Cardigan Community Resource Centre

Model of Care

1. Purpose

The purpose of this paper is to set out the proposed model of care in the new Community Resource Centre in Cardigan and to consider the changes in staffing that will be necessary. This will be an evolving and developing model, which will be shaped by the emerging clinical framework for Hywel Dda Health Board and the emerging models of social care in the three unitary authorities of Carmarthenshire, Ceredigion and Pembrokeshire.

2. Context for Change

The current system of health and social care is fragmented and disjointed from a service user and professional perspective in the Cardigan area. Primary, community and social care services in Cardigan are currently provided by separate teams employed by different organisations, based in three different counties, in buildings which are not fit for purpose, using separate information systems, different referral and assessment criteria and with a variety of contact points.

A new approach to service delivery is needed, to achieve greater independence and better outcomes for individuals and to improve the environment for staff and service users.

3. Proposed Model of Care

The aim of the proposed service model is to achieve and sustain the greatest degree of independence for people living in and around Cardigan, by providing services which are flexible and responsive to needs.

The model of care will be based on the principles of the Three Counties Community Services work stream, 'Supporting People in our Communities', which aims to establish a single point of contact, introduce a unified assessment process and implement a chronic conditions service across the local health and social care communities.

In Cardigan, this will be achieved by:

- The establishment of a Community Resource Team in the Cardigan area, by bringing together those staff already working in the community into a coherent team to
    - Support primary care in improving outcomes for patients with complex needs and
    - Positively impact on the delivery of scheduled and unscheduled care as well as improving the patient experience.
- The development of a Community Resource Centre, which will act as a resource and communications hub at the centre of the community. This will support Hywel Dda's service redesign proposals for acute services, which will:
    - Reduce unnecessary demand on general hospital services and
    - Address access and equity issues by the provision of a better balance of services more locally.
- The introduction of a single point of contact for service users.
- The full implementation of the Unified Assessment Process (UAP).
- The extension of services 24/7, including a rapid response service.
- The development of admission avoidance schemes and supportive discharge schemes

- Inpatient beds for slow stream rehabilitation (step-up/step-down), palliative care, respite (for those who meet the NHS respite criteria) and continuing care assessment
- Medicines management provision
- Pre-assessment clinics
- The provision of Telemedicine systems to provide remote access to specialist advice and diagnostic test results.
- The development of Assistive Technology to support people in living independently at home.
- The implementation of integrated IT systems across primary, community and social care with access for all staff.
- The appointment of lead GPs for chronic conditions management to shift the focus towards active management of high risk groups.
- The engagement of all parties (including clients/citizens/patients/carers) in the self-management of their care and the planning of services.
- A focus on prevention of ill health and promotion of health and wellbeing
- The adoption of solutions that will be appropriate and effective in a rural area.
- The introduction of training packages that will support new roles for generalists and specialists.
- The rebalancing of the system away from institutional forms of care.
- The pooling of budgets and resources across organisational boundaries.

Cardigan Community Resource Centre will be the catalyst to bring services together and enrich the way in which staff members work together. It will provide the opportunity to create a future system of care that is seamless, with integrated service provision across geographical and organisational boundaries.

4. Core Services

Core services will include:

- GP Practice (Cardigan Health Centre GP Practice)
- GP Out of Hours service (currently based in Llandysul)
- Primary and secondary prevention services
- Specialist outreach
- Base for Community Resource Teams
- Rehabilitation Day Unit
- Reablement and rapid response
- Minor Injury Unit
- X-Ray
- Outpatient facilities for pre-assessment and outpatient consultations by visiting Consultants, Specialist Nurses/Therapists and Social Workers
- Inpatient facilities for short stay assessment, management of exacerbation of long-term/chronic conditions, rehabilitation, respite, palliative care and end of life care.

The new Centre will be the base for the Community Resource Team in the Cardigan area and will provide a service in south Ceredigion, north Pembrokeshire and along the Teifi Valley into Carmarthenshire.

The Community Resource Team will provide the following:

- Single point of contact
- Unified assessment
- Rapid response/crisis intervention
- Specialist outreach
- Chronic conditions management
- Rehabilitation
- Management of continuing care packages
- Effective discharge planning

An integrated workforce plan will be developed, supported by a competency based training programme, which will result in more generic workers supporting specialist staff.

5. Primary Care

5.1 General Medical Services

The Cardigan GP Practice will be based in the new Centre and will provide primary care services to the practice population. Current Practice-based staff are as follows:

Staff	Number	WTE
GPs	5	4.75
Practice Nurses	5	2.63
Health Care Assistant/ Phlebotomist	1	0.61
Practice Manager	1	0.91
Assistant Practice Manager	1	0.81
IT Manager	1	0.81
Receptionists	5	2.84
Secretarial/admin	5	2.28
Prescribing Clerk	1	0.88
Total	**25**	**16.52**

The practice is accredited to undertake minor ops and is also intending to apply for training status.

5.2 Chronic Conditions Management

Within Hywel Dda, a Chronic Conditions model of care has been proposed by the Associate Medical Director for Primary Care in association with the Associate Medical Director for Community Care. There are many different levels to the model that will link primary to secondary care, health to social care, be provided in individuals' homes, GP surgeries, community hospitals, day centres and leisure centres. The following is an overview of how the model will look from a health perspective.

5.2.1 Networked Primary Care

GP practices are beginning to align themselves in natural networks. These are:

- Carmarthenshire
  - Amman/Gwendraeth Valley
  - Carmarthen
  - Llanelli
- Ceredigion
  - North Ceredigion
  - South Ceredigion
- Pembrokeshire
  - North Pembrokeshire
  - South Pembrokeshire

A lead GP has been appointed in each of these networks to take the lead on chronic conditions management. These GPs will work with colleagues in primary care to offer expert advice and drive forward strategic changes in the delivery of services for people with chronic conditions. They will form a link with secondary care and social care colleagues and be instrumental in the development of multi-disciplinary team working within the community. They will be supported by care co-ordinators who will provide population based information on needs and provide senior managerial support for the delivery of integrated health and social care. They will also work with community pharmacists to improve medicines management of people with chronic conditions.

5.2.2 Community Resource Team

Within each networked practice area a number of smaller localities will be identified which are likely to vary from 5-8 per county. These will be based around smaller clusters of GP practices within natural geographies. Within each of these localities a core multi-agency health and social care team will be developed using the existing health and social care staff. This will be achieved by building sustainable core services rather than by establishing new teams. These teams will provide a generic approach to the management of chronic conditions and develop the generic worker role who will work at a support worker/healthcare assistant level across health and social care.

Team members will need skills assessment and training within the community so that they are able to manage more complex needs in conjunction with the GP without the need to refer to the disease specific services.

A rapid response service is being estabished so that conditions can be managed within the community without needing acute hospital admission e.g. cellullitis, bronchiectasis etc. As part of the development of community services in Ceredigion, plans are in place to establish a rapid response/admission avoidance team, which will be attached to the Reablement Services, working closely with District Nursing.

5.2.3 Provision of 24 hour care for people with chronic conditions

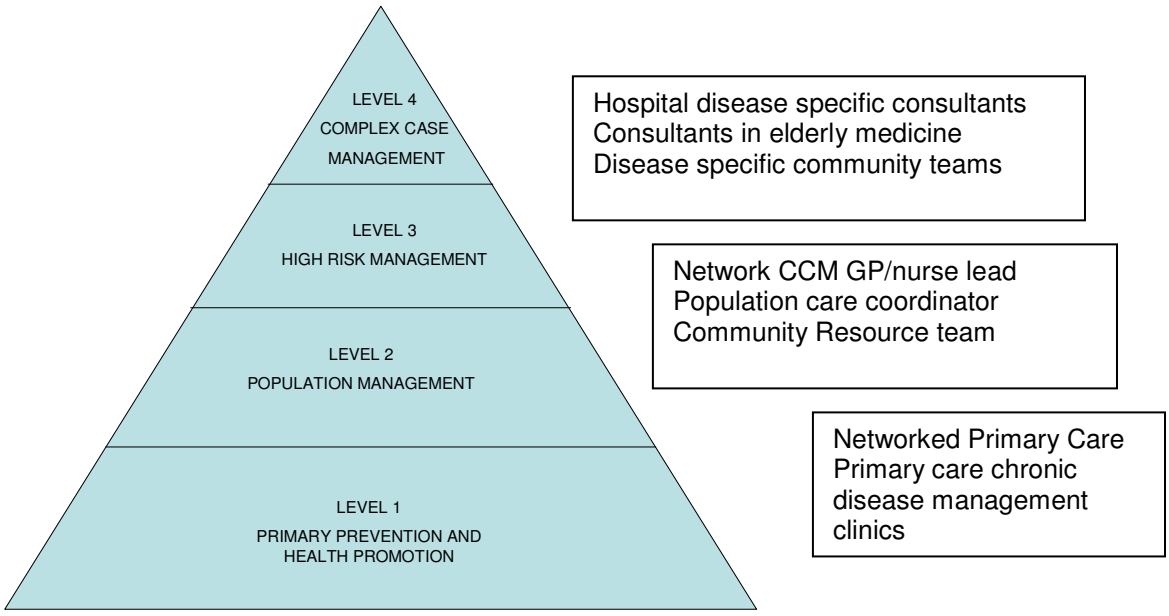
There will be times however when individuals need twenty-four hour support because of a deterioration in their health which is not serious enough to require acute hospital admission. This 24 hour support will be made available through the implementation of the Unscheduled Care Action Plan in Ceredigion and the development of an integrated Hywel Dda 'Out of Hours' service.

5.2.4 Disease specific services

There are a number of disease specific services that are run by the Local Health Boards and Hywel Dda NHS Trust e.g. cardiac rehabilitation, heart failure clinics, diabetic clinics, COPD services, falls service etc. These services will dovetail into the Community Resource team providing expert advice and knowledge when required and forming the links between individual disease specific consultants and the community.

5.2.5 How does this fit in with the Wales 4 tier Chronic Conditions Management model?

The services previously described will be expected to provide care at the following levels.



In the further development of the model, access to services will be simplified and co-ordinated, with a single assessment process in place to maximise the sharing of information and to reduce the need for duplication.

6. Base for Community Resource Team

A base will be provided for the primary care and community staff currently working at Cardigan Hospital and Cardigan Health Centre, together with the Ceredigion Social Services Adult Team, the Reablement Service and Rapid Response team. This will support the development of closer working relationships, in line with the Ceredigion Community Services Change Programme. Staff groups are as follows:

- GP Practice staff
- Home Care Team
- Social Services Adult Team
- Reablement Team/Rapid Response Team
- Health Visitors
- School Nurses
- District Nurses
- Macmillan Nurse
- Midwives
- Community Psychiatric Nurses
- Physiotherapy
- Occupational Therapy
- Speech and Language Therapy
- Podiatry
- Dietetics
- General Office
- Ward staff
- Community Resource Team Manager/Centre Manager

Clinical staff will draw upon the expertise of medical staff, specialist nurses, therapists, social workers and mental health teams when required.

Case management will be provided by the Social Services Adult Services Team who will be relocating to the new Centre and also by Community Nurses. There will be close links with the

Home Care Team, Care Assessors and Reablement staff to provide a continuum of care between the Centre and the community, providing an in-reach/out-reach service.

There will be opportunities to change the profile of community based services by multi-skilling staff and releasing resources into rehabilitation services.

7. Rehabilitation Service

The new model of care will place an increased emphasis on rehabilitation and purpose built facilities will be provided to promote independence. This will be an integrated department, including Physiotherapy, Occupational Therapy, Speech and Language Therapy, Dementia Service and the Integrated Independence Service, which is being established to provide a rapid response and reablement service in Ceredigion (see below). The aim of this department will be to avoid an increasing dependency on long term care provision, hospital admissions and long term residential care.

8. Integrated Independence Service – Rapid Response and Reablement

The Integrated Independence Service will be made up of health, social care and voluntary sector staff, working with GPs to identify people at risk of loss of independence or unnecessary admission to hospital and will work together to help prevent people falling into crisis. The service will be developed as an arm of the Reablement Service with the brief to respond within a short time for a limited period to facilitate earlier discharge from hospital and prevent inappropriate admissions, where a support package in the community can be provided at very short notice. This will rely upon a new approach in relationships and working practice with district nurses who will provide an assessment, care planning and case management role, having direct access to the Integrated Independence Team, utilising generic care assistants to support a time limited intervention. This will extend the amount of nursing support available outside of existing core hours. Social Care Professionals will also be able to access the service when individuals are identified as needing rapid social care, for example support out of hours or carer breakdown. Emphasis will be placed on preventative services, such as falls prevention and co-ordinating well-being activities.

The service will be available between 7am and 10pm, 7 days a week.

The service will also have access to 2 beds within the residential setting for a period not in excess of 5 working days to allow for assessment and development of an appropriate health or social care package to maintain people within their home environment. This will be in addition to the existing five ‘Joint Care’ beds in Ceredigion.

There will also be the opportunity to develop joint services and to improve cross border provision between Carmarthenshire, Ceredigion and Pembrokeshire.

In 2009/10, the opportunity for developing a shared IT system and developing a single assessment record will be taken forward. Another development is to expand the Assistive Technology Service in Ceredigion and increase the first response service. This project has been successful in developing relationships with the Ambulance service and opportunities to link both service developments will be explored.

Year two will provide the opportunity to begin to align other core services within health and social care to develop and support this model. Some examples of initiatives to support this include:

- Placing, on a rotational basis existing core staff; for example Assessor Care Managers, Community Care Assistants, Community Occupational Therapists and Assistive Technology Staff within this new Independence Service.
- Creating an integrated therapy service across community and secondary care.
- Ensuring that the voluntary sector services are recognised, utilised and supported to provide a broader range of integrated care in the community.
- Establishing formal links with GP practices to identify people at risk of loss of independence as part of Chronic Conditions Management.

- Identifying and agreeing a revised Integrated Structure that will support the creation of Multi-agency Teams.

A review of the existing service model for Older People in Social Services has recommended that consideration be given to developing an intake model, where all individuals requesting Social Services input are offered an initial assessment, which will be a functional assessment of their need for services. There is potential to re-align existing Social Work Teams and the Community Occupational Therapy Team to distinguish their role as being initial assessment and short term care, or longer term care. This will require re-structuring in Social Services and discussions are ongoing around the relevant changes required. The Integrated Independence service supports this direction and there will be an opportunity to pilot new ways of working in Social Services by the rotational placement of relevant staff as outlined above.

9. Dementia Care

Services for people with dementia will be based on the model of dementia care that is to be piloted in Ceredigion. Specialist input will be provided by the mental health team to support ward and community staff in caring for patients with dementia and there will be a shared responsibility across health and social care. The aim will be to delay the onset of symptoms and offset continuing care needs. Specialist day care facilities are provided in Aberystwyth and it is planned that a satellite therapeutic day service will be established in Cardigan to address the predicted growth in dementia in the older population.

10. Minor Injury Service

The Minor Injury Unit (MIU) will offer a nurse-led, walk-in service, with telemedicine links to Accident and Emergency to obtain a senior medical opinion or to discuss treatment options.

The MIU will be staffed by qualified Nurse Practitioners who have been trained to deal with minor injuries. Patient Group Directives (PGDs) are in place to enable the Nurse Practitioners to use and dispense agreed medications. Prescriptions can also be obtained from the Accident and Emergency Departments in the Trust's acute hospitals if required.

Two separate examination/treatment rooms will be provided plus a children's treatment room, with computer network points in each for remote consultation using videoconferencing.

11. Xray Department

A 9am-5pm Monday to Friday service will be provided within the Xray department. Referrals will be accepted from GP Practices, Minor Injury Unit and Outpatient Department. Ultrasound will also be available on site. Digital imaging equipment will be available with reporting undertaken remotely, linked to the PACS system.

12. Outpatient Department

The Outpatient Department will be designed to support the full range of Outpatient services that will be delivered from the new Centre. The space requirements for outpatient activity is expected to increase to enable the service to meet waiting times targets. It is proposed that all clinic rooms should be designed as combined consulting/examination rooms to ensure the greatest degree of flexibility.

The current allocation of visiting Consultant clinic sessions is shown in Annex 1. In addition, space will need to be allocated within Outpatients for the following services/clinics that currently take place in the Health Centre (see Annex 2):

- Family Planning & GUM Clinics
- Community Dental Service
- Child Health Services
- Mental Health Services for Children

- Mental Health Services - Adults and EMI
- Primary Care Mental Health Team
- Drug Abuse Workers and Alcohol Advice Teams e.g. PRISM
- Podiatry and Orthotic services
- Voluntary Counselling services - CRUSE

13. Inpatient Beds

13.1 Number of beds

It is proposed that there will be 25 inpatient beds in the new facility in Cardigan, two of which will be for Palliative Care. This is based on a capacity modelling exercise undertaken by Tribal Consulting, which has confirmed that there will be an increase in the number of community hospital beds required unless certain factors are addressed, including the strengthening of community and social care services to reduce admissions and by efficiency measures such as reducing length of stay and increasing throughput.

The inpatient beds will be on one floor and there will be 60% single rooms with en suite facilities for infection control purposes, based on Health Building Note Guidance and Health Technical Memoranda, (HBNs and HTMs). A rehabilitation area and assessment kitchen will be provided adjacent to the ward area for assessment, treatment and therapy.

It is envisaged that bed occupancy levels and throughput will increase in the new facility, with the requirement for higher levels of monitoring and intervention.

The new admission arrangements will:

- Maximise nurse-led services
- Minimise acute hospital length of stay
- Improve access and equity

13.2 Designation of Beds and Medical Input

The designation of the inpatient beds will be flexible, as it is anticipated that they will be utilised for slow stream rehabilitation (step-up/step-down), palliative care, respite (for those who meet the NHS respite criteria) and continuing care assessment. GPs will undertake ward rounds on a regular basis and will directly participate in multi-disciplinary meetings. Leadership and specialist advice will be available from the Associate Medical Director for Community Services.

Palliative care patients admitted to the new Centre will receive specialist medical input from a Palliative Care Consultant on a weekly basis and specialist nursing input from the Macmillan Nurse, based on the recommendations of the Sugar Report.

13.3 Criteria for admission

Admission to a community hospital bed will be for a period of treatment, multi-disciplinary assessment, rehabilitation or palliative care for patients whose condition does not require the resources of an acute hospital. These are patients with complex health care needs with a high level of physical dependency requiring 24 hour care, whose care needs are beyond the capacity of the traditional primary care team to provide that care in any other setting.

Patients will be accepted as transfers from acute hospitals or as direct admissions from GPs, community nurses or social services staff. Each individual's needs must be assessed prior to admission by the medical practitioner and lead nurse on duty in the ward. An assessment visit may be undertaken by nursing staff prior to transfer to assess the individual's suitability.

Admission will fall into the following categories:-

GP Medicine – individuals who require medical and/or nursing care which cannot be provided in their own homes, either because of the nature of care required or because of the

individual's circumstances. The individual's condition would not, however, be expected to need the more specialised care/treatment available in a District General Hospital.

Slow-stream Rehabilitation – The services provided will be medical input by a medical Practitioner; nursing and rehabilitative care by ward nursing staff and specialist nurses/therapists.

Palliative and End of Life Care – Palliative/nursing care will be provided for those individuals who need short term health care and support over and above the level which can be provided within their own homes, or, in some instances, nursing homes. The individuals admitted would not normally be expected to need the specialised services of a District General hospital. This will be for symptom control and support during illness, including those who are undergoing chemotherapy, radiotherapy and terminal care.

Assessment/Monitoring – Some individuals may be admitted from the community, via the Accident and Emergency Department at West Wales General Hospital or from the Minor Injuries Unit for short stay assessment, monitoring and/or investigation.

Respite – Patients will be admitted for medical/therapeutic respite, a planned period of care for assessment and treatment where current medication/other care interventions are not maintaining the patient at home with the optimum level achievable.

Continuing Care – Consideration is being given to designating a number of community hospital beds as 'continuing care'. This will enable patients to receive slow stream rehabilitation during their inpatient stay to enable them to achieve the highest degree of independence prior to assessment for continuing health care funding.

13.4 Exclusion Criteria

Individuals not usually considered suitable for admission include:

- Children/young people under 18 years of age;
- Individuals who are profoundly confused or have acute psychiatric conditions.

13.5 Staffing and Skill Mix

As there will be an increased emphasis on rehabilitation in the new model of care, the staffing skill mix will need to be adjusted to reflect this. This will take a period of time to achieve, as there are historical deficiencies in the number of therapy staff in Cardigan. It is therefore proposed that a process of restructuring of the workforce will take place, by introducing Generic Workers who will work across health and social care to undertake a range of patient care duties, tasks and therapeutic interventions to meet the needs of patients who are on rehabilitative programmes of care.

Workforce planning will take into account the recommendations of 'A Community Nursing Strategy for Wales' and emerging roles such as the Rural Practitioner which is referred to in the consultation document 'Rural health Planning – Improving Service Delivery Across Wales'.

13.6 Pathway Redesign

To support service integration, evidence based pathway development will be required, involving all key stakeholders. NICE guidelines and National Service Frameworks will be taken into account and referenced throughout pathway development. It is anticipated that the Map of Medicine will be adopted across Hywel Dda.

14. Ambulance Service

Non urgent transfers will be undertaken by the patient transport services. Emergency cases will use the urgent or 999 service via ambulance control at Carmarthen.

15. Management Arrangements

A Management Board will be established for strategic decision making. Day to day operational issues will be co-ordinated by the Centre Manager.

16. New Technology

New technology, including telemedicine, telehealth and assistive technology will be fully utilised within the new centre, providing links with other healthcare facilities for remote consultation, specialist opinion and diagnostic services and also to support people in remaining as independent as possible in their own homes. A mobile videoconferencing unit will be required for use in MIU, outpatients and ward areas and network points will be available throughout the clinical areas to maximise the use of new technology. Access to primary care, secondary care and social care information systems is essential, with integration of IT systems where possible.

Computer network points will be incorporated into bed head services for inpatients and access to the internet and client/patient/carer information will be made available in public areas.

17. Future Service Integration Opportunities

Future opportunities exist to work more closely with Social Care, by re-designating a number of inpatient beds as 'Joint Care' beds and releasing this income stream into additional day care and/or rehabilitation facilities in the new Centre. The 'Joint Care' beds are used as a means of avoiding admission to an acute bed. Another alternative would be to commission a number of social care beds as in the South Pembrokeshire model. (This is subject to further negotiation).

Also under development on the Bath House site is a 48 unit Extra Care housing facility and there is a similar 40 unit Extra Care facility planned nearby in Crymych, which are being developed by the Family Housing Association (FHA). It is anticipated that these developments will present further opportunities for collaboration and discussions are taking place with the FHA to explore the potential for joint working.

18. Assumptions

This proposal is based on the assumption that the service model will be revenue neutral and can be delivered within existing resources. Any new funding streams that become available during the planning phase will be utilised to integrate services in line with Hywel Dda Local Health Board's service redesign proposals, e.g. Continuing Care; Invest to save; Palliative Care.

Annex 1

Allocation of Clinic Sessions –Outpatient Department						
Utilisation of Consulting/Examination Rooms						
Day/period		**Number of rooms utilised***				
Monday	**am** *(5)	Urology (2 rooms – consulting and flow tests) Twice a month – 2nd and 4th Mondays	Paediatrics (2 rooms - consulting plus BPs) 1st and 3rd Mondays	CPN – (1 room for counselling patients) - every Monday	Orthoptist – (1 room – Ophthalmology Consulting Room with specialised equipment) - 3rd Monday	
	pm *(2)			CPN – (1 room for counselling patients) - every Monday	Orthoptist – (1 room – Ophthalmology Consulting Room with specialised equipment) - 3rd Monday	
Tuesday	**am** *(8)	Orthopaedics – 2 consulting rooms - once a month	Ophthalmology – 1 Consulting Room plus 1 Fields Room plus 1 vision testing room – every Tuesday	Continence Clinic – 1 consulting room for bladder scanning – 3rd Tuesday	Surgical appliance clinic – 1 consulting room – 2nd and 4th Tuesday	Phlebotomy clinic – 2 rooms or 1 large room with 2 cubicles – every Tuesday
	pm *(6)	Orthopaedics – 2 consulting rooms - once a month	Ophthalmology – 1 Consulting Room plus 1 Fields Room plus 1 vision testing room – every Tuesday	Continence Clinic – 1 consulting room for bladder scanning – 3rd Tuesday	Surgical appliance clinic – 1 consulting room – 2nd and 4th Tuesday	
Wed.	**am** *(6)	General Surgery – 1 minor ops room plus 1 consulting room plus 1 examination room – 1st, 3rd and 4th Wednesday	Child Psychology – 1 large consulting room to accommodate families – child friendly – 1st and 3rd Wednesday	Dietetics – 1 consulting room – once a month	Low visual aid clinic – 1 consulting room – 2nd Wednesday	
	pm *(7)	General Surgery – 2 man clinic – all 5 rooms are utilised – 1st, 3rd and 5th Wednesday	Child Psychology – 1 large consulting room to accommodate families – child friendly – 1st and 3rd Wednesday	Dietetics – 1 consulting room – once a month		
Thursday	**am** *(7)	Obstetrics – all 5 rooms are utilised by Obstetricians and midwives – every Thursday	Phlebotomy clinic – 2 rooms or 1 large room with 2 cubicles – every Thursday			
	pm *(5)		Phlebotomy clinic – anti coagulation - 2 rooms or 1 large room with 2 cubicles – every Thursday	Psycho-geriatric clinic – 1 consulting room – every Thursday	Psychiatry – 2 consulting rooms – every Thursday	

Allocation of Clinic Sessions –Outpatient Department						
Utilisation of Consulting/Examination Rooms						
Day/period		**Number of rooms utilised***				
Friday	**am** *(6)	Ophthalmology – 1 Consulting Room plus 1 Fields Room plus 1 vision testing room – 1st, 2nd and 4th Friday	Paediatrics – 1 consulting room plus 1 room for weighing and measuring patients – once a month	Haematology – 1 consulting room – every 2 months	Ultrasound Clinic – 2 consulting rooms – once a month	Movement Disorder clinic – 1 consulting room – every 2 months
	pm *(5)	Ophthalmology – 1 Consulting Room plus 1Fields Room plus 1 vision testing room – 1st, 2nd and 4th Friday		Haematology – 1 consulting room – every 2 months	Ultrasound Clinic – 2 consulting rooms – once a month	

In addition, two rooms are required for the Diabetic Retinopathy Clinic, on a flexible basis.

Annex 2

Allocation of Clinic Sessions – Primary Care						
Utilisation of Consulting/Examination Rooms						
Day/period		**Number of rooms utilised for community nursing and mental health services within the Health Centre**				
Monday	**am**	CMHT				
	pm	CMHT	Family Planning	Family Planning	Family Planning	
Tuesday	**am**	CMHT	H/Visitor			
	pm	CMHT	Counselling Pembs			
Wed.	**am**	CMHT	Dietitian	CRUSE		
	pm	CMHT	PRISM			
Thursday	**am**	CMHT	Child Health	Child Health	Child Health	
	pm	CMHT	Family Planning	Family Planning		
Friday	**am**	CMHT	PRISM	CRUSE		
	pm	CMHT	PRISM	Counselling (Pembs)		