Dorset Mental Health Acute Care Pathway Project

Notes from the Shortlisting Workshops held on 21st July 2016 and 16 September 2016

1. INTRODUCTION

The Co-Production Group (CPG) of the Dorset Mental Health Acute Care Pathway to identify a shortlist of options for implementing the new vision for mental health care. This was carried out in two workshops one on the 21 July 2016 and the other on the 16th July 2016. This paper describes the process used and sets out the conclusions that were reached.

2. PROCESS

There were 34 participants at the workshop on the 21 July and 26 participants on the 16th September. A table showing the organisations represented at both sessions is seen in **Appendix A.**

In both workshops the process used was an "Options Framework" approach, as recommended in the best practice guidance for Business Cases promoted by HM Treasury (the "Five Case Model"). The options framework helps groups identify what choices are potentially open to them, then make those choices with clear reference back to the objectives of the project and the important "success factors" which have also been defined.

3. OBJECTIVES AND CSFS

The Project Objectives were defined early in the project and are set out in detail at Appendix B. They can be 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.

In addition, the CPG previously identified factors that would be crucial to the success of any option for example, affordability and achievability. These are set out in detail at Appendix C. They are that options must be:

- Implementable
- Sustainable and Safe
- Affordable
- Acceptable
- Based on best practice
- Delivering a better experience.

4. DIMENSIONS OF CHOICE

The new service vision is clear in terms of the key elements of service which are proposed and how they might work together. However, there are a number of options about how this vision might be realised in practice. In particular, decisions need to be made on the following dimensions:

- The number and location of "Retreats" to be provided
- The operating hours of the new "Connection" service (which will enhance the existing Crisis Line)
- The balance of investment in other services, particularly Recovery Beds and Community Front Rooms
- The pace of implementation of the changes once approvals have been achieved.
- The number and location of inpatient beds.

Each of these dimensions of choice is explained in more detail below.

4.1 Number of Retreats

The development of Retreats is a key part of the proposed new vision. For a Retreat to be viable, it would need to serve a critical mass of population. Analysis suggests that there are two areas in Dorset where there is sufficient concentration of population to make this feasible: the Bournemouth/Poole conurbation and the Weymouth/Dorchester area. The choices open are, 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, either Weymouth or Dorchester). A three retreat option was ruled out because it would be unaffordable.

Number of Retreats: Options					
1	**2**	**3**	**4**	**5**	**6**
Existing No Retreats	**One: Bournemouth /Poole**	**One: Weymouth**	**One: Dorchester**	**Two: Bournemouth/Poole Weymouth**	**Two: Bournemouth/Poole Dorchester**
No retreats. Services as now.	One retreat, located in the Bournemouth/ Poole area. Assumed to be open 16:00-24:00 Mon to Thurs and 17:00-02:00 Fri-Sunday.	One retreat, located in the Weymouth area. Assumed to be open 16:00-24:00 Mon to Thurs and 17:00-02:00 Fri-Sunday	One retreat, located in the Dorchester area. Assumed to be open 16:00-24:00 Mon to Thurs and 17:00-02:00 Fri-Sunday	Two retreats. One to be in the Bournemouth/Poole The other to be in the Weymouth area assumed to be open 16:00-24:00 Mon to Thurs and 17:00-02:00 Fri- Sunday	Two retreats. One to be in the Bournemouth/Poole area. The other to be in the Dorchester area assumed to be open 16:00-24:00 Mon to Thurs and 17:00-02:00 Fri- Sunday

4.2 "Connections" operating hours

The telephone Connections service is a crucial part of the proposed new vision (as described at Section 2.5). This is an enhancement of the existing Crisis Line service. The Crisis Line will continue and there will be additional staff cover the peak times. The Connection service will provide a telephone support service for people in crisis, or their carers or people working in mental health or other service professions such and police and ambulance. The aim will be to support people to manage their own crisis as defined by them. People will be able to call in and talk through their situation with a mental health practitioner or peer support worker.

The choices open relate to the operating hours for this enhanced service. It could, of course, operate on a 24/7 basis alternatively it could operate on a more restricted basis, targeted at the times of day when demand for the service is highest. Analysis of existing activity suggests that the greatest need for such a service is between 6pm and 2am each day. There are relatively few crisis calls after 2am; and relatively few during the daytime hours because the community mental health teams (although staffing during daytime hours is, of course, less costly).

The choices which explored test a 24/7 offering; an offering just for “peak” hours; an “overnight” offering; and a daytime (plus peak) offering.

Connections Operating Hours: Options				
1	**2**	**3**	**4**	**5**
Existing **No connection service**	**24/7**	**Peak** **18:00 – 02:00**	**"Overnight"** **18:00 – 09:00**	**"Daytime + Peak"** **10.30am – 02:00**
No Connection service. A service as now – that is, Crisis Line continues as now.	Crisis Line continues 24:7. In addition, there will be staff available on the Crisis Line number 24/7 to provide the enhanced Connections service.	Crisis Line continues 24:7. In addition, there will be staff available on the Crisis Line number between 18:00 and 02:00 every night to provide the enhanced Connections service.	Crisis Line continues 24:7. In addition, there will be staff available on the Crisis Line number between 18:00 and 09:00 every night to provide the enhanced Connections service.	Crisis Line continues 24:7. In addition, there will be staff available on the Crisis Line number between 10.30am and 02:00 every day to provide the enhanced Connections service.

4.3 Recovery Beds and Community Front Rooms

In addition to the Retreats and Connections service discussed above, the new vision for care will be enhanced by other services. These services are likely to be delivered through third sector, volunteer and community focused organisations, helping establish a different style of provision and care. The key elements here will be Recovery Beds and Community Front Rooms.

There are already seven Recovery Beds within Dorset (all in Weymouth). There is an opportunity as these are re-commissioned to enhance their place in the pathway, use them more effectively, and ideally distribute them to the east and west of the country rather than having them all located in one place.

The resources available for these services are the £350k that is currently supporting the seven Recovery Beds; plus new funding of £300k which the CCG has obtained provided to achieve "Parity of Esteem". This means there is a total of £650k available to invest in some combination of Recovery Beds and Community Front Rooms.

The choices open relate to the balance to be struck in allocating these resources – how much towards Recovery Beds and how much towards Community Front Rooms. Two "extreme" options were explored (all Recovery Beds, or all Community Front Rooms); one option where existing numbers of Recovery Beds are maintained but the rest of the resource is all invested in Community Front Rooms; and one option where there are additional Recovery Beds as well as some Community Front Rooms. At this stage no decision is being made about *where* any Community Front Rooms would be located – this would be decided on the basis of need and prevalence, as well as local community resources. We are, however, making choices about where the emphasis should be for targeting new money.

At this stage in the project it is not possible (or desirable) to define the exact form of a "Community Front Room". The operating model and hours of each would be designed in partnership with the community within which it sat. For the purposes of this exercise, an assumption has been made about the cost of a "typical" Community Front Room, based on weekend opening between midday and midnight, and opening for two weekdays from 6pm to midnight. This equates to a cost of £120k.

Similarly, the cost of a Recovery Bed will not be known until the procurement exercise is undertaken; but for the purposes of this exercise an average cost of £40k has been assumed.

Recovery Beds and Community Front Rooms: Options				
1	**2**	**3**	**4**	**5**
Existing **Recovery Beds (7 beds)** **0 CFRs**	**CFR invest** **Rec Beds (7)** **3 CFRs**	**CFR focus** **0 Rec Beds** **5 CFRs**	**Balance** **10 Rec Beds** **2 CFRs**	**Recovery focus** **16 Rec Beds** **0 CFRs**
The existing seven Recovery Beds are retained in their existing location. No Community Front Rooms.	Seven Recovery Beds are commissioned, split across east and west Dorset to enhance access. Three Community Front Rooms are established (locations to be determined based on more detailed planning work). Assumed to be open 15:00-23:00 Thursday to Sunday	All existing Recovery Beds are decommissioned, and the resource re-directed towards Community Front Rooms. Five Community Front Rooms are established (locations to be determined based on more detailed planning work). Assumed to be open 15:00-23:00 Thursday to Sunday	Ten Recovery Beds are commissioned, split across east and west Dorset to enhance access. Two Community Front Rooms are established (locations to be determined based on more detailed planning work). Assumed to be open 15:00-23:00 Thursday to Sunday	Sixteen Recovery Beds are commissioned, split across east and west Dorset to enhance access.

4.4 Implementation

There are some elements of the new service vision which are relatively clear (for example, the development of Retreats and the Connection service). There are other elements which will take longer to define operationally and plan for (for example, Host Families and – to some extent – Community Front Rooms). Although work will continue on these elements, it is likely that even once public consultation is complete there will still be work to be done.

There are two choices about the implementation tactics. One approach would be to say that we should not proceed to implement any part of the new model until all parts are clearly described and ready to be implemented. An alternative approach is to say move to implement one element (that is, as soon as all necessary consultations and approvals are successfully completed), and implement that while in parallel continuing to work up the detail of other elements.

Implementation: Options		
1	**2**	**3**
Existing	**Wait...** **till all elements clear**	**Act now...** **with what we have**
No implementation. Services continue as now.	Wait until all elements of the new model are clearly defined and ready to be implemented before moving forward.	As soon as approvals and consultations are complete, begin to implement those parts of the model that are "ready to go" while continuing to develop the others.

4.5 Number and location of inpatient beds

The analysis of need and demand shows that alongside the other service changes there is a requirement for 22 additional inpatient beds in Dorset. These along with the other options in the pathway will enable a reduction in the use of out of area placements as well as increase the ability of the system to offer inpatient care in as near to home as possible e.g. within 33 miles of their place of residence in the best unit to meet their needs.

There are issues with the way in which existing services operate. The beds are currently in three sites across the county. St Ann's in Poole, Forston Clinic nr Dorchester and the Linden Unit in Weymouth. St Ann's and Forston are the two strategic sites because these two units enable people living in Dorset to access an inpatient service within 33 miles of their home. People should be able to access an inpatient service within 33 miles and this means that 42% of people in the county cannot access the Linden within 33 miles, whereas, at St Ann's it is only 20% that cannot and Forston only 5%.

Linden unit is a well-managed inpatient unit that is rated "outstanding" by CQC. Despite this there are challenges related to the unit because it is an isolated unit which means that it does not have the same resources available in terms of additional staff cover for example when someone becomes more acutely unwell needing additional support or lower stimulus environment. The unit would require a significant refurbishment to bring it up to the physical standard required.

The choices are about whether to retain the Linden unit or not and if not where the Linden beds are should be relocated and finally where to accommodate the additional beds increasing the inpatient provision by 22 beds.

- An assessment has been made of possible locations for additional beds and there are two options to consider. Option one an additional 12 beds or option 2 additional 16 beds. To create additional bed capacity there is scope to retain the Linden Unit in the short term (up to five years) and use modular buildings to create space. The preferred option at this stage is to close Linden and reprovision 15 beds and increase the bed stock by a further 16 beds, that will be shared between Forston and St Ann's and the implementation staged over five years to enable Linden to remain whilst other space is created.

The choices for all the options explored are shown below.

The discussions at the shortlisting workshops on 21st July 2016 and the 16 September 2012 enabled a shortlist of 6 options to be produced, plus a "do minimum" benchmark, which achieves all our objectives and are realistic, affordable and implementable. The approach used to achieve this, and the conclusions reached, are described in section 6 onwards.

	1	2	3	4	5	6
No. of Retreats	**Existing** No Retreats	One: B'mouth/Poole	One: Weymouth	One: Dorchester	Two: B'mouth/Poole Weymouth	Two: B'mouth/Poole Dorchester
Connection Operating hours	**Existing** No connection service	**24/7**	**Peak** 6pm - 2am	**"Overnight"** 6pm - 9am	**"Daytime + Peak"** 10.30am - 2am	
Recovery Beds and Community Front Rooms	**Existing** Recovery Beds (7 beds) 0 CFRs	**CFR invest** Rec Beds (7) 3 CFRs	**CFR focus** 0 Rec Beds 5 CFRs	**Balance** 10 Rec Beds 2 CFRs	**Recovery focus** 16 Rec Beds 0 CFRs	
Implementation	**Existing**	**Wait...** till all elements clear	**Act now...** with what we have			
Beds	**Existing** **(**119 beds)	Retain Linden 12 beds to Forston	Retain Linden 12 beds to St Ann's	Retain Linden 12 beds split Forston / St Ann's	Close Linden 27 beds split Forston / St Ann's	Close Linden 31 beds split Forston/ St Ann's

When all the choices are considered together they represent a large number of possible combinations. The "long list" of options is seen below in section 5.

5.0 Long list of options for the ACP

	1	2	3	4	5	6
No. of Retreats	Do nothing No Retreats	One: B'mouth/Poole	One: Weymouth	One: Dorchester	Two: B'mouth/Poole Weymouth	Two: B'mouth/Poole Dorchester
	DN	reject	reject	reject	SL	**PWF**
	1	2	3	4	5	6
Connection Operating hours	Do nothing No connection service	24/7	Peak 6pm - 2am	"Overnight" 6pm - 9am	"Daytime + Peak" 10.30am - 2am	
	DN	reject	**PWF**	reject	reject	
	1	2	3	4	5	
Recovery Beds and Community Front Rooms	Existing Recovery Beds (7 beds) 0 CFRs	CFR invest Rec Beds (7) 3 CFRs	CFR focus 0 Rec Beds 5 CFRs	Balance 10 Rec Beds 2 CFRs	Recovery focus 16 Rec Beds 0 CFRs	
	DN	**PWF**	reject	SL	reject	
	1	2	3	4	5	
Implementation	Existing	Wait... till all elements clear	Act now... with what we have			
	DN	reject	**PWF**			
	1	2	3	4	5	6
Beds	Existing (119 beds)	Retain Linden 12 beds to Forston	Retain Linden 12 beds to St Ann's	Retain Linden 12 beds split Forston/St Ann's	Close Linden 27 beds split Forston / St Ann's	Close Linden 31 beds split Forston/ St Ann's
		REJECT	REJECT	REJECT	SL	**PWF**

6. APPRAISAL OF THE LONG LIST OF OPTIONS

6.1 Process

The approach used to identify a shortlist of options to take forward is the one recommended as best practice in HM Treasury's "Five Case Model" for business cases and decision making. The CPG took each dimension of choice in turn, and considered the available choices in light of the Objectives of the project and the Critical Success Factors. Having considered whether each choice met the objectives and success factors, the Group decided:

- Which options should be rejected, because they failed to meet objectives and/or success factors?
- Which option would be the "preferred way forward", on the basis of current information and understanding?
- Which other options, if any, should be retained on the shortlist for further consideration – with better analysis, and testing them through wider public consultation?

The workshop on the 21st July followed this approach for the first four dimensions of choice (Retreats, Connection, Recovery Beds /Community Front Rooms and Implementation). The workshop on the 16th September used the same approach to consider the final dimension (number and location of inpatient beds).

The conclusions reached are set out below.

6.2 Appraisal of "Number of Retreats" Options

The table below illustrates the conclusions reached about the options for "Number of Retreats". Having considered their performance against all the Objectives and Success Factors, the CPG concluded that **the best way forward would probably be option 6**; but that **option 5 should also be shortlisted** for consideration and further examination. The rationale for this recommendation is explained below the table.

	No. of Retreats	1	2	3	4	5	6
		Do nothing No Retreats	One: B'mouth/Poole	One: Weymouth	One: Dorchester	Two: B'mouth/Poole Weymouth	Two: B'mouth/Poole Dorchester
Objectives							
1	Achieve Consistency	N	N	N	N	Y	Y
2	Improve Accessibility	N	Y	Y	Y	YY	YYY
3	Community facing	N	Y	Y	Y	YY	YY
4	Style/Culture	N	Y	Y	Y	YY	YY
Success Factors							
1	Implementable?	N	Y	Y	Y	Y	Y
2	Sustainable/Safe?	N	Y	Y	Y	Y	Y
3	Affordable?	N	YY	YY	YY	Y	Y
4	Acceptable?	N	N	N	N	Y	YY
5	Best practice?	N	Y	Y	Y	YY	YY
6	Better experience?	N	Y	Y	Y	YY	YY
	PWF / SL / DN / reject:	**DN**	**reject**	**reject**	**reject**	**SL**	**PWF**

Rationale:

- Option 1 (the "existing" benchmark) meets none of the Objectives and none of the Success Criteria. It fails to meet the objectives because it does not address any of the problems identified. It would not be affordable, sustainable or implementable because the existing pattern of services is under unsustainable pressure both financially and in terms of staffing, and this option does nothing to address these pressures. It does not represent best practice, nor improve the experience of those who use the services; and it would not be acceptable to stakeholders, who are clear that improvements and changes are needed.
- The "Consistency" objective is achieved only by those options that offer a Retreat both in the east and the west of the county.
- "Accessibility", "Community Facing" and "Style/Culture" would be improved by all options 2 - 6; but they would be most improved in options 5 and 6, because these options offer benefits to more of the population.
- Analysis of travel times indicates that Option 6 is slightly better than Option 5 in terms of Accessibility, both for the population generally and also if considering the pattern of prevalence of mental illness in Dorset.
- All options (except option 1) are Implementable and Sustainable.
- All options (except option 1) are Affordable. Options 2 – 4 would be lower cost than options 5 and 6, so are even better on Affordability.
- Options which provide only one Retreat would not be Acceptable, because of the disparity they create between areas of Dorset and the impact on travel times. Options 5 and 6 would both be Acceptable; and travel time analysis suggests that Option 6 would achieve the best travel times within acceptable limits.
- All of options 2 – 6 offer a "best practice" solution in line with available evidence, and will provide a better experience for those who use the service. This is especially true for options 5 and 6 where Retreats will be available locally for the widest populations.

6.3 Appraisal of "Connections Operating Hours" Options

The table below illustrates the conclusions reached about the options for "Connections Operating Hours". Having considered their performance against all the Objectives and Success Factors, the CPG concluded that **the best way forward would be Option 3.** The rationale for this recommendation is explained below the table. There was also a suggestion that more information should be gathered about Option 5, to test the extent to which it would meet the pattern of need and demand, and its affordability.

ANNEX 1

	Connection Operating hours	1	2	3	4	5
		Do nothing No connection service	24/7	Peak 6pm - 2am	"Overnight" 6pm - 9am	"Daytime + Peak" 10.30am - 2am
Objectives						
1	Achieve Consistency	N	Y	Y	Y	Y
2	Improve Accessibility	N	YY?	Y	Y	Y
3	Community facing	N	(Y)	(Y)	(Y)	(Y)
4	Style/Culture	N	Y	Y	Y	Y
Success Factors						
1	Implementable?	N	N	Y	Y?	Y?
2	Sustainable/Safe?	N	N	Y	Y?	Y?
3	Affordable?	N	N	Y	N	N?
4	Acceptable?	N	YY	YY	Y	Y
5	Best practice?	N	Y	Y	Y	Y
6	Better experience?	N	Y	Y	Y	Y
	PWF / SL / DN / reject:	**DN**	**reject**	**PWF**	**reject**	**More work needed**

Rationale:

- Option 1 (the "existing" benchmark) meets none of the Objectives and none of the Success Criteria. It fails to meet the objectives because it does not address any of the problems identified. It would not be affordable, sustainable or implementable because the existing pattern of services is under unsustainable pressure both financially and in terms of staffing, and this option does nothing to address these pressures. It does not represent best practice, nor improve the experience of those who use the services; and it would not be acceptable to stakeholders, who are clear that improvements and changes are needed.
- The introduction of the Connections service would go some small way towards addressing the community facing objective, since it would provide advice and signposting to services in the community; however this in itself would not make a major impact on the objective. For this reason all options that include a Connections service are shown as "(Y)" – a positive impact, but only marginal.
- All options 2 – 5 meet the objectives for Consistency, Accessibility and Culture. It could be argued that the 24/7 option is best of all, because it would be available all the time; however, the pattern of current demand for crisis services suggests that there is relatively little demand out of peak hours so the extent of this advantage is questionable.
- Option 2 is probably not Implementable because of the need for additional (scarce) staff to provide the service on a 24/7 basis. For the same reason there are substantial doubts over its Sustainability. Similar concerns might arise (although to a lesser degree) about options 4 and 5. Based on current information it is only the Peak Hours option that can be said with confidence to be implementable and sustainable.
- Based on current costings, it is believed that only the Peak Hours option is affordable. (There was a suggestion that the "Daytime plus Peak" option

might be affordable, and that this might be worth exploring if demand could be shown to justify it. This was agreed to be an additional piece of analysis that should be done prior to public consultation, and these options reviewed if necessary when the information was available.)

- The view-seeking work carried out earlier in the project suggested a strong preference amongst service users for *either* 24:7 operation, *or* Peak Hours operation. There were few voices in favour of other arrangements. Options 2 and 3 are therefore considered best on the "Acceptability" factor (although none of the options would be "unacceptable" except option 1).
- All of options 2 – 5 offer a "best practice" solution in line with available evidence, and will provide a better experience for those who use the service.

6.4 Appraisal of "Recovery Beds and Community Front Rooms" Options

The table below illustrates the conclusions reached about the options for "Recovery Beds and Community Front Rooms". Having considered their performance against all the Objectives and Success Factors, the CPG concluded that **the best way forward would be either Option 2 or Option 4.** It was considered difficult to select which of these looked best at this stage, since more discussions are needed on how Recovery Beds and Community Front Rooms will operate in practice. We are required, however, to select a notional "preferred way forward", and so (on the basis of a show of hands), Option 2 was selected. Option 4 is also shortlisted. The rationale for this recommendation is explained below the table.

	Recovery Beds and Community Front Rooms	1	2	3	4	5
		Current Recovery Beds (7 beds)	CFR invest Rec Beds (7) 3 CFRs	CFR focus 0 Rec Beds 5 CFRs	Balance 10 Rec Beds 2 CFRs	Recovery focus 16 Rec Beds 0 CFRs
Objectives						
1	Achieve Consistency	N	Y	Y	Y	Y
2	Improve Accessibility	N	Y	N	Y	Y
3	Community facing	N	Y	Y	Y	N
4	Style/Culture	N	Y	Y	Y	Y?
Success Factors						
1	Implementable?	N	Y	Y	Y	Y
2	Sustainable/Safe?	N	Y	Y?	Y	Y
3	Affordable?	N	Y	Y	Y	Y
4	Acceptable?	N	Y	N?	Y	N?
5	Best practice?	N	Y	Y?	Y	Y?
6	Better experience?	N	Y	Y?	Y	Y?
PWF / SL / DN / reject:		**DN**	**PWF**	**reject**	**SL**	**reject**

Rationale:

- Option 1 (the "existing" benchmark) meets none of the Objectives and none of the Success Criteria. It fails to meet the objectives because it does not address any of the problems we have identified. It would not be affordable, sustainable or implementable because the existing pattern of services is under unsustainable pressure both financially and in terms of staffing, and this option does nothing to address these pressures. It does not represent best practice, nor improve the experience of those who use the services; and it would not be acceptable to stakeholders, who are clear that improvements and changes are needed.

- All of the options 2 – 5 achieve Consistency.
- Options 2, 4 and 5 all improve Accessibility. Option 3 would improve Accessibility through Community Front Rooms but because it would remove all access to Recovery Beds it is considered to not be an improvement overall.
- The Community Facing objective is achieved in all options that include Community Front Rooms.
- All options 2 – 5 achieve the objective on Style and Culture (although the lack of Community Front Rooms in option 5 casts some doubt over the extent to which this is achieved).
- All options 2 – 5 are Implementable and Affordable.
- All options are probably Sustainable, although there are concerns about how the loss of Recovery Beds in option 3 would impact on the rest of the care pathway.
- Options 2 and 4 would be Acceptable to stakeholders. Option 3 would be unpopular with those who value Recovery Beds highly; and Option 5 would be unpopular with those who are enthusiastic about the potential of Community Front Rooms.
- All options would deliver a "good practice" solution, and a better experience for users. However, without either Recovery Beds (in option 5) or Community Front Rooms (in option 3) the full potential of a "best practice" package of services would be lost.

6.5 Appraisal of "Implementation" Options

The table below illustrates the conclusions reached about the options for "Recovery Beds and Community Front Rooms". Having considered their performance against all the Objectives and Success Factors, the CPG concluded that **the best way forward would be Option 3.** The rationale for this recommendation is explained below the table.

	Implementation	1	2	3
		Do nothing	Wait... till all elements clear	Act now... with what we have
Objectives				
1	Achieve Consistency	N	Y	Y
2	Improve Accessibility	N	Y	Y
3	Community facing	N	Y	Y
4	Style/Culture	N	Y	Y
Success Factors				
1	Implementable?	N	Y	Y
2	Sustainable/Safe?	N	N	Y
3	Affordable?	N	Y	Y
4	Acceptable?	N	N	Y
5	Best practice?	N	Y	Y
6	Better experience?	N	Y	Y
PWF / SL / DN / reject:		**DN**	**reject**	**PWF**

Rationale:

- Option 1 (the "existing" benchmark) meets none of the Objectives and none of the Success Criteria. It fails to meet the objectives because it does not address any of the problems we have identified. It would not be affordable, sustainable or implementable because the existing pattern of services is under unsustainable pressure both financially and in terms of staffing, and this option does nothing to address these pressures. It does not represent best practice, nor improve the experience of those who use the services; and it would not be acceptable to stakeholders, who are clear that improvements and changes are needed.
- Option 2 meets most objectives and success factors, but fails to give an assurance of Sustainability or Acceptability. This is because the problems and pressures on the service are being felt acutely now, and there is a strong feeling that improvements need to be pursued as swiftly as possible.
- Option 3 meets all objectives and success factors.

6.6 Appraisal of "Number and location of Beds" options

The table below illustrates the conclusions reached about the options for "Number and Location of Beds". Having considered their performance against all the Objectives and Success Factors, the CPG concluded that **the best way forward would be Option 5.** The rationale for this recommendation is explained below the table. .

	Beds	1	2	3	4	5	6
		Do nothing (119 beds)	Retain Linden 12 beds to Forston	Retain Linden 12 beds to St Ann's	Retain Linden 12 beds split Forston / St Ann's	Close Linden 27 beds split Forston / St Ann's	Close Linden 31 beds split Forston/ St Ann's
Objectives							
1	Achieve Consistency	N	N	N	N	Y	Y
2	Improve Accessibility	N	Y	Y	Y	YY	YY
3	Community facing	N	N	N	N	Y	Y
4	Style/Culture	N/A	N/A	N/A	N/A	N/A	N/A
Success Factors							
1	Implementable?	N	Y	Y	Y	Y	Y
2	Sustainable/Safe?	N	N	N	N	Y	Y
3	Affordable?	N	N	N	N	YY	Y
4	Acceptable?	N	N	N	N	Y	Y
5	Best practice?	N	N	N	N	Y	Y
6	Better experience?	N	Y	Y	Y	Y	Y
PWF / SL / DM / reject:			**REJECT**	**REJECT**	**REJECT**	**SL**	**PWF**

- Option 1- 4 meet very few of the success factors or objective because in the long run they are either unaffordable or unsafe and do not future proof the service. They fail to meet the objectives because they do not address any of the problems

identified. Therefore options 1-4 are unaffordable, they do not improve accessibility, they do not change the style or culture and are not community facing i.e. meeting the needs in the areas of highest demand.

- Option 6 is the preferred way forward in terms of meeting all the objectives and most of the critical success factors.

6.7 Conclusion – building the shortlist of options

The conclusion of the appraisal of the long list of options is illustrated in the Options Framework below. The gold cells represent the Preferred Way Forward for each category of choice. The grey cells are the "do nothing". The green cells indicate where alternative options have been shortlisted for further consideration.

	1	2	3	4	5	6
No. of Retreats	Existing No Retreats	One: B'mouth/Poole	One: Weymouth	One: Dorchester	Two: B'mouth/Poole Weymouth	Two: B'mouth/Poole Dorchester
	DN	reject	reject	reject	SL	**PWF**
	1	2	3	4	5	6
Connection Operating hours	Existing No connection service	24/7	Peak 6pm - 2am	"Overnight" 6pm - 9am	"Daytime + Peak" 10.30am - 2am	
	DN	reject	**PWF**	reject	reject	
	1	2	3	4	5	
Recovery Beds and Community Front Rooms	Existing Recovery Beds (7 beds) 0 CFRs	CFR invest Rec Beds (7) 3 CFRs	CFR focus 0 Rec Beds 5 CFRs	Balance 10 Rec Beds 2 CFRs	Recovery focus 16 Rec Beds 0 CFRs	
	DN	**PWF**	reject	SL	reject	
	1	2	3	4	5	
Implementation	Existing	Wait... till all elements clear	Act now... with what we have			
	DN	reject	**PWF**			
	1	2	3	4	5	6
Beds	Existing (119 beds)	Retain Linden 12 beds to Forston	Retain Linden 12 beds to St Ann's	Retain Linden 12 beds split Forston / St Ann's	Close Linden 27 beds split Forston / St Ann's	Close Linden 31 beds split Forston/ St Ann's
		REJECT	REJECT	REJECT	SL	**PWF**

ANNEX 1

In order to build a shortlist of options which should be taken forward for further development and then public consultation, the CPG have combined all possible permutations of the shortlisted elements shown above.
The resulting shortlist of options is illustrated below:

	No. of Retreats	Connection Operating hours	Recovery Beds and Community Front Rooms	Implementation	Beds
Option A Existing	Existing No Retreats	Existing No connection service	Existing Recovery Beds (7 beds) 0 CFRs	Existing	Existing (119 beds)
Option B - PWF	Two: B'mouth/Poole Dorchester	Peak 6pm - 2am	CFR invest 7 Rec Beds 3 CFRs	Act now... with what we have	Close Linden 31 beds split Forston/ St Ann's
Option C	Two: B'mouth/Poole Dorchester	Peak 6pm - 2am	Balance 10 Rec Beds 2 CFRs	Act now... with what we have	Close Linden 31 beds split Forston/ St Ann's
Option D	Two: B'mouth/Poole Weymouth	Peak 6pm - 2am	CFR invest 7 Rec Beds 3 CFRs	Act now... with what we have	Close Linden 31 beds split Forston/ St Ann's
Option E	Two: B'mouth/Poole Weymouth	Peak 6pm - 2am	Balance 10 Rec Beds 2 CFRs	Act now... with what we have	Close Linden 31 beds split Forston/ St Ann's
Option F	Two: B'mouth/Poole Dorchester	Peak 6pm - 2am	CFR invest 7 Rec Beds 3 CFRs	Act now... with what we have	Close Linden 27 beds split Forston / St Ann's
Option G	Two: B'mouth/Poole Dorchester	Peak 6pm - 2am	Balance 10 Rec Beds 2 CFRs	Act now... with what we have	Close Linden 27 beds split Forston / St Ann's
Option H	Two: B'mouth/Poole Weymouth	Peak 6pm - 2am	Balance 7 Rec Beds 3 CFRs	Act now... with what we have	Close Linden 27 beds split Forston / St Ann's
Option I	Two: B'mouth/Poole Weymouth	Peak 6pm - 2am	Balance 10 Rec Beds 2 CFRs	Act now... with what we have	Close Linden 27 beds split Forston / St Ann's

7. OPTIONS SHORTLIST

The options the workshops recommend to be taken forward for further consideration (including testing through public consultation) are as follows:

- The **Existing** option (including additional PICU beds) is included only as a benchmark.
- **Option A** is the combination of the "preferred" choices at this stage, and is the nominal **Preferred Way Forward**.
- Options B to H are variants which test combinations of the other shortlisted choices.

Figure 1: Shortlisted options

Option	Description
Option A	**Existing** Retain services as they currently exist.
Option B	**Preferred Way Forward** Two retreats: • One to be in the Bournemouth / Poole area and the other to be in the Dorchester area. Assumed to be open Monday to Thursday 16:00-24:00 Friday to Sunday 17:00-02:00. • Crisis Line continues 24/7 enhanced by additional staff available between 18:00-02:00 every night to provide the Connections service. • Seven Recovery Beds are commissioned, split across east and west Dorset to enhance access. • Three Community Front Rooms are established (locations to be determined based on more detailed planning work against specific criteria). Assumed opening hours Thursday-Sunday 15:00-23:00. • Close Linden and re-provide the 15 beds and increase the bed stock by a further 16 beds shared between St Ann's and Forston • Implement as soon as approvals and consultations are complete, begin to implement those parts of the model that are "ready to go" while continuing to develop the others.
Option C	Two retreats: • One to be in the Bournemouth / Poole area and the other to be in the Dorchester area. Assumed to be open Monday to Thursday 16:00-24:00 and Friday to Sunday 17:00-02:00. • Crisis Line continues 24/7 enhanced by additional staff available between 18:00-02:00 every night to provide the Connections service. • Ten Recovery Beds are commissioned, split across east and west Dorset to enhance access. • Two Community Front Rooms are established. Assumed opening hours Thursday-Sunday 15:00-23:00. • Close Linden and re-provide the 15 beds and increase the bed stock by a further 16 beds shared between St Ann's and Forston • Implement as soon as approvals and consultations are complete, begin to implement those parts of the model that are "ready to go" while continuing to develop the others.

Option	Description
Option D	Two retreats: • One to be in the Bournemouth / Poole area and the other to be in the Weymouth area. Assumed to be open Monday to Thursday 16:00-24:00 and Friday to Sunday 17:00-02:00. • Crisis Line continues 24/7 enhanced by additional staff available between 18:00-02:00 every night to provide the Connections service. • Seven Recovery Beds are commissioned, split across east and west Dorset to enhance access. • Three Community Front Rooms are established (locations to be determined based on more detailed planning work against specific criteria). Assumed opening hours Thursday-Sunday 15:00-23:00 • Close Linden and re-provide the 15 beds and increase the bed stock by a further 16 beds shared between St Ann's and Forston • Implement as soon as approvals and consultations are complete, begin to implement those parts of the model that are "ready to go" while continuing to develop the others
Option E	Two retreats: • One to be in the Bournemouth / Poole area and the other to be in the Weymouth area. Assumed to be open Monday to Thursday 16:00-24:00 and Friday to Sunday 17:00-02:00. • Crisis Line continues 24/7 enhanced by additional staff available between 18:00-02:00 every night to provide the Connections service. • Ten Recovery Beds are commissioned, split across east and west Dorset to enhance access. • Two Community Front Rooms. Assumed opening hours Thursday-Sunday 15:00-23:00. • Close Linden and re-provide the 15 beds and increase the bed stock by a further 16 beds shared between St Ann's and Forston • Implement as soon as approvals and consultations are complete, begin to implement those parts of the model that are "ready to go" while continuing to develop the others
Option F	**As per option B but with 12 additional beds rather than 16**.
Option G	**As per option C but with 12 additional beds rather than 16**.
Option H	**As per option D but with 12 additional beds rather than 16**.
Option I	**As per option E but with 12 additional beds rather than 16**.

The CPG is confident that all these options (except for the benchmark **do nothing** achieve the objectives of the project, are likely to be affordable and achievable, and are therefore realistic and attractive options to be explored and discussed through public consultation.

Workshop Attendees

Coproduction Group (CPG) Attendee (organisations represented)
Dorset Clinical Commissioning Group
Service user and carer representatives
Dorset HeatlhCare
Bournemouth Borough Council
Dorset County Council
Borough of Poole
Dorset Mental Health Forum
Rethink Mental Illness
South West Ambulance Service Foundation Trust
Dorset Police
The CPG is made up of heads of care, service managers and clinicians, commissioning managers and representative service users and carers. The CPG members have attended most of the modelling workshops and are the recommending group of the modelling workshop process.

PROJECT OBJECTIVES

Objective:	ACHIEVE CONSISTENCY: To ensure consistency of provision and access and care
What it means:	• To develop a consistent acute MH care pathway across Dorset where people using services will know what to expect from each service • To define the range of skills that will be available at each level of service by end March 2017 • Ensure that this is in place consistently across Dorset by end 2017 acknowledging that operating models might differ e.g. rural service may be different to urban • To ensure that consistent service 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 that 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

Objective:	IMPROVE ACCESSIBLIITY: To ensure that services are accessible wherever you live in Dorset
What it means:	• Ensure better access to prevention, self-management, 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

Objective:	COMMUNITY – FACING: To ensure that services are community facing and that local community assets are fully utilised
What it means:	• 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

Objective:	STYLE / CULTURE: To ensure that the style and culture of the service delivery is person centred and recovery focussed
What it means:	• 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 to Mental Health act assessments

PROJECT SUCCESS FACTORS

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 there be any negative impact on current workforce? Will there be any sustainability issues related to future 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? Will the implementation be achievable within 3-5 years? Will the options provide a flexible platform for the future especially considering other strategic changes?
Does the option deliver services which are clinically **sustainable** and **safe**?	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 (eg sickness, absence)? Will the option be flexible enough to manage peaks and troughs in demand?
Will the option be **affordable?**	Using high-level estimates, do we believe that the option can be delivered by reshaping existing resources? Are there likely to be any one off revenue or capital costs associated with implementing the model options? 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 travel times be acceptable and within agreed limits 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? Will the models meet expected standards set by NICE and Royal Colleges? Will options meet mandated requirements?
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 give patients choice? Will it “help us live the lives we want to live”?