

### Energy Performance

Rating A	-	up to 55 GJ/100m <sup>3</sup>
Rating B	-	55-65 GJ/100m <sup>3</sup>
Rating C	-	65-75 GJ/100m <sup>3</sup>
Rating D	-	over 75 GJ/100m <sup>3</sup>

The results of the assessment process are detailed in Table 3.

Property	Estate Condition	Functional Suitability	Space Utilisation	Statutory Compliance	Energy Performance
The Gables	B	D	A	B	A
The Pines	B	C	A	B	A
ECH Wards	B	C	A	B	B
Dove House	C	C	C	B	B
The Larches	B	B	A	B	B

### 2.6.1.2 Backlog Maintenance

The total cost of backlog maintenance associated with these buildings is given in Table 4. Full details of these properties, their general condition, backlog maintenance and aspects of functional suitability are provided in Appendix B.

Table 4: Estimated Backlog Maintenance at 2002-03

Property	Estimated Value £,000
The Gables	20
The Pines	45
ECH Wards	15
Dove House	10
The Larches	31
<b>Total Backlog Maintenance</b>	<b>121</b>

### 2.6.2 Activity

Table 5 provides activity details for the Adult and Older Peoples mental health in-patients services due to be re-provided under this project, for the five year period covering 1997/98 to 2001/02.

Table 5 Adult & Older Peoples Mental Health Activity – 1997/98 to 2001/02

	Adult Mental Health			Older Peoples Mental Health		
	Admissions	OBDs	Avg LoS	Admissions	OBDs	Avg LoS
1997/98	428	14,684	34.5	273	9,190	33.7
1998/99	530	16,129	30.4	281	12,599	44.8

1999/2000	603	15,107	25.1	259	13,776	53.2
2000/2001	722	15,992	22.1	256	13,847	54.1
2001/2002	570	16,602	29.1	158	14,673	92.9

### 2.6.3 Financial Position

The Trust was established on 1<sup>st</sup> April 2002 following an extensive stakeholder review and consultation. The Trust brings together mental health and specialist learning disability services previously provided by two Social Services and five NHS Trusts, and resulted in the dissolution of two of the NHS Trusts on the 31<sup>st</sup> March 2002. The Trust is also host to the Anglia Support Partnership which is the shared services provider in the Cambridgeshire health system.

As this is the first year of operation, the Trust does not, at this stage, have a financial track record in its own right. The financial performance of the two key predecessor organisations, Lifespan Healthcare NHS Trust and the North West Anglia Healthcare NHS Trust, over the past three years is outlined in the Table 6a. The planned financial position of the new Trust for 2002-03 is highlighted in Table 6b.

Table 6a – Financial performance of key predecessor organisations 1999-2002

	1999- 2000 £'000s	2000- 2001 £'000s	2001- 2002 £'000s
<b>Lifespan Healthcare NHS Trust</b>			
Total Income	57,378	59,751	52,796
Surplus/(deficit) for year	12	6	0
<b>North West Anglia Healthcare Trust</b>			
Total Income	53,379	37,813	36,210
Surplus/(deficit) for year	21	19	(2)

Table 6b Financial Plan of the Trust 2003-03

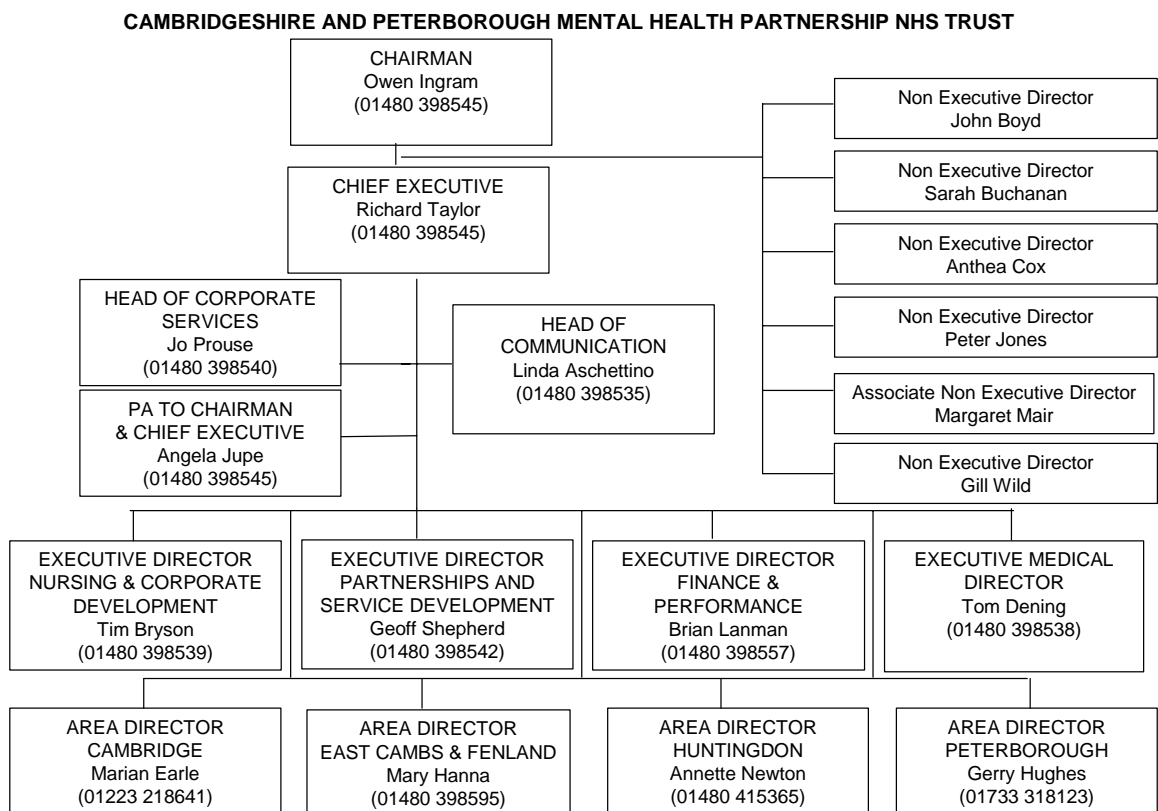
#### A SUMMARY

		<b>Annual Budget £'000</b>
1	INCOME	(76,842)
2	EXPENDITURE - Pay	54,404
3	EXPENDITURE - Non-Pay	22,434
4	EXPENDITURE - Reserves	1,035
4a	EXPENDITURE - b fwd CIP	(1,031)
5	TOTAL EXPENDITURE	76,842

**2.6.4 Resources**

The Trust employs around 3000 staff across 80 sites within its catchment area. The services are managed within the framework outlined below.

**Trust Management Structure**



The Trust has developed a number of strategies and policies to improve recruitment and retention in the key areas of staff shortages in mental health services. These include:

- Five year workforce plans for service areas;
- Enhancements to the Trust’s ‘Return to Nursing’ campaign;
- Extension of the ‘Family Friendly’ policies;
- Piloting of a self-rostering scheme;
- Appointment of a Chair in Community Psychiatry;
- Establishing key links with the education sector via the Cambridge University;
- Improving the working environment for staff.

## 2.7 Historical Performance and Future Bed Projections

An analysis was commissioned and undertaken by RKW<sup>30</sup> Health Planners which identified the comparative performance levels (length of stay) of the Adult and Older People's Services in the locality in relation to the best internal and external practice (see 2.7.3).

### Adult Mental Health In-patients

The analysis has shown that the current performance level of Adult Acute Services is approximately 17% below the best external comparator. However, the best internal performance is 12% above the best external comparator. Good performance within in-patient care is dependent upon comprehensive and robust inter-agency community services. These figures indicate that the use of acute in-patient care could improve, however this is dependent upon additional investments, particularly in social care support which is not available in the lifecycle of this project due to the financial pressures on both Cambridgeshire County Council and Peterborough City Council and Social Services departments. Despite these investment uncertainties the development of more robust community support services, particularly the Assertive Outreach and Extended Hours Community Services over the past two years, is likely to have a positive impact on the usage of in-patient beds.

### Older People's Mental Health Services

For Older People's Mental Health Services the current overall performance level is 20% below the best internal performance and 72% below the best external comparator. The majority of the difference relates to Dove Ward. These are organic patients, several of whom have been In-patients for many years. Over 40% of the In-patients on Dove Ward have stayed for over 84 days. This significantly skews the results and accounts for the very low performance level.

### Bed Occupancy

The National Beds Inquiry<sup>20,31</sup> set a bed occupancy planning target of 82% by 2003/4. The target was set at Health Authority level and covers all In-patient activity. For both Adult and Older People's Mental Health Services a bed occupancy rate of 85% is considered appropriate. This is close to the average ward occupancy over the past five years.

### 2.7.1 Key Assumptions

The Trust has considered potential changes to activity levels and resources up to 2010, based on:

- PCT activity and forecast population growth.
- General changes in the health needs of the population.
- Achieving performance levels in line with national and local benchmarks.
- Changes in service provision and care models, including changes stemming from the Local Delivery Plans and other local strategies.
- The impact of the NSF's and National Beds Inquiry.

It has been assumed that current referral patterns will continue with no changes in workload from the peripheral PCTs.

### 2.7.2 Population and Demographics

Table 7 details the activity and population growth for all services by PCT area. The figures are based on local authority and PCT estimates and forecasts. This ensures consistency with other health service planning and is considered more reliable than the current OPCS estimates. The forecasts indicate an overall growth in activity of 5.8% by 2010. More detail information is provided in Appendix C.

Table 7 Activity and Population Growth by PCT (excludes Learning Disabilities)

Location	Activity 1999-2000 (Admissions)	% Population Growth 2000 to	Projected Activity 2010
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		<b>2010</b>	
<b>North Peterborough PCT</b>	458	0.0%	458
<b>South Peterborough PCT</b>	273	13.4%	310
<b>East Cambs and Fenland PCT</b>	67	12.9%	76
<b>Other</b>	64	5.0%	67
<b>Total</b>	862	5.8%	911

The Peterborough locality catchment population varies from inner city to dispersed rural settlements. The activity for the East Cambs and Fenland PCT only covers the part of the resident population traditionally served by Peterborough services. Services for East Cambs and Fenland are also provided by the Trust from units in both the Cambridge and Huntingdon localities, with referrals from the Wisbech area supported by the Mental Health services in Kings Lynn, operated by the West Norfolk Primary Care Trust.

Admission rates for the Greater Peterborough PCT's show a higher rate of 0.4% for the North Peterborough PCT against a rate of 3% for the South Peterborough PCT. The difference may reflect the higher levels of social deprivation in parts of the city centre that fall within the North PCT population.

An assessment of the Peterborough population based on the MINI<sup>32</sup> index identifies a requirement for 50 adult acute beds.

### 2.7.3 Benchmarked Performance Levels

The RKW analysis of the relevant activity and performance included comparisons with nationally published data. Table 8 details the current bed complement, average length of stay and occupancy for the adult and Older People's Mental Health wards using 2001-02 data.

Table 8 Bed Allocation and Performance Levels for 2001-02

<b>Ward</b>	<b>Client Group</b>	<b>Beds</b>	<b>Average Length of Stay (days)</b>	<b>Average Occupancy</b>
<b>Ward 1</b>	Older People's Functional	20	87.4	102%
<b>Dove House</b>	Older People's Organic	22	99.3	87%
<b>Ward 5</b>	Adult	30	24.8	91%
<b>Gables</b>	Adult	18	39.7	98%
<b>HDU</b>	Adult	3	24.9	94%

The current and future bed requirements for Adult and Older People's Mental Health In-patients has been assessed using four planning models:

**Base Line** - Capping ward occupancy at 85% but maintaining current length of stays.

**Best Internal Practice** - Capping ward occupancy at 85% and using best length of stay by ICD 10 grouping and consultant.

**Best External Practice** - Capping ward occupancy at 85% and using National Case Mix Office targets by ICD 10 groupings.

**Trimmed** - Capping ward occupancy at 85% and assuming all patients staying over 84 days are transferred to long stay beds elsewhere.

The results of the assessment are given in Table 9. This indicates there is scope for performance improvements in both Older People's and Adult services, however some parts of the adult service are already working above the National Case Mix Office targets.

Table 9 Current and Forecast Bed Requirements Based on Planning Models

	Current	Base line	Best Internal	Best External	Trimmed
Current requirement (2000)					
<b>OPMH</b>	42	45	36	19	28
<b>AMI</b>	50	47	36	41	40
<b>LD</b>	10	<b>10</b>	<b>10</b>	<b>10</b>	<b>10</b>
<b>Total</b>	<b>102</b>	<b>102</b>	<b>82</b>	<b>80</b>	<b>78</b>
Forecast for (2006)					
<b>OPMH</b>		26	37	20	30
<b>AMI</b>		48	36	41	42
<b>LD</b>		<b>10</b>	<b>10</b>	<b>10</b>	<b>10</b>
<b>Total</b>		<b>104</b>	<b>83</b>	<b>71</b>	<b>82</b>
Forecast for (2011)					
<b>OPMH</b>		47	38	20	30
<b>AMI</b>		50	37	43	43
<b>LD</b>		<b>10</b>	<b>10</b>	<b>10</b>	<b>10</b>
<b>Total</b>		<b>107</b>	<b>85</b>	<b>73</b>	<b>83</b>

Table 9 uses 1999/00 activity data as the base line and utilising population forecasts of the PCTs, the bed requirements for 2006 and 2011 have been calculated. These forecasts are based on:

- Ward occupancy level of 85%.
- Average population growth of 1% per annum.
- Four length of stay scenarios;
  - ◇ Current average length of stay facilitates the BASE LINE figure, which shows slight variation from the actual number of beds in situ.
  - ◇ Length of stay based on BEST INTERNAL practice. This is the number of beds required if all lengths of stay were no greater than 30 days.
  - ◇ Length of stay based on BEST EXTERNAL practice. This is calculated by examining other providers of a similar size and geographical area, utilising national statistics to provide this data. The impact of Social Services provision and investment is therefore taken into account since this has direct impact on a community service's ability to sustain individuals outside of in-patient facilities. The best external projected figures are lower than the projected requirements for this development, the present level of investment by both local Social Services departments, whilst increasing over time, still remains lower than comparable authorities. The uncertainty around significant future investment and its impact on in-patient requirements makes these figures unrealistic at this stage of the PFI process. Furthermore, the National Beds Inquiry, whilst making no specific reference to Mental Health, did recommend, in general, that no new in-patient facility should have less beds than was previously provided.
  - ◇ Current length of stay split between <84 days and => 84 days to show the potential impact separating out long-stay patients from the acute provision.

Service developments such as the Assertive Outreach Team and Extended Hours Community Team are likely to have an impact on admission rates and thus bed occupancy levels. As these teams have not been operating fully for a significant period of time it is too early to provide accurate statistics of their impact. Early experience from the Assertive Outreach service has indicated an increase in occupancy and length of stay for some service users. It would appear this is due to the new service successfully engaging a wider client base.

## 2.7.4 Other Factors

No allowance has been made for changes in medical technology or new drug treatments. The majority of future changes in the demand for inpatient services is likely to come from:

- The integration of health and social care.
- The development of new service models based on active rehabilitation.
- The continuing development of the community support infrastructure.
- The adoption of best practice models.
- Changes to the epidemiology of the local population.
- The development of an academic based service in the locality through the Chair in Community Psychiatry development.

It is assumed these changes will have the following impact on activity levels:

### **Adult Mental Health In-patients**

The development of the community infrastructure through Assertive Outreach teams and Mental Health Assessment Teams should have a positive impact on the level of admissions to in-patient beds and the length of stay, in the longer term. However, the development of community services also impacts on the client base which becomes engaged in mental health services, increasing the client base as the services become more accessible.

There is also a likely increase in demand for in-patient beds as a result of the need to provide accommodation for more individuals who are considered to be at risk or a risk. The general increase in levels of substance misuse, particularly among younger people is an example of this.

Within the Peterborough locality there is also a significant and growing population of asylum seekers. This population group, as a result of their life experiences and social deprivation and isolation suffered, tends to display a higher than average need for acute mental health services.

There is also a proposal to develop an 800 place Prison for both male and female offenders in the Peterborough locality, which is likely to impact on the local mental health services.

### **Older People's Mental Health**

The development of the community support infrastructure for these services is likely to have a positive impact on the number of admissions and the length of the inpatient stay. However, this is balanced by the rate of growth of the Older Peoples population, the risks on the availability of suitable Nursing home places, and the impact on the beds required.

### **Learning Disabilities**

This is a comparatively small service with only 10 beds and a need to maintain a minimum practical quantum. The assumption is that the level of demand for these beds will remain stable although it is recognised that the patient attributes for admissions may change over time.

These assumptions have been factored into the resource planning for the project.

## 2.8 Problems in Current Service Delivery

Section 2.5 clearly sets out the strategic background to the objectives for the development of in-patient services for acute mental health and learning disabilities in the Peterborough locality, and how these have been incorporated into the Local Delivery Plan. However, the current

accommodation configuration and the nature of the facilities being used mean many of these objectives are not, and can not be achieved. The principal service gaps are:

- Inability to fully meet gender separation requirements within existing ward environments;
- No ability to offer 'true' women only services within the in-patient environment;
- Lack of ready access to a High Dependency Unit for all Adult In-patient Services;
- 50% shortfall in available accommodation against NHS Estates Guidance;
- Lack of appropriate accommodation to allow for a full range of therapeutic services;
- None of the present facilities were designed for psychiatric care and therefore the current facilities are inappropriate for the services they now accommodate. In particular, they do not meet the safety requirements identified by the Royal College of Psychiatrists in their document 'Not Just Bricks and Mortar';
- Patients do not enjoy single room accommodation, thus removing dignity, security and privacy during their stay;
- The In-patient accommodation is split over three sites across the city, none of which are closely linked to the main District General Hospital.

These service gaps have been clearly recognised and the need to resolve them has been incorporated into Local Delivery Plans. Therefore, this project forms a coherent part of the local health strategy and is fully supported by all the local health and social care partners.

## 2.9 The Case for Change

The need to redevelop the existing in-patient services in the Peterborough locality can be justified on the basis of:

- The constraints the existing inflexible facilities make on the strategic service developments required for a modern, inclusive service.
- The 50% shortfall in available accommodation within which to deliver in-patient care.
- The unacceptable clinical risks and inability to improve clinical effectiveness.
- The increased cost of providing services which are fragmented and duplicated.
- The inadequacies of the current facilities to provide a safe caring environment.

### 2.9.1 Strategic Service Developments

Sections 2.3 to 2.5 of the OBC clearly lay out the strategic context for the project and the local service developments required in meeting these strategic goals. The Trust has also looked forward to take account of the likely changes in service demand that will stem from local population growth and the planned service developments (see Section 2.7).

Delivering the service developments and meeting the changes in demand will not be possible within the Trust's current health estate. The existing buildings would need as a minimum to be upgraded and expanded to meet the physical and operational standards expected from modern Mental Health Services. Such expansion is not possible in all locations. In addition, full integration cannot be achieved without eliminating the fragmentation of the services over three sites.

Investment in the health estate is a prerequisite to the Trust meeting its obligations and targets in the Peterborough locality. This project will deliver the investment required and ensure the strategic goals are achieved.

### 2.9.2 Clinical Quality and Risks

The In-patient facilities were designed for purposes other than acute In-patient care. It has not proven possible to eliminate all the risk areas or meet current standards for gender separation without substantial capital investment. The operation of the Care Programme Approach, within in-

patient care, as required by the NHS Plan, will be compromised by the fragmented nature of the services that result from the provision of In-patient care split across three sites.

### **2.9.3 Increased Cost**

The Trust is currently incurring increased costs due to the poor quality of some buildings, the need for staff to travel between sites and the occasional need to transfer patients between sites. This is redirecting funds away from direct patient care.

### **2.9.4 Inadequate Facilities**

Without reducing current bed capacity, or operating each facility as either a male or female only unit the Trust will not meet the targets for gender separation. The new design guidance requires all patients to be accommodated in single rooms and provided with separate facilities. This will require a significant increase in the size of the Trust's current facilities which is not feasible in the longer term.

### **2.9.5 Evidence to support the case for change**

The national frameworks, policies and guidance for mental health services outlined in section 2.2 above clearly set out the standards mental health services are expected to achieve. The inadequacies identified above provide clear evidence of the current deficit in inpatient services against the targets.

In addition the Mental Health Act Commission has raised a number of concerns relating to the present mental health facilities in their regular unannounced visits to the Trust. These include poor observation of patients on Ward 5 due to the ward layout, a lack of facilities for the relatives of terminally ill patients in Dove House and the lack of patient support facilities on Ward 1. It is envisaged that these and associated issues would be 'designed out' through this development process.

### **2.9.6 How the services will change**

The Trust and its partners have worked together to develop new service models that reflect the strategic priorities and standards contained in the NSFs and the expected changes in activity and case mix over the next ten years. They have sought evidence of best practice to ensure the service proposals are forward thinking and innovative.

The emphasis of the service will be on helping individuals to maximise their potential and return to their normal place of residence as quickly as possible. This will be facilitated by the application of socially inclusive clinical practices which will reflect the reality of the wider community. In a change of focus away from age and disease to one of clinical risk, patients will only be admitted when the risks of self-harm, harm to others, exploitation by others or poor self care are too great for them to be cared for in the community setting.

The service will provide direct access to a range of support services specifically designed to help and encourage individuals to care for themselves within the limitations of their enduring illness. The inpatient services will act as a safeguard in times of real crisis for service users and support the Assertive Outreach, Mental Health Assessment Team and Extended Hours Service which have been established to enable service users to remain within the community.

Full details of the service models and service philosophy are contained in section 3.7 and Appendix D, Clinical Output Specifications.