

REVIEW OF MENTAL HEALTH INPATIENT SERVICE PROPOSALS

NOTES OF THE PUBLIC MEETING *

Council Chamber, County Hall, Preston
Monday 18th October 2010 – 6.30pm to 8.30pm

Facilitators / staff		
DN Nixon (DN) (Chair)	Strategic Director for Mental Health	Lancashire
Rebecca Davis (RD)	Network Director – Mental Health Commissioning	Lancashire
Janet Ledward (JL)	Director of Procurement, Contracting and Market Management	NHS Central Lancashire
Alex Walker (AW)	Associate Director of Transforming Community Services	NHS Central Lancashire
Tracey Callaghan-Hayes (TCH)	Project Manager	Lancashire Partnership Team
Pat Rolph (PR)	Senior Project Support Officer	Lancashire Partnership Team

Audience – 27 people in attendance

Staff – 6 members of staff in attendance (*as above*)

Introduction

(DN) welcomed everyone to the meeting and introductions were made. DN explained the purpose of the meeting, advising that although the meeting was scheduled from 6.30pm-8.30pm, there was flexibility on timings to meet the needs of the group. DN acknowledged the short notice of the meetings, but stressed that this was not a formal public consultation but an involvement and engagement exercise. DN noted that she or a member of the team would be happy to come and meet with local groups/networks.

DN advised that a written record of the discussions * would be taken by PR, and a copy of the discussion notes will be made available, along with a report collating themes from all six public meetings held, on the Lancashire Mental Health and Social Care Partnership Board's website by the end of November 2010. Copies could also be forwarded directly to anyone wishing to leave their contact details with PR.

**Every effort has been made to capture the discussion at meeting as fully as possible, especially comments and questions from people attending. However sometimes people spoke softly or quickly, or more than one person spoke at the same time. The notes are not a verbatim transcription or quotation. For clarity of reading the notes are mainly presented as short whole sentences, whereas of course people often spoke in more informal phrases. Acronyms are expanded in the text, where they may not have been at the meeting.*

Meeting Notes

Please note comments noted in bold and labelled 'C', were made by members of the public in attendance. Comments labelled 'R' noted responses from members of staff present.

C: Re Avondale – are you going to close all sites?

R: No. (DN)

C: How many people are there in a team?

R: Crisis Resolution Teams range in size between twenty and thirty people. (RD) *(This has been confirmed via annual 'Mental Health Service Mapping').*

C: Looking at 500 beds across Lancashire, will there be any beds in Preston?

R: I'll pick that up towards the end of the presentation (DN).

C: Why not, rather than close one whole unit, take two beds from each unit instead rather than shutting the unit in Preston?

R: We need 'fit for purpose' units. (DN)

C: I have been in the units, they are 'fit for purpose'.

R: From the original sites, none of which are 'fit for purpose'. (JL)

R: For quality, there may have to be trade offs for access versus 'fit for purpose'. (DN)

C: Wards are being closed at Avondale, yet the Platform is being kept open, what's the difference as in 'fit for purpose'? *(Note: 'the Platform' is a six bedded unit for 16- 17 year olds)*

R: We are commissioners not providers. There is disability access on the ground floor. (JL)

C: There is a lift.

R: There is a difference in how patients are managed, patients can't be taken outside. There is different legislation for adults. (JL)

C: It needs be evened out in Preston, where people are, where they live, they sometimes need a bed.

At this point DN suggested breaking into smaller groups for more detailed discussion, and so attendees could sit more comfortably in the ante room with a cup of tea / coffee.

C: I received notice about the public meetings by email on 12th October, we've not had enough notice, it was diabolical (Councillor).

R: This is not a formal public consultation, this is an opportunity to have a dialogue and share information. Apologies for short notice, we are working to a very tight timescale, which has been imposed. I am happy to come and meet with local groups. (DN)

C: Can you update us on progress on inpatient units, the four sites? The only one with a business plan is Whyndyke Farm. There are supposed to be other units, what's the progress? Units are being closed in advance of new units being built, people need to know.

C: No finance has been assured for the other sites.

C: Are Deloitte's of London on that one?

R: This is a PCT process; we are not looking at the number of sites. I am not aware of any work by Deloitte's. (DN)

C: It looks like you don't want to build on the sites.

R: Re Whyndyke Farm and other sites; the Trust (LCFT) are dealing with these proposals, we've noted bed closures and that there has been investment made in the community but can't discuss sites. Any communication needs to be open and transparent. (DN)

C: There are people at the Avondale unit and its closing. It's the same at Elm House.

R: It's good to have a discussion, I'm happy to pick up discussions. We are here to listen. We will move into smaller discussion groups next door, with flip chart notes being recorded from each group. A summary of the smaller group discussions will then be fed back to the main group. (DN)

People divided into three smaller groups with one or two facilitators to a group, including; JL, AW, RD and TCH, with DN circulating all three groups. Flip chart notes were taken from each group discussion (*Appendix 1*).

When group discussions ended, everyone rejoined the main group to hear feedback from each discussion as recorded.

DN summarised advising all information would be collated into the final report.

Feedback was given from group 1 (TCH & JL)

DN advised that information regarding Lancashire wide bed usage over the last twelve months could be provided. The following questions/comments were raised:-

C: There had been criticism about the previous consultation process.

C: GPs hope to refer patients through the GP system, this is alright, until you get to the GP reception desk. What happens to people who are desperate when people on the front line don't have a clue?

R: It will be helpful to work with GPs; this will be an important and serious part of the discussion. (DN)

C: It's sad if we can't look after vulnerable people in a civilised society.

Feedback was given from group 2 (RD). The following questions/comments were raised:-

C: With regards to travel, one of the key measures is to be close to family. If placed out of the local area, how would people get to hospital?

C: This was captured in the session.

R: Information to understand how many people this affects with regards to travel. (RD)

R: What it would look like? (DN)

C: In Chorley Hospital I know of three patients, one has eight people visit regularly, that's a lot of people, others may have two to four visitors.

R: We are all agreeing we do need to look at travel. (DN)

C: If facilities are closed, then we have a new way of working down the line. How can we bridge that gap?

R: We need to look at the detail, but we are significantly down the journey although not at the end of it. It may mean fewer beds. There is a good story to tell so far, recognising and responding to change. It's time to take stock. (DN)

C: One more thing, some service users were not confident that services were in place, after the last consultation.

R: Absolutely right, what are those community services are they enough? (DN)

Feedback was given from group 3 (AW). The following questions/comments were raised:-

C: Re transport and the needs of families, you will need to get a balance right in the final decision. Look at how to transport people who are distressed and need safe inpatient services. You need to think about people who are acutely ill.

R: It's unrealistic not to have transport issues due to the wide area of Lancashire. (AW)

C: There is the cost of travel for families as well as the time it will take e.g. it's £5 to travel by bus to Blackpool and about £7 for the train, but also there is the traveling time involved.

R: We need to start to look at that. (DN)

C: Everyone asks about travel, but it's the quality of care for patients. Nobody is bothering about patients. They don't want to be moved, they don't want a modern building they just want the best care and treatment.

R: Agree to some extent but then nothing would ever change. Inpatients need to have access to outdoors, fresh air and activities. We have done a lot of work around Dementia care and it makes an astounding difference. (AW)

C: Tell that to the people put into elderly care home. £600 per month or per week, it's more important to get the right care.

R: I can take you to two or three places where it does make a difference. (AW)

C: Where?

R: The Lodge, Chorley. (AW)

DN suggested to finishing the discussion at this point, explaining that themes had been captured. Slips with the team's contact details were available to take away. DN recapped advising a report will be produced and taken through to GP Consortia and PCT Boards. The work will continue through to the final recommendations in February 2011.

An initial report will be prepared by the end of November 2010 to start to shape the process. DN confirmed this will be made available on the Partnership Board's website, and will be taken to the Lancashire Joint Overview and Scrutiny Committee.

DN asked if there were any further questions or comments, but there were none so it was agreed to end the meeting. DN advised she of a member of the team would be happy to meet with local groups for further discussion, advising the report will be taken to 'part 1' of PCT Boards meetings, which are open to the public.

C: Thank you for allowing us to come along and having the opportunity to talk.
(Applause)

Appendix 1

Group Flip Chart Notes – Preston 18th October 2010

Group 1: Jan Ledward / Tracey Callaghan Hayes

Experience:

- So many changes
- Consultation – right people consulted – criticism of original
- Don't want to leave my locality
- Better control – general hospital, local facilities
- Expectations of consultation
- Transition to new units managed

Improved:

- Access to crisis
- Not reliant on accident and emergency
- Assurance inpatient when needed
- Dementia – separate issue
- Transport – family, carers, affordability
- Health passport
- Frontline appreciation of need

Consultation responses:

- Demographics (concern, re; flawed)
- Appropriate population needed
- Salford evaluation of legitimacy

- Expectation – alternatives/ new units in place before closures
- Community – experiences for those without carers?
- Assurance that inpatient units will be in place
- Already beds reduced / need reduced
- Been through so many changes
- Importance of central point
- Link to general hospital, this will help reduce stigma (security of general staff)
- Transport – route that is accessible
- Experience – link with other organisations
- Don't want to leave my home city
- Experience – would have to section to go to attractive unit

- No access to appointments with consultants, led to accident and emergency, long wait, had to be moved to other locality unit (A&E Liaison was poor)
- Experience – good service in mental health unit
- Clarify bed occupancy locally
- Reliance on A&E, should be crisis team
- Should be an integrated IT system
- Health passport would improve access (at end of bed?)
- Sites, how will transition to new sites to be managed
- Travel – patients and family difficulty
- Affordability transport
- Dementia beds – low numbers, high priority, should be separate issue.

Group 2: Rebecca Davis

- Outreach – person in crisis not seen for several days.
- Concerns about 24/7 access/ immediate help
- Need to have complete confidence in services to respond
- Support where it is needed, e.g. workplace
- Crisis and respite beds, more local
- Timelines of alternatives being ready – is there a gap? It needs to be seamless
- Financial, is there enough money
- What about the rural areas
- Should there be big or small units?
- How far will people have to travel?
- How many people are affected?
- Pathways are not good enough
- Needs to be uncomplicated choice, are you informed?
- Dementia patients
- What will happen in Preston
- How will families get there?
- Are GP's to be involved?
- Will services respond to carers as well, e.g. if they call for someone.
- Concerns about transition – how change is done? E.g. Glen House in Lancaster
- People will turn to services they know and have used in the past
- Do we need specialist dementia beds
- Travel policy, is needed! Not everyone has access to a car, hospitals not part of transport integrations, this would need to be addressed.

Group 3: Alex Walker

- Locally based services
- Transport issues
- Child care issues
- Improved community services may address concerns
- Need variety of community provision
- By visiting people at home a greater possibility of building therapeutic relationship
- Community is less institutionalised
- Specialist centres (same as the acute trust)
- Are the depth of community services in place to support the whole community network (families, carers, partners)
- Opportunity for third sector and statutory services to work together (dementia services is a good model)
- Widening support Networks to their full capacity: utilising volume/ community services
- Respite services/ care
- Children as carers
- Single parent families, impact if admitted to hospital
- Do not want it to be seen as “community – good” “inpatient – bad” some people do need inpatient services (complex needs) but environment does need improving
- Consultation at the time was not informed, people are now more informed, concern about numbers consulted
- Local services are important
- Would there be some assistance for travel? Would there be a dedicated bus service?
- Challenge – range of community V’s Inpatient local
- Needs more than one unit: would suggest 4!