Kent and Medway NHS
NHS and Social Care Partnership Trust

TRANSFORMATION PROGRAMME

Medway Council Health and Adult Social Care O&S Committee
Highlight Report – July 2014

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Reporting Officer:	Ivan McConnell	**Report completed by:**	Rheanna Mitchell	**Reporting to:**	Medway HASC

1. Introduction:

In June, the HASC received an update from KMPT in relation to its Transformation Programme and this report now follows on from this to with the aim to:

- Update on the progress made towards delivery of the planned service developments
- Report on the benefits realised to date

2. Summary:

As we move into the second quarter of 2014/15, KMPT has been making efforts to improve its engagement within Medway, in relation to both our current service provision and our Transformation plans. For instance, at the beginning of July Malcolm McFrederick, Executive Director of Operations, and Ivan McConnell, Executive Director of Transformation and Commercial Development, met with the membership of the Medway 5 carers group. This meeting led to some interesting discussions and KMPT is optimistic that this new relationship will enable KMPT to better support the needs of carers in Medway.

In July we also heard some positive feedback from Medway GPs in relation to improved interface between KMPT and GP providers of primary care services. In 2011, GPs were asked to undertake a survey of their views about secondary mental health services. In response to this feedback, an improvement plan was developed by Consultant Psychiatrists in Medway and a number of engagement events and training sessions have now been delivered. We have been pleased to hear that the modules, which included topics such as 'Managing Depression' and 'Dementia and Delirium', have been well received.

Key achievements in relation to the Transformation Programme include observed improvements to the assessment process in the Medway Community Mental Health Team. An improved assessment process, with early access to comprehensive MDT assessment and physical health monitoring, has enabled the Medway community staff to improve their caseload management and this has resulted in a managed reduction in caseload sizes. Another positive step has been taken in relation to delivering a Single Point of Access, with significant progress made in researching best practice and developing options for models in North Kent. Engagement with local service users, carers and partners around the best fit for Medway will take place in August and September.

For each planned service developments there is an agreed set of benefits. The metrics used to track progress in delivering these benefits are included in the tables in the 'Benefits Realisation' section of this report. By regularly reviewing these data sets, we are able to monitor our progress in delivering against the agreed benefits. When evidence suggests that the implemented changes are not having a positive effect on service delivery, corrective steps can then be taken in a proactive way.

3. Progress report:

Inpatient Programme

- **Aim:** High quality care in safe, purpose-built accommodation and access to appropriate staffing (24 / 7) and bringing together our expertise into three clinical communities.
- **Updates**: The new Emerald phase 1 enablement works and moves commenced in July. KMPT is reviewing models for Acute Day Treatment Services and other admission avoidance schemes, such as Recovey or Crisis Houses. These are currently in the development stage, with internal discussions underway. An engagement exercise with service users and carers, staff and partner organisations is underway in relation to the unique identifiers of Communities of Excellence and feedback on outcomes will be shared at the end of August.

Urgent Care Programme

- **Aim**: Develop from a bed based service to a responsive, accessible and modern service. We will provide an improved urgent response, with timely access to assessment and choice about how acute care is provided.
- **Updates:** An Urgent Care meeting for North Kent CCGs took place in July and progress was noted in relation to improving partnership working across providers. Interest was expressed in relation to accesses training opportunities for GPs, such as Dementia Training packages developed by Older Adult services.

Planned Care Programme

- **Aim:** Skilled workforce that delivers high quality assessments and interventions on the care pathways that we are contracted to provide and holistic recovery focussed care provided within environmentally healing and ecologically sustainable buildings.
- **Updates:** Improvements observed in the Medway Community in relation to caseload management, with a managed reduction in caseload sizes and improved assessment processes, with early access to comprehensive MDT assessment. The Medway team have received positive feedback from Medway GPs in relation to GP engagement events led by Consultant Psychiatrists over the past 12 months - the events have helped to improve understanding of mental health management and have provided an oppportuntiy to develop relationships between primary and secondary care services.

Integrated Care for Older Adults Programme

- **Aim:** Address the mental health needs of people who are being treated primarily for physical health problems and provide a collaborative response, developing a multi disciplinary and centralised approach, with our partners.
- **Updates:** Project support identified and engagement underway with CCGs, with a workshop held on 16 July. Result in developed of a detailed PID and project board. Prefered model to be presented in September.

4. Benefits realisation

Project	Metrics	Baseline	Target	Apr-14		May-14		Jun-14		Variance from targ
Inpatient Programme - SRO: Karen Dorey-Rees - Programme Manager: Phillipa MacDonald				Trajectory	Actual	Trajectory	Actual	Trajectory	Actual	
Increasing Acute Inpatient Capacity	Bed count against commissioned beds - with CCG breakdown	163 beds	174 beds	163	163	163	163	165	163	-2
	Implementation of the friends and family test, as outlined in the CQUIN schedule	NK/EK	N/A	Finalise CQUIN	Achieved	Finalise CQUIN	Achieved	Complete PID	Achieved	
	External OBD	NK/EK	0	0	44	0	126	0	226	226
	Average length of stay	23.3	23	23	*N/A*	23	31.4	23	26.1	-3.1
	Occupancy rate	NK/EK	85-95%	*N/A*	*N/A*	*N/A*	97.8%	*N/A*	98.6%	-3.6%

Exception narrative:

- *Bed Count: Variance in beds relates to delay to opening of 2 beds in Priority House, these are now open*
- *External OBD: Full analysis of external OBD usage is available in separate report*

Project	Metrics	Baseline	Target	Apr-14		May-14		Jun-14		Variance from targ
Urgent Care / Crisis Programme - SRO: Rosarii Harte / Chris Koen - Programme Manager: Rheanna										
Street Triage	Number of s136 presentations	*92*	*N/A*	<90	61	<90	90	<90	69	-21
	Conversion rate	*20%*	*N/A*	*N/A*	18%	*N/A*	17%	*N/A*	15%	
Liaison Psychiatry	2 hour urgent referral target	*79.5%*	*90%*	82%	84.4%	84%	89.4%	86%	84%	-2

Exception narrative:

- *2 hour urgent referral target: In June there were two separate days where demand for urgent assessments was exceptionally high. 12 urgent referrals on two separate days, in comparison to an average of about 4 per day*

Project	Metrics	Baseline	Target	Apr-14		May-14		Jun-14		Variance from targ
Planned Care Programme - SRO: Mark Dinwiddy - Programme Manager: Rheanna Mitchell										
Well Being Centres	Group of expert service users established, who can advise on our building environments	0	3	1	0	1	0	1	1	0
	To demonstrate, through the National Audit of Schizophrenia, full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in patients with schizophrenia, in line with CQUIN requirements	*N/A*	*N/A*	Finalise CQUIN	Achieved	Finalise CQUIN	Achieved	Completed PID	Achieved	
	Implementation of the friends and family test, as outlined in the CQUIN schedule	N/A	N/A	Finalise CQUIN	Achieved	Finalise CQUIN	Achieved	Completed PID	Achieved	
Caseload	No. of cluster days 1,2,3	*6816*	*0*	*N/A*	6414	*N/A*	6993	*N/A*	*N/A*	-177
	Reduction in rate of referrals not accepted to secondary	*8.40%*	*5.0%*	8.1%	7.2%	7.8%	6.6%	7.5%	6.3%	1.2%
	% of referrals with a pathway	*71%*	*80%*	72%	71.2%	73%	71.2%	74%	68.9%	-5.1%
	Reduction in number of open referrals	*10,179*	*N/A*	*N/A*	10,179	*N/A*	10,179	*N/A*	10,252	
	% of referrals with a cluster that is within the cluster review	*N/A*	*95%*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	88.9%	
	Of patients audited, there is an up-to-date care plan has been shared with the GP, including ICD codes, medications prescribed and monitoring requirements, physical health condition and on-going monitoring and treatment needs, in line with CQUIN requirements	*TBC*	*90%*	Agree CQUIN	Achieved	Agree CQUIN	Achieved	Completed PID	Achieved	
	No. of professions with a defined and agreed job plan outline.	*2*	*6*	2	2	2	2	2	2	
	No. of Experts by Experience employed by the service line	*11*	*22*	13	15	15	15	17	15	-2

Exception narrative:

- *No. of cluster days 1,2,3: Cluster days, that is the length of time a client has been open to KMPT under a specific cluster, is a measure used under Care Pathways and Pricing to understand activity levels. Of the Clusters 1,2,3 open to KMPT, there are 6 open in Medway CMHT. These will be reviewed as part of the scheduled caseload management activity*
- *% referrals with a pathway: In Medway, 80% of referrals have a pathway – this is within the target range and the remaining 20% are anticipated to be within the assessment part of the pathway*

Project	Metrics	Baseline	Target	Apr-14		May-14		Jun-14		Variance from targ
Integrated Care for Older Adults Programme - SRO: Justine Leonard - Programme Manager: Vicky Stevens										
Review and redesign of Community Services for Older People	No. of cluster days, Cluster 18	*96,912*	*<10%*	*<1%*	0.7%	*<2%*	6.9%	*<3%*	*N/A*	*>8.9%*
	Reduction of severe and moderate falls, as outlined in the CQUIN schedule	*TBC*	*<20%*	Finalise CQUIN	Achieved	CQUIN PID	Achieved	*N/A*	11	*N/A*
	Count of delivery of training to Care Homes via EK Home Treatment teams	*152*	*N/A*	*N/A*	152	*N/A*	163	*N/A*	181	*N/A*

Exception narrative:

- *No. of cluster days 18: There are 33,000 cluster days in relation to Medway patients under care cluster 18.*

5. Detailed Transformation Programme milestone tracking report

The table below provides a headline summary of the work that we have undertaken to date and are proposing on our transformation programme.

NB: Information that relates specifically to Medway is highlighted in bold, with other information contained for information or to give context.

PROJECT / SCHEME	PROGRESS THIS MONTH	FORECAST ACTIVITY NEXT MONTH	DEPENDENCIES
Increased inpatient capacity	• *DVH* refurbishment works commenced. • *Priority House* (existing ward) additional room works completed. • ***Little Brook* tender packages developed** • ***Emerald* (new ward) initial design approved and preferred design contractor identified, with the business case submitted to the Trust Board and the TDA.**	• Work completes August 2014. • **Seek permission for adaptations**	• On going commissioner support in relation to additional capacity created • ***LB:* External signage is dependent on highways agencies. KMPT is awaiting a response from them about the potential to improve signage to hospital.** • ***Emerald:* Plans include management of transport arrangements, in partnership with Experts by Experience and the PET.**
Personality Disorder Therapeutic House	• **Pro-active engagement with local residents and positive staff engagement for open day.** • **Beds opened in July (Monday – Wednesday)** • **Revised model in light of Band 7 and Band 4 vacancy and reduced unsocial hours.** • **Team days to rehearse scenarios and ensure**	• **Phase III Estate work tender process continues**	• **Securing recurrent funding post pilot.**

	understanding of protocols. • **Agreement with Medway CCG in relation to key reporting metrics in relation to impact on reduction of OBDs and presentations to A&E.**		
Street Triage	• **Proactive recruitment to Band 6 post**	• **Implement agreed model**	• **Challenges in recruiting to Band 6 post**
Liaison Psychiatry	• **Operational in Medway 24/7, funding through Winter Pressures money, with formal commitment from the CCG to provide recurrently (use of Winter Pressures money in Q3/Q4)**		• **Finance** • **Commissioner support**
Single Point of Access	• **Follow up Urgent Care workshop with NK CCGs in July.** • **Development of models** • **Visit to NHS111**	• **Engagement with CCGs and partners to agree model and implementation plan**	• **Commissioner support.** • **Telephony infrastructure.**
Crisis Accommodation / Recovery Accommodation	• High level PID outlining potential future service in development under discussion internally.	• Planning phase continues and includes: o Engage with potential partners o Scope models used nationally o Develop model and business case	• Commissioner support • Support from potential partners • **Resources – including estate and staffing (currently specific details, such as the locations of the premises, are yet to be determined)**
Acute Day Treatment Service	• Discussion paper, considering national models, drafting and	• Planning phase continues and includes:	• Identification of suitable estate to deliver service.

	considered internally.	○ Consider links to other services and service developments ○ Develop model and business case to include base to deliver service from and transport plan	• Commissioner support to ensure service can be developed and is sustained. • **Resources – including estate and staffing (currently specific details, such as the locations of the premises, are yet to be determined)**
Caseloads Project	• **Developed Core Assessment standards as part of the Care Pathways work** • **Agreed key principles of the entry/exit to pathways**	• **Workshop to agree local approaches and mechanism to monitor progress, with agreed timeframes for improvement**	• Workforce • Single Point of Access
Workforce Project	• **Survey of Care Coordinators in Medway to understand the key challenges behind their role** • **Review the role and contribution of professional within the MDT.** • **Job plan pilot for nursing staff.**	• **Workshop to consider and respond to the learning from the care coordinator survey.** • **Job plans refined to support the unique contribution of professionals within the MDT.**	• **Care Pathways and Pricing** • **Caseloads project** • **Cross Service Line workforce plans**
Well-Being Centres Project	• Recovery workshops led in SKC have been reviewed and learning is being used to develop new modules that can be rolled out more widely. • Improving our welcome steering group established	• Community teams to be invited to participate in the early adopter sites for recovery workshop roll out. • Service User reps to be identified to undertake assessment of our welcome and receptions to contribute to improvement plans.	• Communities of Excellence • Estates Strategy • IM&T Strategy

Embedding Care Pathways	• **Care pathways launched internally** • Continued engagement will key parties to support implementation and management of Care Pathways and Pricing. • Internal monitoring via performance meetings. • Service User led development of Care Pathway communications and engagement documentation	• Continued monitoring and improvement plans	• Communication and engagement. • Information Management.
OASSIS	• Design and outline business case developed in relation to the re-location of Cranmer Ward, Canterbury	• Project steering group to continue to monitor progress. • Attend Patient Consultative Committee in November/December 2014	
Older Adult Community Services redesign	• Workshop with CCGs and KMCS completed in July to agree collaborative approach to older adult service provision and clarify links to CQUIN delivery.	• Agree governance arrangements in relation to shared care planning.	• Cross Service Line workforce plans • Commissioner support
Integrated Models of Delivery	• Demand and capacity work in relation to Rehabilitation services continues, with exploration of Community Rehabilitation models.	• Develop options and discussion paper internally	