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Mental Health in England

Laying the foundations for better acute mental healthcare

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Description	Laying the Foundations is a workbook designed to assist those involved in the review, planning and re-design of their adult acute mental health services and to inform any related capital developments being proposed. This publication will therefore be of equal benefit to all mental health related Planning, Estates and Commissioning departments.
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Laying the foundations for better acute mental healthcare

A service redesign and capital investment workbook

Laying the foundations for better acute mental healthcare

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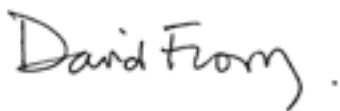boasts the following environmental credentials:

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Foreword

'Laying the Foundations' is an excellent practical workbook. It provides the context and a step-by-step process for local stakeholders to analyse their current acute mental health provision and to strategically plan services to meet the future needs of their local population.

Commissioners and providers of acute mental health services should make themselves familiar with this workbook. It provides a very helpful basis for developing a shared perspective and ownership of the challenges and for engaging with other key stakeholders. It will assist better-informed service commissioning and capital planning decisions, encouraging stakeholders to think about the scope of future provision and how investment in new buildings can enable effective delivery of the appropriate service model and care pathway(s).

It is universally recognised that a poor physical ward environment can have a detrimental effect on the well-being and recovery of service users. Within acute mental health, too many facilities are of poor quality and in need of refurbishment or replacement. To address this, the NHS has been undertaking the most significant mental health capital investment programme since its foundation in 1948.
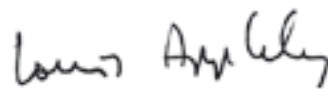
This joint collaboration between Care Services Improvement Partnership (CSIP) and the Department of Health (DH) Gateway Review, Estates and Facilities Division recognises the importance of putting much more focus on ensuring that acute mental health facilities are fit for purpose. We need to realise the full benefit from the opportunity presented by the current investment programme, and share learning and best practice.

A new Health Building Note is currently in preparation that will focus on the specific design requirements of adult acute in-patient units. Completing the five-step process detailed in 'Laying the Foundations' should be seen as a necessary precursor to any "case for change" decision that new buildings are needed and to ensure the best-value investment.

The step-by-step process outlined in 'Laying the Foundations' involves robust consideration and feedback on how services and buildings can best be organised and designed to facilitate desired outcomes. It could also be usefully adapted and applied by other client groups considering the redesign of their services and investment in new facilities.

David Flory
Director General of NHS Finance Performance and Operations

Professor Louis Appleby
National Clinical Director for Mental Health

Acknowledgements

Executive summary

This workbook provides assistance for commissioners and providers of acute mental health services seeking to improve and develop their current services. It involves a step-by-step process of strategic analysis and modelling, summarised below.

Towards acute mental health service redesign and capital investment – The five-step approach

ASKING THE RIGHT QUESTIONS	GATHERING INFORMATION	WHAT IT MEANS FOR YOU
Step One		
What are your aims and desired outcomes?	What are the national policy drivers, legal requirements and evidence for acute mental healthcare?	How well are you doing against these and what challenges remain?
	What are your service aims and desired outcomes?	
Step Two		
What does the model pathway look like?	What are the local whole-system influences on demand?	What does an ideal integrated care pathway look like for your area? What relationships do you need to enable effective functioning between service components?
	What capacity will be needed to flexibly meet the demand?	
	In what ways, and with what effects, could this capacity be apportioned to the service components?	
Step Three		
How well does your current service model fit the desired care pathway?	What is the gap between the ideal model and your current care pathway in terms of numbers of places, apportionment and efficiency?	Are new facilities necessary to enable quality improvement in the whole acute care pathway?
	What are the options for improving the efficiency of the care pathway and service users' experience of it?	
Step Four		
How can you make the best use of your capital investment?	How can you improve patient, staff and carer experience of acute in-patient services?	What are the potential capital investment options to facilitate the achievement of desired outcomes and an optimum care pathway? What are the implications of the options for different service user journeys and different stakeholder perspectives?
	How can links between in-patient services and other components of acute care work best for service users?	
Step Five		
How do you formalise your capital investment?	How does all this plug into the formal planning processes for capital investment? Progressing to Health Building Note	What steps will you take to formalise your capital investment?

Laying the foundations for better acute mental healthcare

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Introduction

This workbook is designed to assist those involved in the review, planning and redesign of adult acute mental health services. It is intended to help you to make decisions about investment both in developing service components such as Crisis Resolution/Home Treatment (CRHT) teams and in new adult acute in-patient units and related facilities.

It provides a step-by-step process for stakeholders to determine how best to enable local delivery of the whole system of acute care envisaged in the National Service Framework for Mental Health (NSF) (DH, 1999), rather than prescribing any set solutions or building templates. It is intended to test assumptions that new buildings are needed to facilitate improved care, and to work through options for service redesign first. If, after this process, the decision is taken to build new acute facilities, project teams should then refer to the current Health Building Note 35 – 'Adult acute in-patient units' (DH, 1996; being revised) for detailed planning and design guidance.

1. to identify the aims and priorities of your service and the outcomes you would like your acute care service to achieve in line with national and local policies;

2. to assess the required capacity of the acute care service and the desired roles of its component parts based on likely future needs-led demand;

3. to evaluate how well your current service arrangements fit the desired service configuration, identifying any gaps or potential for redeployment of existing resources to better fit the estimated needs-led demand, and to determine whether or not new buildings would be required to achieve this;

4. to assess key issues to determine how you would get the most benefit out of any proposed capital investment in new or refurbished buildings; and

5. to draw up a plan for the transition to the formal Business Case process including a declaration of how your service vision is to be implemented.

Who should use it?

People involved in reviewing, commissioning and providing local acute mental healthcare services for adults, and those thinking of planning investment in new buildings for acute mental healthcare, will benefit from working through this process. The process should be undertaken in a multi-stakeholder context with the involvement of commissioners/purchasers at an early stage and the involvement of service users, carers and acute care staff at all stages. In line with the 'Mental Health Policy Implementation Guide (MHPIG): Adult acute in-patient care provision' (DH, 2002), each provider trust should have an Acute Care Forum (ACF) to inform the process and facilitate the involvement of key stakeholders.

Aims of this document

The workbook is based around the following five key steps:

Scope of the document

Throughout the document, "acute care services" refers to the whole system of provision for those in acute mental distress – a system that needs to include CRHT and in-patient care options as integrated components.

This workbook does not specifically cover services for adults over the age of 65 years, child and adolescent mental health services, or forensic provision. However, the process outlined in the workbook can be usefully adapted for review of these services and in considering connections and care pathways between these services and adult acute services.

Context

The NSF (DH, 1999) led to the start of major modernisation of adult acute mental health services. Considerable investment has enabled the establishment of over 340 CRHT services to provide community treatment alternatives to hospital admission. CRHT

services delivered over 95,000 episodes in 2006 (National Audit Office (NAO), 2007).

Since 1992 over £1.9 billion has been invested in renewing the mental health estate in England – the most significant capital investment programme since the founding of the NHS (Mental Health Strategies, 2007). Provision of psychiatric intensive care units, respite/crisis houses, and modern in-patient wards with single rooms and better facilities is now more common across the country, but much still remains to be done before this becomes the norm.

In-patient provision is not the only component of modern acute mental healthcare, but it remains a vital one for service users at their most distressed and vulnerable. While there have been many improvements, there is still a range of concerns associated with in-patient provision, as identified in the adult acute in-patient MHPIG (DH, 2002), and other literature, including:

- lack of access to alternatives to admission;
- overcrowded wards/high bed occupancy and delayed discharges;
- arrangements for safety, privacy and comfort;
- poor-quality ward environments;
- issues of inequality (race, gender);
- insufficient staff contact;
- lack of meaningful activity for service users;
- poor continuity of care arrangements between community and in-patient services;
- problems with substance misuse; and
- stigma and social exclusion associated with admission.

Many of these issues were assessed as part of the 2006/07 Healthcare Commission's (HC) review of acute in-patient services (Healthcare Commission, 2007).

Why is this document needed?

Many areas have improved their services and buildings, but there is still some way to go nationally to deliver the whole system of acute care envisaged in the NSF. Some current provision and planned capital schemes may be over-reliant on traditional split hospital/community perspectives and allegiances.

In these cases, there is often not enough emphasis on such key considerations as:

- how buildings can be planned to assist the treatment model and important care pathway relationships, such as between CRHT and acute in-patient wards;
- how buildings can be used to reduce stigma, create opportunities and promote social inclusion and community engagement and education about mental health issues; and
- the interdependency of all elements of the acute care service – in particular the impact of new components of the service (such as CRHT) on the delivery of in-patient care.

Some existing schemes may have suffered from needing to accommodate wider estates and financial imperatives; such as when acute mental health is part of a larger general hospital replacement, where the clinical aims and joint working philosophy of the whole system of acute mental healthcare may be compromised. Fractures may then occur between "acute in-patient hospital" and "community" services, with negative consequences for patient care and the use of resources. Time pressures on Business Cases can also lead to initial aims being overlooked, and a failure to use the reprovision as a catalyst for positive public consultation and attitudinal change.

Without proper whole-system planning, there will be unnecessary admissions, delayed discharges and overcrowded wards – all of which are detrimental to a person's recovery. Buildings are tools that should be used to enable the delivery of an improved acute care model focused on recovery and social inclusion.

There is a continuing momentum of investment and improvement in the development of acute mental health services. However, there is a need to ensure that service and capital planning decisions are consistent with current policy direction. We should ensure best use of this opportunity to use our skills and resources to improve the quality of services and the care environment for service users, carers and staff. Local stakeholders asking the right questions are key to enabling a strong foundation for service provision and estates development.

How to use the document

The following pages will guide you through a process of examining acute mental health services from first principles. By asking the right questions about who the service is for, what the key service components and connections are, and where and when they should be available, stakeholders can then start to consider how things could be commissioned and provided locally to best enable service improvements.

Table 1 Towards acute mental health service redesign and capital investment – The five-step approach

ASKING THE RIGHT QUESTIONS	GATHERING INFORMATION	WHAT IT MEANS FOR YOU
Step One		
What are your aims and desired outcomes?	What are the national policy drivers, legal requirements and evidence for acute mental healthcare?	How well are you doing against these and what challenges remain?
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	What are the options for improving the efficiency of the care pathway and service users' experience of it?	
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How can you make the best use of your capital investment?	How can you improve patient, staff and carer experience of acute in-patient services?	What are the potential capital investment options to facilitate the achievement of desired outcomes and an optimum care pathway? What are the implications of the options for different service user journeys and different stakeholder perspectives?
	How can links between in-patient services and other components of acute care work best for service users?	
Step Five		
How do you formalise your capital investment?	How does all this plug into the formal planning processes for capital investment? Progressing to Health Building Note	What steps will you take to formalise your capital investment?

There are five steps to be undertaken in sequence (see Table 1 above – The five-step approach). Steps One to Three encourage stakeholders to first think about the general context of acute care, the design of their whole local care pathway, how the in-patient service can be embedded within this, and how services might best be commissioned and provided. You should only move on to planning for this in steps Four and Five if completion of the first three steps has resulted in a clear case for new facilities, estates redesign or refurbishment. These later steps encourage planners to reflect upon the purpose and care pathway context of an in-patient admission and how this may be facilitated by the physical environment. At this point, when Business Cases for capital investment are being developed, planning teams should consult the latest DH capital

planning and building design advice at www.dh.gov. uk/en/Managingyourorganisation/Estatesandfacilities management. This can be done with the confidence that there is a solid case for change, with clearly expressed needs and defined outcome measures.

Each step begins with open-ended questions that are intended to provoke debate and reflection among stakeholders about how best to improve local acute care services and make best use of resources. This is to enable planners to articulate and record the basic principles behind their services and proposed improvements and to test their ideas together. While this work should be based on core values and general national policy direction, specific developments will need to be tailored to local contexts.

Each step is accompanied by a commentary explaining the relevance of the questions. There are also 12 suggested tasks to work through to assist groups to develop a clearer picture of what they want their service to achieve, what redesign work is needed, and finally what, if any, building development is required.

"Real life" case studies of projects within the NHS are used to illustrate potential solutions to the challenges of redesigning the acute care pathway and providing appropriate facilities.

There is a strong emphasis throughout on the need to focus on facilitating improved service outcomes. The steps will lead local stakeholders to be clearer about what success should look like for them in terms of desired outcomes. This in turn should enable them to evaluate and monitor developments and their degree of success in achieving the desired outcomes. Key outcomes could include better service user satisfaction, prompt access, reduced lengths of stay and re-admission rates, fewer delayed discharges, reduced out-of-area spending, reduced suicide and untoward incident rates, better rates of return to employment or education for service users, and improved staff morale, recruitment and retention.

Definition of the acute care pathway

What is meant by the "acute care pathway" or "acute care service"?

Acute mental health services exist for those people experiencing, at risk of, or recovering from a mental health crisis, and comprise a number of key component service elements. The term "acute care pathway", used throughout the document, refers to the journey a service user makes from initial referral to discharge from acute services. An "integrated acute care pathway" refers to the interlinked services and agencies working together to support service user and carer needs and achieve the desired outcomes. An effective pathway is one where all those involved in providing the service share aims, priorities and values as well as operational policies. The relationships between the component parts are as important as the qualities of the parts themselves. There need to be clear arrangements in place for the cohesive overall management of a locality's acute care services.

What are the core component services of the acute care pathway?

Crisis Resolution/Home Treatment Team (CRHT): a mobile multi-disciplinary team operating 24 hours, seven days a week, which provides treatment at home for those acutely unwell but not requiring admission, gate-keeps (assesses the appropriateness of) in-patient admissions and facilitates early supported discharges. The policy implementation guidance (DH, 2001, 2006 [Fidelity Statement]) recommends that a standard CRHT of 14 staff covers a population of 150,000. While home treatment constitutes the major part of a CRHT's workload, the team also provides intensive support to help people be discharged from in-patient care earlier than would otherwise have been possible.

Respite/Crisis house provision: in some areas, the CRHT can access and support people in crisis beds, which are provided for those who cannot be treated at home but do not need to be admitted to an acute in-patient unit. This provision is usually made in ordinary supported housing in partnership with local voluntary or social care organisations.

In-patient beds: are an essential part of an integrated acute care pathway, intended to "provide a high standard of humane treatment and care in a safe and therapeutic setting for service users in the most acute and vulnerable stage of their illness" ('MHPIG on adult acute inpatient care provision', DH, 2002). Admissions are considered where this would play a necessary and purposeful part in a person's progress to recovery from the acute stage of their illness.

Acute day treatment services: provide an alternative to admission for people who are acutely unwell, and are a means of facilitating early discharge and preventing re-admission. Acute day treatment services may be provided as an integral element of an acute unit or as a stand-alone facility.

Psychiatric intensive care units (PICUs): part of the overall acute service, providing a more intensive level of in-patient support and intervention for those people exhibiting high levels of agitation or disturbance, as well as for those who may be particularly vulnerable. PICUs usually serve a wider catchment area population than a CRHT or admission ward. They can be sited as a stand-alone unit adjacent to other mental health in-patient facilities or as a ward within a larger unit (see the MHPIG on national minimum standards for PICUs, DH, 2002).

Place of safety provision: a small suite of rooms for the emergency psychiatric assessment of those detained by the police under Section 136 of the Mental Health Act. These have often traditionally been located in police

stations, but it is now considered far more appropriate to site them within mainstream healthcare, adjacent to or as part of an acute unit.

Step-down and supported housing accommodation: some services find it helpful to develop partnership arrangements with voluntary and independent sector providers to ensure that discharge of a patient from acute care is not inappropriately delayed.

The core component parts and key relationships between functions of the acute in-patient care pathway are shown in Figure 1 below. Fuller descriptions and good practice examples of each of these component services can be accessed via the Virtual Ward website at www.virtualward.org.uk.

Figure 1 The acute in-patient care pathway
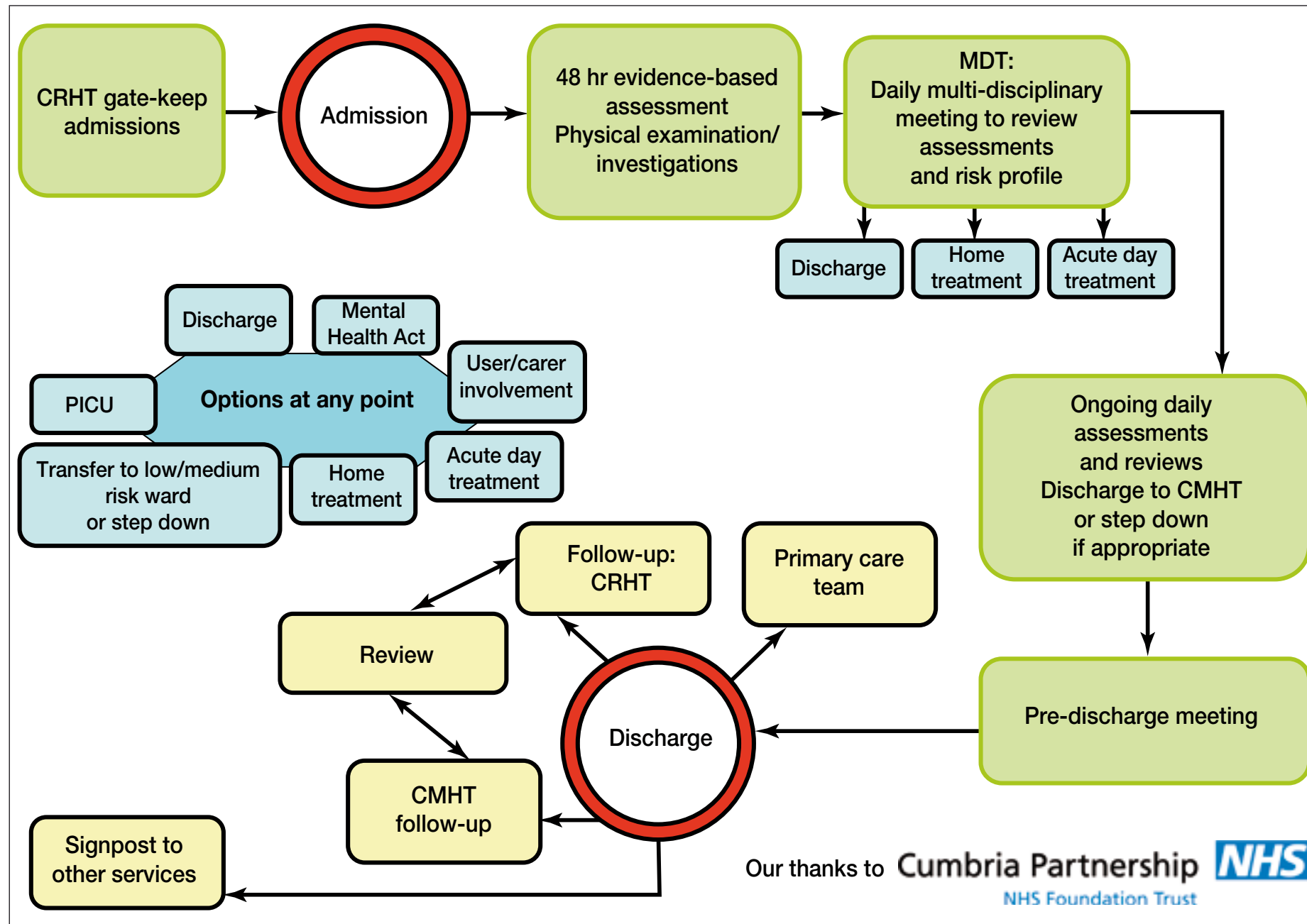
Step One: Defining service aims and desired outcomes

Key questions

- What are the national policy drivers underpinning adult acute mental healthcare?

- What evidence is there for effective adult acute mental healthcare?

- How do you define specific service aims and outcomes?

What are the national policy drivers underpinning adult acute mental healthcare?

Acute mental health services are a core and integral component of the NSF model of care, and need to provide:

"timely access to an appropriate hospital or alternative bed or place, which is in the least restrictive environment consistent with the need to protect them and the public – as close to home as possible." NSF Standard 5 (DH, 1999)

While the numbers of acute in-patient beds have declined as new community teams and alternative options to admission have been introduced, it must be recognised that they are still an essential component of the care pathway. One of the benefits of the introduction of these new services should be not just to reduce an over-reliance on in-patient admission but to positively influence the quality of the in-patient service, for example by reducing high occupancy rates and overcrowding. To achieve such gains it is crucial that in-patient wards have integrated working arrangements with the community elements of the acute care service.

In 'NSF for mental health: Five years on' (DH, 2004), the National Director for Mental Health noted that there was still substantial work to do in improving in-patient environments:

"… there are in-patient wards in use that are not suited to the care of distressed people. A comprehensive, sustained programme of repair and replacement is now required ... to eradicate all unsuitable wards through increased capital investment …" (DH, 2004)

Further emphasis was also given to the importance of safety for staff and service users in in-patient settings, particularly the urgent need to take steps to ensure that no female service users suffer intimidation or inappropriate sexual behaviour.

The national Dignity in Care Campaign (Social Care Institute for Excellence, 2007), having been extended to mental health services, draws particular attention to the need for more emphasis on issues of personal safety and autonomy, privacy, an enabling therapeutic environment, and advocacy.

When thinking about redesigning acute care, it is vital that flexibility is built in to the new services to accommodate change. The way care is provided and funded has changed much in the last ten years, and is likely to continue to do so in the next ten. A major driving force in the recent development of mental health services has been the importance of providing care that promotes the social inclusion and recovery of the service user.

Services are also expected to tailor a care package around the "whole person" needs of the service user based on their strengths and preferences, in a move away from the purely medical model of care (although medical interventions are still central). Service users are encouraged to collaborate in planning this care package, and in an increasing number of cases are making use of the Choice Framework (CSIP, 2005) to pick and choose elements of care, which they may then pay for using individualised budgets. Emerging Foundation Trusts are striving to become centres of excellence in providing such responsive care, in an environment where competition for "'business" will increase in future.

This new policy and service landscape is constantly evolving, and services and associated capital schemes need to be flexible enough to continue to respond to the challenges thrown up by new models of care, funding

models, and organisational changes – particularly in terms of reshaping and accommodating our acute mental health services.

What evidence is there for effective acute mental healthcare?

The organisation and operation of acute mental health services is dependent on local circumstances, resources and flexibilities. However, there is a growing body of evidence (from service experience and formal research) about the effectiveness of different practices in terms of service user and carer experience and satisfaction, effects on other elements of the service, staff morale, and user outcomes. In addition, it is useful to view the national picture for benchmarking purposes and to illustrate the issues and challenges commonly faced by acute services and how they can be overcome.

Planners should consider the following types of evidence when thinking about their aims and priorities:

- In 2007 the Healthcare Commission (HC) carried out a service review of all statutory NHS acute in-patient mental health providers. The results and national report will be published in summer 2008. The HC's assessment framework, which underpins the reviews, and the accompanying CSIP handbook 'Onwards and upwards' (CSIP, 2007), provide a basis for benchmarking its criteria and desired outcomes mapped against comprehensive policy references. Both can be downloaded via www.virtualward.org.uk.

- National data against which organisations can benchmark their own services, such as the Mental Health Services Mapping work and the DH Situation Reports (SITREPS) on delayed discharges.

- Feedback evidence about the experiences of service users, carers and staff, including the national patient and staff surveys and the Star Wards initiative. See www.starwards.org.uk.

- The HC's 2006/07 'National audit of violence findings' (HC, 2008): although the focus is on violence, it provides useful evidence across a broad range of relevant issues.

- Evidence about the clinical and cost-effectiveness of types of care for different acute mental health problems such as NICE guidance and the NAO CRHT report (2007).

- Local feedback, including reports from Acute Care Fora.

- Good practice examples from other organisations and countries about what works. Substantial resources can be accessed on:

  - the Virtual Ward website at www.virtualward.org.uk;

  - the DH website at www.dh.gov.uk/en/Managing yourorganisation/Estatesandfacilitiesmanagement;

  - DH's Knowledge & Information Portal at http://estatesknowledge.dh.gov.uk.

This evidence should be collected as a resource library to be used throughout this process of reviewing and planning acute mental health services.

Task 1: Defining specific service aims and outcomes

Table 2 on page 10 is designed as a downloadable template (from www.nimhe.csip.org.uk/silo/files/ltf-template.doc) to assist you in developing and defining the specific service aims and desired outcomes for your local service. This should be treated as a "live" document, to be updated as new policy and evidence emerges and decisions are made. It should be completed for the overall service and should define the specific roles and relationships of each of the main components of the acute service (for example CRHT, day treatment, respite, in-patient units, PICUs). The table provides a mechanism for identifying what the service is aiming for and how progress will be monitored and evaluated. You should populate this table with the information most relevant to your local redesign exercise.

Column 1 identifies seven basic principles to guide all acute mental health service developments. You may wish to add your own to these.

Column 2 provides support for these principles in the form of indicative national policy and evidence. It was not feasible to give an exhaustive list of all the potentially relevant references; these will vary depending on your local redesign priorities. The Virtual Ward website at www.virtualward.org.uk is a source of many relevant references, links and good practice examples specific to acute mental health services. In addition, the electronic handbook 'Onwards and upwards' (CSIP, 2007), also located on the Virtual Ward website, has an extensive list of hyperlinked references to key policy documents and publications.

Column 3 is for defining the specific, measurable outcomes you wish to achieve. These need to be clearly articulated and agreed locally, and should be explicitly defined criteria by which you can monitor and evaluate the success of any redesign and development of services. Indicative desired outcomes have been included, but these need to be customised to your local situation. The HC's 2007 acute in-patient assessment framework can usefully inform the stage of defining local outcomes.

Column 4 is for recording what your service is currently achieving on each service outcome measure detailed in column three. This will provide a baseline from which to consider whether or nor you currently have adequate key performance indicator and feedback information available on which to measure progress. It will also give you an idea of the areas where your service has shortfalls or does not have the seven principles embedded in policy and practice – which may then become priorities for service development.

Column 5 is for inserting variables and factors of particular local importance (see also Step Two). They may be related to local demography, geography, organisational factors, future plans, or anything else affecting local achievement of the desired outcomes. Your desired outcomes and capacity planning will be influenced by local factors. For each of the local influences, assess what this will mean for development of acute care services locally and how it affects desired outcomes for these services. Keep asking, "How might this impact on our services in future?"

Step One Checklist

By completing Step One you will:

✓ have set out the national policy priorities that must be embedded in any service redesign or reprovision;

✓ know where to find principal sources of evidence about acute mental health services and have a plan for keeping up to date with emerging evidence;

✓ be clear about the desired outcomes you wish to achieve from your overall redesign/reprovision project and what success will look like in these specific terms; and

✓ know the level of current achievement on these dimensions and articulate the challenges to achieving desired outcomes.

Table 2 Template for Task 1: Defining specific service aims and outcomes (download from www.nimhe.csip.org.uk/silo/files/ltf-template.doc)

Principle	Supporting policy and evidence	Desired outcome example	Current position	Local drivers
1. Service user and carer involvement	• Service users and carers need involvement in their own care planning, as well as wider operational and strategic planning. *(HC Criterion 4))* • Many service users and carers do not feel adequately involved in decisions about their care planning arrangements. *Effective care co-ordination in mental health services (DH, 1999)* *Reviewing the Care Programme Approach (DH, 2006)* *Onwards and upwards (CSIP, 2007)* *No voice, no choice: A joint review of adult community mental health services in England (HC, 2007)* *Healthcare Commission acute inpatient assessment framework (HC, 2007)* *Refocusing the Care Programme Approach: policy and positive practice guidance (DH, 2008)*	• All service users and carers feel they are in control of their care plan and collaborate with clinicians in decisions. • Service users feel they have a say in planning of/changes to services they use. • Carers are provided information about relevant medical matters, coping strategies and signposting to sources of support. • Access to advocacy services is ensured.		
2. Effective care pathway with appropriate admission and discharge arrangements	• Service users should be able to rapidly access an appropriate level of acute care, which can then be "stepped down" in a timely manner as they recover from the acute episode. *(HC Criterion 1)* • Not all acute care should be in a traditional "hospital setting" – alternatives to admission must be available if clinically appropriate. *Mental Health Policy Implementation Guide: Adult acute inpatient care (DH, 2002)* *Guidance statement on fidelity and best practice for Crisis Resolution Teams (DH, 2006)* *A positive outlook: A good practice toolkit to improve discharge from inpatient mental healthcare' (CSIP, 2007)* *The role of Crisis Resolution and Home Treatment services (NAO, 2007)* *Healthcare Commission acute inpatient assessment framework (HC, 2007)*	• Improved response times for assessment in a crisis. • Access to full range of alternatives to admission, such as crisis accommodation, respite care and day units. • Reduced time from assessment to admission for those who require it. • Reduction in length of stay and % delayed discharges. • Reduction in out-of-area placements. • Carers are involved in the assessment at or after the admission and in the creation of the discharge plan.		

Principle	Supporting policy and evidence	Desired outcome example	Current position	Local drivers
3. Equity of provision	• An equally high standard of service should be accessible to all, and effort should be made to ensure that services are approachable to groups that have been less well-served in the past, such as minority ethnic and rural communities. • Engagement and involvement of the community is a crucial part of planning and running of mental health services and of reducing stigma. • Rates of admission and detention are disproportionately high for some black and minority ethnic (BME) groups. *Delivering race equality (DH, 2005)* *Count me in 2007 (HC, 2007)* *Mainstreaming gender and women's mental health: implementation guidance (DH, 2003)* *Age equality Guidance note Everybody's Business (CSIP, 2007)*	• Referral and admission rates from community agencies and localities improve. • Provision of culturally and gender appropriate services. • Locally specific BME and gender outcome measures. • Monitor impact of distance from home on length of stay.		
4. Individualised whole-person care	• The needs, abilities and aspirations of the whole person should be at the heart of any service; the service user should not be conceived of in terms of their illness alone. This philosophy necessitates close working between health and non-health agencies. *(HC Criterion 2)* • People should be supported to maintain their independence and have services built around their needs. • All service users should have a choice of treatment appropriate to their background, age, etc. • All service users should have their drug and alcohol use assessed. *Our health, our care, our say (DH, 2006)* *Our choices in mental health (CSIP, 2005)* *Dual diagnosis in mental health (DH, 2002)* *Healthy body, healthy mind (NIMHE, 2004)* *Inspiring hope (NIMHE, 2003)* *Healthcare Commission acute inpatient assessment framework (HC, 2007)*	• More service users report satisfaction with the choices they are offered and the support to make choices. • Reduction in number of re-admissions. Improved admission experience for service users and carers. • Bed occupancy levels should never exceed 100%. • 100% physical health screening on admission. • Provision of pharmacy/medication education is available to all. • Service user faith observance and spiritual needs are facilitated.		

Principle	Supporting policy and evidence	Desired outcome example	Current position	Local drivers
5. Promotion of recovery and social inclusion	• Services should take active steps to promote recovery and the social inclusion of service users and help to improve their life chances, including helping them back to work. *(HC Criterion 2)* • Commissioners of acute in-patient provision should seek to develop services in socially inclusive settings that reflect a positive vision of mental health to the community served. • Services should focus on a person's strengths with the aim of improving quality of life and community involvement. *Mental HPIG: Adult acute inpatient care (DH, 2002)* *Mental health and social exclusion report (ODPM/SEU, 2004)* *Commissioning framework for health and wellbeing (DH, 2007)* *Healthcare Commission acute inpatient assessment framework (HC, 2007)*	• Wider range of activities available during evenings and weekends. • More community involvement in developing and supporting service provision. • Number of service users going back to work, into education, gaining qualifications and skills. • Service users are satisfied with the range of options available to help them improve their quality of life through support to get into education, return to employment, etc.		
6. Ensuring the safety of service users, staff and visitors	• Acute mental health services must be sources of comfort and help, and service users and staff should feel security of person, particularly in in-patient settings. Women can feel particularly vulnerable in these settings. Preservation and promotion of dignity, safety and security for all service users should be a primary consideration. *(HC Criterion 5)* • A significant number of women wish to receive care in a women-only ward or self-contained unit within a mixed ward. • Eradicate in-patient wards that provide unsuitable environments. • Prevention of drug misuse in in-patient units is a priority.	• Access to PICU and health-based place of safety provision available when needed. • No unsuitable environments for acute care by 20XX. • Rates of serious untoward incidents, sexual safety incidents, and suicides while an in-patient are regularly audited and reduced. • Rates of missing patients are regularly audited and reduced. • Choice of single sex environment available to those who require it. • In-patient environments are free from drug and alcohol misuse.		

Principle	Supporting policy and evidence	Desired outcome example	Current position	Local drivers
6. Ensuring the safety of service users, staff and visitors *(contd)*	*NSF for Mental Health: 5 years on (DH, 2004)* *Safety, privacy and dignity in mental health units (DH, 2000)* *MHPIG on national minimum standards for PICUs (DH, 2002)* *2006/07 National audit of violence (HC/ RCPsych, 2007)* *Breaking down barriers (DH, 2007)* *National suicide prevention strategy (DH, 2002)* *Safe and therapeutic management of aggression and violence (DH, 2004; being revised 2008)* *Dual diagnosis in mental health inpatient and day hospital settings (DH, 2006)* *Healthcare Commission acute in-patient assessment framework (HC, 2007)*			
7. Developing well motivated staff with appropriate skill mix	Staff must be provided with a decent working environment, appropriate training, and defined career development pathways. *From values to action: Chief Nursing Officer's review of mental health nursing (DH, 2006)* *New ways of working for psychiatrists (DH, 2005)* *Mental health: new ways of working for everyone (DH, 2007)* *Mental health: new ways of working for everyone – a best practice implementation guide (DH, 2007)* *More than just staffing numbers (CSIP-NIHME, forthcoming 2008)* *Acute inpatient mental health care: education, training and continuing professional development for all (NIMHE/ SCMH, 2004)* *Creating capable teams approach (DH, 2007)*	• Qualified and experienced staff are engaged in front-line clinical care for most complex cases. • Staff are trained to be competent in the assessment and clinical management of substance misuse. • Reduce sickness absence rates by x%. • Reduce use of agency and bank staff by x%. • Determine career progression pathways for all staff by 20XX. • Increase proportion of XX-language speakers among staff by x%. • Staff satisfaction surveys.		

Step Two: Planning the acute care pathway

Key questions

- **What local factors will influence demand on your local acute care pathway – including the whole system of agencies providing care to service users?**

- **What should your model acute care pathway look like?**

- **What is the capacity required to meet demand across the pathway?**

- **How should this capacity be apportioned between components?**

The next step is to determine the required overall acute care service capacity to achieve these outcomes and to meet anticipated demand. Below is an outline of why it is necessary when planning total capacity to consider predictable influences on future service demand (Task 2) and the wider system of services available locally to people in acute distress (Task 3).

Considering how best to make use of and work in partnership with the range of agencies and services that impact on the quality of life and recovery of a service user in acute care is vital when planning capacity. They may not provide direct care, but their services (such as respite, housing or employment services) may be essential to a person's ongoing well-being, recovery, and the effective operation of mental health services.

Tasks 4 and 5 are designed to help you model the potential care pathway options and estimate the total capacity required for your catchment area(s) and to apportion this capacity between the component care pathway services. Traditionally, predicting demand for a service has been over-reliant on projecting current and historic service use into the future. While geographic, demographic and morbidity trends and influences are very important, by themselves they present too narrow an interpretation of issues, complexity of need and potential solutions.

Service redesign work provides an opportunity to look more creatively at how the whole system of acute

services functions and how changes to one component can affect demand elsewhere.

Task 2: Assessing influences on demand and capacity

Identify the specific needs and predictable influences on future overall demand for acute services in the immediate/medium term (over the next five years) and the longer term.

To estimate overall service demand and potential influences on future demand, you will need to assess the effect of a number of local variables – examples of which are shown in Table 3 below.

Task 3: Mapping wider system capacity planning

- Identify those local agencies that can directly care for acute service users or provide services that aid their recovery and help improve their quality of life.

- Discuss with those agencies what their plans for the future are, and think about how this will affect demand for your service.

- Consider potential partnership opportunities.

Organisations other than the NHS may directly provide care or accommodation capacity. In a wider sense they can help to interrupt a circle of social exclusion that can result in frequent re-admission, protracted lengths of stay and further exclusion on discharge. Such agencies have enormous potential to reduce the need for over-dependence on acute care services. Forecasting of future demand and planning of acute mental healthcare services should be undertaken in consultation with these partner agencies and should be a feature of local health and social care agreements.

Task 4: Modelling your ideal care pathway

There are a number of tools available to model demand and required capacity, which can help with optimal care pathway design. One useful approach is the system

Table 3 Task 2: Assessing influences on demand and capacity

Local variable	Example	What it means for future service demand
Geography	• Population density and dispersal • Distances and travel times	
Demographics	• Deprivation levels and variations in morbidity • Age profile • Ethnicity profile • Gender profile	
Historical trends in service use	Including access and discharge rates for each component of the service	
Organisational context	• Short-, medium- and long-term goals of organisation • Key relationships and potential partnerships with local agencies • Changing patterns of provision in the local health economy	
Effect of proposed future health and social care service redesign and of achieving desired outcomes from Step One	Future effect on demand of tackling present health inequalities and variance in access rates	
Predictable changes affecting our future population	• Major housing developments, commercial developments etc • Migration	
Existing estate situation	Number of buildings and sites – their functioning and appropriateness of their fit with the model of care	
System factors that may impact on demand	Planned actions of other agencies that service users access may divert demand to or from health services	

dynamics method (NHS Confederation, 2005), which uses software to simulate and appraise potential future service scenarios and map how changes in one part of the system can affect other parts, to aid decisions about care pathway design and capacity. CSIP's 'Acute workload calculator' (2005) provides a spreadsheet-based capacity tool to assess the workload implications of proposed service redesign.

There are other documents available that describe the principles of whole-system planning, such as CSIP's Integrated Care Network's 'Whole system working' (2006) and the guidance on integrated acute care systems in the Adult acute in-patient MHPIG (DH, 2002). The joint strategic needs assessment framework outlined in the 'Commissioning framework for health and wellbeing' (DH, 2007) may also provide a useful model for thinking about basic predictors of demand.

An integrated care pathway (shown in Figure 1 on page 6) is required to coordinate delivery of the most

appropriate level of care at different stages of the illness. While you may require some interrelated care pathway services, such as a PICU, to serve more than one catchment area, all acute care pathway services should adhere to a number of shared principles and policies to ensure integrated service delivery in practice.

Ask how the service overall and the component services can be organised according to the principles identified in Task 1, while constituting a safe, efficient and effectively coordinated service. Key organisational arrangements should include:

• single management and unambiguous lines of responsibility;

• consistent gate-keeping procedures;

• consistent care planning arrangements across the pathway;

• single assessment at point of entry, including risk assessment, which is consistently revised;

- discharge planning from the start;

- a clear purpose for each admission to the pathway; and

- effective and consistent communication mechanisms between clinicians, teams, and agencies.

Task 5: Estimating and apportioning the capacity required

- First, estimate the total capacity required to meet demand across the pathway for acute care in your "optimum care pathway" identified above.

- Secondly, determine how this total number of acute treatment places needs to be apportioned across the service components (and catchment areas). Be clear about relationships between services and maximise care pathway integration. Consider whether there are potential workforce flexibilities for staff to work across services or to extend current service availability.

Using information from the modelling undertaken in Task 4, test different ways of apportioning total acute care capacity across services by asking the following key questions:

- How many places should be provided by the Crisis Resolution/Home Treatment team(s)?

- How many places in crisis houses or respite beds?

- How many acute day treatment places?

- How many acute in-patient beds?

- How many PICU beds?

- What supported housing/social care provision needs to be in place and how should it be provided?

- How might the component services best be combined to serve your catchment area(s)? You may find it useful to map the potential options geographically.

Step Two Checklist

By completing Step Two, you will have:

✓ articulated the whole system of influences on current and future demand and capacity of your acute mental health service;

✓ estimated future service demand based on whole-system considerations;

✓ modelled your ideal acute care pathway relationships; and

✓ estimated the capacity required of each component of the acute care service for the catchment areas served.

Step Three: How well does your current service model perform?

Key questions

- How well do current services perform against the Healthcare Commission assessment framework for acute in-patient services?

- Does the current acute care service have sufficient capacity against the optimal capacity plans/service choices developed in Step Two in terms of numbers of places?

- Are new facilities necessary to enable quality improvement across the whole care pathway?

- What are the options for reconfiguration of existing resources?

This step sets about carrying out a gap analysis to identify the difference between the current acute service model and the desired desired outcomes and ideal care pathway identified in Steps One and Two. This will highlight what is not functioning well and/or what is not available or in the wrong place.

Task 6: Reviewing performance against the Healthcare Commission assessment framework for acute in-patient services

The assessment framework within the Healthcare Commission's 2006/07 acute in-patient service review of all statutory mental health providers (HC, 2007) provides a basis for evaluating and benchmarking the performance of your acute in-patient service against four key criteria:

- There is an effective care pathway that ensures that admission to hospital is appropriate and that discharge from hospital is timely.

- In-patient services provide individualised whole person care that promotes recovery and inclusion.

- Service users and carers are involved in care planning, in how the ward is run, and in operational and strategic planning, evaluation and development.

- The ward has systems, processes and facilities in place to ensure the safety of service users, staff and visitors.

Review how well the local service performs against the Healthcare Commission's assessment framework. What changes would help to improve performance?

Before considering commissioning any new mental health accommodation, there is a need to re-examine existing services and care pathways and to evaluate how effectively things are working. In particular there is a need to evaluate the relationship between in-patient services, Crisis Resolution/Home Treatment and post-discharge support services. It may be that redeploying capacity and making the care pathway more efficient means that there is not a need for new or extra physical accommodation.

Remember that when things go wrong in the care of vulnerable people, it is very often not just deficiencies in particular service elements that are the cause; rather, poor links between different elements and a lack of single oversight for the whole patient journey are often cited as principal contributory factors.

Task 7: Mapping current services against the ideal model

Map the component services of your existing adult acute mental healthcare pathway(s) against your ideal service model. Represent the current capacity for each element.

Then ask:

- Are there gaps between the overall whole-system capacity requirements identified in Step Two and the current situation?

- Do you have all of the elements in place to provide for the range of needs identified?

- What services are working well, and how could this be built on?

- How might current resources be redeployed across service elements to provide a more integrated service and a better match with your estimated demand?

- How could flexibility be introduced to cope with future fluctuations in demand, and evolving service models?

Task 8: Mapping service user and carer journeys through the acute pathway

Map service user and carer journeys into, through, and out of acute services, recording the decisions that are required along the way. Use specific maps to represent particular journeys and sets of needs. What problems can be identified that affect the service user or carer experience or efficiency of the service? What are the potential solutions?

Indicators that the current pathway is not working efficiently may include:

• above-average admissions via Accident and Emergency;

• overcrowded wards – occupancy levels over 90% – which will compromise therapeutic engagement;

• large numbers of delayed discharges, which may indicate poor service cohesion, lack of housing capacity or related problems with discharge planning; or

• inappropriate admissions or high re-admission rates, which may indicate inefficient gate-keeping procedures, or lack of adequate alternative community service provision.

For each stage of the journey, note:

• average timescales and delays between stages;

• bottlenecks;

• any lack of agreement about responsibility;

• crossing of organisational and professional boundaries;

• current inconsistent practice; and

• problems from a provider, service user and carer point of view.

Task 9: Are new facilities necessary to enable performance improvement in the identified areas? What are the options for accommodating reconfiguration of existing resources?

Ask which option has the potential to make a greater impact – investment in new facilities rather than the reconfiguration of services alone, or reconfiguration plus re-use of existing physical assets – by looking at the following issues:

• Are new facilities necessary to achieve your local priorities and national policy aims? How?

• Are new facilities required to enable in-patient services to be more fully integrated into the acute care pathway? How? Could this be achieved through redesign of care pathways and/or reorganisation/ refurbishment of existing buildings?

• Would new facilities help improve the experience of in-patient services for service users, staff and carers? How?

If your planning group agrees that capital investment is required to facilitate an improved acute care service, you should progress to the next section on optimising capital investment.

Step Three Checklist

By completing Step Three, you will:

✓ have identified any gaps and imbalances in levels of current acute care provision;

✓ have determined the priority actions necessary to improve service user experience of the acute care pathway and to meet the demand identified in Step Two; and

✓ be in a position to determine whether system redesign alone will enable you to meet your aims and desired outcomes for the acute care service OR whether capital investment is necessary.

Step Four: How can you make the best use of your capital investment?

If completion of the first three steps has highlighted the need for capital investment, this step looks at key building and design issues that you should consider so that the buildings can best fit the service model and facilitate the desired outcomes – whether by a new build or by the refurbishment/rearrangement of existing provision. The following tasks should inform the rationale for the development and appraisal of the potential capital development options, which involves looking at the configuration, functional content and location of the building options available.

All services need to be as integrated as possible to maximise safety, recovery and inclusion. While the policy drivers and desired service model may ideally suggest small-scale, local, integrated building solutions, there is not a one-size-fits-all answer. Services start from different positions, addressing different catchment area needs, with a different range of resources and flexibilities available to them.

Communal living area, Sandwell Park Unit, Hartlepool

Task 10: Fitting the buildings to your service model

Six key issues have been identified that should be addressed regarding the proposed capital investment in new or refurbished/redesigned acute facilities or review of your existing arrangements. Depending on local circumstances, there may be other key issues you want to add for your planning team to consider.

For each issue, you should consider:

- What do service users, carers, staff and other stakeholders experience at present as a result of the current situation? Does it meet their needs?

- How can the service user, carer, staff and other stakeholder experiences be improved?

- How can these changes help to achieve the desired outcomes defined in Step One?

The planning group should be aware of the 24-hour life-cycle of the current acute care services, through direct experience and observation and by calling "witnesses" to this life-cycle such as service users, carers, clinicians, domestic staff and night staff. Role-playing key processes such as admission, "a day in the life" of the ward, discharge etc may also prove informative.

Issue 1: Where should your facilities be located?

This will be very dependent on what resources and opportunities are available to you. Some potential drivers for location include:

- geography of the catchment area – urban, rural, mixed;

- characteristics of the population(s) served;

- current service availability/unavailability and access rates;

- distance from home, travel times and transport links. A local study in Staffordshire (Macmillan and Adams, 2005) suggests that an in-patient length of stay may be prolonged the further away the person lives. In addition to service user and carer accessibility and convenience, longer journey times will also have consequences for effective staff utilisation and for the overall carbon footprint of the service;

- ensuring a critical mass of staff;

- access to general health and social care facilities;

- site availability/redevelopment potential of existing sites; and

- anticipated planning timeframes.

Showell Green Lane Unit, Birmingham (opening May 2008)

One common feature influencing decisions on the location of new mental health facilities has been "not in my back yard" (NIMBY) opposition to potential development, whether real or perceived. Encouraging community involvement is vital in the planning process, as this can help to overcome NIMBY attitudes and help to increase opportunities and tolerance and promote whole-community mental health.

Developments in new locations also provide the opportunity for greater employment in the area, reflecting the diversity of the catchment area served, which contributes to regeneration and increased prosperity.

Planning groups should consider the benefits of locating acute services close to or integrated within other existing healthcare services, for instance primary care services, rather than purely alongside other mental health facilities.

Another determinant can be the need to redevelop and regenerate existing mental health sites in which most current resources are tied up. Redevelopment of large sites can provide opportunities to prioritise the location of new/replacement mental health facilities so that they integrate with on-site housing, commercial and community developments, that is, developing neighbourhood community facilities adjacent to the acute unit rather than the other way around. In this way, a mental health development can provide benefits to the wider community and surrounding environment in addition to the benefit of the mental health services it provides.

Example 1

Birmingham and Solihull Mental Health Trust treated their Sparkhill/Sparkbrook development as a positive opportunity to raise awareness of mental health issues and tackle stigma. Through an award-winning process of community engagement and involvement, they overcame initial opposition and hostility and have successfully involved the community in the design of the new unit, creating the basis for a long-term constructive partnership with local community organisations.

For more information go to the Birmingham New Hospitals Project website at: www.bsmht.nhs.uk/trustinformation/NHP.htm or contact www.bsmht.nhs.uk/General/GeneralContactUs.htm

Example 2

South West London and St Georges Mental Health NHS Trust are redeveloping their Springfield University Hospital Site of over 30 hectares to mix new mental health facilities with a variety of new non-mental health uses on the site. Their approach is not to develop a smaller separate mental health campus but, by integrating a range of mental health services with community, retail and leisure facilities, to create an environment that addresses the former isolation of the site from the community and the stigma associated with mental health treatment.

For more details go to the Trust website at www.swlstg-tr.nhs.uk

Issue 2: How should facilities be planned to accommodate integrated whole-system delivery of acute care?

There is strong evidence to suggest that well-integrated acute mental health services that jointly manage and co-locate key elements of their local acute mental health services are achieving the most positive outcomes in terms of:

- preventing unnecessary admissions;

- fewer delayed discharges and shorter lengths of stay;

- improved understanding and flexibility of staff skills;

- better informed and coordinated care planning and risk management; and

- improved cost-effectiveness.

The integrated working of the CRHT team and the acute admission wards is particularly important, and a number of the more successful services are those that have chosen to co-locate these service elements in the same premises under a single management structure to enhance this joint working. When commissioning new units or services, particular consideration should be given to accommodating the CRHT team in the adult in-patient unit. Within existing services, consideration should be given to ways in which more effective co-working might be potentially assisted by co-location or, if this is not feasible, how more closely-integrated working between CRHT and in-patient services might be physically accommodated.

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Example 3

Sussex Partnership NHS Trust's Meadowfield Hospital in Worthing opened in 2001 serving a catchment area population of 300,000. Meadowfield, an award-winning design, originally opened as a 48-bed adult acute unit with three 16-bed wards all with individual en-suite facilities. The Crisis Resolution Service (CRS) has recently been integrated into acute care and now falls under a single management structure. The CRS has focused on implementing effective gate-keeping as well as facilitating early discharge from the in-patient service. Along with a number of initiatives implemented within the wards, the CRS has assisted in achieving significant reductions in bed occupancy and average length of stay. As a result, only two of the wards are used for adult acute and the remaining ward has been re-designated for older people who are experiencing acute mental health problems. This has assisted in the integration of older people's and working-age services, with the management structure, facilities and group activities all striving to achieve an "ageless" acute mental health service for the locality.

For more details contact: Theresa.dorey@ sussexpartnership.nhs.uk

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Maple Ward, Meadowfield Hospital, Worthing

Issue 3: How can the distress of admission to an in-patient unit be minimised?

How people are initially received may well set the tone for the rest of their stay, whether this is at a hotel or a psychiatric in-patient unit. Admission to an in-patient unit is by its very nature a daunting and bewildering experience for service users and carers, especially if it is an involuntary or first admission. Yet service users and carers tell us that too often in the past not enough attention has been given to what is needed to reduce anxiety and improve their admission and reception arrangements. Careful consideration needs to be given to modelling the various admission journeys from leaving home to arrival and reception at the in-patient unit.

Clear arrangements need to be put in place at the point of reception to make service users and carers feel welcome, informed and involved. This should include specific space for waiting, refreshment, information and advocacy services. There are a number of services where such features as cafés, family and children's visiting areas and service user-run information offices have been incorporated into the reception facilities.

Issue 4: How best to ensure personal safety and security while remaining therapeutic?

A feeling of personal safety and security is essential to a service user's programme of recovery and a fundamental dignity in care requirement. Planning groups need to carefully consider how both service arrangements and facilities can be designed to promote this. In-patient units need to be safe, containing and therapeutic, with proper attention paid to reducing the risk of service users harming themselves or others and to overcoming some of the design and space limitations of past provision. While safety must be assisted by the reduction in the means of self-harm, suicide, missing patients and trespass, safety is not solely or primarily an issue of physical security provision. As indicated in Issue 1, the overall service safety and individual risk management require that more attention be paid to facilitating communication, continuity of care and joined-up risk assessment by the service components involved and by planning accommodation to assist this process.

Nonetheless, particular attention should be given to:

- **Provision of circulation space:** evidence from the National Patient Safety Agency (NPSA, 2006) and elsewhere indicates that it is in areas of high traffic that many untoward and violent incidents occur. Creating a sense of space by generous provision of circulation space (some architects recommend 40% of total floor space) is particularly important in helping to reduce the potential "pressure cooker" atmosphere often associated with in-patient units.

- **Gender separation:** effective gender separation in acute in-patient units is fundamental to achieving a safe and therapeutic environment. This is a particular issue for women in-patients, many of whom have histories of abuse, including sexual abuse. The physical environment plays an important part in achieving this, although gender-sensitive policy, practice and training are at least as important. The NHS Institute for Innovation and Improvement recently published good practice guidance: 'Privacy

Adult en-suite bedroom, Sandwell Park, Hartlepool

and dignity: The elimination of mixed sex accommodation' (2007), which includes a section on mental health. This reinforces current policy on mixed sex accommodation (DH, 2000/2007 [Chief Nursing Officer's Report on Privacy and dignity]). Key components include:

– gender-separated sleeping and bathing areas must be provided;

– bedrooms should be individual and preferably en-suite;.

– bathing and toilet facilities should be accessible without passing through areas shared by men and women; and

– provision of single-sex day space and external areas should be considered.

Zoning of accommodation to provide distinct male and female areas can provide effective gender separation within mixed wards. This may be an appropriate response in smaller or more specialised units in particular. Needs assessment and user consultation should underpin decisions to provide single-sex wards. In some communities a mixed-sex environment outside the family is an alien concept and women-only provision may be needed to meet cultural, in addition to clinical, needs.

- **Children visiting:** there should be dedicated visiting space, located immediately adjacent to the ward, where patients can visit safely with their children. These should be appropriately furnished in a homely way and with sufficient play materials. See the Mental Health Act Code of Practice (DH, 1999) and 'Parents in hospital' (Mental Health Act Commission, 2007) for further guidance.

- **Access and egress:** 27% of in-patient suicides occur when in-patients go missing from the ward (University of Manchester, 2006). How entry and egress are to be designed and managed needs careful consideration to achieve a satisfactory balance between preventing patients going missing and trespass while avoiding the creation of a too-custodial environment. Helpful guidance on how best to achieve this has been produced (Rae, 2007).

- **Clean and safe:** service users also have the right to receive care in a safe environment that is smoke-free and free from drug and alcohol misuse. Trusts need to have clear policies about how they will create and maintain such an environment.

Much good practice in the provision and management of restricted yet therapeutic environments for acute mental healthcare has been achieved in the development of PICUs, which provide care for patients in a more acutely disturbed phase of their illness. The National Association of Psychiatric Intensive Care Units (NAPICU) is a useful source of advice and information; see www.napicu.org.uk.

Example 4

Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust has recently opened a small five-bed PICU in Doncaster, which was partly funded by a successful bid against the Department of Health capital allocation in 2006 for improving PICUs. The PICU, which is part of the adult acute unit and incorporates a Section 136 facility, places a strong emphasis on achieving an environment that balances security and inclusion and on enabling continuity of therapy and engagement. Features include high levels of service-user involvement in the design, controlled entry systems for main doors and all rooms, good natural light and external spaces.

For more details contact Deborah.wildgoose@rdash.nhs.uk

See main cover photograph

Issue 5: Are service arrangements facilitating social inclusion and maximising opportunities for therapeutic engagement and recreation?

Acute in-patient provision needs to be designed to maximise the opportunity for therapeutic engagement and to protect service users' support networks and community connections. "Boredom and lack of anything to do" has been an often-cited complaint from service users about in-patient care. The potential consequences of boredom include untoward incidents, missing patients and impeded recovery. Adult acute in-patient wards/units need to include multi-purpose large and small group activity spaces that can accommodate a varied timetable of therapeutic and recreational activities, including at evenings and weekends, with opportunities for activities to take place both on and off the ward. Particular attention should be paid to ensuring good access to gardens and outdoor spaces, and to their design.

As the MHPIG for adult acute in-patient care states:

> "The service should be a stepping stone to social inclusion and assist in promoting participation in the mainstream of society". (DH, 2002)

Services should have practical arrangements in place to enable service users to keep up their community links and contacts. It is also important to encourage in-reach to the acute unit from local agencies that offer employment, training, housing and social support by providing them with access to facilities and space. In addition to the implications for size and location of services, providing accommodation for evening and weekend activities and encouraging community in-reach suggests a need to rethink the roles of such traditional acute unit accommodation as the "day hospital" and the "occupational therapy department". The space they offer could make a meaningful contribution towards developing more flexible activity provision, which can be a catalyst for community use and partnerships and help reduce stigma and exclusion.

There is a range of service improvement initiatives that provide a rich source of good-practice examples to assist and inform acute mental healthcare development. These include:

• the Virtual Ward website at www.virtualward.org.uk

• Star Wards at www.starwards.org.uk

• the AIMS project at www.rcpsych.ac.uk/AIMS

• STEPS at www.virtualward.org.uk

• the DH website at www.dh.gov.uk/en/Managing yourorganisation/Estatesandfacilitiesmanagement

• the New Ways of Working website at www.newwaysofworking.org.uk

Issue 6: What are the options for configuring the service?

There are three principal options, with a range of variants:

Option 1: Centralised mental health "campus" model

This option concentrates all or most of the in-patient facilities in a trust's catchment area on one site, usually comprising a range of adult acute and specialty services, often co-located with other mental health services.

Example 5

Northumberland, Tyne and Wear NHS Trust's St Georges Park development in Morpeth, Northumberland, opened in 2006. This is a 201-bed mental health hospital serving a county-wide catchment area population of 318,000. Provision includes three 17-bed adult acute wards, a 15-bed PICU and a specialist 6-bed mother and baby unit on a shared site with older people's mental health in-patient and day services. Features include separate but linked small-scale buildings to reduce any institutional feel to the site, a majority of en-suite bedrooms and a wide range of treatment and support facilities.

For more details contact Tony.Railton@ntw.nhs.uk

Option 2: Locality units

In this configuration, services are dispersed in smaller units serving local catchment area needs. The focus is on delivering an acute service that combines new in-patient facilities with an integrated CRHT function, usually supported by access to crisis/respite beds and day treatment options.

St George's Park, Morpeth

Examples 6 and 7

Norfolk and Waveney Mental Health Partnership NHS Trust's Carlton Court acute mental health unit in Lowestoft opened in 2005. This is a 20-bed unit purpose-built to accommodate an integrated acute care service that provides for Waveney, one of the Trust's six localities, serving a population of 130,000. A pioneering aspect of this service model is that there is a single integrated acute care workforce that works across in-patient and CRHT services and that can be flexed in response to service demand. This approach may be helpful in overcoming the commonly-experienced loss of staff from "hospital" to "community", and some of the staff cover issues sometimes associated with smaller units.

For more details contact Debbie.White@nwmhp.nhs.uk

Tees, Esk and Wear Valleys NHS Trust's Sandwell Park mental health unit in Hartlepool opened in 2006 serving a locality catchment area population of 152,000 people. Sandwell Park provides two discrete wards: a 20-bed ward with en-suite bedrooms for adult acute mental health that includes gender-specific areas and a 16-bed ward for older people. The CRHT is located within the unit and is integral to the working of the acute ward. The ethos of this unit is very much one of local community engagement, and it has developed strong connections, with local mainstream services regularly taking service users out of the unit to use community social and recreational services.

For more details contact Ian.trodden@tney.northy.nhs.uk

Option 3: Core and cluster

This option usually involves specialised services grouped together at a "core" hospital site with local catchment area beds/services in smaller units within the community they serve.

Task 11: Testing out the service configuration and capital options

Produce a shortlist of the range of service configuration options available to you and test their initial feasibility and implications for the delivery of your service aims and desired outcomes. You should refer to the optimal capacity and care pathway designs developed in Steps One and Two.

This may by necessity be a complex task, especially when considering major service and associated capital redevelopment. You may find it helpful to carry this out in three stages as follows:

1. Start off with a diagram of your desired care pathway including key relationships and interfaces. Do this for each of the locality catchment areas served and for the total catchment area.

2. In this care pathway context, focus now on each of the individual acute care services (acute admission wards, PICU, CRHT, day treatment, place of safety) that the proposed capital development addresses, and for each component identify its key functions and accommodation needs. A simple diagram of the functional components can then be drawn that can assist you in identifying connections and further developing the shortlist configuration options to be tested.

3. Develop a functional organisation and process diagram for each configuration option identified and identify which options best facilitate the delivery of your service model and desired outcomes for further analysis as part of the formal capital planning and procurement processes.

Step Four Checklist

By completing Step Four, you will have:

✓ considered key strategic issues in terms of current stakeholder experiences and how these might be improved in future;

✓ determined a shortlist of options for the proposed capital development required to address service need and to inform the future design process and allow the investment to facilitate service aims; and

✓ tested a shortlist of potential configuration options for your service to determine the best ways to facilitate the model care pathway and desired service outcomes.

Step Five: Formalising your capital investment

Decisions relating to capital investment for the delivery of mental health services need to be seen alongside the trust's broader business strategy and estates strategy, which may be driven by conflicting requirements. The DH website has an evolving "Index and Route Map" for all capital investment projects: www.dh.gov.uk/en/Managingyourorganisation/Estatesandfacilities management/DH_4118956.

The advent of NHS Foundation Trusts has brought the needs of a business strategy into sharp focus, and in England from April 2007 the New NHS Capital Regime applies to all NHS trusts. The aims are to:

- replace capital funding via Public Dividend Capital with interest-bearing loans;
- "incentivise sound financial management";
- require trusts to generate sufficient surplus cash flow to finance capital investment;
- encourage retention of cash generated through operations for reinvestment;
- enable trusts to borrow to finance further capital investment subject to a Prudential Borrowing Limit (PBL) and ability to service the debt.

An estates strategy is increasingly seen as part of an organisation's effective management of its assets. The DH's 'Capital Investment Manual' (2007), 'Developing an estates strategy' (2005) and 'Estatecode' (2007) provide collective guidance on the estate strategy requirements that underpin estate investment decision-making in support of service development. An estates strategy is a requirement of Business Case submissions to Strategic Health Authorities and DH.

Step Five is where you summarise the key decisions underpinning your proposed need for capital investment, after working through the tasks in this document – to produce the case for change. It is important that it is easily understood and can be communicated to a wider audience including:

- service users and carers;
- staff;
- voluntary agencies;
- external professionals such as architects;
- Strategic Health Authorities;
- commissioners;
- local authority elected members and officers.

Typically, this should draw on the kernel of the project and encapsulate the major objectives, ethos and themes that characterise the proposed service. It should become the centrepiece that drives the "project brief", which will necessarily become more elaborate as the scheme develops and should feed into the formal brief development alongside Health Building Note guidance. It should also be written with a view to being a benchmark by which the project outcomes can be assessed.

Task 12: Summarising your project to inform intended capital development proposals

Summarise your decisions from the steps in this workbook in a form that can be taken forward into the strategic and financial option appraisal of the formal capital investment process (see Appendix 1). You may find it useful to develop a summary statement identifying and prioritising the key requirements, challenges and benefits for each of the shortlisted options that you have developed.

This should include:

- **key service principles, aims and desired outcomes,** based on your development of the key principles, associated aims and outcomes outlined in the table in Step One;
- **a clear description of your preferred care pathway(s);**

- **key issues and operational requirements identified:** What are the priority issues you have identified? What needs to be done to enable your proposed care pathway?;

- **building requirements to facilitate the operational needs:** If the principles are to be upheld, and key outcomes achieved, what are the building requirements?;

- **monitoring and evaluation criteria:** How will you keep track of progress, and how will you know that you have successfully put operational and building requirements in place to uphold the principles? Achievement of the outcome indicators from Step One and performance against identified benchmarks should inform this.

Step Five Checklist

By completing Step Five, you will:

✓ understand the business capital planning and procurement process and how you will answer the demands of writing a Business Case, using your work from Steps 1–4; and

✓ have developed a clear summary of your work, linking service principles and objectives, the operational and building requirements to facilitate the achievement of these, and the criteria by which you will determine success.

Appendix 1: The capital investment process

When deciding to commit to a capital investment, there is a formal process to follow, including business planning.

Capital investment in the NHS follows the procedures set out in the 'Capital Investment Manual' (DH, 2007). It outlines the general good-practice principles that should be followed when commissioning a healthcare facility and bringing it into operational use.

The service planning work carried out in Steps One to Three determines the service objectives of any capital development. It is important that these objectives remain at the forefront in determining any decision to build new or refurbish existing buildings. They form a sound approach underpinning the capital investment process. If you are considering capital investment, you will have identified gaps in service and formulated an approach to delivering the service. You will need to:

- establish a formal project organisation; and

- develop a Business Case to support the capital investment.

For schemes requiring NHS Executive approval, trusts will be required to demonstrate that they have appointed individuals with the necessary skills and training, and have a project organisation in place to provide an appropriate and effective management structure. For any project, three major in-house roles need to be clearly defined:

1. the Investment Decision-Maker, who must consider whether the project fits the strategic direction of the organisation, its short- and long-term affordability, and whether it represents the best use of resources;

2. the Project Owner, usually the Chief Executive, who defines the project objectives and is responsible for ensuring that they are met;

3. a Project Manager to provide a single point of responsibility for the project brief and product design, and for the day-to-day oversight of progress.

Details of how to establish a formal project organisation are found in 'Capital Investment Manual – Project Organisation' (DH, 1994).

Preparing a Business Case

A Business Case must convincingly demonstrate that the project is both strategically and economically sound (through an option appraisal of the viable options to achieve your strategic direction outcome targets); is financially viable (affordable to the trust and purchasers); and will be well managed. In addition, a Business Case for any investment should show that the proposal has clearly identified "case for change" benefits for service users and that purchasers support it. The success of any major investment may ultimately depend on the extent to which purchasers support the resulting revenue consequences. The strong case for investment that you have built up by working through previous steps, and the fact that you can show how capital investment will help you to achieve your desired outcomes from Step 1, will be helpful in gaining purchaser support. Service commissioners should be part of the stakeholder groups from the start.

In Steps One to Three you will have covered much of the ground necessary for preparing a robust Business Case. It is therefore important to understand the process and plan for it carefully. It should clearly present valid answers to the key questions, for which you have already prepared substantial answers through your work so far:

- What services should be provided now and in the future?

- How will these service requirements be met in the most efficient and effective way?

- Why is capital spending proposed?

- How does this proposal offer good value for money?

The Business Case comprises three phases, which are set out with checklists in the 'Capital Investment Manual – Business Case' (DH, 1994). These are illustrated in Figure 2.

First Phase: consolidates the work already done and establishes the strategic context for investment. Typical outputs would include:

- documentation of the trust's capital investment strategy and clear business objectives;

Figure 2 The Business Case process
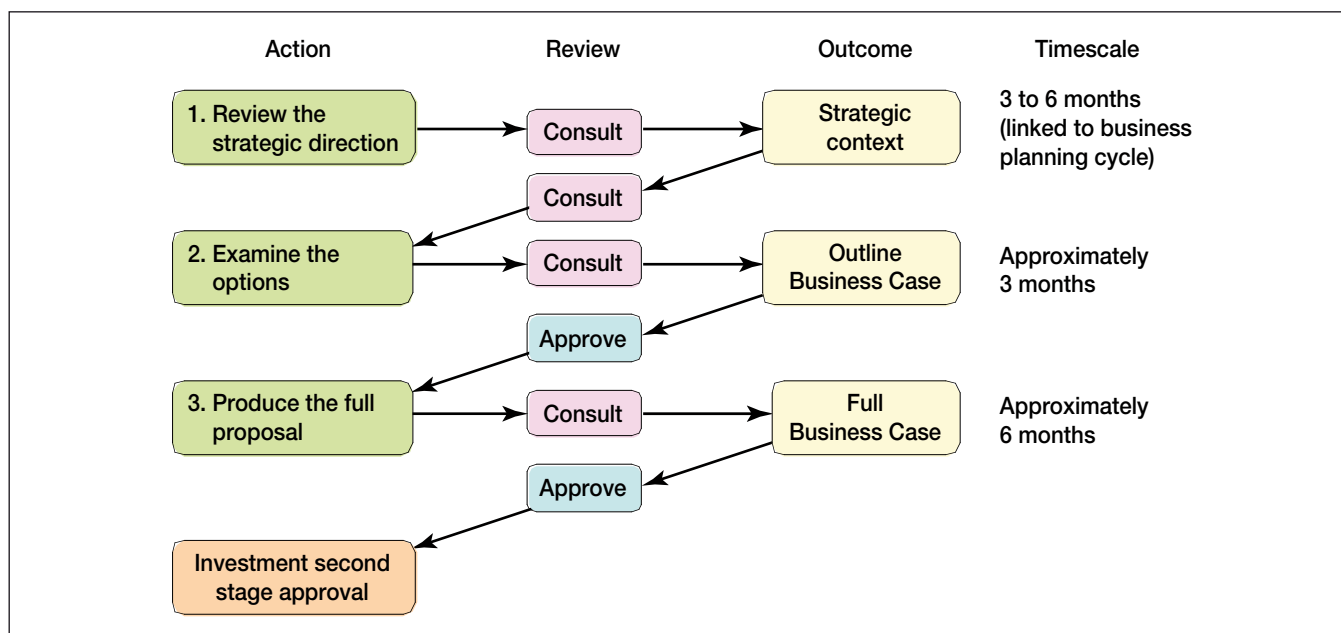
- demonstration of an understanding of the market within which the trust operates and the trust's own strengths and weaknesses;

- demonstration of the affordability of investment;

- an outline description of the services that the trust intends to provide in the future, noting areas for development and retrenchment; developments that are required and investment to purchasers;

- identification of specific service developments that are required; and

- an indication of the affordability of investment to purchasers.

Second Phase: the objective of the second phase is to identify the preferred option for the investment, through an objective investment appraisal process, and to develop an Outline Business Case. Typical outputs would include:

- the objectives of the investment;

- the shortlisted options and the costs, benefits and risks related to each option;

- workforce planning and revenue cost implications;

- initial design development of the preferred option, development of preliminary schedules of accommodation, and initial discussions with the planning authorities;

- the preferred option (in outline) and the impact on the trust's position in the market and ability to meet financial and service objectives.

Third Phase: once the Outline Business Case has been approved, the investment appraisal will proceed

to production of the Full Business Case. Normally trusts will proceed to Phase 3 only if capital funds have been identified and purchaser support obtained. Typical outputs would include:

- a review of Phase 1, including more precise quantification of future service requirements;

- a review of Phase 2, including validation of the main elements of the investment appraisal carried out for the Outline Business Case;

- detailed development of the preferred option; and

- formulation of plans for project monitoring and post-project evaluation.

Timescales

The elapsed time to conduct a Strategic Review and prepare Outline and Full Business Cases depends upon the scale of the potential investment, the resources deployed and its degree of complexity.

Indicative timescales for each phase of a typical investment are:

- Phase 1: three to six months (linked to the business planning cycle);

- Phase 2: approximately three months;

- Phase 3: approximately six months.

Clearly, small, straightforward schemes may take only a few months, while larger schemes can take much longer.

Glossary

ACF	Acute Care Forum
AIMS	Accreditation of Adult Acute Inpatient Mental Health Services
BME	Black and minority ethnic
CCTA	Creating Capable Teams Approach
CNO	Chief Nursing Officer
CPA	Care Programme Approach
CRHT	Crisis Resolution Home Treatment
CRS	Crisis Resolution Service
CSIP	Care Services Improvement Partnership
CSIP-NIMHE	Care Services Improvement Partnership – National Institute for Mental Health in England
DH	Department of Health
HBN	Health Building Note
HC	Healthcare Commission
LOS	Length of stay
MDT	Multi-disciplinary team
MHAC	Mental Health Act Commission
MHNSF	Mental Health National Service Framework
MHPIG	Mental Health Policy Implementation Guide
NAO	National Audit Office
NAPICU	National Association of Psychiatric Intensive Care Units
NICE	National Institute for Health and Clinical Excellence
NIII	NHS National Institute for Innovation and Improvement
NIMBY	"Not in my back yard"
NIMHE	National Institute for Mental Health in England
NPSA	National Patient Safety Agency
NSF	National Service Framework
ODPM SEU	Office of the Deputy Prime Minister Social Exclusion Unit
PBL	Prudential Borrowing Limit
PICU	Psychiatric intensive care unit
RCPsych	Royal College of Psychiatrists
SCIE	Social Care Institute for Excellence
SITREPS	Department of Health Situation Reports
STEPS	Successful Team Engagement in inpatient Psychiatric Services
VW	Virtual Ward website

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Useful websites

DH estates and facilities information:
www.dh.gov.uk/en/Managingyourorganisation/Estates andfacilitiesmanagement/index.htm

DH Knowledge and Information Portal:
http://estatesknowledge.dh.gov.uk

National Association of Psychiatric Intensive Care Units (NAPICU) website:
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New Ways of Working website:
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Star Wards website:
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