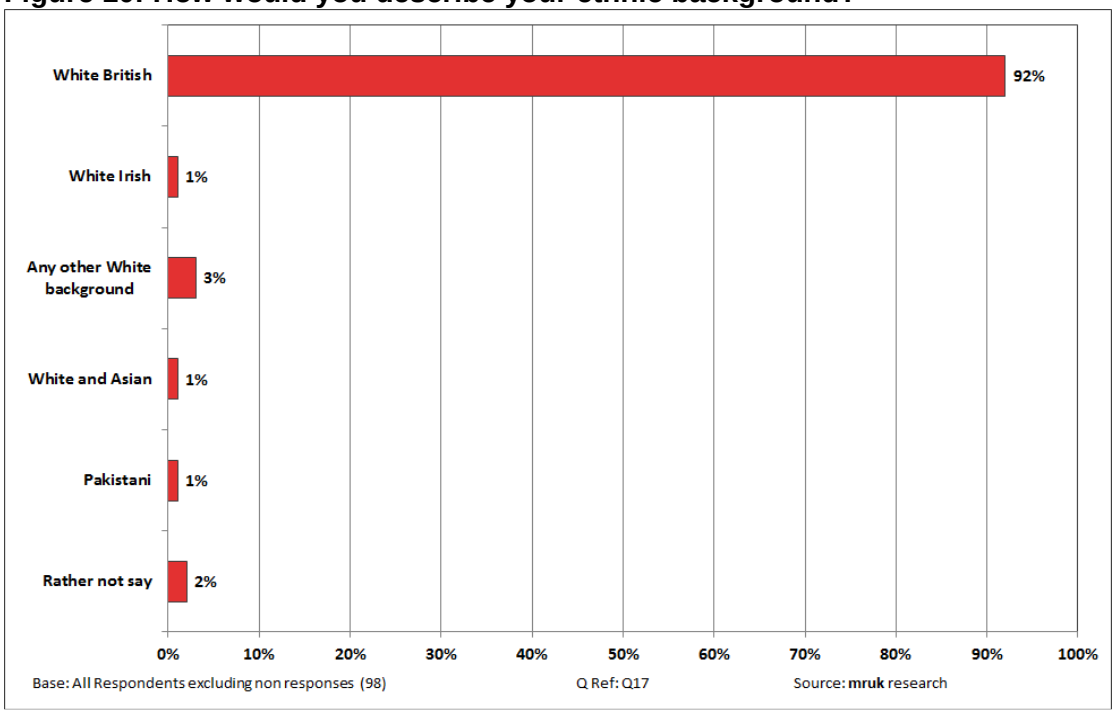
Figure 9: Do you consider yourself to have a disability?



10.6 Ethnic Group

The vast majority of respondents were White British (92%). Few respondents were White Irish (1%) or another White background (3%). 1% of respondents were White and Asian and 1% were Pakistani. 2% of respondents did not give their ethnic background.

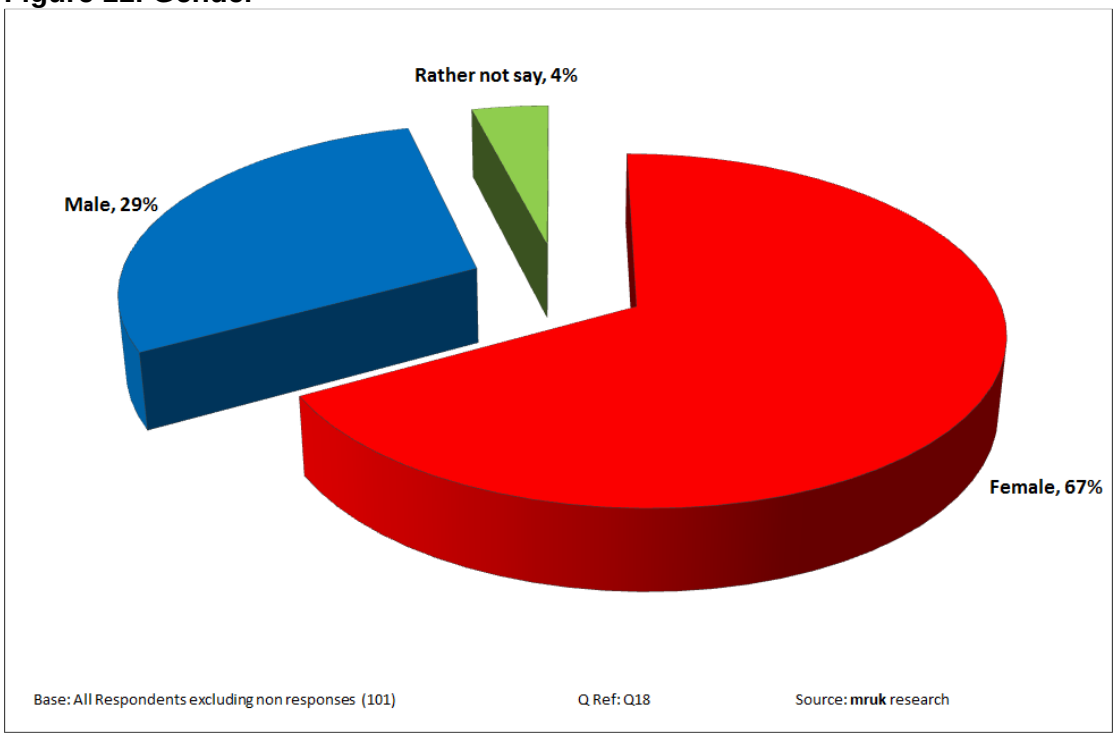
Figure 10: How would you describe your ethnic background?



10.7 Gender

Just over two thirds of respondents were female (67%), 29% were male and 4% of respondents did not want to give their gender as illustrated below.

Figure 11: Gender

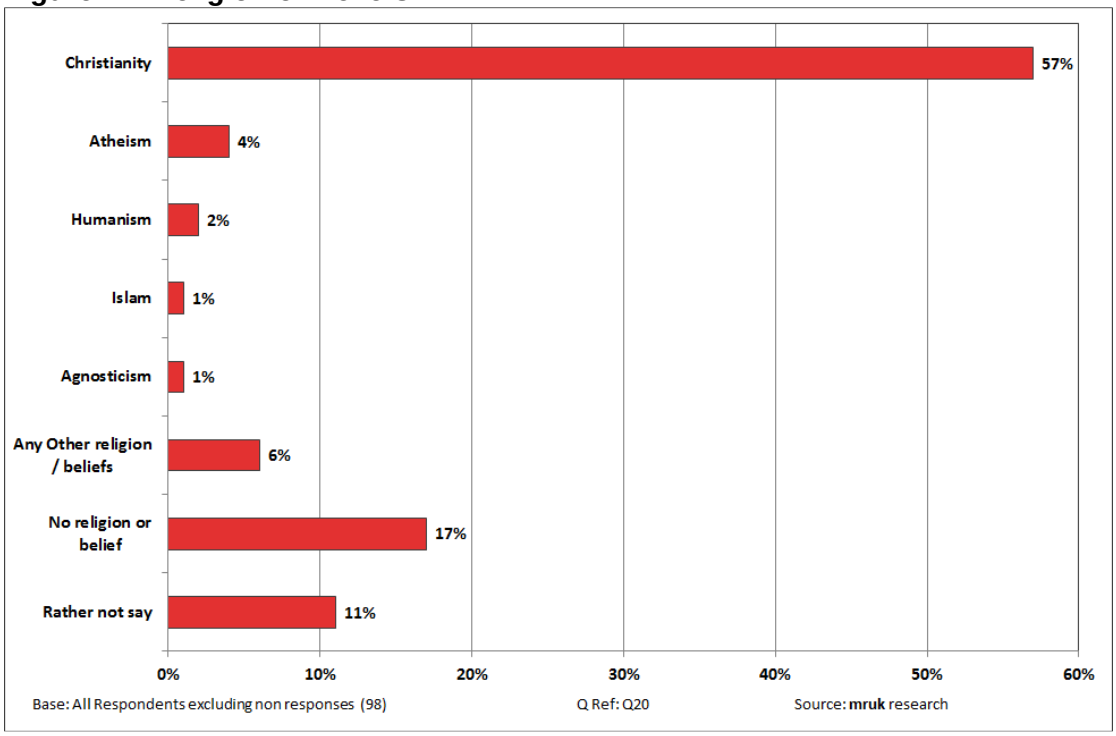


Respondents were also asked if they considered themselves to be transgender, the vast majority (92%) said they were not transgender and 8% did not want to say.

10.8 Religion or Beliefs

Over half of respondents said they followed Christianity (57%), 4% followed Atheism and 2% followed Hinduism. Just under a fifth of respondents (17%) did not follow a religion or beliefs and 11% did not want to say.

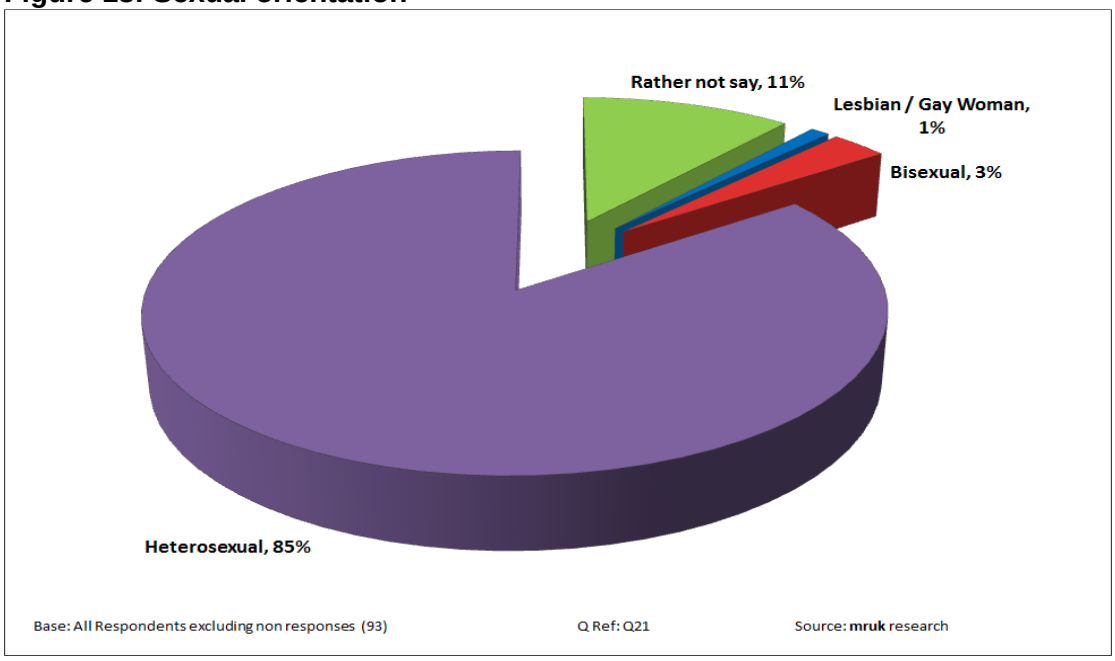
Figure 12: Religion or Beliefs



10.9 Sexual Orientation

The majority of respondents were heterosexual (85%), 3% were bisexual and 1% were lesbian. Just over one in then respondents did not want to say what their sexual orientation was (11%).

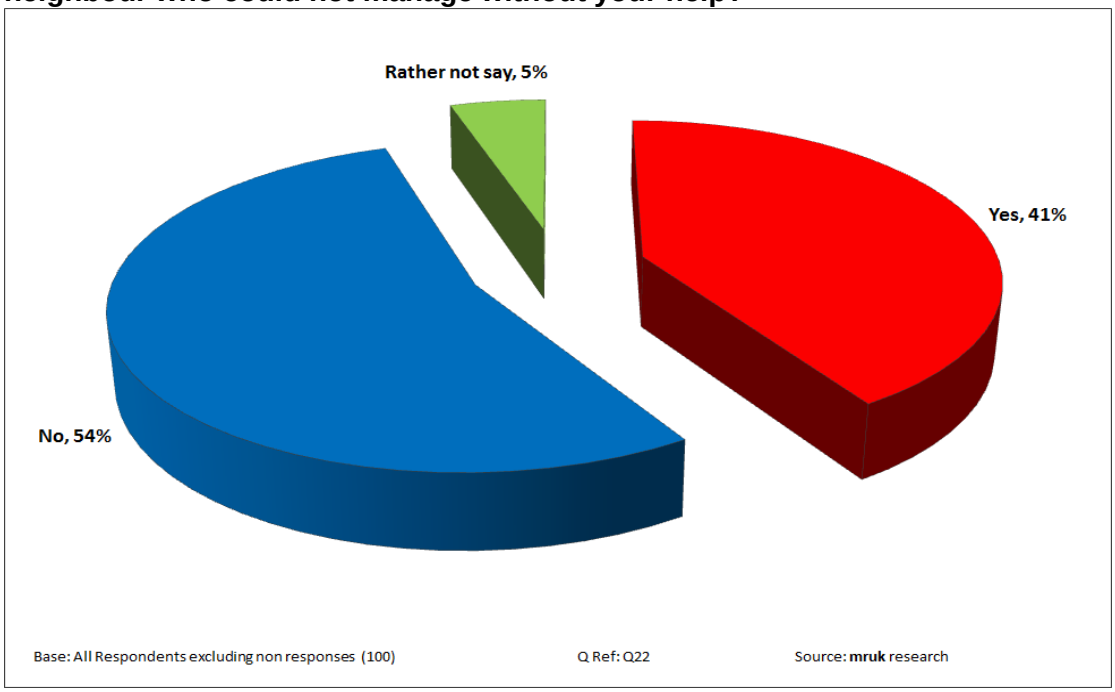
Figure 13: Sexual orientation



10.10 Support Carer

Just over two fifths of respondents were providing support to a partner, child, relative, friend or neighbour who could not manage without them (41%).

Figure 14: Are you currently providing support to a partner, child, relative, friend or neighbour who could not manage without your help?



Appendix A –Questionnaire
Please complete and return the Questionnaire

We appreciate you taking the time to tell us what you think. Please be assured that all the information collected is for use by NHS Cambridgeshire only and any views made public as part of a report will be made anonymous. Once completed, please return this questionnaire to our FREEPOST address:

FREEPOST
RSCR-GSGK-XSHK
NHS Cambridgeshire
Lockton House
Clarendon Road
Cambridge
CB2 8FH

1. Do you agree with the idea of a 24/7 Single Point of Access for mental health services?

☐ Yes ☐ No ☐ Don't know

Comments:

2. If you are a GP, how would you like to access the services provided by the Mental Health Trust?

Comments:

☐ No comments

3. If you are a service user, how would you like to access mental health services?

Comments:

☐ No comments

4. Do you agree with our proposals to set up a new Primary Care Mental Health Service?

☐ Yes ☐ No ☐ Don't know

If you have any concerns or further comments to make, please provide these below:

5. Do you agree with our proposals to combine a number of inpatient wards for adults?

☐ Yes ☐ No ☐ Don't know

If you have any concerns or further comments to make, please provide these below:

6. Do you agree with our proposals to combine a number of inpatient wards for older people?

☐ Yes ☐ No ☐ Don't know

If you have any concerns or further comments to make, please provide these below:

7. efficient?

☐ No comments

8. Please provide any further comments you may have regarding these proposals:

Tell us about yourself

Please tell us a little about yourself. All of your comments will remain confidential and anonymous. This information will be used to make sure we're hearing from people of all backgrounds.

9. Are you responding as:

☐ A member of the public ☐ A health or social care professional
☐ On behalf of an organisation

If you are providing a response on behalf of an organisation, which organisation?

10. If you are providing a response on behalf of an organisation, please give details about who the organisation represents, and how you gather the views of your members, and if you are happy for your organisation's response to be published.

.....
.....
.....

11. Are you currently a service user of CPFT or another mental health organisation?

☐ Yes ☐ No

12. Are you: (tick all those that apply)
☐ Providing your own response ☐ Providing a response for someone else

13. Do you currently work for or within the NHS?
☐Yes ☐No

14. Please tell us your age:

Under 16		50-59	
16-21		60-69	
21-29		70-80	
30-39		80+	
40-49		Rather not say	

15. Do you consider yourself to have a disability?

☐ Yes ☐ No ☐ Rather not say

16. If you answered yes to question 15, do you have a:

☐Physical Impairment

☐ Sensory Impairment
☐ Learning Disability
☐ Mental Health Condition (Long Term)
☐ Other Health Condition (Long Term)

17. How would you describe your ethnic background?

Asian or Asian British
☐ Bangladeshi ☐ Indian
☐ Pakistani ☐ Any other Asian Background (please state) :

White
☐ White British ☐ White Irish
☐ Any other White Background (please state):

Black or Black British
☐ African ☐ Caribbean
☐ Any other Black Background (please state): _____

Mixed
☐ White and Asian ☐ White and Black African
☐ White and Black Caribbean ☐ Any other Mixed Background (please state):

Other Ethnic Group _____
☐ Chinese ☐ Any other Ethnic Group (please state):
☐ Rather not say _____

18. Gender
☐ Female ☐ Male ☐ Rather not say

19. Gender Reassignment
Do you now, or have you ever considered yourself to be transgender?
☐ Yes ☐ No ☐ Rather not say

20. Religion or Beliefs

☐ Atheisim ☐ Jainism ☐ Agnosticism
☐ Judaism ☐ Buddhism ☐ Sikhism
☐ Christianity ☐ Hinduism ☐ Humanism
☐ Islam ☐ Any other Religion/Belief (please state): _____
☐ No religion or belief ☐ Rather not say

21. Sexual orientation

☐ Bisexual ☐ Lesbian/Gay Woman ☐ Gay Man
☐ Heterosexual ☐ Other ☐ Rather not say

22. Are you currently providing support to a partner, child, relative, friend or neighbour who could not manage without your help and/or support?

☐ Yes ☐ No ☐ Rather not say

23. Please could you provide us with the first four digits of your postcode in the box below. This will help us ensure we are receiving responses from across Cambridgeshire and Peterborough

Thank you for completing this consultation questionnaire.

Alternate formats
This document can be made available in large text or Braille, or other languages, on request. Contact NHS Cambridgeshire's PALS on 01223 725588 or FREEPHONE 0800279 2535 04 email pals@cambridgeshire.nhs.uk

Issued by NHS Cambridgeshire,
Cambridgeshire Primary Care Trust, Lockton House, Clarendon Road, Cambridge, CB2 8FH

October 2011
For more information about NHS Cambridgeshire visit
www.cambridgeshire.nhs.uk

APPENDIX 8- SUMMARY OF CONSULTATION RESPONES FROM MEMBERS OF THE PUBLIC

All names and addresses have been removed

4 November 2011

Comment/concern/issue
Object to closure of Cobwebs ward – as social inclusion is an essential part of rehabilitation, Cobwebs is ideally situated away from the hospital atmosphere, and in Cambridge city centre with all its facilities, where the residents can easily mingle with people leading everyday lives. This also includes easy access to voluntary work, an important part of rehabilitation.
Found the staff both at Cedars and Cobwebs to be caring, efficient and helpful.
Cedars is in an isolated position at the Fulbourn Hospital site. It cannot compare with a unit in a central location where individual freedom is possible.
The statement in the Cambridge News that Cobwebs is 'barely used' was not correct at time of print. At that time the house was fully occupied (19 Oct) but by November 3rd most of the occupants had been moved to other accommodation in preparation for 'temporary closure' as soon as possible.
The consultation paper states the proposed changes to Cobwebs are scheduled for January-March 2012. The action of starting the closure of Cobwebs now contradicts this, ignoring any public consultation. We would urge you to rethink this step.

22 December 2011

Issue	Comment/concern
Finance	The tables show a shortfall between required efficiency savings and proposed savings of £2,347,000. The assumption is that this will be made up by increased income. The document does not show the sources of this income (presumably because this is commercial and confidential). Unless the assumption is robust the remainder of the proposals will be put at risk. Some indication of the sources of the proposed income is needed, to assess the proposals, and confirmation that a comprehensive risk assessment has been undertaken. The Commissioners will need to be certain that the proposals are achievable and a contingency plan will be needed to meet any situation where there is an income shortfall. This should be made public
Advice and Brief Intervention Centre	This proposal is to be welcomed and should be of great assistance to professional staff from services other than those working in the mental health field. The service will be beneficial to

	service users and carers.
Advice and Brief Intervention Centre – Long term and chronic conditions	Consideration should be given to those users who have long term chronic conditions with chaotic lifestyles, as they are unlikely to be able to avail themselves of the service for intervention. The service will probably be unable to undertake initial assessments of these individuals and alternatives will need to be in place through the individual's care programme
Advice and Brief Intervention Centre - function	It will be helpful if the Centre can have access to a summary of contact points and other information for all those patients with a care programme, through a computerised system. This will enable the appropriate professional staff to be involved as soon as possible, following any approach by patients or carers
Primary Care Service	This proposal is to be welcomed. Association with GP practices and localities is sensible but will require adequate funding. Concern that this service will be the first to suffer if the resources outlined in Section 3 (More Efficient Services) of the consultation document are not achieved, especially in relation to the income to be generated.
Primary Care Service – Community Teams	The need for Community Teams to travel some distance in the North of the Trust's area to visit those in hospital must be taken into account when allocating resources and determining Team size and location.
Primary Care Service – Community Teams	There is no indication whether Teams will generic or specialist. This decision will determine Team size and overall numbers
Consolidation of inpatient wards for adults	Proposal to house inpatients in good purpose built accommodation is welcome, as is the opportunity to offer a wider range of services in each location
Consolidation of inpatient wards for adults – permanent closer of Acer Ward	This will have serious implications for patients from Huntingdonshire. It will worsen the non-clinical aspects of their care and is likely to make it harder for them to meet with their community staff, and other agencies, leading to possible delays in discharge. It will also take longer for those in a place of safety to be transferred to proper facilities.
Consolidation of inpatient wards for adults – Acer Ward	There appears to be a factual error in that there are single rooms on Acer ward and not all beds are in dormitories
Consolidation of inpatient wards for adults – number of acute beds	The reduced number of acute beds in Peterborough, before those at Lucille van Geest become available in 2014, will need careful management if bed shortages are not to occur, leading to a premature discharge with consequences for care planning and Community Teams.
Consolidation of inpatient wards for adults – number of acute beds	The number of acute beds in Lucille van Geest unit will be the same as at Acer Ward. Will the size of the unit lead to similar problems to those that led to the early closure of Acer? There is no indication of how this risk will be managed. Will cover be provided from the Cavell Centre and if so, will this dilute the service available there?

Consolidation of inpatient wards for adults	The proposal to have all rehabilitation beds in Cambridge will have implications for the resettlement of patients from the north of the area to their home locality. It will also make it more difficult to link with Community Teams and other agencies, for families to keep in touch, and may lead to patients being reluctant to enter rehabilitation
Consolidation of inpatient wards for adults – travel	Consideration should be given to looking comprehensively into a Travel Strategy for relatives from Huntingdon. The Strategy should take account of the needs of acute, rehabilitation and elderly services, as well as the geography, for the whole Trust catchment area. There are currently issues in respect of the difficulty some patients have in attending Peterborough from Wisbech.
Consolidation of inpatient wards for adults – travel	Staff communications between Hospital and Community Teams will also be affected and the need for the additional time spent travelling must be taken into account, when Team numbers are considered
Consolidation of inpatient wards for adults	It is important that all Community Teams are able to spend adequate time with patients to enable them to properly plan care programmes; discharge arrangements and resources allocated accordingly.
Consolidation of inpatient wards for adults	Rehabilitation needs may have been underestimated. Inadequate provision of needs for rehabilitation will lead to blocking of acute beds
Consolidation of inpatient wards for older people	The proposal to house patients in modern accommodation is to be welcomed
Consolidation of inpatient wards for older people	There is no indication of the success or otherwise of the decision to use more beds in residential and nursing homes on the closure of Hawthorn ward at Hinchingbrooke Hospital.
Impact	The proposals to make services age inclusive is to be welcomed and should lead to more flexibility in the use of resources
Community services for those with severe and enduring mental illness	The review of pathways is to be commended
	The availability of good community services in localities will be important to this group of patients. They will need, as will other groups, other services in localities such as outpatients and day care. Places of safety will need to be available and staffed adequately in each location.

3 January 2012

Issue	Comment/Concern
	Fully in support of any changes made to the current service which make accessing acute mental health care a) actually possible b) easier for user and referrer and c) which provides immediate access to support, help and care when needed.
Difficulty in accessing services, support and help	The letter describes the author's experiences of trying to access help, support and care from Mental Health Services in Cambridgeshire during 2011. Experience was that it was difficult to access, with very slow response from the Gateway Worker (GW) – it took five weeks to get an appointment with the Gateway Worker, at a time when the service user felt very vulnerable. When it came to the appointment, the Gateway Worker was 40 minutes late which inconvenienced the service user's childcare arrangements and meant she had to leave the appointment shortly after the GW arrived. Experience that the GW was impatient with the service user and made them feel like they were an inconvenience.
Slow response and bad experience with Gateway Worker	Service user first requested help on 1 April 2011. First contacted by the Mental Health Service on 21 May 2011. During this time she/he had been left to struggle, unsupported with mental illness.

4 January 2012

Issue	Comment/Concern
Savings targets	Acknowledge the difficult savings targets both CPFT and the PCT have imposed on them by Central Government, however overall savings targets for mental health at over £14 million is not an insignificant amount of resource to take out and worry about the lack of detail that has been made available to help the individual figures stack up
Corporate savings	Can the wider Public of the County be given any assurance that absolute rigor has been applied to reduce management costs?
Public Transport	Closure of Acer Ward in Huntingdon raises particular concern given the level of public transport available from many villages in West Huntingdonshire to reach Huntingdon and then Peterborough. Taking this ward out of the service provision is not at all wise. The sheer effort in getting visitors from places such as Needingworth, Keyston, Kimbolton etc to Peterborough City Hospital will be no small effort, then there is individual cost and the time it will physically take to reach City, the County Transport system is clearly not up to speed with this and has already said we have no dedicated funding to address the shortfall, so how will people get to Peterborough City and at a time of rising fuel costs?
Community Teams	A large proportion of this redesign is predicated on the ability of Community Teams to take up the shortfall,

	we have seen no detailed templates as to where teams will be based or bolstered, we have seen no indication of existing workloads – particularly for CPN's never mind any detail as to what the skill mix will look like between experienced front line clinicians and low grade practitioners. We all know that the need for more intervention is growing due to the mental health of the wider Community
Reduction of beds	Grave concerns about the reduction of functional beds at a time when more people are becoming much sicker before admission. The population of the county continues to grow and we will in the period beyond these proposals have major developments coming on stream at Alconbury and Northstowe – where in any forward thinking or planning are these factored in?

Response from service user with Bipolar Disorder for 15 years, 6 admissions to Acer Ward. Response received 11 January 2012

Issue	Comment/concern
Loss of essential services in Huntingdonshire	Being indicated that Acer will remained closed and we will have lost our last remaining Psychiatric Ward in Huntingdonshire, causing great hardship to patients and their families. Hawthorn Ward for older people was closed last year, as was the Adult Service Intensive Support Team. In recent years we have also lost the Day Hospital at Park House, which has been greatly missed by service users. Currently our Home Treatment team is now also working from Peterborough, as it has lost its Acer Ward base.
Transport	Service users, their families and friends are really struggling with the hour by car journey (from St Neot's for example) to Peterborough, and that is those who have a car. For the many that don't, 3 changes of bus and several hours are the norm. Expensive bus fares and it takes too long on the bus.
Transport and visitors	Lack of contact with family and friends makes recovery so much more difficult, and as we are constantly told that it is only the most severely ill people who will be getting a hospital bed, visitors are all the more essential
Transport	If a patient has weekend leave, which is always a key part of the discharge process, how will they manage to cope with three buses? Many people's illnesses are so distressing that even taking buses when one is quite well and at home is a very difficult thing
Transport	Mental illness often affects those people who are not well off, so this travel situation is very serious for many service users.
Transport	Not convinced that a robust Travel Strategy will be drawn up

Transport	A community car scheme, as mentioned at the public consultation meeting as an option, will be essential for service users if Acer Ward is lost. This must also be made available to friends who visit as many service users do not have families and friends are often their most vital support structure
Transport	One service user at the consultation meeting, who had recently been at the Cavell Centre highlighted this issue by saying that when on Acer she had a visitor every other day but while in Peterborough was lucky to get one a week.
Transport	There is also difficulty getting people from the Peterborough Bus Station to the new general hospital and Cavell Centre.
Admission via Hinchingbrooke A&E Department	Many people with severe mental health issues are often admitted via A&E, which can be a very traumatic process involving doctors who do not understand, long waits for on call psychiatric staff etc. How is this going to be helped by removing Acer Ward? The long painful admission will now be added to by an hour long journey to Peterborough at the end of it. This was always considered to be a point of great distress, if Acer was full and one had to be transferred out of area. Now this will be the norm. This means a whole loss of the community that the person lives in, which will make it an even bigger re-adjustment when that person comes back home, slowing down recovery.
Quality of care for Huntingdonshire residents at the Cavell Centre	Looking at the last CQC review (Feb 2011) of the Cavell Centre is extremely concerning, with the centre only scoring adequately in one of the 5 areas. At the recent public consultation meeting a service user who has had to receive treatment at the Cavell Centre, Peterborough, was not able to see her psychiatrist for 3 weeks, being told that as she was not a Peterborough patient; her psychiatrist was not around to visit her. This situation caused the patient mentioned to be put on completely different and inappropriate medication, which made her worse. It was only when she returned from the Cavell Centre that she was able to return to her actual Psychiatrist and go back on suitable medication. Managers at the service user meeting offered absolutely no reassurance that this would not happen over and over again for Huntingdonshire patients. This seems woeful that the most severely ill people will not receive any continuity of care at the Cavell Centre.
Distance of Cavell Centre from Huntingdon and travel issues	Another patient was not able to take her daily 2 hour escorted leave from the Cavell Centre, because her family and friends lived too far away to be with her, and staff were too busy. Normally, if on Acer she would have been going home and settling herself back into her life. This has made her recovery significantly more difficult.
	Hunts Post received a letter saying that a lady's son was constantly leaving the ward at the Cavell Centre, travelling home in taxis and that he didn't seem to be getting better. On Acer he

	always made a swift recovery. She was very concerned about the Cavell Centre's ability to care for her son properly in terms of how they let him off the ward when he was so unwell.
Quality of care for Huntingdonshire residents at the Cavell Centre	A staff member from the Rehabilitation and Recovery Team based in Huntingdon said at the Public Meeting that they were no longer able to pick patients up from the ward (as they had done on Acer), take them home to deal with bills, domestic affairs, pets etc. and to try to settle people back at home to prepare for discharge, as it was simply too far. She was very concerned that this was seriously compromising quality of care for patients at a difficult time, namely the reintegration of patients back to their homes. This is very worrying at a time when Mental Health Services in Cambridgeshire have been severely criticised by the Care Quality Commission in the early part of this year.
Quality of care for Huntingdonshire residents at the Cavell Centre	A person commented that during a recent admission she found the language issues at the Cavell Centre very difficult, in that she was extremely distressed, but could not understand the staff as their English was very poor. She also said that she felt the staff, though well meaning, couldn't take responsibility for the safety of vulnerable mental health patients.
Quality of care for Huntingdonshire residents at the Cavell Centre	At the Service User Meeting it was outlined how a patient may be admitted to the Cavell Centre and the several different units they may be held in. This appears rather like a 'washing machine type effect' to me (referring to the 3:3:3 model)…I am not convinced that all these changes of location is what is really helpful at a time of severe mental distress. Surely it would be far better for services to come to the patient, as used to happen on Acer Ward? If staff want to still bear these stages in mind (referring to 3:3:3 model) then that may be ok, though I'm not convinced that recovery falls so neatly into these boxes.
Quality of care for Huntingdonshire residents at the Cavell Centre	Ultimately a Huntingdonshire service user loses their whole community when they are admitted out of area. This makes it much harder to recover and reintegrate. It also means that new friends made on the ward may actually live many miles away. These new friends often become part of a person's support structure and really help to prevent illness in the future.
Home Treatment problems	Home treatment is being held up as the Holy Grail, which will prevent a lot of people needing a hospital bed. Problems with this are time limiting the amount of visits people are allowed, phone calls not visits, quality of care received, seeing a bewildering array of different staff who don't seem to have read a patient's notes, regularity of visits etc. Below are some examples of service users' issues with this service:
	a) At a recent service user support group meeting, a patient spoke of how he had to wait for hours to receive a visit from the Home Treatment Team and that so often this so called treatment was simply a telephone call. At the consultation meeting on 19 December, several people indicated that this had been the case for them, that at a time of great crisis in their

	lives, they had to wait 2-3 days for visits. It was also said that people were upset by seeing so many different staff, many of which didn't seem to have a clue about them and their condition. It would seem that service user notes were most definitely not being read and information about patients was not being passed on between staff members.
	b) Another service user felt that this service (Home Treatment) resulted in her being ill for three times as long as when she had a bed on Acer, and that it put enormous strain on her family to care for her…when she wasn't being seen or receiving a phone call.
	c) At the public meeting it was said there had been incidents of people being asked to drive to Peterborough to receive Home Treatment. This seems very dangerous as the Home Treatment Team is there to give people in crisis support, who would once have received a bed. A lot of severe psychiatric illnesses and the medications used to deal with them mean that it is illegal for people to drive…
	d) At the public meeting in Huntingdon (January meeting) a mother said she had to wait 20 hours for the Home Treatment team after her son became psychotic.
	e) We had the story in the Hunts Post (2011) about a patient I had been on Acer ward with (Ian from Great Staughton) that had been refused a hospital bed and given Home Treatment, which resulted in his death by suicide. On Acer he had the support of the ward community, and was not alone at home apart from short visits or impersonal phone calls
Patients not wishing to seek help	Patients with very serious mental health conditions may not wish to seek help, because they do not wish to be so far away from home at a time when they feel so ill. With psychotic illnesses, if the person does not seek prompt help, they may lose touch with reality and start to think they are not ill at all. This is when a person can become very dangerous to themselves and possibly others.
Misrepresentation of Acer Ward in the consultation document	Acer is described as a dormitory style ward, and a patient is described as being unsettled and unable to get well, as they have to go into a dormitory. This is used to imply that the ward, which is only about 18 or so years old, and was purpose built, is out moded in some way. However Acer has 8 ensuite rooms and one only goes into the dormitories (one 3 bed for women and one 3 bed for men). The staff on Acer were also praised for making these dormitories as sensitively arranged as possible. Why is Acer misrepresented and is this legal during a consultation process?
Quality of ward environment at the Cavell Centre	I have seen Acer described as being of domestic style i.e. Homely. This contrasts with new build wards at the Cavell Centre, which I would describe as 'A grand hall Big Brother design'. The main feature seems to be a huge room with a staff office overviewing everything, with TV going at one end and a radio at the other. While very attractively decorated, I felt very stressed while

	visiting a friend. Too much space and too much noise! Patients have viewed the wards as too large and that they are overlooked constantly. Acer had smaller more homely rooms and always managed to keep patients safe too. I think I am right in saying that they had an unblemished record in terms of never losing a patient to suicide. Sadly a brand new ward at Fulbourn (Springbank) has already had a patient take their own life on the ward.
Quality of the surrounding environment at Acer	Acer had a wonderful surrounding environment. When the person is feeling a little better they can have walks in the hospital grounds, and access to the Cafes and shops in the hospital. Staff also take service users for walks in Hinchingbrooke Park, which also has a café. Huntingdon is a short walk or bus ride away. Sadly the Cavell Centre does not sit in such pleasant and therapeutic surroundings. It is out of the city centre, a city centre which could be said to be large, disorientating and not necessarily all that safe.
Misleading, ill-timed and inefficient consultation process	a) Misrepresentation of Acer Ward in consultation document, as mentioned above. B) Presenting of a stream of highly questionable reasons why we cannot have Acer. Firstly, misrepresentation of Acer in the consultation document as dormitory style. In a Care Quality Commission report, Acer is commended for their sensitive work with the dormitory space, while other wards are said to need work on theirs.
	At the service user meeting it was said that the ward had ligature points. Again looking at the same report, other wards are criticised for ligature points, but not Acer. On 5/1/2012, it was reported in the Press and on the CQC site that wards at Fulbourn still have ligature points
	At the same service user meeting it was said that, owing to no other psychiatric wards being present, staff could not be called up in a crisis. Surely it would not be too difficult for some staff in Hinchingbrooke Hospital to be trained and the re-positioning of the Home Treatment Team back on Acer could also help with this. Acer always coped for the 18 years or so before this when it had about 24 patients. While patients now may be more ill, it has to be remembered that extremely unwell patients are placed in a secure unit, such as George Mackenzie at Fulbourn.
	We see in Hunts Post (end Dec 2011) that we can't have Acer because 3 GPs say that the ward is not of a suitable quality and that patients cannot access a full range of treatments because it is not attached to a larger hospital. Psychological therapies, cognitive Behaviour Therapy, anxiety management, art therapy, counselling and many more area available at Newtown Centre in Huntingdon, Mind in St Neots and GP surgeries across Huntingdonshire. Therefore I find it very hard to believe that things could not be arranged for Acer patients, as they have been in the past.
	Inappropriate time for consultation. Around Christmas is the very worst time for service users and their families. Stress is usually high and many people are seasonally affected in a negative way by winter.

	The Service User consultation meeting seemed particularly poor, especially after attending the Public Meeting. The document had to be asked for, no overheads were given, and criticisms of the proposals were rushed over.
The bottom line – modernise Acer Ward instead	It is proposed to relocate Lucille van Geest to the Cavell Centre via complete new build, dispensing with the 16 rehab beds and making them acute beds. How about saving some money and just giving Acer a spruce up, training new staff in the hospital to be called on in a rare crisis, re-siting and re-vamping the Home Treatment Team, and facilitating Acer to do what it does best, care for people very well. Peterborough has numerous wards, I'm sure they won't miss one, while we will be penalised constantly for the loss of ours.

Response submitted on NHS Cambridgeshire website 'Guest Book'

Keep Acer Ward open	I would like to add my comments to those in support of keeping Acer Ward at Hinchingbrooke. We have personal experience of a dear young friend who had great need of that support a few years ago; we know from visiting her whilst she stayed in Acer Ward just what a valuable resource it provided for her and for those with her at that time; we also know what a huge difference it made to her recovery. We also do not necessarily recognise the picture of a dormitory style ward which has been evoked in the statements in favour of its closure. On the contrary the feeling when we visited was one of warmth and strong individual support. A similar resource further away would not have been so accessible in this part of the county.

Undated – service users from Huntingdon

Keep Acer Ward open	Although we have not yet needed their particular care, we are aware how much support the ward has continually provided for people locally. We have friends as patients and carers, who have found Acer Ward a safe and trusted haven in difficult times.

Undated – service user from Huntingdon (Old Hurst)

Keep Acer Ward open – transport issues	Carer for husband who has bi-polar disorder. I do not drive and have no family living nearby, so have to rely on public transport to see my husband in hospital in case he

	has another episode.
	Live in a rural village, bus service runs to Hinchingbrooke Hospital but if I had to go to either Cambridge or Peterborough, I would have to get at least 3 buses, can you imagine the stress of this to me, yet alone to my husband as he would be working wondering where I am. I am not in good health myself as I have a physical disability.
Modernise Acer Ward	Please would you reconsider modernising Acer Ward as I am sure there will be other people in my situation as well.
Transport issues - cost	I am also on limited income whereas the cost of fares would also be a concern.

Petition to re-open Acer Ward received Jan 2012 – received by post

Petition contains 8 names

Online petition to re-open Acer Ward– received by email

Petition contains 110 names

Petition against closure of Acer Ward – received by post 13 January 2012,

Petition contains 510 names. The main points raised in the cover letter to the petition are listed below:	
Travel	Unfair to patients having to travel to Peterborough, the journey alone will cause extra stress and complicate their condition.
Travel	Expensive journey for family and friends to visit patients
Atmosphere at Peterborough compared to Acer ward	Peterborough can never replicate the peace and tranquility of Acer.
Staff	Staff and support persons will also be uprooted or lose their jobs.
Cost	The authorities say they will save millions, they will waste millions and end up with an inferior service.
Staff travel	If staff did not have to travel to Peterborough, the time saved in travel would be better used and the service would benefit all round and cost less to implement

12 January 2012

Criticism of public consultation	As a governor of CPFT, I feel that the public consultation has

	been a sham. People have been able to express their views on the present proposals but no alternative plans have been presented. Decision to close locally based units (Hawthorn and Acer) was effectively made when the decision was made by the board to commission the building of a big facility at the Cavell Centre, rather than refurbishing wards at Hinchingbrooke to present day standards and building a smaller unit at Peterborough.
Transport	The public meetings in Huntingdon expressed clearly the difficulties for service users and carers of visiting the unit in Peterborough. It is costly in both time and money to visit loved ones.
More flexible visiting hours requested	As it is obvious on economic grounds that the proposals will go ahead, I would ask that the board would look into more flexible visiting hours especially on weekdays for those on Oak Ward.
Car parking charges	It would be helpful if those visiting from the Huntingdon area could have car parking charges waived, to reduce the cost of visiting loved ones.
Cost of visiting	My third recommendation is that next of kin who are living on benefits could be given some financial help to help defray the expensive cost of visiting.
Service users in St Ives	Cambridge is much nearer for service users from St Ives, than Peterborough and there is a regular bus service. Could they not be sent to Cambridge instead? I point out that Huntingdon and St Neots are nearer to Cambridge so why did the Board decide to build a big facility in Peterborough?

Undated – response from resident of St Ives

Closure of Acer Ward	Having been very grateful for the service provided by Acer Ward. I feel we really do need a local service, contact with family is vital and can cut short a stay within the hospital, saving money in the long run.

Undated – response from resident of Somersham

Opposes closure of Acer Ward	Strongly oppose proposed closure of Acer Ward at Hinchingbrooke Hospital. As a resident of Somersham whose family has used the mental health services at Hinchingbrooke in the past, believe Acer Ward should remain open and well-funded and resourced. Proximity of local hospital is extremely important for patients and families who do not own a car and rely on public transport. As well as quality, the accessibility, cost and ability to reach their local hospital has to be taken into account. Peterborough is too far away from service users and is not a practical or fair solution. It seems patients suffering from mental health problems are always pushed to the back of the queue and their needs are put at the bottom of the heap. Families with members suffering mental health problems are already struggling to cope and support their loved ones and this makes life even more difficult for them.

Detailed response to Q5. Do you agree with our proposals to combine a number of inpatient wards for adults? Dated 16 January 2012

No – I do <u>not</u> agree with the closure of Acer ward at Hinchingbrooke Hospital. In my view, this represents an appalling cut in services for people across the Huntingdonshire area, both current mental health service users and carers and those who need to access acute services in the future. Regarding this ward closure, I cite the following concerns and issues:
Impact of the loss of a local inpatient facility
The consultation has informed us that, without a ward locally, Huntingdonshire service users would be admitted to the Cavell Centre, Edith Cavell in Peterborough should they require inpatient care (and in the case where there is not a bed available there to an inpatient ward at Fulbourn, Cambridge). This returns the service to the unsatisfactory and inequitable situation which existed prior to Acer's opening in 1994. The permanent closure of this ward in Huntingdon would be accompanied by a loss of benefits which both service users and carers have derived from being able to access acute inpatient services at a closer proximity to their home address. Specifically, two significant components to aid local people's recovery from an acute episode of mental illness will be adversely affected by these plans: family and friends being able to visit and making first steps towards going home.

My own personal experience reveals the importance of family and friends being able to make more frequent visits and arrangements for leave from the ward being easier. While I have been fortunate to be able to be on a ward local to me, my Dad was not. Throughout my childhood, and in the years before, when he was unwell my Dad was admitted to a ward at Fulbourn, which my Mum says he found very isolating. He would on a fairly regular basis leave the ward (abscond, sometimes while under Section) and make his way towards home in Ramsey. She, with myself and my younger brother and sister to look after, was only able to travel to Cambridge to visit occasionally and our visits as a family were more limited still. One clear memory is of a Christmas when I was 4/5 years old and Dad was not permitted leave from the ward at Fulbourn, meaning we were unable to spend any of Christmas Day as a family. Again weekend leave was limited and the drive to and from the hospital (at least an hour each way) cut into the time he was able to spend at home with family.

Facilities at the Cavell Centre

The consultation has tried to persuade us that better outcomes are possible at the Cavell Centre, while reports heard from service users and carers of these flash facilities and new systems of care provide evidence to the contrary. For instance, a story and letter from a carer (published in the Hunts Post 26.10.11) reported that her son was showing no progress following a 6 week admission at the Cavell centre while his mental health would previously have stabilised within 2 weeks at Acer. A Trust spokesperson chose to respond to this story by claiming that it takes people time to get used to a new system and that it was much better as there were single ensuite rooms. I read in disbelief that no apology was made within this response and that the blame was shifted to the service user. I felt sure too that given the choice he would rather take a bed (even a dormitory bed) close to his family and in his community. At a public consultation meeting (7.12.11), individuals who had been treated in the Cavell Centre reported a drop in visits; not being able to see their regular consultant (to the point that a complete change in medication was implemented without their doctor's knowledge) and community staff reported finding facilitating visits home for service users very difficult (due to the time involved to travel to Peterborough to their Hunts homes and back to Cavell Centre) eg. to check their mail.

I have visited a female friend on Oak ward at the Cavell Centre and found the environment to be far from the glowing impression we are given – the huge room means that you feel continually watched and there is little true interaction between staff and patients in this ‘interventions unit’. By contrast, Acer is a ward whose accommodation the NHS Choices page describes as ‘of a high quality and in domestic style’. That is to say, as far as an acute mental health ward can, it felt like home. In fact, my friend and I joke that, for a part of our lives when our mental health was not so great, it was our second home.

I remain unconvinced by 'proposed' changes: As continually voiced by service users, carers and other concerned members of the public, the value of a local inpatient ward and locally-based home treatment team is over and above the provision offered to the people of Huntingdonshire by these proposals. Commissioners consider that a travel strategy will solve any difficulties that being admitted to a ward in Peterborough/Cambridge would cause. In suggesting this as the solution, they are showing their misunderstanding of the impact that being treated out of area will have on service users and their family and friends. The case of my father clearly demonstrates these difficulties. I know too that when friends have been admitted to wards in Peterborough or Cambridge in the past, when Acer has not had a bed free or when they have required more specialist treatment, I have visited much less frequently than I would have liked and would have been able to had they been in Huntingdon. A pop in after work for a cuppa doesn't happen and visits become a real possibility only at weekends or, if you do go in the week, the extra travelling and time required soon eats into your energy levels and ability to cope with making the visit. The times in which a loved one is in hospital are also hugely stressful to the people who care about them and adding any extra stress at this time is unfair.

Misrepresentation of Acer ward in the consultation document

Someone unfamiliar with Acer ward and only availed of the information contained in the consultation document could be forgiven for considering it to be a failing ward, where quality of care and standards of accommodation are poor. The descriptions given of a 'dormitory style ward [in which] the patient finds the facilities intimidating with other patients in the room and remains unsettled' however do not accurately describe Acer. As I pointed out at the public consultation meeting in Huntingdon on Wednesday 7th December, if this 'patient case' were submitted as a piece of evidence in a court of law it would be thrown out as inaccurate and completely unsubstantiated. There were a number of service users (around 20 at least) present at the meeting that evening who testified to this not being a typical experience of Acer ward's facilities and instead told of positive experiences of the ward helping them through difficult times.

Its description as a 'dormitory style ward' is a misrepresentation of the bed allocation. In fact the ward has 10 single ensuite rooms, 1 ICU bed (single ensuite) and the remainder of the beds are dormitories (2 x 3).The wording in the consultation document makes out that all beds are 'dormitory style' when in fact this is a minority. Improvements have already been made to dormitories to improve privacy and dignity arrangements with bathrooms now inside each dormitory instead of along the corridor. Moreover to bring the 2 inpatient wards at Fulbourn (Friends and Adrian House) up to standard there will be investment to remove dormitories there – so why not at Acer too? Also, although it is reported that a patient would find this bed situation intimidating and remain unsettled, I have witnessed a very different scenario. There was actually clinical rationale as to placing patients in a dormitory rather than a room on their own - eg. when I was admitted suffering from severe depression, I had a dormitory bed which actually helped to facilitate my recovery as, after weeks at home on my own, I was around people.

Two public documents support the fact that Acer ward is a good quality mental healthcare facility, painting a picture in contrast to that of the consultation document:

1) Within the CPFT Quality report 2010-2011, results for the PEAT (Patient Environment Action Team) audit - see pg 22-23 main report and pg 5 of summary report -Acer ward scores as well as the Cavell Centre and is rated as 'Excellent' regarding privacy and dignity, an aspect which the consultation document says is not up to standard.
2) There is also AIMS (Accreditation for Inpatient Mental Health Services), a national scheme which includes input from experts from the Royal College of Psychiatry. The membership document shows that Acer Ward has been accredited until October 2012. Again an indication that it reaches high standards of inpatient care, meeting national criteria regarding: general standards; timely and purposeful admission; safety; environment and facilities; therapies and activities. In fact, if you look back on previous membership lists, Acer received accreditation without the difficulties experienced by Adrian House/Friends Ward at Fulbourn, Cambridge which initially had 'accreditation suspended' until changes were made to care there to bring up to the required standard.

I can personally attest to standards of care being as good as, if not better than, you would get on an inpatient ward elsewhere in the Trust or indeed that provided on acute mental health wards in other areas of the country. The manner in which it has been suggested otherwise within the consultation process and this unfair portrayal of Acer has been deeply upsetting to all those connected with the ward – service users, carers and I'm sure, though they have not been able to discuss publicly, staff.

Circumstances surrounding the ward closure:

It has emerged that staffing was the problem that ultimately led to the decision following the National Clinical Advisory Team (NCAT) visit in September 2011 ruling that the ward was 'unsafe'. It's a complete 'chicken and egg' situation: rumours were circulating by March/April 2011 that Acer ward was to close and the Trust have admitted that they were open with staff about the 'possibility' of the closure so that they had an opportunity to take up posts elsewhere, including the new ward for personality disorder patients: Springbank on the Fulbourn site opened May 2011. It is my opinion that if the closure had not been as pre-determined, staff would not have considered looking for employment elsewhere as the only option. Also I don't think the continuing anxiety about job cuts at Hinchingbrooke following the takeover of Circle helped at all in the attempts to recruit replacement staff to posts vacated by those taking up opportunities at Springbank. Although Acer is run by CPFT, people generally regard it as part of Hinchingbrooke Hospital and this will include potential employees. As suggested at the recent Huntingdonshire District Council Overview and Scrutiny Committee (Social Wellbeing) meeting by one of the lady Councillors, these staffing issues could be overcome.

Having followed the situation since rumours first began to circulate, I have observed how the service at Acer was continually undermined - including I believe telling other services to no longer refer patients there - so of course the number of inpatients dropped, to suggest it was no longer needed! The more I hear and learn about the behind the scenes political aspects of the ward closure, it has become obvious that the 'reasons' put forward in the consultation document - the standard of its accommodation, the access to different therapies and care, etc – are nothing but excuses. Overall, it seems to be all about money: Acer ward has been pinpointed as an efficiency saving in this redesign. John Ellis said at the last public meeting (4.1.12) that if Acer was to have money spent on improvements needed to bring it up to the standards for it to be reopened, it would be taken from services elsewhere eg.proposed primary care services. As I remarked then in frustration, surely then the reverse is true, but he replied that wasn't what he was saying. And if beds are being reprovided in Peterborough and this involves the rebuilding of the Lucille Van Geest how much can really be being saved?
Increased emphasis on Home Treatment
I have watched with interest over the last 5 years or so as the Recovery Model has been implemented within services. For years I had been asserting that fellow service users needed to be given more hope for what they might achieve and therefore welcomed this transition, recognising however the difficulties of shifting services to this new stance. More recently, I have witnessed the use of the Recovery Model as justification for 'service transformation'. In relation to the Acute Care Service, this 'service development' has been in the guise of CRHT teams, with their main objective becoming increasingly to prevent (more costly) admission to hospital where at all possible, rather than offering an alternative or to support early discharge. With the closure of Acer, there would be an even greater emphasis on Home Treatment and this seems to be led primarily by its monetary value in comparison to inpatient care, rather than what service users and carers say they want and need.
Within the service transformation process, a need for increased training for community staff has been highlighted, as they will be working with people who are more ill, who might previously have been cared for in hospital. In my view this is not always – despite the rhetoric which tries to suggest otherwise – in the best interest of the service user. The continued national policy re care in the 'least restrictive setting' ignores the fact that when seriously mentally unwell sometimes the best place for you is in hospital - not always easy either but preferable to being at home with little real contact from mental health services - intermittent visits and phone contact - which places a huge burden on family and friends. Sometimes being in the 'safe haven' of an inpatient mental health ward is where you need to be and I firmly believe there is still a place for inpatient care in a revised recovery-centred service. In this context I speak from personal experience of receiving home treatment when a short admission to hospital would have stabilised my condition - in the end after 8 weeks unwell at home, I had an admission of over 4 weeks and this lengthy episode has had a long term effect on my depressive episodes since.
Comments regarding the consultation process

In this public consultation, more so even than others I have previously contributed to, it has appeared that all the decisions have already been made and any amount of protest and advocacy of any alternative way forward seems almost futile. As I observed at the beginning of the first consultation meeting in Huntingdon on 7/12/11 regarding the closure of Acer ward and other changes: “It feels like today we are not talking about proposals but we are reflecting on something that has happened”. I have been particularly concerned about the manner in which the Trust has sought to justify its temporary (and most probable permanent) closure of Acer and feel whatever I or anyone else might say to the contrary, this will ultimately go ahead. I have felt this powerlessness time and again over the last few months. But every time I’ve thought ‘what’s the point?’ or ‘it won’t make any difference’, someone has told me that they, too, find the closure of Acer Ward so wrong or I’ve heard a story that has reminded me why I felt so impelled to speak out in the first place, when I wrote to the Hunts Post letters page back in October.

Of everything, I have been most disappointed and quite frankly appalled that John Ellis, as lead of the consultation process and lead mental health commissioner, has such a poor handle on the issues in context, particularly those relating to the local context of Huntingdonshire, as has been obvious at both public consultation meetings and HDC’s Overview and Scrutiny Committee meeting. I am a former service user of mental health services in Huntingdon between the years of 1999 and 2011. OK, I have an Open University degree in Health & Social Care, am currently studying to complete an MSc in Public Health and now work in health research, which has helped a lot towards the understanding I bring to this issue. But this is his job and one which I am sure he gets paid good money for - the kind of money that would be better used contributing to the budget required to reopen Acer. Similarly it is my view that the performance and salaries of those in other ‘public engagement’ positions at NHS Cambridgeshire should be reviewed. The consultation process was not reported widely and at the beginning it seemed, unless you had browsed for it on the Internet knowing it was there, you would have had little chance of finding it. Also when I rang during the last week of October/beginning of November (the consultation process having begun on Monday 16th October) to enquire why copies of the consultation document were not in the county’s libraries, I was informed by the PALS advisor that this had been overlooked and they would be sent out - tomorrow.

‘Save Acer ward’ campaign

The subsequent campaign facilitated by a number of service users and carers from the Huntingdon area has done more to encourage true public engagement in the consultation, despite the apathy expressed by many as it seemed like a foregone conclusion, than anything organised and facilitated by NHS Cambridgeshire. While we are now learning that other CPFT inpatient wards have received fresh criticisms from the Care Quality Commission during their latest inspection visit in November, which is providing a platform for patients/their families and friends to reveal some of the horror stories they have been witness to, Huntingdonshire service users and carers have been actively advocating and campaigning against the closure of Acer ward. This tells you more than any inspection: I doubt very much that the closure of the Cavell Centre or wards at Fulbourn would muster the same level of public support and interest. It is indicative of the nature of the care and support we and our families received from the well-established staff team at Acer that we have been moved to step forward and speak out against the ward closure.

Recent support from Huntingdonshire District Council has given us a boost but we realise that there is a long road ahead if Acer is to re-open. There has also been press coverage recently about the new chief executive Dr Attila Vegh's approach to improving care within the Trust and he has been quoted as saying, "I'm asking everyone to play a role in moving forward, starting having courageous conversations and not to accept the unacceptable". I think that typifies our campaign - many have bravely put forward their views and certainly got across the fact that the closure of Acer ward is something that is unacceptable and will not be just accepted.
It is my sincere hope that the views expressed to this public consultation will be honestly assessed and fresh consideration given to the future of Acer ward – that it has been continually spoken of in the past tense during the consultation process leads the cynic in me to suspect it won't matter what any of us has said. Nevertheless I'm proud of us all and, whether or not Acer ward re-opens, we can always know that we truly did everything we could. Acer ward has been recognised as a valued service which has helped many people through difficult times and there has been acknowledgement that its permanent closure would be a loss to our local community. I will be continuing to pray that it will be reopened and once again people living in Huntingdonshire will be able to access inpatient mental health treatment within the locality.
NB: I am also attaching to this email the content of a blogspot which I found online at http://cpftaccutecareservice.blogspot.com/ (author unknown) and reminded me why I am so against the closure of Acer ward and have been working so hard on this campaign - the respect for service users and carers during the stressful times of an admission comes through in this description of the ward.