

Single Participant Interview Transcripts

This document should be read or used as a reference to appendix 3 and chapters 2, 8 and 9 of Plymouth's Mental Health Accommodation Strategy.

Appendix 5 contains copies of the original transcripts taken from two single participant interviews, implemented as part of a research plan designed to inform the development of the Mental Health Accommodation Strategy.

The first interview was undertaken with the Deputy Chief Executive of Plymouth's teaching Primary Care Trust who is also the Director of Operations and Director for Mental Health and Learning Disabilities. The second interview was undertaken with the Director of Nursing who is also the Deputy Director of Mental Health services.

This appendix is arranged in two parts. Part one provides copies of the original transcripts and part two is presented in the same format but coded for the purpose of assessment and analysis, which can be found in appendix 3.

Part One

Single participant interview transcript one

Interviewee: Steve White Director of Operations and Director of Mental Health

Interviews were undertaken by two facilitators, who will be identified as facilitator one and facilitator two.

Facilitator 1:

Q1 *Do you think the workforce operating across the 4 stages shown in the Accommodation Pathway will need additional training to better enable service users to move on and sustain independent living and what value might additional training have to the teaching Primary Care Trust?*

Facilitator 1: Its kind of two questions in that, I've double barrelled it because I thought that would open the interview up a bit.

Director: I think that there's another layer in this as well, work force training is one area but I also think organizationally the PCT board and senior management team need awareness training. A level of support to look at how services are changing, so partially our non executive directors, our

commissioning team and senior clinicians need a level of awareness and understanding.

If you're looking at positive risk taking and increasing the risk in a positive way, making sure people are supported in a community setting and not necessarily cared for in residential units to avoid risk, I think we've probably got to look at the organizational approach. Then we need to look at how the staff in the field are supported, risk assessments are drawn and training awareness of other agencies as well, so they can play a role in how other agency staff are trained, educated and supported.

There's a range of packages we need to make sure are in place and can deliver those packages, whether it's us or University or a combination of both, so in short yes we do need to look additional training but I think it is a multi-layered and multi-agency in its approach.

We also need to look at what government arrangements are in place to know where the responsibility lies for formulating our training package so which agencies have got the lead who provides it to our standards who credits it are the staff interchangeable in roles if you've got a support system working for a housing association have the got they similar skills to the local authority support system our support system when you look at merged roles there are a number of HR and training applications.

Facilitator 1: How would you normally apply that to say that supported housing in the voluntary sector? We give them that training could we have, would we include them, is there any way that we could draw them into that to make them part of that process?

Director: I suppose through the commissioning or contracting process, so say if we're looking for some form of accreditation of providers, or preferred providers you could well we need this range of skills and expertise and some form of accredited course. How that's provided, who it's provided by is up for debate but you could through some form of accreditation and again from a commissioning perceptive look at how the links are made across a range of providers, so we can encourage other providers and I would include PCT providers in that to work together.

Facilitator 1: Raising the standards within other sectors – rather than saying we'll work a different way just to accommodate a way of working within other service sectors, we're saying basically what skills might there be, and that way we can really look with confidence at actually moving people on from stages one, to two three and eventual independence for many.

Director: Yeah, and you have got to look at people's at the organizations and the roles within the individual stages as well, so make sure that where someone needs care at a higher level only expose that user to the service level of care at the period of time it's appropriate and then have the ability to move them on to the next tier either up or down and again and again it's

having the staff with the skills to recognize that the that person is ready to move either up or down the intensity scale.

Facilitator 1: Great

Q2 what cashable and non cashable benefits will a Crisis House have for the mental health community and Plymouth's teaching Primary Care Trust?

Facilitator 1: Now I use the term mental health community because I'm thinking obviously in the voluntary sector with all the pieces and parts that play into that rather than going into the scripted way of discussing a question, what about young people, what about older people, what about people with dual diagnosis, that's mental health and learning disability or dual diagnosis substance misuse. I'd rather say the mental health community so that's kind of encompassing all of it into that.

Director: The immediate impact for the PCT will be less patients being admitted to Glenbourne, therefore less beds being used, it cuts down on our operation costs, reduce our bed capacity in general so that would be the immediate capacity, but I think if you then look at some of the other measures we don't count, which would be difficult to count would be a swifter return to an individual's placement. Normal placement as it is, less time out of employment if they're in employment, less impact on the family, less carer's costs, swifter return to support within the community, so you don't then have the level of institutionalization, to use that phrase as someone's mind so Glenbourne, if we use Glenbourne as an example, is only used as a high intensity perhaps only people detained and to support making sure those individuals and their families stay together so the immediate cost for us at the PCT is less identifiable but if we can improve our society costs it will be less overall but perhaps less easy to measure.

Facilitator 1: So they'll be a lot of indirect benefits that will come through, savings, cashable ones and non cashable ones, benefits to carer's as you say and all those things that aren't so easy to measure much softer outcomes we could probably measure over a period of once we have it in place.

Director: Yeah, I mean whether it when you set up this particular service it could build and audit at the very beginning so if look at someone's frequency of admission to hospital over a period of the last 3 to 4 years if it's someone who's know to the service and once this service is set up the frequency of admission after that and then perhaps impact on benefits and there may be some measurable there. But nothing is as important as building some sort of evaluation at the beginning instead of what we usually do which is at the end or part way through retrospective.

Facilitator 1: OK Do you want to ask?

Facilitator 2: OK the third question is around barriers.

Q3 What barriers might prevent the accommodation pathway from working efficiently and, or effectively?

Director: Professional territories, organizational territories, public awareness, users willingness, the range of barriers potential barriers there.

Facilitator 2: Can you explain a little bit more for me what you mean by organizational territories is not a word I'm

Director: Organizational territories would be perhaps who's, when funding becomes tight arrangements, if it seems either half placements or local authority placements if partnership arrangements aren't as robust as they could be there is opportunity for individual managers to preserve their own budgets to say right we expect someone else to be accountable for this whereas if you've got a proper partnership arrangement in place certainly between the local authority and the PCT joint pooled budgets, there's less opportunity for that so if you can avoid some of the boundaries being put up to start with that avoids some of the barriers later.

Facilitator 1: And you also mention professional territories as well

Director: Yeah Health, certainly in Health circles there are occasions where the judgment of nurses, therapists, doctors will be completely consistent but there are occasions when they'll agree to differ and I suppose someone's experience and views in a particular form of care, they've used elsewhere in the country comes down ...maybe result in some resistance into implementing it so if we work with staff just within the PCT and the local Authority within the teams we're also looking at some of the professional issues. For example; approved social workers who have admission rights with facilities who haven't got admission rights what's the team approach, what's the individual approach? So there's a range of potential barriers we've got we just need to think them through, iron them out and also more importantly have a sub clause within the agreement and operational policy to say 'OK' if we come across a barrier or a difficulty this is the way of arbitration to work it through recognizing there may be occasions and situations where disagreement's may occur but then it's important to have the method of resolutions as apposed to just leaving it and saying its too difficult to do.

Facilitator 2: ok

Director: I suppose also, sorry another barrier would be the relevant funding streams we're tied to, health, local authority, supporting people, direct payments, individual budgets whatever other new government initiatives may come in and there's making sure we've got as secure funding streams tied up for these policies and that everyone knows about them so it's education I suppose is another way of getting over a barrier.

Facilitator 2: Is there anything you wanted to add?

Facilitator 1: No

Q4 how might the re-distribution of resources across the statutory and voluntary and community service sectors be used to support the implementation of the accommodation pathway?

Director: If you look in health we've got a high cost for individual placements, which the direct costs to the PCT are fairly easy to calculate but then you've got the additional cost to the community in terms of patients being separated from their families, travel costs for carer's, various other cost that we don't usually take account of so the IPP cost can be translated into budgets within the PCT, less expenditure for commissioning used to fund additional support within the community. So those are fairly easy to look at the non-expenditure either from benefits or from personal costs for families. Again these will be contained within the service so you're not spending unnecessarily on transport, out of the area accommodation for visits, whatever. I suppose the interesting part of where we go with some of the money is if you look at a pooled budget ...the... I don't think we've yet got into a situation where we can properly look at how a pooled budget is spent. If it's a significant contribution by one agency, local authority or by health can we then spend that on care which is not normally provided from other sorts of budgets, for example if we need to look at increasing the level of low intensity care by enablers or by community support workers is that something the health service has traditionally funded? Well we have to some extent but if we do need to bump that up could that be seen as a local authority contribution. But at the end of the day if it's one pot of money with an agreed way of how we split it then it shouldn't really matter providing people are getting the right support at the right stage of there care.

Facilitator 2: So am I hearing you right when really what you're saying is the setting up of establishments of that pooled budget and the governance around that money is the key to the success of?

Director: Yeah I think so, you need to identify what money is being spent across the whole of the patient pathway, which is quite a big piece of work but if you can re-direct that money and use it differently, one I think that would be a saving to the organization, patients will receive care in a more appropriate environment but while making that saving you could provide more care to a wider range of people and I know DAAT commission used to be housing a lot but certainly John has got a few ideas about how we should be looking at spending more money on health promotion preventing people getting into the services which is something we don't do an awful lot of to a certain extent. But its better to spend some of our savings on that rather than some on the direct patient care area so it's an area people are trying to pull some money out, which is just slightly different to what we do now.

Facilitator 1: So a pool budget would be an opportunity for joint commissioning eventually

Director: I think yeah pooled budget if you look at the commissioning and provision services how we spend that budget is there's got to be a clearer governance agreements in place but there has to be a clear commissioning

strategy from both the local authority as wide as you know the commissioning arrangements but also within the PCT on having commissioning services and I think if you can be there to link the two commissioning agencies or big bigger commissioning agencies together the providers certainly got to have a better understanding its just how they fit in to the overall picture.

Facilitator 1: Thanks

Single participant interview transcript two

Interviewee: Sara Mitchell Assistant Director of Operations and Director of Nursing

Interviews were undertaken by two facilitators, who will be identified as facilitator one and facilitator two.

Facilitator 1:

Q: Do you think the workforce operating across the 4 stages shown in the Accommodation Pathway will need additional training to better enable service users to move on and sustain independent living and what value might additional training have to the teaching Primary Care Trust?

Director: I think for me where the stages are quite different and the staff within each step or I guess have a different background, knowledge, experience etc; but I think what would be useful is that everybody is working towards the same principles in terms of recovery and wellbeing, and actually what that means in terms of supporting people taking it forward, encouraging people to empower themselves rather than focusing on their illness. I think generally if we have that set of principles across the four stages then for me that is the main thing and if there are any gaps in terms of mental health knowledge which I don't know if there is because I don't know some of the stages very well, but if there is then identifying what those gaps might be and what sort of training is required would be useful.

Certainly I think the first stage being is patient focussed. If I remember rightly, I think probably even there, there might be some more requirement for recovery knowledge and input and trying to work away from the models that we have used in the past which is I guess about focusing on illness and much more focusing on empowerment now, so yes I do think there is a general need for training but I always think there is general need for training whatever its in relation to, but yes I do.

How do I think it will benefit the PCT – I guess it will benefit the PCT because the prime thing in my mind having the recovery service and the accommodation strategy working together will enable our patients to work their way through a seem less service so they are actually independent so that might mean that living independently, being there's some support, no

support and I guess that benefits the PCT for one because it frees up some of our capacity and two is certainly is a great step forward in relation to IPP's and bringing IPP's back moving patients through the system and so I guess there are lots of benefits in terms of cost, progression and giving our service users what they need really, so for me it can only be positive.

Facilitator 1: Thanks, I think that covers most of Q1. I won't dwell on that so I will move onto Q2 if that is ok.

Q2: *What cashable and non cashable benefits will a Crisis House have for the mental health community and Plymouth's teaching Primary Care Trust?*

Facilitator 1: ok.

Director: I think the Crisis house is a difficult one because I think things have moved on and we are in a very different place from where we were 2 years ago and I think well I believe that this is mainly due to the input of the Home Treatment Team and now that it is City wide we don't actually have need for that patient group which probably would have fitted well into a Crisis House model, the need isn't there and I have spoken to both the Inpatient Manager and Home Treatment Manager and they have only identified from their services a possible 12 each of patients who could use a Crisis House in its truest model which only gives you 100 bed days a year which would mean our original thoughts about having a Crisis House probably isn't sustainable. So I would be quite sort of weary, I think we don't want to get ourselves into a position where we are funding a Crisis House and taking on a property where we are not utilising it really, I don't think that would be a cashable benefit. I think it would be quite the opposite really. That said I do think there is a need to provide some type of accommodation for those patients of perhaps slightly wider remit that are experiencing perhaps a broader type of crisis than we originally looked at. I think that would require a different type of staffing model and we would have to go back revisit that model. So cashable benefits, I mean I think once again it's about capacity in demand it's about having the crisis house will prevent those patients that may once have been admitted to Glenbourne being admitted there.

That doesn't need to happen if they don't necessarily need to be tied into the crisis team then that frees up the crisis team, I think there are cross benefits I just have a big question mark for me over the utilisation of it really because we could be paying out costs that we don't need because there might be a much cheaper way of actually setting up a crisis house.

But I do think it is essential to have some beds whatever they look like.

Facilitator 2: Do you think with the increasing focus on the IPP patients and bringing them back into Plymouth might increase the demand for crisis?

Director: No not really, not personally, no. I see the majority of the IPP's coming back to Glenbourne and the Edgcumbe route and I think that

depending on the patient group and I think that what we have already said is that we wouldn't particularly want to use Crisis House as a step down from Glenbourne but there will be the exceptional case but generally speaking it rules out Glenbourne and I think they would be very keen to actually training up staff at Edgcombe to deal with a more difficult group of patients that will be coming back from IPP's placements and I would really question that that group is probably going to be a little bit too challenging for Support Time and Recovery workers to work with, which it will probably be the staffing compliment of the Crisis House.

Facilitator 1: To take this point a bit further, its really the space created at the existing rehabilitation units by the people moving into the community, would they benefit from, because they will be new to the community having been in rehabilitation units or residential for quite some time and coming into the community would they then benefit as a result. Because they are obviously moving on to make space so that IPP's can return.

Director 2: Possibly, but I think we would want to get away from that model of moving people who are trying to become independent and then putting them back into a crisis accommodation. I mean that model might work because I guess the remit is going to be short, sharp and snappy so if we were saying sort of 4-5 days stay those people and there says a remit that we could possibly use it, but I personally would be much more keen to boost up their support in the community rather than putting them back into the Crisis House really.

Q3 What barriers might prevent the accommodation pathway from working efficiently and, or effectively?

Director: Lack of knowledge, lack of sign-up from teams that I think not being aware of what's in existence. I think not having the right people in post to actually push that through. Not staffing the accommodation areas correctly, not having that working relationship between the PCT and other sectors and the areas you work in, I think the lack of funding possibly, I think the funding for me is still a big issue and I know last week '.....' was saying that you know where they were experiencing problems, that in her view that all the funding went to the PCT and none to the other sectors, who got very little funding and I guess that's something else we need to look at.

I think unrealistic expectations; I think it's expecting other sectors and not the right ones necessarily to take the more difficult challenging patients. So I think we need to get that right. I think we need to really sort of closely define which stage is relevant for the right type of patient and the right accommodation that sits there really because obviously different patients have different needs. I think also the communication issue is going to be really important in this because there is no point in the voluntary sector thinking they are going to get lots of support from the PCT when actually they don't or vice versa and I guess as long as we communicate then most of those things can be overcome.

I think it is about knowledge and it's about getting sign up from people and people knowing exactly what's available from different patients really.

Facilitator 1: Would you consider risk to be a barrier?

Director: yes I think so, but that for me would be incorporated into getting the accommodation right for the right patient really. All staff involved across the board to actually be aware of the risks that it involved in each stage that really sort of closely defining that.

I think risk is always an issue but you never know, you can only go on the information you have from somebody's history and how they present now. I certainly don't think that should be a barrier if it is managed properly, but risk can always be an issue whether its inpatient services or outpatients services.

Facilitator 1: With effective communication you can negate someone at risk by managing it effectively.

Director: Well I think you can, yes. I think you probably need to be much more creative so you need to get sort of a seamless working from Assertive Outreach Service from the Primary Care Liaison Teams from the Home Treatment Team, into those services which probably may not be staffed with trained staff in the way that other teams are. I think with effective communication, it should overcome those things really.

Q4 How might the re-distribution of resources across the statutory and voluntary and community service sectors be used to support the implementation of the accommodation pathway?

Director: Have we got any re-distribution of services. I guess we are playing at what we got really. I think that is about having an understanding of what all of those stages involve really. Looking at it once again I think that is about communication, getting the right people involved at the right time, looking at what resources are going into those services, do they need reallocation, should we be going back to the commissioners, are they equitable, it might be that they are not equitable but they are right for those services but also it might be that they are right for those services and I think the more demands the PCT puts on voluntary organisations and there has to be some input of funding, be it staff, be it monies, be it whatever, but I think we need to look closely at realistic expectations and if we are asking particularly the voluntary sectors to take on more difficult challenging patients then there needs to be that input there really.

I don't think there is a black and white answer, I don't think you can re-distribute what you have got because I think you probably need to closely analyse those services to see what they have, and I don't know off the top of my head what they all have.

I think it is about being equitable and having what's required really, and as I say if the PCT is asking for more support, input, beds, and then we somehow

commission that effectively. I don't think the implementation of the accommodation pathway should be that difficult, as long as what we have covered in the previous questions is done really.

I think everybody would be fully supportive of an accommodation pathway particularly with changes in Mental Health, but it is the same with anything, its having the right things behind it and the right systems to actually make it work.

Facilitator 1: So just drawing the question together really, in summery it's about pulling resources together so they are mutually beneficial.

Director: Yes absolutely.

Facilitator 1: So the voluntary sector can come in and align much more closely with what it actual needs and vice versa in terms of support.

Director: And that I guess is a money support, it's a staff support, it might be a knowledge support, it's a number of things really. Yea that's what I would say.

Facilitator 1 & 2: thanks

Part Two

Single Participant interview transcript one – coded

One: Training

I think that there's another layer in this as well, work force training is one area but I also think organizationally the PCT board and senior management team need awareness training. (1A)

A level of support to look at how services are changing, so partially our non executive directors, our commissioning team and senior clinicians need a level of awareness and understanding. (1A)

If you're looking at positive risk taking and increasing the risk in a positive way, making sure people are supported in a community setting and not necessarily cared for in residential units to avoid risk, I think we've probably got to look at the organizational approach. (1B)

Then we need to look at how the staff in the field are supported, risk assessments are drawn and training awareness of other agencies as well, so they can play a role in how other agency staff are trained, educated and supported. (1C)

There's a range of packages we need to make sure are in place and can delivery those packages, whether it's us or University or a combination of both, so in short yes we do need to look additional training but I think it is a multi-layered and multi-agency in its approach. (1C)

I suppose through the commissioning or contracting process, so say if we're looking for some form of accreditation of providers, or preferred providers you could well we need this range of skills and expertise and some form of accredited course. How that's provided, who it's provided by is up for debate but you could through some form of accreditation and again from a commissioning perceptive look at how the links are made across a range of providers, so we can encourage other providers and I would include PCT providers in that to work together. (1C)

Yeah, and you have got to look at people's at the organizations and the roles within the individual stages as well, so make sure that where someone needs care at a higher level only expose that user to the service level of care at the period of time it's appropriate and then have the ability to move them on to the next tier either up or down and again and again it's having the staff with the skills to recognize that the that person is ready to move either up or down the intensity scale. (1C)

We also need to look at what government arrangements are in place to know where the responsibility lies for formulating our training package so which agencies have got the lead who provides it to our standards who credits it are the staff interchangeable in roles if you've got a support system working for a housing association have the got they similar skills to the local authority support system our support system when you look at merged roles there are a number of HR and training applications. (1D)

Two: Crisis House

The immediate impact for the PCT will be less patients being admitted to Glenbourne, therefore less beds being used, it cuts down on our operation costs, reduce our bed capacity in general so that would be the immediate capacity, ...(2A)

Yeah, I mean whether it when you set up this particular service it could build and audit at the very beginning so if look at someone's frequency of admission to hospital over a period of the last 3 to 4 years if it's someone who's know to the service and once this service is set up the frequency of admission after that and then perhaps impact on benefits and there may be some measurable there. (2A)

...but I think if you then look at some of the other measures we don't count, which would be difficult to count would be a swifter return to an individual's placement. (2B)

Normal placement as it is, less time out of employment if they're in employment, less impact on the family, less carer's costs, swifter return to support within the community, so you don't then have the level of institutionalization, to use that phrase as someone's mind so Glenbourne, if we use Glenbourne as an example, is only used as a high intensity perhaps only people detained and to support making sure those individuals and their families stay together so the immediate cost for us at the PCT is less identifiable but if we can improve our society costs it will be less overall but perhaps less easy to measure. (2B)

But nothing is as important as building some sort of evaluation at the beginning instead of what we usually do which is at the end or part way through retrospective. (2C)

Three: Barriers

Professional territories, organizational territories, public awareness, user's willingness, the range of barriers potential barriers there. (3A)

Yeah Health, certainly in Health circles there are occasions where the judgment of nurses, therapists, doctors will be completely consistent but there are occasions when they'll agree to differ and I suppose someone's experience and views in a particular form of care, they've used elsewhere in the country comes down ...maybe result in some resistance into implementing

it so if we work with staff just within the PCT and the local Authority within the teams we're also looking at some of the professional issues. For example; approved social workers who have admission rights with facilities who haven't got admission rights what's the team approach, what's the individual approach? So there's a range of potential barriers we've got we just need to think them through, iron them out and also more importantly have a sub clause within the agreement and operational policy to say 'OK' if we come across a barrier or a difficulty this is the way of arbitration to work it through recognizing there may be occasions and situations where disagreement's may occur but then it's important to have the method of resolutions as opposed to just leaving it and saying its too difficult to do. (3A)

Organizational territories would be perhaps who's, when funding becomes tight arrangements, if it seems either half placements or local authority placements if partnership arrangements aren't as robust as they could be there is opportunity for individual managers to preserve their own budgets to say right we expect someone else to be accountable for this whereas if you've got a proper partnership arrangement in place certainly between the local authority and the PCT joint pooled budgets, there's less opportunity for that so if you can avoid some of the boundaries being put up to start with that avoids some of the barriers later. (3B)

I suppose also, sorry another barrier would be the relevant funding streams we're tied to, health, local authority, supporting people, direct payments, individual budgets whatever other new government initiatives may come in and there's making sure we've got as secure funding streams tied up for these policies and that everyone knows about them so it's education I suppose is another way of getting over a barrier. (3B)

Four: Support

If you look in health we've got a high cost for individual placements, which the direct costs to the PCT are fairly easy to calculate but then you've got the additional cost to the community in terms of patients being separated from their families, travel costs for carer's, various other cost that we don't usually take account of so the IPP cost can be translated into budgets within the PCT, less expenditure for commissioning used to fund additional support within the community. (4A)

So those are fairly easy to look at the non-expenditure either from benefits or from personal costs for families. Again these will be contained within the service so you're not spending unnecessarily on transport, out of the area accommodation for visits, whatever. I suppose the interesting part of where we go with some of the money is if you look at a pooled budget ...the... I don't think we've yet got into a situation where we can properly look at how a pooled budget is spent. If it's a significant contribution by one agency, local authority or by health can we then spend that on care which is not normally provided from other sorts of budgets, for example if we need to look at increasing the level of low intensity care by enablers or by community support

workers is that something the health service has traditionally funded? Well we have to some extent but if we do need to bump that up could that be seen as a local authority contribution. But at the end of the day if it's one pot of money with an agreed way of how we split it then it shouldn't really matter providing people are getting the right support at the right stage of their care. (4B)

I think yeah pooled budget if you look at the commissioning and provision services how we spend that budget is there's got to be a clearer governance agreements in place but there has to be a clear commissioning strategy from both the local authority as wide as you know the commissioning arrangements but also within the PCT on having commissioning services and I think if you can be there to link the two commissioning agencies or big bigger commissioning agencies together the providers certainly got to have a better understanding its just how they fit in to the overall picture. (4B)

Yeah I think so, you need to identify what money is being spent across the whole of the patient pathway, which is quite a big piece of work but if you can re-direct that money and use it differently, one I think that would be a saving to the organization, patients will receive care in a more appropriate environment but while making that saving you could provide more care to a wider range of people and I know DAAT commission used to be housing a lot but certainly John has got a few ideas about how we should be looking at spending more money on health promotion preventing people getting into the services which is something we don't do an awful lot of to a certain extent. But its better to spend some of our savings on that rather than some on the direct patient care area so it's an area people are trying to pull some money out, which is just slightly different to what we do now. (4C)

Single Participant interview transcript two – coded

One: Training

I think for me where the stages are quite different and the staff within each step or I guess have a different background, knowledge, experience etc; but I think what would be useful is that everybody is working towards the same principles in terms of recovery and wellbeing, and actually what that means in terms of supporting people taking it forward, encouraging people to empower themselves rather than focusing on their illness. (1C)

Certainly I think the first stage being is patient focussed. If I remember rightly, I think probably even there, there might be some more requirement for recovery knowledge and input and trying to work away from the models that we have used in the past which is I guess about focusing on illness and much more focusing on empowerment now, so yes I do think there is a general need for training but I always think there is general need for training whatever its in relation to, but yes I do. (1C)

How do I think it will benefit the PCT – I guess it will benefit the PCT because the prime thing in my mind having the recovery service and the accommodation strategy working together will enable our patients to work their way through a seem less service so they are actually independent so that might mean that living independently, being there's some support, no support and I guess that benefits the PCT for one because it frees up some of our capacity and two is certainly is a great step forward in relation to IPP's and bringing IPP's back moving patients through the system and so I guess there are lots of benefits in terms of cost, progression and giving our service users what they need really, so for me it can only be positive. (1C)

I think generally if we have that set of principles across the four stages then for me that is the main thing and if there are any gaps in terms of mental health knowledge which I don't know if there is because I don't know some of the stages very well, but if there is then identifying what those gaps might be and what sort of training is required would be useful. (1D)

Two: Crisis House

But I do think it is essential to have some beds whatever they look like. (2A)

I think the Crisis house is a difficult one because I think things have moved on and we are in a very different place from where we were 2 years ago and I think well I believe that this is mainly due to the input of the Home Treatment Team and now that it is City wide we don't actually have need for that patient group which probably would have fitted well into a Crisis House model, the need isn't there and I have spoken to both the Inpatient Manager and Home Treatment Manager and they have only identified from their services a possible 12 each of patients who could use a Crisis House in its truest model which only gives you 100 bed days a year which would mean our original thoughts about having a Crisis House probably isn't sustainable. So I would be quite sort of weary, I think we don't want to get ourselves into a position where we are funding a Crisis House and taking on a property where we are not utilising it really, I don't think that would be a cashable benefit. I think it would be quite the opposite really. That said I do think there is a need to provide some type of accommodation for those patients of perhaps slightly wider remit that are experiencing perhaps a broader type of crisis than we originally looked at. I think that would require a different type of staffing model and we would have to go back revisit that model. So cashable benefits, I mean I think once again it's about capacity in demand it's about having the crisis house will prevent those patients that may once have been admitted to Glenbourne being admitted there. (2B)

That doesn't need to happen if they don't necessarily need to be tied into the crisis team then that frees up the crisis team, I think there are cross benefits I just have a big question mark for me over the utilisation of it really because we could be paying out costs that we don't need because there might be a much cheaper way of actually setting up a crisis house. (2B)

No not really, not personally, no. I see the majority of the IPP's coming back to Glenbourne and the Edgumbe route and I think that depending on the patient group and I think that what we have already said is that we wouldn't particularly want to use Crisis House as a step down from Glenbourne but there will be the exceptional case but generally speaking it rules out Glenbourne and I think they would be very keen to actually training up staff at Edgumbe to deal with a more difficult group of patients that will be coming back from IPP's placements and I would really question that that group is probably going to be a little bit too challenging for Support Time and Recovery workers to work with, which it will probably be the staffing compliment of the Crisis House. (2C)

Three: Barriers

Lack of knowledge, lack of sign-up from teams that I think not being aware of what's in existence. I think not having the right people in post to actually push that through. Not staffing the accommodation areas correctly, not having that working relationship between the PCT and other sectors and the areas you work in, I think the lack of funding possibly, I think the funding for me is still a big issue and I know last week '.....' was saying that you know where they were experiencing problems, that in her view that all the funding went to the PCT and none to the other sectors, who got very little funding and I guess that's something else we need to look at. (3A)

I think unrealistic expectations; I think it's expecting other sectors and not the right ones necessarily to take the more difficult challenging patients. So I think we need to get that right. I think we need to really sort of closely define which stage is relevant for the right type of patient and the right accommodation that sits there really because obviously different patients have different needs. I think also the communication issue is going to be really important in this because there is no point in the voluntary sector thinking they are going to get lots of support from the PCT when actually they don't or vice versa and I guess as long as we communicate then most of those things can be overcome. (3A)

Well I think you can, yes. I think you probably need to be much more creative so you need to get sort of a seamless working from Assertive Outreach Service from the Primary Care Liaison Teams from the Home Treatment Team, into those services which probably may not be staffed with trained staff in the way that other teams are. I think with effective communication, it should overcome those things really. (3B)

I think it is about knowledge and it's about getting sign up from people and people knowing exactly what's available from different patients really. (3C)

yes I think so, but that for me would be incorporated into getting the accommodation right for the right patient really. All staff involved across the board to actually be aware of the risks that it involved in each stage that really sort of closely defining that. (3C)

I think risk is always an issue but you never know, you can only go on the information you have from somebody's history and how they present now. I certainly don't think that should be a barrier if it is managed properly, but risk can always be an issue whether its inpatient services or outpatients services. (3C)

Four: Support

Have we got any re-distribution of services. I guess we are playing at what we got really. I think that is about having an understanding of what all of those stages involve really. Looking at it once again I think that is about communication, getting the right people involved at the right time, looking at what resources are going into those services, do they need reallocation, should we be going back to the commissioners, are they equitable, it might be that they are not equitable but they are right for those services but also it might be that they are right for those services and I think the more demands the PCT puts on voluntary organisations and there has to be some input of funding, be it staff, be it monies, be it whatever, but I think we need to look closely at realistic expectations and if we are asking particularly the voluntary sectors to take on more difficult challenging patients then there needs to be that input there really. (4A)

I think everybody would be fully supportive of an accommodation pathway particularly with changes in Mental Health, but it is the same with anything, its having the right things behind it and the right systems to actually make it work. (4B)

I don't think there is a black and white answer, I don't think you can re-distribute what you have got because I think you probably need to closely analyse those services to see what they have, and I don't know off the top of my head what they all have. (4C)

I think it is about being equitable and having what's required really, and as I say if the PCT is asking for more support, input, beds, and then we somehow commission that effectively. I don't think the implementation of the accommodation pathway should be that difficult, as long as what we have covered in the previous questions is done really. (4C)

And that I guess is a money support, it's a staff support, it might be a knowledge support, it's a number of things really. Yea that's what I would say. (4C)

- **Implications arising from the research**
- **Other themes**
- **Positive**
- **Negative**

Possibly, but I think we would want to get away from that model of moving people who are trying to become independent and then putting them back into

a crisis accommodation. I mean that model might work because I guess the remit is going to be short, sharp and snappy so if we were saying sort of 4-5 days stay those people and there says a remit that we could possibly use it, but I personally would be much more keen to boost up their support in the community rather than putting them back into the Crisis House really.