5 Boroughs Partnership NHS
NHS Foundation Trust

Proposal for a New Model of Care

Adult Acute Care Pathway

4th November 2011

A Better View

Contents

Executive Summary

This model outlines proposals to qualitatively change the nature and balance of service provision by 5 Boroughs Partnership NHS Foundation Trust (hereafter called 'The Trust') and its partners for people having their mental health needs met within the Adults Business Stream.

A new and robust model of care is proposed, that will enable the modernisation of services, focussing upon improving access to assessment, diagnosis and evidenced based treatment whilst streamlining the patient journey through services, offering more effective early intervention and home/community based support and treatment. Working closely with local authority partners mental health services are envisaged to continue to be provided on a partnership basis.

Trust strategic objectives emphasise that recovery focused mental health services require statutory and voluntary agencies to work together and closely with service users, carers and families to ensure that services are needs-led, local, accessible and well resourced.

In accordance with National drivers, the model aims to concentrate on improving productivity and eliminating duplication whilst focusing on clinical quality (DoH 2010a). This proposal offers the development of services within existing financial frameworks and expectations. We aim to deliver in partnership a comprehensive, evidence based Adults Mental Health specialist model (DoH 2008). This will encompass core functions to deliver a high quality rapid response, evidence based, collaborative needs led care service for adults.

The model includes a proposal to provide an enhanced assessment service that will provide three teams that will directly support GP practices and the 3 local acute Trusts within the footprint of the Trust up to 24 hrs per day.

1 The increased capacity and skill-set of the service will ensure that adults requiring assessment will be subject to only one comprehensive assessment, wherever or whenever that assessment is required. The new service offers greater efficiencies' of working compared to the existing differing teams, duplicated interventions and assessments. This will support increased contract activity at key parts of the care pathway, enabling effective navigation.

2 The new enhanced assessment service would also be able to offer a model of consultation and liaison at the interface between primary and specialist mental health care

3 The model proposes a dedicated and focussed home treatment service that will work closely with existing adult inpatient services to increase the effective capacity of the treatment team to

avoid hospital admission and facilitate early discharge wherever possible. This will provide greater integration between inpatients and community services

4 It is proposed to consolidate the functions of the range of separate community teams into an integrated local service that can offer a focus of support and recovery to the local community. The Trust currently has over 70 teams across various localities and opportunity exists to offer increased co-ordination of the various functions to increase clinical activity and efficiencies.

5 The model encompasses a dedicated community Mental health service to deliver person-centred interventions and care on the basis of need not age, in accordance with the Department of Health's four priority areas (DOH 2010b). These are an integral part of improving the care and experience of service users and carers.

Building on current partnership working with statutory and voluntary sector organisations will enable the provision of additional support on a range of areas including accommodation, welfare benefits, advocacy, carer assessment. Thus supporting and promoting the personalisation agenda.

The model is designed to improve productivity by simplifying the assessment and treatment pathway, whist offering a focus for recovery thereby creating the capacity to meet increased demand for the services.

This model of care will, if successful reduce in patient activity, however there will be no agreed plans to reconfigure the inpatient estate until the model has been fully implemented and evaluated, then any emerging plans would be subject to a separate consultation exercise.

In summary the model will deliver the following benefits:

- Increased capacity, improved skill set and increased activity
- Increased levels of consultation and liaison to support primary care
- Focussed home treatment service
- Consolidation of existing community teams
- Person centred interventions promoting personalisation

It is intended to review the improvements in community services as part of the project implementation. Local Implementation Teams are proposed for each locality that will have the responsibility to monitor and report project objectives and the baseline performance measures. Membership of the teams will include representation from all operational stakeholders. It is proposed to report progress formally to evidence progress at 6 and 12 months to facilitate stakeholder evaluation and inform next steps.

1. Introduction

Using the principles and objectives contained in recent Department of Health publications, we aim to deliver a community based service supporting to people to remain at home, whilst improving and maintaining the quality of life of service users and their carers.

The care pathway will clarify and standardise the care delivered to adults with complex functional and psychological conditions whose needs are best met by specialist health services.

The Assessment Service will deliver improved waiting times and offer more efficient diagnosis of patient needs in a wide range of accessible localities.

The dedicated Home Treatment Service will be supported by access to specialist in-patient beds in instances when the service user cannot be safely or appropriately managed safely within their local community.

Facilitated by the new Recovery Service, the model proposes a comprehensive and integrated secondary care pathway for adult mental health services that will enable the Trust and its partner agencies to deliver a comprehensive range of integrated, evidence based services in accordance with stakeholders' wishes and appropriate to meet the challenge of rapidly increasing levels of need.

If progressed, the planning assumption of the model is that it is expected to reduce the need for adult in-patient beds in the future.

The clinical model's activity testing indicates that the benefits of getting the assessment right first time and by increasing the capacity and focus of home treatment services. The benefits are projected to offer a reduced need in overall inpatient bed capacity.

The longer term aim is therefore to allow the release of resources to support the development of the quality of inpatient services with an excellent physical environment with care delivered by a specialist multi-professional team of staff.

2. Scope

The model includes the delivery of service within the geographical footprint of the five boroughs of Halton, St Helens, Knowsley, Warrington and Wigan, including services commissioned by NHS commissioning bodies within this area.

The primary focus of the model includes all services delivered to adults with complex mental health and psychological conditions whose needs are best met by specialist mental health services. The model includes older people with a functional illness whose particular needs are better met by adult mental health services. Early Intervention in Psychosis" services are considered to be examples of "best practice", with a strong evidence base and will be retained as a separate service.

3. Background

To build a healthier, more productive and fairer society in which we recognise difference, we have to build resilience, promote mental health and wellbeing, and challenge health inequalities. We need to prevent mental ill health, intervene early when it occurs, and improve the quality of life of people with mental health problems and their families. Improving assessment, treatment and recovery services will be a key part of the Trust's objectives to support the agenda of the wider health community.

The quality of mental health care has improved significantly in recent years. Skilled and committed front-line staff have developed services that are internationally recognised. Two examples are the development of Early Intervention in Psychosis teams and the Improved Access to Psychological Therapies. The development of community-based services and the widespread integration of health and social care have meant that fewer people need inpatient care and the number of inpatients taking their own life has reduced.

The Trust wish to continue and add to the improvements by developing the Acute Care Pathway and monitor the outcomes of its introduction and work alongside partner agencies to promote mental health and wellbeing. The improved assessment services will aim to prioritise early intervention for all complex mental health difficulties and incorporate mental health promotion and wellbeing.

The Acute Care Pathway aims:

- to identify mental health problems and intervene early across all age groups;
- to ensure equity of access for all groups over 18 years of age, including the most disadvantaged and excluded to

high-quality, appropriate, comprehensive services;

- to build care and support for outcomes that matter to individuals to enable them to live the lives they want to live, including good relationships, education, housing and employment;

- to offer people age and developmentally appropriate information, and a choice of high quality evidence and/or good practice based interventions, including psychological therapies for all service users.

- to ensure that all people with severe mental health problems receive high quality care and treatment in the least restrictive environment, in all settings; supporting the achievement of NICE guidance for mental health conditions.

- to work with the whole family, using whole-family assessment and support plans where appropriate

In devising the Acute Care Pathway all workers in the assessment services have been involved in setting the good practice agenda of the assessment services based on experiences and suggestion to improve existing services

The Acute Care Pathway has been developed following a series of three briefing meetings and five expert workshops with clinicians and commissioners from across the 5 Boroughs Partnership NHS Foundation Trust foot-print. The workshops used system dynamics modelling approaches to ensure any activity assumptions are resiliently tested and determined.

Furthermore through a series of briefing meetings front-line practitioners have contributed to the design, planning of the proposals of the Acute Care Pathway service proposals as they are often well placed to help GPs and local partners in commissioning high-quality services.

3.1 Current service configuration and environment

Evaluation of the Trust's current services for adults considers the impact of the previous strategic change initiative "Change for the Better" aimed to capture the expectations and configuration of the NHS plan services that were accompanied with population based activity and staffing targets. This change event excluded Ashton Wigan and Leigh PCT due to commissioning intentions at the time and did progress the Trust to add to successful achievement of DoH targets, however effective access to services remained an issue for the local health communities, particularly General Practitioners.

The challenge for the project group was of reviewing how to best manage the resources allocated to over 70 differing functions of clinical teams to ensure the attributes any new blueprint of service focussed upon the delivery of care. A number of the existing functions were nationally prescribed functions that were linked with specific investment

streams as part of the DoH Mental Health National Service Framework and associated Policy Implementation Guides. Unintended consequences created a degree of service fragmentation and overlapping of resources with resulting inefficiencies, service user and GP concerns.

Additional investments and initiatives have sought to address the issue of access with limited success. One of the key themes of the expert group involved in the development of this proposed Acute Care Pathway (ACP) recognised the importance and long term benefits of investing in the skills and capacity of any assessment service to a greater degree than previously implemented.

3.2 Current staffing skill mix

The current staffing mix has been informed by the previous change event and considerations have been given during workforce planning. Workforce considerations were to ensure that the proposed services that populate the Acute Care Pathway take full opportunities of creating teams that offer the right skills to support the patients' journey through the pathway. Views of all professional groups were solicited during the development of the teams and consensus has been reached to ensure that an appropriate balance of professionals is achieved to support the expectations of NICE guidance and whilst offering the expectation of competitiveness and efficiency that the public expect of statutory services.

Investment in Local Authority services within the localities of the Trust understandably varies in relation to local needs and priorities. The agenda of integrated working and a joint approach to patient care will be fully supported by the new teams.

Please note that the workforce details below are numbers of staff employed not whole time equivalent

Table 1 Breakdown of Adult Services Community staff

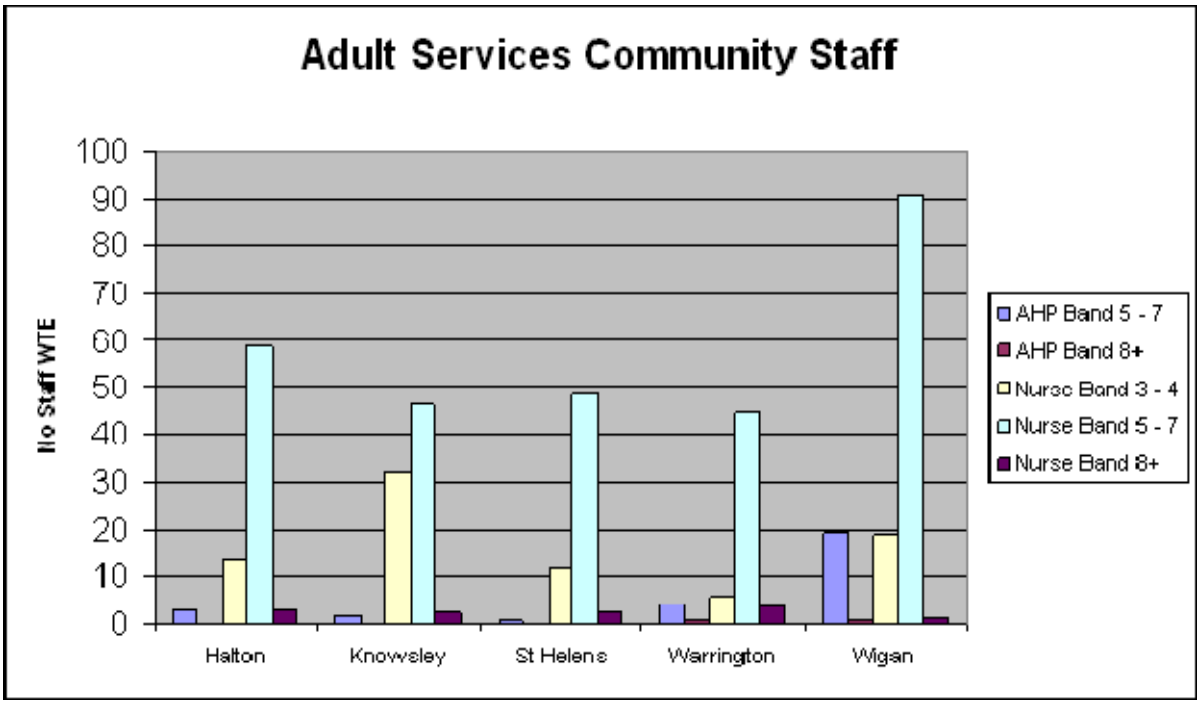


Table 1 illustrates that the majority of staff (Band 7 and below) working across community services are qualified nurses. This is followed by Nursing Assistants and Allied Health Professionals (Including Occupational Therapists and Psychologist).

Table 2 (below) illustrates that the majority of in-patient staff (Band 7 and below) working across inpatient services are qualified nurses. This is followed by Nursing Assistants. There are no practitioners working at Band 8 and above within in-patient services.

Table 2 Breakdown of Adult Services In-patient Staff

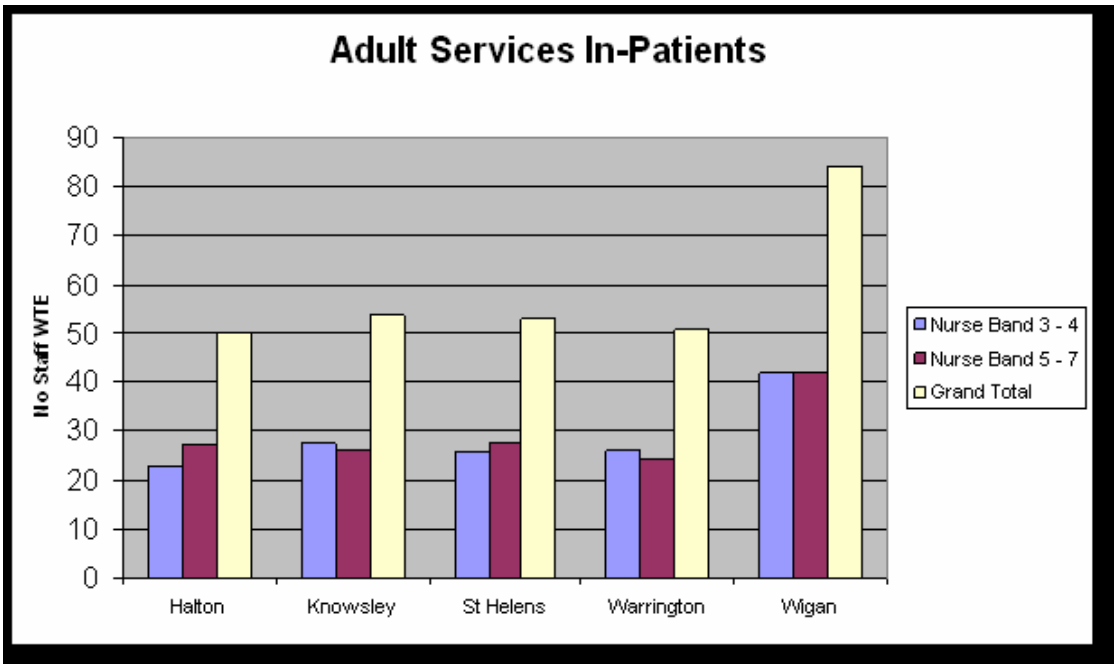
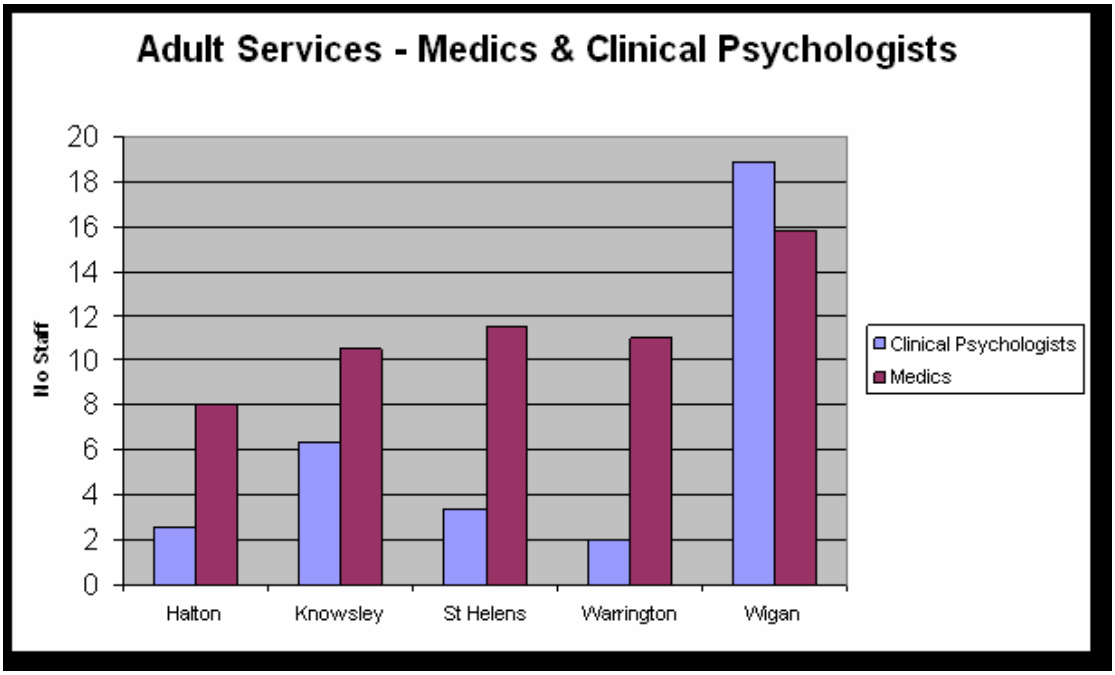


Table 3: Breakdown of Medical Staff and Clinical Psychologists working across both community and inpatient settings



There is a total of 56 Medical staff working across inpatient and community services. (Please note Warrington currently is not commissioned to provide secondary care based

psychological therapy services; St Helens and Knowsley have a psychologist based Eating Disorder Service).

Local Authority Staff

The majority of community teams are jointly delivered with local authority staff, underwritten with formal Partnership agreements with all local authorities. Discussions regarding how best to allocate local authority resources within and around the ACP will focus upon meeting the particular local community needs. We will continue to deliver services in an integrated approach with local authority colleagues and managers to ensure the model meets the needs of our service users and carers now, and in the future.

3.3 Challenges: the need for change

The drivers for change are summarised as:

1. Service User concerns and complaints regarding their transfer between the often confusing range of existing community services

2. Service User concerns regarding the timeliness, capacity, location and diagnostic accuracy of the current assessment functions of the Trust.

3. This is particularly relevant in the existing Access and Advice Service and can lead to pathway distortions and increased referral for unscheduled assessments by the existing Crisis Resolution and Home Treatment Teams

4. Concerns regarding consistency and effectiveness of carer support. Themes have presented via the Trust's complaints processes around how the Trust shares information to enable carers to support and inform care planning;

5. GP concerns regarding the Trust's effective management of GP referrals to its secondary / complex care services;

6. GP concerns regarding the Trust's capacity to deliver collaborative working practices to fully support all GP Practice patients registered on practice Severe Mental Illness (SMI) registers.

7. Differing configuration and scale of Local Authority and Primary Care Services: This can create demand issues from differing referral locations and impacts upon signposting opportunities to support people closer to their communities;

8. Concerns from front line clinicians who have expressed (St Helens Lean Business Process Review) that the effect of multiple teams, assessment, and governance processes negatively impacted upon available clinical time with patients.

9. The current absence of a "Clozapine at Home" service requires inpatient admission solely for Clozapine initiation.

10. The quality, innovation, productivity and prevention (QIPP) challenge is an opportunity to prepare the NHS to defend and promote high quality care in a tighter economic climate. We know we have one more year of guaranteed growth in 2010/11, but the NHS needs to be making efficiency savings of £15-£20 billion per year by 2013/14. Frontline NHS staff will play a crucial role in this work because they have first-hand experience and knowledge of the areas where QIPP will start to make a difference.

11. Opportunities created by the 2007 amendment of the Mental Health Act 1983 which abolished the professional role of the approved social worker and created that of the Approved Mental Health Professional.

12. This role is broadly similar to the role of the approved social worker but is distinguished in no longer being the exclusive preserve of social workers. It can be undertaken by other professionals including community psychiatric nurses, occupational therapists and psychologists.

13. In addition the Trust would like to fully explore the role of other lead professionals undertaking the role of Responsible Clinician.

14. The development of Payment by Results for mental health, work continues on developing currencies for use in the commissioning of mental health services for adults of working age and older people. The ultimate goal is the creation of a national tariff for these currencies. Any new care pathway will need to clearly articulate the interventions that are required to solicit a cluster payment.

4. National and Local Strategies and Drivers

4.1 National Policy and Guidance

There has been a growing body of policy and guidance in recent years including:

- the white paper '*Equity and Excellence: liberating the NHS*' (DOH 2010)
- the '*Revision to the Operating Framework for the NHS*' (DOH 2010)
- *Equality Act* (DOH 2010)
- *Equity and excellence: Liberating the NHS* (DoH 2010)
- '*No health without mental health: a cross-Government mental health outcomes strategy for people of all ages* (DOH 2011)
- *"The economic case for improving efficiency and quality in mental health"* (DoH 2011)
- *Talking therapies: a four year plan of action* (DoH 2011)
- *Delivering better mental health outcomes for people of all ages* (DoH 2011)
- Personalisation of Adult Social Care services
- The National Dementia Strategy (DOH 2009)
- *Early Intervention in Psychosis: Achieving Ordinary Lives* (2010)

These publications have been consistent in promoting services based on need, holistic person-centred responsive and consumer centred services. The need for a whole-systems response that integrates mental health services and actively involves service users and carers by supporting carers and supporting people in the community as far as possible.

Liberating the NHS stated that Department will "implement a set of currencies for adult mental health services for use from 2012/13" It also committed to "develop payment systems to support the commissioning of talking therapies."

The themes and recommendations implicit in these documents underpin the review of the Trust's adult service provision, and continue to shape our service redesign.

4.2 Quality Initiatives

Innovation is one of the central focuses for the Department of Health and the NHS, as demonstrated by the Quality Innovation Productivity Prevention (QIPP) programme. Organisational innovation and service redesign also have a major role in improving patient care, and lean methodologies are increasingly being adopted into the NHS, boosting efficiency and productivity.

Within the Adult Business Stream there are a number of Quality

Initiatives across the boroughs:

- Essence of Care (EOC) – Rating assessment and peer review has been undertaken across all teams / services / wards to identify areas of good practice. The new model supports the sharing of good practice across the Business Stream.

- Accreditation of Inpatient Mental Health Services (AIMs) – whilst a number of our existing wards have been successful in gaining accreditation through the Royal College of Psychiatrists' accreditation programme, a number of recommendations for further improvement remain unresolved e.g. access to therapies in the in-patient setting.

- Improving Access to Psychological Therapies in Wigan and Knowsley boroughs in Primary Care Services. In addition to successful waiting list initiatives in St Helens and Halton for Secondary Care services.

- Development of a new Personality Disorder Hub Service that works in partnership with service users. It provides expert assessments for people who may have a Personality Disorder in order to develop an appropriate care plan as soon as the person is referred to the Trust. The service also provides nationally recognised training in Personality Disorder for Trust staff, colleagues from partner organisations (such as Primary Care), service users and carers. The training is jointly provided by staff and service users who have been diagnosed with a Personality Disorder.

- Mental Health Passport, an innovative approach to the Care Programme Approach values and principles, a paper based folder that is completed in partnership with the patient during their stay as an inpatient and kept by the patient following their journey through mental health services. It has the advantages of driving up patients' engagement, but also limits duplication and provides a live experience from a patient perspective, which directly informs care planning.

- "Single Point of Access Pilot", an 18 months pilot exercise of a newly developed clinical model for Access & Advice service at Warrington, promoting prompt access to treatment ,reducing waiting times, reinforcing communication with GPs and improving patient's journey . Outcomes of this clinical initiative have offered evidence based justification for the Acute Care Pathway

- CQUINN contract activities that deliver physical health screen for some of our most vulnerable and at risk patients prescribed anti psychotic medication

4.3 Health of the Nation Outcome Scale (HoNOS) and Payment by Results (PbR)

The business stream has implemented HoNOS across community as well as inpatient services. HoNOS plus is being used as the basis for 'clustering' for Payment by Results.

The proposed new model directly relates the assessment and intervention processes to the clinical presentation of patients and their resultant PbR cluster PBR will be delivered via 21 clusters, this model of care will inform a framework of delivery in the non organic clusters (see table 5 below).

Table 5 Map of PBR Clusters

Cluster	**1**	**Common Mental Health Problems (Low Severity)**
Cluster	**2**	**Common Mental Health Problems (Low Severity with greater need)**
Cluster	**3**	**Non-Psychotic (Moderate Severity)**
Cluster	**4**	**Non-Psychotic (Severe)**
Cluster	**5**	**Non-Psychotic Disorders (Very Severe)**
Cluster	**6**	**Non-Psychotic Disorder of Over-valued Ideas**
Cluster	**7**	**Enduring Non-Psychotic Disorders (High Disability)**
Cluster	**8**	**Non-Psychotic Chaotic and Challenging Disorders**
Cluster	**9**	**Blank cluster**
Cluster	**10**	**First Episode Psychosis**
Cluster	**11**	**Ongoing or recurrent Psychosis (Low symptoms)**
Cluster	**12**	**Ongoing or recurrent Psychosis (High Disability)**
Cluster	**13**	**Ongoing or recurrent Psychosis (High Symptoms and Disability)**
Cluster	**14**	**Psychotic Crisis**
Cluster	**15**	**Severe Psychotic Depression**
Cluster	**16**	**Dual Diagnosis**
Cluster	**17**	**Psychosis and Affective Disorder - Difficult to Engage**
Cluster	**18**	**Cognitive Impairment (low need)**
Cluster	**19**	**Cognitive Impairment or Dementia Complicated (Moderate Need)**
Cluster	**20**	**Cognitive Impairment or Dementia Complicated (High Need)**
Cluster	**21**	**Cognitive Impairment or Dementia (High Physical or Engagement)**

Needs Led Care Framework

Co-ordination of care/Collaborative Care arrangements must be negotiated based upon individual service user needs. Presentation and need is likely to change, therefore ongoing review is required, this framework will offer a context to practitioners when considering clustering patients within the Assessment Service

Need 5	(Severe – High Needs) **Risk & Complex case Management Interventions** – Intensive Risk and Crisis Management/Inpatient treatment (PBR Clusters Organic 21, Functional 5,6,7,8,13,15,17)
Need 4	**(**Moderate – Severe Need**) Crisis Prevention Intervention –** Intensive home treatment, Specialised treatment, Acute hospital liaison (PBR Clusters organic 20,21 Functional 4,5,6,7,8,12,13,15,17)
Need 3	**(**Moderate Needs**) Personalised Symptoms Management Intervention –** To work with families to reduce stress, Respite care, Specialist care home clinics, Medication reviews, Family, carer and staff training (PBR Clusters organic 19 Functional 3,4,11)
Need 2	(Mild - Moderate Needs) **Early intervention & Rehabilitation Intervention –** To aid with adjustment, Diagnose, Specialist groups, Cognitive Behavioural and psychodynamic therapies, Cognitive stimulation, Anti dementia drugs, Family and carer support (PBR Clustering 18,19 Functional 2,3,4,11)
Need 1	(Mild Needs) **Self (Family) Management & Health Promotion Intervention –** To maintain health and well being, Primary healthcare In home practical social care packages, Day care, Voluntary networks (PBR Clustering organic 18 Functional 1,2)

4.4 Demographic Factors

An overview of the prevalence of mental health issues can be found below. Trends indicate to 2030 a reduction in the overall population and presentation of mental health disorders by approximately 4 percent in line with the associated population reduction. Appendix iix describes the prevalence of psychological needs that would be expected to be supported by the IAPT services within the Trust footprint. The Trust delivers IAPT services within the Wigan and Knowsley localities and it is planned that this service will offer a high degree of operationally seamless integration with the proposed secondary care pathway avoiding referral back to GPs.

The overall reductions in population demand support the consolidation of pathways and teams proposed allowing services to focus upon achieving quality outcomes.

Table 4: An Overview: Profile of population that is likely to have a mental health need.

	% males	% females
Common mental disorder	12.5	19.7
Borderline personality disorder	0.3	0.6
Antisocial personality disorder	0.6	0.1
Psychotic disorder	0.3	0.5
Two or more psychiatric disorders	6.9	7.5

Data taken from PANSI

Table 5: Breakdown of the local population and projections for 2030

	Total Population 18-64		Number with Mental Health Disorder		Number with 2 or more psychiatric disorders	
Borough	**2010**	**2030**	**2010**	**2030**	**2010**	**2030**
Halton	74,400	68,700	12,045	11,086	5,357	4,949
Knowsley	92,600	87,000	15,067	14,101	6,680	6,272
St Helens	108,600	102,500	17,555	16,494	7,831	7,373
Warrington	123,800	124,600	19,858	19,933	8,890	8,955
Wigan	190,500	184,500	30,694	29,602	13,724	13,270
Total	**589,900**	**567,300**	**95,219**	**91,216**	**42,482**	**40,819**

(Data source: POPPI 5.1; Department of Health, 2010)

Looking at this data by percentage change highlights the variances across the 5 Boroughs (see Table 6).

Table 6: Projected percentage range from 2010 to 2030

	Total Population 18-64		Number with Mental Health Disorder		Number with 2 or more psychiatric disorders	
Borough	**Change (2010-30)**	**Change in 2030**	**Change (2010-30)**	**Change in 2030**	**Change (2010-30)**	**Change in 2030**
Halton	-5,700	-7.7%	-959	-8.0%	-408	-7.6%
Knowsley	-5,600	-6.0%	-966	-6.4%	-408	-6.1%
St Helens	-6,100	-5.6%	-1,061	-6.0%	-458	-5.8%
Warrington	800	0.6%	75	0.4%	65	0.7%
Wigan	-6,000	-3.1%	-1,092	-3.6%	-454	-3.3%
Total	**-22,600**	**-3.8%**	**-4,003**	**-4.2%**	**-1,663**	**-3.9%**

(Data source: POPPI 5.1; Department of Health, 2010)

5. Performance Trends

Analysis of performance trends over recent years, along with projections for future performance supports the development of the new strategic model.

The breakdown below details the available bed days against the occupied bed days across the Trust for the past 5 years

	2006/07	2007/08	2008/09	2009/10	2010/11
Available Beds	82,075	77,976	68,888	67,924	67,100
Occupied Beds	82,857	68,349	62,611	65,233	61,736
% Occupancy	101.0%	87.7%	90.9%	96.0%	92.0%

The breakdown below details the total community plan against the actual plan for the last 3 years.

	2006/07	2007/08	2008/09	2009/10	2010/11
Number of Total Contacts	158,461	192,783	203,517	217,055	260,042
Plan Contacts			168,611	223,009	247,882
Actual V's Plan			120.7%	97.3%	104.9%

Overview of Total ACP Planned Activity compared to 11/12 Contract Activity

Trust Total Planned Activity on the ACP Model V's 11/12 contract activity

5 Boroughs Partnership NHS
NHS Foundation Trust

Indicative	Planned Activity	11/12 Contract*	% Variance	11/12 YTD Actual	11/12 Forecast**	% Variance against Planned
Assessment Service	32,860	28,895	12.07%	16,641	33283	-1.29%
Recovery Service	158,720	130,929	17.51%	75,830	151660	4.45%
Home Treatment Service	42,660	20,420	52.13%	11346	22691	46.81%

*This is based on basic realignment of the teams, please note the Crisis function which has been split based on the teams functions.
* 4897 planned contacts for Other Adult have been aligned to the Recovery Team

** Based on ytd activity April - September 2011

This overview of activity endeavours to illustrate the activity of health care funded practitioners. This table did not presume to include the activities of any of local authority professionals who currently practice with community teams as part of the Trusts current partnership agreements.

6. Proposed New Model of Service

The proposed new model reflects the Trust's Strategic Development Objectives to have; Effective and Efficient Organisations, Service Innovations and Business Development, Financial Viability, Governance and Organisational Development.

The configuration of adult services within the 5 Boroughs Partnership NHS Foundation Trust has traditionally been on a locality basis and the economies of scale that a large mental health trust may offer have not been fully explored by the provision of pan borough clinical services.

The model that the clinical stakeholders developed offers the opportunity for more consistency and robustness of service delivery than a locality based approach that is exposed to a risk of fragmentation.

Local commissioning communities have invested funding into community services however the challenge moving forward is assuring all stakeholders that available resources are delivered to ensure front line clinical services are best designed to meet the national agenda.

The clinical model offers three main community services that support people with complex mental health needs to avoid and reduce the necessity for hospital based inpatient care.

As part of the delivery of the Assessment Service, Home Treatment Service and the Recovery Service it is proposed that all 3 services will be within all 5 localities of the Trust. It is important

to emphasise that whilst St Helens / Knowsley and Warrington / Halton will share Assessment and Home Treatment teams all localities will have community clinics to ensure local delivery of services working closely with local authority resources. These joint management arrangements offer increased efficiency and the Trust currently applied this management model within its Early Intervention Teams.

Initial Service Specifications of the 3 new services have been developed and copies of the draft documents for discussion can be found in appendix xii-xiv. It is envisaged that their ongoing development will continue with partners after the TAG remit is complete.

Consideration has been given to recent guidance regarding Early Intervention Services and it is felt the provision of one Trust wide service to meet this agenda would be most appropriate and this service will remain as commissioned

The redesign of inpatient services is not proposed at this juncture until the benefits of the new Acute Care Pathway can be demonstrated following their implementation.

6.2 Assessment Service

It is proposed to replace the existing assessment arrangements with one service that offers assessments based upon the three health economy areas of Cheshire, Manchester and Merseyside. The guiding principle emphasised by the clinical staff was that all types of assessment should be managed wherever possible by the same team. The issues of differing teams conducting differing and sometimes multiple assessments was considered clinically questionable and an inappropriate use of resources by the clinical team. It is proposed to consolidate the assessment functions within Access and Advice" "Hospital Liaison" and the current Crisis Resolution teams into one coordinated assessment service that is proposed to have 24hour seven day per week accessibility. This new service would interface with all localities within the community and acute hospital environments'.

For example when a person presents themselves at the Accident and Emergency department of a local hospital this demand for service will be managed or signposted onwards to another part of the care pathway by the new Assessment Service. This will result in less duplication, delay and improved risk management.

The services increased capacity will enable not just assessment but also advice to referring agencies. Working closely with our local authority partners the ability to jointly assess offers more effective use of resources together with a more effective user experience and subsequent navigation through the services provided and available within the wider community. It is intended that the point of contact of the assessment teams is to be consistent and widely circulated. Issues in respect of the format of referral forms have been raised and it is proposed to establish a task and finish group working with

GPs' and other stakeholders to develop the format to meet service users' needs. Following assessment service users care pathway will be internal to the provider wherever possible. The benefits of one comprehensive initial assessment will negate any reason to refer back to the GP to re-refer to another part of this Trust care system.

Discussions regarding the Warrington Prison In-reach Assessment Service being within scope of the Warrington and Halton Assessment Service may offer increased efficiencies. Discussions are planned with the local PCT Commissioner to consider any benefits of this transfer of resources.

6.3 Home Treatment Service

The DoH in England has recommended Crisis Resolution and Home Treatment (CRHT) in its best practice and policy implementation guidance since 2000. In 2007 it described CRHT as a key step in implementing the mental health National Service Framework, partly to ensure inpatient care is only used where necessary. So far several studies have found a reduction on admission rates, and reduced length of inpatient stay following introduction of CRHT. However a common problem in assessing the impact of CRHT is that service development generally anticipates the introduction of CRHT teams by reducing inpatient bed numbers. The reduction in beds may have increased pressure on inpatient wards to discharge patients earlier than would previously have been the norm, resulting in a reduction in length of stay.

Differing patterns of staffing and operational policy also led to different outcomes in service. Evidence from the National Audit Office demonstrates that CRHT teams are sufficiently staffed and resourced they reduce inpatient admissions. The success of CRHT services appears to be dependent to some extent on there being medical support and full gate keeping responsibility intrinsic to the team. It has been found that if there are limited resources or if essential functions such as gate keeping are absent, the services tend to deviate from the core aims of CRHT service provision and spend more time performing assessments and providing longer-term care.

This tendency has been evidenced by Judy Harrison, when from 2008 Central Manchester home treatment service, to meet local activity targets, referral routes into CRHT were extended to include primary care, as a result the throughput more than doubling and 20% of referrals coming directly from primary care. The average duration of contact with the service fell significantly; the main interventions for those with less severe illness are assessment, support and signposting to other services.

A similar trend has been identified on 5 Boroughs Partnership NHS Foundation Trust CRHT teams with a increased focus on assessments and a diminished capacity to provide treatment for acute and severe mental illness at

home as an alternative to admission or early discharge.

The development of a revised Acute Care Pathway, aims to create a parallel to inpatient team aiming to provide to all service users a full psychiatric history, regular medical reviews, physical examination and investigations and medicines management. Interventions will offer short term supervision and support of up to 6 weeks to patients who can be safely managed outside hospital.

The new Home Treatment teams will have allocated sessions of supervision and assessment as needed from psychologist.

Psychosocial intervention will be offered as a matter of routine to reinforce the outcomes for improving mental health as a whole for our service users. The service is intended to be offered 7 days per week from 8am to 8pm.

Furthermore the care team will be on-call 24/7 out of hours to ensure consistency of care.

6.4 Recovery Service

It is proposed to consolidate the various prescribed community teams into one borough based Recovery Service which will be accessed via the Assessment Service. The Recovery Service will have a clear aim to improve the quality of life and social functioning of people with severe and enduring mental health needs. It will provide multi-disciplinary care management, support and biological, psychological and social interventions to enable people receiving our services to manage or reduce symptoms, gain insight, learn skills and participate in psychological therapy
This team will promote independence and the personalisation and personal health budgets agenda will be a key enablers in developing service user centric care packages.

Furthermore, working with commissioners and others in the development of the service specifications the Trust will agree to adopt clear outcomes measures that measure the recovery of the people we care for.

The functions of the Recovery Service will retain the skills knowledge and abilities of the Assertive Outreach, Personality Disorder, and Dual Diagnosis practitioners. The sharing of practitioner skills and knowledge of specialist practitioners will be supported by a service wide training plan as it is felt that all community team members would benefit from this knowledge sharing.

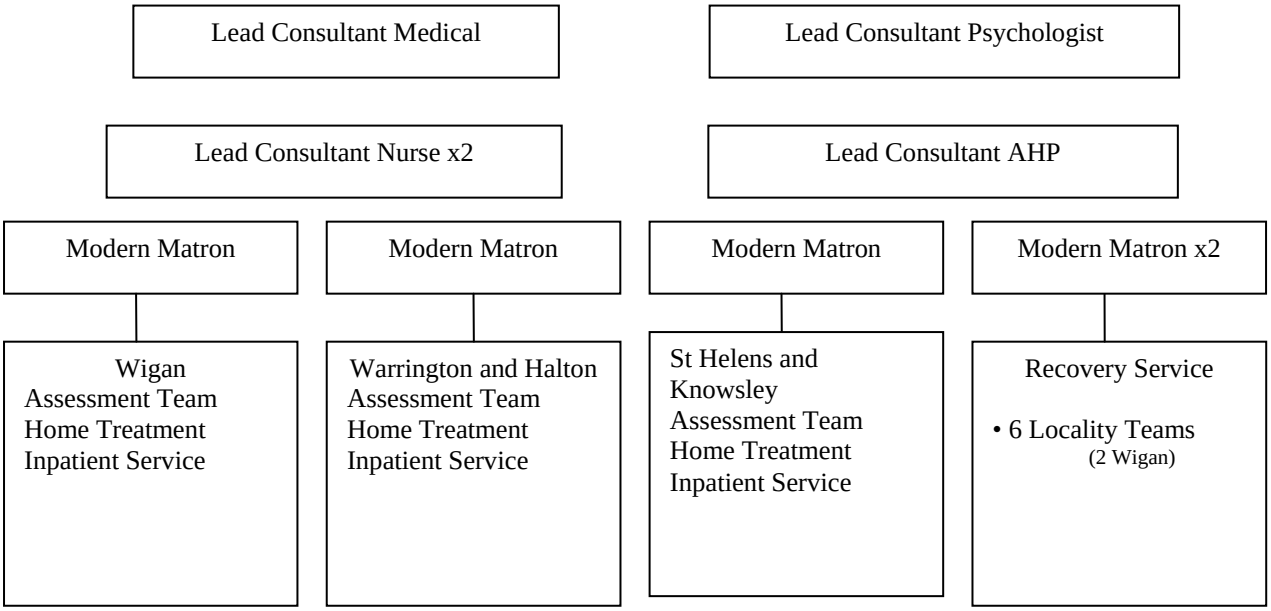
This service will also manage the initiation of medication regimes that help avoid the use of in-patient beds for example Clozapine.

Service Users will be supported from 8am up to 8pm 5 days per week. It is recognised that the user profile of the recovery service will be predominantly of treatment periods of up to 2 years, however the service will support people with long term complex mental health needs and any associated risk issues.

6.5 Leadership

To ensure effective leadership and management the new model proposes that each borough has a dedicated integrated clinical leadership team that is fit for purpose to provide key functions. The Leadership Team will comprise senior operational managers and senior clinical staff from a range of professions.

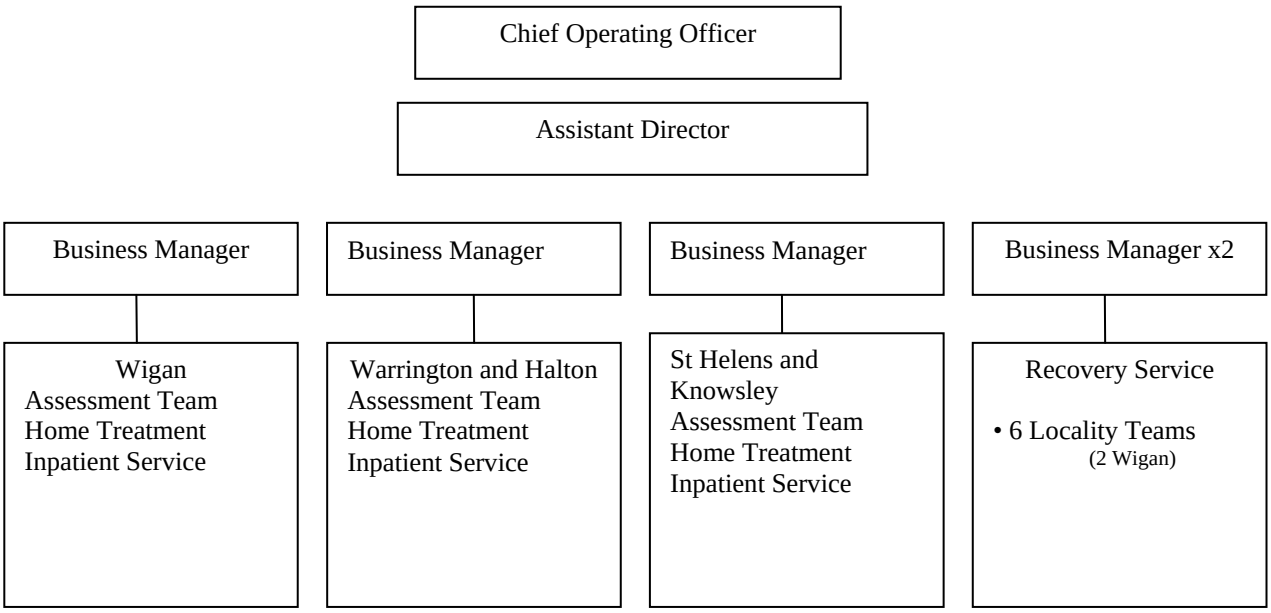
Figure 2 Proposed Leadership Model



In summary the proposed new model offers the following clinical benefits to patients:

- Operates extended hours in line with GP opening times (8am to 8pm, Monday to Friday) for scheduled referrals and 24 hour access to emergency referrals.
- Single point of access
- Same day screening
- All referrals accepted seen within 10 days (inclusive of weekends and bank holidays)
- Clear intervention pathway through services
- Good quality early diagnosis and intervention
- Specialist detailed single comprehensive assessment
- Improved crisis prevention
- Dedicated and focused Home Treatment opportunities
- Fully Integrated Access, Crisis, Inpatient, Liaison Service Delivery.
- Acute liaison support to Acute General Hospital A&E departments.
- All team members will work flexibly across areas and interface to cover annual leave and staff absence improving service resilience

Figure 3 Proposed Management Model



Consideration has been given wherever possible to preserve the value of the existing locality based visibility of operational managers and clinical leadership. The proposed arrangements seek to maintain this whilst offering the opportunity of more consistent service developments across the Trust.

7. Evidence-Based Clinical Care

Within the new model, greater emphasis is placed on the provision of *evidence-based* clinical care, in accordance with National Institute of Clinical Excellence (NICE) guidance.

Common conditions that will be supported by the ACP include:

- Mental and behavioural disorders due to psychoactive substance use.
- Mood disorders,
- Neurotic, stress related disorders and somatoform disorders
- Eating disorders (St Helens and Knowsley only),
- Schizophrenic, schizotypal and delusional disorders,
- Behavioural syndrome associated with physiological disturbances and physical factors,
- Disorder, of adult personality and behaviour

The evidence suggests that people can benefit from a wide range of psychological therapy to reduce mental health problems, increase quality of life, increase the effective management of long term conditions (including diabetes and heart disease), decrease the rates of suicide and increase independence in the community (Positive Practice Guide, 2009). Psychological therapy can also help to address wider health and social care costs by reducing GP appointments and having less reliance on the prescription of anti-depressants, reducing contact with A&E departments, and reducing admission to mental health in-patient services.

The Spending Review states that by 2015, every patient in the country should be able to get timely access to evidence-based psychological therapies and that money needs to be invested to up-skill staff in therapeutic interventions to enable the provision of evidence based psychological interventions as defined in NICE Guidance. The new model will be fully integrated with Trust IAPT services to add value to the care pathways and offer clinical support to the practitioners working within these services.

The development of IAPT Services will benefit people whose needs fall into clusters 1, 2, 3 and 4 and evidence suggests that psychological therapy is beneficial for the remaining clusters as well.

8. Enablers

8.1 Estates and Facilities

The Trust currently provides services, both in patient and community, across 31 sites within the 5 Boroughs Partnership NHS Foundation Trust foot-print.

The model of care is committed to providing community services locally. The Care Pathway helps to determine where service users should receive their assessment and treatment.

There are many instances where this will typically be in the service users home, others will require access to a local “out-patient clinic” environment.

As part of the process to recommend the estate for the future delivery of the model of care a full options appraisal has taken place.

8.1.2 Community estates

Through the use of enabling technologies it is anticipated that service users will receive increasingly more assessment care and treatment in their own homes whenever appropriate. When access to clinics is required or access to group interventions for service users or carers is appropriate, then these will be provided locally using existing facilities.

All local community clinics will be welcoming and will be fully equipped to carry out assessment, diagnostics and interventions.

8.1.3 In-Patient Estate

The Trust currently operates in-patient services from five main sites:

- Hollins Park - Warrington
- Leigh Infirmary – Ashton, Wigan & Leigh
- Knowsley Resource & Recovery Centre
- Peasley Cross – St. Helens
- Brooker Centre – Halton

And also two satellite units:

- Fairhaven Unit – Warrington
- Willis House – Knowsley

Adult inpatient wards are currently located on each of the five main sites.

The acute care pathway building requirements have informed the Trusts Realignment Business Case.

The ambition of the model is to further promote community interventions and reduce reliance on in patient services. Should this aim be realised the Trust will bring forward further ideas for discussion and agreement in regard future in patient estate.

8.1.4 Assessment Service

This service is proposed to be offered by 3 separate teams supporting the needs of the 3 health communities. The assessment teams will offer assessment and liaison to the

presentation of adults with mental health needs to GPs and A&E departments by the establishing a local focus and visibility to other health care providers.

To facilitate this, local assessment teams are proposed to be administratively based at:

- Whiston Hospital, Prescot
- Boston House, Wigan
- Wakefield House, Warrington

To support all localities however there it is proposed to be local buildings facilitates to support clinical assessments within all localities. This will also support the reduction in travelling time for clinicians and was a key concern from our statutory partners.

8.1.5 Home Treatment Service

Similarly this service is proposed to be offered by 3 separate teams supporting the needs of the 3 health communities. The home treatment teams will offer support to the Trust inpatient wards and therefore will be based at the areas of greatest provision.

To facilitate this local Home Treatment teams are proposed to be based at:

- Peasley Cross Court Hospital , St Helens
- Leigh Infirmary, Leigh
- Hollins Park Hospital , Warrington

8.1.6 Recovery Service

This service is proposed to be offered by six separate teams supporting the local needs of the five localities. The recovery teams will offer support and integrated care pathways with the resources of the local authorities. As such they will be based within the five existing community localities

- St Helens Recovery Team, Peasley Cross Court
- Warrington Recovery Team, Wakefield House
- Halton Recovery Team St Johns
- Knowsley Recovery Team Dudley Wallis Centre
- Wigan Recovery Team, Boston House / Wigan Investment Centre
- Leigh Recovery Team Leigh Infirmary

8.2 Workforce Planning and Development

Detailed workforce development plans are in place to support operational staff throughout the change process. Staffside engagement is currently ongoing to facilitate the development of the proposals and this will be continued.

In preparation for implementation a range of activities are being planned to ensure that the new care pathway is delivered to the highest standard. Examples being

- Interview Skills Workshops
- Managing Personal Change & Stress Workshops
- Counselling Services via OH
- Coaching Sessions for Team Managers
- Managing Change – e-book for Managers
- Team Development Planning for Team Managers

Additionally workforce skills development exercises have considered the following as priority areas:

- Risk Assessment and Management
- Best Practice in Managing Risk
- Physical health assessment
- Drug & Alcohol assessment
- Personality Disorder assessment

8.3 Information and Communication Technologies

The Trust in currently piloting a range of enablers to facilitate working efficiencies, .this supports increased patient contacts from practitioners.

Current pilots are considering the use of digital pen and dictation facilities to support increased accuracy, completeness and timeliness of recording clinical interventions

Mobile working infrastructure is also being explored to fully support all community staff recording directly and securely into Trust clinical databases.

Furthermore the Trust is currently implementing a complementary change programme “Making Time for Clinicians” with the objective to review clinical processes

The trust will adopt the appropriate IT infrastructure to support the full implementation of PBR and this model of care.

8.4 Shared Care within Primary Care

Shared care agreements have now been clinically agreed for all localities and the implementation of same will support the success of the ACP. The Trust in collaboration with PCT partners is developing a financial model for the transfer of resources to support the effective prescribing of mental health medication at the GP interface. Before entering into the shared care of a patient, the GP must be fully aware of his/her responsibilities for monitoring, when to refer back to the consultant etc. The shared care agreements clearly identify the roles and responsibilities of G.Ps and Consultants. The GP should be aware that by prescribing for the patient under a shared care agreement they are

accepting full legal and clinical responsibility. The Trust has recently reviewed its policy in respect of shared care and this is available on request.

8.4 Improving Access to Psychological Therapies (IAPT) Step 2 and 3 Primary Care Services

Significant progress and local investment has been achieved to support IAPT primary care services to reduce waiting times for psychological therapies. This service supports the successful discharge of patients back to the community and the consistent provision of IAPT steps 2 and 3 will be a key enabler to the ACP. The Trust currently provides primary care psychological services with Wigan and Knowsley and will manage referrals directly between these services thus avoiding the necessity of a referral back to the local GP.

8.5 Personalisation and Personal Health Budgets.

Personalisation can be described as placing the person at the centre of everything you do and understanding that they are “best placed to know what they need and how those needs be best met”. The expectations of this agenda are currently being advanced by local authorities and considerations of how this proposed community redesign can compliment this vision.

As set out in the “High Quality Care for All” paper launched in June 2008, the NHS is moving towards an NHS which empowers staff and gives patients choice. It is a vision which aims to help people stay healthy by focusing on improving health and tackling sickness. As one of the steps towards reducing ill health, the government has set out a vision that Health Authorities will provide Personal Health Budgets. The development of the Recovery Service is expected to provide a coordinating focus for this approach with the local authority. As service specifications and operational policies are developed it is expected they will provide the operational framework for these empowering activities.

9. Service Users and Carers

The pressure for a new clinical model was initially supported by service user and carer concerns and complaints regarding delays and inconsistencies within the assessment process for eligibility for Trust services. Navigation of service users through a care pathway that included numerous teams and assessment processes inadvertently created delays and confusion to the people we care for at times that they were most vulnerable. This is further supported by messages from staff within the existing limited assessment access and advice services. Currently there is a programme of service user and carers’ engagement being undertaken. The key messages from this listening exercise will continue to inform the proposed improvements to community services.

10. Summary of Benefits

The increasing expectations of timely and effective clinical services supporting adults represents a serious future challenge and we can only meet this by working in partnership with a broad range of local partners and stakeholders. Most importantly we must regard the service users we care for and their families as active partners and their active engagement is essential if we are to ensure that their lives are healthy and meaningful.

We are committed to working in partnership with key stakeholders and commissioning colleagues, to ensure that service gaps are appropriately addressed. This will enable the delivery of our vision to provide high quality, accessible, community services to support service users in their own homes and communities for as long as possible to promote quality of life. In addition, when in-patient treatment is required it will be available; the new model will be supported by considerable capital investment to ensure when required, it is delivered in fit for purpose local accommodation that offers a full range of specialist assessment and treatment opportunities'

In summary, this new model aims to deliver:

- Extended Opening Hours
- Timely response to assessment
- Rapid Response to urgent referrals, same day face to face
- Single care assessment process
- Improved clinical outcomes
- Improved quality of care
- Reduced psychological distress
- Improved Access to Psychological therapies
- Shorter length of stay in in-patient settings
- Reduced readmission rates
- Coordinated service delivery individual to need and performance
- Needs led services
- Increased interface between services
- Strong leadership presence
- Cost effectiveness
- Improved carer/service user experience
- Improved quality of assessment and care in general hospital A&E Deportments
- Reduced and more effective patient journey
- Increased consistency and quality of service provision across localities

11. Mapping the Change

The trust has mapped out the current position to future state which is up to 2014. The following have been developed to support the development of the model -

- A workforce plan to establish what impact the change will have on the existing workforce
- A financial model which includes the impact of estate development within the proposed model
- A service delivery plan to demonstrate all the stages from development, to engagement, consultation and implementation of the model. It describes the milestones, timescales and identified leads
- A training needs analysis to ensure that all staff have the skills and knowledge required to enable them to deliver quality clinical care within the new model
- A consultation and communication plan has been developed.

There is a nominated Business Transformational lead working with the senior managers and a Business Transformation Steering Group established to oversee the projects progress. The Steering Group is overseen by the Trust Operational Management Board.

12. Cost Improvement and Efficiency

Monitor and the Department of Health have published their planning guidance for Foundation Trusts for the foreseeable future. The guidance identifies that each Trust is required to make a 4% cost improvement each year for the next few years.

In 2011/12 and in future the PCTs through the national tariff will reduce contracts with Trusts by 4% to reflect this, this money will therefore sit in PCT (or successor bodies) budgets. Trusts's will be given uplifts to reflect inflation but this is to offset automatic price increases like pay awards and inflation.

This means that in real terms, year on year the Trust will be 4% worse off and if it doesn't make savings it will fall into deficit.

So in order to stand still financially the Trust has to put in plans to improve efficiency and reduce costs by 4% each year (20% over five years). Putting this into context; the Trust has an had, 2010/11, an income of approx £100m (excluding secure services) and an annual turnover of £148m, so a 4% efficiency gain is the equivalent of £6m a year, or £30m over 5 years.

The Trust's plans and strategic intent is to make this happen whilst maintaining the level and quality of the services provided to patients and

contracted for by commissioners, without any need for new investment by commissioners.

Appendix (i) Adult Business Stream – Community and Out-patients data

						Forecast Information using Average Increase year on year			
	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Number of Referrals Received	27,220	29,226	34,658	37,579	39,081	42,418	46,040	49,971	54,237
Number of Total Contacts	**158,461**	**192,783**	**203,517**	**217,055**	**260,042**	**289,846**	**323,067**	**360,095**	**401,367**
Total DNA's	2,948	16,658	21,478	22,610	26,330				
% DNA's	1.8%	8.0%	9.5%	9.4%	9.2%				
Number of Discharges	19,335	24,630	27,675	32,710	36,095				
% Increase Year on Year Referrals Received		6.9%	15.7%	7.8%	3.8%				
Average Increase Year on Year					**8.5%**				
% Increase Year on Year Total Contacts		17.8%	5.3%	6.2%	16.5%				
Average Increase Year on Year					**11.5%**				

Appendix (ii) Adult Business Stream – In-patient Profile

						Forecast based on 85% Occupancy Levels			
	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Average LOS	45.8	38.4	29.4	25.4	26.9	24.0	24.0	24.0	24.0
Available Beds	82,075	77,976	68,888	67,924	67,100	67,160	55,480	52,560	43,800
Occupied Beds	82,857	68,349	62,611	65,233	61,736	57,086	47,158	44,676	37,230
% Occupancy	101.0%	87.7%	90.9%	96.0%	92.0%	85.0%	85.0%	85.0%	85.0%
Total Commissioned Beds			192	184	184	184			
Actual Number of Beds at Year End	**218**	**204**	**190**	**184**	**184**	**184**	**152**	**144**	**120**
Number of Beds by Borough									
Halton	29	28	28	28	28				
Knowsley	31	23	33	33	33				
St Helens	34	32	32	32	32				
Warrington	66	64	39	33	33				
Wigan	58	57	58	58	58				

Notes :
All data includes PICU Beds

Appendix (iii) Number of Admissions by Admission Source

Borough of Ward	Admission Source	2006/07	2007/08	2008/09	2009/10	2010/11
Adult Mental Health Admissions	Local Authority Pt 3 Residential Accommodation	1				
	Missing data					1
	NHS prov - High Security	1	1		1	
	NHS provider - WD for general pts or YPD or A&E	121	114	163	245	287
	NHS provider - WD for Mat or Neonates	3	3	1	2	
	NHS provider - WD for MI or LD	56	45	71	28	30
	NHS run care home	6	1	5		1
	Non-NHS Hospice (not LA)			1		
	Non-NHS Hospital	14	26	3	1	5
	Non-NHS Residential Care Home (not LA)	5	1	2		
	Penal, Court or Police Stn	60	54	64	48	58
	Temporary Residence	21	12	23	48	34
	Usual place of Residence	1,583	1,510	1,763	1,779	1,853
	(blank)					
	Total	**1,871**	**1,767**	**2,096**	**2,152**	**2,269**

Appendix (iv) Occupancy April 2010 to 14/15 projections

Adult Mental Health (including PICU) - Total Number of Beds as at Year End

						Forecast Information			
	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	13/14
Total Number of Beds	218	204	190	184	184	184	152	144	120
% Reduction Year on Year		-6.4%	-6.9%	-3.2%	0.0%	0.0%	-17.4%	-5.3%	-16.7%
Average Reduction					-4.1%	Forecast Average - Year on Year		-9.8%	

Available Beds

						Forecast Information			
	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Available Beds	82,075	77,976	68,888	67,924	67,100	67,160	55,480	52,560	43,800
% Reduction Year on Year		-5.0%	-11.7%	-1.4%	-1.2%	0.1%	-17.4%	-5.3%	-16.7%
Average Reduction					-4.8%	Forecast Average - Year on Year		-9.8%	

Occupied Beds

						Forecast Information to remian at 85% occupancy			
	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Occupied Beds	82,857	68,349	62,611	65,233	61,736	57,086	47,158	44,676	37,230
% Reduction Year on Year		-17.5%	-8.4%	4.2%	-5.4%	-7.5%	-17.4%	-5.3%	-16.7%
Average Reduction					-6.8%	Forecast Average - Year on Year		-11.7%	

% Occupancy

						Forecast Information			
	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Occupied Beds	101.0%	87.7%	90.9%	96.0%	92.0%	85.0%	85.0%	85.0%	85.0%

Appendix (v) Mental Health Act (Sections) Report

TOTAL Occupied Beds

Adult Wards	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	2010/11 Total
Austen Ward	515	535	548	515	414	420	505	499	531	532	516	506	**6,036**
Bridge Ward	336	387	399	397	414	395	380	421	421	441	379	395	**4,765**
Cavendish Unit	812	762	720	748	714	700	744	755	739	753	565	687	**8,699**
Coniston Unit	470	539	448	425	293	423	506	484	538	554	497	498	**5,675**
Grasmere Unit	464	416	433	492	345	400	375	398	329	380	316	412	**4,760**
Iris Ward	421	420	436	453	301	392	421	416	350	300	337	370	**4,617**
Lakeside Unit	775	786	658	595	671	727	759	748	771	809	696	761	**8,756**
Rivington Unit	214	214	230	213	179	214	232	203	208	191	211	244	**2,553**
Sheridan Ward	465	461	456	474	477	441	467	461	483	471	381	448	**5,485**
Taylor Ward	424	525	480	492	507	340	457	472	516	522	469	517	**5,721**
Weaver Ward	423	392	395	408	339	373	395	414	421	407	341	361	**4,669**
Total	**5,319**	**5,437**	**5,203**	**5,212**	**4,654**	**4,825**	**5,241**	**5,271**	**5,307**	**5,360**	**4,708**	**5,199**	**61,736**

Total Occupied Beds of SECTIONED patients

Adult Wards	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	2010/11 Total
Austen Ward	240	266	248	183	169	179	147	152	180	295	208	166	**2,433**
Bridge Ward	116	143	132	131	126	144	143	180	147	100	79	154	**1,595**
Cavendish Unit	248	280	216	216	192	213	192	219	231	293	234	235	**2,769**
Coniston Unit	198	178	136	168	94	131	117	94	123	240	258	259	**1,996**
Grasmere Unit	208	145	137	218	157	174	133	64	79	109	104	189	**1,717**
Iris Ward	136	147	163	141	154	201	142	147	114	146	79	53	**1,623**
Lakeside Unit	106	210	171	239	289	381	488	362	369	377	391	504	**3,887**
Rivington Unit (PICU)	214	212	229	213	179	214	232	203	207	190	206	244	**2,543**
Sheridan Ward	188	202	201	172	306	314	157	109	107	55	77	156	**2,044**
Taylor Ward	214	292	285	197	233	177	234	281	263	296	261	315	**3,048**
Weaver Ward	76	34	74	118	66	100	84	127	139	60	40	49	**967**
Total	**1,944**	**2,109**	**1,992**	**1,996**	**1,965**	**2,228**	**2,069**	**1,938**	**1,959**	**2,161**	**1,937**	**2,324**	**24,622**

% of Sectioned Patients on Wards

Adult Wards	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	2010/11 Total
Austen Ward	46.6%	49.7%	45.3%	35.5%	40.8%	42.6%	29.1%	30.5%	33.9%	55.5%	40.3%	32.8%	**40.3%**
Bridge Ward	34.5%	37.0%	33.1%	33.0%	30.4%	36.5%	37.6%	42.8%	34.9%	22.7%	20.8%	39.0%	**33.5%**
Cavendish Unit	30.5%	36.7%	30.0%	28.9%	26.9%	30.4%	25.8%	29.0%	31.3%	38.9%	41.4%	34.2%	**31.8%**
Coniston Unit	42.1%	33.0%	30.4%	39.5%	32.1%	31.0%	23.1%	19.4%	22.9%	43.3%	51.9%	52.0%	**35.2%**
Grasmere Unit	44.8%	34.9%	31.6%	44.3%	45.5%	43.5%	35.5%	16.1%	24.0%	28.7%	32.9%	45.9%	**36.1%**
Iris Ward	32.3%	35.0%	37.4%	31.1%	51.2%	51.3%	33.7%	35.3%	32.6%	48.7%	23.4%	14.3%	**35.2%**
Lakeside Unit	13.7%	26.7%	26.0%	40.2%	43.1%	52.4%	64.3%	48.4%	47.9%	46.6%	56.2%	66.2%	**44.4%**
Rivington Unit (PICU)	100.0%	99.1%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%	99.5%	97.6%	100.0%	**99.6%**
Sheridan Ward	40.4%	43.8%	44.1%	36.3%	64.2%	71.2%	33.6%	23.6%	22.2%	11.7%	20.2%	34.8%	**37.3%**
Taylor Ward	50.5%	55.6%	59.4%	40.0%	46.0%	52.1%	51.2%	59.5%	51.0%	56.7%	55.7%	60.9%	**53.3%**
Weaver Ward	18.0%	8.7%	18.7%	28.9%	19.5%	26.8%	21.3%	30.7%	33.0%	14.7%	11.7%	13.6%	**20.7%**
Total	**36.5%**	**38.8%**	**38.3%**	**38.3%**	**42.2%**	**46.2%**	**39.5%**	**36.8%**	**36.9%**	**40.3%**	**41.1%**	**44.7%**	**39.9%**

Appendix (vi) Diagnosis Data

All Patients admitted to Adult Wards in year with Primary Diagnosis as below

Primary Diagnosis	2006/07	2007/08	2008/09	2009/10	2010/11
Behavioural and emotional discorders with onset usually occurring in childhood and adolescence	1	4		2	8
Behavioural syndromes associated with physiological disturbances and physical factors	10	4	8	9	20
Disorders of adult personality and behaviour	71	94	135	220	228
Disorders of psychological development	10	10	14	14	7
Mental and behavioural disorders due to psychoative substance use	236	186	329	415	266
Mental Retardation			1		5
Mood [Affective] disorders	599	626	825	871	789
Neurotic, stress-related and somatoform discorders	162	172	258	259	252
Organic, including symptomatic, mental discorders	8	10	27	27	31
Other	128	102	137	96	212
Schizophrenia, schizotypal and delusional disorders	488	493	652	596	593
Unknown	243	188	1		2
Unspecified Mental Discorder	3		1		
Total	**1,959**	**1,889**	**2,388**	**2,509**	**2,413**

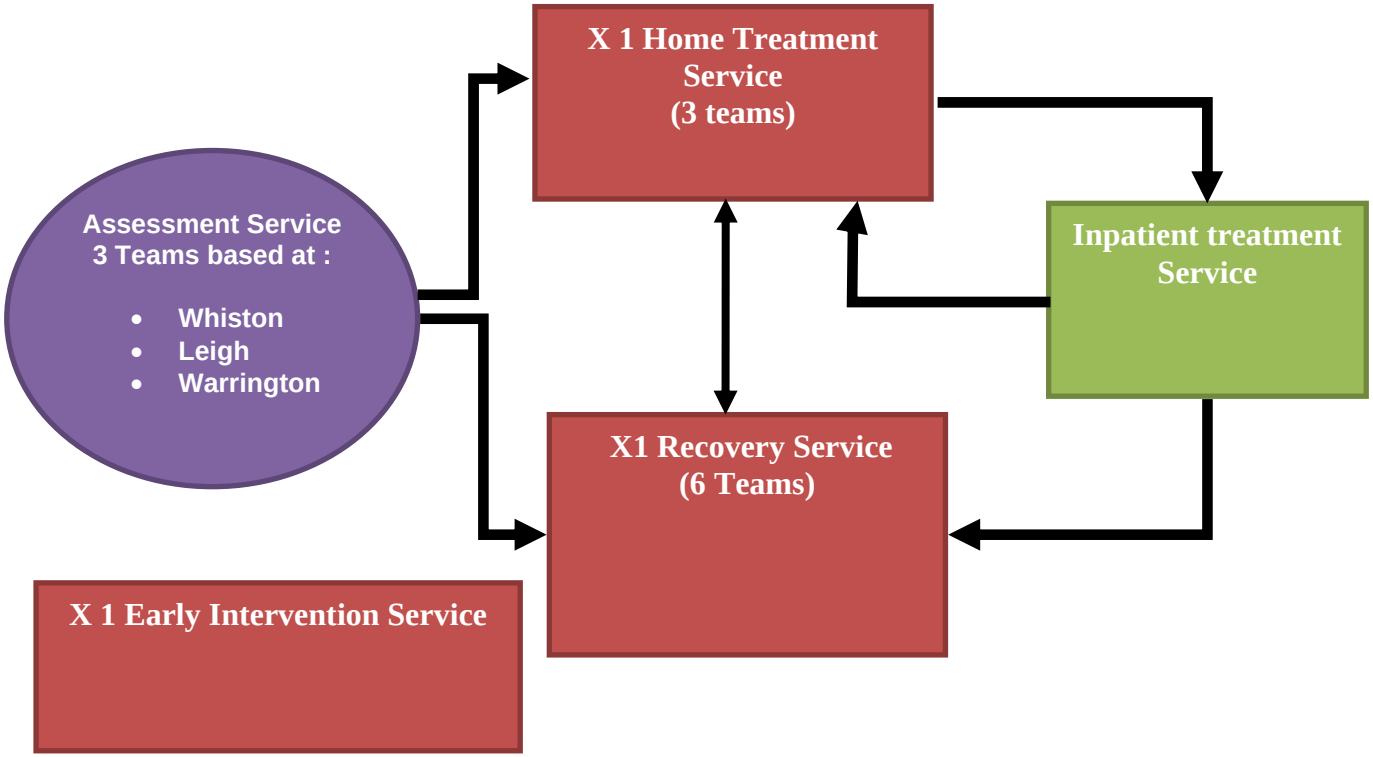
Appendix (vii) Delayed Discharges – Total days lost by Ward

		Number of Days Lost		
Ward	**Responsibility**	**2008/09**	**2009/10**	**2010/11**
Austen Ward	Attribute to Both	70		
	Attribute to Social Care (Note that these days will qualify for reimbursement)	152		
	Responsibility of NHS (i.e. includes patients making own arrangements)	161	670	337
Austen Ward Total		**383**	**670**	**337**
Bridge Ward	Attribute to Both			110
	Attribute to Social Care (Note that these days will qualify for reimbursement)	48		
	Responsibility of NHS (i.e. includes patients making own arrangements)	350	38	
Bridge Ward Total		**398**	**38**	**110**
Cavendish Unit	Attribute to Both	35		
	Attribute to Social Care (Note that these days will qualify for reimbursement)	52	147	
	Responsibility of NHS (i.e. includes patients making own arrangements)	13	56	
Cavendish Unit Total		**100**	**203**	
Coniston Unit	Attribute to Both	69		
	Attribute to Social Care (Note that these days will qualify for reimbursement)		31	
	Responsibility of NHS (i.e. includes patients making own arrangements)	21	236	318
Coniston Unit Total		**90**	**267**	**318**
Grasmere Unit	Attribute to Social Care (Note that these days will qualify for reimbursement)	16	9	23
	Responsibility of NHS (i.e. includes patients making own arrangements)	84	35	4
Grasmere Unit Total		**100**	**44**	**27**
Iris Ward	Attribute to Both			1
	Attribute to Social Care (Note that these days will qualify for reimbursement)	21	38	
	Responsibility of NHS (i.e. includes patients making own arrangements)	300	492	109
Iris Ward Total		**321**	**530**	**110**
Lakeside Unit	Attribute to Both	28		
	Responsibility of NHS (i.e. includes patients making own arrangements)	713	822	1,142
Lakeside Unit Total		**741**	**822**	**1,142**
Rivington Unit (PICU)	Responsibility of NHS (i.e. includes patients making own arrangements)		921	698
Rivington Unit (PICU) Total			**921**	**698**
Sheridan Ward	Attribute to Both	43	35	
	Attribute to Social Care (Note that these days will qualify for reimbursement)	168		132
	Responsibility of NHS (i.e. includes patients making own arrangements)		30	
Sheridan Ward Total		**211**	**65**	**132**
Taylor Ward	Attribute to Social Care (Note that these days will qualify for reimbursement)	21		
	Responsibility of NHS (i.e. includes patients making own arrangements)	201	239	463
Taylor Ward Total		**222**	**239**	**463**
Weaver ward	Attribute to Social Care (Note that these days will qualify for reimbursement)	2		
	Responsibility of NHS (i.e. includes patients making own arrangements)	87		51
Weaver ward Total		**89**		**51**
Total Days lost in Adult Services		**2,655**	**3,799**	**3,388**

Appendix (vii) Delayed Discharges – Number of Patients by Ward

		Number of Patients		
Ward	Responsible	2008/09	2009/10	2010/11
Austen Ward	Attribute to Both	1		
	Attribute to Social Care (Note that these days will qualify for reimbursement)	5		
	Responsibility of NHS (i.e. includes patients making own arrangements)	5	6	4
Austen Ward Total		**11**	**6**	**4**
Bridge Ward	Attribute to Both			2
	Attribute to Social Care (Note that these days will qualify for reimbursement)	1		
	Responsibility of NHS (i.e. includes patients making own arrangements)	5	3	
Bridge Ward Total		**6**	**3**	**2**
Cavendish Unit	Attribute to Both	1		
	Attribute to Social Care (Note that these days will qualify for reimbursement)	3	3	
	Responsibility of NHS (i.e. includes patients making own arrangements)	1		
Cavendish Unit Total		**5**	**3**	
Coniston Unit	Attribute to Both	1		
	Responsibility of NHS (i.e. includes patients making own arrangements)	1	3	11
Coniston Unit Total		**2**	**3**	**11**
Grasmere Unit	Attribute to Social Care (Note that these days will qualify for reimbursement)	1	1	2
	Responsibility of NHS (i.e. includes patients making own arrangements)	2	1	1
Grasmere Unit Total		**3**	**2**	**3**
Iris Ward	Attribute to Social Care (Note that these days will qualify for reimbursement)		1	
	Responsibility of NHS (i.e. includes patients making own arrangements)	10	3	4
Iris Ward Total		**10**	**4**	**4**
Lakeside Unit	Attribute to Both	1		
	Responsibility of NHS (i.e. includes patients making own arrangements)	10	8	16
Lakeside Unit Total		**11**	**8**	**16**
Rivington Unit (PICU)	Responsibility of NHS (i.e. includes patients making own arrangements)		9	8
Rivington Unit (PICU) Total			**9**	**8**
Sheridan Ward	Attribute to Both	1	1	
	Attribute to Social Care (Note that these days will qualify for reimbursement)	2		2
	Responsibility of NHS (i.e. includes patients making own arrangements)		2	
Sheridan Ward Total		**3**	**3**	**2**
Taylor Ward	Attribute to Social Care (Note that these days will qualify for reimbursement)	1		
	Responsibility of NHS (i.e. includes patients making own arrangements)	4	8	8
Taylor Ward Total		**5**	**8**	**8**
Weaver ward	Attribute to Social Care (Note that these days will qualify for reimbursement)	1		
	Responsibility of NHS (i.e. includes patients making own arrangements)	3		1
Weaver ward Total		**4**		**1**
Total Number of Patients Delayed in Adult Services		**60**	**49**	**59**

Appendix (iix) New Secondary Care Pathway



Appendix (ix) IAPT Population Need (Projected)

North East Public Health Observatory
Mental Health Brief no 4: May 2008 (Extract)

Estimating the prevalence of common mental health problems in local and nearby PCTs in the northwest

A first approximation of the expected caseload for new psychological therapy services

		Rates per 1000 population							Estimated cases							
PCT Name	PCT 2006	Any neurotic disorder	All phobias	Depressive episode	Generalised anxiety disorder	Mixed anxiety depression	Obsessive compulsive disorder	Panic disorder	Any neurotic disorder	All phobias	Depressive episode	Generalised anxiety disorder	Mixed anxiety depression	Obsessive compulsive disorder	Panic disorder	Population 16-74
Ashton, Leigh and Wigan	5HG	201.0	26.5	27.6	63.8	108.2	17.2	2.9	45389.1	5974.4	6225.3	14399.3	24435.8	3892.2	650.5	225815
Warrington	5J2	185.1	24.5	25.3	59.0	99.6	15.8	2.6	26239.3	3478.1	3593.0	8368.1	14116.1	2235.7	374.0	141745
Knowsley	5J4	247.0	32.4	34.2	76.9	133.2	21.0	3.6	27050.4	3544.9	3743.2	8426.6	14587.9	2299.6	393.1	109509
Halton and St Helens	5NM	209.2	27.4	28.9	66.0	112.5	17.8	3.1	45559.5	5959.1	6291.3	14376.8	24487.7	3875.2	664.9	217757
Sefton	5NJ	216.1	28.0	29.7	68.8	115.9	18.2	3.2	43377.2	5616.4	5972.1	13804.2	23270.0	3649.6	638.2	200743
Wirral	5NK	220.5	28.6	30.5	69.9	118.3	18.7	3.3	49165.4	6379.5	6810.7	15580.0	26365.3	4161.6	727.1	222939
Liverpool	5NL	262.2	34.4	35.9	77.9	143.0	23.2	3.6	86025.0	11280.8	11780.9	25572.2	46923.2	7605.0	1196.3	328149
Western Cheshire	5NN	164.6	21.4	22.6	51.9	88.7	14.0	2.4	28284.1	3676.0	3889.0	8917.0	15239.5	2398.8	407.7	171812
Central and Eastern Cheshire	5NP	148.2	19.5	20.4	47.7	79.4	12.5	2.1	48484.3	6366.7	6677.0	15594.6	25989.6	4095.0	701.9	327245
Trafford	5NR	206.5	27.3	28.1	65.8	111.3	17.4	3.0	31485.4	4167.1	4288.5	10032.6	16964.7	2655.0	454.9	152474
Manchester	5NT	263.2	35.2	35.2	74.7	146.0	24.1	3.5	88398.2	11821.1	11830.7	25079.0	49011.7	8107.2	1164.4	335806

This supplementary spreadsheet accompanies Mental Health Brief no 4. It provides data on estimated rates and case numbers in the population for 2006-reorganisation PCTs. Data on rates are presented as total cases per 1000 population aged 16-74. Detail of case numbers are presented for males and females, for quinary age-groups. These are not intended to be used at this level, rather to provide flexible data for grouping up.

Appendix (x) Nice Guidance

CG 100: Alcohol dependence and harmful alcohol use: provides recommendations in the diagnosis and management of alcohol related physical complications The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below..

http://www.nice.org.uk/nicemedia/live/12995/49004/49004.pdf

CG115: Alcohol use Disorders: provides recommendations in the diagnosis, assessment and management of harmful drinking and alcohol dependence. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below.

http://www.nice.org.uk/nicemedia/live/13337/53194/53194.pdf

CG 45: Antenatal and Post Natal Mental Health makes recommendations in antenatal and postnatal mental health in terms of clinical management and service guidance. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/11004/30432/30432.pdf

CG 72: Attention Deficit Hyperactivity Disorder makes recommendations in the diagnosis and management of Attention Deficit Hyperactivity Disorder in children, young adults and adults. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/12061/42107/42107.pdf

CG 38: Bipolar Disorder makes recommendations for the management of bipolar disorder in adults, children and adolescents, in primary and secondary care. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/10990/30191/30191.pdf

CG123: Common Mental Health problems makes recommendations for the identification and pathways to care for common mental health disorders including depression, generalized anxiety disorder, panic disorder, obsessive compulsive disorder, post traumatic stress disorder and social anxiety

disorder. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/13476/54523/54523.pdf

CG 52: Drug Misuse: Opioid Detoxification and Psychosocial interventions (CG51) make recommendations about the psychosocial interventions to be used in substance misuse services and good practice for opioid detoxification. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE in the substance misuse services in the Trust. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/11813/35996/35996.pdf

CG 76: Medicines adherence makes recommendations for involving patients in decisions about prescribed medicines and supporting adherence. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/11766/42891/42891.PDF

CG 31: Obsessive Compulsive Disorder makes recommendations for the core interventions to be used in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/10976/29945/29945.pdf

CG120: Psychosis with coexisting substance misuse offers best practice advice on the assessment and management of people with psychosis and coexisting substance misuse. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE and is supported by the Nurse Consultant Dual Diagnosis lead in the Trust. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/13414/53731/53731.pdf

CG 82: Schizophrenia guidance makes recommendations relating to the treatment and management of schizophrenia for adults in primary and secondary care. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/11786/43610/43610.pdf

CG 25: Violence makes recommendations relating to the short-term management of disturbed / violent behaviour in in-patient psychiatric settings

and emergency departments. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE within in-patient areas. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/10964/29716/29716.pdf

CG 89: When to suspect child maltreatment offers guidance on alerting features of child maltreatment with recommendations to either ‘consider’ or ‘suspect’ child maltreatment. The Acute Care Pathway will offer compliance to this group of interventions to the standards illustrated by NICE. For more information please access the link below

http://www.nice.org.uk/nicemedia/live/12183/44872/44872.pdf

Appendix (11) ACP Existing Activity and Resources compared to Proposed

Halton Borough Total Planned Activity on the ACP Model V's 11/12 contract activity

	Proposed ACP Team Activity++	11/12 Contract*	% Variance against Planned	11/12 YTD Actual***	11/12 Forecast**	% Variance 11/12 Forecast against Proposed ACP
Assessment Service**	**4,093**	**5,145**	**-25.71%**	**708**	**1416**	**65.40%**
Recovery Service	**23,760**	**17,229**	**27.49%**	**10672**	**21344**	**10.17%**
Home Treatment Service	**5,379**	**2,819**	**47.58%**	**1453**	**2906**	**45.97%**

*This is based on basic realignment of the teams, please note the Crisis function which has been split based on the teams functions.
* Other Adult have been aligned to the Recovery Team
** Assessment service contract, has been based on historic data, informed by Open Minds being physically based in the Halton Borough.
Overall the capacity and contract activity for Halton & St Helens is exceeded by 8.31%

Knowsley Borough Total Planned Activity on the ACP Model V's 11/12 contract activity

	Proposed ACP Team Activity++	11/12 Contract*	% Variance against Planned	11/12 YTD Actual***	11/12 Forecast**	% Variance 11/12 Forecast against Proposed ACP
Assessment Service	4,871	3,628	25.52%	1028	2057	57.78%
Recovery Service	27,920	23,934	14.28%	13768	27536	1.38%
Home Treatment Service	6,402	3,935	38.54%	2243	4485	29.93%

*This is based on basic realignment of the teams, please note the Crisis function which has been split based on the teams functions.
* Other Adult have been aligned to the Recovery Team

St Helens Borough Total Planned Activity on the ACP Model V's 11/12 contract activity

	Proposed ACP Team Activity++	11/12 Contract*	% Variance against Planned	11/12 YTD Actual***	11/12 Forecast**	% Variance 11/12 Forecast against Proposed ACP
Assessment Service**	5,949	4,062	31.72%	504	1008	83.06%
Recovery Service	27,920	23,929	14.29%	15622	31244	-11.91%
Home Treatment Service	7,818	4,307	44.91%	2296	4592	41.27%

*This is based on basic realignment of the teams, please note the Crisis function which has been split based on the teams functions.
* Other Adult have been aligned to the Recovery Team
** Assessment service contract, has been based on historic data, informed by Open Minds being physically based in the Halton Borough. Overall the capacity and contract activity for Halton & St Helens is exceeded by 8.31%

Warrington Borough Total Planned Activity on the ACP Model V's 11/12 contract activity

	Proposed ACP Team Activity++	11/12 Contract*	% Variance against Planned	11/12 YTD Actual***	11/12 Forecast**	% Variance 11/12 Forecast against Proposed ACP
Assessment Service	6,727	5,431	19.27%	2033	4066	39.56%
Recovery Service	23,600	25,053	-6.16%	13116	26232	-11.15%
Home Treatment Service	8,841	2,828	68.01%	2405	4810	45.60%

*This is based on basic realignment of the teams, please note the Crisis function which has been split based on the teams functions.
* Other Adult have been aligned to the Recovery Team

Wigan Borough Total Planned Activity on the ACP Model V's 11/12 contract activity

	Proposed ACP Team Activity++	11/12 Contract*	% Variance against Planned	11/12 YTD Actual***	11/12 Forecast**	% Variance 11/12 Forecast against Proposed ACP
Assessment Service	11,220	10,509	6.33%	2754	5509	50.90%
Recovery Service	55,520	40,629	26.82%	21331	42662	23.16%
Home Treatment Service	14,220	6,650	53.23%	3072	6143	56.80%

Please Note:
*This is based on basic realignment of the teams, please note the Crisis function which has been split based on the teams functions.
* Other Adult have been aligned to the Recovery Team
*Primary Care Wigan, IAPT and Eating Disorders have been excluded from this process

*** Based on ytd activity April - September 2011

Please note as this is borough based activity the lead boroughs have the overall alignment of the team.
"++ Individual Borough proposed ACP Team Activity has been been calculated using the 2001 Census adult (20-64) population by Borough

5BP Commissioning Alliance Draft Specification

Home Treatment Service

Service Title: Home Treatment

1. Service Description:

The Team's role is to provide intensive Home Treatment for people who have mental health needs that can only be addressed by a secondary mental health service provider. The Home Treatment Team will respond rapidly to referrals intervening with Service Users at an early stage, actively involving families and carer's and offering a flexible approach to Service Users in the least restrictive and most appropriate community environments.

The Team will work with a range of other professionals and voluntary organisations to ensure smooth pathways are in place between services and back into Primary Care when appropriate.

The Home Treatment Team will provide a service for adults supported by national guidance in relation to Payment by Results Care clustering. The Home Treatment Team will act as a gatekeeper to all hospital Inpatient beds within the 5 Boroughs, rapidly supporting the assessment and appropriate placements of Service Users across the organisation. Gatekeeping is described as the clinical decision making regarding the need to admit someone to inpatient care. The process of locating a bed will be a separate function. The Team will be central to the decision making process in conjunction with the Multi-disciplinary Team and ensuring all referrals are assessed before admission to an Inpatient bed. The team will also support early discharge from inpatient care for those service users whose treatment can be proactively managed in the community with intensive home treatment support. The team will provide 72 hour follow-up for those discharged who have been previously unknown to secondary services and for those receiving home treatment. All other service users will be supported post discharge by the respective recovery teams, including early intervention services.

The Team will work with people over the age of 16 years old. The Team will provide mental health assessment and intensive home treatment for all Service Users referred to the Home Treatment Service. They will have efficient processes that provide fair and equitable response times across the whole community of the 5 Boroughs Partnership Mental Health Foundation Trust as defined in the operational policy.

The Team will work in an integrated way with Inpatient Services and will be inextricably linked to ensure the service users journey is co-ordinated and supportive. It will also link with community organisations across Health and Social Care to avoid unnecessary delays in discharge and to improve

the follow up of Service Users. The Team will operate within the direction of Trust local Policy and Procedures including the CPA process and following relevant National Guidance.

2. **Provider Name:**

   5 Boroughs Partnership NHS Foundation Trust.

3. **Address of Organisation:**

   Trust Headquarters, Hollins Park, Hollins Lane, Winwick, Warrington, WA2 8WA.

4. **Base / Location of Service:**

   The Home Treatment Teams will be located at the following bases:
   - Warrington
   - St Helens
   - Wigan

5. **Lead Contact at the Trust:**

   Chief Operating Officer

   The Chief Operating Officer is responsible for:

   - Ensuring that the strategic direction is consistently communicated to all staff regarding the delivery of the Home Treatment Service.
   - The further development of this Guidance in conjunction with the Accountable Director and other stakeholders.
   - Ensuring that delivery of the Home Treatment Service is subject to monitoring, development and review.
   - Ensuring that resources are available for the commissioned provision of the Home Treatment Service.

6. **Telephone:**

   01925 664000

7. **Service Availability:**

   The Home Treatment Services will be available between the hours of 8.00am until 8.00pm, 7 days a week including Bank Holidays over 365 days per annum. Outside of these hours the team will operate a non-waking night on-call service for those service users who are open to the Team.

8. **Out of Hours Cover:**

Out of hours cover will be provided for service users who have an open episode of care with the Team via a non waking night on-call service.

9. Scope:

- The Home Treatment Service will be available for the catchment population which will be defined by the population of each GP Practice whose surgery address's falls within the defined area of the 5 Boroughs Partnership NHS Foundation Trust and the locality Primary Care Trust. The Service is appropriate for adults over the age of 16 years old who present with a moderate to severe functional mental health problem who will require intensive home treatment. The service will work people with mental health issues not included in Payment by Results clusters 1-4.

Intensive Home Treatment will take place in a variety of settings including:

- Health resources
- Community resources
- Service Users normal place of residence

Referrals to the service will be accepted from in-patient, recovery teams including Early Intervention Teams, Assessment & Liaison teams following the requirements of the electronic care record system.

The Team will adhere to the principles of Access, Booking and Choice and Copying Correspondence to Service Users.

10. Geographical Area Served:

The service will operate within the usual boundaries of the Trust's specific GP Consortia.

11. Key Relationships with other Agencies:

- Work formally in an integrated manner with Local Authority (LA) Social Services staff and other teams including those in the statutory, public and third sector
- To enhance treatment for Service Users with drug or alcohol addiction through close and effective working with Substance/Alcohol Misuse Teams and other teams including those in the third sector

12. Links to other NHS Teams/Services:

The service will work closely with inpatient services, assessment & recovery teams and other Mental Health professionals working within the

locality including other NHS, Social Care and Criminal Justices Services as appropriate.

The service will establish clear and accessible communication links with Primary Care Mental Health Services in order to prevent referrals falling between services.

13. Age Range:

16 years and above with no upper age limit for people with a functional illness. Older adults with a suspected functional mental illness will not be excluded from the Home Treatment Team purely on the grounds of age.

14. Source of Referrals:

Referrals to the Home Treatment Team will come directly from the Trust Assessment Services, mental health acute inpatient services and Recovery Teams including Early Intervention Teams.

15. Response Times:

The Home Treatment team will contact service users within 4 hours of the referral to agree an initial treatment plan. Individual contact times will vary according to need and risk.

16. Risk Assessment and Management including CPA requirements:

This must comply with the guidance in "*Refocusing the Care Programme Approach"* (DH 2008).

17. Age, Culture and Gender Specifics

There are no exclusions on gender and culture.

18. Interventions / Treatments to be offered:

The Home Treatment will use a variety of assessment tools to aid the care planning process of Service Users open to the team. This will include a range of interventions which will take into account the service users assessed clinical and social care needs.

The team will support early discharge from the acute mental health in-patient wards to ensure treatment can be provided in the least restrictive environment that is conducive to the service users recovery.

Treatments will be effective and evidence based interventions. The team will also provide advice and support to Service Users, families and carer's through the carer assessment, planning & evaluation processes offered to them. Upon discharge from the services the teams will liaise closely with

Service Users, families and carer's in conjunction with Primary Care and the relevant community team.

The pharmacological management of Service User symptoms will be considered carefully. The prescriptions of any medication will adhere to the National Institute of Clinical Excellence (NICE Guidelines).

19. Choice:

The NHS encourages choice and people from other geographical areas out with the usual catchment zone can choose to have their Inpatient care provided at the Trust. The follow up care may therefore require liaison with a team from another area. This process will be managed via the PbR system in respect of payment for care.

20. Workforce Issues:

The team consists of:

- Team Manager
- Deputy Team Manager
- Senior Nurse Practitioner
- Occupational Therapist
- Consultant Psychiatrist
- Staff Grade / Speciality Doctor
- Office Manager
- Administrative staff

The team will have active support and input from a Psychologist, Pharmacist and Junior Doctors. The team will work in an integrated way with Local Authority colleagues in accordance with local service provision.

The Trust will provide annual mandatory training for all staff members with updates on safeguarding children and vulnerable adults and management of violence (not an exhaustive list).

Before new staff has contact with Service Users or family/carer they must attend the Trust Induction Programme and an Enhanced Criminal Records Bureau (CRB) check completed.

21. Activity Recording

All staff within the Home Treatment Service will be required to adhere to the Trust Protocol for record keeping. In addition staff will consider other Policies and Procedures for which their work will be defined within such as Care Programme Approach and the Trust Safeguarding Children's Policies and Vulnerable Adult Policy and Procedures. This list is not exhaustive.

22. Key Targets to be achieved:

All Service Users must be seen within locally agreed response times. The Home Treatment Team will be required to meet or exceed the local delivery plan targets for the number of episodes for Home Treatment as outlined in schedule 5 of the contract. The Team Manager will work closely with the Performance and Information Department to collect the mandatory monthly returns and any adhoc data reporting as agreed.

23. Financial

TBC

24. Performance Monitoring Arrangements:

At a minimum there will be quarterly contract meetings with the commissioning alliance to discuss performance, finance, quality and activity aspects of the contract. There will also be monthly meetings with local commissioners from Primary Care Trust's (PCT's) to discuss service developments, operational and quality issues pertinent only to that local area.

The performance data must be submitted in a monthly basis by the 15th working day following month end.

In addition the provider will produce a report detailing its performance against the clinical quality indicators set out in schedule 3 part 4A. From 2010 this will be published on a public basis as per the national requirement.

As per clause 31.1 of the contact the provider shall meet the service targets (where stated) in this service specification in addition to any applicable national targets and outcomes measures from time to time set out in guidance or otherwise specified by the Secretary of the State. The procedure for any underperformance due to an unforeseen increase in demand, or as a result of action taken or omitted by a commissioner is described in clause 31.2.

Schedule 15 describes the process that will be followed to correct any serious problems.

25. Audit Requirements:

Regular audits of the service should be undertaken to ensure that gaps in service provision are filled and quality of care meets the required standards. Audit should always include feedback from Service Users and their family/carers via the Patient Opinion website and Patient Experience Questionnaires.

26. National Strategy or Policy Context;

In developing this service specification particular emphasis has been placed on:

- The Mental Health Act 2007
- Implementation of 'Refocusing the Care Programme Approach' (DH 2008)
- Ten High Impact Changes for Mental Health – National Institute for Mental Health in England (NIMHE) 2006
- Related guidance and clinical guidelines such as achieving the National Suicide Prevention Strategy and (NICE) Guidelines for Schizophrenia
- The Journey to Recovery (DH Publications November 2001)
- No Health without Mental Health (2011)
- Health and Social Care Bill (2011)
- PIG for CRHT
- Personalisation

27. Local Strategy or Policy Context:

TBC

28. Quality Measures / Standards:

The quality measures outlined in Appendix 2 including:

- Personalisation Agenda – Scope for Direct Payments Unable to collect
- Employment Assistance Unable to collect although we do produce the LA 149 and 150 which is employment and settled accommodation data.
- Help with Accommodation as above
- CQUINN and 'Advancing Quality'
- Multiple Anti-psychotic prescribing where applicable – not able to extract
- Compliance with NICE guidance – not able to produce
- Care Quality Commission Standards Compliance (From 1st April 2009) do you mean the monitor compliance? As I don't think we can do this to team level
- Health Promotion activities unable to produce
- Research Requirements – unable to produce
- Liaison Activity - what do you mean by liaison activity, would this not be face to face seen.

Quality monitoring should be facilitated by selection from an appropriate number of indicators, such as:

- HoNOS Score - ? would this not be pbr – as currently we don't produce community HONOS
- % of patients with a carer who is in receipt of carer's assessment
- Admissions per 100,00 population
- Patient Survey Scores – performance are unable to produce
- SDQ – Strengths and Difficulties Questionnaire – unable to produce
- Experience of Service User Questionnaire (ESQ) unable to produce
- Waiting/Response Times
- Complaints – numbers received and response times
- Litigation Claims
- Number of Serious Unexpected Incidents (SUI's)
- Threshold Assessment Grid (TAG) unable to produce
- Treatment Outcome Profiles (TOPS) in Substance Misuse unable to produce
- Essence of Care Benchmarks unable to produce
- Others (to be determined and/or negotiated)

29. What is the Service Intended to Achieve:

Ensure an effective assessment and appropriate care plan for those Service Users referred to the Home Treatment Team. The assessment will include a comprehensive timely and multi-disciplinary review looking at all aspects of an individual's health and social needs incorporated in a qualitative risk assessment and management plan. The team will provide intensive home treatment as an alternative to hospital admission and will support early discharges from the adult acute inpatient wards. Upon completion of the care plan the Service User may be referred onto Recovery Services or back to Primary Care.

30. Transfer and Discharge Process:

The team will remain involved with the Service User until the episode of Intensive Home Treatment is completed. Following the completion of Home Treatment appropriate sign posting, transfer or discharge will occur. Whatever process is followed it should include the following:

- A formal plan detailing the Service Users needs and any contingency plans should a re-referral be required in the future
- A summary of the Intensive Home Treatment that has been provided alongside the outcomes that the Service User has obtained
- Details of any follow up arrangements

31. Community Partners Involved in Service:

- Social Services
- Local Crisis facilities where present
- Local Authority Leisure, Libraries and other community support

- Primary Care Mental Health Team
- General Practitioner
- Drug and Alcohol Action Teams (DAAT's)
- Housing
- Local Voluntary Sector
- Social Enterprise Organisations
- Adult Education
- Job Centres
- Community Pharmacists

32. Local Variations:

33. Approval Date:

34. Approved by:

35. Review Period:

5BP Commissioning Alliance Draft Specification

ASSESSMENT SERVICE

Service Title: ASSESSMENT SERVICE

1. Service Description:

The Team's role is to provide assessment, for people who may need contact with secondary mental health services. Assessment service practitioners will support access to services in a timely manner, as well as ensure arrangements are in place to enhance smooth pathways between primary care and secondary services.

The Assessment Team will provide a mental health service for adults with moderate to severe symptoms. In addition to mental health and risk assessments, the team provides support for the delivery of educational and self-help material in a variety of locations, including the client's home, where appropriate. Good partnerships are maintained with services in the non-statutory sector, to ensure effective care for people with more severe conditions.

The Team will work in partnership with primary care and acute Trusts to provide a service for patients who require specialist psychiatric assessment using Payment by Results clustering and / or management of people who have severe mental illness who cannot be supported in primary care alone. NM - Not quite sure what it means?

The service will provide a triage function and act as a 'gatekeeper' to mental health services including inpatient care, as appropriate. Rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service. NM - the gatekeeping role for inpatient care is on the Home treatment team? The issue of gatekeeping remains with Home Treatment during 8-8 but the above sentence states that the service will provide this role when appropriate but will need clarification in operational guidance

The service will provide access to specialist mental health services through a single point of access. This service will ensure that anyone requiring specialist mental health assessment or advice has ease of access to a timely response. This forms part of a wider acute care system provided by the Trust and this service performs a crucial coordinating function to ensure that service users experience a smooth journey through the most appropriate care pathways.

This Service will operate in the context of Effective Care Co-ordination Policies and Procedure, and all other Policies of the Trust and Local Authorities.

2. Provider Name:

5 Boroughs Partnership NHS Foundation Trust

3. Address of Organisation:

Hollins Park, Hollins Lane, Winwick, Warrington WA2 8WA

4. Base/location of Service:

The Assessment Teams will be located at the following bases:

Warrington
Delete St. Helens Knowsley
Wigan

5. Lead Contact at Trust: Chief Operating Officer

The **Chief Operating Officer** is responsible for:

- Ensuring that the strategic direction is consistently communicated to all staff regarding the delivery of Assessment service.
- The further development of this Guidance in conjunction with the Accountable Director and other stakeholders.
- Ensuring that delivery of Assessment service is subject to monitoring, development and review.
- Ensuring that resources are available for the commissioned provision of Assessment service

6. Telephone:

01925 664007

7. Service Availability:

The services will available 24 hrs a day 365 days a year with its core business hours operating between the hours of 8am to 8pm, 7days a week including Bank holidays.

8. Out of Hours Cover:

Not applicable.

9. Scope:

The Assessment service has a number of key components. Each must be in place if the service is to operate effectively

The service is appropriate for adults NM - (>18) who present with a moderate to severe functional mental health problem. There needs to be a statement agreed with Linda Kellie relating to scope of service in terms of age range email forwarded today (20/10/11) at 12:45.

The service will work people with mental health issues not included in Payment by Results clusters 1-4 (May need clarification of this sentence)

The following paragraph and bullet points relating to service exclusions were deleted

Assessments/interventions will take place in a variety of settings including police custody suites, places of safety, acute hospitals assessment centres and service users home.

- The service will provide a single point of access into secondary services. All referrals will be screened for eligibility criteria as above.
- If referral does not meet eligibility criteria the referral will be signposted to the most appropriate service and referrer informed in writing within 2 working days
- Everyone who is referred, who meets the eligibility criteria, will be offered assessment with 7 working days The referrer will receive a written response detailing the outcome of the assessment within 10 working days after the assessment
- GP's who require telephone advice in respect of a patient who is known to secondary mental health services will have a response within 1 working day. The outcome of this advice will be confirmed in writing within 2 working days. If the person is open / known by Recovery the response must come from them.
- *All assessments will be prompt and risk factors taken into account when prioritizing referrals. Referrals considered high risk will be undertaken within 24 hours, these may be completed or coordinated by the assessment team*
- *Where appropriate a multidisciplinary assessment of service users needs and level of risk will involve a process of consultation with other mental health professionals.*
- *Mental Health Act assessments will be conducted by appropriate practitioners. and will be coordinated by the assessment team*
- *The assessment team will follow the agreed trust procedure for Service users who Do Not Attend.*
- Assessment will actively involve the service user, carers/family and all relevant others, for example, GP.
- Service user involved in decision making and monitoring effects of medication.
- *The Principles of "access booking and choice" and "copying correspondence" will be adhered to.*

10. Geographical Area Served:

The service will operate within the usual boundaries of the Trust's specific GP Consortia, but this needs to be agreed contractually

11. Key Relationships with other Agencies:

- Work formally in an integrated manner with Local Authority (LA) Social Services staff. An issue relating to referrals for safeguarding children or adults by central duty teams / clearing house in social services may need addressing with LA colleagues
- To enhance treatment for a service user with drug or alcohol addiction through close and effective working with Substance/Alcohol Misuse Teams and other teams including those in ***the third sector***.

12. Links to other NHS Teams/Services:

The service will work closely with other Mental Health teams working within the locality and other NHS, social care and criminal justices services as appropriate.

The service will establish good links with primary care mental health services so as to prevent referrals falling between services.

The service will establish close working relationships with general practitioners.

13. Age Range:

18 years and above with no upper age limit for people with a functional illness. Older adults with a suspected functional mental illness will not be excluded purely on age grounds. Email sent to Linda Kellie (20/10/11) to confirm statement to be used

14. Source of Referrals:

The Team will operate an "open access" referral system, accepting referrals from e.g. Primary Care, deleted self-referral family/carer (where the individual is aware of and agreeable to the referral), statutory and voluntary agencies on completion of the teams' referral form or local Choose and Book systems. Referral to the service should be easy and referral pathways clear to all involved.

It is expected that routine referrals from other professionals will be via the referral form. This must be completed in full, be legible and with accurate information. The team will not accept responsibility if the demographic information is incorrect

Urgent referrals will be accepted via the telephone a referral form will be completed by an assessment team practitioner during the call to ensure all essential information is collected. Deleted Note about self presentation

15. Response Times:

The assessment team will provide a response according to need and risk. This is not an emergency service.

GP's who require telephone advice in respect of a patient who is known to secondary mental health services will have a response within 1 working day from assessment or recovery service as appropriate. The outcome of this advice will be confirmed in writing within 2 working days.

Everyone who is referred, who meets the eligibility criteria, will be offered assessment within 7 working days. The referrer will receive a written response detailing the outcome of the assessment within 10 working days after the assessment

All assessments will be prompt and risk factors taken into account when prioritizing referrals. Referrals considered high risk will be completed within 24 hours. The team will make all reasonable efforts to contact service user within 2 hrs of receiving referral.

16. Risk Assessment and Management including CPA requirements:

This must comply with the guidance in "Refocusing the Care Programme Approach" (DH 2008).

17. Age Culture and Gender Specifics:

There are no exclusions on the grounds of age, gender and culture.
Deleted The service will also …

18. Interventions/Treatments to be offered:

- Prompt, expert and holistic assessment of mental health problems and risk assessments will be provided

- Signpost, transfer or discharge to appropriate service.
- Provision of information for service users and carers about how their treatment and care should progress and the options available to them.
- Effective, evidence based brief interventions will be provided where appropriate (by the medical consultant only) to reduce and shorten distress and suffering
- Provide advice and support to service users, families and carers
- Telephone advice to GPs on management of potential referrals and known service users to the recovery team

- The pharmacological management of service user's symptoms will be considered carefully. The prescriptions of any medication will adhere to the National Institute for Clinical Excellence (NICE) guidelines.

20. Choice:

The NHS encourages choice and people from other geographical areas out-with the usual catchment zone can choose to have their inpatient care provided at the trust. The follow up care may therefore require liaison with a team from another area

21. Workforce Issues:

The Team consists of:

Team manager
Deputy team manger
Senior nurse practitioner
Occupational therapist – MW (from Cath Burrows) -The only comment that I have is that I feel that the team does not need an Occupational Therapist as these posts would be better situated within a home treatment or recovery team, it does however need more band 6 practitioners to provide the service within the spec, 24 hour/7day service both to the community and A&E, which is also to provide brief interventions as the staff will have to care co-ordinate these clients and provide intensive input. I also feel that the admin compliment within the team is very inadequate and that there should only be Band 3 and above admin, given the constraints of the Band 2 job spec. I am also a bit unclear as to why the team needs input from a clinical psychologist? Stays in until after consultation
Social worker (AMHP)
Consultant Psychiatrist
Staff grade/specialty doctor
Office manager
Administrative staff
Consultant Psychologist

The team will have active support and input from:

Pharmacist and junior Doctors,

The Trust will provide annual mandatory training for all staff members with updates on safeguarding children and vulnerable adults and management of violence. Deleted along with

Before new staff has contact with service users or their family/carer they must attend the trust induction programme and an enhanced Criminal Records Bureau (CRB) check completed.

22. Activity Recording:

- *All services users will have relevant Effective Care Co-ordination documentation completed following assessment.*
- *Records will be kept in keeping with the trusts records lifestyle management policy and information governance policy.*
- *Written and electronic records will conform to the Mental Health Minimum Data Set.*
- *The team will ensure that all clinical activity and Effective Care Coordination documentation is inputted onto the Trusts information systems.*

- Staff will at all times practice in accordance with the Trust's Safe guarding Children's Policy and Procedures. Staff should ensure that they document and communicate NM - through the Trust electronic communication form directly with the Trusts Safeguarding Children and Adults Team, Named Nurse Child Protection lead should they identify concerns or require advice.

In addition to the data items in the mental health minimum data (MHMDS) set a number of quality and outcome measures are to be recorded. The full list is shown in Schedule 5 of the contract.

23. Key Targets to be achieved:

All patients must be seen after triage or referral within the response times agreed and the caseload must meet or exceed the Local delivery Plan (LDP) targets as outlined in Schedule 5 of the contract.

Data will be supplied by the Team Manager on a monthly basis to monitor referrals to the Service. Other data to be collected on a monthly basis to include –

- Referral source
- Referral type
- Seen within target time
- Date of assessment
- Response letter to GP
- Activity
- Outcome of contacts
- Age band
- Gender
- Ethnicity
- Letters to referrer

24. Financial: ?????

25. Performance Monitoring Arrangements:

At a minimum there will be quarterly contract meetings with the commissioning alliance to discuss performance, finance, quality and activity

aspects of the contract. There will also be monthly meetings with local commissioners from Primary Care Trusts (PCTs) to discuss service developments, operational and quality issues pertinent only to that local area.

The performance data must be submitted on a monthly basis by the 10th working day following the month end.

In addition the provider will produce a report detailing its performance against the clinical quality indicators set out in schedule 3 part 4A. From 2010 this will be published on a public basis as per the national requirement.

As per clause 31.1 of the contract the provider shall meet the service targets (where stated) in this service specification in addition to any applicable national targets and outcomes measures from time to time set out in guidance or otherwise specified by the Secretary of State. The procedure for any underperformance due to an unforeseen increase in demand, or as a result of action taken or omitted by a commissioner is described in clause 31.2. Schedule 15 describes the process that will be followed to correct any serious problems.

26. Audit Requirements:

Regular audit of the service should be undertaken to ensure that gaps in service provision are filled and quality of care meets the required standards. Audit should always include feedback from service users and their family/carers.

27. National Strategy or Policy Context:

In developing this service specification particular emphasis has been placed on:

- The Mental Health Act 2007.
- Implementation of 'Refocusing the Care Programme Approach' (DH 2008).
- Ten High Impact Changes for Mental Health - National Institute for Mental Health in England (NIMHE) 2006,
- Related guidance and clinical guidelines such as achieving the National Suicide Prevention Strategy and (NICE) Guidelines for Schizophrenia.
- The Journey to Recovery (DH Publications November 2001)
- No Health without mental health (2011)
- Health and Social care bill (2011)
- Talking Therapies a four year action plan (DH, 2011)

28. Local Strategy or Policy Context:

This Next section needs to be agreed with performance department consistently for each service specification., Do assessment team need carers assessment as an outcome / quality measure

29. Quality Measures/Standards:

The quality measures outlined in Appendix 2 including:

- Personalisation Agenda - Scope for Direct Payments
- Employment Assistance
- Help with Accommodation
- CQuin and "Advancing Quality"
- Multiple Anti-psychotic prescribing where applicable
- Compliance with NICE guidance
- Care Quality Commission Standards Compliance (From 1st April 2009)
- Health Promotion activities
- Research Requirements
- Liaison Activity

Quality monitoring should be facilitated by selection from an appropriate number of indicators, such as:

- HoNOS Score
- % of patients with a carer who is in receipt of a carer's assessment.
- Admissions per 100,000 population
- Patient Survey Scores
- SDQ –Strengths and Difficulties Questionnaire
- Experience of Service User Questionnaire (ESQ)
- Waiting/Response Times
- Complaints – numbers received and response times
- Litigation Claims
- Number of Serious Unexpected Incidents (SUIs)
- Threshold Assessment Grid (TAG)
- Treatment Outcome Profiles (TOPS) in Substance Misuse
- Essence of Care Benchmarks
- Others (To be determined and/or negotiated)

30. What is the service intended to achieve:

- Ensure effective risk assessment and safe management of risk within the new guidance on CPA.
- A comprehensive, timely and multi disciplinary mental health assessment that includes all aspects of an individual's health and social needs incorporating a qualitatitive risk assessment and management plan.
- Following assessment appropriate signposting, transfer or discharge

31. Transfer and Discharge Process:

The team will remain involved with the client until the assessment is completed. Following assessment appropriate signposting, transfer or discharge will occur.

Handover should include:

- An agreement on the appropriateness of referral
- A formal plan detailing the service users needs and contingency plans including risk factors and relapse signatures.

.

- If a service user moves out of area arrangements will be made with an appropriate team receiving the referral
- Deleted bullet-point On discharge from the assessment team …
- A letter will be sent to the person's referrer and GP within the agreed timescale following discharge or transfer.

32. Community Partners involved in Service:

- Social Services
- Local Crisis facilities where present
- Local Authority Leisure, Libraries and other community support
- Primary care Mental Health Team
- General Practitioner
- Drug and Alcohol Action Teams (DAATs)
- Housing
- Local Voluntary Sector
- Social Enterprise Organisations
- Adult Education
- Job Centres
- Community Pharmacists

33. Local Variations:

34. Approval date:

35. Approved by:

36. Review Period:

5BP Commissioning Alliance Draft Specification

Recovery Service

Service Title: Recovery Team

1. Service Description:

The recovery team will work predominately with service users with functional severe and enduring mental health needs over the age of ?18(*awaiting clarity from CAMHS*) who cannot be managed appropriately or solely within primary care mental health services, or who require shared care with such teams when appropriate, due to the level of risk. It includes any person with moderate to severe functional mental health problems and has been assessed as requiring secondary mental health services.

The majority of service users seen by the recovery team will have been included in Payment by Results (PBR) clusters 11-17 and may require monitoring and treatment as part of their ongoing recovery process which could take several years.

The recovery team will work with service users included in PBR clusters 5-8 who will be referred back to the Primary Care Mental Health Team (PCMHT) and/or their General Practitioner (GP) after a period of treatment when their condition has improved.

Recovery Teams are a specialist secondary mental health service and will work with partner agencies and services to:-

- Ensure that the service is targeted to assist people appropriately within a recovery model and make effective use of resources.
- Provide a suitable response within the agreed timescales. (See Response Times Section)
- In conjunction with service users and carers, continually assess individual needs, develop care plans and review the appropriateness of these plans. These actions will be in line with the agreed Effective Care Co-ordination (ECC) process.
- Ensure that the personalisation agenda/direct payments is addressed
- Offer a carer's assessment and where required refer to a provider service.
- Identify young carers and liaise with Children's Services to ensure an appropriate assessment is undertaken.

- Assess and identify risk, developing risk management strategies as part of individual care plans. This will be in accordance with the guidance provided by the ECC process.

- Share expertise to assist colleagues to support service user's both within the organisation and externally.

- Strive to provide services that are sensitive to issues of ability, ethnicity, gender and sexual orientation and involve service users and carers in all aspects of service planning and delivery.

- Work with the service users and other agencies to promote good physical health and wellbeing.

2. Provider Name: 5 Boroughs Partnership NHS Trust

3. Address of Organisation:

Hollins Park, Hollins Lane, Winwick, Warrington, WA2 8WA

4. Base/location of Service:

The recovery teams will be based at the following locations
Halton
Knowsley
St Helens
Warrington
Wigan

5. Lead Contact at Trust:

Lead Contact at Trust: Chief Operating Officer

The Chief Operating Officer is responsible for:

- Ensuring that the strategic direction is consistently communicated to all staff regarding the delivery of Assessment service.
- The further development of this Guidance in conjunction with the Accountable Director and other stakeholders.
- Ensuring that delivery of Assessment service is subject to monitoring, development and review.
- Ensuring that resources are available for the commissioned provision of Assessment service.

6. Telephone: 01925 664007

7. Service Availability:

Core hours will be Monday to Friday 9am to 6pm – excluding bank holidays (there will be flexibility to work between the hours of 8am to 8pm to meet the needs of service users)

8. Out of Hours Cover:

Service users would need to be transferred to the home treatment team should for a short period of time an out of hours service be deemed necessary

9. Scope of the Service:

To include the following conditions:

Those individuals with a severe and enduring mental health problem included in PBR clusters 5-8 and 11-17 with evidence of severe social disability which may include risks to the individual or others and would include those with severe and enduring mental health problems and severe and enduring mental health problems and substance misuse problems. They are likely to have complex problems and may present difficulties with engagement. Typically such patients may require interventions under the Mental Health Act. They will present predominantly but not exclusively with a psychosis such as schizophrenia or bipolar disorder. This will also include severe disorders of personality where these can be shown to benefit by continued contact and support with secondary core mental health services.

Those disorders requiring specialist and/or intensive treatment such as psychological therapies and/or medication maintenance for treatments such as Clozapine or the initiation of medications such as lithium requiring blood tests where the level of risk is greater than can be dealt with safely by the primary care team. They may need assistance with activities of daily living either themselves or with the support of a carer. The Recovery Team will help with a range of activities, for example in education, employment and social activity, which will help promote recovery. Where it is commissioned this may involve working with those who are homeless.

10. Geographical Area Served:

The service will operate within the usual boundaries of the Trust specific GP Consortia but these will need to be agreed contractually.

11. Key Relationships with other Agencies:

Recovery Teams will work closely with other services such as Local Authority Departments and staff, Criminal Justice, Substance Misuse, Advocacy; Health promotion

- To support them in managing Service Users receiving care from the Recovery Team within agreed protocols.

- To pilot and evaluate new ways of working with other services.

- To access services and departments such as housing, education, leisure and other teams based on local Partnership agreements.

- The Recovery Teams will work jointly with other specialist services including those in the third sector.

12. Links to other NHS Teams/Services:

The links with Primary Care Teams are paramount and joint protocols must be established to ensure continuity of care and expedite the transfer of cases from the Recovery Team back to primary care. Links with the PCMHT also need to be clear to ensure that physical health needs are met as soon as indicated by the presenting clinical status.

The Recovery Team will work closely with the Home Treatment Team who will normally work with a similar client group but who take the lead when the service user is in an acute phase and where there is a risk of admission to hospital. The Recovery Team will take over when the acute phase has subsided. The Recovery Team will also work closely with in patient services and may take discharges from in patient services where the service user has been known previously to the Recovery Team or where they are not previously known they will have had a plan of care that will be met most appropriately by the Recovery Team.

Links to the Assessment team must be clear so that service user's assessed as requiring on going treatment for a severe and enduring mental health problem can move swiftly through to the Recovery Team.

13. Age Range:

?18 years upwards with no upper age limit. Older adults with severe and enduring functional mental needs should not be excluded purely on age grounds. Their needs should be assessed and treatment provided by the most appropriate team based on needs. Clients who have problems related to ageing or dementia should be transferred to the Later Life and Memory Services regardless of age.

14. Source of Referrals:

Referrals will routinely come from the Assessment Team but referral's will also be accepted from Early Intervention services (EI), in-patient services and home treatment.

15. Response Times: to referrals received

Clients must not wait longer than 10 working days for initial contact with the Recovery Team and the type and timing of the initial contact will be determined by the route of referral and assessment of need and risk assessment carried out by the referring team.

16. Risk Assessment and Management including CPA requirements:

This must comply with the guidance in 'Refocusing the Care Programme Approach' (DoH 2008) and will be initiated by the referring team and will be reviewed by the Recovery Team on an on-going basis

17. Anti-discriminatory Practice:

There will be no exclusions or discrimination on the grounds of age, gender, race, sex, disability, sexual orientation and religion or belief.

18. Interventions/Treatments to be offered:

- Use of agreed care pathways and interventions compliant with NICE guidance and Per pathways
- Active involvement and liaison with the ward staff where a service user is admitted to hospital.
- Risk Assessment, care planning, monitoring and review in line with ECC policy.
- Assessment and support with their physical health needs and onward referral to services such as smoking cessation or weight management services if appropriate.
- Shared care with primary care for the prescribing of atypical anti-psychotic medications.
- Maintenance for service users with relatively stable severe and enduring mental health needs when appropriate until transfer back to Primary Care Services can be organised in line with Pbr pathways.

Following assessment and care planning the recovery teams will provide services that will meet the needs of the service user which promote recovery and independence away from specialist mental health services.

- This may involve a process of on-going assessment of needs following the initial assessment.
- Continued care planning that focuses on recovery and independence.
- To provide individual care co-ordination when in an acute phase of ill health and a point of contact while planning recovery, prior to discharge from services.
- To provide information or assessments that support commissioning of services by local authority or specialist health services.
- To support the client in the maintenance of their physical health, by assessing needs and linking in to appropriate resources to help improve health.
- To provide evidence based therapies and medical, nursing, psychological and occupational interventions.
- To work closely with other services to avoid duplication of information and a smooth transition between services
- Evidence based psychological therapies? not commissioned in Warrington
- Evidence based treatments such as Occupational Therapy, relapse prevention strategies and psycho-education.
- Treatments will be based on need whilst also promoting choice and recovery

Physical Health Care

- Physical health needs need to be given a priority and be regularly assessed and action and/or advice given if indicated. Assessing and addressing the physical health needs of the service user should be given a high priority particularly those people on anti-psychotic medication.

Health promotion

- The Recovery Team must ensure that service user's should have assess to activities which look at diet, nutrition; substance misuse, sexual health, smoking cessation, and exercise. The Recovery Team should also encourage access to dental and optical examinations and flu vaccinations where appropriate.

- Assessments should address the adequacy of housing, educational and leisure needs and where appropriate assessments, including risk, should be referred onto local authority departments or other agencies to tackling and resolving issues. Each service users accommodation status should be assessed and actions taken to ensure security of tenancy where applicable.

- N.B. The socially excluded adults Public Service Agreement (PSA) 31 has signalled the Government's priority in achieving improved

settled accommodation outcomes for adults receiving secondary mental health services.

- The service user's employment status and needs should be assessed and referral made to employment support where applicable.

19. Choice

The NHS encourages choice and service user's from other geographical areas outside of the usual catchment area and can choose to have their care provided at the Trust. This may therefore involve liaison with teams from another area.

20. Workforce issues:

The recovery team is multidisciplinary and includes Doctors, Nurses, Occupational Therapists, Psychologists, Psychological Therapists and Social Workers as well as other qualified or experienced health and social care professionals. All staff will be supervised and supported in providing recovery services. Supervision will consist of mandatory management and clinical or professional supervision.

The team will have active support from a Pharmacist.

The Trust will provide mandatory training for all staff members with updates on safeguarding children and vulnerable adults and the management of violence.
Before new staff members have contact with service users and/or their family/carer they must attend the Trust induction programme and have an enhanced Criminal Records Bureau (CRB) check.

21. Activity Recording:

All service users will have relevant ECC documentation completed Records will be stored in keeping with the Trusts records lifestyle management policy and information governance policy
Written and electronic records will conform to the Mental Health Minimum Data set.

The team will ensure that all clinical activity and ECC documentation is inputted onto the Trusts information systems.

Staff will at all times practice in accordance with the Trusts Safeguarding Children and adult Policy and Procedures.

In addition to the data items in the mental health minimum data set (MHMDS) a number of quality and outcome measures are to be recorded. The full list is shown in Schedule 5 of the contract.

22. Key Targets to be achieved:

All patients must be seen after referral within the response times agreed and the caseload must meet the Local Delivery Plan (LDP) targets as outlined in schedule 5 of the contract.

23. Financial:

???????

24. Performance Monitoring Arrangements:

At a minimum there will be quarterly contract meetings with the commissioning alliance to discuss performance, finance, quality and activity aspects of the contract. There will also be monthly meetings with local commissioners from Primary Care Trusts (PCTs) to discuss service developments, operational and quality issues pertinent only to that local area.

The performance data must be submitted on a monthly basis by the 10th working day following the month end.

In addition the provider will produce a report detailing its performance against the clinical quality indicators set out in schedule 3 part 4A. From 2010 this will be published on a public basis as per the national requirement.

As per clause 31.1 of the contract the provider shall meet the service targets (where stated) in this service specification in addition to any applicable national targets and outcomes measures from time to time set out in guidance or otherwise specified by the Secretary of State. The procedure for any underperformance due to an unforeseen increase in demand, or as a result of action taken or omitted by a commissioner is described in clause 31.2. Schedule 15 describes the process that will be followed to correct any serious problems.

25. Audit Requirements:

Regular audit of the service will be undertaken to ensure that gaps in service provision are filled and quality of care meets the required standards. Audit should always include feedback from service users and their family/carers.

26. Strategy or Policy Context:

In developing this service specification particular emphasis has been placed on

- Implementation of 'Refocusing the Care Programme Approach' (DH 2008).
- The Mental Health Act 2007 as amended
- Ten high impact changes for Mental Health – National Institute for Mental Health in England (NIMHE) 2006
- Clinical guidelines such as NICE Guidelines for schizophrenia, bi-polar disorder and borderline personality disorder
- The Road to Recovery (DH publications Nov 2001)
- No Health without Mental Health (DoH 2011)
- The Health and Social Care bill (2011)
- Talking Therapies a four year action plan (DoH 2011)

27. Local Strategy or Policy Context:

This needs to be agreed with the Performance Dept for each service specification.

28. Quality Measures/Standards:

The quality measures outlined in ? Appendix 2 including

- Physical Screening and Wellbeing Advice
- Smoking Cessation
- Referral for Personalisation Agenda - Scope for Direct Payments
- Referral for Employment Assistance
- Help with Accommodation
- CQuin and "Advancing Quality"
- Multiple Anti-psychotic prescribing where applicable
- Compliance with NICE guidance
- Care Quality Commission Standards Compliance (From 1st April 2009).
- Health Promotion activities
- Research Requirements
- Liaison Activity

Quality monitoring should be facilitated by selection from an appropriate number of indicators such as:

- HoNOS Score
- % 7 day follow up
- % of Emergency Re-admissions within 28 days
- DNA rate first attendance
- DNA rate subsequent attendance
- % patients with a comprehensive care plan
- % of patients with a carer who is in receipt of a carer's assessment.
- Admissions per 100,000 population
- Patient Survey Scores

- SDQ –Strengths and Difficulties Questionnaire
- Experience of Service User Questionnaire (ESQ)
- Waiting Times
- Complaints – numbers received and response times
- Litigation Claims
- Number of Serious Unexpected Incidents (SUI)
- Patient Health Questionnaire (PHQ) PHQ9 and GAD7
- Clinical Outcomes Routine Evaluation (CORE)
- Quinmac: Quality Improvement Network for multi agency child and adolescent mental health services (CAMHS)
- Threshold Assessment Grid (TAG)
- Treatment Outcome Profiles (TOPS) in Substance Misuse
- 12 Week retention in treatment for Substance Misuse
- Essence of Care Benchmarks
- Duration of Untreated Psychosis (DUP)
- Others (To be determined)

29. What is the service intended to achieve:

The overall aim of the Recovery Team is to promote recovery, prevent relapse and encourage as well as facilitate social inclusion. The team will strive to reduce the stigma attached to mental illness and the distress that this can cause to service users and their carers/families

The Recovery Team should:

- Maximise the potential of service users to recover from their mental illness to a level that they aspire to.
- Improve engagement with service users, provide evidence-based interventions and promote recovery.
- Reduce hospital admissions and length of stay.
- Increase stability in the lives of service users and their carers/family
- Improve social functioning and inclusion, facilitate personal growth and provide opportunities for personal fulfilment.
- Provide a service that is sensitive and responsive to service users' cultural, religious and gender needs.
- Support the service user and his/her family/carers for sustained periods.
- Promote effective interagency working.
- Ensure effective risk assessment and safe management of risk.
- Promote good physical health and wellbeing.

30. Transfer and Discharge Process

When the care pathway has been provided and or a good level of recovery is has been sustained for six months, transfer back to the PCMHT should be considered. A care plan will be provided with a relapse plan for the primary care team and service user to use, if necessary in the

future. The care co-ordinator will be responsible for supporting the discharge and this will involve meetings with primary care and universal services as indicated in the care plan

If re-referral to the Recovery Team is required there should be arrangements in place to ensure this will receive priority within the assessment team.

If a service user moves out of area the transfer arrangements should be made with appropriate teams in the receiving patch.

A discharge letter will be sent to the service users GP within the agreed timescale following discharge or transfer.

31. Community Partners involved in Service:

- Social Services
- Local Authority Leisure, Libraries and other community support
- Primary care Mental Health Team
- General Practitioner
- Housing
- Local Voluntary Sector
- Social Enterprise Organisations
- Adult Education
- Job Centres
- Community Pharmacists

32. Local Variations:

33. Approval date:

34. Approved by:

35. Review Period:

Open Letter from Director of Finance to TAG

5 Boroughs Partnership NHS
NHS Foundation Trust

Our Ref: Tender
Your Ref:

Date: 28/10/11

Hollins Park House
Hollins Lane
Winwick
Warrington
WA2 8WA

Tel: 01925 664025
Fax: 01925 664052
Email: dean.marsh@5bp.nhs.uk

Open letter to members of TAG

Dear colleague

Ref: Financial aspects of Acute Care Pathway and Later Life model of care at 5 Boroughs

At the last TAG meeting the Trust was challenged over the depth of its financial information in support of the proposed models of care for adult and later life services at 5 Boroughs.

Whilst I maintain that the emphasis of the advisory group is to review the clinical and operational aspects of the models of delivery proposed, I recognised at that meeting that there were some assurances that TAG members would need to be able to support the model:

i) Value for money

ii) Extent to which the service models support the QIPP agenda

iii) Ensuring that costs are not inadvertently passed onto other organisations.

I write this open letter to TAG members to respond specifically to these three areas of assurance.

Value for Money

The national indicator used to monitor value for money is the reference cost indices. This is an annual exercise carried out by the Department of Health and compares the average cost of services of every provider organisation in the NHS. It compares 'like with like' by comparing mental health service providers with mental health service providers for example. The average cost of all providers across the country is calculated and this is given a standard reference cost of 100. Providers with reference cost of less than 100 therefore have a lower than average unit cost. The latest set of published data (available on the DoH website) relate to 2009/10, and the results for 2009/10, for the mental health trusts across the North West are shown in the table below.

Mental Health Provider	2009/10 Reference cost index
5 Boroughs Partnership	**95**
Cheshire and Wirral Partnership	105
Greater Manchester West	92
Merseycare	106
Manchester Mental Health and Social Care Trust	96
Pennine Care	90
Cumbria Partnership	108
Lancashire Care	119
National average for MH Trusts	**100**

From the table we can see that 5 Boroughs costs are 5% lower than the national average for mental health trusts and that only two trusts across the North West had a lower reference cost in 2009/10, and neither of these provide services across the footprint commissioned by those commissioners represented at the TAG.

The unpublished data for 2010/11 has suggested that for that reference period 5 Boroughs reference cost index has fallen even further.

QIPP

Whilst the TAG concerns itself with the clinical model, pathways and operational aspects of the Trust's proposals, a question has been raised about the extent to which the new models support the QIPP agenda. I maintain that it is not the Trust's 5-year financial strategy that should be under review, as there are many other groups and forum that deal specifically with this matter (primarily the commissioning and contract meetings held with our commissioners). In order to support the TAG though, I have produced information below which shows the specific financial impact of the changes currently under consideration by the TAG.

	Baseline £'000	2012/13 £'000	2013/14 £'000	2014/15 £'000	2015/16 £'000	2016/17 £'000
Acute Care Pathway	18,290	16,786	16,423	16,423	16,423	16,423
Later Life	4,820	4,209	3,419	3,544	3,544	3,544
Total for proposed models	**23,110**	**20,995**	**19,842**	**19,969**	**19,969**	**19,969**

As colleagues will know from our original presentation the Trust will already lose upwards of 4% per annum from its contract as part of the QIPP agenda and it is the effective redesign of services that reduces cost but maintains or improves quality and outcomes that will make the QIPP process a successful one. The Trust's proposals seek to do just that. The table above should show that the two proposals would contribute on an ongoing basis £3.1m towards the Trust's QIPP target.

TAG colleagues should note that these figures do not include any contribution to QIPP from the realignment of any estate across the Trust as a consequence of impact of the new model of care.

Chief Executive: Mr. Simon J. Barber
Chairman: Mr. Bernard Pilkington
Trust Headquarters, Hollins Park House, Hollins Lane, Winwick, Warrington, WA2 8WA
Mini Com Number 01925 664094

'Cost shunting'

The passing of costs from one organisation to another is rarely, if ever, as a consequence of a financial strategy or financial decision. It usually arises where an organisation removes part or all of a service or function that it has historically undertaken or carried out (I accept that this may be as a consequence of a savings plan). It is therefore not possible to express this in financial terms, other than to state that it remains the stance of 5 Boroughs not to pass responsibility or costs for functions currently carried out by the Trust, by stealth, to its partners.

The real test for this assurance has to come through the TAG testing out the operational delivery of the proposed model of care and all stakeholders having mature conversations about the role and responsibilities of the Trust under the model of care. It is of course always possible that commissioners will decommission services and transfer responsibility to another provider (shared care is a good example) and the responsibilities and costs that would then transfer from one organisation to another contractual conversations that take place in the appropriate forum for those negotiations.

I hope that this responds to the points raised by TAG members.

Yours faithfully

Dean Marsh
Director of Finance

A Better View... *of mind & body*

Chief Executive: Mr. Simon J. Barber
Chairman: Mr. Bernard Pilkington
Trust Headquarters, Hollins Park House, Hollins Lane, Winwick, Warrington, WA2 8WA
Mini Com Number 01925 664094

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