Delivering High Quality Services Through Efficient Design

Report of the Responses to the CWP Questionnaire

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Executive Summary

1. **Introduction**

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

2. **Questionnaire**

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

3. **Analysis**

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

3.1.1. Section A – The majority of responses were from service users, carers and voluntary groups (n= 29, 67.4%).

3.1.2. Section B – There were more responses from community services (n= 4) than inpatient services (n= 2).

3.1.3. Section C – Responders in this section were from Adult Mental Health services (n= 5) and Other sources (n= 5).

3.1.4. Section D – The majority of responses were from Central and Eastern Cheshire (n= 16, 57.1%).

3.1.5. Section E – The source material accessed were predominantly from the Consultation Document and the Website.

3.1.6. Contact Details – From the 32 questionnaires received 29 provided contact details.

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

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

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

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

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

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

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

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

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

4. Correspondence

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

5. Overall Conclusion

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

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

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

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

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

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

3. Analysis

3.1 Demographics

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

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

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

3.1.1 Section A. Personal Demographics

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

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

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

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

3.1.2 Section B. Place of Work

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

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

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

Figure 1: Place of Work

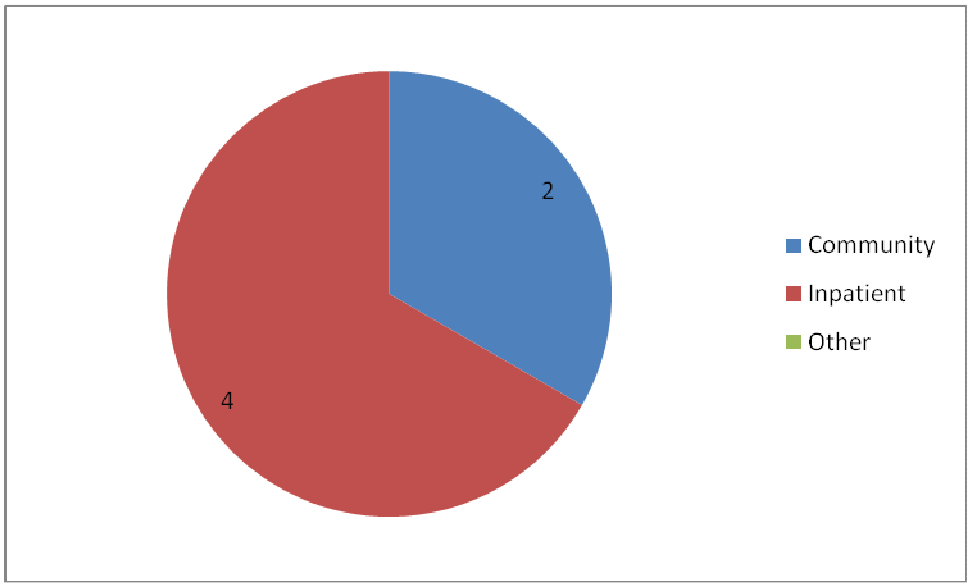


Table 2 indicates that there were two from the inpatient area and four from the community, with none responding with other. There was one User, two Voluntary and one staff responders indicating that they considered themselves to be employed in the community. The low numbers reflecting that the majority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

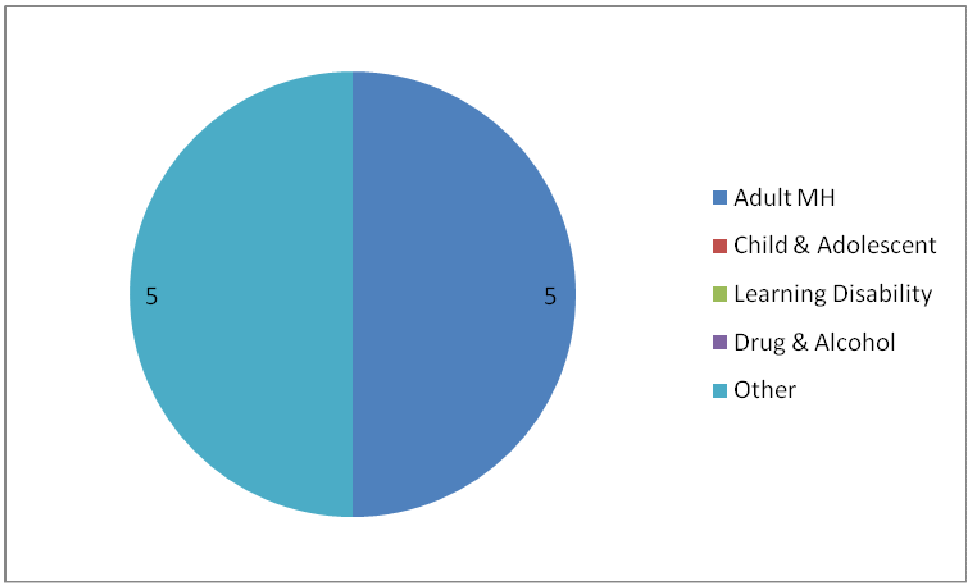
3.1.3 Section C. Work Areas

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

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

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

Figure 2: Work Areas



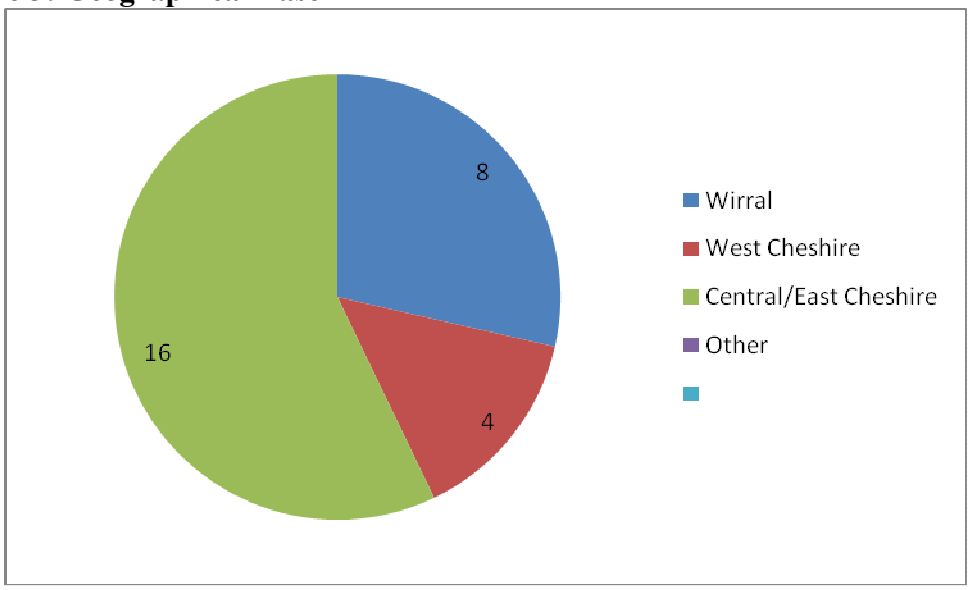
3.1.4 Section D. Geographical Base

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

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

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

Figure 3: Geographical Base



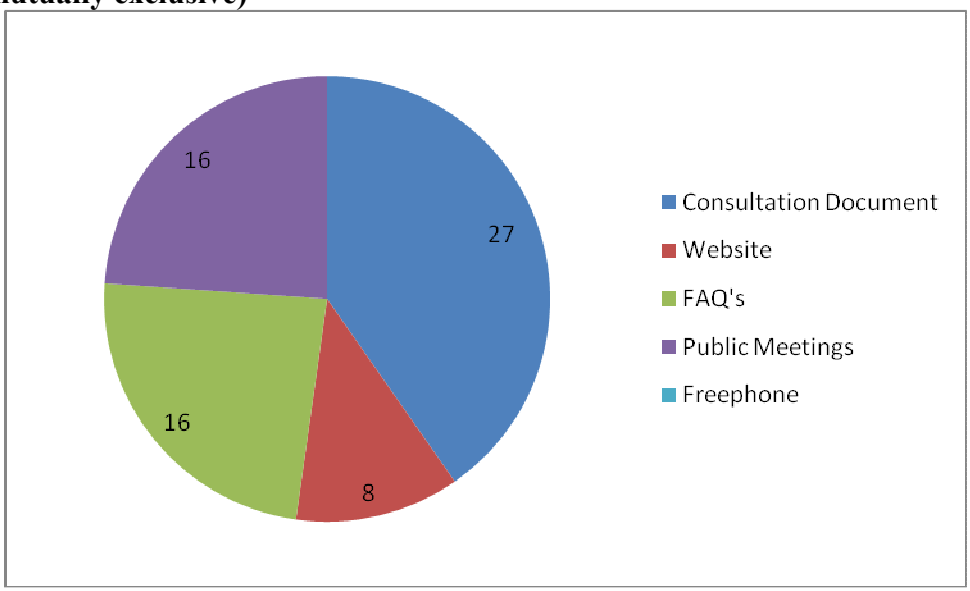
3.1.5 Section E. Consultation Material

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

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

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

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



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

3.1.6 Contact Details

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

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

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

Table 6: Responses to Proposal

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

Figure 5: Responses to Proposal

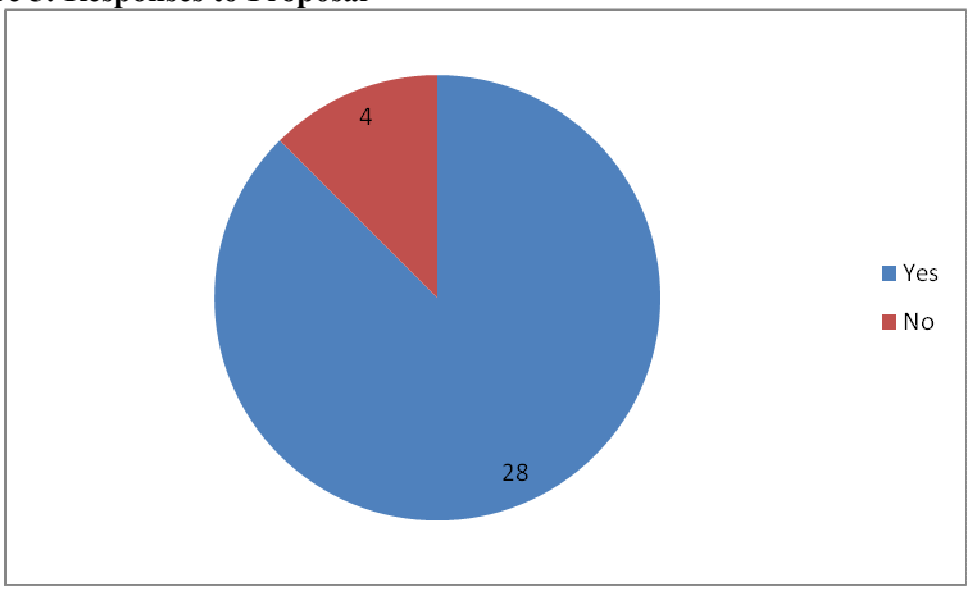


Table 6 and Figure 5 indicate that the majority of the responders answered 'yes' (n=28, 87.5%) to this question with only 4 (12.5%) answering 'no'. The greatest number of responses were from the User, Carer and Voluntary groups (n= 22, 68.75%) with 21 (95.4% of this group) answering 'yes' and 1 (4.5%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

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

Users –

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

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

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

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

Carers –

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

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

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

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

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

Voluntary –

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

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

'There must be transport to attend specialist clinics'.

Trust –

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

Other –

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

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

Carers –

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

Trust –

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

Governors –

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

Staff –

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

Analysis

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

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

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

Conclusion to Question 1

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

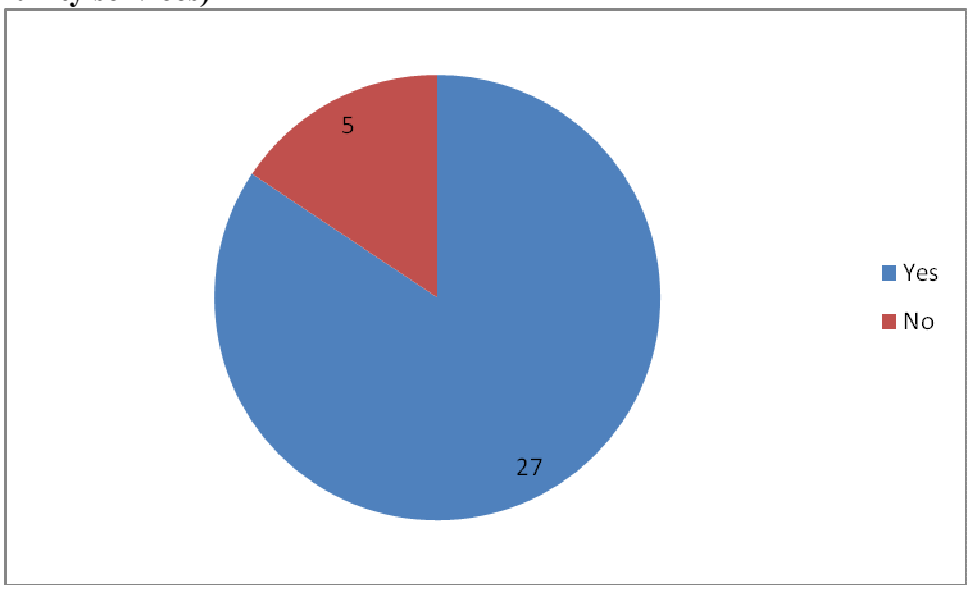
- A wide range of services are required across age ranges, diagnostic categories and service types.
- The mixing of individuals with differing clinical conditions was a concern.
- There was a perception that choice is being reduced which was perceived negatively.
- There were some positive suggestions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

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

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

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

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



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

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

Users –

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

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

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

'Expansion of community mental health services'.

Carers –

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

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

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

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

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

Voluntary –

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

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

'Public transport again a necessity'.

Trust –

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

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

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

Other –

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

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

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

Carers –

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

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

Trust –

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

Staff –

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

Other –

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

Analysis

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

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

Conclusion to Question 2

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

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

The main suggestions are themed as:

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

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

Table 8: Responses to Question 3 (Reducing inefficiencies)

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

Figure 7: Responses to Question 3 (Reducing inefficiencies)

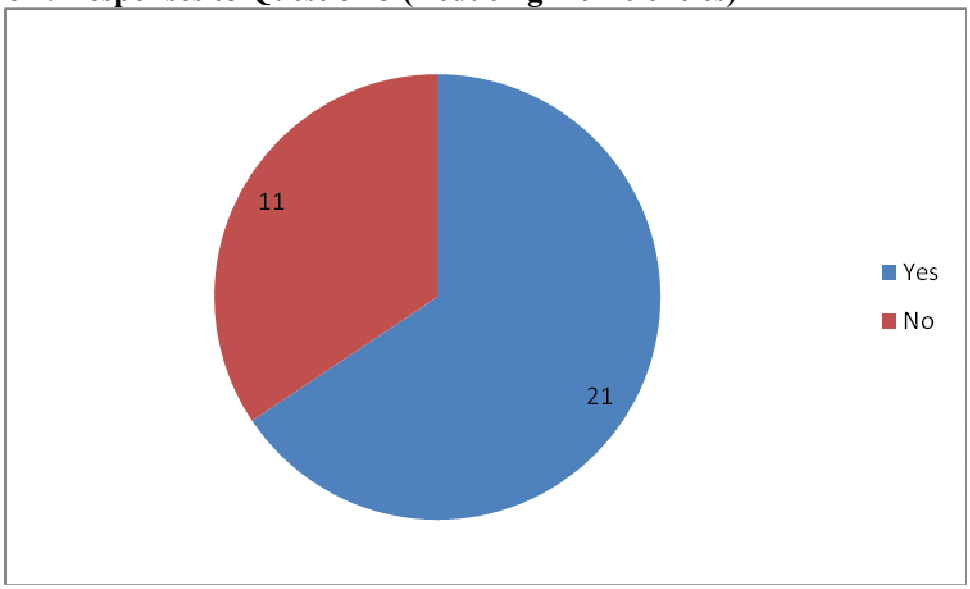


Table 8 and Figure 7 indicate that 21 (65.6%) responders reported 'yes' to this question with 11 (34.3%) answering 'no'. The majority (n= 22, 68.7%) of respondents were from the User, Carer and Voluntary groups with 16 (72.7% of this group) voting 'yes' and 6 (27.2% of this group) voting 'no'. (Percentages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

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

Users –

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

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

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

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

Carers –

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

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

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

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

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

Voluntary –

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

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

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

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

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

Trust –

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

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

Other –

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

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

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

Carers –

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

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

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

Voluntary –

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

Trust –

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

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

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

Governors –

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

Staff –

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

Other –

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

Analysis

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

Conclusion to Question 3

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

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

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

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

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

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

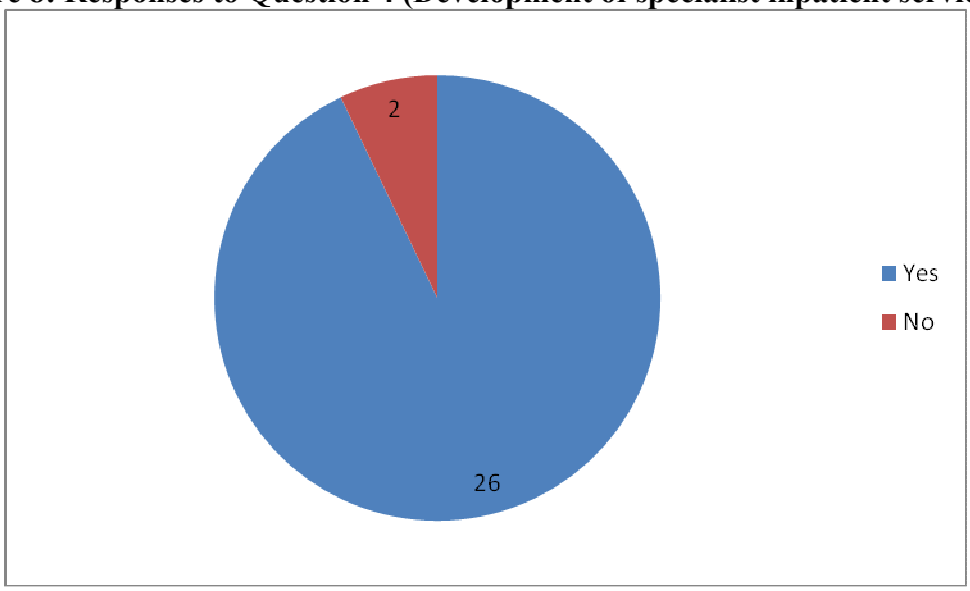


Table 9 and Figure 8 show that 26 (92.8%) responders answered 'yes' to this question with only 2 (7.1%) indicating 'no'. The majority of respondents were from the Users, Carers and Voluntary groups (n= 18, 64.2%) with 17 (94.4% of this group) answering 'yes' and 1 (5.5%) answering 'no'. It should be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

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

Users –

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

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

'Specialist services for drug and alcohol'.

Carers –

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

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

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

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

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

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

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

Voluntary –

'Should all be given same priority'.

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

'Transport required to cover geographical area'.

Trust –

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

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

Staff –

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

Other –

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

'Intensive rehabilitation'.

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

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

Carers –

'You must steal from Peter to pay Paul'.

Trust –

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

Analysis

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

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

Conclusion to Question 4

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

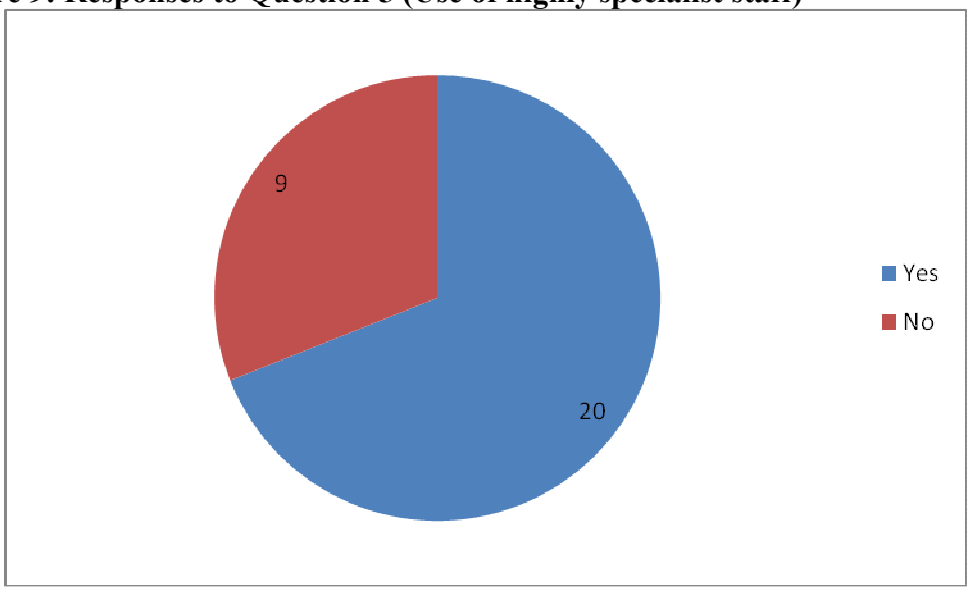
- There should be a range of services developed.
- Peripatetic specialist staff should be made available.
- Access across boundaries.

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

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

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

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



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

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

Users –

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

Carers –

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

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

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

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

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

Voluntary –

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

'Transport required'.

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

Trust –

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

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

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

Governors –

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

Other –

'Increase number of beds in a specialist unit'.

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

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

Users –

'Specialised services must be based on locality and need'.

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

Carers –

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

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

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

Trust –

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

Staff –

'Give equal priority to all the services'.

Other –

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

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

Analysis

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

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

Conclusion to Question 5

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

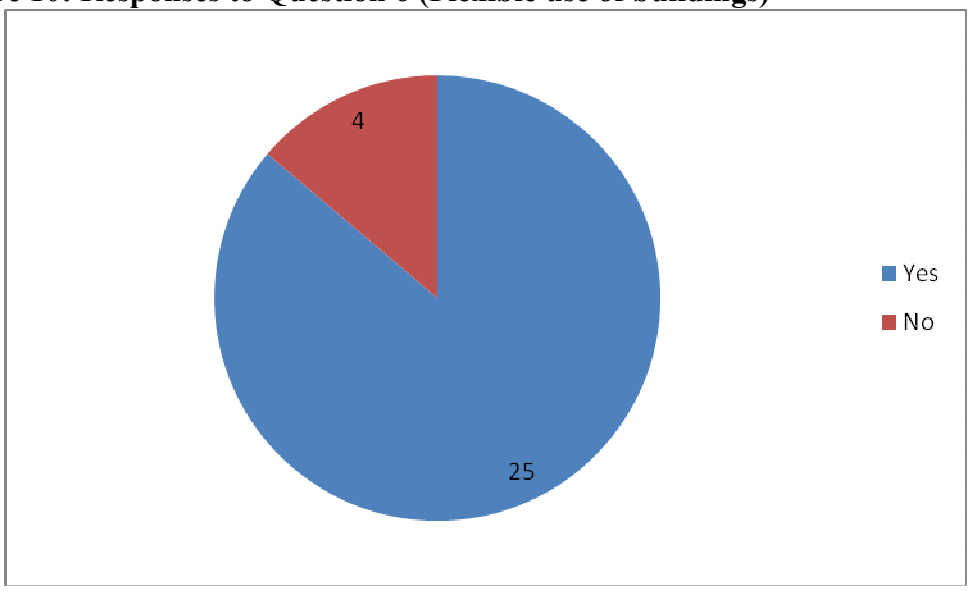
- Transport to services.
- Services for dementia sufferers a priority.
- The need to develop other specialist areas.

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

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

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

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



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

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

Users –

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

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

Carers –

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

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

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

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

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

Voluntary –

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

Trust –

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

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

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

Other –

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

'Specialist unit for people with dementia'.

'Be pragmatic and approachable'.

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

Carers –

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

Trust –

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

Staff –

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

Other –

> *'Too confusing for some people'.*

Analysis

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

Conclusion to Question 6

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

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

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

Table 12: Responses to Question 7 (Reporting arrangements)

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

Figure 11: Responses to Question 7 (Reporting arrangements)

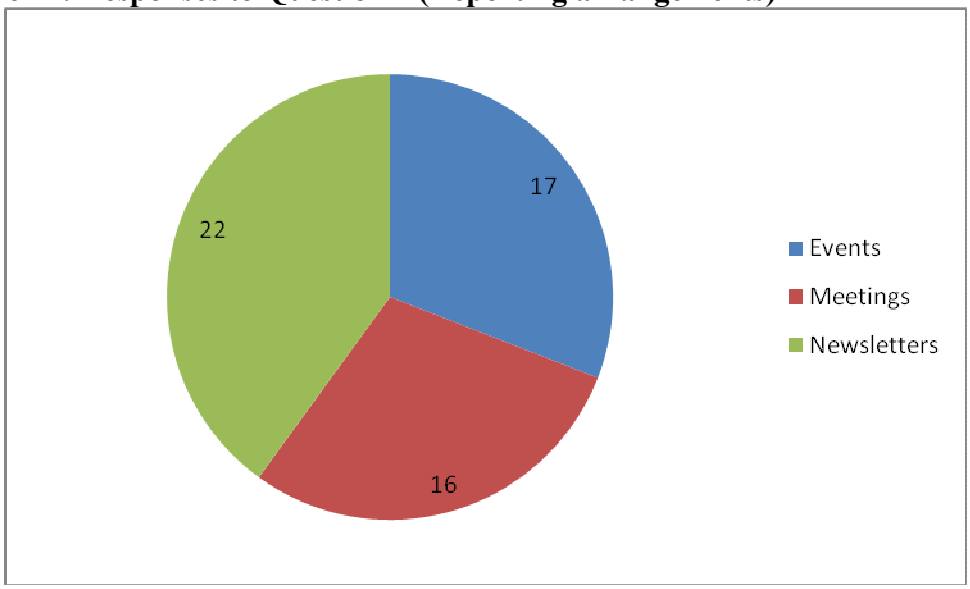


Table 12 and Figure 11 indicate the responses regarding reporting arrangements and the use of 'Newsletters' was the most popular, closely followed by 'Events' and 'Meetings'. This clearly shows that an array of reporting mechanisms are preferred rather than a focus on just one.

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

Users –

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

'Website, Local and National Newspapers'.

Carers –

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

'Make your annual reports more widely available'.

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

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

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

Voluntary –

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

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

'Use of website. Use of local media'.

Governors –

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

Trust –

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

Other –

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

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

'Local media – newspaper, radio, tv'.

Analysis

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

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

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

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

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

Table 13: Main Suggestions Regarding Service Improvement

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

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

Users –

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

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

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

Carers –

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

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

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

Voluntary –

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

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

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

Trust –

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

Staff –

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

Other –

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

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

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

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

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

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

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

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

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

6. References

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

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

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

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

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

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

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

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

Q2. Yes

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

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

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

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

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

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

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

Appendix 2 Letter from an Individual (name provided)

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

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

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

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

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

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

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

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

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

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

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

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

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

Name supplied.