MH1 Patient Ward Communities, Implementing "Sense of Community" in High Secure Wards

Scheme Name	**MH1 Patient Ward Communities, Implementing "Sense of Community" in High Secure Wards**
Eligible Providers	The Three Providers of High secure MH services
Duration	April 2016 to March 2018 or beyond depending upon research protocol developed.
Scheme Payment (% of CQUIN-applicable contract value available for this scheme)	CQUIN payment proportion [Locally Determined] should achieve payment of £250,000 + B*£2,500 + C*£7,500, (B, C are patients respectively in partial and in full intervention arms, as in Payment Trigger section, below): Target Value: Add locally CQUIN %: Add locally
Scheme Description	
The aim is to implement an intervention across selected wards focused on developing a psychological *Sense of Community* (SoC). SoC is described as a sense of belonging, that individual members matter to a community and to each other, and that individual needs can be met through a shared community commitment (McMillan & Chavis, 1986). The aim is to implement the SoC in full on three wards, partially on three wards and not at all on three wards (i.e. community as usual group). This will allow for comparison across the wards to determine the impact of the intervention. The actual intervention will be recorded according to a taxonomy devised within the evaluation protocol. Interventions in the full and partial intervention arms of the trial should be costed respectively at £2,000 and £6,000 per patient (assuming a minimum of six months). This would be justified by staff assignment to roles supportive of the SoC intervention. The intervention would be assessed using a standard pre, during and post follow-up design where records of incidents, Security Information Reports, Suspected Bullying reports and ward atmosphere ratings are collected, with clinical records reviewed. It would also include use of the Psychological Sense of Community Index (SCI). The intervention will then be implemented and review of progress determined at eight weeks (during), and at two further time points of eight weeks (post 1 and post 2). The 25% premium for CQUIN incentives translates this scheme into a CQUIN payment of £250,000 + B*£2,500 + C*£7,500, (B, C as in Payment Trigger). Hence for a 180 patient provider, with 60 patients in partial and 60 in full intervention arms (for a minimum of six months), the CQUIN Payment would be £250,000+£150,000+£450,000)=£850,000. This figure as a proportion of the estimated contract value becomes the CQUIN payment proportion.	

Measures & Payment Triggers	
A. Commissioning by the three providers of an academically sound research trial to explore the effectiveness and cost-effectiveness of different interventions in creating ward communities and achieving better outcomes for patients. B. The number of patients in wards included in the in the partial intervention arms of the trial C. The number of patients in wards included in the in the full intervention arm of the trial	
Partial achievement rules	
Payment is contingent upon setting up a research trial as indicated. Payment is proportional to the number of patients receiving the interventions and the months during which they receive them, weighted by 3:1 for intervention vs partial intervention arm, as a proportion of planned numbers (similarly weighted) – capped at 100%.	
In Year Payment Phasing & Profiling	
Local determination. However, the costs of intervention should include some upfront set up costs, followed by more intensive involvement with the intervention wards to implement the scheme. Hence, costs will be incurred fairly evenly across the intervention period.	
Rationale for inclusion	
The change expected is an improvement in patient well-being through the development of being part of a positive community. It would do this by decreasing the risk for intra-group aggression. Any intervention that can develop a positive sense of community and enhance belonging and well-being would be expected similarly to improvement ward running, atmosphere and patient perceptions of safety.	
Data Sources, Frequency and responsibility for collection and reporting	
Reports to commissioners will be required detailing: - the commissioning of the research oversight of the trial - the staff assigned to support the full and partial intervention ars of the trial - the interventions undertaken in the course of the Trial, specifying the numbers of patients and duration of their involvement in each arm of the trial - the Trial evaluation	
Baseline period/ date & Value	N/A
Final indicator period/date (on which payment is based) & Value	As above.
Final indicator reporting date	Month 12 Contract Flex reporting date as per contract
CQUIN Exit Route *How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?*	For review following conclusion of evaluation – regarding whether the intervention is cost-increasing or otherwise

Supporting Guidance and References

SoC is described as a sense of belonging, that individual members matter to a community and to each other, and that individual needs can be met through a shared community commitment (McMillan & Chavis, 1986). It comprises four key elements, all of which will be addressed by the intervention:

1.) Membership: This includes creating emotional safety [security], a sense of belonging and identification [community acceptance], personal investment in the ward community, a common symbol [e.g. logo development] and boundaries.

2.) Influence: Increasing a sense of empowerment among the patient community which involves raising shared decision-making [e.g. teaching patients how to express views at community meetings, the importance of acknowledging the needs and values of others].

3.) Integration and fulfilment of needs: Building in rewards for participation in group aims; Identifying group similarities and building on these as shared group values.

4.) Shared emotional connection: Developing a shared history/community story through art; increasing opportunities for personal positive interaction; Ensuring no negative events are left without closure; increasing individual investment in a community; raising the potential for public community rewards and removing the risk of public humiliation.

The aim of such an intervention is focused on the development of a positive community as a means of enhancing feelings of safety and reducing incidents of aggression. It is becoming increasingly applied in non-secure settings, being utilised for example with gang related work.

Research suggests, for example, that intra-group aggression (e.g. patient bullying) is driven substantially by the environment and the community that is developed from this. Managing the community more effectively and developing a 'Healthy Community Approach' in the form of intervention and strategy is thought a primary means of enhancing safe living spaces. The more a community invests in each another, the less likely they are to display uncontrolled and manipulative aggression. Each element of the SoC will be designed to capture what is possible and appropriate at ward level. For example, the element of membership could comprise a ward activity focusing on developing a logo for their community [common symbol] and shared group activities [sense of belonging though group activities such as games].Boundaries would focus on input with patients on their expectations of behaviours towards one another and what as a shared community they consider acceptable.

Any intervention that can develop a positive sense of community and enhance belonging and well-being would be expected to similarly improvement ward running, atmosphere and patient perceptions of safety.