Mental Health Acute Care Pathway Modelling Workshop Programme							
14 December	6 & 7 Jan 2016	26 Jan 2016	22 & 24 Feb 2016		29 April 2016	5 May 2016	21 July 2016 16 Sept 2016
Scene setting and objective clarification day with CPG	Launch Days Background presentations and reflections Innovation and visioning Initial model and thoughts	CPG /urban and rural groups Refining thoughts taking differences into consideration Initial pathway creation	Service Users CPG & Folio Opportunity for wider co-production with service users and carers	Break in modelling workshops to enable the initial costing and modelling work to be done to inform next coproduction modelling workshops	Urban Modelling Rural Modelling Refining thoughts from the previous workshops	2nd Service user and carer crosscheck day	Shortlisting Days Community Services & Inpatient services
1 day CPG Members Folio	2 days CPG Members and Urban and Rural Groups	1 day Urban and Rural Modelling coproduction group	2 days 22 Feb Service User Cross Check 24 Feb CPG: Assimilation and initial model options/ Cross Check		1 day Urban and Rural Modelling coproduction group	1 day Service user Crosscheck day	2 days 21 July CPG Members Folio 16 September CPG Members

Days	Groups	Key discussion points Each workshop built on the last workshop: there was recapping and the addition of new information at each session and in between the workshop sessions additional work was being undertaken to develop the concepts further

14 December 2015
 	
Scene setting and objective clarification day
	Co-Production Group (CPG)
	
	The CPG is largely made up of managers, service managers, service leads and service users and carers. The organisations represented are: Dorset CCG, Dorset HeatlhCare, the three Local Authorities, Dorset MH Forum, and Rethink Mental Illness.
	
	There are approximately 30 people in the CPG
		• Coproduction - what coproduction means and why it is so important
		• Reviewed the ACP work to date including needs and data analysis and feedback from service user and carer engagement
		• Discussion on policy drivers and imperatives
		• Update on DHC CMHT review and key challenges from Dorset HealthCare perspective including bed use and demands on the community services
		• Key challenges from the Local Authority perspective
		• Achieving a shared understanding: coproducing five to ten statements that capture the over-arching challenges to be addressed
		• The Treasury's Five Case Business Case Model - meeting NHS Assurance requirements
		• Revisiting the over-arching challenges
		• Small group working to identify SMART objectives
		• Feedback and agreement of objectives
		• Planning for next meeting (visioning and modelling days)
		• Identified some of the key challenges
		  ○ increased demand and
		  ○ reducing budgets
		  ○ need to improve services
		• Gained an understanding of the business case model that is to be used for the ACP
		• Developed the overall objectives of the project
		• Planned for the launch days

Days	Groups	Key discussion points Each workshop built on the last workshop: there was recapping and the addition of new information at each session and in between the workshop sessions additional work was being undertaken to develop the concepts further
6 and 7 January 2016 Launch days: Background information and reflections and Innovation and Visioning Facilitated by ImROC and NDTi	CPG and Urban Rural Groups The CPG is made up of mental health staff, representatives from the local authorities, police, ambulance service, Dorset HeatlhCare and organisations from the third sector currently working in Dorset. The groups also had service users and carers attending the workshops. The urban rural groups also had the CPG members in attendance for continuity and collective memory of previous workshop outcomes. Approximately 72 people attended the urban /rural group sessions.	• Introduced the project and the objectives to all attendees • Introducing options for people approaching crisis from national and international examples **Themes:** ○ What options do we want in Dorset when thing start going wrong? ○ How can we personalise crisis support in Dorset? ○ Increasing the range of support in the community ○ How can we provide people with clinical and social support they need? ○ Could personal budgets and peer support have a role in personalising support in Dorset? ○ How can we improve access to services in Dorset for people new to services and for people returning to services? ○ Social Networks and Social Prescribing ○ Addressing questions raised by some case studies ○ Comments, questions, additions and amendments to the pathways on the wall ○ Considering ways of improving consistency, communication, continuity and culture of the care pathway. ○ What could be introduced to ensure that everyone's experience is improved? • Facilitated discussion on all the themes Themes to be followed through to next workshop were: **Style and Culture** • Listening, sincerity, integrity, transparency, genuineness • Need to support staff (learning and development, wellness, development, family friendly

		employment, valuing lived experience) – improve recruitment and retention • Allow staff to specialise so that there is a clearer range of treatment and support options in every locality • Use of IT, social media, skype, apps • Discharge Planning/transition planning, graduation, use of 117 monies • Whole system transformation – person and their lives in their communities at centre, services need to provide best support for them to live well • Current system stifles creativity and innovation **Accessible** • Need to improve existing services AND support new innovations • Remember key interest groups: Carers, families, friends, Homeless people, BME groups • Attention to transitions from CAMHS and into older people's services • Take circumstances into account – child care, teenage care, family support • Need alternatives to hospital at front and back end of admission **Community Facing** • Community businesses, social enterprises, invest in communities • Transport issues, distance, geography and accessibility • Supported Housing as a means of reducing admission and facilitating whole lives **Consistent** • Need to shift from reactive to preventive • Need for social support in primary care even once discharged from secondary services • Physical Health care alongside emotional support These themes were also endorsed in the case study discussions and there are themes that came through that start to form the basis of the modelling objectives.

Days	Groups	Key discussion points Each workshop built on the last workshop: there was recapping and the addition of new information at each session and in between the workshop sessions additional work was being undertaken to develop the concepts further
26 January 2016 Urban Rural Refining thoughts from Innovation days taking differences into consideration Initial pathway creation Facilitated by ImROC and NDTi	Urban Rural Groups	The Project to date including needs and data analysis which included community services and inpatient services. • Summary from the Launch Days • Introducing the first model proposal • Asset mapping - What does your organisation bring to the party? • Facilitated table discussions: In Urban and Rural Groups • What do you think about the first model proposal? • Feedback and questions The Straw man –this is what we called the first draft, of a potential model that shows some of the options that sought to address the key issues that people raised in the launch events. The straw man is the introduction to: • Retreats • Community Front Rooms • Host Families • The Connection • Recovery House Models All based on best practice and innovations from other parts of the UK and the USA.

Days	Groups	Key discussion points Each workshop built on the last workshop: there was recapping and the addition of new information at each session and in between the workshop sessions additional work was being undertaken to develop the concepts further
22 February 2016 Service User and Carer Crosscheck day	Crosscheck Group The Cross Check days were attended only by people who use services either as a patient or as a Carer. Approximately 30 people attended these sessions.	Introduction and background • What you said and what we have done so far • What outcomes should be delivered • First thoughts from each table • The Dorset Picture – mental health prevalence and need including demand for community services and inpatient services • Facilitated table discussions - what is important to you? • Feedback and discussions • Introduced the Straw Man model – for the group to see how it would meet their needs based on the experience of using services. • Introduced the workbook describing innovative practice from the launch days • General consensus that locally developed services will be a good thing for local communities • Issues around travel times and the group suggested that travel up to 25 minutes would be manageable as long as there was the service needed when they arrived.

Days	Groups	Key discussion points Each workshop built on the last workshop: there was recapping and the addition of new information at each session and in between the workshop sessions additional work was being undertaken to develop the concepts further

24 February 2016
 	
Facilitated by ImROC, NDTi, Folio and CCG
 	
Options for wider co-production community to feed in
CCG local events for SU/ Carers
	CPG	• Scene setting for the day
		• Parameters of the project
		• Dorset HealthCare CMHT and Inpatient demand Reviews where the groups heard about the inpatient services review and information was shared in relation to how the beds could be used in a different way to meet demand and this could have possible implications for the Linden Unit as an isolated unit
		• Demand, prevalence and need across Dorset
		• Discussion based on all the previous discussions: including demand profile and cost benefit analysis
		• Objectives were signed off ahead of project board and JCB
		• Critical Success Factors and Inclusion Criteria
		
		Table discussions to talk through the initial model proposals:
		• Concerns that using hospital base might be too clinical
		• Use of staff and making sure that staff teams are skilled and use their skills because they have the time to do it
		• Use of technology for support and to ensure best use of clinical time
		• Amalgamate crisis and CMHT into one team, thereby reducing barriers; linkages to staff; shared ownership. 1 in Bournemouth, suggest Kings Park and 1 in Poole, suggest Alderney.
		• What staff would you need to go out and keep the front door open; should be able to triage on to right service.
		• Triage – relationship building.
		  • Psychosis – personality disorders – people should have a safe place to go.
		  • Peer support workers have a better level of understanding.
		  • What criteria constitute getting referred to CMHT – needs to be consistent.

Days	Groups	Key discussion points Each workshop built on the last workshop: there was recapping and the addition of new information at each session and in between the workshop sessions additional work was being undertaken to develop the concepts further

29 April 2016
 	
Urban rural day
 	
Final proposals for the model for CPG refinement e.g. costing and modelling
	Urban Rural Groups	• Summary of process so far
		• Agreed objectives: any options has to meet the objectives: Consistency, Accessibility, Community facing and Style and Culture
		• New comments and national requirements form the five year forward view which includes no / reduction in out of area beds used from 2017 and hospital care to be provided within 33 miles of home and 24/7 access to MH crisis care
		• Data analysis and context for the modelling including inpatient provision and community services
		• Reflection time on the data to start understanding/ discussing impact on future options
		• Initial model: Functions – what you said we needed in Dorset
		• Benchmarking outcomes
		• Dorset HealthCare proposals for what they could deliver within current budget
		• Outcome of DHC's bed review and considerations for options: This included an discussion about bed use and demand across the County. The group heard about some options, for example moving beds from Linden to Forston and St Ann's to ensure that the provision is adequate in the area where the demand is at its highest (70% urban)
		• What we have now and pathway mapping of the new functions
		• Mapping of priorities within tight options for CFRs, recovery beds and retreats
		• Attendees asked to outline on map preferences for two or three acute inpatient units
		• Development of priorities for the pathway taking in to account:
		  ○ Cost
		  ○ Prevalence
		  ○ Consistency
		  ○ Distance
		• Community assets – what can we use that is already there initial asset mapping completed

Days	Groups	Key discussion points Each workshop built on the last workshop: there was recapping and the addition of new information at each session and in between the workshop sessions additional work was being undertaken to develop the concepts further
5 May 2016 Final service user crosscheck event	Crosscheck Day	• Summary of Process so far and the group were given the same information as the Urban Rural group and were informed about the urban rural groups comments and thoughts on the models of care so far; • Dorset Health Care shared the operational possibilities • The groups were asked what they think about the model and the operational interpretation. • What this looks like as a pathway- weaving it all together • The group had table discussion about the models and operational issues **Feedback was:** The feedback provided by people at the Urban and Rural Workshops and Crosscheck days has been themed and compiled in a separate report but below is a summary of the significant areas of interest related to the emerging models of care. **The use of technology** There were numerous comments about the use of technology that will enable people who use services to access Mental Health support in different ways and enable staff to work differently and more efficiently across the county. These views were balanced with the request not to replace people with technology because human contact is important in recovery. **Keeping people safe** Comments suggested that care earlier could help keep people safe and if an individual reaches the point where they require acute care there should be services in place to meet their need. The required services ranged from somewhere safe to be when intoxicated to a formal place of safety in the West to meet the demand. **Staff wellbeing, recruitment and retention**

		There was general concern expressed about staff wellbeing and more specific concern about staff retention and recruitment. There were comments about staff having the right skills and the right support and improved supervision to enable them to work safely and effectively including the provision of clinical support e.g. access to psychological support as needed. **Workforce changes and development related to peer support workers** There were views about the future workforce and the need to include peer support worker/support time recovery workers or navigators to ensure that Mental Health services focus on the whole person not just on their medical needs. Alongside this view there are concerns about how it can be achieved for example are there enough people who could become peers support workers to meet the anticipated demand and how can this be sustained. **Transport** Transport has been an issue throughout the discussions and there were comments ranging from, cuts to services; the need for a transport budget to cross boundary working to ensure that people who live near a boundary could potentially access services in another CCG area for example, Avon and Wiltshire or Hampshire.

Days	Groups	Key discussion points Each workshop built on the last workshop: there was recapping and the addition of new information at each session and in between the workshop sessions additional work was being undertaken to develop the concepts further
21 July 2016 Shortlisting day for community model All options to be discussed and shortlist developed	CPG	• Structure of the day • The ACP story so far recap as per all the other workshops with any additional information to share Making it this a reality? Choices the group had to make: • Number of retreats and where they should be • Connection operating hours • Recovery beds and Community Front Rooms • Implementation Beds had been removed from the discussion as CSR had put preferred options forward for community sites and it was felt that the CSR consultation would run first and the bed modelling would be dependent on the outcome of that consultation in terms of the Westhaven site. The long list of options and appraisal of each to ensure that the chosen options met the objectives and the critical success factors • Appraisal of the long listed options • Deciding the shortlist for consultation • Summary and next steps

Days	Groups	Key discussion points **Each workshop built on the last workshop: there was recapping and the addition of new information at each session and in between the workshop sessions additional work was being undertaken to develop the concepts further**
19 September 2016 Shortlisting day for acute inpatient model All options to be discussed and shortlist developed		Beds were reintroduced into this stage of discussion as the CCG wanted to understand the MH priorities/ options for the pathway and for the ACP consultation to run in parallel with CSR is feasible. • Structure of the day • Recap on community model and shortlisted options • Recap on prevalence, demand and update on bed usage in West and East • Present options vs objectives, challenges and costs Making it this a reality? Choices the group had to make: • Judgement on how the options met objectives and shortlisting criteria • Which supported prevalence requirements the best • Which were implementable There is very little capital in the system and this was discussed. The challenges surrounding Linden was discussed and the constraints of the estate. The only option put forward as meeting the objectives and shortlisting criteria was to close Linden and deliver an additional 12 beds across the system (total reconfiguration of 27 beds). The option had a reliance on Alderney site becoming available to move OP mental health services there. There were concerns regarding this as the time scales were unknown as the CSR consultation had not taken place. **The implementation plan would need to deliver an interim position to ensure the pressure on the system was released. It was agreed that that would be developed**. Concern was raised that a further 4 beds had been identified by DHC's external consultancy as being required in Dorset if no other changes were made to the system (total of 22 additional beds including PICU). Although the ACP should deliver significant changes there is no direct evidence base for how this will impact Dorset, as this will be tested throughout implementation. As a result of this **it was agreed that a second option would be costed and shortlisted if affordable to deliver the additional 4 beds**