HEALTH AND ADULT SOCIAL CARE
OVERVIEW AND SCRUTINY COMMITTEE

18 DECEMBER 2013

IMPLEMENTATION PLAN – ACUTE SERVICES REDESIGN

Report from: Barbara Peacock, Director of Children and Adults

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Summary

This report sets out the implementation plan for the acute services redesign received from West Kent CCG as the commissioners for acute mental health for Kent and Medway, in response to the recent reconfiguration proposals and as promised at the last meeting of the Joint Health Scrutiny Committee between Kent and Medway held on 30 July 2013.

1. Budget and Policy Framework

1.1 Under Chapter 4 – Rules, paragraph 22.2 (c) terms of reference for Health and Adult Social Care Overview and Scrutiny Committee has powers to review and scrutinise matters relating to the health service in the area including NHS Scrutiny.

2. Background

2.1. At the meeting of the Joint Health Scrutiny Committee on 30 July 2013 the covering report to that Committee explained that Kent and Medway NHS and Social Care Partnership Trust, in the light of the clinical strategy and acknowledging the specific needs of the population of Medway, proposed the following: in relation to the way forward on mental health beds:

- Developing 8-10 intermediate care beds and a day care intensive treatment service for patients with Personality Disorder (through capital investment).
- Establishing a recovery house model in partnership with a third sector provider where 8-12 people would be able to be supported in supervised accommodation with intervention/input from mental health professionals.
- Developing 12 extra acute beds within Maidstone as added capacity in addition to the proposed additional beds at Dartford.
- Changing the function of and extending Dudley Venables House to allow the provision of an additional 8-10 acute beds in Canterbury.

2.2. A number of requests were made by the Committee which were as follows:

The Kent and Medway JHOSC requested:

- A significant increase in the retention for reinvestment, to be spent on further increases in crisis resolution/home treatment and a small number of additional acute beds;
- A clear plan being developed for the delivery of the elements of genuine centres of excellence in the three remaining sites;
- An action plan to be prepared within three months to be overseen by NHS England and Kent County Council and Medway Council Health Overview and Scrutiny Committees; and
- Regular monitoring of performance to be undertaken in light of experience as changes progress.

2.3. At the conclusion of the JHOSC the following decision was taken, following a Vote (Medway Members abstained):

AGREED that the Committee supports the NHS proposals and asks that the report and recommendations of the independent report commissioned by the JHOSC be presented to the Clinical Commissioning Groups (CCGs) when they are asked to consider the next steps set out in the NHS briefing paper on p.21 of the Agenda. In particular, the Committee asks for, in line with the independent report:

- A significant increase in the retention for reinvestment, to be spent on further increases in crisis resolution/home treatment and a small number of additional acute beds;
- A clear plan being developed for the delivery of the elements of genuine centres of excellence in the three remaining sites;
- An action plan to be prepared within three months to be overseen by NHS England and Kent County Council and Medway Council Health Overview and Scrutiny Committees; and
- Regular monitoring of performance to be undertaken in light of experience as changes progress.

2.4. Attached, as appendix 1, to this report is the follow up from that meeting which is an implementation plan acute services redesign programme initiation document received from West Kent CCG who will be represented at the meeting by the CCG's Chief Officer. He will respond to Members' questions. This implementation plan will also be considered by Kent's Health Overview and Scrutiny Committee (HOSC) early in the New Year.

3. Risk management

3.1.

Risk	Description	Action to avoid or mitigate risk
Insufficient mental health acute beds in Medway to meet demand	That there are insufficient beds for Kent and Medway in the new reconfiguration	Members have been assured by West Kent CCG, the commissioners of the service, that the reconfiguration will meet the needs of both Kent and Medway residents
Impact on Medway of the proposed reconfiguration	Potential deterioration of service for Medway service users and their carers/families.	O&S will be rigorously testing the robustness of the proposals at necessary milestones in the implementation

4. Legal and Financial Implications

4.1. There are no legal or financial implications for the Council.

5. Recommendations

5.1. Members are asked to comment on the acute service redesign programme initiation documentation and agree dates to keep the plans under review during their implementation.

Background papers:

None.

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Kent and Medway NHS
NHS and Social Care Partnership Trust

ACUTE SERVICE REDESIGN

PROGRAMME INITIATION DOCUMENTATION [PID]

Version:	1.1.2	**Status:**	Draft	**Date:**	28/10/2013

DOCUMENT TRACKING

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REVISION HISTORY

Version	Status	Date	Issued to / Approved By	Comments
V1.0	Draft	16/09/13	Executive Management Team [EMT]	Inclusion of Executive Summary and Rolled Up Plan

SUMMARY OF REVISIONS

Version	Date	Details of Revision
V1.1.1	17/09/13	Incorporates comments from EMT on V1.0
V1.1.2	28/10/13	Incorporates updated governance structure

APPROVALS: This document requires the following approvals. A signed copy should be placed in the Programme files.

Programme Role	Name	Job Title	Signature	Date Approved
	Ivan McConnell	Director of Commercial Developments and Transformation		17/09/13

DISTRIBUTION: This document has been distributed to:

Version	Date	Name	Job Title
V1.0	16/09/13	EMT	

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1 EXECUTIVE SUMMARY

The lack of consistency in acute mental health care provision specifically around inpatient environments led to a consultation on acute services between 26 July 2012 and 26 October 2012[1]. The proposals noted that:

- Beds required realignment so that capacity would best fit demand.
- Inpatient environments needed to be fit for purpose, enhancing patient experience and promoting wellbeing and recovery.
- Acute community services needed to be enhanced, providing alternatives to inpatient care.
- Psychiatric intensive care [PIC] outreach services needed to be extended to cover East Kent.

The consultation feedback broadly supported the proposals and subsequent discussions and further analysis has led KMPT to its current proposals for service development. These are:

- Development of three centres of excellence – improved inpatient environments.
- Increased capacity to manage demand.
- Development of alternatives to admission including, crisis houses, support time recovery [STR] investment to crisis resolution home treatment [CRHT] services, intensive day treatment, and personality disorder crisis service.
- Extension of PIC outreach.

These proposals will deliver the following benefits:

Increased alternatives to admission.
Greater skill mix of workforce including the use of people with lived experience and peer support.
Inpatient accommodation which is fit for purpose, meeting requirements for health and safety, privacy and dignity and promotes wellbeing and recovery.
Improved satisfaction.
Robust 24/7 services.
Improved performance.
Reduction in delayed transfer of care / transfer pressures.
Reduction in length of stay.
Decreased incidents of violence and aggression.
Reduction of external placements.
Reduction in staff sickness.
Improved retention and recruitment of staff.

[1](2012) *Achieving excellent care in a mental health crisis: Consultation Document* (KMPT available at http://www.kmpt.nhs.uk/Downloads/Trust-Services/Mental-Health-Consultation.pdf)

There are a number of interdependent projects which together will deliver the Acute Services Redesign Programme. The projects range from capital investment to develop bed capacity and quality of inpatient environments, to development of alternatives to admission which will provide choice and build capacity within acute care. In addition these projects will deliver improved relationships with stakeholders, improved quality and will have a positive impact on outcome and satisfaction measures. Current projects and those under development include:

Project	Status
Street Triage	This development has been agreed with NHS Commissioners
PIC Outreach	This development sets out KMPT's current thinking; it needs to be worked up in line with NHS Commissioner intentions
Dudley Venables House [DVH] Refurbishment	This development has been agreed with NHS Commissioners
Birch Ward Upgrade	This development has been agreed with NHS Commissioners
STR Development	This development has been agreed with NHS Commissioners
Transport	This development has been agreed with NHS Commissioners
Intensive Day Treatment	This development sets out KMPT's current thinking; it needs to be worked up in line with NHS Commissioner intentions
Crisis House	This development sets out KMPT's current thinking; it needs to be worked up in line with NHS Commissioner intentions
Maidstone Additional Capacity	This development has been agreed with NHS Commissioners
Personality Disorder Crisis Services (Hostel and Day Therapy)	This development has been agreed with NHS Commissioners

2 DOCUMENT PURPOSE

The purpose of the Programme Initiation Documentation [PID] is to define the programme, in order to form the basis for its management and an assessment of its overall success. The PID gives the direction and scope of the programme and (along with the programme plan) forms the 'contract' between the programme manager and Programme Board.

The three primary uses of the PID are to:

1. Ensure that the programme has a sound basis before asking the programme board to make any major commitment to the programme.

2. Act as a base document against which the Programme Board and programme manager can assess progress, issues and ongoing viability questions.

3. Provide a single source of reference about the programme.

The PID is a living product in that it should always reflect the current status, plans and controls of the Programme. Its component products will need to be updated and re-baselined, as necessary, at the end of each stage, to reflect the current status of its constituent parts. It is the responsibility of the programme manager to keep the PID up to date and ensure agreed changes are communicated.

The version of the PID that was used to gain authorisation for the programme and the most recent version of the PID agreed via the change control process are preserved as the basis against which performance will later be assessed when closing the programme.

3 PROGRAMME DEFINITION

This section of the PID sets out the background, programme objectives and desired outcomes, programme scope and exclusions, constraints and assumptions, the user(s) and any other known interested parties and dependencies.

3.1 **Background:** Every year, around 3,000 of the 1 million men and women of working age in Kent and Medway have a mental health crisis[2] and need treatment urgently. Such treatment is provided by high quality specialist acute care services comprising a multi-disciplinary team of psychiatrists, mental health nurses, occupational therapists and other highly trained staff.

In the past, people in a mental health crisis would always be admitted to hospital. Over the last eight years services have been dramatically transformed. Most people now prefer to be and are now treated in their own homes by specialist CRHT teams who are available 24 hours a day, 7 days a week. Treatment at home helps promote quicker recovery and helps people stay well for longer. As a result those who do get admitted to hospital are those that are most unwell, with a real risk to themselves or others. Many are under a section of the Mental Health Act [MHA] 2007.

Unfortunately not everyone in Kent and Medway is currently getting access to equally good services. A review by KMPT and NHS Kent and Medway in 2012 concluded, over the previous four year period, there had been a reduction in use of hospital beds by people in a mental health crisis as a direct result of successful home treatment. In 2012 there were 160 Kent and Medway beds for people in a mental health crisis but in 2011-12 an average of 144 were occupied. Additionally, it concluded there are too few hospital beds available in East Kent, more than needed in West Kent, while those in Medway are not fit for purpose. The too few beds in East Kent result in patients being admitted into other areas where ties with their own CRHT team are more difficult. This can lead to disjointed care and delayed discharge, as well as having a knock on effect for patients from other areas also being admitted out of area. The long-standing concerns about Medway beds[3] (provided at A Block at Medway Maritime Hospital) remain unresolved despite years of effort. A Block continues to offer a lower standard of environment to patients from Medway, Sittingbourne and Sheppey, compared with the rest of Kent. This has an impact on people's care and on their hospital experience.

In 2010 the Care Quality Commission [CQC] highlighted concerns about the environment from a privacy and dignity perspective. These concerns were addressed and the improvements noted by the CQC on a subsequent visit in 2011. The improvements included additional staffing (including an extra 0.5 whole time equivalent senior consultant) and occasional reduction in bed numbers. This has the benefit of maintaining safety and capacity within the allocated resources but the dis-benefit of reducing capacity for Medway patients. However, it is acknowledged that the environment continues to present challenges. This is despite the constant vigilance and monitoring by staff. The environment also presents further challenges with some

[2] "Mental health crises include: suicidal behaviour or intention; panic attacks / extreme anxiety; psychotic episodes (loss of sense of reality, hallucinations, hearing voices); other behaviour that seems out of control or irrational and that is likely to endanger self or others. These types of situation can also be described as 'acute' and require access to 'acute' services." (Mind, 2013 available at http://www.mind.org.uk/mental_health_a-z/8038_crisis_services)

[3] Medway beds (provided at A Block, Medway Maritime Hospital) are currently provided as dormitory bays, with four to five beds in each area and only curtains between the beds for privacy. Two bathrooms are shared between sixteen patients on each ward. Access to outside space, known to promote recovery, is limited and restricted. In contrast the wards in West Kent (provided at Little Brook Hospital, Dartford and Priority House, Maidstone) and in East Kent (provided at St Martin's Hospital, Canterbury) have single ensuite facilities for every patient.

of the highest incidences of verbal and physical violence and aggression. Though well supported by the PIC services, further improvements could be made by enhancing the patient environment. In West Kent and Medway there are effective PIC outreach services. These services help prevent patients deteriorating and help people stay on the ward first admitted to (rather than moving between acute and PIC wards). These services are not available in East Kent.

Since 2004, the local NHS has tried many times to find somewhere in Medway more suitable than A Block. Options explored include altering the current environment to make it more suitable for mental health crisis care and building a designed for purpose new unit. These solutions would cost between £7 million and £13 million. In the current economic climate a new building is impossible, especially as KMPT does not own any land that could be used, even if the capital funds could be found.

Published research (refer *Achieving excellent care in a mental health crisis: Consultation Document*[1] for a full list of clinical evidence) suggests:

- Ward environment makes a big difference to people's recovery and wellbeing when they have to stay in hospital. Key factors that reduce violence and aggression, improve the patient / carer experience and raise staff morale are: individual ensuite rooms; a range of therapeutic spaces; single sex facilities; quiet rooms; activity areas; easy access to secure; safe outdoor spaces; and good sightlines for staff.
- Offering a range of interventions and contact with different staff groups in a centre of excellence is effective at: enhancing patient wellbeing; reducing hospital stays; achieving consistent treatment practices; ensuring resilient staffing levels, all day, every day, with the right mix of skills so therapy is available in the evenings and at weekends, and there are enough staff to provide safe care round-the-clock; and helping the NHS get better value for money.
- Properly joined-up working by CRHT teams, inpatient units for people in a mental health crisis and psychiatric intensive care brings: better patient and carer satisfaction; less violence and aggression; less staff sickness; shorter stays in hospital; more prompt discharges back home; and better quality of care.

Following extensive engagement with stakeholders (including but not limited to people who use services, carers, voluntary organisations, advocacy networks, general practitioners [GPs], mental health specialists, commissioners and other clinicians and representatives of the public) a number of proposals were developed. These included:

- Strengthening community based CRHT teams to provide more support to people outside hospital.
- Developing three centres of excellence for people in a mental health crisis, each providing:
  - ✓ Faster and more complete recovery for service users;
  - ✓ Patients having a better experience including feeling safe and being able to see the progress they are making in recovering from crisis;
  - ✓ An excellent acute inpatient mental health service in itself, delivered by highly effective staff who are well supported and able to deal with any crisis 24 hours a day, 7 days a week;
  - ✓ More opportunities for therapeutic interventions at weekends and into the evening;
  - ✓ Purpose-built accommodation for safe care, with calm environments that support recovery;
  - ✓ Hubs of good practice with a research programme that attracts and retains highly qualified, expert and motivated staff.

  These will be based in Dartford, Maidstone and Canterbury. This means people from Medway, Sittingbourne and Sheppey will be able to receive treatment in fit for purpose facilities and within a safe environment that promotes recovery.

- Concentrating stays for PIC in one purpose-built hospital unit, the Willow Suite at Dartford, allowing the former Canterbury PIC unit (DVH) to be converted to provide an additional 18 acute beds in East Kent.
- That people who live in Medway would use the centre of excellence at Dartford.
- Researching, in conjunction with our academic partners, the outcomes and benefits to service users of a new range of alternatives to hospital, such as offering time in a crisis lounge or structured day therapy as part of planned home treatment, and / or access to a crisis house or specialist hostel for people with a personality disorder experiencing a crisis.

These proposals are based on key criteria:

- Quality and safety: delivering the best quality service and experience for service users.
- Access: allowing patients, families and carers better access to services from their local CRHT team and PIC service and easy access to a centre of excellence;
- Sustainability and flexibility: services that are able to meet the current and future demand for inpatient beds and are adaptable to meet peak demand;
- Environment: offering the kind of therapeutic environment known to deliver better recovery;
- Staff recruitment, training and development: attractive to staff, with appropriate levels of training for staff and research opportunities;
- Integration: all associated services can work closely together for the benefit of patients;
- Value for money: all services must make best use of NHS resources. These proposals and all the options are affordable within current budgets.

3.2 **Programme objectives and desired outcomes:** That everyone in Kent and Medway receives high quality inpatient care in safe, purpose-built accommodation that promotes recovery, with good access to the full range of treatments, resilient staffing (24 hours a day, 7 days a week) and sharing of best practice.

Wherever possible, people should be in beds used only by their CRHT team so that care is consistent and integrated, discharge is faster, and the patient experience is better.

To develop tighter partnership working between CRHT teams and inpatient wards, in line with best practice, while building on the trend for more people to be treated at home with fewer having to stay in hospital. This will be achieved by:

- Strengthening CRHT Teams: by investing £297,000 a year in additional CRHT team staff (STR workers) from August 2013. To continually review the balance of work between the hospitals and the CRHT teams and make further minor staffing adjustments between them as necessary.
- Acute mental health wards: by developing three centres of excellence (Little Brook Hospital, Dartford; Priority House, Maidstone; and St Martin's Hospital, Canterbury), with the right number of staff and with the right skill mix to deliver very high standard, innovative care; measurable results for service users; constantly improving practice expertise; evidence based research; close integration of care with the CRHT teams. Each centre will have modern, purpose built accommodation offering single ensuite rooms, spacious communal and therapeutic areas; and safe, secure landscaped outdoor space. This will provide an indicative total of 174[4] acute inpatient beds and will enable a move out of the unsuitable accommodation at Medway.

[4] The original consultation[1] recommended provision of 150 acute inpatient beds. Following challenge by the Kent and Medway Joint Health and Overview Scrutiny Committee [JHOSC] at its meeting on 13 February 2013, further bed sensitivity analysis was undertaken. This concluded the basis for 150 acute beds being sufficient for Kent and Medway was no longer supported by data. The new indicative calculation of beds needed worked out at 174. This was supported by the JHOSC at its meeting on 30 July 2013[5]. Final capacity requirements, bed numbers and locations are currently being defined in collaboration with NHS Commissioners.

- PIC: by expanding the PIC outreach service across the whole of Kent and Medway, so that all three centres of excellence benefit from its support and strategies that help prevent the need for admission to a PIC bed. PIC beds will be consolidated at the Willow Suite, so that those at DVH are always available for acutely unwell people from East Kent. This will reduce the number of PIC beds in Kent and Medway by 8.
- Alternatives to hospital: to research with academic partners the outcomes and benefits to service users of a new range of alternatives to hospital, such as offering time in a crisis lounge or structured day therapy as part of planned home and / or access to a crisis house or specialist hostel for people with a personality disorder experiencing a crisis.

3.3 **Programme scope and exclusions:** The Acute Service Redesign Programme is about plans to improve treatment services for people of working age having a mental health crisis, so that they get better faster and stay well longer. It is not concerned with treatment of other mental health problems. Services include CRHT teams, inpatient services, and PIC services.

3.4 **Constraints and assumptions:** The Acute Service Redesign Programme is subject to the following constraints:

- The redesign must support the integrated acute adult mental health care pathway.
- The redesign must be affordable within the capital and revenue budgets available.
- The redesign must meet the Trust's stated objective as per the Integrated Business Plan [IBP] of providing inpatient accommodation from three main hubs within Kent and Medway.
- The redesign must provide consistency of service delivery and environment not only with existing East Kent younger adult facilities but also with similar facilities across the whole geographical area of the Trust.
- Delivery of the redesign within the shortest timeframe possible ensuring any tension between implementing changes quickly and maintaining quality is minimised.
- Language and definitions: words and terms - such as 'urgent'; 'local', 'centres of excellence' - all mean different things to different people. There is a need for clarity in definition and understanding.
- Alignment with Clinical Commissioning Groups [CCGs]: how will services fit with the new CCG boundaries, what will this mean for services, and how will this impact on available resources.
- Resources available / required to deliver: this requires ongoing review of workforce particularly where development of additional services are being considered i.e. additional bed capacity, alternatives to hospital admission.
- Demand pressures for inpatient beds: the need to develop additional capacity and the additional pressure that may occur during existing ward upgrades and refurbishment.
- Future demand pressures being unknown: the need to build in flexibility which will meet long term strategic direction in addition to providing a solution to short term demands and a local focus.
- Service needs to be responsive: delivery needs to fit within the broader developments of delivering urgent care.
- Risk of competitors emerging for the provision of acute care.
- Management of expectations of a variety of stakeholders including staff, service users, carers, primary care, and other services.
- Planning permission: how will this impact on the time to deliver improved facilities and additional bed capacity.

Assumptions have been made around future demand and bed numbers. The basis for

these assumptions is contained in the *Briefing Paper for JHOSC – 30 July 2013*[5].

3.5 **The user(s) and any other known interested parties:** Users and other known interested parties include service users and carer, staff, acute local hospital Trusts, the Police, South East Coast Ambulance NHS Trust [SECAM], primary care and third sector organisations.

3.6 **Dependencies:** The Acute Service Redesign Programme incorporates a number of interdependent projects. These are listed below and are included in the Programme Plan.

- Street Triage;
- PIC Outreach;
- DVH Refurbishment;
- Birch Ward Upgrade;
- STR Development;
- Transport;
- Intensive Day Treatment;
- Crisis House;
- Maidstone Additional Capacity;
- Personality Disorder Crisis Services (hostel and day therapy).

In addition the Acute Services Redesign Programme is subject to the following dependencies that will be carefully monitored and managed throughout the lifespan of the programme:

- On-going commissioner support including CCGs and other primary care based commissioning bodies.
- On-going stakeholder support.
- Availability of capital funding.
- The move to commissioning aligned geographic structures, and other projects of the Whole Systems Operational Programme Board [WSOPB] as part of the Trust's Transformation Agenda.

[5] (Godfrey T, 2013) *Briefing Paper for JHOSC – 30 July 2013* (Kent County Council [KCC] available at: https://democracy.kent.gov.uk/documents/g5337/Public%20reports%20pack%2030th-Jul-2013%2014.00%20Kent%20and%20Medway%20NHS%20Joint%20Overview%20and%20Scrutiny%20Committee.pdf?T=10)

4 PROGRAMME APPROACH

This section of the PID sets out the current situation and risks and benefits.

4.1 **Current situation:** These proposals were considered, and approval gained to proceed to public consultation, by the:

- KMPT Trust Board (25 June 2012)
- NHS Kent and Medway Primary Care Trust [PCT] Cluster Board (26 June 2012)
- NHS South of England Strategic Health Authority [SHA] Board (29 June 2012)
- Kent County Council [KCC] and Medway Council's Kent and Medway NHS Joint Overview and Scrutiny Committee [JHOSC] (3 July 2012)

Public consultation took place between 26 July 2012 and 26 October 2012. In the last three days of the consultation period, the Department of Health [DH] conducted a Health Gateway Review[6]. This centred around the implementation phase of the programme. The report outlined six recommendations:

1. Continue to develop a detailed response to the emerging findings from the consultation to fully support the final submissions to the approving bodies.

2. Identify the main initiatives required to achieve the anticipated outcomes and put in place a performance framework to assure delivery.

3. Implement a comprehensive risk and issues management process and produce and maintain an updated risk register to reflect the current status of the programme.

4. Produce contingency plans to address the risks associated with challenge and delay in order to maintain momentum in seeking better patient outcomes and increased efficiencies.

5. Prepare a detailed implementation plan which captures all of the activities, dependencies between all of the workstreams and which identifies the critical path.

6. Review and implement new governance arrangements to ensure clear reporting and accountability lines for performance and delivery.

These recommendations were fully implemented.

At the end of the consultation the Centre for Nursing and Healthcare Research at the University of Greenwich carried out an independent analysis of the views expressed by stakeholders about the proposals and options and an independent evaluation of the consultation process. The report[7] concluded:

- There was strong agreement with the aims of the review.
- The work on which the consultation was based has been examined independently and found to be clinically sound and of high quality.
- The independent research team analysing the consultation responses is clear that the consultation has been properly conducted.
- Stakeholders strongly supported the consultation's aims.

[6] DH (2009) *Health Gateway Review – Review 0 : Strategic Assessment* (DH, Health Gateway ID: DH741 Version 2.0 (Issued))

[7] Barhshal K et al (2012) *Kent and Medway Acute Mental Health Services Review: An independent analysis of the public response to a consultation on 'achieving excellent care in a mental health crisis' by the Centre for Nursing and Healthcare Research at the University of Greenwich* (Centre for Nursing and Healthcare Research at the University of Greenwich)

- Two-thirds of respondents supported the proposals in Option A, giving a clear mandate to proceed.
- A number of key issues raised in the consultation needed to be addressed to facilitate establishing and embedding the proposed changes. These centred around: travel and transport and service user priorities expressed in the consultation.
- None of these issues is of sufficient substance reasonably to prevent the proposed changes going ahead.
- The proposed centres of excellence are the kind of acute units that The Schizophrenia Commission wants to see established.

The report also made a number of recommendations to the NHS Boards:

- To approve the implementation of Option A: People from Medway to use beds at Little Brook Hospital; people from Swanley to continue to use beds at Little Brook Hospital; people from Sittingbourne and Sheppey to use beds at Priority House; people from Faversham to continue to use the beds at St Martin's Hospital. The CRHT team working with people in Sittingbourne and Sheppey would work with Priority House and the Medway CRHT team would work with Little Brook Hospital.
- To approve the actions in response to the points raised by respondents to the consultation.
- To endorse the implementation plan.
- Encourage the establishment of a recovery house in Medway and in other areas of Kent where that model would be appropriate to local needs.

These were considered by and gained approval to proceed by the:

- NHS Kent and Medway PCT Cluster Board (20 March 2013)
- KMPT Trust Board (28 March 2013)
- JHOSC (30 July 2013)

On 20 August 2013 Medway Council's Health and Adult Social Care Overview and Scrutiny Committee [HASC] exercised its power to report to the Secretary of State [SoS] about the proposed reconfiguration of acute mental health services on the following two grounds:

1. The local authority is not satisfied that the consultation on acute beds has been adequate on the grounds of seriously flawed data presented by the NHS, limited options and other errors made throughout the consultation process.

2. The local authority considers that the proposal would not be in the best interests of the health services in the area of Medway.

A decision from the SoS remains pending at this time.

The Acute Service Line has reviewed feedback from the consultation, JHOSC and HASC. It has also taken into consideration the feedback received during the series of clinical conversations which have taken place around delivering urgent care in mental health during the summer of 2013. The flow diagram attached at Appendix A illustrates how the range of acute services will help achieve the benefits and critical success factors and issues raised during the consultation and clinical conversations. Key messages arising from these consultations and conversations are around ensuring acute services are accessible, responsive and provide a range of acute care. Acute mental health services should not solely rely on the provision of inpatient care. The developments proposed will enhance patient experience, improve quality and address some of the current pressures within the acute care service. There will be three points in which acute care can be accessed.

- Street Triage (countywide service)[8]: This is a service where a mental health worker will be based with the Police and will provide an immediate joint screening assessment and support to residents within Kent and Medway who may be experiencing a major mental health crisis. Those requiring acute mental health care will be able to access the acute pathway directly. This service will provide an improved response to persons in crisis and reduce the time spent dealing with incidents by supplying a better initial assessment. It also offers both police officers and mental health service staff the opportunity to benefit from cross over training, identify early warning signs and to develop an understanding of the challenges faced by each agency. It is anticipated that this will ensure those who do require mental health intervention receive this in a timely way and that the number of Section 136 assessments will decrease. A pilot commenced on 12 September 2013. The pilot service runs Thursdays, Fridays and Saturdays 16.00 hours to midnight for 12 weeks. KMPT provides a band 6 nurse which amounts to 1.40 whole time equivalent [wte] and the service is based in the East Kent CRHT team where the police officer will sit with the nurse. The Police provide a police constable and vehicle. This pilot will be evaluated and if it provides a positive impact a business case will be developed to continue and expand this service.
- Liaison Psychiatry (countywide service)[8]: This service is established across Kent and Medway. The service provided in North and West Kent is being extended to be coterminous with the level of service provided within the East. This service provides mental health screening, advice, assessment, and where required intervention. Individuals who attend accident and emergency [A&E] departments in mental health distress and also those presenting with physical conditions that the acute team assess as requiring a mental health opinion are referred to and seen by the liaison psychiatry team. Those requiring acute mental health care will be able to access the acute pathway directly. Additionally it is planned to increase service provision to 24/7 at Medway Maritime Hospital (Medway) and Darent Valley Hospital (Dartford) to manage winter pressures.
- Urgent Care Single Point of Entry[9]: This service will be established to screen and triage all referrals from primary and secondary care for those who are assessed as being at significant risk of requiring admission to an acute mental health bed. The service will identify if the individual requires an assessment for acute care or signposting to another part of the care pathway. The assessment will determine what choices in acute care are offered to the individual.

The proposed acute care pathway will offer a range of options within acute care over and above a bed based service to ensure service users have access to high quality care and receive services of excellence. The development of the following services will be key components in delivering this:

- Crisis House[9]: This is smaller than a recovery house (6 beds) and would be run either in partnership with the third sector or with a people with lived experience social enterprise. This provides a brief respite (24 / 48 hour) from the current home situation which is impacting on an individual's mental health and will prevent unnecessary admission to hospital. Access to the crisis house beds will be via the CRHT teams. There should be at least one per health economy; these could be extended to one per locality to be accessible to local populations if required.
- STR Development[8]: Provision of home treatment is a significant part of what the acute service provides. Providing acute care within the individual's own environment maintains social networks and promotes recovery and minimises distress. The investment of STR workers into CRHT teams will support the delivery of home treatment. This service is closely linked to the centres of excellence. The model is being implemented across Kent and Medway. Recruitment to the remaining posts is underway.

[8] This development has been agreed with NHS Commissioners.
[9] This development sets out KMPT's current thinking; it needs to be worked up in line with NHS Commissioner intentions.

- Intensive Day Treatment[9]: This will be a 7 day service which runs 10:00 – 20:00 hours. The service will provide a range of therapeutic interventions, medication and support. Attendance will be on a sliding scale based on need. It is anticipated that initially an individual would attend full time until mental health presentation improves. This would be offered either as an alternative or in addition to home treatment and would only be accessible to those on the CRHT team caseload. This provides the level of support available from admission but for those who do not require overnight accommodation. It is anticipated this will have significant impact on quality of care and on inpatient bed use. Peer support and people with lived experience will be key in providing a robust and comprehensive service. This service will be co-located with the CRHT team and will be managed by that service. It will have a dedicated multidisciplinary team. The main locations will be at Canterbury, Dartford and Maidstone with the potential to develop satellite bases in areas of high deprivation / need such as Medway and Thanet. Transport solution will need to be identified potentially utilising patient transport services [PTS] or the current volunteer driver scheme. It is planned these services will be delivered in two phases, with the first phase focussing on the two areas that have the greatest need: East Kent and Medway. Agreed metrics will be used to monitor impact and progress. Workforce will be a combination of some existing acute staff, and investment for additional staff including peer support workers and people with lived experience. Phase 2 would include roll out to sites at Maidstone and Dartford. It is anticipated the model will replicate that delivered in the early implementer (phase 1) sites. Consideration is also being given to a satellite service within the Thanet locality in addition to the service being delivered out of Canterbury.
- Inpatient Care[8]: A range of inpatient care will be considered according to need. Most of the provision will be within the centres of excellence. Should further support be required PIC outreach will be engaged. Admission to PIC units will be via PIC outreach. Other services maybe accessed based on need and this includes out of area placements, NHS continuing care or rehabilitation.

In addition to the increased range of acute care provision people with personality disorder presenting in an acute mental health crisis will have access, if appropriate, to the personality disorder crisis services (hostel and day therapy)[8].

It is anticipated that the acute service will, by providing a robust range of services, be able to create greater capacity within the system. For those accessing the service, it is anticipated they will find it is responsive and effective and that they will receive an experience of excellence. Through the development of these areas the acute service will achieve its 'no service full' ethos.

Workforce is central to the delivery of the service redesign. As an organisation KMPT is committed to:

- Building a culture of excellence across the organisation.
- Building a strong clinical leadership and to drive improvements.
- Support, develop and value staff.
- Developing tools that support a performance culture.
- Staff engagement and recognition.

In the transition period from the current position to the future redesign services the following has been established to support the workforce and to ensure service safety and quality is maintained; particularly within the Medway locality where there is significant impact on the workforce.

- Management, Leadership and Engagement: Regular engagement sessions between the workforce and service line management; develop incentive programme.

- Mitigation: Increasing capacity of workforce via over recruiting; short term NHS Professionals [NHSP] contracts; reduce ward size; develop intensive day treatment as an alternative to admission.
- Governance and Quality Assurance: Ratio of permanent to locum staff to be monitored and escalated if this exceeds 50:50 split – trends will be monitored weekly and reviewed at monthly governance meetings; overview in monthly performance report to monitor trends; ensure local accountability with roster approval process.

Prior to implementation of the redesign programme, where indicated staff consultation will be conducted and preferences will be elicited. The future service promotes development of skills and a breadth of workforce including the development of peer support / people with lived experience workers.

The Executive Management Team [EMT] agreed in August / September 2013 that, pending Finance and Resource Committee [FRC] approval, the redesign should proceed in part, and at risk, as follows:

- The Birch Ward Upgrade to complete by 1 December 2013.
- The DVH Refurbishment to complete by 28 February 2013.

4.2 **Risks and benefits:** There are many advantages for service users in making the change to three centres of excellence. These outweigh the difficulties that some visitors will face in having to travel further and the extra effort staff will need to put into working relationships, at least initially, to provide good, joined-up care. The table below summaries these.

Advantages	Disadvantages
Each patient will have:	
• Equal access to high quality purpose built accommodation. • Their privacy and dignity better protected. • Their own single, ensuite room. • Good access to safe outside space which is proven to help recovery. • Greater access to consultant reviews (which service users want) because the doctors will be concentrated on fewer sites. • Opportunities for activities and therapy in the evenings and at weekends instead of just during the day. • More support for service users and carers at home. • Equal access to PIC from the outreach team visiting the hospital ward. • More joined up care because the CRHT team will always be working with their hospital. • Realignment of beds to health economies and improved capacity mean patients will be placed in the unit closest to their home and community team, improving links and continuity of care. • Greater choice in acute care as alternatives to hospital admission are developed.	• Medway and Swale patients will not be within their locality.
Carers will:	***Carers may have:***
• Not be expected to transport service users to hospital when they are experiencing a mental health crisis – the NHS will do this. • Have more support and reassurance as the CRHT team capacity increases. • Transport plan supports close family and carers in maintaining contact with the individual in	• Longer journeys where the admitting unit may be further from home; this may present some carers a challenge in maintaining contact should admission be required.

hospital via voluntary transport scheme and flexible visiting when required.

Visitors have:

- Free parking at KMPT hospitals.
- A welcoming environment.

Visitors may have:

- Longer and more costly journeys from Medway.
- Longer journeys from Sittingbourne and Sheppey.

Staff will:

- Be better aligned to patients throughout their pathway.
- Be more resilient and able to offer a better quality of care in fewer centres, with consolidated staffing levels.
- Have more opportunities for innovation in working practices, research and development.
- CRHTTs will be expanded to include peer support workers and so offer a range of help for service users and carers.

Staff may, in addition:

- Need to put more effort into working relationships:
  - When some start work in new hospital units or are aligned to different patient journeys;
  - Between Community Mental Health Teams [CMHTs] and CRHT teams to ensure their links continue to work smoothly in support of service users and carers.

Services will:

- Be able to plan more effectively, improve consistency, quality and equity of care.
- Have the opportunity to develop more innovative practice and generate a strong evidence of what 'excellence' means in mental health crisis care, working with one or more university.

Services may:

- Lose local connection as a result of Centres of Excellence.

5 PROGRAMME PLAN

This section of the PID sets out the programme plan. The table below sets out dependencies and risks. Appendix B sets out a detailed plan.

The Acute Service Redesign Programme incorporates a number of interdependent projects. The following table summarises the key dependencies, risks and indicative timeframes for delivery.

Project	Dependencies	Risks	Timeframe
Street Triage		• Ongoing funding. • Impact on reducing Section 136 less than expected.	Pilot commenced: 12 September 2013
PIC Outreach		• Unable to fill internal secondment. • Delays in recruitment. • Recruitment from within existing resource increasing pressure on system.	Service commences: 1 October 2013 Fully operational: 2 January 2014
DVH Refurbishment	PIC Outreach needs to be operational before decant	• Decision required around bed numbers[10]. • Delays with planning permission. • Lack of user involvement.	28 February 2014
Birch Ward Upgrade		• Potential Private Finance Initiative [PFI] issues and additional costs. • Inconsistency in quality of acute ward environments.	1 December 2013
STR Development		• Clarity of model not achieved. • Adequate training. • Recruitment not achieved or delayed.	31 January 2014
Transport	Maidstone Additional Capacity	• Plan not agreed. • Affordability. • Limited access to voluntary transport scheme. • System not in place to support plan.	1 December 2013
Intensive Day Treatment	Maidstone Additional Capacity	• Funding. • Resourcing. • Will not deliver impact expected.	16 December 2013
Crisis House		• Third Sector Partner. • Funding. • Resourcing.	1 July 2014
Maidstone Additional Capacity	Intensive Day Treatment	• Decision required around preferred option.	April 2015
Personality Disorder Crisis Services (Hostel and Day Therapy)		• Will not deliver impact expected.	13 January 2013

[10] Minimum 14 beds. Ongoing discussions with NHS Commissioners to finalise.

6 PROGRAMME GOVERNANCE AND MANAGEMENT STRUCTURE

This section of the PID sets out the management and governance structures including reporting mechanisms, risk management and assessment processes.

6.1 **Management Structure**: The Acute Service Redesign Programme is being managed in accordance with best practice managing successful programmes[11] and project management principles[12]. KMPT's Executive Director of Operations is the Programme Sponsor and the Accountable Officer with overall responsibility for delivering the programme. The table below shows the structure of the senior programme team.

Project Role	Name	Organisational Role
Executive Sponsor	Marie Dodd	Executive Director of Operations
Senior User / Programme Director	David Tamsitt / Anne Markwick[13]	Service Line Director Acute
Senior Supplier (Capital)	John Carey	Director of Capital Planning and Estates
Senior Supplier (Resource)	Rosarii Harte / Karen Dorey-Rees	Assistant Medical Director Acute / Associate Director Acute
Programme Manager / Programme Support	Philippa MacDonald	Acute Service Line Programme Manager

6.2 **Governance Structure**: Appendix C sets out the governance structure. In addition within the Acute Service Redesign Programme there are a number of workstreams. These are led by members of the Transformation Group with support from the Programme Manager.

6.3 **Highlight Reports, Issues Log and Risk Register**: The risk management process is dynamic and risks are reviewed, updated and reported on a regular basis. The risk management strategy is based upon the following principles:

- Identifying possible risk in advance, putting in place mechanisms to minimise the likelihood of risks occurring and their associated adverse effects.
- Having processes in place to ensure up to date, reliable information about risks is available, and establishing an ability to effectively monitor risks.
- Establishing the right balance of control is in place to mitigate the adverse consequences of risks, should they materialise.
- Ensuring that the high level risks are integrated within the Trust's corporate governance arrangements and thus considered regularly by the Trust Board.

Initial risk identification and analysis has been and continues to be undertaken using an inclusive and partnering approach. Risks are reviewed and considered by each sub group and group within the programme management structure with the programme manager taking responsibility for the collation and management of the full risk register. Key risks are reported to the WSOPB with high level risks incorporated into the Trust's corporate governance structure. Escalation procedures are in place.

Appendices D and E set out sample highlight and end stage / project assessment reports respectively; appendices F and G set out the issue log and risk register respectively; appendix H sets out the quality impact assessment [QIA].

[11] Managing Successful Programmes (2011) The Stationery Office
[12] PRINCE2 (2009) Office of Government Commerce and Association of Project Management
[13] David Tamsitt retires on 30 September 2013; role fulfilled by interim successor Anne Markwick from that date.

6.4 **Change Control**: All reports / papers are signed off at the WSOPB prior to circulation. The programme director and programme manager are responsible for maintaining programme document control. Appendix I sets out a sample change control template.

6.5 **End Stage / Programme Assessment**: Due to the number of schemes within the Acute Service Redesign Programme it is anticipated that end stage assessments will be conducted at the end of each stage / project as appropriate and a full programme assessment once all projects have been completed.

The programme / projects will be evaluated by undertaking the following investigations:

- A review of the business case capital and revenue costs to confirm that:
  - The capital costs were robust and adhered to, and
  - The actual and projected revenue costs were realistic.
- A review of the plan and adherence to it throughout the life of the project.
- A review of the benefits detailed in the benefits strategy and confirmation that they have been met.
- These investigations will focus on four client groups:
  - Patients – for their perspective on the new services;
  - Clinical users (staff) – for their views on whether they were sufficiently involved, whether the project / programme outcome met clinical needs, whether it had a positive impact on practice;
  - Project / Programme Team – for their views on the overall project / programme from planning to implementation;
  - Commissioners – for their views as to the delivery of their stated commissioning requirements.

7 BENEFITS STRATEGY

This section of the PID sets out the benefits expected from the delivery of the programme. It includes critical success factors and benefits realisation. Appendix J sets out the benefits plan.

7.1 **Critical Success Factors:** The critical success factors have been identified as follows:

Business Needs	How well the Acute Service Redesign Programme provides a holistic fit and synergy with other key elements of KMPT and its commissioners' strategic objectives for secondary mental health services.
Strategic Fit	How well the Acute Service Redesign Programme provides holistic fit and synergy with other key elements of national, regional and local strategies. In particular in regard to implementing the acute mental health care model and in reducing avoidable admissions and minimising length of stay for inpatients through integrated working, and moving the Trust to upper quartile performance.
Benefits Optimisation	How well the Acute Service Redesign Programme supports service development and integration including: • New ways of working. • Improved patient experience. • Reduced length of stay and reduced readmission rates. • Recruitment and retention of staff. • Value for money.
Achievability	The organisation's ability to innovate, adapt, introduce, support and manage the required level of change, including the management of associated risks, meeting the requirements of external review; and with the availability of the appropriate skilled individuals with the capacity and capability to lead the change and to engender acceptance by staff.
Availability	The organisation's ability to innovate, adapt, introduce, support and manage the required level of change, including the management of associated risks, meeting the requirements of external review; and with the availability of the appropriate skilled individuals with the capacity and capability to lead the change and to engender acceptance by staff.
Affordability	The organisation's and health economy's ability to fund the capital and revenue consequences associated with the proposed developments and investment.

7.2 **Benefits Realisation:** Monitoring and tracking of the identified benefits form part of the programme management arrangements in the first instance and as the programme moves into its operational phase, via KMPT's corporate mechanisms. Benefits include:

- Increased alternatives to admission offered including crisis accommodation, intensive day treatment and home treatment.
- People with lived experience contributing to the provision of acute care.
- Reduced delays in transfers of care.
- Reduced length of stay.
- Improved satisfaction and experience (service users, carers, staff).
- Decreased incidents of violence and aggression.
- Inpatient accommodation which is fit for purpose, promotes privacy and dignity and as far as possible meets Health Building Note [HBN] 35 guidance.
- Improved performance.
- Reduced external placements.

- Reduction in staff sickness.
- Improved retention and recruitment of staff.
- Improved skill mix across the acute care pathway.
- Robust 24/7 services.

8 COMMUNICATION AND ENGAGEMENT MANAGEMENT STRATEGY

This section of the PID sets out the communications and engagement management strategy to support the delivery of the programme.

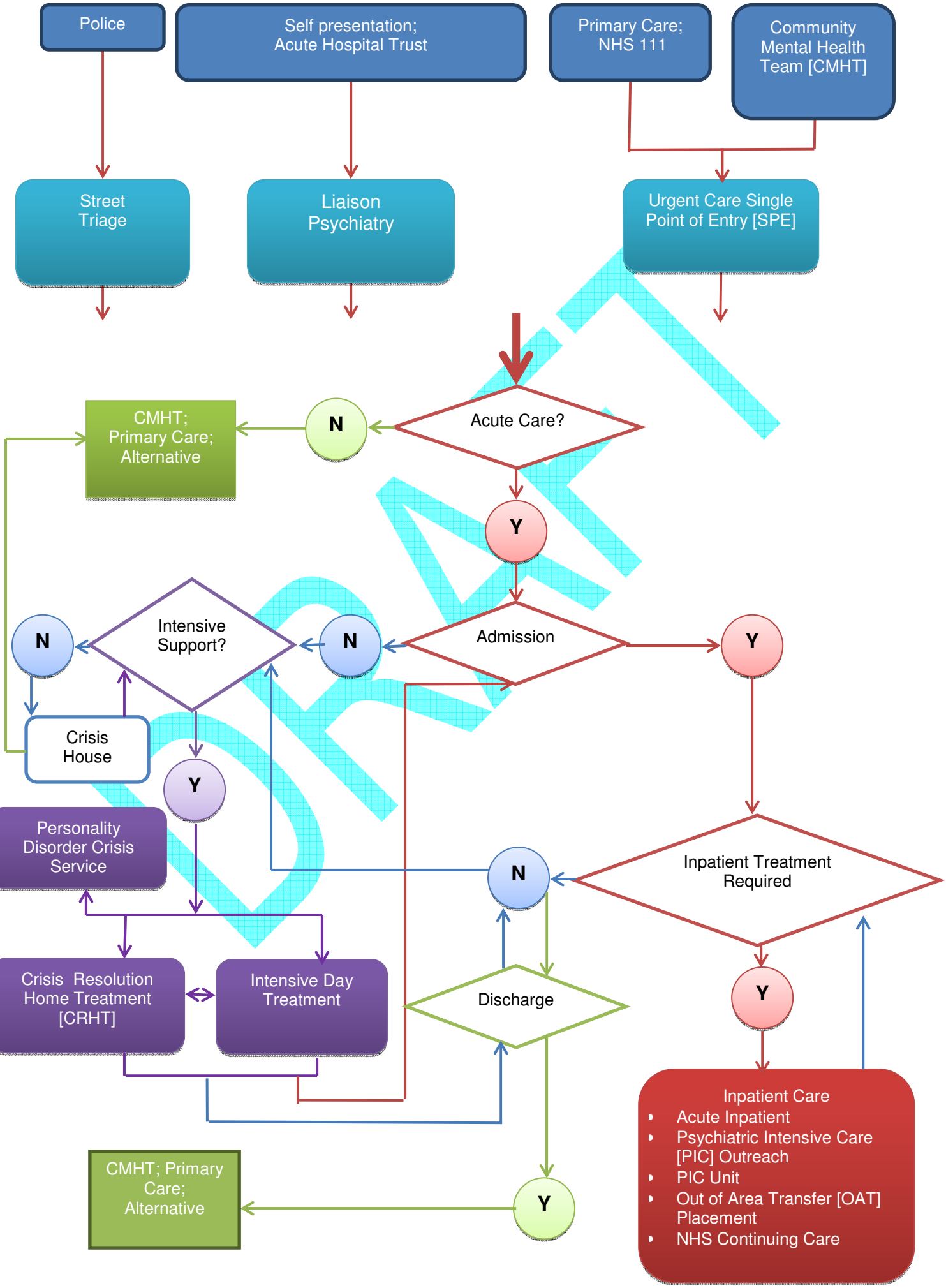
From the start of the review and redesign of acute mental health services it was acknowledged that a strong communication and engagement approach was required and would inform the development of the service redesign and subsequent consultation. The engagement strategy aimed to:

- Regular, clear, user friendly information to keep stakeholders up-to-date.
- Ensure the new distribution of services in the proposed redesign reflect the views of service users, carers, staff and stakeholders and that services would be shaped by these views.
- Keep the community informed and gather the views of interested parties who want to participate.
- Enable everyone to have their say including people who find conventional methods of communication difficult to understand or use.
- Listen to people who use the service, staff and the wider community and provide reassurance that they can influence their local NHS.
- Provide prompt and professional management of any media issues arising from the redesign and consultation.

A wide range of stakeholders were identified, and a range of communication and engagement activities were employed to meet the various needs of these groups. This included briefings, individual meetings and focus groups. The communication and engagement strategy going forward aims to maintain principles articulated above as the acute service redesign moves forward from the consultation phase to implementation.

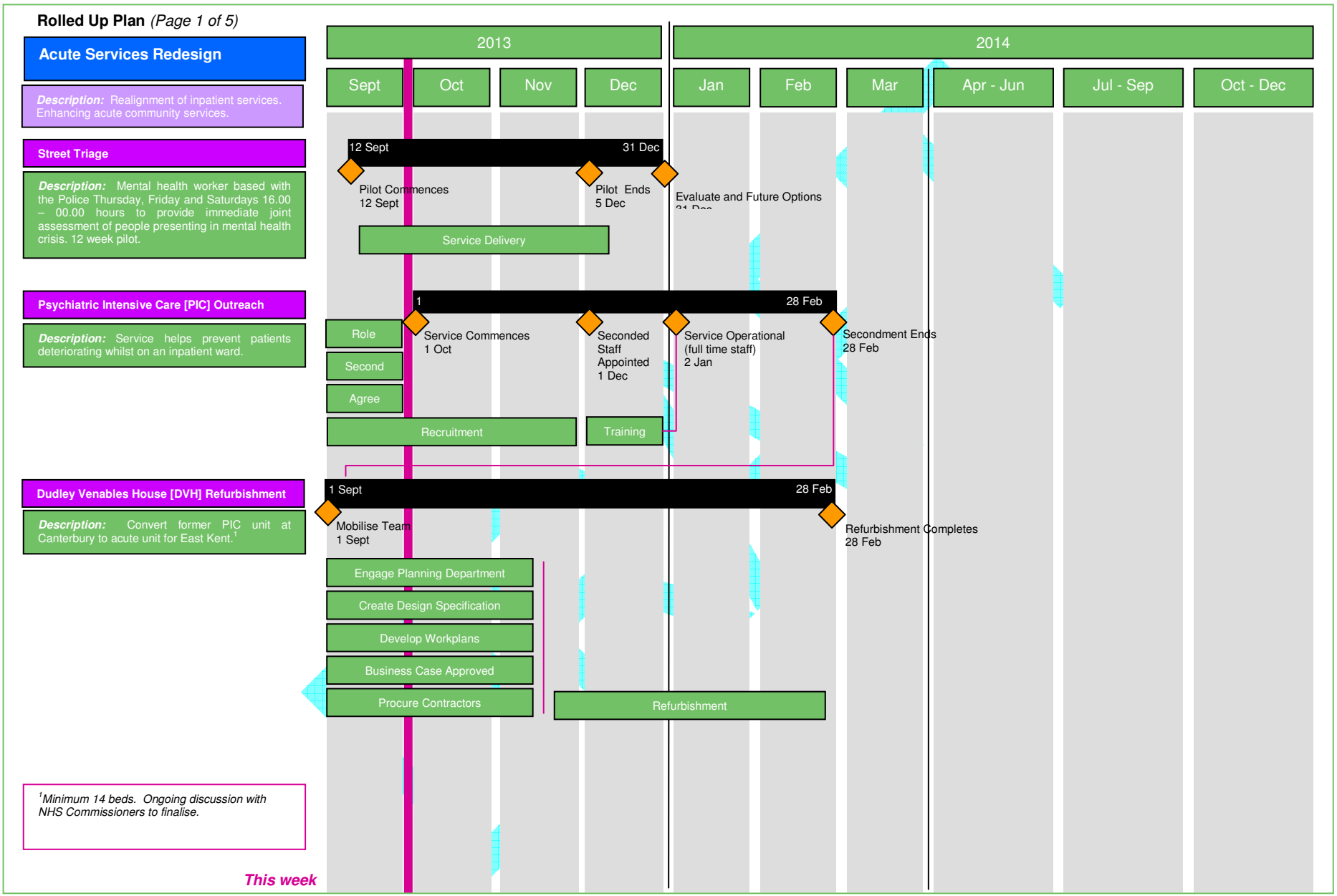
Appendix K sets out the communications and engagement management plan.

APPENDIX A : ACUTE SERVICES

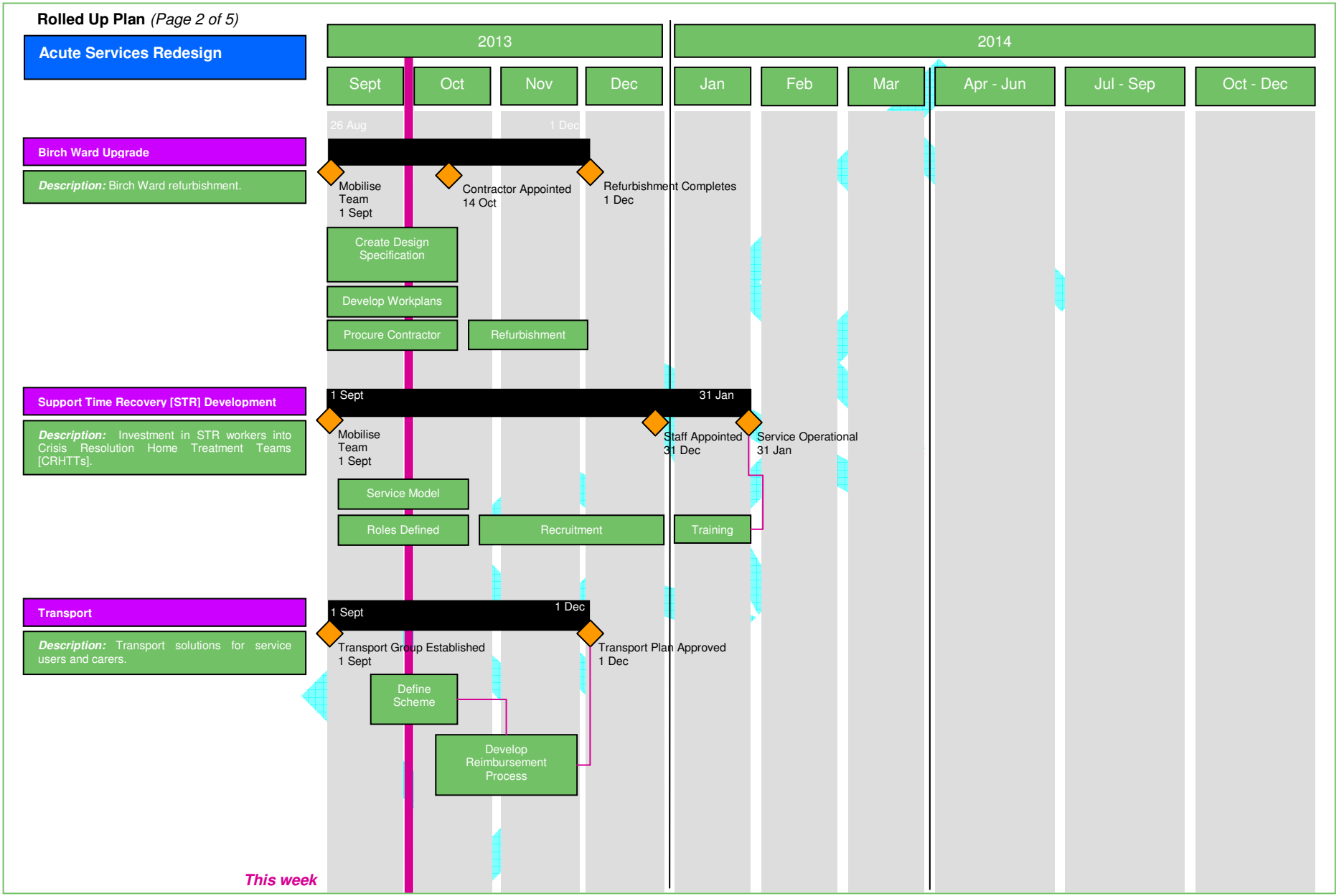


APPENDIX B : PROGRAMME PLAN

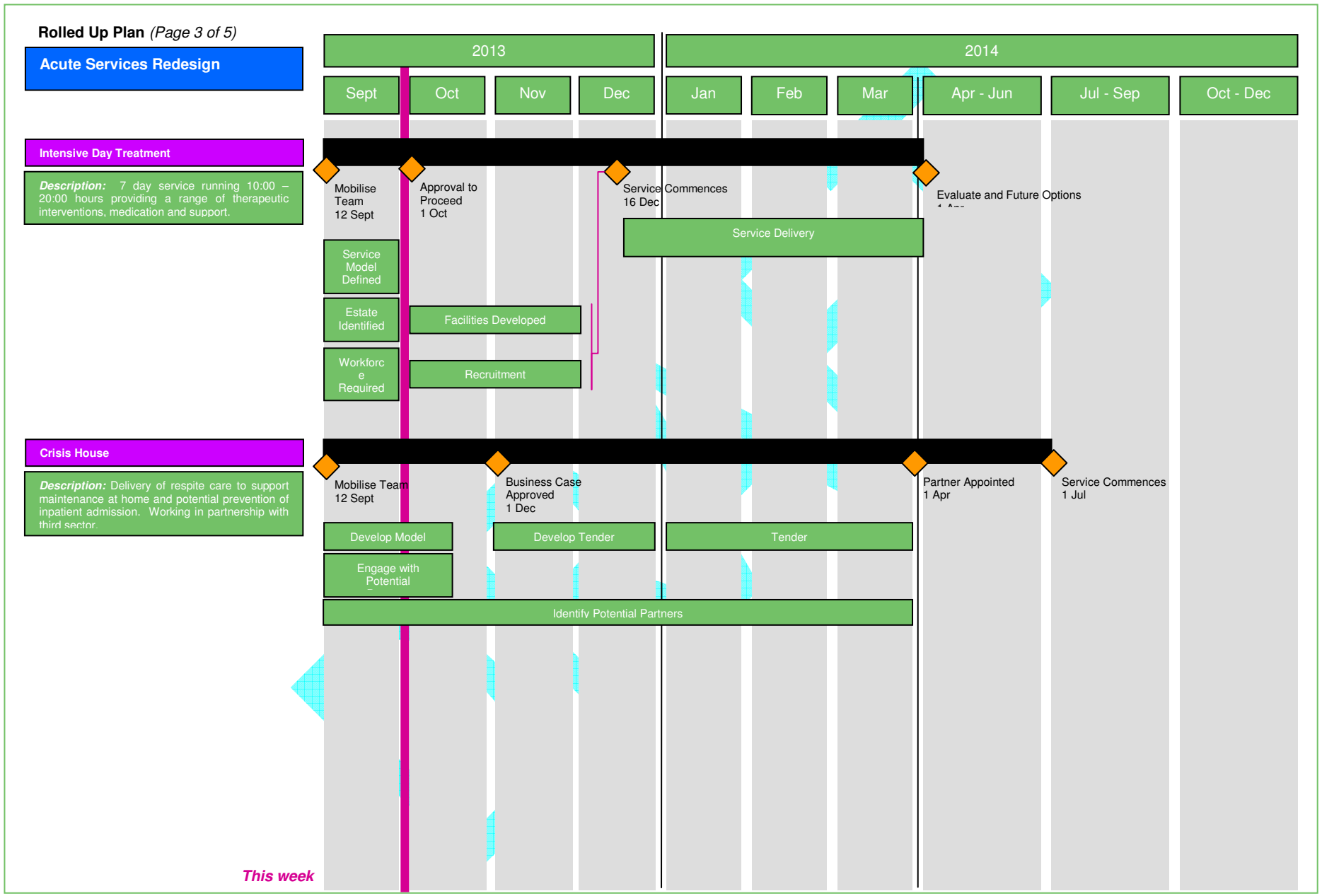
Rolled Up Plan *(Page 1 of 5)*



Rolled Up Plan *(Page 2 of 5)*

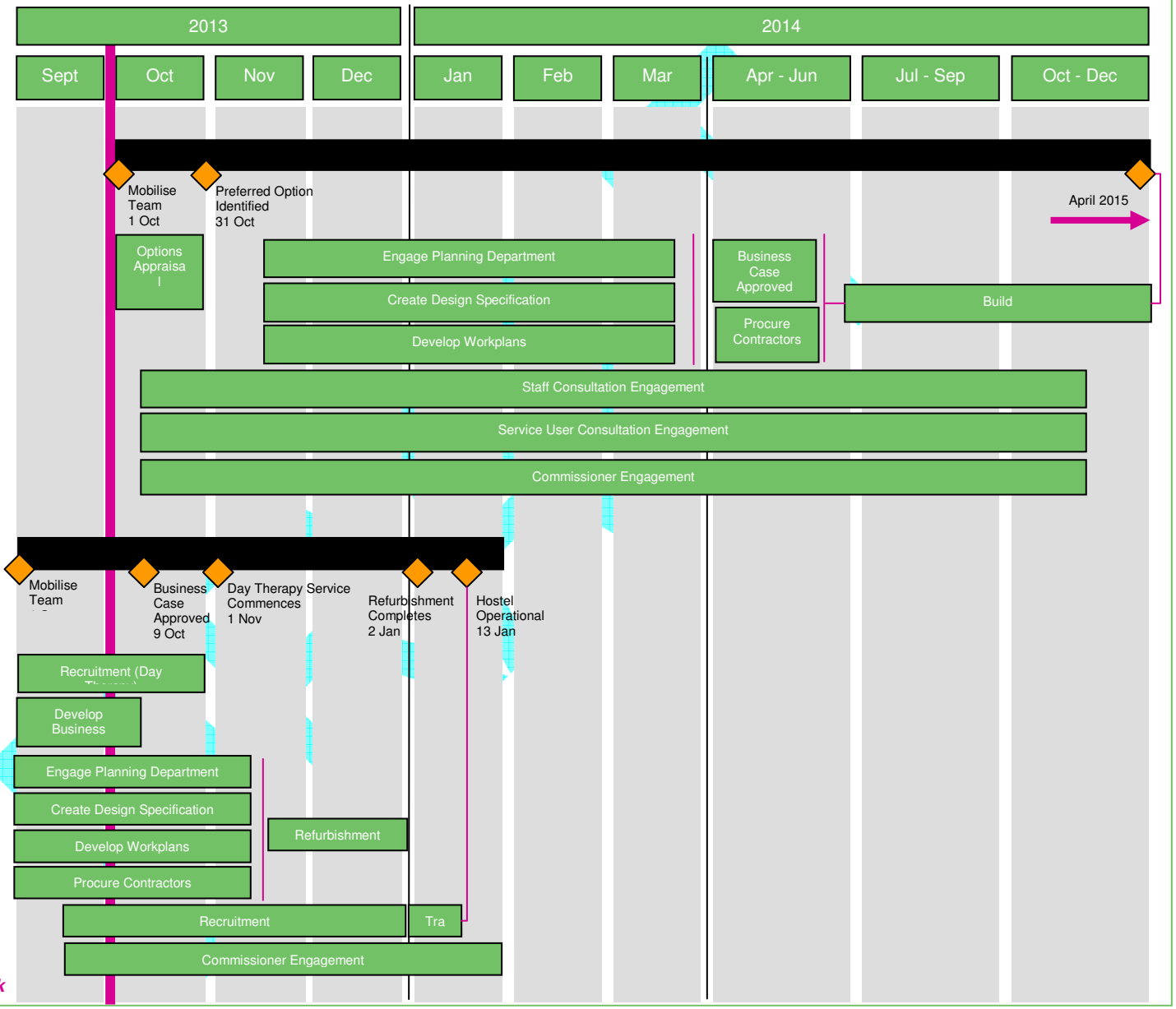


Rolled Up Plan *(Page 3 of 5)*



Rolled Up Plan *(Page 4 of 5)*

Acute Services Redesign



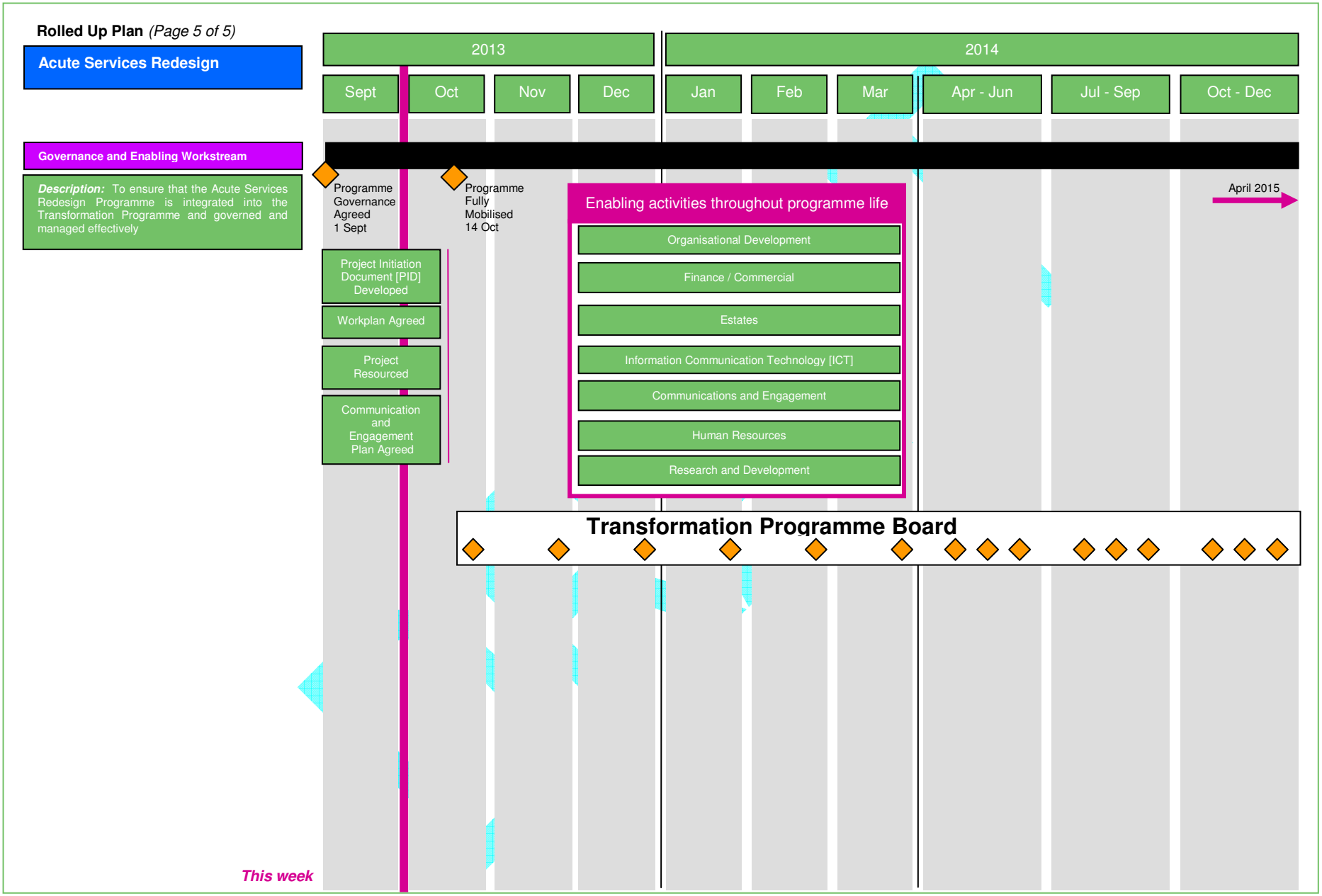
Description: Develop additional capacity at Maidstone.[2]

Personality Disorder Crisis Service

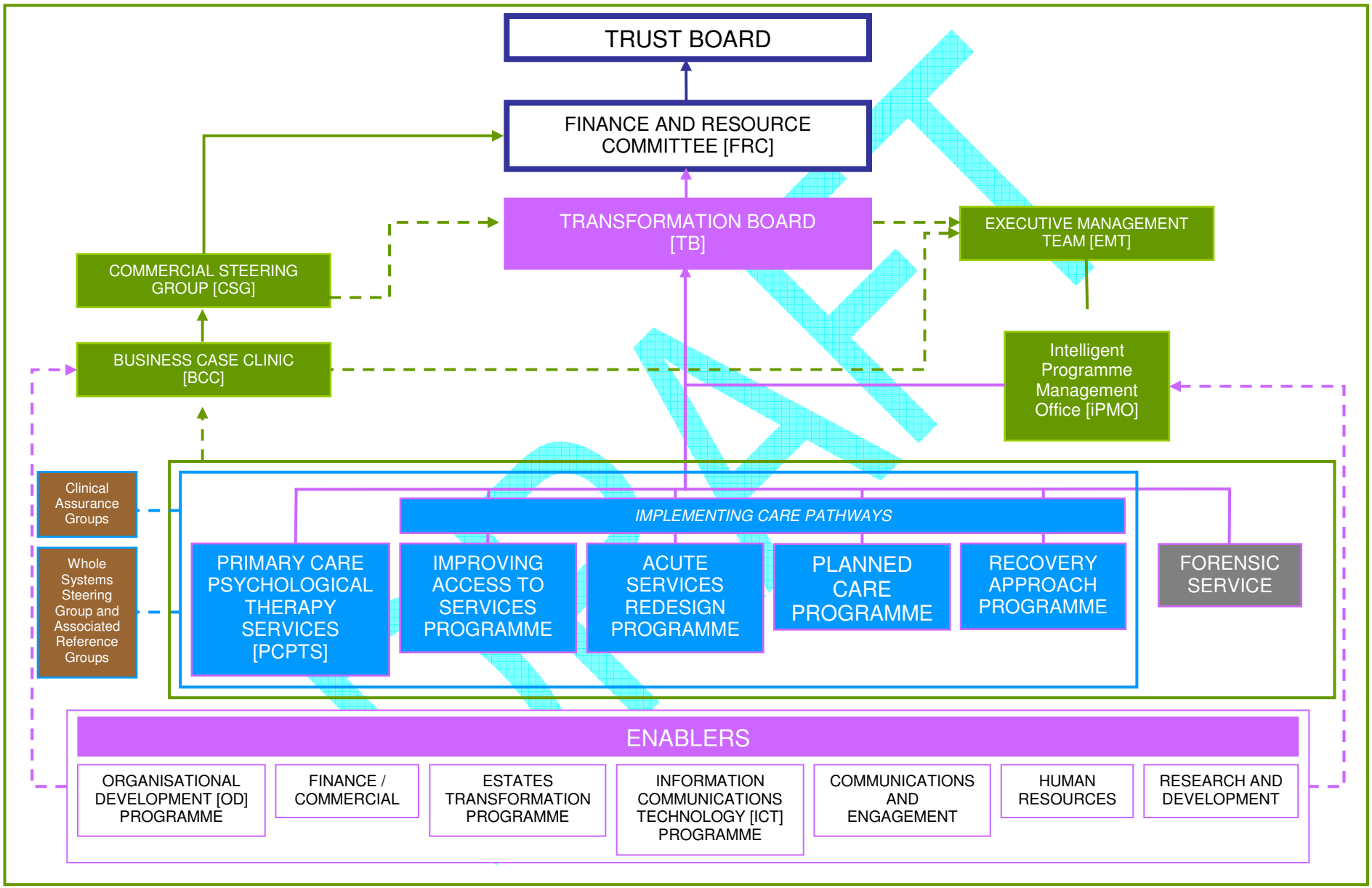
Description: Day therapy service and hostel for people presenting with a personality disorder as alternative to hospital admission.

[2] *Capacity requirement being defined in collaboration with NHS Commissioners to finalise Beds numbers and locations.*

Rolled Up Plan *(Page 5 of 5)*



APPENDIX C : GOVERNANCE STRUCTURE



APPENDIX D : HIGHLIGHT REPORT (Sample template)

HIGHLIGHT REPORT

Project Name		Project Owner		Status	

Project Description	

Proposed Activities

Activity	Owner	Timescale

Forecast Activities

Activity	Owner	Timescale

Actual Activities

Activity	Owner	Timescale

Issues

ID	Type	Date Raised / By Whom	Description	Priority	Status

Risks

ID	Type	Source / Owner	Description	Likelihood	Impact	Proximity	Mitigating Action	Status	Date Raised	Date of Last Review

Signed	
Date	

APPENDIX E : END STAGE / PROJECT ASSESSMENT REPORT (Sample template)

END STAGE / PROJECT ASSESSMENT REPORT

Project Name		Project Owner		Status	

Project Description	

Project Manager's Report (*summarising stage / project performance*)

Review of Business Case (*summarise validity of stage / project business case*)

Deviations from Approved Business Case

Review of Stage / Project Objectives *(how stage / project performed against planned targets and tolerances for time, cost, quality, scope, benefits and risk. Review effectiveness of stage /project strategies and controls*)

Review of Team Performance *(include recognition for good performance)*

Lessons Learned Report (*what went well, what went badly, recommendations)*

Benefits

Achieved To Date	Residual Benefits Expected	Expected Net Benefits

Review of Products

Product	Quality Record (Planned)	Quality Record (Completed)	Approval Record	Off Specification

Stage / Project Handover (*confirmation by customer that operations and maintenance function are ready to receive stage / project product)*

Action Recommendations *(request for Project Board advice about who should receive each recommended action. Recommended actions related to unfinished work, ongoing issues and risks, other activities needed to take products to next phase of life)*

Signed	
Date	

APPENDIX F : ISSUE LOG

ISSUE LOG

Issues						
ID	Type *(request for change / off specification / problem or concern)*	Date Raised / By Whom	Description	Priority *(essential / important / useful / not important for now)*	Severity (minor / significant / major / critical)	Status
1	Concern: Communication and engagement	September 2013 Ivan McConnell	Level of support available from communication team to contribute to the development and delivery of the communication and engagement plan. Clinical, service user, carer groups not engaged fully and aware of service redesign and developments. Communications delayed, risk that message articulated is not consistent, timely or in a manner which is accessible.	Essential	Significant	Amber
2	Concern: Workforce (retention)	September 2013 Louise Ross	Lack of progress on implementation of staff retention within acute services at Medway is poor.	Essential	Significant	Amber
3	Concern: Workforce (morale)	September 2013 Louise Ross	Staff morale in acute services affected by changes, impacting on sickness, retention and recruitment.	Essential	Significant	Amber
4	Request for change / off specification: Transport	September 2013 Philippa MacDonald	Extension of scope required for transport project to include facilitation for service users to access intensive day treatment services.	Essential	Minor	Amber

APPENDIX G : RISK REGISTER

RISK REGISTER

Risks										
ID	Type	Source / Owner	Description	Likelihood	Impact	Proximity	Mitigating Action	Status	Date Raised	Date of Last Review
1	Financial	Marie Dodd / Anne Markwick	Affordability of redesign	4	4	Current	• Reduction of use of external beds • Stability of staff decreasing • Increasing agency costs	Red	Aug 2013	
2	Reputation / organisation	Marie Dodd / Anne Markwick	Legal challenge – Secretary of State [SoS] upholds Medway Health and Adult Social Care Overview Scrutiny Committee [HASC] appeal	2	4	December 2013	• Robust plans to develop alternatives and manage environmental challenges	Amber	Aug 2013	
3	Organisation / clinical	Marie Dodd / Anne Markwick	Redesign does not address demand capacity issues	2	4	2014/15	• Monitoring of alternative to admission projects • Revise bed capacity plans accordingly	Amber	Sept 2013	
4	Organisation / clinical	Marie Dodd / Service Directors	Whole systems approach not attained - disconnect between community, acute, older adult and specialist services increasing pressure	2	4	2014/15	• Move from service line to geographic structures	Amber	Sept 2013	

APPENDIX H : QUALITY IMPACT ASSESSMENT

Quality Impact Assessment [QIA]	**Programme / Scheme Number:**	A01b&c
	Date of QIA:	14.03.13

Programme / Scheme Name:	Acute Services Redesign Programme						
Programme / Scheme Description:	Achieving excellence in mental health crisis (development of three centres of excellence, development of psychiatric intensive care [PIC] outreach, development of crisis resolution home treatment [CRHT], option A preferred outcome of consultation)						
Programme / Scheme Phase: *This application relates to the following phase of the project / scheme*	**Design:**	Y	**Implementation:**	Y	**Post-Implementation:**		
Previous QIA? *Has a QIA been submitted for any previous phase of this project / scheme? YES / NO and date submitted*	No						
Benefits to Patients:	Delivering acute care services within Kent and Medway from three centres of excellence will optimise care within purpose built accommodation and provide opportunity for staff to share experience, knowledge and best practice. This will also optimise productivity. There will be an improved environment for patients, staff and visitors. The accommodation within the three centres reduces ligature risks that are present within current environment in Medway. This will also provide a critical mass of staff and optimises skill mix. Supports the delivery of the acute care pathway. The scheme addresses inequality of inpatient environment, reduces ligature risks, addresses concerns relating to privacy and dignity, reduces the likelihood of out of area placements. Improved environments have a positive impact on incidents of violence and aggression, recruitment and retention of staff, reduced sickness.						
Implementation Plan Summary:	Refer to High Level Project Plan						
Implementation Date:	30 July 2013						
Programme Director / Scheme Lead Name:	David Tamsitt / Anne Markwick						
Programme / Scheme Lead Clinician Name:	Rosarii Harte						
Quality Indicator(s) *Consider Performance Management Framework [PMF], Performance Assurance Framework [PAF], Key Performance Indicators [KPIs], Complaints, Serious Incidents [SIs], Staff and Patient Survey, Nursing Metrics, etc*	*For Design-phase applications, please also list indicator measures and baseline figures on the 'QI Tracking' worksheet. These will be tracked through to post-implementation at quarterly intervals or as dictated by the Star Chamber.*						
	Length of stay; occupancy; delayed transfers of care [DToC]; spell length; patient satisfaction; staff satisfaction; home treatment episodes; admissions; out of area transfers [OAT] placements; patient led assessments of care environments [PLACE]; vacancies; sickness absence; Care Quality Commission [CQC]						

Risks to Patient Safety *(Datix Identity…)*	**Details (include mitigation)**	**Consequence**	**Likelihood**	**Score**
	This will have a positive impact on patient safety. The development of the three centres of excellence will mitigate against the current and inherent risks present in Medway.	1	1	1

Risks to Clinical Effectiveness	**Details (include mitigation)**	**Consequence**	**Likelihood**	**Score**
	This will have a positive impact on clinical effectiveness. The three centres of excellence will enable shared learning and opportunities for shadowing and coaching which in turn will improve the quality of care delivered. Skill mix and expertise will be optimised across the pathway. The scheme will also	1	1	1

	support robust clinical leadership and consistency to the leadership provided across all aspects of acute care. It supports the delivery of the acute care pathway and supports / encourages the implementation of audit and peer review.			
Risks to Patient Experience	**Details (include mitigation)**	**Consequence**	**Likelihood**	**Score**
	Overall improvement to the patient experience. The scheme delivers improved inpatient environment, ability to have own room when an inpatient and access to external space both of which are limited in Medway. The development of the acute care pathway supports and actively promotes individualised care. The consolidation of staff onto three centres also improves level of expertise and skill mix available. However the scoring noted reflects for some this may have a negative impact regarding the proximity to friends, family and carers to the inpatient facilities and their ability to visit. A transport plan has been developed to aid mitigation of this, and provide support where applicable. Concerns remain regarding sufficient bed capacity due to unprecedented increased demand for acute inpatient care over the past year. Further sensitivity work is being undertaken to review bed capacity. This will inform final decisions regarding the redesign and bed requirements. May impact negatively on staff.	3	3	9
	Overall Risk Score ***(highest from above quality domains)***	9		

Principle to move to three centres of excellence **APPROVED BY:**			
Service Line Director	David Tamsitt	**Date**	15/03/2013
Assistant Medical Director	Rosarii Harte	**Date**	15/03/2013
Star Chamber	Karen White / Pippa Barber	**Date**	02/05/2013

QIA: Quality Indicators

Programme / Scheme Number:	
Programme / Scheme Name:	Acute Services Redesign Programme

For Design-phase applications, please list indicator measures and baseline figures.
These will be tracked through to post-implementation at quarterly intervals or as dictated by the Star Chamber.

Quality Indicator	Baseline Figure	At 3 months	At 6 months	At 9 months	At 12 months
Length of stay: Mean	28.5				
Length of stay: Median	15.0				
Length of stay: Mean (acute element only)	24.6				
Bed occupancy (excluding leave)	98.8%				
Delayed transfer of care	0.9%				
Spell length over 100 days (09/09/2013 snapshot baseline)	21.4%				
Patient satisfaction survey					
Staff satisfaction survey					
Home treatment episodes	743				
Admissions per 1,000 population	4.6				
Out of area placements (occupied bed days)	2,369				
Patient Led Assessment of the Care Environment [PLACE]					
Vacancies (excluding Bank / June 2013 only)	16%				
Sickness absence (Acute Service Line)	5.95%				
Care Quality Commission [CQC]					

APPENDIX I : CHANGE CONTROL REQUEST (Sample template)

CHANGE CONTROL REQUEST					
Project Name		Project Owner		Status	
Project Description					

Description of Proposed Change	Impact of Change / Benefits	How Measured?	Priority Assessment	Decision

Allocation Details	Date Allocated	Completed

Signed	
Date	

APPENDIX J : BENEFITS PLAN

BENEFITS PLAN	Page 1 of 4

Programme Name	Acute Services Redesign	Programme Owner	Marie Dodd	Status	Amber

Programme Description	Acute Service Redesign aims to develop services of excellence. This includes development of three hub sites for the delivery of inpatient care that provides a high standard of accommodation that meets, as far as possible, Health Building Note [HBN] 35 guidance, promotes recovery and dignity and privacy. Alternatives to admission will improve choice to service users, improve experience and health outcomes. Delivering this agenda will see staff development, engagement with third sector organisations and other providers as well as the development of peer support / people with lived experience supporting the delivery of a range of acute care interventions

Desired Outcome	Output	Owner	Metrics	Resources (human or otherwise) to review progress towards full realisation	Baseline against which benefits measured
Choice in acute care	Provision of home treatment, crisis accommodation, intensive day treatment	Anne Markwick	• Outcomes from assessment • Number of admissions • Service user satisfaction survey • Staff satisfaction survey • Length of stay • Occupancy • Out of area placements	• Patient Experience Team [PET] • Human Resources Business Partner [HRBP] • Business and Performance Manager [BPM] • Service Manager	Current date from metrics specified
Peer support / people with lived experience [PWLE] contributing to the delivery of acute care	Crisis house delivered in partnership with third sector / PWLE social enterprise, intensive day treatment	Anne Markwick	• Staff records • Recruitment and retention data • Service user satisfaction • Admissions • Length of stay • Occupancy	• PET • HRBP • BPM • Service Manager	Current breakdown of staff group Current date from metrics specified
Delayed transfers (potential and actual) reduced	Provision of crisis house, home treatment, intensive day treatment, personality disorder crisis service, nurse led discharge	Anne Markwick	• Occupancy • Transfer pressures • Out of area placements • Delayed transfers • Admissions • Length of stay	• BPM • Service Manager	Current date from metrics specified

BENEFITS PLAN

Programme Name	Acute Services Redesign	Programme Owner	Marie Dodd	Status	Amber

Desired Outcome	Output	Owner	Metrics	Resources (human or otherwise) to review progress towards full realisation	Baseline against which benefits measured
Reduction in length of stay	Provision of crisis house, home treatment, intensive day treatment, personality disorder crisis service, nurse led discharge	Anne Markwick	• Home treatments • Number accessing intensive home treatment • Number accessing personality disorder crisis service – number admitted / admission prevented • Number accessing 72 hour assessment beds – number not admitted / going on to inpatient treatment • Number accessing crisis house – number admitted / avoided admission • Number of discharges • Length of stay	• HRBP • BPM • Service Manager	Current occupancy, length of stay, home treatments, discharges
Improved satisfaction	Alternatives to admission, upgraded inpatient facilities, skilled workforce, peer support / PWLE	Anne Markwick	• Patient satisfaction survey • Staff satisfaction survey • Sickness absence • Serious Incidents [SIs] / incidents of violence and aggression • Vacancies / recruitment • Research projects • Patient Led Assessment of the Care Environment [PLACE] • Care Quality Commission [CQC] • Training and development	• PET • HRBP • BPM • Service Manager • Audit Team • Training and Development Team	Current data from metrics specified
Decrease in violence and aggression	Alternatives to admission, personality disorder crisis service, upgraded inpatient accommodation, skilled workforce, psychiatric intensive care [PIC] outreach	Anne Markwick	• Patient satisfaction survey • Staff satisfaction survey • Serious Incidents [SIs] / incidents of violence and aggression	• HRBP • BPM • Service Manager • Health and Safety Team [HST]	Current data from metrics specified
Fit for purpose inpatient accommodation	Upgraded / refurbished wards, crisis house, personality disorder crisis service	Anne Markwick	• PACE • CQC • Patient satisfaction survey • Staff satisfaction survey	• PET • HRBP • BPM • Service Manager • Facilities and Capital Planning Team • HST	Current data from metrics specified

BENEFITS PLAN

Programme Name	Acute Services Redesign	Programme Owner	Marie Dodd	Status	Amber

Desired Outcome	Output	Owner	Metrics	Resources (human or otherwise) to review progress towards full realisation	Baseline against which benefits measured
Improved performance	Alternatives to admission, PIC outreach, Support Time Recovery [STR] investment, peer support / PWLE, upgraded inpatient accommodation, street triage, nurse-led discharge	Anne Markwick	• Length of stay • Occupancy • Use of out of area beds • Expenditure • PACE • CQC • Vacancies • Sickness absence • Staff satisfaction survey • Patient satisfaction survey • SIs / incidents of violence and aggression	• HRBP • BPM • Service Manager • Service Line Management [SLM] Accountant • Training and Development Team	Current data from metrics specified
Reduction in external placements	Crisis house, home treatment, intensive day treatment, admission / discharge co-ordinator	Anne Markwick	• Bed availability • Occupancy • Length of stay • Expenditure	• BPM • SLM Accountant • Contracts Manager • Service Manager	Current data from metrics specified
Reduction in staff sickness absence	Alternatives to admission, upgraded inpatient accommodation	Anne Markwick	• Staff satisfaction survey • Sickness absence	• HRBP	Current data from metrics specified
Improved recruitment and retention	Alternatives to admission, upgraded inpatient accommodation, personality disorder crisis service	Anne Markwick	• Staff lists • Recruitment reports • Staff satisfaction survey	• HRBP • Service Manager • Training and Development Team	Current data from metrics specified
Improved skill mix	Alternatives to admission, STR investment, peer support / PWLE, nurse-led discharge, personality disorder crisis service	Anne Markwick	• Staff lists • Training and development • Recruitment	• HRBP • Training and Development Team	Current data from metrics specified

BENEFITS PLAN

Programme Name	Acute Services Redesign	Programme Owner	Marie Dodd	Status	Amber

Desired Outcome	Output	Owner	Metrics	Resources (human or otherwise) to review progress towards full realisation	Baseline against which benefits measured
Robust 24/7 services	Crisis house, home treatment, intensive day treatment, personality disorder crisis service, upgraded inpatient accommodation, street triage, urgent care single point of entry	Anne Markwick	• CQC • Patient satisfaction survey • Staff satisfaction survey • Sis • Admissions • Home interventions • Section 136 data	• HRBP • BPM • Service Manager	Current performance data

APPENDIX K : COMMUNICATIONS AND ENGAGEMENT PLAN

COMMUNICATIONS AND ENGAGEMENT PLAN

Programme Name	Acute Service Redesign	Programme Owner	Marie Dodd / David Tamsitt / Anne Markwick	Status	Amber

Programme Description	Acute Service Redesign aims to develop services of excellence. This includes development of three hub sites for the delivery of inpatient care which will provide a high standard of accommodation that meets, as far as possible, Health Building Note [HBN] 35 guidance, promotes recovery and dignity and privacy. Alternatives to admission will improve choice to service users, improve experience and health outcomes. Delivering this agenda will see staff development, engagement with third sector organisations and other providers as well as the development of peer support / people with lived experience supporting the delivery of a range of acute care interventions

What we are delivering	Who needs to know?	What is the message?	How are we going to achieve this?	Whose responsibility is it?
Capital investment: upgrade of facilities, development of additional capacity Alternatives to admission – day treatment programme, crisis house, street triage Psychiatric intensive care [PIC] outreach Transport Personality disorder crisis services	• Patients, carers and the public • Mental health clinicians and interested disciplines • Clinical Commissioning Groups [CCGs] and General Practitioner [GP] members • Health and Overview Scrutiny Committees (Kent / Medway) • District / Borough Councillors • Members of Parliament • GPs as providers of primary care • Local Medical Committee [LMC] • Royal Colleges / professional bodies • South East Coast Ambulance NHS Trust [SECAmb] • Police • Emergency care providers • Social care providers • Prisons • Voluntary organisations • Out of hours providers • NHS 111 • Regional and local media	• Acute services are improving and people do not always need to be admitted to hospital – there are more to acute services than beds • Staff development and training building skills and expertise • Creating choice in acute care with real alternatives to hospital admission including care nearer to home and in the local community • Improving patient environments so all units are fit for purpose and promote well being and recovery • Working in partnership with other providers and people with lived experience	• Engagement sessions / roadshows (internal and external) • Presentations • Newsletters / briefings • Service user and carer representation within projects • Updates available on website with ability for people to leave comments / suggestions • Through local media as appropriate • Social media as appropriate	Anne Markwick / Sian Carter