NHS
Dorset
Clinical Commissioning Group

Mental Health Acute Care Pathway

Outline Business Case

September 2017

NHS
Dorset
Clinical Commissioning Group

Mental Health Acute Care Pathway

Outline Business Case

September 2017

DOCUMENT TRAIL AND VERSION CONTROL SHEET

Heading	Mental Health Acute Care Pathway Outline Business Case
Project Sponsor	Dr Paul French: Clinical Lead for Mental Health
Purpose of document	This document is the Outline Business Case. It describes the preferred option to be approved and implemented
Date of document	29 August 2017
Authors	Kath Florey-Saunders Elaine Hurll
To be Approved by	NHS Dorset CCG Governing Body
Status	Final Version for Approval
Version	Version 7.0

CONTENTS

EXECUTIVE SUMMARY

Introduction

Dorset Clinical Commissioning Group (CCG) launched the Mental Health Acute Care Pathway (MH ACP) Review in 2015. The CCG and partners have been through a rigorous process of needs analysis, view seeking, model development and public consultation and co-produced a model of acute mental health care which was initially described in the Strategic Outline Case (SOC) **Appendix 1.**

The options proposed have been through a two-month public consultation process and informed by this. The next stage is to make the case for implementing the final preferred option in this Outline Business Case (OBC). The OBC present a fully costed preferred model of care to implement and consequently improve Dorset's response to people experiencing mental health crisis.

The OBC follows the five case model approved by HM Treasury Department. The OBC outlines in detail the strategic context and describes the economic and commercial landscape. The OBC also reviews the shortlisting process used to reach the preferred option on which the consultation was based. The financial case describes a fully costed preferred option for the pathway. The management case describes the proposals for implementing the new MH Acute Care Pathway.

Key elements of the Outline Business Case

The Outline Business Case (OBC) describes the review and the background in the strategic case. The economic case hones in on the preferred option describing in detail the shortlisting processes and reviewing them in the light of the consultation. The financial case proposes, in full detail, a costed model for the MH ACP and the management case describes how that will be implemented. The financial case presents a detailed and costed model that can be implemented within the current system spend.

Conclusion

The OBC presents the case for change and outlines the preferred way forward that was consulted on and described below.

The preferred way forward

- Two Retreats, one in Bournemouth and the other in Dorchester. The planned opening hours are to be Monday to Thursday 16:00-24:00 and Friday to Sunday 18:00-02:00
- Crisis Line continues 24/7, which will be called the Connection Service and this element of the pathway will be enhanced by additional staff available between 18:00-02:00 every night to provide the Connection Service

- Seven Recovery Beds re-commissioned and split across East and West Dorset to enhance access
- Three Community Front Rooms (CFR) are to be established one in the North of Dorset, one in the West of Dorset and one in the Purbeck area and the assumed opening hours will be Thursday-Sunday 15:00 – 23:00
- The pathway will include 16 new beds, 12 will be at St Ann's Hospital and 4 will be at Forston Clinic
- The Linden Unit will close and the 15 beds will be re-provided at St Ann's Hospital to meet the demand

CHAPTER 1
INTRODUCTION AND OUR PROCESS OF CO-PRODUCTION

1

1. INTRODUCTION AND OUR PROCESS OF CO-PRODUCTION

1.1 The purpose of this Outline Business Case (OBC) is to propose the preferred option for the Mental Health Acute Care Pathway (MH ACP) taking account of the feedback from the public consultation and further modelling. This Business Case has been developed through the MH ACP review and additional modelling post consultation which included:

- A needs and data analysis
- Benchmarking innovate practice
- An independently constructed findings report from the view seeking stage
- A co-produced engagement and modelling process
- Public consultation

1.2 The proposed MH ACP is for the care, treatment and support of people who experience serious mental illness (SMI) and people who are at risk in terms of their mental state and who at times may be in need of crisis/acute mental health care. There are three main elements of this case:

- Service redesign through workforce reshaping and redistribution: matching resource to demand to ensure sustainable services through improving skills mix and providing more consistency of care
- Innovative new service configuration to provide services at times that reflect people's needs, enable services to focus on prevention and ensure that there is more comprehensive support for carers, service users and professionals
- An increase in acute mental health in-patient beds and a proposal to consolidate these to ensure safety and the ability for all units to support the most complex range of needs

1.3 The proposed changes will bring significant benefit to the people who use the services through wider choice, increased access times and options for self-referral. It is hoped that this will enable people to have a greater sense of control and improved recovery outcomes as defined by them.

1.4 This OBC document is the 'decision-making business case' as set out in recent planning guidance[1]. It sets out the preferred option that will deliver the proposed new model.

1.5 All the shortlisted options described in the Strategic Outline Case (SOC) were viable, but each had a slightly different approach and modality.

1.6 Option B is the preferred way forward supported through the consultation process, with additional modelling and this is fully described and costed in the financial case of the OBC.

1 Planning, assuring and delivering Service Change for Patients, NHSE, 1 November 2015

How this Outline Business Case has been produced

1.7 Throughout the MH ACP, the Project Board's methodology has been to apply best practice in its decision-making processes. The MH ACP project was co-designed with service users and partners and the view seeking and modelling stages (2&3) were co-produced.

1.8 The MH ACP project from inception to date has been co-produced and the modelling was based on views of over 750 people (over 3,500 views). The team has engaged with the Dorset Joint Health and Scrutiny Committee, having given four presentations to the committee during the view seeking and modelling stages and undertaking workshops on the consultation. The Joint Health and Scrutiny Committee also gave a formal response to the consultation. All local councillors were invited to the view seeking events and to the public consultation events and were asked to promote the project to their constituents.

1.9 The Dorset and Bournemouth and Poole Health and Wellbeing Boards receive updates on mental health which demonstrate the progress being made on the MH ACP. This project is also a key deliverable within the Crisis Care Concordat and our 19 partner organisations, many of whom were on the Co-Production Groups (CPG) or were represented by a member of the group. The Pan Dorset Joint Commissioning Board has also received three presentations on the project updating members on the progress, but most importantly senior Local Authority officers have been on the Project Board to ensure that decisions and progress has been actively shared in their organisations.

1.10 **Stage 1** of the project was a comprehensive mental health needs analysis and the output from this stage was a Needs and Data Analysis report that built on the Dorset Joint Strategic Needs Assessment (JSNA) and was developed jointly with Public Health Dorset.

1.11 **Stage 2** was a substantial view-seeking exercise led by NHS Dorset CCG in partnership with Dorset HealthCare University NHS Foundation Trust, the Local Authorities and Dorset Mental Health Forum. The output from stage two was a comprehensive, thematic analysis report produced by Bournemouth University's Market Research Group in **Appendix 2**. Commissioning the university as an external organisation to the review ensured the analysis was impartial.

1.12 **Stage 3** of the project was the model options development stage. The development of the new service vision and the options for its achievement was a fully co-produced exercise. Co-production is a value driven approach in which decision makers e.g. professionals and citizens are involved in a relationship in which power is shared wherever possible and where there is recognition that everyone involved has a contribution to make. NHS Dorset CCG commissioned ImRoc and NDTi[2] to facilitate the co-production process and introduce best practice and innovation in mental health to the CPGs. Folio Partnership was commissioned to advise on the process and development of the Treasury approved five case business case model. Co-production

2 Implementing Recovery Through Organisational Change – www.imroc.org
National Development Team for inclusion – http://www.ndti.org.uk/

was important for the MH ACP project for many reasons:

- To ensure that people who use services and their carers/supporters were able to contribute to the design of the model depending upon their situation and experience of mental health services
- It ensured that all key commissioning partners were fully involved with the process from beginning to end with shared responsibility for the project
- Everyone contributed to the production of the key deliverables of the project and any subsequent recommendations
- To ensure that all the learning and experience from previous mental health service re-design in Dorset was taken into account
- To ensure that many views and perspectives on acute mental health care were taken account of
- To engage with the voluntary sector in the design of a Dorset model and learn from their experience
- To provide a "no surprises" approach to service design
- To meet the mandated obligation to engage with patients prior to making any service changes

1.13 **Stage 3** brought all the key stakeholders together into a series of modelling workshops that focussed on innovation to start with and then developed those innovative concepts into operational possibilities. The groups were set up to do slightly different but overlapping pieces of work.

Type of group	Purpose
Co-Production Group (CPG) (27 people)	The CPG was made up of heads of service, team managers, service managers, commissioners and people who have lived experience of mental illness and carers. The CPG met as a single group as part of the Urban Rural Groups for continuity and collective memory. The CPG was responsible for making recommendations to the Project Board through formal shortlisting of options.
Urban/Rural Groups (60 people)	Dorset has a mix of rural areas and conurbation and the Urban/ Rural Groups were created to ensure that the interests of both were considered. The groups were made up of the CPG and additional service managers, staff members and Local Authority representatives and additional people who have lived experience, carers and third sector organisations.
Crosscheck Groups (25-30 people)	The Crosscheck Groups were solely for people who have a lived experience of mental illness and carers (some were also members of staff). The purpose of the crosscheck events was to make sense of the other groups' work by applying potential care models to their experience and challenge it or build on it. This group also engaged a high representation of people who use services and their carers or supporters.

1.14 **Stage 4** was public consultation. The consultation lasted for two months. The consultation included 16 public events at locations across Dorset. These events attracted over 500 people who asked questions and gave their views. The consultation also included online and paper questionnaires that were completed by 1156 people. The questionnaire was designed by Bournemouth University (BU) Market Research Group and the team at BU evaluated the responses and presented the findings in a report and slide pack. Concerns that were raised have been looked into and considered in the development of the OBC. The consultation outcome shows that the preferred option was supported in terms of overall percentages. Crucially the preferred option had the most support from the people who use services, carers and staff.

1.15 The evaluation report is found in **Appendix 3**. The consultation process also highlighted additional areas of work ahead of the final sign off process. The additional areas specifically relate to:

- The Linden Unit and the rationale for closure needing clear explanation about how the decision to close was reached and this is now described more fully in the economic case.
- The rebalancing of the bed numbers to meet demand needing clearer explanation including the male /female split in bed numbers for the west of the county that will reassure people that the proposed number of beds will meet the demand for men and women who require an admission. The evaluation of this is found in the financial case together with additional clarification on access to beds within 31 miles from people's homes is also provided.
- Additional clarity is required about the Retreats and Community Front Rooms specifically about the location of the services and how they will be staffed to ensure that they are safe and well managed described in the financial case.
- Questions were raised about people who use drugs or alcohol and how they will be supported in the services being proposed. This is answered in the financial case.
- Transport concerns were raised because bus routes have been altered or ceased and this has prompted additional travel analysis linked to the Clinical Services Review (CSR) travel analysis. The travel planning is an ongoing piece of work being carried out between the CCG and the three local authorities.

1.16 The SOC (**Appendix 1**) was prepared using HM Treasury's recommended "Five Case Model" for business case development[3]. This has been adapted as necessary to meet the specific requirements of NHS Assurance and applied proportionately to the nature of this scheme. It explores the proposal from five perspectives. The Outline Business Case follows the same "five case model" and will serve as the decision making business case for the MH ACP. In the OBC:

- The **strategic case** explores the case for change, whether the proposed change and investment is necessary and whether it fits with the local and national strategies. It also sets out the vision for the new pathway and its key core functions and incorporates views expressed through the public consultation process. Finally, it

3 www.gov.uk/government/uploads/system/uploads/attachment_data/file/469317/green_book_guidance_public_sector_business_cases_2015_update.pdf

tests out the assumptions made in the SOC to ensure that the preferred option is the best fit to meet Dorset's requirements.

- The **economic case** reviews the shortlisting process and shows how the choices and options for the new pathway were arrived at. It demonstrates how the preferred option, endorsed through the consultation process remains the best options in terms of value for money and in terms of delivering the key objectives. It demonstrates how the new pathway can be implemented.
- The **commercial case** describes the provider market and demonstrates that the service can be delivered in the area and by the best provider for the job.
- The **financial case** presents the fully costed proposal for how the preferred option can be delivered.
- The **management case** presents the implementation plan and highlights issues and risks and demonstrates that NHS Dorset CCG and partners are capable of delivering the proposed service care pathway.

CHAPTER 2
THE STRATEGIC CASE

2

2. THE STRATEGIC CASE

2.1 The strategic case describes the existing situation, explores why change and investment is necessary, sets out the objectives for change and describes how this fits within the strategic requirements of the NHS Dorset CCG and its commissioning partners in the context of the Sustainability and Transformation Plan (STP).

2.2 The case reflects the work of the CPGs in building a vision for a new mental health acute care pathway and reflects the feedback from the public consultation which has endorsed the preferred option.

2.3 It describes how the proposals meet the new national standards of mental health care as described in the NHS Implementing the Five Year Forward View for Mental Health document and the update to The Five Year Forward View plan. (https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf)

2.4 It is also supported by the vision described in the Dorset Crisis Care Concordat action plan. http://www.crisiscareconcordat.org.uk/areas/dorset/ . It also reflects the Wessex Strategic Clinical Network's recent strategy.

2.5 The services in scope of the MH ACP review are listed below as the services likely to be included in the reconfiguration at this stage:

- Inpatient units including Psychiatric Intensive Care Unit (PICU)
- The Community Mental Health Teams (CMHT) (adult and older peoples functional)
- The Crisis Resolution Home Treatment Teams (CRHT) including the Crisis Line
- Street Triage
- Recovery House

2.6 There are other closely related services which are either part of or critically dependent on other review processes. They have been discussed as part of this project but their way forward will be determined by these other reviews:

- Psychiatric Liaison Service: is to be reviewed to meet the Five Year Forward View requirements once the decision relating to Dorset's acute hospital configuration is completed
- Further development of a personality disorder pathway
- A review of Mental Health Complex Care and Recovery will be taking place
- A review of all dementia services is underway and this is related to the MH ACP because the Older People's CMHTs provide both a functional and organic mental health service.

The Strategic Context

2.7 The vision of NHS Dorset CCG is to value mental health equally with physical health in order to achieve "parity of esteem" and to provide equitable services across Dorset for people who experience serious mental health challenges.

2.8 The strategic context is framed by the national NHS mandate which outlines the objectives for the NHS as a whole:

- Preventing people from dying early
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

2.9 Within this framework, the Mental Health Acute Care Pathway and Mental Health Crisis Management were identified as high priorities for NHS Dorset CCG in 2014/15 at the Five Year Forward Stakeholder Prioritisation event. This was supported by Dorset's declaration of support, signed by all key partners in December 2014, for the Crisis Care Concordat (CCC) launched by Norman Lamb in February 2014. The aim of the Concordat is to deliver dramatic improvements in emergency support for people in mental health crisis and to drive up standards of care for people experiencing mental health crisis. NHS Dorset CCC declaration[1] has been used in the development of a joint action plan published on the CCC website and many of the key deliverables for the action plan are dependent upon the successful outcomes of the MH ACP review.

2.10 The Crisp report says that many people have to travel over 50km (31 miles) to inpatient service and that this practice must stop. The report also lays out key challenges which drive the development and delivery of the new MH ACP in Dorset, and the Mental Health Task Force has included some mandated targets and ambitions for mental health provision. http://www.rcpsych.ac.uk/pdf/Old_Problems_New_Solutions_CAAPC_Report_England.pdf

2.11 The following are key areas for attention that are of particular relevance for the MH ACP:

- Elimination of out of area non specialist acute placements by 2020/21
- People treated and supported closer to home and no non specialist adult acute hospital admission should be more than 31 miles (50km) away from home
- 7 days 24-hour access to services for people when in crisis
- People held in restrictive settings for the least amount of time
- Physical health checks for people with SMI
- The updated Five Year forward view also includes waiting time targets and mandates Individual Placement Support services that improve employment outcomes for people who have SMI and this work will be introduced as a work stream under the complex care and recovery review.

The OBC supports the vision for mental health in the NHS Dorset CCG's STP, the link is below: http://www.dorsetccg.nhs.uk/Downloads/aboutus/Our%20Dorset%20STP/Our%20Dorset%20Substainability%20and%20Transformation%20Plan%2020%2004%2017.pdf The proposals also support the delivery of the 2017-2019 planning

1 http://www.crisiscareconcordat.org.uk/areas/dorset/#action-plans-content

guidance, specifically: Access to crisis resolution and home treatment services through innovative delivery options providing choice as developed in conjunction with service users and carers.

Need and Demand

2.12 In stage one of the project, a needs and data analysis was completed and this shows the demand, the prevalence and the resources available. The needs and data analysis significantly enhances the local Joint Strategic Needs Assessments (JSNA: http://www.dorsetccg.nhs.uk/aboutus/JSNA.htm).

2.13 A Needs and Data Analysis report was produced which comprehensively shows where the demand profile for MH services and where key pressure points are in the pathway. This report has been updated throughout the project and it has been updated for the OBC to ensure that the information is accurate and up to date. A full copy of the report is attached **Appendix 4**.

2.14 The report highlights that the existing model of care will not meet the level of demand in the current configuration. It also shows that access to services is disjointed and varies depending upon where you happen to live in Dorset. The Needs and Data Analysis report shows that:

- The Public Health England SMI profile for NHS Dorset CCG shows Dorset GP practices have significantly higher proportions of people with recorded SMI than the national average.
- Across Dorset and within GP localities, there are significant variances in the prevalence of SMI.
  - Prevalence is higher in the urban areas of Dorset (0.99%) compared to the rural areas (0.73%).
  - The highest levels of SMI prevalence are seen in practices within the East Bournemouth GP locality (1.56%), although the prevalence range within the locality varies considerably
  - The lowest prevalence is in the East Dorset GP locality (0.57%).
- In the SOC the assumption based on the public health SMI Profile was that although the number of people with SMI is expected to increase over time due to overall population growth, the prevalence rate would not increase significantly. It is the case however that between 2013/14 and 2015/16 NHS Dorset CCG has seen an increase of 462 people with recorded SMI with the prevalence rate increasing 0.05% from 0.90% in 2013/14 to 0.95% in 2015/16. The recorded increase may be due to epidemiological factors (such as an ageing population) or to increased case finding and recording on GP systems. The latter seems a more feasible explanation of the short term increase as the experience of the Dorset CMHTs shows there had not been an impact on the caseload numbers during this period but has possibly had an impact on thresholds and the ability for services to work preventatively.
- The external bed modelling outlined the requirement for 22 beds. Five of these beds have already been provided through the opening of a five-bedded female PICU in Poole and adding one more male bed into the PICU service. The review

identified a need for additional skills-based training for staff to ensure there is a consistent approach to management of specific groups of disorders such as emotionally unstable personality disorder and bipolar disorder. The internal review also identified the need for refresher training on a formulation based approach for managing psychosis.

- Dorset HealthCare NHS Foundation Trust workforce issues are important to note as 40% of their Community Mental Health workforce are aged in their 50s and could potentially retire and there are not the same numbers of people coming in to the workforce to fill the gap, this will be addressed in the workforce plan. Retention of staff is crucial to the system working well.
- Across Dorset there are more women (58%) than men (42%) on the CMHT caseload who have low-moderate to severe non-psychotic disorders (payment by results care clusters 1-4). Nationally women have a higher representation in clusters 1-4.

Cluster 1: common mental health problem low severity often related to life's events.

Cluster 2: common mental health problems with greater need but often related to life events and or more significant problems in the past and representing with low level symptoms.

Cluster 3: non-psychotic moderate severity with depressed mood, anxiety or other non-psychotic disorder with no serious risk issues although risk may be present. Clusters 1-3, best served by self-help including access to Peers Recovery Education Centre etc. Primary care services from GP and or Steps to wellbeing which is Dorset's IAPT service.

Cluster 4 non-psychotic but severe, a group is characterised by more severe depression and or anxiety and or other non-psychotic disorder but with an increasing complexity of needs and or are individuals who have had more severe disorders and or symptoms and are transitioning back to primary care. Some will require the support of secondary mental health services under Standard care, it is unlikely that people in this group would require CPA although a few may.

- People in clusters 1-3 should generally not be supported in secondary care and would be expected to access support through primary care and Steps to Wellbeing. As of May 2017 the Dorset CMHT caseloads recorded 224 people in clusters 1-3 and 579 people in cluster 4, these figures make up 10.8% of the total CMHT caseload. Purbeck locality has the highest percentage of total caseload in clusters 1-4 (20.8%), East Bournemouth has the lowest percentage of total caseload in clusters 1-4 (4.9%). 25% of all of the people on CMHT caseload within clusters 1-4 are registered with North Dorset locality.
  - The MH ACP / Steps to Wellbeing interface is reliant on the system supporting expansion to 25% of the prevalent population in line with the 5 Year Forward View and Sustainability and Transformation Plan (STP).
- Analysis of the CMHT workforce profile versus caseload complexity and active

caseload suggests that historically resources have not been allocated in line with the predicted demand. However, an ongoing internal review of CMHTs by Dorset HealthCare has been addressing this through an internal reconfiguration of resources across CMHTs which is near completion.

- There is a domino effect within the system showing that where one part is not functioning efficiently there is an impact on other services. For example; if the CMHT is unable to see a patient when they are becoming unwell due to capacity issues, it escalates to the point where CRHT is required and when they are unable to meet the demand, the Local Authority, Out of Hours Service or Street Triage or the Emergency departments are likely to be required to intervene. Peak hours for urgent services are between 18:00 and 02:00.

2.15 The findings described above suggest that a realignment of provision to meet demand is crucial and within this there is a need to ensure that the staff teams have the skill set and experience to meet the demand in terms of prevalence, complexity and severity.

In 2015 when the first version of the needs analysis was completed the predicted percentage prevalence rate of SMI was not anticipated to change for the foreseeable future regardless of population increase. However, table 1 below shows that the prevalence rate in 2015/16 is 0.95% which is a 0.05% (462 people) increase since 2013/14. The predicted increase of people with SMI in 2020/21 remains static at a prevalence rate of 0.95%, as the predicted increase is based purely on population projections.

Table 2 shows the 2015/16 prevalence rates for each GP locality. The predictions for 2020/21 are that the average prevalence rate in the urban areas of Dorset will be 1.04% and the average for the rural areas will be 0.77% with an overall rate of 0.95% against the England rate of 0.90%.

Table 1: Dorset SMI prevalence rates

Year	Population size	SMI Register	Estimated CMHT caseload increase	SMI Prevalence
2013/14	777,935	7,007	n/a	0.90%
2014/15	783,543	7,239	232	0.92%
2015/16	789,684	7,469	230	0.95%
2020/21	817,338	7,731	262	0.95%

Table 2 shows the 2015/16 prevalence rates for each GP locality. The predictions for 2020/21 show the same prevalence rates as in 2015/16: the average prevalence rate in the urban areas of Dorset is will be 1.04% and the average for the rural areas will be 0.77% with an overall rate of 0.95% against the England rate of 0.90%.

Table 2: Prevalence rates for each locality

CCG Locality	2015/16			
	List Size	Register	Prevalence	Ranking
East Bournemouth	73,742	1,147	1.56%	Highest
Poole Bay	73,780	878	1.19%	
Weymouth & Portland	74,794	838	1.12%	
Dorset West	41,087	441	1.07%	
Central Bournemouth	56,651	561	0.99%	
Bournemouth North	66,709	606	0.91%	
Poole Central	62,383	541	0.87%	
Purbeck	33,861	275	0.81%	
Mid Dorset	43,625	354	0.81%	
Poole North	52,413	401	0.77%	
North Dorset	86,876	644	0.74%	
Christchurch	54,513	388	0.71%	
East Dorset	69,250	395	0.57%	Lowest
NHS Dorset CCG Total	**789,684**	**7,469**	**0.95%**	
England	**57,549,410**	**518,320**	**0.90%**	

The following are key facts from the updated data analysis based on 2015/16 and 2016/17 data:

Key issues identified in the Needs and Data Analysis
• Dorset has higher than national average SMI prevalence at 0.95% of the population vs. an England average of 0.90% with specific areas such as East Bournemouth (1.56%) and Poole Bay (1.19%) having very high levels • Urban areas average prevalence is 1.04% and rural average is 0.77%.
• There were 7,007 people on the GP SMI register in 2013/14 and in 2015/16 there were 7,469 which is a 6.6% increase (462 people) on the SMI register and by 2021 it is anticipated to rise to 7731 however the prevalence rate of 0.95% is forecast to remain.
• As at 31 May 2017 there are 6,647 people on the functional CMHT caseload. This illustrates a reduction of 5% from 2015 figures, which is equivalent to 350 people.
• 27.8% of the current functional CMHT caseload are under the Care Programme Approach (and as an aspiration this should be around 70-80% given the target population).
• There are 803 people in clusters 1-4 on the CMHT caseload. There are 224 in cluster 1-3 and 579 in cluster 4
• In 2016/17, 65.1% of occupied bed days for inpatient admission were to St Ann's Hospital with 21.7% to Forston Clinic and 13.1% to The Linden Unit
• CRHT, Street Triage, Psychiatric Liaison and the Out of Hours service all see people who are already on the CMHT caseload. In years 15/16, around 80% of the Street Triage contacts have been with people known to services.
• In April to December 2015, 48% of Street Triage cases had contact with the CMHTs 24 hours prior to them being detained under section 136 of The Mental Health Act, 1983.

2.16 The Dorset area comprises a wide rural population as well as an urban conurbation such as Bournemouth and Poole and Weymouth and Portland and a number of county towns. There are important issues about accessibility of services and travel times to and from various sites across the county. **Appendix 5** indicates the population and prevalence coverage related to each proposed site and shows the percentage of people able to access a service within 25 minutes. It also shows the number of people unable to access a service within a number of timeframes by car and by public transport.

Existing Service Provision

2.17 The current NHS Mental Health provider is Dorset HealthCare University NHS Foundation Trust, and they provide all of Dorset's statutory NHS mental health care in the county. NHS Dorset CCG and the Local Authorities also commission MH services from the third sector for example; Dorset's Recovery House is commissioned by the CCG from a mental health third sector organisation, Rethink Mental Illness.

2.18 Until 2011, there were two NHS Mental Health providers in the (partly urban) east and another in the (largely rural) west of the county. The two providers were operationally very different and provided different models of care. The two providers merged in 2011 and Dorset HealthCare has worked hard to ensure that practice and care is consistent across the county but some areas of difference remain.

2.19 There is some inequity of service provision across Dorset not just because of the differences between urban and rural areas. Some differences impact on the level of responsiveness to service users and their families, carers or supporters, for example: in the west of the County there is a Recovery House with seven beds which provides an alternative to admission. Currently the bed spaces are underutilised with an average occupancy of approximately 50%, meaning 50% of the contract value is not going directly on client support. There is no similar provision in the East of the county despite the need for alternatives to admission.

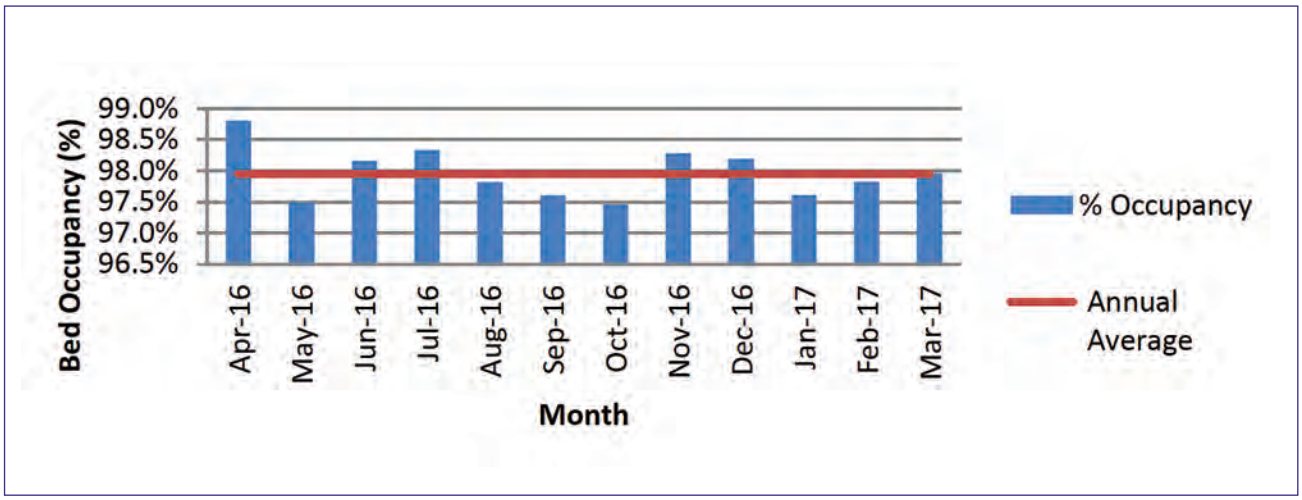
2.20 Current acute care pathways have a wide range of services and many access points and it seems complex and confusing to people who use services and even people who work in them. There is also a lack of anything preventative in the mix of provision.

Inpatient Services

2.21 Sitting in the lower end of the interquartile range, Dorset has under the national average number of beds for the population size of nearly 800,000. Dorset has approximately 16.1 beds per 100,000 head of population vs. a median position of 19.0 beds per 100,000 head of population nationally. The current provision of acute inpatient beds is at St Ann's Hospital in Poole, Forston Clinic near Dorchester and the Linden Unit in Weymouth. Wards within the three units are running at a bed occupancy of between 97-100% with an average annual 98% occupancy.

2.22 The table opposite shows the overall 2016/17 bed occupancy for the MH ACP inpatient wards in Dorset. The Royal College of psychiatry recommends 85% bed occupancy as optimum.

Patient Bed Occupancy for Mental Health Acute Care Pathway Inpatient Wards April 2016 – March 2017



2.23 The current acute inpatient bed provision is shown below:

Hospital Site	Ward Name	Type of Bed	Number of Beds
St Ann's Hospital	Seaview	Acute Assessment Unit	14
	Chine	Acute Female Treatment	17
	Harbour	Acute Male Treatment	16
	Alumhurst	OPMH Functional	20
	Total		**67**
Forston Clinic	Waterston AAU	Acute Assessment and treatment Unit	14
	Melstock House	OPMH Functional	12
	Total		**26**
Westhaven Hospital	The Linden Unit	Acute Treatment	15
Bed provision in East Dorset			**67**
Bed provision in West Dorset			**41**
Total bed provision			**108**

Data Source – Dorset HealthCare NHS University Foundation Trust May 2017

In addition to the acute inpatient bed stock there are also male and female psychiatric intensive care units (PICU) based at St Ann's Hospital in Poole with a total of 12 beds.

2.24 An external modelling exercise commissioned by Dorset HealthCare identified that an additional 22 beds (including 16 new beds and the PICU expansion of 6 beds) would be required to manage future demand in a safe manner, should no other changes be made to the system. The 16 new beds consist of 12 new beds at St Ann's Hospital and 4 new beds at Forston Clinic. The 6 additional PICU beds were operational from December 2016. This number was identified as the number that would meet current demand.

2.25 The external review also indicated that demand could be managed more effectively by moving beds to reflect the usage patterns. The Mental Health Strategies report can be found in **Appendix 6**. Moving beds to meet the demand would mean that more patients could be treated nearer to home and ensure that out of area beds are used only in exceptional circumstances.

2.26 Following the MH ACP consultation, additional bed modelling was undertaken by NHS Dorset CCG. The table below shows the number and percentage of patient admissions from East Dorset, West Dorset and other area postcodes to Dorset Mental Health Hospitals.

	Area of Admission			
Hospital of admission	Admissions from East Dorset postcodes	Admissions from West Dorset postcodes	Admissions from unknown or out of area postcodes	All admissions
St Ann's Hospital	419 74.0% 67.4%	103 18.2% 42.4%	44 7.8% 61.1%	566 (60.4%)
Forston Clinic	136 57.6% 21.9%	83 35.2% 34.2%	17 7.2% 23.6%	236 (25.2%)
The Linden Unit	67 49.6% 10.8%	57 42.2% 23.5%	11 8.1% 15.3%	135 (14.4%)
All admissions	**622 (66.4%)**	**243 (25.9%)**	**72 (7.7%)**	**937 (100%)**

Data Source: Dorset HealthCare NHS University Foundation Trust – MH Admissions Dataset Notes – Percentages in blue show the percentage of admissions for each hospital from each admission area (horizontal). Percentages in red show the percentage of admissions for each admission area to each hospital (vertical)

2.27 The above figures show 66.4% (622 admissions) of all admissions in 2016/17 (total 937 admissions) were to patients from east Dorset postcodes and 32.6% (203 admissions) of these patients were admitted to a west Dorset inpatient unit. The figures also

show 25.9% (243 admissions) of all admissions in 2016/17 were to patients with a west Dorset postcode and 42.4% (103 admissions) of these patients were admitted to the east Dorset inpatient unit, the majority of these patients were admitted to the Seaview Assessment unit (76 admissions) and the Dorset PICU (20 admissions) within the east Dorset based St Ann's Hospital.

2.28 During 2016/17 there were 26,845 acute mental health occupied bed days (OBDs) at St Ann's Hospital and 14,405 OBDs at Forston Clinic and the Linden Unit (these figures exclude home leave). The figures show 65.1% of OBDs took place in the east Dorset unit and 34.9% in the two current west Dorset units. The breakdown of each OBD by patient's admission postcode was unavailable therefore patient's postcode at the time of admission was analysed. Admission analysis previously described shows patients travelled across the county to use available beds. During the CCG bed modelling analysis, patient's postcode at admission was reviewed. Results showed that of the 772 patients admitted to acute mental health wards (excluding older people's mental health and PICU beds), 81.5% of patient admissions were closest to St Ann's Hospital and 18.5% were closest to Forston Clinic.

2.29 The national drive is that no one should travel long distances to be admitted to hospital. On the basis of the Crisp report the CPG's modelling work agreed to model care accessible no further than 31 miles (50km) from a person's place of residence. The additional post consultation bed modelling shows that everyone in Dorset can access a psychiatric inpatient bed within 31 miles if beds were situated at St Ann's Hospital and Forston Clinic. The table below shows that 16.8% of people in Dorset with SMI can't access St Ann's Hospital within 31 miles and 16.0 % of the prevalent population would be unable to access Forston Clinic within 31 miles. Analysis also showed that 53.2% of the prevalent population would not be able to access the Linden Unit within 31 miles.

Hospital Site	Prevalence coverage (numbers)	Prevalence coverage (%)	Prevalence not covered (numbers)	Prevalence not covered (%)	Areas not accessible within 31 miles
The Linden Unit	3432	46.8%	3894	53.2%	Shaftesbury, Gillingham, Bournemouth, Christchurch, some areas of Poole, most of East Dorset
Forston Clinic	6156	84.0%	1169	16.0%	Verwood, Ashley Heath, Iford, Southbourne, Christchurch and some coastal areas
St Ann's Hospital	6133	83.7%	1193	16.3%	Sherborne, Gillingham, Portland, parts of Weymouth, some coastal areas between Studland and Osmington (Swanage is accessible) and areas west of Dorchester

2.30 During the CCG post consultation bed modelling exercise an analysis was undertaken to show the optimum distribution of acute inpatient beds according to the patient postcode at admission and gender details of the 2016/17 admissions data. Further details of the methodology used and results can be found in **Appendix 7**.

2.31 Work was undertaken to double check the allocation of beds would meet demand in each unit and also that the smaller unit in the west could meet demand by gender. OBDs were allocated to either St Ann's Hospital or Forston Clinic according to patient's area of admission (east areas to St Ann's Hospital and west areas to Forston Clinic) with an adjustment for patients admitted from west Dorset postcodes being allocated to their closest unit. The modelling was based on 85% bed occupancy of the proposed 92 acute inpatient beds (74 at St Ann's Hospital and 18 at Forston Clinic). The 85% bed occupancy is recommended as optimum by the Royal College of Psychiatry.

The table below shows a comparison of the proposed and modelled OBDs and bed numbers and highlights the optimum number of beds in the east and west of the county to manage male and female admissions.

		Scenario 3						
		Patients with an East Dorset admission postcode attend St Ann's Hospital, patients whose postcode area is in the West attend their closest hospital (Overall 85% Occupancy)						Actual % occupancy for modelled OBDs based on proposed bed numbers
		Occupied bed days			Number of beds			
Hospital Site		Proposed	Modelled	Difference	Proposed	Modelled	Difference	
St Ann's Hospital	Males		13,040			42,031		
	Females		10,210			32,909		
	Total	**22,959**	**23,250**	**-292**	**74**	**74,940**	**0.94**	**86.1%**
Forston Clinic	Males	3,723	3,266	457	12	10,527	-1.47	74.6%
	Females	1,862	2,027	-166	6	6,534	0.53	92.6%
	Total	**5,585**	**5,293**	**292**	**18**	**17,060**	**-0.94**	**80.6%**
Grand Total		**28,543**	**28,543**	**0**	**92**	**92,000**	**0.00**	**85.0%**

2.32 The modelling shows that at 85% bed occupancy of the proposed acute bed numbers and with patients attending a hospital in the area of their admission postcode, the optimum number of beds at St Ann's Hospital would be approximately 75 and 17 at Forston Clinic. The modelled figures do however produce results in part beds (decimals) therefore optimal bed numbers will change according to rounding up or rounding down of these calculated bed numbers. The modelling shows that if beds are allocated according to the proposals (74 at St Ann's Hospital and 18 at Forston Clinic) then this would be adequate as average bed occupancy at St Ann's Hospital would be 86.1% and 80.6% at Forston Clinic.

2.33 The modelling also shows that the optimum 17 beds at Forston Clinic should be split approximately 10 male and 7 female beds. On initial analysis this implies one of the allocated male beds at Forston Clinic may be best re-allocated as a female bed however the rounding up or rounding down factor for male/female beds at Forston Clinic is particularly an issue as optimum modelled beds are calculated as 10.527 male beds and 6.534 female beds. With 6 female beds, the female ward is 166 OBDs short of 85% bed occupancy. If beds are allocated according to the proposals (12 male and 6 female) then this would be adequate as the average bed occupancy on both wards (male 74.6% and female 92.6%) would be similar to the current bed occupancy at Forston Clinic acute ward for females and lower for males.

2.34 The bed modelling analysis showed that at 85% bed occupancy of the 92 proposed beds there are 28,543 available OBDs. In 2016/17 the actual OBDs were 27,016. This means the proposed bed capacity will meet the current demand (with an extra 1527 OBDs or an equivalent 4 beds in the system) and so with the additional capacity in the system the actual acute ward bed occupancies are likely to be lower than modelled therefore further supporting the proposed bed numbers being adequate and having capacity for people to choose to be informally admitted which should prevent rising acuity.

2.35 Challenges in the system:

- At present, the location of inpatient provision does not reflect the levels of SMI prevalence across the county. Currently the demand for inpatient services is 78.3%% in the east of the county and the bed numbers in the east do not match this level of demand.
- The Police and Ambulance Services have only two health based options to take people to who are in mental health distress: Emergency departments and the Section 136 suite at St Ann's Hospital.
- Before December 2016 there were no female PICU beds in Dorset which meant that women who required this level of service were being sent out of area (OOA). In December 2016 the specialist 5 bedded female PICU opened, this enabled women to be supported and treated in-county. One bed was also added to the male PICU which has seven male PICU beds. The opening of the unit supports the implementation of the Five Year Forward View for mental health and the 9 must dos that aim to bring the system back into aggregate balance through the reduction in OOA placements.
- With the additional PICU beds and on the basis of the collective analysis a further 16 acute inpatient beds are required to deliver care in county: at any one time there are approximately 5-6 people out of area and 4-5 waiting in the community or in an Emergency Department (ED) for an inpatient bed, although this can be significantly higher at times. All inpatient beds must be able to support the most complex individuals to ensure that the system can be run as efficiently as possible.
- The Linden Unit in Weymouth supports people who are acutely unwell at the time of admission but it is an isolated unit and it does not have the same support structures in terms of staffing resources as Forston Clinic and St Ann's Hospital. There are significant challenges related to the unit.

- Workforce challenges regarding recruitment and retention
- It is an isolated unit so there are fewer opportunities to cross cover and respond to challenging situations
- Lack of ease of access to interventions when acuity increases such as easy access to low stimulus isolation environments
- The physical environment requires upgrading including removal of ligature points to bring it up to a similar standard as the other sites
- Over 53% of the population with a SMI cannot reach the Linden Unit within 31 miles of their place of residence where as 83.7% can get to St Ann's Hospital and 84% to Forston Clinic

2.36 In summary although there are challenges in the system such as not having the right number of beds in the right place, the modelling work post consultation suggests that the proposals presented will enable:

- Everyone in Dorset to acute mental health inpatient bed within 31 miles
- The OBDs will be running at an overall 85% capacity instead of the current average of 99% which will enable the demand to be managed
- The distribution of beds will meet the demand in the east and west of the county and people will receive care closer to home
- In the west of the county at Forston Clinic there will be enough female beds to manage the demand

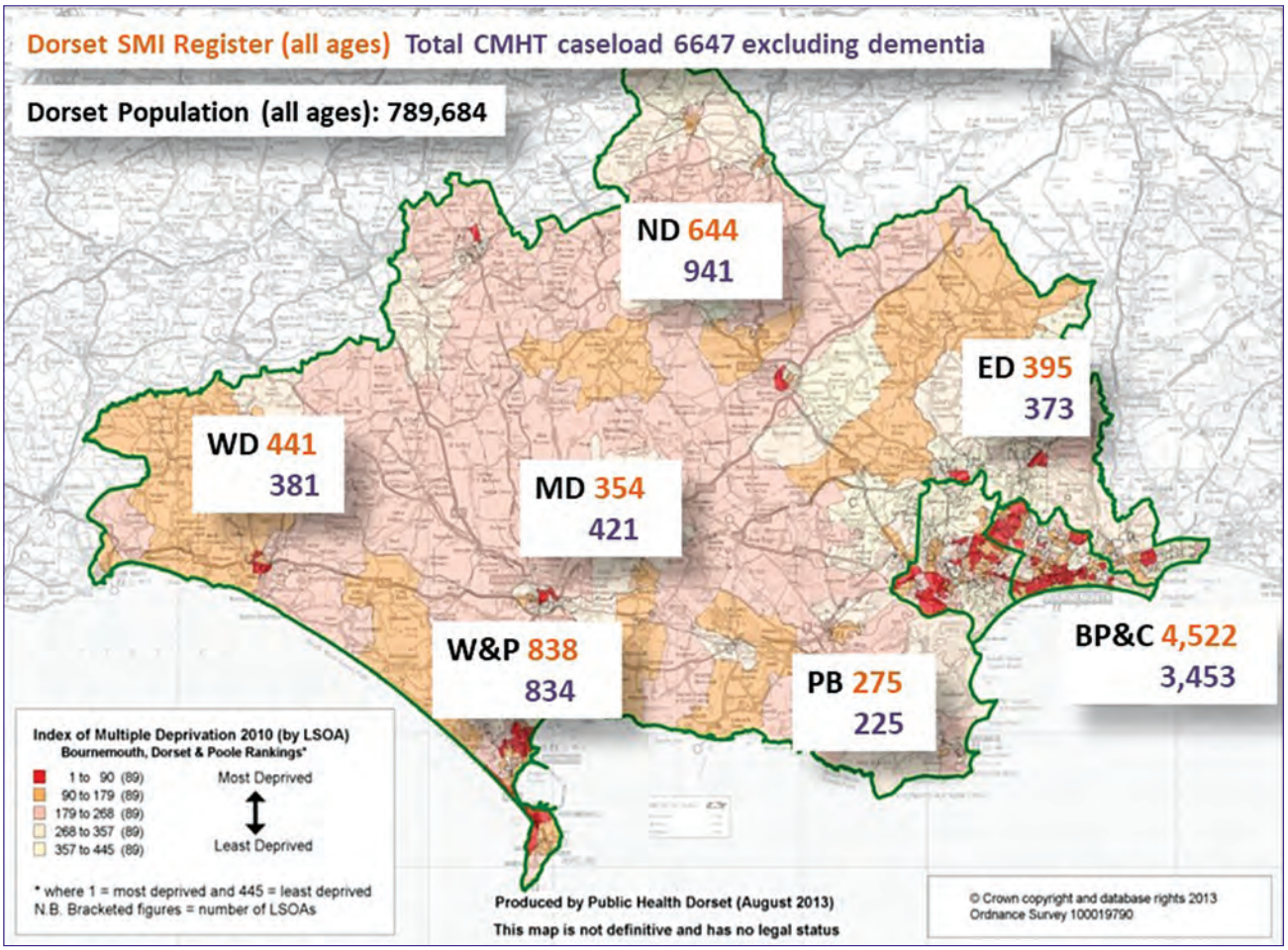
Community Mental Health Teams (CMHTs)

2.37 Dorset has 13 adult CMHTs and 12 Older people CMHTs. The CMHTs across the county have integrated managers and the social work input to the services is the Local Authority contribution and responsibility. One of the assumptions of the Strategic Outline Case was that there would be no reduction in Local Authority staff for mental health services. It appears however that this will be tested as austerity continues to hit Local Authorities.

2.38 The teams all work differently to meet the level of demand in their area. There are high levels of demand both in relation to number of referrals and the level of acuity patients present with. The conurbation and urban areas (Bournemouth, Poole and Christchurch and Weymouth and Portland) teams have 37.1%% of their caseload (excluding organic) in clusters 10-17 (psychotic with degrees of complexity) and another 25.1% are in clusters 7 and 8 which although are not psychotic there is complexity in terms of the levels of support people present with. In the rural parts of Dorset 26.1% of the case load are in clusters 10-17 and 24.6% in clusters 7 and 8.

2.39 In the view seeking, people who work in the teams fed back their desire to work more proactively with people and to help them to recover, but with the current volume and acuity of caseloads in many areas their focus was on assessments rather than interventions.

2.40 The map below highlights the caseloads that are pertinent to each area within Dorset. The updated date tables in the Needs and Data Analysis report show that although the SMI prevalence rate has increased by 0.05% from 2013/14 to 2015/16 across the county, the CMHT caseload has actually reduced in size for nearly all the teams in the same period.



2.41 The proportion of people who are on the Care Programme Approach (CPA) is low (27.8%) and even with the fact that some people open to secondary care do not meet the level of need required to be on CPA the number should be around 70-80% on CPA. The view seeking feedback centred on lack of capacity to manage the caseloads effectively to this level in the current configuration. There is an ongoing risk to caseload management of the reducing local authority budgets and ever increasing ability for LA staff to focus only on statutory duties.

2.42 The project benchmarked with Nottingham Mental Health Trust and the ImRoc lead associated with this Trust and it was recommended that for people on CPA a CPN caseload (based on one band 6 CPN and two band three peer support workers) should be 50. During the modelling this was deemed to be undeliverable and Dorset HealthCare have started modelling the number of people on caseloads with floating peer support. The numbers are being reviewed as part of the reconfiguration and will be based on clinical need in terms of acuity and workforce development as the pathway develops.

The Crisis Resolution Home Treatment Teams (CRHT)

2.43 Dorset has a 24/7 CRHT. The team are responsible for gatekeeping all admissions to inpatient units and also hold a home treatment caseload of between 40-50 people. The team works to ensure that admission rates are reduced year on year. There was a reduction in 2015/16 the target of less than 128.6 per 100,000 per head of population was achieved with an admission rate of 98.78 per 100,000 per head of population. In 2016/17 the target was less than 110 and at year 67 was achieved.

2.44 Dorset HealthCare was an outlier in terms of the number of home visits that the Home Treatment Team (HTT) carried out after 22:00. The majority of these visits were to deliver medication which is not good practice as clients should receive treatment and medication on a more managed basis.

2.45 The Crisis Line provides a 24/7 telephone support and advice service. In 2015/16 took in the region of 17,000 calls per year. In 2016/17 the service took 15,197 calls, an average of 1,266 per month. During 2015/16 many of these calls were from services such as the CMHTs and the average call length was 6 minutes. There is minimal time for staff to support people fully through this service and anecdotally people have outlined that it tends to be formulaic rather than interventional and person centred.

Street Triage and Out of Hours

2.46 The street triage service was a jointly funded pilot that operates between 19:00 and 03:00 seven evenings per week with the aim of reducing the use of Mental Health Act Section 136 detentions and stopping the use of police cells for people in mental health distress. The police often come into contact with people experiencing mental distress and this service enables them to discuss the case on the telephone and receive information, personalised advice and support for their subsequent decisions based on a review of the person's mental health records where they are already known to services. The service also proactively screens the emergency call log and identifies where advice may assist the responding officer prior to or/as they attend the scene.

2.47 The police come into contact with people who use mental health services are being supported by the CMHTs. A review of service use between April and December 2015 showed 59% of those individuals discussed with the Street Triage had telephone contact with the CMHT up to two days prior to them being seen by the police. The review also showed 80% of the clients that came to the attention of the Street Triage were open to the CMHTs.

2.46 The street triage service was a jointly funded pilot that operates between 19:00 and 03:00 seven evenings per week with the aim of reducing the use of Mental Health Act Section 136 detentions and stopping the use of police cells for people in mental health distress. The police often come into contact with people experiencing mental distress and this service enables them to discuss the case on the telephone and receive information, personalised advice and support for their subsequent decisions based on a review of the person's mental health records where they are already known to

services. The service also proactively screens the emergency call log and identifies where advice may assist the responding officer prior to or/as they attend the scene.

2.47 The police who come into contact with people who use mental health services are being supported by the CMHTs. A review of service use between April and December 2015 showed 59% of those individuals discussed with the Street Triage had telephone contact with the CMHT up to two days prior to them being seen by the police. The review also showed 80% of the clients that came to the attention of the Street Triage were open to the CMHTs.

2.48 The Local Authority, **Out of Hours** (OOH) service is a statutory provision and covers all assessment work required out of usual office hours. The service is responsible for safeguarding adults and children and undertaking Mental Health Act assessments. The Mental Health Act assessment work equates to 72% of the visiting/assessment workload. Approximately 75% of the people assessed by OOH under the MHA are not admitted or detained. These figures were presented to Bournemouth Health Scrutiny in June 2017. The team takes referrals from anywhere including e.g. families, social care/health professionals, the police and from care homes.

Recovery House

2.49 Rethink Mental Illness is currently commissioned to deliver a seven bedded Recovery House in Weymouth. The service is commissioned until July 2018. The main objective of the Recovery House is to help avoid admissions by providing an alternative to hospital admission.

2.50 The service receives very positive feedback from visitors however the service is under utilised. The access criteria have been changed to try to remedy the situation by enabling CMHTs and CRHTs in the East of the county to refer in to the service. This has increased usage but not to full capacity and evidence is developing that people do not want to travel to Weymouth from parts of rural Dorset or from the East of the county to use the service.

2.51 Since writing the Strategic Outline Case the usage of the Recovery House as at May 2017 is running at around 50%. This is equivalent to only 3.5 beds which equates to a cost of approximately £100k per year per bed. Only three of the bed days are occupied by people from the west of the county and very few people go to the recovery beds from the east.

Third Sector and Private Providers

2.52 In Dorset there is a range of third sector and private mental health providers which are a mix of local and national organisations. The providers have a range of expertise for example, supported housing/registered care, day opportunities and employment services, recovery houses. Dorset Mental Health Forum has been heavily involved in the MH ACP and they jointly deliver the Recovery Education Centre, Wellbeing and Recovery Partnership and Peer Development.

2.53 As part of the MH ACP project a community asset mapping document was produced to show the range of providers (other than NHS) operating in the county. The Mapping document can be found in **Appendix 8**. It is the intention to further support the voluntary sector to deliver services to our population.

2.54 The CCG investment in services is split between NHS and third sector providers. The mental health commissioning acquires 92% of its services from the NHS provider and 8% from third sector providers.

The Financial Context

2.55 If NHS Dorset CCG does not change how the health community works, it is forecasting overspend of £433,000 per day by 2020/21. This forms part of the case for change in the Clinical Services Review. The system must do things differently and innovate if it is to deliver financial sustainability within the context of both the financial and workforce challenges.

2.56 The CCG invested over £800k in 2015/16 to support OOA PICU placements while the new PICU unit at St Ann's Hospital was being developed, £620k to deliver a 24/7 psychiatric liaison service bringing the investment up to £1.2 million in psychiatric liaison, and £150k for the crisis line and £130k for street triage.

2.57 The MH ACP project parameters were set and outlined at the beginning of the project and reiterated throughout the modelling stage. One of the parameters was that any change to the pathway had to be achieved within the current spend. It has been emphasised that this was not a cost cutting review and it is in line with the national vision for increasing investment in mental health services and achievement of parity of esteem.

2.58 Since the start of the project, additional funding has been identified to invest in the MH ACP to support the delivery of parity of esteem requirements. It has been confirmed that an additional recurrent £500k funding for parity of esteem has been allocated to this project. This funding will be used to support the delivery of the community front rooms and prevention and recovery based services.

2.59 Financial circumstances are continually being reviewed to ensure that the finances balance. In the light of the on-going review processes it is proposed that the funding for the Community Front Rooms and Recovery beds are included in the Dorset HealthCare Contract and Dorset HealthCare will be prime provider for the CFRs and Recovery beds. The budget will also include £350,000 investment from the re provisioning of 7 recovery beds.

2.60 The financial modelling assumptions were cautious in the SOC, with higher end costs assumed. In addition, the assumptions made were on staff costs only. The OBC details additional non pay costs. Medical costs were not shown within the SOC as they sit outside of direct service budgets. Medical costs will remain 'as is' and therefore cost neutral for this exercise. Dorset HealthCare will be undertaking an exercise to more clearly demonstrate medical costs against each service, rather than as one total medical budget.

2.61 The SOC described the proposed pathway development which takes account of the additional non-budgeted spend (overspend) on OOA placements which will continue and potentially grow if a new pathway is not delivered. The Local Authorities contribute social work and social care to the community teams and the LA shares the funding of integrated managers.

2.62 Funding for additional beds is modelled on a system spend reduction. In 2015/16 £2 million was spent on OOA placements in addition to the £853k funding from the CCG (total £2.85 million) for PICU placements. It is agreed that the system requires an additional 16 acute in-patient beds (22 if PICU is included) to offset the need for OOA placements. Recurrent funding for the required number of beds is sought through this business case. The OOA spend for 2016/17 based on month 12 financial reporting was £2.5 million. £853k was budgeted which means that £1,647,000 is a system spend not included in the baseline budget.

2.63 During the latter part of 2016 the female PICU beds were opened and this has reduced the out of area placements but there are still significant issues related to people being held in emergency departments or in the community whilst waiting for a bed or being sent out of area. Dorset HealthCare also contracts with the YMCA in Bournemouth to accommodate people who are able to be discharged from hospital.

2.64 The OBC presents all the costs based on the current out of area spend and predicted growth in out of area costs to ensure that the new MH ACP is developed within existing spend.

2.65 System Cost Improvement Plan (CIP) requirements (4%) were not included in the SOC and continue not to apply to the OBC.

2.66 NHS England invited bids for capital funding to deliver places of calm and Dorset HealthCare submitted and won £600k a bid. This is to enable the capital improvements to be made to current estate to deliver aspects of this new pathway, particularly safe haven options that will reduce the number of Mental Health Act, Section 136 detentions and reduce the number of Emergency Department presentations. The £600k will be used to develop the Retreat in Bournemouth at Hahnemann House.

The Case for Change: A Co-Produced Approach

2.67 The need for a different approach to the Acute Care Pathway has been demonstrated through a comprehensive needs and data analysis (Stage 1 of this project); a significant view-seeking exercise (Stage 2); gathered views and experience of the CPG (during Stage 3); and a two-month public consultation (Stage 4).

2.68 The View Seeking report's thematic analysis (developed in stage 2) confirmed the findings of the data analysis. The methodology was co-produced with service users to ensure that it was appropriate and compelling. 906 responses were received equating to 3,355 views. **Full details can be seen in Appendix 2**.

2.69 The report's key findings were:

- Services should reflect the desire of people with an SMI to be treated as individuals and that services should be flexible to cope with each case individually.
- Poor experiences with services and how they are delivered appear to result from demand outweighing supply, with services often under-staffed, under-resourced and therefore unable to provide the required level of care and support to those who are in need.
- Increased staff levels, with fully trained staff within inpatient units, Crisis Teams and CMHTs, coupled with improved out-of-hours access to services would mean that care and support would be more likely to result in improved outcomes for those with an SMI and their families and carers and this includes parents who have an SMI who have children to care for.
- Face to face time with clinical staff is important especially when it is quality time with the right kind of intervention but other kinds of support are seen as important such as Peer Support from people who have lived experience of mental illness or Support Time Recovery workers. These approaches provide a diverse workforce that can meet the need of individuals.
- There is a need to provide more beds, or enough beds in the right place, to meet the needs of patients. Having the right number of beds means that service users are more likely to receive the care and treatment they need, when they need it in a hospital that is near to where they live.
- A service review should also address the need for more joint working between services and IT systems that facilitate this, including sharing of information so that patients do not have to repeat themselves and those providing care have a better understanding of each individual case.
- Communication should also be improved between service providers and those with an SMI and their families and carers, with more involvement in care planning.
- There should also be efforts to raise awareness of mental health with the general public, GPs, the police, employers and within schools. This would remove the stigma attached to mental illnesses and would also result in those with an SMI being treated appropriately.

2.70 Services are currently fragmented and have been set up in such a way that silo working is inevitable, hindering continuity and reducing consistency of care, and there is little choice of service or communication channel for people using services.

2.71 The need for trust in the supporting team is paramount to people who require support and the vision seeks to improve this area for people who use services. For example, a patient open to secondary care could be passed between several services and between several different clinicians in the course of an episode of treatment and care. There are many possible 'clinician and team transfers' between the CMHT, the CRHT, the inpatient service/s and back to the CMHT or to another service in the overall mental health service provision/care pathways.

Project Objectives

2.72 The project objectives were co-produced with the CPG and they were defined to address the key problems identified. The objectives are shown overleaf and in the management case, the table shows how these will be monitored and evaluated:

Objectives	What it means
To ensure consistency of provision and access and care	• Develop a consistent acute mental health care pathway across Dorset where people using services will know what to expect from each service • Define the range of skills that will be available at each level of service • Ensure that this is in place consistently across Dorset acknowledging that operating models might differ e.g. rural service may be different to urban • To ensure that consistent services e.g. waiting time or performance targets and patient outcomes are delivered in all geographical areas of Dorset • To ensure that IT and other systems are in place and are accessible and allow staff to give time and attention to the patient and that enables people, where possible, to tell their story only once, in the way they want to tell it
To ensure that services are accessible wherever you live in Dorset	• Ensure better access to prevention, self-management, and support services that reduce need for in-patient care • Ensure sufficient inpatient provision to meet the need of the population • Ensure access to effective treatment and therapies where appropriate • To ensure that comprehensive and accurate information about services is available to all in an accessible way • To ensure that there is an easy and effective process for referral to all mental health services across Dorset • To develop a broad range of services that are available on a 24/7 basis so that people can access support when needed especially when they are experiencing a crisis • To develop services to address specific gaps in provision

Objectives	What it means
To ensure that services are community facing and that local community assets are fully utilised	• Ensure that people who use services are able to engage in community/social activities as part of their recovery plan • To achieve increased understanding of mental health issues amongst the general population • Develop partnerships with the third sector to ensure access to community resources
To ensure that the style and culture of the service delivery is person centred and recovery focussed	• Ensure that the success of services is measured in terms of the achievement of personal goals set by the individual service user and recorded in all care plans • The achievement of outcomes reflected in commissioning model (e.g. increased employment of service users, reduced length of inpatient stay; improved satisfaction with services, increased staff satisfaction). • To ensure appropriate referral for Mental Health Act assessments

2.73 The Co-production and Urban and Rural Groups were facilitated by national specialists in mental health and social inclusion, ImRoc and NDTi, and they helped all the groups to consider how services would need to change if the objectives of the project are to be met. The workshops explored areas of best practice through the project team's benchmarking activities, the facilitators gathered the views of all the participants and the groups considered innovation in the UK and other parts of the western world. The innovation presentations can be viewed in **Appendix 9**. The project team also undertook a number of benchmarking visits to learn from organisations already doing things differently and the outcome of this can been seen in **Appendix 10**.

2.74 The series of workshops started with two days of innovation and envisioning. The aim of these two days was to bring people together to consider possibilities in relation to mental health care. After the two innovation days all three groups met twice in rotation so that the CPG developed the ideas, the Urban Rural Groups challenged and developed them and the Cross Check Groups critiqued the work solely from the point of view of, "how would that work in my case?".

2.75 The outputs from the CPGs show that the objectives cannot be met without re-shaping existing services. The vision developed by the CPGs is of; services that are accessible, consistent, community-focused and person-centred in style and culture and to achieve this will require a move away from the current model of care that is unable to intervene soon enough to help people manage their condition and prevent crisis into something more preventative and proactive in nature.

2.76 The CPGs developed a service vision based on national guidance, NICE guidelines, best practice and especially drawing on the views of service users, carers, clinicians, service managers and commissioners and informed by national and international innovation in mental health. The key elements of this service vision are as follows:

- In the reconfiguration of services, the aim is to maintain all the core functions of the existing services but enable them to work together and differently and more flexibly across the county. The aim is to offer more choice and the option to self-referral in order to improve ease of access to services and this will mean services will be provided in a different manner as resources are not increasing.
- There will be no reduction in the number of beds across Dorset: 16 new acute beds will be added to the system (22 including PICU) to manage capacity in Dorset.
- The Crisis Home Treatment functions will be integrated with the CMHTs so that teams have all the expertise and skills required to support people experiencing mental health crisis. This change will also reduce the number of teams people in crisis are referred to. The crisis management side of the CRHT will in part deliver the Connection Service along with the Street Triage team.
- Capacity is to be created in the CMHTs by people in clusters 1-3 being supported in primary care, through Steps to Wellbeing, primary care services and Recovery Education. The model proposes in-reach in GP surgeries to provide support to people closer to their homes and also development of more advice and guidance for primary care.
- The Home Treatment Teams will be integral to the CMHTs and will be provided across broader team areas e.g. Bournemouth, Poole, West Dorset and North Dorset to ensure resilience especially out of hours to ensure that there is a viable alternative to hospital admission through home treatment. The core hours will be 9am-10pm and support will be provided through the Connection Service team outside of these hours.
- People who have been open to CMHTs and discharged will be able to refer themselves back to the CMHT without going to their GP. This is important because people want support earlier and GP referral slows access to MH teams.

2.77 The additional elements of the service are:

- Enhancing the existing Crisis Line and creating the **Connection** that will be available 24/7 but will have increased staffing at peak hours to enable people to access the support they need, through a range of channels, to avert or manage their developing crisis and access this support when they feel they need it. This will include face-to-face assessments within 4 hours, which will also be supported by Psychiatric Liaison in the Emergency Departments.
- With the reconfiguration of the CMHTs/ HTT/CRHT the intention is to develop two **Retreats**. The retreat is somewhere to go when things start to go wrong and where an individual can access a service geared up to addressing their need when they present. This can be self-referral, referral from GPs and other services or can be an alternative to ED or Police Custody when someone is experiencing mental distress. These will be open over times when other services are not in operation: Monday to Thursday 16:00-24:00 and Friday to Sunday 18:00-02:00. Police and ambulance

services could also access these services should this be appropriate. They are places of calm and will be supported by a mix of clinically qualified staff and people with lived experience.

- **Recovery beds** are currently provided in the west of the county and do not meet the demand and the intention is to commission the same number of recovery beds but spread across the east and west of the county.
- **Community Front Rooms** (CFR) are safe places to go when things start to go wrong, similar to the Retreats but not necessarily developed on the same sites as CMHTs. The Front Rooms can be based in existing community assets, where there are high levels of privacy available and not in openly public spaces. They would be set up as safe spaces to help people manage their own concerns and/or crisis through contact with other people, peer support workers and or clinicians and open at times that people have outlined are pertinent to feeling anxious and isolated in their communities. Because of the nature of CFRs, each one will need to be closely tailored to the needs and resources of local communities and may well include recovery focussed activities for people to maintain their wellbeing. There are local groups and organisations that already support people in maintaining their wellbeing and as the CFRs develop there are likely to be opportunities to develop relationships with already existing groups. The CFRs are modelled on being open on Thursday to Sunday from 15:00-23:00, in line with when people have indicated they feel most socially isolated.

Summary

2.78 During Stage 3 of the review, the CPG considered the findings of Stages 1 and 2, and used them to articulate the key problems that should be addressed in resolving the Acute Care Pathway.

2.79 Stages 1 and 2 of the project highlight several key issues; consistency, accessibility and meaningful relationships with their care coordinators and care teams. They also highlight that services should be community facing to help raise awareness of mental health and reduce stigma in local areas. They also support that services must be set up to be person-centred not service centred which is also highlighted in the objective related to style and culture.

2.80 The specific objectives agreed by the CPG are set out in **Section 2.72 and Appendices 11&12**. They can be summarised as:

- To ensure consistency of provision and access and care
- To ensure that services are accessible wherever you live in Dorset
- To ensure that services are community facing and that local community assets are fully utilised
- To ensure that the style and culture of the service delivery is person-centred and recovery focussed

2.81 The OBC describes how the preferred option can be delivered. There are a number of ways in which the type of pathway described could be achieved. However, the CPG

remains clear that the future Acute Care Pathway must reflect the vision set out above if the objectives are to be achieved.

2.82 Stage 4 of the project brought all the proposals together in a consultation document that presented the shortlisted options to the public for comment and critique.

2.83 The consultation feedback endorsed the preferred option, option B, and this was especially true for people who use services, carers and staff. The responses indicted that people want earlier support in community settings to help them prevent crisis from occurring. The consultation outcomes are described in the economic case; the full Consultation Analysis report is in **Appendix 3**.

Benefits

2.84 A number of benefits are anticipated to flow from the MH ACP developments some are described in the objectives and some are described in the financial case (sections 5.6-5.13). The main benefits are shown below. As the project progresses the benefits will be measured to ensure that the changes to the pathway, once fully implemented, are identified and reported clearly.

	Softer outcomes/benefits – patient and staff reporting and contract monitoring
Service users	• The services will be consistent: service users will be able to tell their story once and know the clinicians who are supporting them • People will be able to have appropriate clinical time and relevant interventions from the clinical teams • Service users will know what choices are available and how to use them • People who have used services before will not have to be re-referred by their GP to get back into the mental health system when they know they need it • People will have more control over how they and their supporters receive support • The crisis response will be more rounded and person-centred than in its current format, e.g. people defining their own crisis and services responding appropriately to that • Teams will be multifunctional to reduce handoffs that are currently inherent in the system • Staff will be more fulfilled and less likely to move on • There will be other skilled people e.g. peer workers etc. involved in support which will enable clinicians to focus on what they need to do

	Softer outcomes/benefits – patient and staff reporting and contract monitoring
Families/ carers	• Staff will have more time to talk to carers and take account of their needs and issues • The Connection Service will provide advice when needed and act as a route through which concerns can be raised • Teams will be multifunctional to reduce handoffs that are currently inherent in the system making things easier to understand
Staff	• Staff will spend a higher proportion of their time doing the work they are trained to do, making better use of their skills • There will be opportunities to learn new skills and work in different ways • Working with peers will be fulfilling • Staff will know they are able to prevent crises and improve the lives of the people they work with • Teams will be resourced to reflect demand to provide fairer allocation of staff • Resource (funding and people) are utilised where the demand is • Staff should be more fulfilled and less likely to leave or retire early
Service sustainability	• Better outcomes for the population we serve, fewer crises • A strong foundation for ongoing partnership working with service users and others (continuing co-production) • Improved reputation, seen as using best practice • Better understanding of service issues and priorities • An improved commissioning cycle and a dynamic commissioning approach through continuous feedback • Stronger relations across the STP • Opportunities for market development / a more diverse market • A more supportive market framework, particularly for smaller providers • Services will be aligned with primary care services to ensure that there is a bridge between levels of care

Group to benefit	Outcome	Measured through contract monitoring	System Costs
People who use services The mental health system Carers	• People will be able to get support close to their home. • People will be able to get support at times when they need it • There will be a reduction in the use of admissions and use of The Mental Health Act because intervention will be earlier rather than at crisis point • Support will be provided in the least restrictive setting to meet someone's need and always as close to home as possible • More choice for people using services in terms of how they manage their own crisis situations • Get a response when it is needed	• No admissions out of area • Patients in non-specialised adult acute inpatient settings no further than 31 miles away from home • Fewer Mental Health Act Assessments • Less MH Act Assessment Activity in out of hours • Fewer section 136 detentions • Contract monitoring of complaints about crisis services • Fewer Emergency Department presentations due to MH crisis	• MH Act Assessment costs approximately £498 • Approved MH Professional (AMHP) costs £30 per hour Sec 12 Doctor costs £174 • Average MH Act Assessment 5 Hours. • Section 136 Assessment costs approximately £1,780 per assessment including AMHP, Sec 12, Police and Ambulance, 136 suit etc. • Out of Hours Assessments Cost £318,222 in 2015/16 there were 639 assessments at £498 per assessment

Risks

2.85 The key risks to the successful achievement of the project's objectives are described in a risk log which is in **Appendix 13**.

Parameters

2.86 In the Strategic Outline Case stage there was an agreed service line budget for the MH ACP. At the start of the review it was deemed highly unlikely that any additional funding would be made available. A parameter was set that the MH ACP developments would need to be undertaken within the current spend.

2.87 At the OBC stage it is agreed that there is an additional £500k funding for the creation and delivery of the community front rooms and to develop the interface with primary care.

2.88 All the other developments have to be delivered within the system spend.

2.89 Additional Parity of Esteem funding was released at the SOC stage to support the pathway redesign, and this money will be specifically targeted at the development of the 3 CFRs and 7 Recovery beds through a lead provider which will be Dorset HealthCare.

2.90 Recurrent funding for the delivery of the reconfiguration of inpatient acute beds will be offset through the reduction in OOA placements and subsequent unbudgeted costs. The other parameters that were identified throughout the project are as follows:

- St Ann's Hospital and Forston Clinic are to remain as the strategic sites
- The pathway must support nationally mandated targets and objectives
- NICE clinical guidance and quality standards should be met
- Nothing should be included in the MH ACP model that is not evidenced in the Needs and Data Analyses or View Seeking report and subsequent co-production

Dependencies

2.91 There are several ongoing initiatives on which this project is dependent or which might significantly affect the success of this project. Some are internal to the CCG and others relate to commissioning partners and providers.

Initiative	Nature of dependency	How we are managing the dependency
Clinical Services Review (CSR)	The end point model where 15 Linden Unit Beds are moved to St Ann's Hospital is dependent on the older people functional ward at St Ann's Hospital being relocated to another site Reliant on the outcome of the CSR consultation for a decision on community services locations and resultant time scales Integrated ways of working across physical and mental health integrated teams will be key to achieving parity of esteem	The project team have developed a staged implementation plan that enables the system to become sustainable whilst other decisions are being made regarding service location. This does not initially deliver the beds in the prevalent areas but will deliver the bed base required for 4-5 year, by continuing to deliver services from the Linden Unit.
Ongoing maintenance of local authority (LA) social worker budget in the MH ACP	The delivery of the pathway assumes social worker input and case management	Confirmation has been received from all local authorities that currently no LA resources will be removed from MH services within the next year. The caveat is about mid-term financial planning that will continue to squeeze current resources. This will be monitored on an ongoing basis and discussion on impact to the system will be taken to the Joint Commissioning Board to discuss formally.
Primary Care Strategy	A number of clients are currently being supported in secondary care services when their level of acuity would be more appropriately managed in primary care and/or IAPT services	A business case for IAPT expansion has been developed and funding received to start the expansion. This aims to increase capacity in line with the requirement of the NHS planning guidance which will enable more people to be treated by this service. There will be input into the primary care delivery plan by the MH team and Dorset HealthCare to ensure that support mechanisms such as advice and guidance are put in place prior to any specific transition period

2.92 **Stage 4** of the project was a public consultation which was the culmination of the coproduced work to date. The consultation documentation presented the case and proposals for the new model of Mental Health Acute Care Pathway. There were a range of options presented for consultation. The proposals add a range of services that enhance existing services in the current pathway. These new additions focus on prevention of crisis and on ensuring that where a crisis does occur there is the right provision in place to meet that need, including additional inpatient beds.

2.93 The public consultation highlighted a range of themes and issues, these are highlighted below, and they formed the basis of additional work that was undertaken to deliver the OBC development.

MH ACP Consultation Findings
Closing the Linden Unit requires additional explanation to help people understand how the recommendation to close the Linden Unit was reached.
The re-provision of MH beds across Dorset requires additional clarity so that the rationale is wholly understood including the bed usage and provision for men and women in the West of the county which will include the four additional beds at Forston Clinic that will be female beds.
Issues related to the workforce challenges in Dorset have been raised especially in relation to recruiting, staff retention and the fact that 40% of the Dorset HealthCare workforce is heading towards their 50s and in a position to retire.
Workforce in relation to training and skill and safety for the Community Front Rooms and Retreats and assurance about the suitability of these options for people who experience serious mental illness.
Transport is a theme in the consultation feedback and additional travel time analysis is required.
The consultation analysis showed to some extent that the older age ranges were less likely to support the retreat and Community Front Room proposals.

Assumptions Tested

2.94 The key purpose of the OBC is to test the assumptions outlined in the SOC and describe whether they remain sound or whether additional modelling work is required to provide assurance that the preferred way forward remains the best options to meet Dorset's requirements.

2.95 The assumptions are as follow:

- Based on the bed usage for men and women in the west of the county 18 beds should meet the demand for inpatient care for people within 31 miles of their home
  - This was reviewed as a result of the consultation and the previous calculations appear to remain accurate based on the flow through the wards and the additional four female beds being introduced at Forston Clinic. There is an optimum range of bed provision for men and women and 12 male beds and 6 female beds at Forston Clinic is within the required range.

- People in clusters 1-3 and some people in cluster 4 would benefit from being supported in primary care by GPs and Steps to Wellbeing
  - People in clusters 1-3 are being referred back to primary care where appropriate and not taken on by the CMHT teams when newly referred unless there appears to be a more complex presentation

- There would be no significant growth in the SMI % prevalence rates even with a population increase
  - The assumption about the increase in prevalence rate was incorrect for 2015/16 because there has been a 0.05% increase in prevalence rate from 2013/14 to 2015/16; however, this has not had an impact on CMHT caseload numbers which have reduced since 2014/15 but might have had an impact on services ability to work preventatively

- Travel and transport links would remain
  - People who were part of the modelling work who use services said that they would drive up to 25 minutes to access a retreat or Community Front Room if they knew that the support they received when they arrived was going to be good. The project team has reviewed the travel time analysis to ensure that the assumptions were correct about the locations of the Community Front Rooms and correct about the 31 mile access from home to inpatient units.
  - In terms of the travel analysis of 25 minutes by car the initial travel assumptions remain correct for the Retreats being in Dorchester and Bournemouth and correct for the indicative sites for the Community Front Rooms being in Bridport, Sturminster Newton and Swanage.
  - However, the additional review of public transport strongly suggests that Shaftesbury and Wareham are likely to be better options because of the direct links to public transport. A north Dorset CFR may also be better placed in the Shaftesbury area due to the significant forecast increase in population expected in Gillingham.
  - The review shows that public transport is not generally the best option for people who need to get to any of the sites. Only 20-30% of people with an SMI would able to access the Retreats or Front Rooms within the 25 minutes by public

transport. If all of the sites are in the areas where the connections are better it will make the situation as accessible as possible.

- The CCG is working with the three Local Authorities to address the concerns about public transport not being available to take people to key NHS locations including the mental health locations. The mental health locations also include sites for the Community Front Rooms and Retreats.

- The social care resource will not be reduced in the CMHTs
  - Since the modelling work was carried out assurance has been given from Bournemouth and Poole that no LA resource will be removed from MH services within the next year but there is a caveat about mid-term financial planning that will continue to put pressure on current resources.
  - Dorset County Council regards the mental health support services as a priority but are looking to maximise the use of resources, reduce costs where they can and look at new delivery models which support the principles set out in the MH ACP.

CHAPTER 3
THE ECONOMIC CASE

3

3. THE ECONOMIC CASE

3.1 The economic case reviews the process to date and takes the outcome of the public consultation into consideration. It outlines the shortlisting process that led to the proposals in the consultation and hones in on the preferred option which has emerged through the consultative process. It outlines the shortlisting for community and inpatient proposals.

3.2 The strategic case has been reviewed and updated in light of national policy, local strategy and the public consultation and confirms that with a few minor amendments described in the strategic case nothing has emerged of any significance to make the co-production team change the recommendations and preferred option.

3.3 The new service vision is clear in terms of the key elements of service being proposed, and how they might work together. This is described in the financial case which presents an updated costed model.

3.4 The economic case explains the process for how the preferred options were developed, and how a wide range of possible options was reduced to a shortlist of just a few for consultation. The overall aim being to ensure that the final option represents the best possible value for money and that it can achieve the expected outcomes.

3.5 The consultation presented a number of options to the public that had previously been shortlisted by the CPG. The shortlisted options are the best way to ensure that the vision is realised. The shortlisting process included Retreats, Community Front Rooms, Recovery Beds and the Connection Service and increasing bed numbers overall to meet the demand and moving existing beds to the areas of highest demand.

3.6 The consultation document presented all the short listed options. It asked the public to comment on the overall proposal and specifically to comment on the parts of the developments that could be influenced through consultation.

3.7 The final recommendation has been influenced through the public consultation which supported the preferred option. The quantitative data was decisive about the preferred option. The qualitative information formed the basis of any additional work required in order to develop the Outline Business Case.

3.8 The shortlisting followed a process the meets the requirements for the Treasury approved five case model for business case development.

3.9 The CPG agreed the objectives and the critical success factors (CFS). Both are shown below. The Objectives are fully described in Appendix B but summarised as:

- **Achieve consistency** – ensure consistency of provision and access and care
- **Improve accessibility** – ensure that services are accessible wherever you live in Dorset

- **Community facing** – ensure that services are community facing and that local community assets are fully utilised
- **Style / culture** – ensure that the style and culture of the service delivery is person-centred and recovery-focused.

3.10 The Critical Success Factors (CSFs):

Factor to be considered	Issues to be included when considering this factor
Can the option really be **implemented?**	Will there be sufficient / appropriate workforce? Will it be attractive enough to retain the workforce? Will the necessary IT systems be in place? Will all other necessary systems be in place?
Does the option deliver services which are **safe** and **sustainable**?	Will there be sufficient staffing and systems to ensure the safety of staff and people who use services in all settings? How vulnerable will the services be to unexpected staff shortages (e.g. sickness, absence)?
Will the option be **affordable**?	Using high-level estimates, do we believe that the option can be delivered by reshaping existing resources? If there will be short-term transitional costs, do we believe there will be a way of funding them? Will the option be affordable in the long term?
Will this option deliver services which will be **acceptable** to people?	Will services be acceptable / attractive to people who use services? Will they be acceptable to the families and carers of those who use services? Will they be acceptable / attractive to all groups – for example, BME communities?
Is the option based on **evidence of best practice**	Is there objective, accepted evidence of the effectiveness of the proposed service model?

Factor to be considered	Issues to be included when considering this factor
Will this option result in **a better experience** for those who use the service?	Will it promote positive relationships between those who use the service and the clinicians who support them? Will it "help us live the lives we want to live"?

The Shortlisting Process for the Community Services

3.11 At the Strategic Outline Case (SOC) stage the best way forward was determined with reference to the objectives and the critical success factors outlined above and the public were presented with some options that could genuinely be influenced by their input. The options that could be influenced were the location of the Retreat in the west of the county, the number of Community Front Rooms and the number of Recovery Beds.

3.12 The other elements of the proposal were included in the consultation document because they are critical for the whole pathway. However, the recommendations about these elements were not consulted on. These included; reconfiguration of the CMHTs and the Connection Service. The shortlisting process related to the Connection Service indicated only one viable option that meets all the CSFs and objectives which meant there was no value in including it for public influence.

3.13 The other option was to increase the number of acute inpatient beds by 16 and close the Linden Unit and re-provision the 15 Linden Unit beds to the area of highest demand for inpatient care. The public were asked whether they support an increase in bed numbers and whether they support putting beds where they are most needed. The public were also asked to comment if they had anything to say about the overall proposal and all the elements included.

3.14 The number of Retreats: The development of Retreats is a key part of the proposed new vision. For a Retreat to be viable it has to serve a critical mass of population. Analysis suggested that there are two viable areas in Dorset: the Bournemouth/Poole conurbation and the Weymouth/ Dorchester area. The choices at the shortlisting stage were to have just one Retreat (in Bournemouth/Poole, Weymouth or Dorchester); or to have two Retreats (one in the east in either Bournemouth/Poole and one in the west in either Weymouth or Dorchester). A three Retreat option was ruled out because it would be unaffordable and there were only two areas in Dorset where there was the required critical mass of people to make the Retreat viable.

3.15 The number of Community Front Rooms and Recovery Beds: The development of the Community Front Rooms is crucial to the spread of services across the rural areas of Dorset and to enable as many people as possible to be able to access a support service. These were also crucial in relation to the project objectives and CSFs as they related to reducing stigma and having community facing services. The recovery beds are

also vital to the pathway to enable people to have access to support to prevent crisis outside of a hospital setting. The recovery beds provide a less restrictive option that should enable people to avoid crisis and in turn avoid hospital admission.

3.16 The shortlisting process delivered two viable options for the CFRs and Recovery beds. The options were ten Recovery beds and two CFRs or seven Recovery beds and three CFRs. The preferred option was the latter because this mix gave the best access to the highest number of people.

3.17 Having considered their performance against the objectives and critical success factors the CPG concluded that the preferred way forward was for two Retreats, three CFRs and seven Recovery Beds. The options included are in the Options Table in the shortlisting summary document in **Appendix 14**.

The Shortlisting Process for the Inpatient Services

3.18 The rationale for including the 16 additional beds and their possible location through the public consultation is described in the strategic case. The shortlisting and conclusion went through several processes that were more complex than the community elements of the proposals.

3.19 Initially the shortlisting process included 12 additional beds in all the options because 12 was the number that the Dorset HealthCare and the project team initially thought would suffice, rather than future proof. However, CPG finally concluded that the best approach was to increase the beds by 16, to enable the future demand for inpatient services to be met.

3.20 The shortlisting process is briefly described below but it is important to note that ahead of the shortlisting sessions the CPG and project team had lengthy discussions about other options that were eventually ruled out because they did not meet the objectives or the critical success factors.

3.21 Some options were ruled out because they did not allow enough access for people within the 31 mile limit and some were ruled out because of issues with estates, others because they did not enable all the inpatient units to accept everyone who requires an admission. Some options were excluded because they were not affordable in the context of the project objectives.

3.22 The primary reasons for proposing the Linden Unit closure were concerned with safety and accessibility: the Linden Unit is a stand-alone unit that does not have the same resilience in terms of staffing for example it has no capacity to call upon other staff resource when a situation with a patient escalates. Because this is the case the unit has to choose patients that can be supported safely and this in turn excludes other patients. It is also inaccessible within 31 miles for a large majority of the population who have a SMI.

3.23 The complete write up of the first round of shortlisting process can be found in **Appendix 14** Summary of Shortlisting.

3.24 Further to the formal shortlisting sessions there were further discussions within the project team and CPG. During these sessions refinements were made to the proposals that confirmed the preferred option which included:

- 16 Additional beds, split 4 to Forston Clinic and 12 to St Ann's Hospital
- Close the Linden Unit and move the 15 Linden Unit beds to St Ann's Hospital

3.25 The above options were finally included in the consultation because the number of beds best matches demand in the areas of highest demand, is achievable within the estate and provides access to most residents in Dorset within the 31 mile limits that the project set as a best practice ambition as described in the Crisp report.

Outcome of the Public Consultation

3.26 Through the public consultation the preferred option was endorsed to a great extent or to some extent. The preferred option is:

- To increase the inpatient beds by sixteen new beds, 12 at St Ann's Hospital and 4 new beds at Forston Clinic: 70.4% of the respondents supported this proposal: 54% to a great extent and 16.4% to some extent
- Move the beds to where the demand for inpatient service is the highest: 63% of the respondents agreed with this proposal to a great extent or to some extent
- Create two Retreats, one in Bournemouth and the other in Dorchester: 77% of respondents supported these proposals and 74 % of respondents preferred Dorchester to Weymouth
- Create three Community Front Rooms: 74% supported this, 50% a great deal and 24% to some extent. 67% supported the commissioning of seven Recovery Beds across the county and 67% of people preferred to have three Community Front Rooms and seven Recovery beds.

3.27 The CCG took account of the consultation views, and as a result of questions raised during the consultation, has undertaken a detailed analysis of the views expressed and has subsequently reviewed the key elements to ensure that the preferred option is the best way forward.

3.28 Following the consultative process and whilst developing the business case, the finances were re-examined to ensure affordability and cost effectiveness. There is capital available to deliver the development of the Forston Clinic site and enough provision for women with ensuite facilities. This raised questions about some of the assumptions about the Linden Unit closure which were linked to the possible costs of rebuilding or refurbishing the unit. However, it should be noted that the primary reasons for recommending the closure of the Linden Unit are:

- As a standalone unit without the same staffing resilience as the other two sites it is unable to take all the patients who require inpatient treatment
- The Linden Unit is not accessible to 53.2 % of the prevalent population within the best practice ambition of 31-mile limit.

3.29 The OBC presents a costed proposal in the financial case showing how the preferred option delivers the best access to the services; best delivers the key outcomes and is best value for money.

CHAPTER 4
THE COMMERCIAL CASE

4

4. THE COMMERCIAL CASE

4.1 The purpose of the commercial case is to demonstrate that the recommended option is deliverable, with providers ready and willing to offer their services. NHS Dorset CCG, three Local Authorities and Dorset HealthCare (the existing NHS mental health provider) are confident that the preferred option for the MH ACP can be delivered and that the implementation will include appropriate time scales to develop the workforce and test elements of the model.

4.2 The Retreat concept will be tested first and the CCG will double fund this phase and this will ensure that there is no disruption in the rest of the pathway before we understand whether the Retreat concept delivers against the objectives. This is based on the co-produced model options development work, which has been crucial to the project.

4.3 The commissioning partners and mental health providers have been involved in the project from the beginning. They have raised concerns and issues and risks as the project has developed and the proposals have been adjusted to take those in to account.

4.4 The partnership process in the project has been the cornerstone ensuring that everyone at every stage of the project inputs into the development of the model. They have, at every stage, been able to say whether the proposal is viable, in line with best practice guidance, deliverable and can meet the requirements stated in the View Seeking report.

Procurement Strategy

4.5 Dorset HealthCare operates within a block contract for acute mental health services and the funding currently in the contract will remain. This provider has been clear on how it can restructure and what it can deliver in the vision for the MH ACP within its current budget and current spend, whilst maintaining and delivering NICE and assessment and treatment standards

4.6 The CCG has the intention to follow a lead provider model for the CFRs and the Recovery beds and that the funding will be ring fenced and transferred to Dorset HealthCare under a waiver to procure without competition. Dorset HealthCare will be responsible for procuring these services which is expected to include voluntary sector provision where viable.

4.7 NHS England requested bids in 2016 to fund capital improvements/development of calm spaces/safe spaces, Dorset HealthCare put in a bid and was awarded £600k for the development one of the Retreat sites. The Retreat in the east of the county will be located at Hahnemann House, Bournemouth. Planning permission has been granted and the £600k will be used to refurbish that site. The site in the west for the Retreat will be in Dorchester, with the exact location to be identified during 2018 as the Retreat in the East is tested.

4.8 The current contract for the Recovery House is valid until end July 2018 and therefore the CCG will seek an extension to the contract to enable Dorset HealthCare to procure a service across West and East Dorset.

4.9 Dorset HealthCare will be the lead provider and as such will be responsible for the delivery of the MH ACP including the delivery of the Community Front Rooms and Recovery Beds and associated outcomes. As the lead provider they will lead a tender process to contract partner organisations to deliver/ part-deliver the CFRs and Recovery beds. There is a healthy market of providers in Dorset who already support people with a mental health need including:

Richmond Fellowship	Dorset Mental Health Forum
Rethink Mental Illness	2Care
Dorset Mind	YMCA
Bournemouth Churches Housing Association	Shared Lives (local authorities)
HOPE	Together
Two Saints	Providers of Accommodation & Support (PAS)
St Mungo's	Key ring Trust
Yew Trust	

4.10 Procurement timetable

Recovery beds and Community Front Rooms

Milestone	Date
Tendering process start with market testing happening from November 2017	April 2018
Contract(s) awarded	April 2019
Contract signed and Mobilisation	June 2019

CHAPTER 5
THE FINANCIAL CASE

5

5. THE FINANCIAL CASE

5.1 The purpose of the financial case is to set out how each element of the services can be operationalised and clearly show the financial impact of the investment proposal. The OBC shows how the preferred option is financially viable by evidencing each element of the service.

5.2 It details the financial implications of the preferred option measuring against the baseline (business as usual option) and finally the section includes the assumptions that have been made for the OBC.

5.3 The financial envelope has increased from what was described in the SOC because the SOC only included staffing costs and the OBC includes all costs including cost of capital and non-pay costs for the Retreats and Connection Services. In 2016/17, the out of area costs were £2.5 million. The cost of the new pathway remains less than the current system spend including unbudgeted out of area spend.

5.4 The costs included in the OBC financial plan include staff costs and non-pay cost they are also dependent on no further reductions to social work input within mental health services.

5.5 It should be noted that the totality of the funding for Older Peoples CMHTs is included in the financing. Payment by results clustering data indicates that an approximate average of 46.1% of patient activity (in clusters 18-21) within these teams relates to dementia (though this may not represent the level of cost). The exact funding relating to dementia services and to functional mental illness services within Older Peoples CMHTs cannot be accurately identified or separated; however, any changes to Older Peoples CMHTs as a result of the MH ACP will ensure remaining capacity within those services to continue to also support people with dementia.

5.6 The financial analysis in the OBC and specifically in this section is based on detailed modelling and costing work for each element of the pathway.

5.7 The proposed pathway improves existing services through a significant reconfiguration of teams to enable workforce to be used more effectively to meet the demand and supports self-managing, preventative and recovery focussed approaches through new services.

5.8 The 'additional' aspects of the proposed model include two Retreats, the Connection Service, three Community Front Rooms and 16 additional inpatient beds. In addition, there will be seven recovery beds re-procured and they will be mobilised in line with the closure of the existing recovery house. The definitions are described in the strategic case in sections 2.21-2.24.

5.9 The **assumptions** in the SOC were based on services that Dorset benchmarked against. The preferred way forward took some of the best elements of the benchmarked services to match the demand and to address the issues that the people who use services raised in the view seeking and modelling stages of the project.

5.10 The assumptions have been tested for the OBC and are described in the next few sections. The modelling shows potential demand for each element and shows detailed costing for each element.

5.11 Below is a brief summary of the key elements including the demand and costs:

Retreats

5.12 The concept of the Retreat was trialled in the USA. The Retreat (described as a Living Room in USA) was always linked to a community mental health service because this enables immediate access to the right level of support, be it contact with a psychiatrist or community psychiatric nurse or a peer support worker. The Dorset model will be based on the tested Bournemouth model and open after usual CMHT hours which means that the links to the CMHT will not be quite the same as those trialled in the USA.

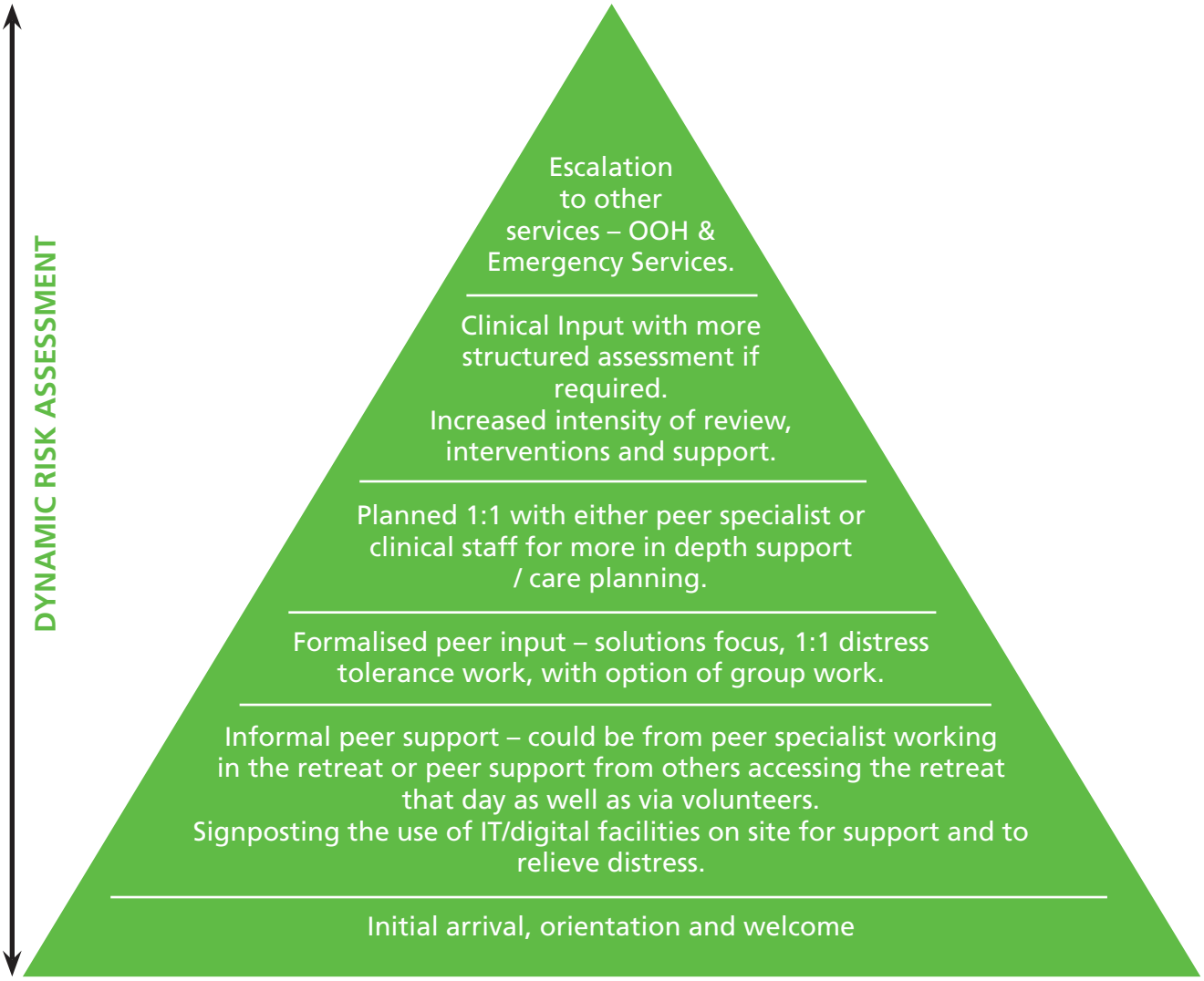
- The Chicago Retreat reports that up to 93% of the guests use it instead of the emergency department and up to 84% of the guests to the Retreats found the interventions helpful enough that they were able to return home instead of a psychiatric admission.

5.13 Other benchmark information for similar concepts came from the Survivor-led Crisis Service (SLCS) in Leeds.

- Leeds has a population similar in size to Dorset. The 2016 population number is 794,250. Leeds has the City Centre and other districts surrounding the City and approximately 75% of the visitors said that if Dial House had not been available then they would have had to use an alternative such as ED.

5.14 The operational and financial modelling following the outcome of the public consultation shows that the Retreat can be delivered and will work in the following ways at a cost of £591,000 for staffing for two Retreats. The Retreat will offer the following:

- A welcome upon arrival with a Peer Specialist with lived experience to talk through what has brought someone to the Retreat that day.
- Differing levels of input based on a person's needs and wishes. This is demonstrated via the model on the next page:



The Retreat in Practice

The Bournemouth Retreat will run with one NHS pay band 7 member of staff, one band 6 who is professionally registered, one band 4 as a senior peer specialist and one band 3 peer specialist. There will also be a band 3 admin post.
The staffing costs to run the east Retreat over the intended hours are £378k.

The Retreat in the west has been modelled to run with one band 6 member or staff who is professionally registered, one band 4 member of staff as a senior peer specialist and one band 3 peer specialist. However, this might be reviewed in light of the retreat testing in Bournemouth.
The staffing costs to run the Retreat in the west are £213k.

The Retreat will be an open access service, however people will be encouraged to telephone in advance via the Connection Service to agree when they will visit the Retreat and this will help manage the demand and ensure space for people in the Retreat.

The Retreat in Practice

It is not anticipated that a person would necessarily stay for the entire period of opening hours on a given day, and therefore capacity to see people would total more than ten per day, but be ten at any one time. The intention would be to stagger arrival / departure times and to agree this with a person prior to their arrival at the Retreat in order to support as many people as possible.

The Retreat will foster a culture of people taking responsibility for their own wellbeing and this will be modelled via working with people as to when they need the support of the Retreat and encouraging them to contact the Retreat to discuss this prior to arrival. This will be via the Connection Service telephone line.

The service will have access to an individual's mental health records, but will access these with the knowledge/consent of the person to better tailor the support offered.

The Retreat will not be branded or promoted as a mental health service, but as a place of sanctuary or safety for those in mental/emotional distress.

The Retreat is intended to work in a recovery model, supporting people to access their own strengths and resources. The Retreat will not include medical input or a prescription/ medication service. The band 6 member of staff would be able to telephone the on call medic via the existing on call arrangements for advice in an emergency as per any Dorset HealthCare service, though it is not anticipated this will be a frequent occurrence. There will be no access to medication via the Retreat.

Emergency services and acute general hospitals (e.g. accident and emergency departments) will use a booking system via the Connection Service telephone line prior to arrival to discuss who they feel would benefit from the Retreat rather than their service.

The Retreat will offer structured voluntary opportunities, especially from people who have used and benefitted from the service in the past, to help coach and support others accessing the service. This will be in addition to the employed Peer Specialists. The Retreat will also offer student placements.

The Retreat is not designed to offer support over the longer term. The Retreat is to support people when they feel in mental health crisis to help them cope in the immediate term and look at other opportunities to prevent crisis in the future, which may well be via signposting to the support of other services.

If a person attends the Retreat repeatedly but engages minimally, there will be a review process to consider how best to support this person.

The Retreat will offer some wound care to help reduce the need for a person to have to go to an urgent care centre or the accident and emergency department if they have self-harmed.

5.15 The Bournemouth Retreat has been modelled to allow capacity for up to 10 people to access it for support at any given time. However, because it is not anticipated that the same 10 people will be in the service all evening and each evening there will be throughput the actual number of people seen each evening is likely to be more than 10. This activity modelling has been based upon the number of people currently seen by the Crisis and Home Treatment Team once with no follow up (e.g. they are not accepted onto Crisis Team caseload), and those seen by Psychiatric Liaison Teams once (e.g. no follow up indicating an ongoing need to stay in an acute hospital), as it is anticipated that in the future model, people would be redirected to the Retreat in these circumstances. Some additional capacity has also then been built in to account for people who may not use existing crisis services due to them not meeting their needs but who may choose to use the Retreat. The Dorchester Retreat will be modelled in the same way once the test of concept has been concluded. However, it is likely that the Retreat in the West will see fewer people and so will not be staffed at the same level and the Dorset area also has three Community Front Rooms to improve access in rural areas.

5.16 The staff training and induction programme will be the same for professionally registered clinicians and Peer Specialists and there will be parity between the roles in terms of acknowledgement of the unique skills both roles will bring. The Retreat cannot function without both. There will be a focus not just on the skills required, but the values required in order to work within the Retreat, with an emphasis on compassion based therapy. Recruitment will be values based.

- It should be noted that the Retreat in Bournemouth is being staffed at a higher staffing ratio because of the SMI prevalence in Bournemouth and this will support the testing of the Retreat in order to determine the best operating model, as the wider system changes will not have been implemented during the pilot to support the service:
  - 1 X band 7 clinician
  - 1 X band 6 clinician
  - 1 x band 4 senior peer specialist
  - 1 x band 3 peer specialist
  - 1 x band 3 administration support (for calls, bookings etc. in the absence of the Connection Service)

5.15 In addition, a non-pay budget of £10,000 will be allocated for the Retreat pilot, to cover expenses such as equipment and supplies, staff parking permits, transport etc. This will be reviewed during the pilot to fully understand operating non pay costs.

The Connection Service

5.16 The Connection Service staffing has been modelled looking the number of calls to the crisis line and street triage activity. The modelling took into account the number of missed calls and the length of time each call took and takes following assumptions into consideration:

- Each call will take up to 30 minutes including logging details on to 'Rio', Dorset HealthCare's Patient Administration System (previous average call time is approximately 6 minutes): benchmarked Leeds service had average 22 minutes.
- Street triage calls will take 45 minutes including logging details on to 'Rio'.
- Missed calls from the previous 'crisis line' have been factored in to ensure current demand is accurate
- From 22:00 until 08:00, the historical home visits for assessment or medication delivery has been factored in at an average of 3 hours per visit, to ensure that the proposed staffing can continue to meet this demand should that still be necessary once preventative services are in place.
- This modelling still provides additional 'capacity' to meet further demand as a safety net.

5.17 The staffing for the Connection Service will be as follows:

- 10.00 – 18.30 – 1 band 6 and 1 band 3
- 18.00 – 02.00 – 2 band 6 and 2 band 3
- 01.30 – 10.30 – 2 band 6 and 1 band 3

5.18 The Connection Service line will have a dedicated number for emergency services (e.g. Police) to call for advice or support/ triage. The Street Triage worker would be co-located with the Connection Service line (moving out of the Police control room where they are currently based).

5.19 The Connection Service will have one base but cover the county of Dorset. The Connection Service will either directly provide face-to-face assessment within four hours when required, or facilitate this via other local services according to their need.

5.20 Staff working within the Connection Service will undergo a similar compassion based therapy training programme to the Retreat and be assessed /appraised based upon values/empathy as well as skills.

5.21 Potential capital costs for the Connection Service need to be identified from the restructuring of the community teams and this will not happen until 2019 after the Retreat has been tested.

Community Mental Health Teams and Home Treatment

5.22 The Community Mental Health Teams will continue to work in set locality areas, integrated with social services. The aims and objectives set out within the SOC for CMHTs continue to be relevant within the OBC; to improve continuity of care and reduce handoffs for people between services, especially when they are in crisis.

5.23 The CMHT core hours will remain Monday – Friday, 09.00 – 17.00 with the existing staffing levels and operating costs (pay and non-pay).

5.24 The SOC included an ambition to co-locate more urban teams on one site e.g. for all Bournemouth CMHTs to come together but this is no longer viable as The Kings Park site is no longer being redeveloped. This does remain a longer term ambition however this will be dependent on a wider estates strategy.

5.25 A home treatment function will be amalgamated to sit alongside the CMHTs rather than work as a standalone crisis team. The home treatment function of a CMHT will operate between the hours of 09.00 and 22.00, seven days a week.

5.26 The new proposal will still see 24/7 crisis support being available via a range of services including the Connection Service with the ability for emergency face-to-face assessments within four hours. home treatment will be planned where ever possible during the day and home visits can be carried out up to 22.00. Home visits will not usually happen after 22.00. This change is to improve the planning of day time care and will enable the focus to be on more acute needs for people requiring urgent assessment.

5.27 Aligning the home treatment function to CMHTs will improve continuity of care in a crisis and mean one team maintains oversight of a person's care during period of crisis and periods of routine support.

5.28 The home treatment function will work to broader super locality areas and with no reduction in caseload e.g. the teams will be covering Bournemouth, Poole, North Dorset and Mid Dorset for improved resilience and to reduce isolated working, especially outside of CMHT core hours.

The home treatment element of the service will have the following staff. There will be six band 6s per shift with seven on Saturday and Sundays and four band 3s per shift county wide.

The shift patterns will be 09.00 – 17.00 and 14.00 – 22.00 which will result in enhanced staffing during the cross over period of 14.00 – 17.00 to help prevent crisis escalating out of core CMHT hours where possible.

Inpatient Services

5.29 The plan to develop Forston Clinic will happen in phases to create new bedrooms plus additional support rooms.

5.30 The development will provide six female beds with ensuite facilities which will be Health Building Notes (HBN) – Department of Health compliant. HBN provide best practice guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities. They are guidelines however and they describe best practice on how buildings should be designed so should be followed as far as possible). The Care Quality Commission (CQC) expect any new developments/

refurbishments are HBN compliant.

5.31 These developments will ensure that the female bedroom accommodation is suitably positioned in the ward negating the need to walk through the male area to access other parts of the ward.

5.32 The development will also provide new support functions for the ward including interview and consultation space, a de-escalation and seclusion suite, a welcome suite, and a centralised nurse base providing good line of site to the rest of ward to enhance safety.

5.33 The seclusion suite will enable the service to manage high acuity patients ensuring care closer to home and mitigate the need to send out of area or to St. Ann's hospital.

5.34 A centralised day space immediately outside the nurse base with direct access to the external garden will also be provided. This will enhance the overall feel of the ward enabling patient integration and social activities to take place. Natural light will stream in through large glazed windows/doors that lead straight out to the garden area.

5.35 There will also be an increase in bed provision at St Ann's Hospital. In the first stage there will be a 12 bed increase to the acute inpatient services. These beds will be provisioned in a new build on the St Ann's Hospital site. Stage two will see the closure of the Linden Unit in Weymouth and the 15 beds from the Linden Unit will be re-provisioned at St Ann's Hospital.

5.36 These changes will ensure high quality accommodation meeting CQC standards in the two strategic inpatient sites and ensure that the right number of beds are in the right place to match the demand.

Recovery Beds and Community Front Rooms

5.37 The purpose of the recovery beds is to provide an alternative to hospital admission when a person is in crisis and value for money in comparison to high cost hospital provision saving about £241 per day. Guests who have used the Recovery House in Weymouth have found it to be friendly and welcoming whilst providing space that helps them to manage their crisis and helps to prevent the need for more acute hospital based support or treatment.

- Currently NHS Dorset CCG commissions seven recovery beds situated in a property in Weymouth. The cost is £348,000 per annum. The cost per person per week is approximately £956 (annual cost per bed approximately £50k assuming 100% occupancy). The assumption for the modelling, through benchmarking other services are that these could be procured for £40k per bed per annum in the future dependent on the market and how the procurement package is presented.

The intention is for the CCG to end the current contract for seven recovery beds in Weymouth and for Dorset HealthCare to procure seven recovery beds that will be spilt

across the county based on demand modelling. On the basis of the bed modelling, Dorset needs three Recovery Beds in the west of the county and four in the east.

Community Front Rooms

5.38 The concept of the Community Front Room is similar to the Retreat in that they provide an additional choice for people who are in or heading towards a crisis point. The benchmarked service is the Aldershot Crisis Café: Aldershot has a population of approximately 200,000 people and three people staff the service every evening from 6pm to 11pm. It utilises an already functioning site and brings mental health NHS clinicians together with the third sector support worker/peer support.

5.39 Approximately 16% of people who access the service use it instead of attending at an emergency department and approximately 74% of the attendees use the service for maintaining their wellbeing.

5.40 As seen above a large percentage of the people who use the service in Aldershot are people who use it to help them maintain their mental wellbeing. There is a strong social contact element to how the service runs which should not be underestimated in terms of how the it helps people to maintain their mental wellbeing.

5.41 The local population that could be covered by three CFRs in Dorset and specifically the localities identified as having the best access to the highest number of people are shown in the table below. The table includes the localities and the SMI prevalence.

Table showing locality population and SMI prevalence rates 2015/16

Locality	Population	Areas included	SMI Register	Prevalence %
Purbeck (preference Wareham)	33,861	Wareham, Swanage, Corfe	275	0.81%
West Dorset (preference Bridport)	41,087	Bridport, Charmouth, Lyme Regis	441	1.07%
North Dorset (preference Shaftesbury)	86,876	Shaftesbury, Sherborne, Gillingham, Sturminster Newton and Blandford	644	0.74%
Total	**162,824**		**1360**	

5.42 The modelling for the Community Front Rooms is based on activity in three potential locality areas: Wareham (Purbeck), Sturminster Newton/Shaftesbury (North Dorset)

and Bridport (West Dorset) but will provide a service to anyone living in Dorset.

5.43 The commissioning approach for the CFRs will depend upon several factors, the criteria used to determine where and how they will be commissioned are described in section 5.5. However, the services will have a recovery focussed approach that will make them helpful to people in their recovery and to support them to maintain their wellbeing.

5.44 The initial suggestion for the North Dorset site was Sturminster Newton as this was the best option in terms of access for people with a SMI within the travel time analysis (based on 25 minutes by car): it supports 97.75% of the of the prevalent population to be able to access a Retreat for CFR within 25 minutes by car. In the consultation people fed back that Sturminster Newton not an easily accessible area due to a reduction in transport. If Shaftesbury was the CFR site, it would support 97.19% of the prevalent population in Dorset to access a Retreat or CFR within the defined travel time (0.56% less which equated to 41 fewer people). In both site options all of the estimated prevalent population would be able to access a Retreat of CFR site within 30 minutes. There is also predicted population growth in the Shaftesbury and Gillingham area and the CCG has considered these facts in the modelling work.

5.45 Taking account of the views expressed in the public consultation, Shaftesbury was considered as a site for a CFR in the post consultation modelling. Public transport was also considered in the post consultation modelling as it not reliable in some areas of the county and the preferred CFR and retreat sites should be located where the public transport is likely to be better e.g. with rail and/or bus links.

5.46 On the basis of the additional analysis the preferred locations for the CFRs are: Bridport, Shaftesbury and Wareham.

5.47 The modelling of potential demand for the Community Front Rooms used the following details:

- Street Triage (ST) and the number of mental health incidents dealt with that did not require an admission
- Emergency Department (ED) and the number of MH presentations where a psychiatric condition was identified but where the person was not admitted
- Local Authority Out of Hours (OOH) where a MH Act Assessment was requested that did not result in a psychiatric admission
- Psychiatric Liaison (PL) after hours' presentations to ED
- Crisis Response Home Treatment (CRHT) referrals in the west of the county where the person was not taken on by the service

5.48 The table below shows the 7-day demand based on known crisis activity per month.

Services	Purbeck	West Dorset	North Dorset	Total Urgent / Emergency
CRHT Referred not taken on	6	6	5	17
LA OOH Assessed but not admitted	26	26	26	78
PL seen and discharged	6	4	6	16
ST Contacts	3	2	2	7
ED seen and discharged	47	47	47	141
Usage instead of urgent/ emergency care	88	85	86	259

5.49 Additional demand is expected to come from people in clusters 1-4 (described earlier) and people on the depression register. This mirrors those attendees at the Aldershot café who use the service to manage their wellbeing and supports the need to provide people with preventative services. The table below shows the potential demand from people who will use these services to maintain their wellbeing.

5.50 The table below shows the number of people in clusters 1-4 and on the depression register in the same localities. This outlines the number of people who may at some point wish to access prevention services such as the CFR. The evaluation will look to identify clearly who uses the services and the impact of this on other services such as CMHTs and primary care.

Clusters 1-4 CMHT Caseload and Depression Register		
Purbeck	Clusters 1-4	58
	Depression register	2415
West Dorset	Clusters 1-4	43
	Depression register	2863
North Dorset	Clusters 1-4	201
	Depression register	4522

5.51 Investing in three CFRs will bring some savings to the system and improve the experience of people in mental health crisis. The investment in the CFRs has potential to eradicate all activity that does not result in an admission as seen in the above table.

5.52 The forecast cost savings relating to reduction in the uses of formal assessments and presentation at EDs are:

Activity	Cost per assessment	Cost based on known activity	Potential System Benefits of CFRs
MH Act Assessments	£498 (45 Assessments per month across 4 days)	£ 266,358	Investment (staff costs) £366k Prevent of OOH MH Act Assessments Sec 136 ED presentations
Section 136 Assessments	£1,780 (4 Assessments per month across 4 days)	£85,440	
ED Presentations	£250 (81 Assessments per month across 4 days)	£241,714	
Total		**£593,512**	**£227,512**

Financial Consequences

5.53 The costing for the current situation and the preferred option are tabled below:

Option A: Existing including additional PICU beds option

Existing including planned additional PICU beds		
	WTE	£'000
Community Mental Health Team – Adult	150.51	5,378
Community Mental Health Team – Older	109.23	3,833
Crisis – East	35.60	1,411
Crisis – East	27.80	1,120
Inpatients	185.15	6,859
Intensive Psychological Therapies (IPTS)	7.81	352
Psychiatric Liaison	23.24	916
Street Triage	2.70	130
Recovery House		350
SCENARIO 1 TOTAL COST	**542.04**	**20,348**
Current Budgets	542.04	20,348
(SAVING)/SHORTFALL	**0.00**	**(0)**

5.54 The table on the previous page shows the current baseline budget including the PICU beds at St Ann's Hospital and this is the business as usual budget including all the current services. It does include the IPTS service which has been taken out of the OBC finances because the IPTS is part of another service development. It does not include the additional £570K being allocated to deliver Community Front Rooms and Recovery Beds (£500k parity funds and £70k remaining from Recovery Beds which have been costed differently in the OBC).

5.55 In 2016/17 £2.5 million was spent on out of area placements £853k of this allocated to Dorset HealthCare and this is spending over and above budgeted spend.

Option B. The Preferred Way Forward

5.56 This option reconfigures the existing Community Mental Health Teams/CRHT to enable them to meet the demand across the county and working 09:00 to 17:00 Monday to Friday. Where possible, and as part of a phased estate transformation plan, the adult and older peoples MH teams will be co-located but continue to work independently.

5.57 The current telephone support element of the Crisis Resolution Home Treatment service will be restructured into the Connection Service structure and the Street Triage functions will be merged into the Connection Service structure.

5.58 The Home Treatment Team is to be formed from current CRHT and will sit alongside the CMHTs taking referrals from the Connection Service and Retreat. The Home Treatment Team will work alongside the CMHTs across four broader locality areas; Bournemouth, Poole, North Dorset and West Dorset with the working hours: 09:00 to 22:00 seven days a week. Cover for home treatment after 22:00 will be via the Connection Service.

5.59 A Retreat in the East (Bournemouth) will be created. The opening hours of the Retreat have been modelled as: open 16:00-24:00 Monday-Thursday and 18:00-02:00 Friday to Sunday. A Retreat in the west (Dorchester area has been modelled as: open 16:00-24:00 Monday-Thursday and 18:00-02:00 Friday to Sunday.

5.60 The Connection Service (including crisis line) will be run from the urban Retreat in the east. The Connection Service opening hours will be 24/7 with a staffing compliment outlined below. Four-hour face-to-face assessments after 22:00 would be carried out by staff on the Connection Service with additional back up from the Retreats or by psychiatric liaison.

Shift Assumptions		
10:00 -18:30 with 0.5hr break	8.00-hour shift	1 x B6, 1 x B3
18:00 – 02:00 with 0.5hr break	7.50-hour shift	2 X B6, 2 X B3
01:30 – 10.30 with 0.5hr break	8.5-hour shift	2 X B6, 1 X B3

5.61 The inpatient configuration in Stage 1 would be 12 new beds in St Ann's Hospital and four new beds in Forston Clinic.

- Maintain the Linden Unit and update the environment and keep 15 beds in the

interim while other units are being built/renovated

- As described earlier, renovate internally at Forston Clinic to deliver four additional female in-patient beds (6 in total) section 4.31-4.13

5.62 Stage 2 of the implementation will see 15 Linden Unit beds move to St Ann's Hospital.

5.63 The new inpatient bed configuration is described in the table below:

Hospital site	Ward name	Type of bed	Number of beds
St Ann's Hospital	Seaview	Acute Assessment Unit	14
	Haven	Male PICU	7
	Haven Female	Female PICU	5
	Chine	Acute Female Treatment	17
	Harbour	Acute Male Treatment	16
	Alumhurst	OPMH Functional	20
	Stage 1 new	Additional beds	12
	Stage 2 new	Transfer beds from the Linden Unit	15
	Total		106
Forston Clinic	Waterston AAU	Acute Assessment Unit	14
	Melstock House	OPMH Functional	12
	Stage 1 new	Additional female beds	4
	Total		30
Westhaven Hospital Weymouth	The Linden Unit	Acute Treatment	0
Bed provision in East Dorset			106
Bed provision in West Dorset			30
Total bed provision			**136**

5.64 The four new female beds at Forston Clinic and the additional 27 beds (12 new and 15 transferred from the Linden Unit) at St Ann's Hospital will enable the demand for inpatient provision to be met. By having 12 male and six female beds in the Waterston unit at Fortson there will be a sufficient number to meet the demand for men and women in the west of the county.

5.65 During the modelling for the new pathway and bed provision Dorset HealthCare had commissioned an independent report suggesting that the beds should operate at under 100% capacity. In parallel with this report, the CPG noted the NHS Benchmarking report

2015 and the Royal College of psychiatrists' guidance which suggests 85% capacity. The CPG agreed that Dorset should aim to manage at the best practice level wherever possible. This will enable services to manage additional capacity and demand. It makes the system sustainable and safer for patients, and it enables people to get inpatient help at an earlier point through informal admissions due to there being more capacity to do so.

5.66 The table below shows how the beds numbers meet the demand in the east and west of the county and for men and women.

		Scenario 3						
		Patients with an East Dorset admission postcode attend St Ann's Hospital, patients whose postcode area is in the West attend their closest hospital (Overall 85% Occupancy)						Actual % occupancy for modelled OBDs based on proposed bed numbers
		Occupied bed days			Number of beds			
Hospital Site		Proposed	Modelled	Difference	Proposed	Modelled	Difference	
St Ann's Hospital	Males		13,040			42,031		
	Females		10,210			32,909		
	Total	**22,959**	**23,250**	**-292**	**74**	**74,940**	**0.94**	**86.1%**
Forston Clinic	Males	3,723	3,266	457	12	10,527	-1.47	74.6%
	Females	1,862	2,027	-166	6	6,534	0.53	92.6%
	Total	**5,585**	**5,293**	**292**	**18**	**17,060**	**-0.94**	**80.6%**
Grand Total		**28,543**	**28,543**	**0**	**92**	**92,000**	**0.00**	**85.0%**

5.67 The additional annual revenue costs associated with increasing in-county inpatient provision by 16 beds is £1.555m.

5.68 The table below shows a slightly different configuration of costs to the SOC, because of the available budget being slightly increased due to pay inflation being funded.

5.69 In addition, CMHT and Home Treatment costs are shown as a total rather than broken down by locality. The revenue cost is more than the SOC to reflect the revenue consequence of upgrading Forston Clinic and providing en-suite facilities for female patients.

5.70 The difference in overall cost from the SOC to the OBC is £203k and the additional recurrent investment required is £1.555m. The SOC sought to be accurate within £200k of the OBC.

5.71 Capital costs are to be met by Dorset HealthCare. Dorset HealthCare intentions are to ensure that inpatient facilities are developed to a high standard in line with CQC recommendations.

5.72 The capital costs for the additional inpatient beds are £12.719m an increase from

£3.9 million described in the SOC and this is to be funded by Dorset HealthCare. The increase from the SOC is down to Dorset HealthCare's intention to invest in the quality of the inpatient services at Forston Clinic and the build at St Ann's Hospital to accommodate the additional beds.

5.73 Dorset HealthCare will sign off the capital investment in September after the CCG's Governing Body approve the OBC.

5.74 The preferred way forward – cost summary table is outlined in the table below.

Preferred Option (B)		
Recurrent Revenue Costs	**WTE**	**£'000**
Community Services		
Community Mental Health Team – Adult	157.44	5,556
Community Mental Health Team – Older People	101.40	3,685
Connection – 24/7 (Incl. Street Triage function)	16.05	740
Home Treatment Team	35.42	1,468
Psychiatric Liaison	23.00	1,038
Retreat -East – located in Bournemouth	8.59	378
Retreat – West – located in Dorchester	5.16	213
7 Recommissioned Recovery Beds	TBC	280
3 Community Front Rooms	TBC	366
Inpatient Wards – Staffing Costs	207.82	7,721
16 Additional Inpatient beds – Staffing Costs	35.08	1,388
Additional Non-pay for Retreat and Connection		30
Community Front Rooms premises & Primary Care Interface		200
16 Additional Inpatient beds – Cost of Capital (Annual Revenue)	-	726
16 Additional Inpatient beds – Additional non-pay	-	129
TOTAL COST	589.96	23,919
Current Dorset HealthCare Staff Budget	553.96	20,660
Current CCG Budgets		350
CCG Investment		500
TOTAL BUDGETS	**553.96**	**21,510**
(SAVING)/SHORTFALL	**589.96**	**2,409**
Dorset HealthCare OOA Allocation		**(853)**
(SAVING)/SHORTFALL Revenue Costs		**1,555**
Capital Costs		
16 Additional Inpatient beds – Capital		12,719
TOTAL CAPITAL		**12,719**

5.75 As described earlier the Retreat will provide recovery focussed services that people in crisis can access.

5.76 The intention is to test the Retreat in Bournemouth to ensure that it is safe and effective. The Bournemouth Retreat will be staff to a higher level because of the prevalence and demand in the conurbation area. The CCG has identified non recurrent funding to double run whilst the Retreat is being tested.

5.77 The MH ACP Consultation feedback has identified that there are risks within the system of services being proposed. All of the risks will be fully evaluated once the services are up and running. The risks are:

- If there was additional funding the CCG would look to provide a community based service in Weymouth due to the prevalence and this would address the concerns raised through the consultation.
- The Connection Service will be evaluated after implementation and after the year test running the Retreat. The evaluation will ensure that the staffing is adequate and the technology sufficient to manage all the calls coming in to the service and from different locations in Dorset.
- The model of home treatment is significantly different and staffing resource has been calculated on a likely model in terms of function and activity but will require clear evaluation.

Financial Implications

5.78 The financial case has demonstrated that the preferred way forward is operationally possible and affordable in the context shown i.e. within the agreed current system spending.

5.79 The £500k CCG parity of esteem investment supported at the SOC stage is subject to agreement alongside the other additional investments.

5.80 Delivery of the recommended inpatient beds is dependent on approval of the required recurrent funding of £1.555m and this aims to eliminate the use of out of area placements, except in extenuating circumstances.

5.81 The revenue cost of £1.555m is £203k more than the high level costs described in the Strategic Outline Case and this is largely due to the revenue consequence of updating Forston Clinic.

5.82 The 2016/17 out of area spend was approximately £2.5 million, the unbudgeted spend on OOA was £1,647,000 (£853k allocated to Dorset HealthCare).

5.83 In the long term, as new bed provision is put in place and used and the other services prevent crisis, OOA placements will gradually be eradicated. This will deliver a system saving of approximately £92k.

5.84 The double running to test the Retreat in 2018/19 will cost £378,000. The CCG has identified non-recurrent funding to cover the double running costs.

5.85 The capital requirements for the pathway are £12.719 million which will be sought from the current system by Dorset HealthCare and this is assumed to be an achievable position.

Conclusion

5.86 The financial case has demonstrated that the preferred way forward is operationally possible and affordable in the context shown i.e. within the agreed current system spending:

- Delivery of the recommended inpatient beds is dependent on approval of the required recurrent investment of £1.555m and this would deliver a complete reduction in out of area placements, except in extenuating circumstances and substitute the current overspend on out of area placements.
- The capital requirements for the pathway are £12.7 million which will be sought from the current system by Dorset HealthCare is assumed to be an achievable position.
- In 2016/17 the OOA spend was £2.5m and so in the longer term when OOA placements end there is likely to be a system saving of up to £92k

CHAPTER 6
THE MANAGEMENT CASE

6

6. THE MANAGEMENT CASE

This section of the Five Case Model requires the CCG to describe how it will ensure the ongoing project will be managed effectively and that the objectives are fully achieved and benefits fully realised.

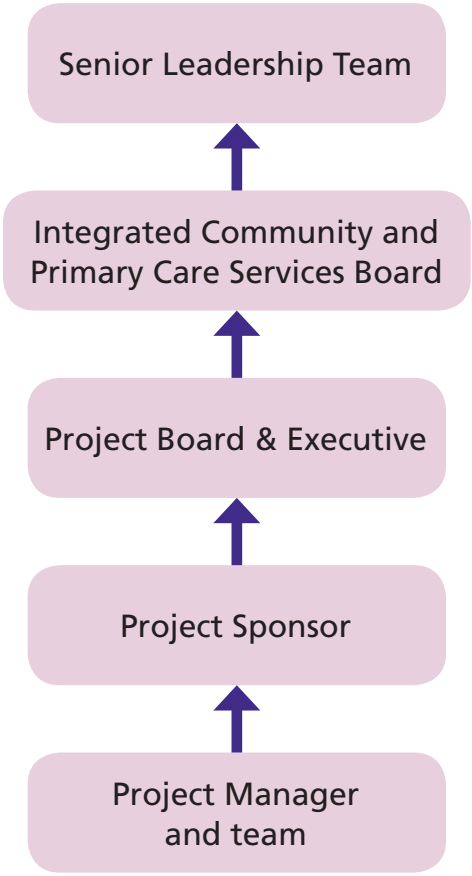
6.1 The MH ACP is part of the CCG's strategic priorities and a key deliverable of the Crisis Care Concordat, and it is being run alongside the CSR. It also supports the delivery of:

- The Mental Health Five Year Forward View
- Dorset STP
- The 2017-2019 planning guidance
- The Wessex Strategic Clinical Network's Strategy for Mental Health, Dementia and Neurology
- The Dorset Crisis Care Concordat

Project Governance

6.2 The MH ACP will come under the Integrated Community Services work stream and be accountable through Dorset's STP Governance.

In accordance with good practice, the ongoing project will deploy the following governance structures under the umbrella of the STP: The project team will implement the new Mental Health Acute Care Pathway is seen below.



6.3 Roles and responsibilities are outlined in the table below.

Role	Responsibility
Project Executive	Collective and final responsibility for the approval to recommend the proposal to the approval authorities
Project Board	Provides the Project Executive with stakeholder and technical input to decisions affecting the project
Project Sponsor	Personal accountability and overall responsibility for the delivery of the successful outcome
Project Manager	Leading and managing the coordination of the Project Team on a day-to-day basis
Project Team	Takes forward the decision of the Project Board and develops the operational elements of the project
Stakeholder forum and user groups	Provides the Project Board with further insight and advice on the detailed requirements of the project

Project Management Arrangements

6.4 In line with the principles of the Accountable Care System and in concordance with the co-production ethos, the management of the implementation will be carried out by a project team lead by Dorset HealthCare and supported by the CCG. Sharing skills across the two organisations will enable the implementation work to proceed utilising the best that both organisations bring in terms of skill sets and knowledge.

6.5 It is also the intention to ensure that the co-production principles of sharing the ongoing evaluation and monitoring and subsequent development with people who use and the services including carers and staff who sometimes have dual roles. The shared participation will include the development of the expected outcomes and the ongoing evaluation and any subsequent research.

6.6 The following arrangements have been put in place to ensure the continuation of the MH ACP project and to ensure that future stages including implementation are delivered on time and that it achieves the stated outcomes.

The Project Team

6.7 The project team is accountable to the Project Board and has responsibility for the day-to-day running of the project and the development and production of all the key deliverables. It is made up of the following roles for stages 4 and 5 which are consultation and Outline Business Case development.

Role	Stage 4
Project Sponsor (STP lead)	Dorset HealthCare Chief Operating Officer (COO)
Project Manager	Dorset HealthCare
Lead Primary Care Clinician	CCG
Lead MH Clinician	Dorset HealthCare
Psychology Lead	Dorset HealthCare
Operational Advisor and Lead	Dorset HealthCare
Lead for recovery	Dorset HealthCare
Evaluation Lead	CCG

Role	Stage 4
Patient Representative	Dorset MH Forum
Communication & engagement	Dorset HealthCare and CCG
Finance	CCG and Dorset HealthCare
Information	CCG and Dorset HealthCare
Local Authority	BBC/DCC/BoP
Quality	CCG/Dorset HealthCare

Project Sponsor and Manager

6.8 The MH ACP Project has a project sponsor who has overall responsibility for the delivery of the project. A project manager will also be in place to ensure that the day-to-day work is carried out in line with the structured project plan.

6.9 Project Manager responsibilities are as follows:

Co-ordinate and implement the project	Ensure the project produces the required deliverables to the required standard, within the constraints
Run project within the tolerances the Project Board approves	Ensure that issues and risks that have been identified are managed effectively
Plan and monitor the project	Direct and motivate the project team
Manage risks and develop contingency plans as agreed	Be responsible for project administration
Report project progress at Project Board meetings	Report to the Project Board through Highlight reports End stage assessments
Prepare the lessons learned report	Take responsibility for overall progress and use of resources and initiate corrective action where necessary

Implementation

6.10 There are a number of areas that will be considered before the pathway can be fully implemented:

6.11 The Community elements are identified below and a timetable with indicative timescales seen in section 5.21:

- The Refurbishment of Hahnemann House to accommodate the Bournemouth Retreat
- Testing out of the Retreat in Bournemouth with ongoing evaluation
- Identification of the site for the Dorchester Retreat
- Dorset HealthCare Staff consultation
- Restructure of CRHT and Street Triage
- Creation of the Connection Service
- Tendering for Community Front Rooms and Recovery Beds

6.12 The inpatient elements are:

- Refurbishing Forston Clinic to accommodate the four new beds and create ensuite facilities for women
- Upgrade the Linden Unit to ensure safety of unit until it closes
- Create space and build 12 new beds at St Ann's Hospital
- The Linden Unit will close and the 15 beds will be re-provided at St Ann's Hospital.

6.13 The MH ACP has illustrated that there are a number of people on the current secondary care caseload who could be supported more appropriately by primary care or IAPT services. There is no intention to undertake a 'mass' discharge process as this could destabilise people receiving services and the system if not managed appropriately.

- The launch of the MH ACP will include defining how best to offer advice and guidance to GPs to enable them to get the support they need to manage people's symptoms effectively in primary care, and also includes more in-reach into GP surgeries.
- Further work will be required to develop appropriate shared care protocols. Primary care will also have more support for their patients, especially out of usual working hours on an open access basis through the Retreats, Community Front Rooms and the Connection Service.

6.14 The operation of the Retreats relies on home treatment operating differently, with some CRHT staff members being redirected in part to the delivery of the Retreats where people can self-refer to receive support and care. This is a trade-off and should deliver far more preventative work in line with what people said they wanted and at the times they said were important to them.

6.15 The system will be testing the Retreat concept to identify and evidence the benefits and how people use them prior to changing the Home Treatment Team staffing allocation. This is being done to ensure that risk is minimised and full roll out of Retreats and subsequent changes to Home Treatment are based on evidence from a year of running one Retreat in Bournemouth.

6.16 There will also be ongoing work by Dorset HealthCare at a Trust wide level to further develop a recruitment and retention strategy in line with the wider STP strategy. The focus of the plan is in recruitment and retention, staff development and recognition. There is also a focus in particular for hard to fill posts such as mental health nursing. The Trust wide strategy includes options around post retirement flexible working arrangements, as well as apprenticeship schemes and incentive schemes to attract staff to posts within Dorset. This will have particular relevance to the workforce required to deliver the MH ACP. Dorset HealthCare want to be an employer that employees would choose and the organisation wants to attract compassionate competent employees. The full workforce plan can be seen in **Annex 5**.

6.17 Procurement of recovery beds and Community Front Rooms will be achieved by Dorset HeatlhCare as lead provider. This process will commence in April 2018 but planning and market testing work will start earlier in November 2017.

6.18 It is anticipated that Dorset HealthCare, supported by the MH ACP project team at the CCG, will undertake all the relevant procurement processes including market testing, to ensure that there is still provider interest related to working with Dorset HealthCare in a sub contractual relationship.

Choices about the locations of the Community Front Rooms were based on the criteria and each CFR will be reviewed to assess its effectiveness in meeting the objectives of the project:

- The areas of highest levels of prevalence in the west of the county
- Accessibility to the population within 25 minutes by car, during off peak opening hours and reviewed travel time analysis
- Availability of appropriate community assets, estate and providers
- The availability of the appropriate organisations to deliver the CFR

6.19 The Community Front Rooms and Recovery Beds will be commissioned on an outcomes basis and agreement regarding the anticipated outcomes will be co-produced to ensure that the project continues to work with people who use the services and carers.

6.20 It is also likely that each CFR will be different dependent on the local area and in this regard some of the outcomes may have a local slant, this will be worked through in the procurement stage of the implementation plan.

6.21 Current estate requires upgrading to provide the Bournemouth Retreat. Dorset HealthCare won £600k through a bid process and there is a need to be able to deliver the pathway due to the urgency for this to be in place.

6.22 The high level timetable for the implementation is seen in the table below:

Action	Timescales	Responsible
MH ACP Community Services		
Review and extend Recovery House Contract	Jul 2017-Mar 2019	CCG
Refurbishment of Hahnemann House	Oct 2017-Jan 2018	Dorset HealthCare
Retreat Launch	1 Aprl 2018	Dorset HealthCare
Test Retreat Concept	Apr 2018-Mar 2019	Dorset HealthCare, CCG, CPG

Identify estate/site for Dorchester Retreat	Apr 2018-Oct 2018	Dorset HealthCare
Preparatory work with staff ahead of consultation process to include preparation for change based on evidence from the Retreat test of concept	Oct 2018-Dec 2018	Dorset HealthCare
Restructure Community Teams including identification of estate and capital for the Connection Service	Jan 2019-Mar 2019	Dorset HealthCare
Staff Consultation	Apr 2019	Dorset HealthCare
Tendering and procurement of Community Front Rooms and Recovery beds including market testing and service specification development	Apr 2018-Mar 2019	Dorset HealthCare,CCG
• Award of contract/s	Oct 2018	Dorset HealthCare, CCG
• Mobilisation	Oct 2018-Mar 2019	Dorset HealthCare, CCG, Provider
• Implementation of CFR and Recovery beds	Apr 2019	Dorset HealthCare, CCG, Provider
Acute MH Inpatient Bed Stage 1		
Upgrade the Linden Unit to ensure safety requirements being met	By Dec 2017	Dorset HealthCare
Forston Clinic refurbishment and 4 new inpatient beds	By Apr 2018	Dorset HealthCare
New build at St Ann's Hospital with new medium secure beds and 12 new acute inpatient beds	Apr 2018-Mar 2022	Dorset HealthCare
Acute MH Inpatient Bed Stage 2		
Open 15 beds at St Ann's Hospital and transfer patients from the Linden Unit as appropriate	Oct 2019 – Apr 2020	Dorset HealthCare
Close the Linden Unit once 15 new beds are open at St Ann's Hospital	Planned Oct 2020	Dorset HealthCare

6.23 The commissioning approach and evaluation will focus on outcomes and these are based on the objectives and the expected benefits of the change for people who use service and the benefits to the system.

6.24 It is anticipated that the evaluation will be led by the CCG, researchers from Bournemouth University and in partnership with Dorset HealthCare. The evaluation will be carried out in stages and it is likely that this will be a mixed method research programme because it is the most ethical and richest in terms of qualitative and quantitative information.

6.25 The table below shows some of the anticipated outcomes from the services redesign and new additions to the pathway. The full range of outcomes will be co-produced reflecting the approach to the whole project.

Service Outcomes	People Outcomes
CMHT	• More meaningful time with clinicians in the CMHTs • Only telling story once • Fewer referrals to other services in the pathway • Self-referral to CMHTs if you are a known client • Be known to the clinicians you are seen by • Support in place earlier to help prevent crisis • Less need of ED to resolve crisis • Crisis avoided so as not to need MH Act Assessment • Crisis managed or avoided • Better experience of crisis intervention • Experience care/support in the least restrictive setting • Use CFRs/Retreats to avoid using ED or other crisis services such as OOH or CRHT • Improved symptoms and self-management of symptoms • Fewer self-harm incidents • Fewer Section 136 detentions • Recovery supported • Person centred care • Staying well longer • Self-management because of additional choice and control in crisis situations
Teams managing people open to them when in crisis Fewer referrals to CRHT Fewer referrals to OOH service Increased job satisfaction Improved staff retention Reduced levels of staff sickness Increased clinician time spent with people who are at crisis point because other people are supported differently	
MH Act Activity	
Fewer unplanned MH Act Assessments Fewer emergency MH Act Assessments OOH Less Section 136 activity Fewer inappropriate MH Act requests	
ED Activity	
Fewer ED presentations for mental health Reduction in self harm presentations to ED Fewer ambulance transfers Fewer ED 4-hour breaches	
Inpatient activity	
All inpatient admissions in county High number of admissions to the patients nearest hospital All admissions within 31 miles of home unless PICU is required Inpatient stays lengthened as required Reduced number of readmissions Reduced (eventually eradicated) out of area placements	
Connection Service	
Fewer missed calls Increase in the number of interventions/solutions or signposting 4-hour face-to-face assessment achieved	
CRHT	
Reduction in the number of referrals not taken on Fewer complaints	
Additional Services	
Recovery beds working to 95% capacity Fewer people needing CRHT interventions Use of CFR to avoid ED or other crisis services Use of Retreat to avoid ED or other crisis/acute service	

It is anticipated that the evaluation of the outcomes and monitoring will be supported by researchers from Bournemouth University and this will be done in stages in line

with the implementation plan. The first stage will be to evaluate the Retreat.

Approach to Risk Management and Benefits Realisation

6.26 This project is developing a pathway that is new and innovative. The initial two years will be key to evaluating the effectiveness of the new model of care. Not all parts of the model have academic, peer reviewed evidence base, but benchmarking with similar services and talking to people who use them has strongly suggested that these work well and focus on recovery and wellbeing. Part of the new model will be reliant on the teams working with communities to develop Community Front Rooms that work for them harnessing the support of existing local services.

6.27 As part of the project management process a risk and issues log are kept and updated according to the project requirements. **See Appendix 13**.

6.28 In addition to the risk and issues log the project identified risks and benefits as part of model development work and these will be taken forward by ensuring that any new risks are incorporated into the risk register with a mitigating plan. The risk register will be regularly updated and signed off at each Project Board.

6.29 Anticipated benefits, as outlined in the Strategic case will be incorporated into the service specifications as expected outcomes alongside the scorecards to ensure outcomes are measurable and monitored.

6.30 A benefits realisation plan will be established and overseen by the Project Board. This plan will clearly describe each benefit including success measure and will also show accountability for its realisation.

6.31 It is anticipated that some parts of the model can be tested during 2018/19 to further develop an evidence base which can assist in the development of a meaningful locally focused benefits realisation plan for the implementation phase.

6.32 The emphasis on co-production and stakeholder engagement will continue during the remaining implementation and monitoring phases of the project.

LIST OF APPENDICES

Mental Health Acute Care Pathway Outline Business Case Appendices Index

Appendix	
1	Strategic Outline Case
2	View Seeking Thematic Analysis report
3	Consultation Evaluation report
4	Needs and Data Analysis report
5	Travel time analysis
6	Mental Health Strategies report
7	MH Bed Modelling figures
8	Mapping Documents
9	Innovation Presentations
10	Benchmarking reports
11	Coproduction group lists
12	Project Objectives
13	Risk log
14	Summary of shortlisting
15	Glossary of Terms

Annex	
1	Modelling dates and key discussion points
2	Equalities Impact Assessment
3	Needs analysis data update
4	Travel time analysis car and public transport
5	Dorset HealthCare Workforce Plan