

# National Clinical Advisory Team - NCAT

**Chair: Dr Chris Clough**

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## NCAT REPORT

**North West SHA – Mental Health Matters:  
Developing Mental Health Services in Lancashire**

**National Clinical Advisory Team Visitors  
Dr John Morgan and Professor Tom Craig**

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**Date of Visit – 7 September 2010**

### Introduction

North West NHS (NWNHS) approached the National Clinical Advisory Team (NCAT) in early August 2010 to conduct a clinical review of the proposals to improve the way mental health services are provided in Lancashire.

The visit took place on 7 September 2010 at Lancashire Care NHS Foundation Trust (LCFT) headquarters at Sceptre Point, Sceptre Way, Walton Summit, Preston.

Meetings were held with appropriate stakeholders including:

#### **Capital Programme Team**

Alistair Rose - Project Director  
Lorraine Ritchen-Stones - Trust Capital Development Project Manager  
Colette Rimmer - Associate Director of Clinical Design  
Ben Brookes – Construction Project Manager Drivers Jonas  
Deloitte

#### **Communications Team including Patient Public Involvement**

Bev Pickover – Stakeholder Engagement Manager  
Sue Fowler – Chair of Blackpool OSC (by telephone)  
Steven Edwards – Service Experience Lead

#### **Service User and Carer Reference Group**

Christine Meredith - Chair Service User Carer Reference Group  
Les Bond - Service User Carer Reference Group Rep  
Laura Richmond - Service User Carer Reference Group Rep  
Graham Hough - Service User Carer Reference Group Rep

#### **Operating Policy Leads**

Nigel Roberts - Clinical Manager, Capital Developments  
Lorraine Johnson - Matron, Adult Inpatient Services  
Dr Craig Smith - Consultant Psychiatrist (Adults)  
Dr John Knapp - Consultant Psychiatrist (Older Adults)  
Don Chapman - Matron, Older Adult Services

#### **Service Transformation Team including Operational Services & Professional Leads**

John Keaveny - Network Director Adult Services  
Ian Huitson - Network Director Older Adult Services  
Cath Fewster - Lead Pharmacist  
Ann Hall - Acting Service Transformation Programme Lead  
Steve Jameson - Interim Director of Estates and Facilities  
Wendy Langtree- Service Transformation Programme Director

### Programme Board Staff Side and Governors

Julie Acton - Staff Side Representative LCFT  
Dan Johnson - Trust Governor  
Moira Mondesire - Trust Governor

### Programme Board Exec Team

Shirley Saunders - Deputy Chief Executive LCFT  
Professor Max Marshall - Medical Director LCFT  
Patrick Sullivan - Director of Nursing LCFT  
Dave Tomlinson - Director of Finance LCFT  
Joanne Marshall - Director of Workforce & Organisational Development LCFT

### Executive Directors responsible for Service Change (Trust and PCT)

Professor Heather Tierney-Moore - Chief Executive (SRO)  
LCFT  
Debbie Nixon - Strategic Director of Mental Health, PCTs  
Amanda Doyle – Medical Director, Blackpool PCT

Prior to the meeting, we were sent:

- Strategic Outline Case v8 July 2007
- NCAT Review of the Future Delivery of Functional In patient Mental Health Services in the Lancaster and Morecambe district of North Lancashire 22 October 2009
- Project Initiation Document Mental Health Matters Capital Programme for reprovision of inpatient services v013 27 January 2010
- Service Transformation Annual Report v6 March 2010
- Communications Plan v4 May 2010
- Lancashire care trust workforce report New Mental health in patient Services v002 8 July 2010
- Letter from Lancashire Care Trust and NHS East Lancashire to SHA detailing programme and technical appraisal process 30 July 2010
- NHS North West terms of reference for NCAT 5 August 2010
- Whyndyke Farm Project Key Project milestones v4 13 August 2010
- Draft Whole Hospital Operating Policy v001 19 August 2010
- Briefing document for NCAT v8 23 August 2010
- Draft Strategic Outline Programme front sheet v5 6 September 2010
- Draft Strategic Outline Programme v5 6 September 2010
- Draft Strategic Outline Programme v5 6 September 2010 appendices

Additional papers provided at the visit or after included:

- Copy of presentation made to Overview and Scrutiny Committee by Caroline Briggs and Lynne Hall 9 February 2010
- Adult Community Mental Health Service Redesign slides
- Letter from Ian Jerams, Chief Operating Officer to stakeholders outlining Doncaster Adult Community Mental Health Services changes 7 June 2010
- Whyndyke Farm Project – Master Programme v2 17 August 2010
- Development of a New Inpatient Unit to serve the Fylde Coast, Chronology of Engagement Work September 2010
- Capital Programme for Reprovision of Inpatient Facilities, Draft Benefits map v8 6 September 2010

### Context and Proposed changes

Lancashire is large county and a mixture of urban and rural environments. It has a population of nearly 1.5 million people and covers 12 borough councils within the county council and two unitary authorities. It is estimated that ethnic minorities constitute 8.5% of the population.

There are five Primary Care Trusts (PCTs) who commission mental health services from Lancashire Care Trust though Blackburn and Darwen have taken on a lead commissioning role more recently.

The trusts current services are delivered through four clinical networks:

1. Adult mental health
2. Older adult mental health
3. Secure services
4. Child and adolescent mental health (CAMHs), substance misuse and early intervention services

Secure services and child and adolescent mental health services are excluded from the scope of the capital elements of the programme although care pathway interfaces are included in the broader service transformation.

Within the adult mental health network there are:

- 10 Primary Care Mental Health Teams
- 8 Crisis Home Treatment Teams
- 18 CMHTs
- 7 Assertive Outreach Teams
- 15 inpatient wards
- 6 PICUs (one temporarily closed)

Within the Older Adult mental health network there are:

- 13 Older adult CMHTs
- 4 Memory Assessment Services
- 2 combined Memory Assessment and Intermediate Support Services
- 3 Intermediate Support Teams
- One Hospital Liaison service
- One Continuing Care team
- 12 inpatient wards (11 have split functional and dementia care)

There are currently 13 acute inpatient sites for working age and older adults.

Following extensive consultation, 'Mental Health Matters' was launched in 2007. It represents a very large programme of improvement in mental health hospital services in Lancashire. The £150 - 200m capital scheme, undertaken by Lancashire Care NHS Foundation Trust over a 10 year span, will provide inpatient mental health services that are fit for modern mental health requirements, replacing the Trust's existing 'not fit for purpose' inpatient accommodation. The 'Mental Health Matters' programme is however not just concerned with new buildings, it is about transforming all the Trust's services to provide the best possible experience and outcome for people with mental health needs in Lancashire.

The programme's aim is to develop affordable modern acute mental health inpatient facilities for adults and older people in Lancashire. Four sites were originally chosen for the new inpatient facilities. These were each to be developed as individual projects within the programmes portfolio as follows:

- |   |                                      |
|---|--------------------------------------|
| 1. North Lancashire (Blackpool, Fylde and Wyre) | Whyndyke Farm, Blackpool             |
| 2. North Lancashire (Lancaster and Morecambe)   | Pathfinder Drive, Lancaster          |
| 3. Central Lancashire                           | Ribbleton Hospital, Preston          |
| 4. East Lancashire                              | Burnley Bridge, (Hepworths), Burnley |

These proposals were based on the key bed demand assumptions within the SOC 2007 and were as follows:

**Source: Proposed bed numbers per site (Table 2 p.25 SOC 2007)**

	Total	Fylde Coast	Central Lancs	East Lancs	Lancaster
Assessment	60	15	15	15	15
Adult Treatment	324	90	90	108	36
Total Adult	384	105	105	123	51
PICU	32	8	8	8	8
Older Adult	144	36	36	36	36
Total	560	149	149	167	95

The following key assumptions were made within the SOC p.25-26:

- a. The preferred way forward i.e. 560 beds for Lancashire (a reduction from current bed provision in 2007 of 649 (Adults 348, Older Adults 260, Psychiatric Intensive Care Unit (PICU) 41 - Source p.36 SOC 2007).
- b. Occupancy level of 85% to 90%
- c. Ward size
  - Assessment 15 beds
  - Adult/Older Adult Treatment 15-18 beds
  - PICU 8 beds
- d. Redesigning the workforce to deliver a new recovery orientated service model.

More recent demand modelling jointly carried out by the PCTs and the Trust in Sept 2009 proposed a further reduction in beds to a county-wide demand of “between 220 and 280”. The demand assumption has not formally been confirmed by PCTs and is under review as part of a Technical Appraisal Process lead by the PCT Strategic Director for Mental Health.

The Trust has updated the original SOC (2007) by producing a draft Strategic Outline Programme based on a planning assumption of 306 beds (PCT Demand (2009) plus some current out of area treatment cases). Design work on the Whyndyke Farm Project is progressing on an assumption of 143 beds.

This option allows for the “Recovery” service model to still provide high quality services, shorter lengths of stay, and lower bed numbers from a larger site providing a full range of therapies, ensuite bedrooms (lower PICU demand), age and gender appropriate accommodation and separate accommodation for those with dementia.

Further to the revised operating framework, the PCTs are now re-testing all the planning assumptions in a revised case for change. The Trust has agreed with the PCT Collaborative that it should continue with the Whyndyke Farm project meantime. The Whydyke project is progressing with two options, a 143 bed option including

dementia beds and a 113 bed option without dementia beds. It is anticipated that the retesting process should be completed by February 2011 so that the Trust is able to proceed with the agreed overall programme.

### Implementation

The development of the programme has been ongoing since 2005 and has been through several cycles during which time estimates for the number of beds and hence the number of inpatient units and their locations have steadily decreased. That it has taken so long to get to the present phase is in part due to the complexity of the organisational changes and the number of stakeholders; with 5 PCTs, 12 borough councils and 13 separate inpatient sites/hospitals. It is hoped that the first major capital investment, the Whyndyke project will open in March 2013.

### Discussion and Conclusions

The discussions focused on the clinical need for the re-provision with an emphasis on factors that might concern patients and their families. It was clear from the documentation and the discussions that a huge amount of work had gone into these plans over several years. There was an understandable degree of frustration that progress had been slow and it is some 5 years since the proposals were first considered.

#### a. Location of new in patient services:

A clear and consistent message emerged from everyone we met on our visit including representatives of the Service User and Carer group, that the existing inpatient facilities were indeed no longer fit for purpose. Existing wards in the District General Hospitals are mainly 'dormitory style' shared accommodation and there are difficulties ensuring separate space for men and women. Their location in the middle of a general hospital means that appropriate outside space for recreation and relaxation is severely limited.

The proposed solution is a new build of a mental health facility that may, as in the case of Whyndyke Farm, be separate from the District General Hospital (albeit the District General Hospital in Blackpool is not far away). This raises two concerns. First that it may appear to some to be a pity to lose the de-stigmatising advantages of co-location of physical and mental health, and second, co-location may be clinically indicated for some patients who have both physical and mental ill health and for rapid responses to medical emergencies. The first of these concerns had been discussed locally and all agreed they would far rather receive care in a pleasant, clean and efficient service than be concerned about location. The second may be particularly relevant for patients suffering from dementia and here co-location with the general hospital has been proposed as best practice by some specialists. Where this is not possible, attention has to be given to getting appropriately speedy access to physical health care through building relationships with primary and secondary care.

There has been a solid effort to involve the public living in the area of Whyndyke Farm in discussions about the proposed new development. There have been a number of public events, mail drops and press briefings and open events. The impression is that initial resistance to the scheme is largely resolved. Links with the Local Authority are good and they are said to be on board with the development.

Overall we believe the preparations, including consultations with service users, their families, staff and the local public have been well implemented and that there is a clear consensus in favour of the development of the Whyndyke Farm site. Although the number of proposed inpatient beds has gradually reduced with the development of community alternatives including crisis resolution home treatment teams, the proposed number of 143 is probably as low as it can reasonably go on any particular new site. We understand that the PCT is currently revisiting all the planning assumptions and in particular whether or not beds for dementia sufferers should be included. We would caution however, that while consideration of retaining dementia beds on an acute hospital site would be reasonable (and assuming they could be provided in an appropriately modernised environment), a stand alone 'dementia unit' separate both from the proposed integrated service at Whyndyke and the district general hospital is the least acceptable model clinically bringing all the disadvantages of isolation from acute medicine with those of isolation and the potential for institutionalisation.

While the proposals for the development of Whyndyke are well under way, the position of the other units is less clear. The original (2007) 4-site proposal is now questionable on the grounds of more recent in-patient demand modelling and the current economic climate. In the more recent modelling, county-wide demand is for between 220 and 280 beds which although not yet confirmed by PCTs might mean that inpatient services could be provided in just 2 units county-wide. This inevitably leads to concerns about the admission of some patients to units far away from where they live and this may be particularly burdensome for older people who are wholly reliant on public transport.

### b. In-patient services in the wider context:

The model of inpatient care provision is part of the wider modernisation and development of mental health services in Lancashire. The care model for the inpatient service was discussed in detail. The essential features are a conceptual separation of assessment, 'triage' admissions and longer specialised admissions. The general principle is that patients should have short admissions (typically around 7 days) with early discharge supported by home treatment. For patients requiring more protracted treatment, this will be provided in wards that are organised around a range of needs including a person's physical health/frailty and vulnerability. Wards are all designed to have a total of 15 beds with clear gender segregation. This approach is increasingly common across inpatient mental health services in England. It represents a consensus position on 'good practice' and efficiency though it is notable that a few areas are finding less need for 'triage' wards when there are well functioning Crisis and Home Treatment teams (CRHTT) and crisis beds in the community.

Although CRHTTs are seen as an essential component of the Trust's approach, there were some anxieties expressed by both service users and professionals about whether these are best co-located with inpatient services or housed separately. Service users felt that there were already instances where the response of these teams to crises were slower than desirable and some concern that an effective home treatment service could not be provided in the face of fewer inpatient beds without some expansion in CRHTT provision. There clearly needs to be further work on these issues and careful modelling of the capacity needed in the light of the proposed continuing reduction in beds. This is an ongoing concern for both health service managers and senior clinicians in the Trust and we were presented with some evidence of an ongoing review of community provision. Linked to this was a discussion of the potential role for non-hospital crisis accommodation or the greater

use of supported tenancies. Both are being explored though as far as we could ascertain, there are no funded proposals for developing these at this time. There is something of a chicken-and-egg nature to this discussion, with some reluctance to enter into commitments on community services until final agreement on bed numbers has been agreed by the PCT.

There is also very impressive ongoing work to agree clinical care pathways with 20 developed to date. These aim to set minimal standards for care and treatment based on implementing evidence based interventions within a recovery framework. This together with discussions on crisis care and the other community mental health teams shows good evidence for coherence between developments in hospital and community settings. This will be all the more needed in the light of the change to health service commissioning over the coming years and the emergence of GP consortia. There is already an increased emphasis on collaborative working with primary care. We were able to discuss clinical service provision and the development proposals with the medical representative of the Blackpool PCT and it was apparent that the Whyndyke Farm development had strong local primary care support. The Trust has launched a strategy to improve its relationship with GPs as the projects move forward and an e-bulletin is now in place, presentations have also been held with PEC chairs and Medical Directors.

### c. Workforce issues

Some modelling for the staffing of the new inpatient units have been carried out. There has already been a change to the shift system for nurses that is being rolled out across the Trust and which is said to be more flexible and broadly acceptable to staff. The proposals for medical cover seem appropriate. It is reasonable to assume that the reduced number of beds will, as elsewhere, mean that those that remain are occupied by more severely ill patients, and that there may well be a higher proportion detained under the Mental Health Act. Together this is certain to place greater demands on clinical time than may be the case currently. As we understand it, current 22-bedded wards have 2 junior doctors each. In the new model there will be one junior doctor for 15 beds. The shift system, time off for study and inevitable service gaps make it very likely that there will be gaps in cover unless some additional resource can be provided. The proposal is to supplement the service by the use of 'floating' junior doctors and staff grades who would work across all the wards in the new inpatient service. These proposals in the draft workforce report seem entirely appropriate though clearly more work will need to be done as the new inpatient facilities come on line in a year or two with the revised plans.

Throughout our discussions it was apparent that there was a degree of frustration about the length of time taken to get to a position of implementing the plans that the organisation, staff, service users and family carers have largely agreed. The PCT is currently re-testing the proposal with a commitment to come to a decision in February.

### Recommendations

1. The broad direction of travel is coherent and in line with good clinical practice. Moving to new inpatient services, built to a high standard with appropriate access to outside space and providing expert level of care can hardly be faulted.
2. A decision needs to be made on the balance between providing dementia care within the new build or within an acute general hospital setting. A

separate, stand-alone dementia service would be the least attractive option and should be avoided.

3. The PCT is encouraged to press on with the final stages of re-examination of the case for change and ensure it is able to give the Trust the necessary confidence to begin implementation of the programme in February 2011.
4. Further work is required on the service models and workforce implications as the plans take shape.
5. Further work is required to assess the impact of the overall programme for the inpatient services particularly if the two site option is chosen. The Trust needs to be satisfied that the proposals represent the best trade off between critical mass and access for patients.
6. The Trust should ensure that the solid foundations of public, service user and carers involvement is built on as the plans are implemented.
7. The development of community crisis facilities and supported living should be given higher priority by the PCT, LAs and the Trust to complement the existing plans.

### Summary

This NCAT visit provides a clinical review of proposed changes to the delivery of mental health services in Lancashire and in particular, the proposal to relocate a number of outdated mental health inpatient services in District General Hospitals to new buildings close to, but separate from DGH sites.

The changes were first explored in 2005 and were expressed as the 'Mental Health Matters' programme in 2007. Since that time there have been extensive consultations with a broad range of stakeholders including service users and their families. There is a broad consensus that the direction of travel is appropriate though as community mental health services have grown in size and strength, it has become apparent that fewer inpatient beds are needed than were predicted when the plans were first put together.

It is possible that the further testing of the proposals might lead to a 2 site option providing services for adults including provision for dementia with a possible third site for a more specialised service. The modelling of bed numbers carried out in the draft Strategic Outline Programme (2010) seem to be based on reasonable assumptions from the benchmarking and bed usage data. The first of these sites has been identified.

The proposed service model is clinically appropriate, with a good balance of inpatient and community provision. There is good evidence of support from GP commissioners and robust public and patient engagement.

Further to the revised operating framework, the PCTs are now re-testing all the planning assumptions in a revised case for change. The Trust has agreed with the PCT Collaborative that it should continue with the Whyndyke Farm project meantime.