Cornwall Partnership NHS
NHS Foundation Trust

Mental Health Acute Care Pathway

Outline Business Case

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Mental Health Acute Care Pathway Programme

Outline Business Case v0.7

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Document Control

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26 July 2013	0.7	Reviewed Exec Summary	Sally May

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Executive Summary

Over the past two years Cornwall Partnership NHS Foundation Trust (the Trust) has focused on improving delivery of its acute inpatient services at Bodmin and Longreach Hospitals. The Trust has invested additional funds into improving ward staffing levels, alongside a significant capital investment programme to improve ward environments.

It is clear that CFT has a comparatively low number of adult acute beds when benchmarked per 100,000 registered population (working age adults). The latest benchmarking analysis reveals variation in provision across the NHS from 16 beds per 100,000 population to 47 beds per 100,000 population. The median position is 23 beds per 100,000 population. The trust is commissioned on the basis of 54 adult acute beds for the population of Cornwall and the Isles of Scilly and this equates to approximately 17 beds per 100,000 population. It is generally recognised that trusts with fewer beds tend to have greater pressure on length of stay due to potentially higher acuity levels in patients that are admitted to beds.

The Trust has also reviewed its crisis resolution Home Treatment Team (HTT) provision against established benchmarks (Guidance Statement on Fidelity and Best Practice for Crisis Services, Department of Health, December 2006). CFT has sustained staffing levels within HTT at the same levels since the service was first commissioned. However, CFT's HTT staffing levels are below those set out in the guidance and need to be increased to meet the needs of local people. Earlier reports suggest that the CFT service met fidelity criteria but our review has confirmed that this incorrectly incorporated Approved Mental Health Professionals (AMHPs).

As a learning organisation, dedicated to the continual improvement of its services, the Trust would like to further enhance its delivery model through investment in its existing inpatient units and Home Treatment Team (HTT), and through the creation of a new Frailty Unit. These enhancements require commissioner investment to secure an enhanced delivery model which would improve patient safety, provide more individualised care and achieve better outcomes for patients. The Trust's proposal enables funds currently expended on out-of-county placements to be redirected to support more resilient in-county services. The proposed investment would increase available adult acute beds to approximately 21 beds per 100,000 population (working age adults) and move HTT close to meeting best practice guidelines.

Our proposed programme has the following key deliverables :

- A better resourced HTT, better able to respond to patients needs
- Inpatient units appropriately resourced with sufficient capacity to ensure individuals needs are met in the most timely manner
- A Frailty Unit to provide care suitable for our most vulnerable patients

The programme has close interdependencies with existing Trust programmes, particularly the refurbishment of Bay Ward at Longreach Hospital. As such it will be necessary for the programme to be adaptable to issues arising from other Trust developments. The programme will also rely heavily upon the expert advice of clinical leaders. The Trust would wish to engage with commissioners at all stages of the programme delivery.

This document presents the Strategic and Outline Business Case for the Acute Care Pathway Programme using HM Treasury's five case model. It seeks to answer the following aspects of the Programme

- the investment, its value and importance
- that we have identified the management and resource capability to deliver the benefits
- that the Project will deliver the highest value opportunities
- The tranches of work required within the Programme are undertaken in the optimum sequence with their interdependencies identified.

This is intended to facilitate an informed business decision(s) about whether the proposed expenditure of resources will deliver the outcomes desired by the NHS Kernow, clinicians, patients and carers and by the Trust.

The recommended way forward

It is formally recommended that Outline Business Case is jointly approved by NHS Kernow and CFT for development into a full business case for the delivery of;

- A Frailty Unit
- Recurrent funding for appropriate staff numbers on the inpatient units
- An expansion of the HTT.
- The creation of an alternative Provision Fund to be utilised and managed by the HTT

This will allow time for strengthened engagement with commissioners and key stakeholders in developing the Full Business Case.

It is recognised that whilst the principles of the four measures mentioned above are agreed there may be need for further assurances to be given. The Trust and commissioners would therefore commit to work together to deliver a Full Business Case within a timescale that will allow the commencement of the reconfiguration of the acute care pathway by April 2014.

Strategic Case (the case for change)

Background

Cornwall has an estimated population of 535,300 residents living in 255,066 households dispersed across the County's 3,559 sq km. The population has been growing since the 1960's, and has consistently grown quicker than the rest of the South West region, and is amongst the fastest growing areas in the UK. Cornwall's population is estimated to reach 633,200 by 2030, an increase of 97,900 (18.3%). This growth is predicted to be driven by migration, largely due to more people moving in than out, but also importantly due to a decline in the number of people leaving Cornwall. Contrary to common perceptions, the net migration is predominantly persons of working age who now equate to approximately 315,000 of the total population.

Alongside the increasing population size is an increasing demand for mental health services. It is recognised that services need to be able to meet the increased demand and complexity of need in the most efficient manner possible. Services should also be structured to meet best practice guidelines in terms of caseloads and referrals.

The Trust reviews its delivery of services on an on-going basis across all operations, including the acute care pathway, utilising available benchmarking and best practice guidelines This process of review has led to significant internal investments into improvements into inpatient care. The Trust has commenced a significant programme of capital investments to improve the environment of its inpatient units, alongside environment enhancements for complex care and dementia facilities.

The recent thematic review by CQC's Mental Health Act Commission identified that there were major problems with bed availability and that this had significant implications for patients and carers. The CQC requires that the Trust's action statement should address how the Trust, with commissioning partners, intends to ensure that sufficient beds are available so that people can be placed locally when there is a need to do so. The CQC have also required that the Trust review the home treatment service.

It is clear, therefore, that the next steps in the improvement of the Trust's acute care pathway requires further development of its existing inpatient

units to maintain a safe staffing level and the creation of a new Frailty Unit for the most vulnerable patients,. providing additional capacity to meet local need, alongside the strengthening of its HTT to ensure consistent 24 hour, 7 day services.

Acute Inpatient Services

The Trust's adult inpatient services currently consist of an acute ward, electro-convulsive therapy (ECT) and a HTT (East) on the Bodmin Hospital site and one ward (Bay ward) and a HTT (West) on the Longreach Hospital site. The Trust also has a section 136 Suite on the Longreach Hospital site which is managed directly by Bay Ward.

The Trust has recently embarked upon substantial enhancements to one of the Acute Mental Health Inpatient wards at Longreach hospital, Camborne. The Bay ward programme of works has yet to be completed and will result in the previous ward of 30 beds being divided into two separate units of 15 beds each. The Trust has prioritised capital investment into delivering this change recognising that, since Longreach Hospital opened, the design of the accommodation has posed significant operational difficulties. The high number of patients in one ward that accommodates male and female patients from the age of 18 to 90+, with a range of serious mental health problems, presents a poor social mix and has proven difficult to manage. There have been numerous attempts to overcome these shortcomings by managerial arrangements that have been only partially successful. Consequently the design and experience of delivering care on Bay Ward was an area highlighted for improvement and investment from the Trust's retained surplus.

Across all of our acute inpatient units, we currently provide approximately 19,000 bed days of care in a year. If patients' leave arrangements are taken into account, our beds are significantly over-occupied at around 117% of available bed days. The number of bed days and overall occupancy for previous years is shown below;

Number of acute inpatient bed days		
	No of days	% occupancy
2009/10	18,331	93%
2010/11	18,896	96%
2011/12	18,883	96%
2012/13	19,172	97%

It is recognised nationally that a clinically safe acute inpatient unit should operate at 85% occupancy, and it is to this level of activity that the Trust will aim to operate. The activity the Trust has delivered

leaves little opportunity for the service to flex to periods of peak demand, as discussed in the out of county section later in this paper.

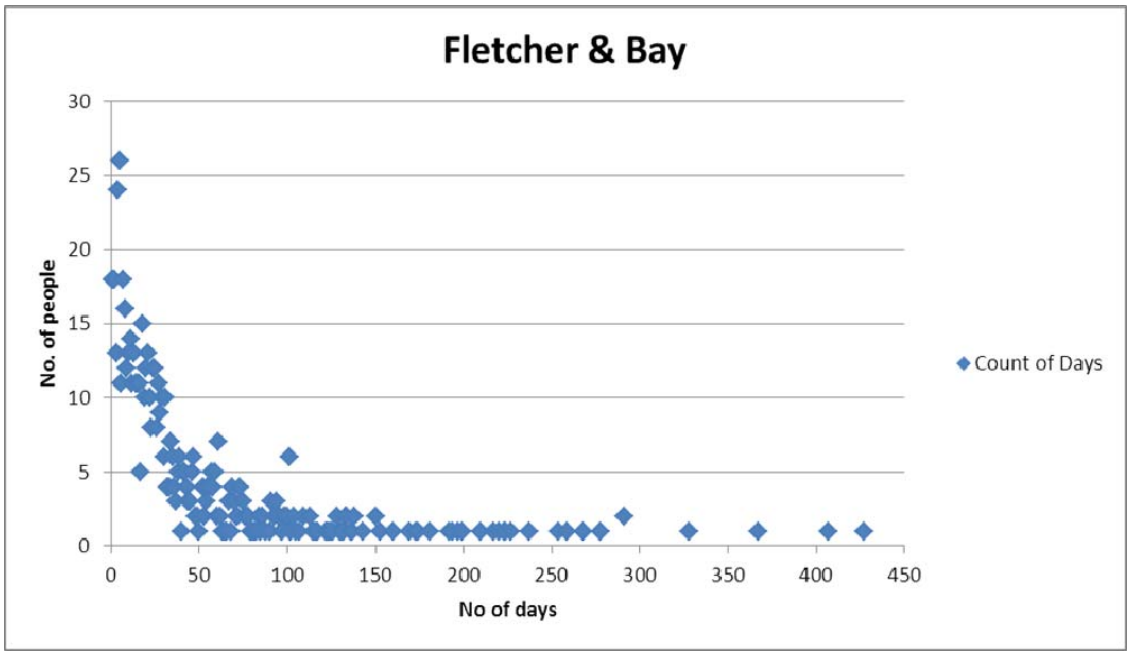
It has also been recognised that the funding of the inpatients units has resulted in staffing levels which are not at the optimum level. The Trust presented a paper [1] to commissioners in March of this year which identified the pressures the inpatient units were operating under. This pressure has been recognised in 2013/14 by commissioners who have invested £866,000 to allow service delivery pressures to be managed. This business case highlights the need for this funding to continue recurrently in order for the inpatient units to maintain safe staffing levels.

Length of stay

The Trust and commissioners both share a joint aim to ensure service users care is as least restrictive as it can be at all times. It is therefore clear that focus needs to be directed at the optimal length of time individuals spend on inpatient units to ensure their needs are met whilst restrictions on their freedom are minimised.

In the paper presented to commissioners in March this year the Trust's relative position to other providers was reflected. This showed the mean length of stay on CFT inpatient units was in line with other providers.

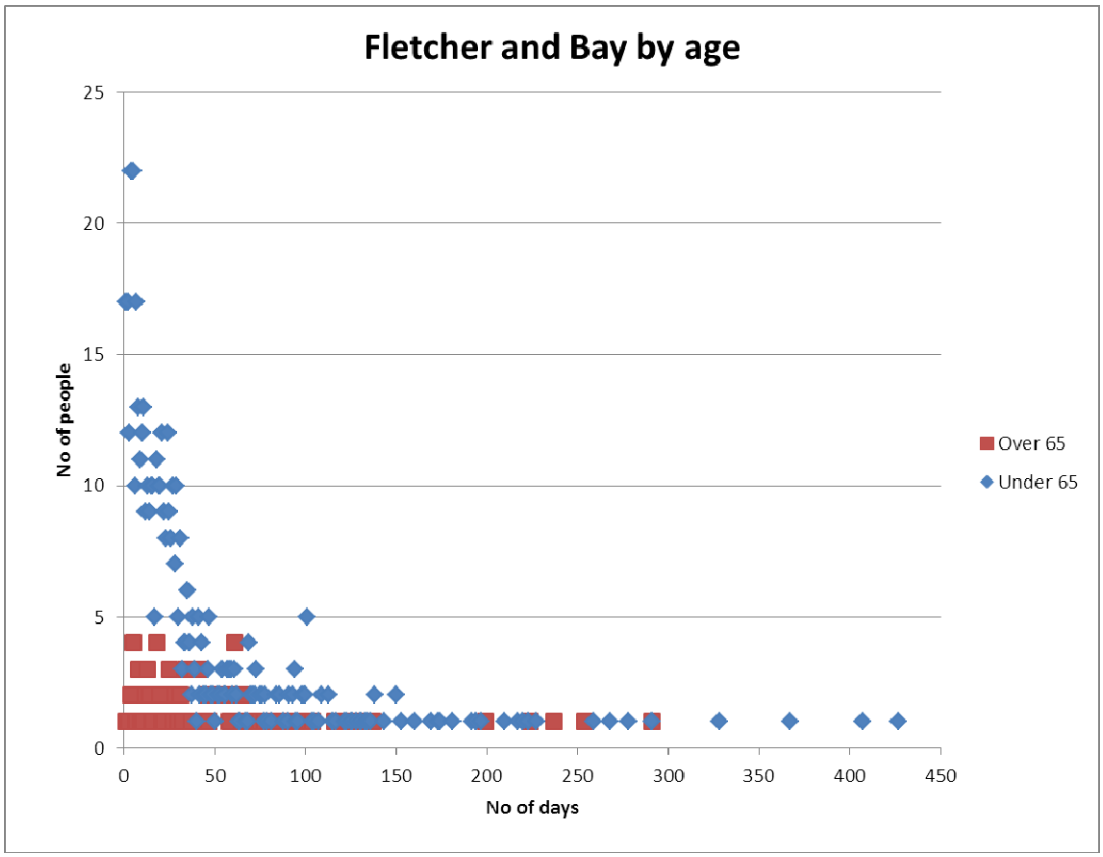
The length of stay for each individual on the Trust's acute inpatient units in 2012/13 is reflected below;



[1] Acute Mental Health Inpatient Enhanced Observation and Length of Stay- High Level Analysis of Current Position, March 2013

The mean length of stay is calculated as 43 days, with a median of 24 days across all patients in the acute inpatient wards last year.

It is also possible to further analyse the length of stay between those individuals under 65 and those over. Whilst this does not give a complete understanding of the complexity of issues facing each client group it does provide interesting analysis.



When the length of stay is split between under 65's and over 65's it becomes apparent the impact the older population have on the overall position.

Average length of stay		
	Mean	Median
Over 65's	55	39
Under 65's	40	22

Further review of the length of stay also highlights the impact of six outliers on the average. The inpatient units deal with some very complex cases, for example an individual diagnosed with Lewy-Body dementia who has a long history of alcohol abuse and anorexia. As such if outliers such as this

individual are excluded from the calculation the average length of stay for 95% of the patients treated in 2012/13 reflects a significantly lower figure;

Average length of stay	
	Mean
Total population	37
Over 65's	52
Under 65's	35

The average length of stay reflected above is in line with that of individuals who receive care out of county, several of whom are then brought back into CFT inpatient units.

The Trust is a member of the NHS Benchmarking Network, and obtains information on the key determinants of length of stay compared to 43 other mental health providers across the country (including other South West providers Devon Partnership Trust and Somerset Partnership Trust). In its latest report the NHS Benchmarking Network [2] reflected the national position for adult acute mental health services. Although CFT did not contribute to this collection, the findings from it are relevant.

The report found that there is variation nationally between 16 to 47 acute adult beds per 100,000 adult population (where adult is classed as those of a working age), with a median of 23. The Trust's bed provision would currently equate to 17 beds per 100,000 population, rising to 21 with the opening of the proposed Frailty Unit (although many of these beds would be used by patients older than working age). This therefore reflects that Cornwall has a low number of beds when compared to the rest of the country.

The report also reflects a national median for the number of admissions of 234 per 100,000 population. CFT admissions are considerably less than this. The report goes on to highlight national average numbers of occupied bed days as approximately 33% higher per 100,000 adult population than CFT provided bed days, and 16% higher than CFT plus out of county provision. The report is therefore clear in describing a position whereby locally provided bed capacity is significantly below national average.

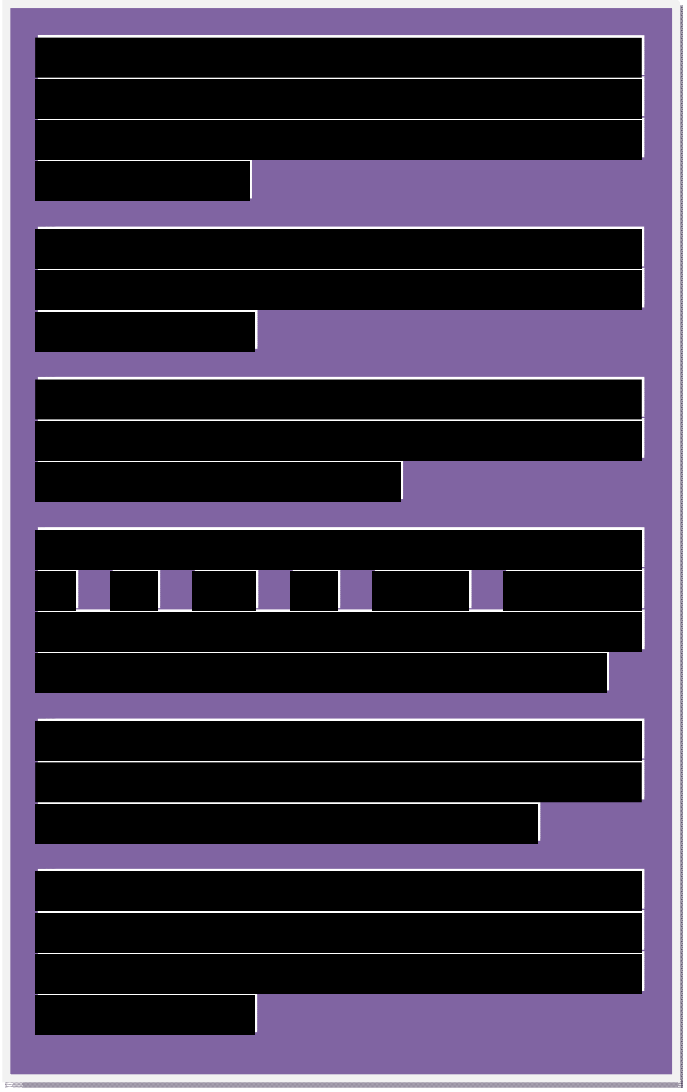
The report describes how "Trusts with fewer beds tend to have greater pressure on length of stay due to potentially higher acuity levels in patients that are admitted to beds". It is the level of acuity that has been reflected earlier in this section as having a significant impact upon the Trust's length of stay, and is one of the reasons why a Frailty Unit will further improve the care provided in county.

The national average mean length of stay is shown as 32 days across all Trusts. As described previously the Trust's mean length of stay for adults of a working age is 40 days, and when outliers (2.5% of patients with the lowest length of stay and 2.5% of patients with the highest length of stay)

[2] Inpatient Benchmarking Report, NHS Benchmarking Network, December 2012

are excluded the mean is 35 days. This, aligned with the low number of beds available, therefore reflects that the Trust is in line with the national position on length of stay.

Therefore, in summary, the Trust has a low number of acute inpatient beds available, which are used by those with potentially higher acuity levels. The Trust's admissions and occupied bed days are low compared to the national average and the length of stay is in line with expectations. As such the Trust is performing well with the resources it currently has, though evidence suggests that more can be done with greater capacity.



Home Treatment Team

The HTT's philosophy and mission statement is:

- We will offer an alternative to hospital care for mental health service users who are in crisis. We aspire to offer an equivalent level of service to that received in hospital and to deliver the quality of service that we would wish our own family and friends to receive.
- We will work to provide a safe service in the least restrictive environment. We will work to promote positive risk taking and management. We aim to work in partnership with our service users, their families and carers to provide individualised care that addresses their 'whole life' issues.
- Where risk or other factors mean that an alternative to admission is not appropriate we will arrange admission to hospital but continue to work towards a return to home as soon as possible.

The HTT is therefore the gatekeeper of the inpatient units, and provides the opportunity for alternative delivery of care to be identified for patients who would otherwise end up on a ward. The HTT is therefore a key element of both the acute care pathway delivered by the Trust and the wider pathway managed by the commissioners which includes specialist out of area placements.

Currently the HTT is not resourced at a level which would allow this gatekeeping function to be delivered most effectively and efficiently. This is particularly evident out of hours, where staffing levels mean that should members of the team be required for the assessment and treatment of a patient; the HTT service is restricted to that of telephone advice.

The HTT received 1,980 referrals in 2012/13 for 1,246 patients. This translated into 843 episodes (defined by national guidance) which equates to 657 patients.

The Trust has undertaken a benchmarking exercise of HTT staffing levels against those reflected in national guidelines. This exercise demonstrated that the Trust's staffing levels (in whole time equivalents) would need to be increased by approximately 70% to meet national expectations.

Vulnerable patients

At the present time, our vulnerable patients with functional mental illness are accommodated on the acute inpatient wards. This results in conflicting needs of different groups, with staff resource being focussed on maintaining a safe environment which could be better focussed on therapeutic care.

The Trust has therefore identified the need for, and ability to provide, a Frailty Unit. This unit would accommodate the most vulnerable patients in a safe environment thus focussing resource on their recovery.

A clinician working within the Inpatient Service Line has also undertaken an assessment of the number of patients on Trust wards on four separate dates across a year that have presentations which the Frailty unit would be best served to manage. These conditions include such things as mobility issues, risk of falling, visual impairment and suicide risk. This assessment has demonstrated that on two of the dates there were at least 10 patients, and on the other two dates there were at least 5. These assessments were undertaken retrospectively and thus do not enable a full and comprehensive review of all other patients including those out of county. The Trust therefore believes that the evidence confirms there is an on-going demand for the provision a Frailty unit will provide.

Out of county activity

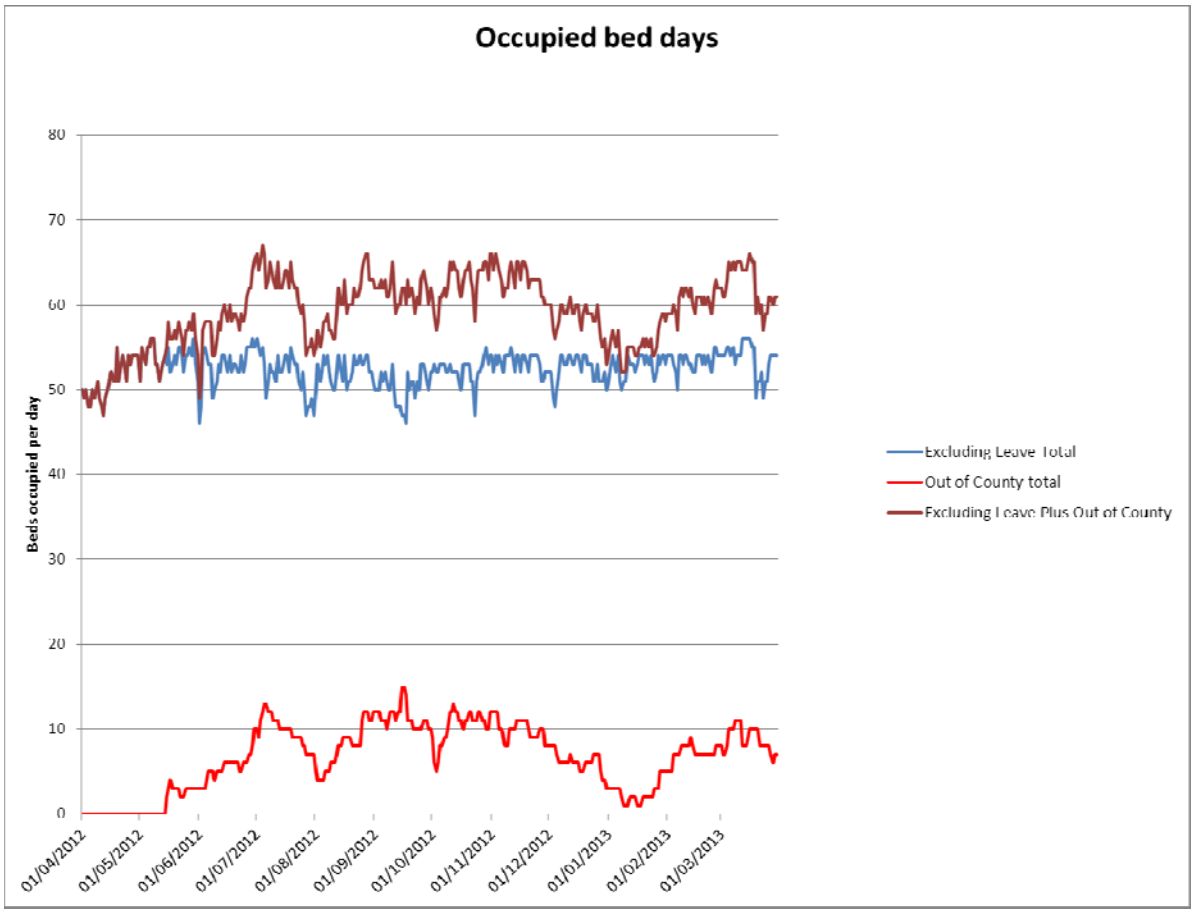
Commissioners have indicated to the Trust that they spend approximately £3m per year in total on out of county placements, though are unable at this time to provide us with more information. The out of county activity consists of three main cohorts of patients;

- Those who would be suitable for a CFT provided inpatient facility
- Those who would not be suitable for a CFT provided inpatient facility (for example staff members)
- Individuals who become ill out of county (typically CFT will make every effort to repatriate these individuals as soon as possible)

The Trust maintains activity information related to the first cohort identified above. Whilst this does not give the full picture it enables review of the demand that exists for inpatient beds.

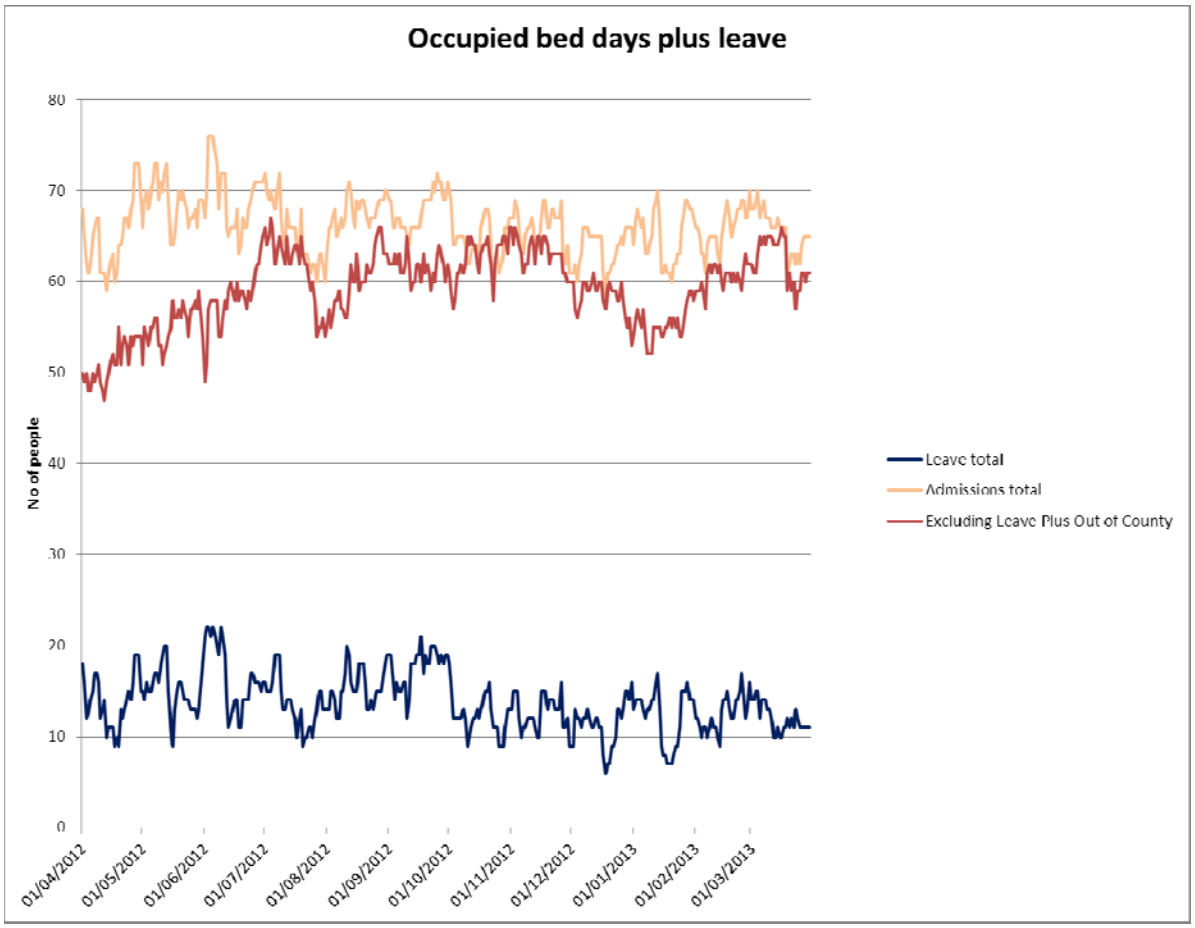
Total activity

The number of inpatient beds used across the financial year 2012/13 is reflected in the graph below;



The graph reflects the total number of beds occupied across the year. Unfortunately the Trust has only partial out of county information; however that which we hold shows a consistent need for facilities out of county, with a peak of 15 in year. The overall picture is therefore one whereby the existing provision in county is operating very close to its maximum capacity, with additional demand then requiring out of county provision.

It is also important to consider the need for patients to be given trial leave from the inpatient units as part of their care. When leave is given providers need to be prepared for that individual to be re-admitted should it be necessary. The graph below therefore takes account across the year of the number of individuals in inpatient units and on leave throughout the year;



The graph reflects the consistent position of there being up to 70 individuals either in inpatient units or on leave at any one time.

Care Quality Commission monitoring visit[3]

A Mental Health Act monitoring visit was undertaken in June 2013 which found significant issues with the number of acute inpatient beds and the capacity of the HTT. These issues are summarised as;

- The number of placements out of county is high compared to other areas
- There is an expectation that the number of beds in-county should increase
- There needs to be greater capacity in the HTT
- The alternatives to hospital admission are limited

The Trust and NHS Kernow therefore need to work together to develop a business case to address the concerns raised.

[3] Care Quality Commission- Mental Health Act 1983 Monitoring visit June 2013

Administrative Position

The Frailty Unit was proposed by the Inpatient service line and has been recognised through the Trust's annual planning process as a key development. The Project Board has met on a number of occasions with formal minutes taken and reported to the Executive Management Group (EMG).

The HTT capacity has been identified as an issue through the inpatient service line business plan. Moreover a recent CQC inspection identified the HTT capacity (particularly at night) as a key issue to be addressed by the Trust and its commissioners.

The issue of safe staffing levels on inpatient units has been reflected both internally to the Trust and through contract discussions with commissioners.

What benefits does the Programme deliver?

Some benefits from the programme will be tangible and measurable in both quality and financial terms.

Others are intangible, less easily measured and more about making our service environment a better place to deliver and receive care. These are, nonetheless, an important gain from the Programme and have informed its decision making.

Acute Inpatient Unit Services

- Safer staffing levels will result in safer, more effective care for patients and improved working conditions for staff

Frailty Unit

- This provision will provide a safe and appropriate environment for patients with complex needs

- Additional in-county provision will reduce substantially the need for individuals to go out of county for their care and thus deliver cost and quality improvements

HTT

- A better resourced service will offer an enhanced and proactive treatment at home, and help to ensure individuals receive care in the least restrictive manner possible

- Patients will be given greater opportunities to have care other than that provided in an inpatient unit

Universal benefits

- The service improvements combine to improve the overall effectiveness of the service and safety of patients whilst in the care of Cornwall Partnership NHS Foundation Trust.

- Overall the Programme is expected to make a major contribution towards the Quality

Improvement plan for the Trust.

- These improvements are expected to have a knock on effect in increasing our organisational ability to recruit and retain staff, allow options for rotation of staff through services to increase the depth of cover and improved staff developmental opportunities we offer them.

- The programme consolidates service provision improving value for public money and frees resources to trial new services (in partnership with commissioners).

Patients and Carers benefits

- Smaller clinically appropriate Acute Inpatient units should improve the experience for patients and carers associated with the environment.

- Staff teams resourced to enable the focus of a defined cohort enabling patients/carers on a daily basis to have a clearer understanding of who is providing their care.

- Better continuity of care

- Improved more personalised care.

Regulatory impact of the Proposal

The proposed changes in the clinical delivery are assessed as having no impact on the current regulatory registration for the Trust.

Trust Mission Statement Alignment

The Trust has a Mission statement declaring itself to be “passionate about its services” with a five part commitment

1. to deliver high quality, safe and accessible services.
2. to maximise the potential of our workforce to deliver high quality patient care
3. to achieve best value and ensure the Trust is sustainable and financially viable in the future
4. to diversify and develop services that meet commissioner and user needs and expectations.
5. to improve mental health and wellbeing by working in partnership to create life opportunities for our clients.

This programme seeks to deliver on those commitments by

- Delivery of improvements to the environment and safety of patients in its inpatient and HTT services (1,5)
- Support its staff by provision of an improved environment for professional delivery of care (2, 5)
- whilst also providing them with a safer working environment.(2)

- Improve our current provision of service to take account of the latest best practise guideline for service delivery.(3)

What Other Strategic Approaches were considered?

The Trust considered enhancements to the pathway alongside;

- Doing nothing with services maintained at currently funded levels
- Working with commissioners to identify concepts outside of the Trust's control

These approaches were considered but are not recommended for the reasons summarised below.

- Doing nothing- this course of action would ignore the increasing demand pressures, and leave the Trust and services under-resourced and vulnerable to future litigation and de-registration of services.

- Working with commissioners to identify concepts outside of the Trust's control- The Trust believes that it is ideally placed to provide the stepped-improvement of acute care pathway services as the current in-county provider of these.

Choice of Delivery Option

HTT

The HTT model is recognised nationally as providing the best service model in the community at times of crisis and therefore the only delivery option.

Inpatient Units

An alternative delivery option is for the service to remain as it is. It has been recognised however that the service is working beyond its capacity and requires investment in order to maintain safe staffing levels and therefore an acceptable standard of care.

Frailty Unit

An alternative delivery option is to maintain the status quo whereby the most vulnerable patients are accommodated on inpatient wards. This option would not address the needs of the individuals, and would therefore result in resource being focussed on creating a safe environment rather than on an individual's recovery.

Economic Case (ensuring value for money)

Critical Success Factors

This business case seeks to improve the quality and efficiency of the acute care pathway. Its success will be judged upon;

- Providing care to individuals pre-admission to an acute ward when they suffer an acute episode
- Providing capacity to identify alternatives to admission
- Providing safe staffing levels on inpatient wards to enable appropriate care to be delivered to all patients
- Provide a suitable, effective care environment for the most vulnerable of patients

Main options

The main options identified to achieve our critical success factors are;

- Option 1- do nothing
- Option 2- enhance capacity of the HTT, achieve safe staffing levels in inpatient units and develop an Frailty Unit
- Option 3- have greater capacity than the national expectation in the HTT and on inpatient units, and have an Frailty Unit on each of the Trust's hospital sites
- Option 4- enhance capacity of the HTT, achieve safe staffing levels in inpatient units

A detailed assessment of the main options is;

Option 1	
Scope	Do nothing
Solution	This option will leave the acute care pathway as it currently operates.
Service delivery	The HTT would continue to operate with an out of hours service from 8pm-8am The acute inpatient units would require enhanced observations at a level greater than that for which they are funded Many patients would receive care in out of county provision
Implementation	Current operations continue
Funding	£866,000 funding for enhanced observations would not meet the actual costs incurred Commissioners would fund out of county placements

Option 2	
Scope	Enhance capacity of the HTT, achieve safe staffing levels in inpatient units and develop an Frailty Unit
Solution	The HTT would have its capacity enhanced to a level in line with national expectations. Enhanced observation funding would be provided at an appropriate level A frailty unit would be opened to enable demand to be met, and vulnerable patients to have their needs met
Service delivery	The HTT would be expanded to provide full shift cover until midnight, thus operating with appropriate capacity at times of peak demand. Enhanced observations would be delivered at levels which benefit from the other service developments The frailty unit would provide more focussed care to our most vulnerable patients, whilst ensuring capacity gaps within Cornwall are addressed
Implementation	The service improvement would be implemented in line with the timescales set out in the Management case section.
Funding	Existing funding would be utilised

Option 3	
Scope	Greater capacity than the national expectation in the HTT and on inpatient units, and have an Frailty Unit on each of the Trust's hospital sites
Solution	The HTT would have its capacity enhanced to a level in excess of national expectations. Enhanced observations would be delivered at currently experienced levels which do not take account of the benefits from other service developments. A frailty unit on each of our hospital sites. This would create greater capacity than current levels of demand. Vulnerable patients would have a more focussed service to have their needs met
Service delivery	The HTT would be expanded to provide full shift cover until midnight, thus operating with appropriate capacity at times of peak demand. Enhanced observations would be delivered at current levels. The frailty units would provide more focussed care to our most vulnerable patients, whilst creating excess capacity within Cornwall.
Implementation	The service improvement would be implemented in line with the timescales set out in the Management case section.
Funding	Funding in excess of current levels would be required

Option 4	
Scope	enhance capacity of the HTT, achieve safe staffing levels in inpatient units
Solution	The HTT would have its capacity enhanced to a level in line with national expectations. Enhanced observation funding would be provided at an appropriate level Many patients would receive care in out of county provision
Service delivery	The HTT would be expanded to provide full shift cover until midnight, thus operating with appropriate capacity at times of peak demand. Enhanced observations would be delivered at levels which benefit from the other service developments Many patients would receive care in out of county provision
Implementation	The service improvement would be implemented in line with the timescales set out in the Management case section.
Funding	Funding in excess of current levels would be required

The anticipated costs of each of the options are shown in the following table;

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]				
[redacted]		[redacted]	[redacted]	
[redacted]			[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
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[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]52

Option 2 therefore is the only option which delivers a reduction in current levels of commissioner spend (estimated).

Economic appraisal

The relative merits of the four options are considered below in relation to the key success factors of this programme

Assessment factor	Option 1 Do nothing	Option 2 Enhance capacity of the HTT, achieve safe staffing levels in inpatient units and develop an Frailty Unit	Option 3 Greater capacity than the national expectation in the HTT and on inpatient units, and have an Frailty Unit on each of the Trust's hospital sites	Option 4 enhance capacity of the HTT, achieve safe staffing levels in inpatient units
Capital cost	Nil	High (most cost effective)	Low	Nil
Revenue cost of services	Nil	High (most cost effective)	Low	Medium
Providing care to individuals pre-admission to an acute ward when they suffer an acute episode	Nil	High	High	High
Providing capacity to identify alternatives to admission	Nil	High	High	High
Providing safe staffing levels on inpatient wards to enable appropriate care to be delivered to all patients	Nil	High	High	Medium
Provide a suitable, effective care environment	Nil	High	High	Nil

for the most vulnerable of patients				
Overall positive economic benefit	**NIL**	**HIGHEST**	**LEAST**	**MODERATE**

Option 1: This option lacks the benefits delivered by other options

Option 2: This option ranks **highest** as it satisfies all the key success factors within existing resource levels

Option 3: This option ranks **least** as although it satisfies all the key success factors its cost is significantly in excess of existing resource levels

Option 4: This option ranks **moderate** as although it satisfies most of the key success factors, it does not satisfy all of them and will cost more than existing resource levels

Preferred option

The preferred way forward is therefore Option 2 as it addresses the gaps in current service delivery in the most efficient manner. The key benefits associated with this option are;

HTT

The HTT will operate until midnight with full capacity and will therefore provide a much improved service. The expanded HTT will provide greater capacity to work with service users and enable even more focus on ensuring service users are treated in the least restrictive environment possible.

The HTT will have greater capacity to liaise with inpatient units, particularly out of hours, and will therefore provide a more integrated care pathway.

The Alternative Provision Fund will give clinicians greater opportunities to meet the needs of service users by enabling more alternatives to inpatient provision to be considered and provided. Examples of these alternatives include;

- Access to alternative accommodation (eg B&B)
- Night sitters
- Carers respite to provide carers with time out so that they can continue caring
- Weekend support from day centres

Frailty unit

The Frailty Unit will provide a service focused on the needs of our most vulnerable patients. It will therefore both reduce operational pressures on existing inpatient units, whilst providing an environment which will better meet the needs of it users.

The development of a Frailty Unit will also create greater capacity in-county, thus reducing the number of individuals who are taken out of county to receive care.

Enhanced observations

On-going funding of enhanced observations will ensure the specific needs of users are met when they require additional care. This is an essential part of an efficiently run inpatient facility and therefore needs to continue to ensure the model operates as effectively as possible.

Benefits Realisation Plan

Milestones for reviews of benefit realisation and a timeline showing when the benefits are planned to be realised will be produced upon moving to a full business case.

Commercial Case (Procurement and Contractual aspects)

Cornwall has a history of making important decisions about enhancements in care provision in a timely manner. There has been a significant shift in the models of care over the past 20 years with mental health services moving from being delivered in a large institution in Bodmin to greater community services and more bespoke specialist service delivery. The proposals outlined in this business case are the next steps in the improvement of service delivery.

The main commissioner to the services outlined in this business case is NHS Kernow (the Clinical Commissioning Group), though it is clear that the benefits derived would benefit many organisations. As individuals have their needs met more effectively so other agencies are able to concentrate resources more effectively, so benefiting the system as a whole.

Procurement

The preferred option involves the development of existing services, and is therefore considered to be an incremental change to the current contract of which CFT and NHS Kernow are parties. As such it is expected that the funding attributable to the service change will be enacted through a variation to the existing contract.

Payment mechanism

NHS Kernow would pay for the services in line with established arrangements for its existing contract with CFT.

Contractual issues

The terms of the existing contract are sufficient to enable the delivery of these services. Performance, quality and governance monitoring of the services will be conducted through established contractual requirements.

Commercial Benefits

Benefits that are hoped to achieved cross matching against the Trusts investment objectives.

Benefit	Realisation	Investment Objective
Integrated Care pathways with "main" Trust services	Day one	• To deliver high quality, safe and accessible services. • To Diversify and develop services that meet commissioner and service user expectations
Provision of care within Cornwall	Day One	• Reduced travelling for patients, their carers and families • To achieve best value
Income source	Early	• Increased service provision will partly address an acute bed shortfall within county and for England as a whole.
Improve staff retention and Career options	Day One, building over first year	• To maximise the potential of our workforce to deliver high quality patient care • Ability for HTT staff to innovate in service delivery
Increase partnership working with partner organisations	During design and build, Operational from Day One	• To improve mental health and wellbeing by working in partnership to create life opportunities for our clients
Provision of Services from high quality facilities	Design and build, Day One	• Improve the facilities and standard of provision of care in Cornwall.
Improve quality and accessibility of services for no extra financial cost	Day One building over first year	• Services provided at a higher quality, closer to patients in bespoke facilities of no increase in cost above current practice.

Strategic risks

Embarking on a programme of this scale presents inevitable risks in the assumptions and potential for overspend, failure to deliver timescales and to achieve the original concepts desired.

Risk	Impact	Mitigation
Risk of the Frailty unit being underutilised	Low probability Medium impact	• Close working between clinicians and commissioners to ensure it meets the needs of people who require it • Publish referral criteria
Timescales slip for provision of Frailty Unit due to inter-dependency with the Bay Ward project	Medium Probability Medium Impact	• Close links across projects
Risk of enhanced observation funding not being sufficient	Medium Probability Medium Impact	• Control measures to ensure enhanced observations are provide only when needed
Inability to employ & sustain suitable staff	Low Probability Medium Impact	• Recruitment exercise • Internal staff recruitment • Employment benefits

The Financial Case (affordability)

"Mental ill health is the single largest cause of disability in the UK, contributing up to 22.8% of the total burden, compared to 15.9% for cancer and 16.2% for cardiovascular disease. The wider economic costs of mental illness in England have been estimated at £105.2 billion each year. This includes direct costs of services, lost productivity at work and reduced quality of life."[4]

The social and financial costs attributable to mental health issues are considerable and growing. At a time when the NHS is required to deliver significant efficiencies in the way it operates, it is essential that services are developed effectively. When assessing services that are being delivered it is as important as ever for provider and commissioner organisations to consider both quality and financial issues.

This business case demonstrates that the acute care pathway can deliver improved quality using currently committed resources. These resources can be readily re-directed to a reconfigured service model which will have the individual needs of its users at its heart.

Summary financial appraisal

There are two elements of financial resource associated to the preferred delivery option; capital investment and annual operating costs.

Capital investment:

It is envisaged that there will be a requirement to spend approximately £100,000 to refurbish a ward that will accommodate the Frailty Unit. As a Foundation Trust, CFT has the ability to invest in its capital resources to enable improvements in estate. As such CFT will commit to funding the upfront capital investment.

Annual operating costs:

The cost of the proposed model is summarised below in relation to current levels of expenditure within the healthcare system;

[4] No health without mental health: A cross- Government mental health outcomes strategy for people of all ages Supporting document – The economic case for improving efficiency and quality in mental health

The preferred model will therefore deliver an improved care pathway within existing resource levels.

Cost of individual service improvements

This section will further explain the costs and key components of each of the service improvements.

Frailty unit:

The key components of the Frailty Unit are;

1. Model of operation

The service will operate three shifts and its operational times will be:

	Start	Finish
Early	7:00:00 AM	3:00:00 PM
Late	1:00:00 PM	9:00:00 PM
Night	8:30:00 PM	7:30:00 AM

2. Rostered staff

Each shift will require the following number of staff working at any time:

	Qualified	Unqualified
Early	3	3
Late	3	3
Night	2	2

3. Non-rostered staff

Non-rostered staff will consist of:

	WTE's
Band 6 Physiotherapist	1
Band 5 Dietician	0.1
Specialty Doctor	1
Band 8a Psychologist	0.25
Band 5 Psychology Assistant	1
Band 3 Ward Clerk	1
Consultant	1
Band 7 Ward Manager	1
	6.35

4. Service cost

The cost of the service is reflected below;

Note:

CFT is able to offer significant efficiencies by utilising existing properties

Home Treatment Team:

The HTT provision will be improved through two measures;

- Expansion of the team to include full cover until midnight every day of the week
- Establishment of an 'alternative provision fund'

The key components of the expansion of the team are;

1. Model of operation

The service will operate have two shifts, operate from East and West bases, with the additional provision of an out of hours service. The operational times will be:

	Start	Finish
Early	8:00:00 AM	4:30:00 PM
Late	3:30:00 PM	12:00:00 AM
Out of hours	8:00:00 PM	8:00:00 AM

2. Rostered staff

Each shift will require the following number of staff working at any time:

	Qualified	Unqualified
Early	8	2
Late	8	2
Out of hours	1	1

3. Non-rostered staff

A band 7 manager will oversee the service, and a band 3 adminstrator will support it

4. Service cost

The cost of the service is reflected below;

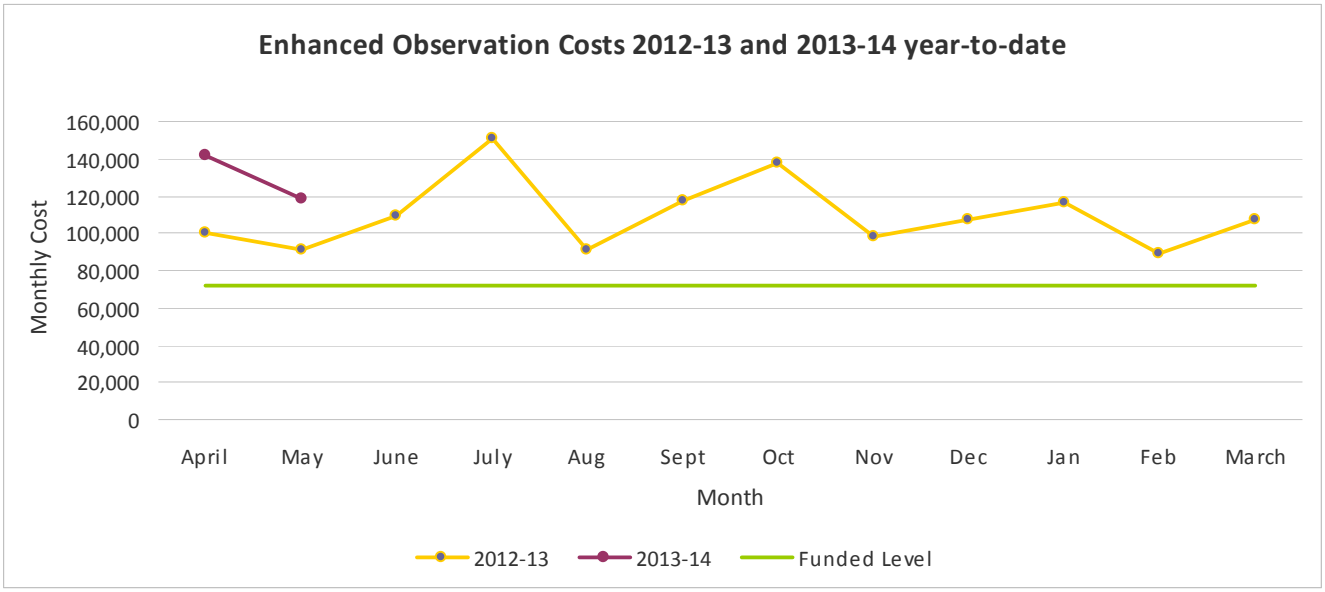
The Alternative Provision Fund will be a pot of money which will be used by practitioners to identify suitable alternative provision to inpatient facilities for service users. This funding will be used to either enable a service user to stay out of hospital from the outset, or to enable service users to be discharged earlier than they would have.

We estimate that the Alternative Provision Fund will have an annual budget of £100,000, though believe that it will avoid greater costs than this through reduced admissions and shorter periods of stay. As this is an innovative approach the evidence of the need for this fund will be gathered once it starts to operate.

Safe staffing levels:

The Trust has been grateful for the recognition commissioners gave to the need for additional funding for enhanced observations in 2013/14.

The spend on enhanced observations for the financial year 2013-13 and the first two months of 2013-14 is represented in the following chart:



The chart demonstrates the pressure upon the enhanced observation funding in the current service delivery model. The Trust believes however that the introduction of a Frailty Unit will provide some additional benefits by providing more focussed care to our most vulnerable patients, thereby reducing the need for some enhanced observations. As such the Trust is seeking the retention of the existing funding of £866,000 recurrently.

Management Business Case (ensuring safe delivery)

Purpose

This section sets out the organisational approach to ensure delivery of the benefits required in a controlled environment within timescale and budget.

Project Approach

To achieve this principles of Managing Successful Programmes (MSP) and PRINCE project management methodology, both world recognised methodologies for major project delivery, will be applied to ensure controlled and managed delivery of this proposal.

In keeping with this , and assuming a successful Business Case, a Project Initiation Document (PID) will be produced early on in the development of the programme that details the arrangements and timescales for delivering the most cost effective build programme and business change.

In addition the Trust is required to apply its own Capital Project Control Manual (which sets out the process for managing a capital scheme). The procedures set out in this manual will be implemented where ever possible within the Project within the confines of the PRINCE methodology.

Project Structures

A dedicated Project Board will be convened.

The Project Board has overall control of the timescales and deadlines for delivery of the various aspects of the Project. The Project Board will itself convene Sub Groups who will have devolved control and responsibility to deliver aspect of the workload and deadlines as dictated by the Project board.

Project Board Terms of Reference

Terms of reference		
Frequency of meeting	Weekly initially with a review once PID has been published.	
Reports to	Executive Management Team – monthly	Exception reporting
Chair	SRO	
Membership (Additional attendees may be invited when particular issues are under consideration and they need to report on progress or answer questions)		Estates and Facilities Programme Manager Senior Therapist Service Line (Associate Director) Service Manager

Receives reports from	• Sub Groups	Reports received in standard format required from each sub group for each meeting of this group.
Quorum	the meeting will be quorate with at least one of each group listed below present: • Chair or identified deputy • All sub group Chairs or identified deputy • Someone identified to take minutes	Cabinet decisions will apply.

Roles and Responsibilities

This group is overall accountable for the delivery of the project and overseeing progress across all of its component sub-programmes or projects for:

1. monitoring progress
2. managing programme level risks
3. managing programme level issues
4. managing dependencies between the programme's sub-programmes or projects
5. Committing (or sourcing from elsewhere) resources across the programme to enable the activities to be successfully achieved.
6. Any issues the Project Team is not able to resolve will be escalated to the project board for resolution.

The project team provides assurance that:-

1. robust project management disciplines are being adopted;
2. the programme is continuing to address the business requirements it was designed to fulfil; and
3. the programme will deliver acceptable outputs

Procedural Requirements

1. Project Meetings will have published Agenda and have action points or minutes taken.
2. Agenda Items can be identified by any Project Team member identified in time for the next meeting's agenda.

Subgroups

1. The Project Team will receive copies of the Sub Group minutes and accept agenda items requested by the work-stream chairs onto its own agenda for discussion, information and decision.
2. The group can request specific reports from Sub Groups and place items on their agenda for their engagement / discussion and response.
3. This group can form and disband Sub Groups, as it deems suitable, to achieve the aims of the overall programme.

Risk and Issue management

Risks are defined as possible impediments to the programme and an Issue is a risk that has occurred (previous identified or not).

Risk and Issues will be rated in accordance with the Trust overall Rag rating (five by five) rating process a single Risk and Issue database will be created for the Programme.

- The Risk and Issue reports will be a standing agenda item for the Project Board.
- All risks and Issues will have an Identified named person who will manage that issue/risk. Progress on such plans will be reported to each Project Board until mitigation has been delivered.
- **Escalation of Programme risks to Corporate Register -** Any risk or Issue that rates above 15 points on the risk register must be discussed and a resolution and action plan to mitigate the risk/Issue agreed by the receiving Project Board.

Due to the requirement for live services to be relocated and supported during the programme the Programme will have the ability to identify an issue that arises that will directly impact either patient or staff safety through an emergency Project Board Meeting to review any such Issues that arise.

If a Risk or Issue cannot be mitigated to below 15 it will be immediately identified to the Trust Main Risk register and Trust Risk Manager for their involvement.

Quality Plan

The Senior Responsible Owner will be the ultimately accountable person for the overall quality of the programme and its deliverables. This is discharged through the Programme Manager and Change Managers.

Resource control plan

The Project Board is the only group to have resource and budget commitment powers and has overall control of the Project Budgets. It may, from time to time approve sub groups to manage a budgeted amount of resource.

Timescales, Sequencing and Tranches of Work

At this early stage of development the programme currently can only define estimates of deadlines for delivery. This will change as tranches of work are fixed and contracted for.

The programme will work to deliver the overall work plan in as fast a timescale as possible within constraints of safety and resources available.

To allow visibly of the progress the project will group tasks into “tranches” which when completed will allow review of the early benefits and to assess the overall progress of the Programme. The tranches will be pulled together into a logical sequence of completion. The tranches and sequencing will be continuously reviewed and monitored for the risk they present within the overall programme.

An outline ‘pencil plan’ for the delivery of the Frailty Unit is attached as Appendix 1.