

## **HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE**

**20 AUGUST 2013**

### **OUTCOME OF NHS CONSULTATION ON ACUTE MENTAL HEALTH BEDS REDESIGN IN KENT AND MEDWAY**

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Leisure, Culture, Democracy and Governance

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#### **Summary**

This report advises Members of the decision of the Kent and Medway Joint Overview and Scrutiny Committee (HOSC), on 30<sup>th</sup> July 2013, to support NHS proposals for changes to adult mental health inpatient services which include the loss of 35 acute mental health inpatient beds in Medway and a requirement, thereafter, for Medway patients to access acute inpatient services in Kent. The Committee is invited to consider whether to accept the position or to report the matter to the Secretary of State for Health. A report can be made to the Secretary of State where the Committee is not satisfied that the NHS consultation with the Joint Overview and Scrutiny Committee has been adequate in relation to content or time allowed or where the Committee considers that the proposal would not be in the interests of the health service in its area.

#### **1. Budget and Policy Framework**

- 1.1. Medway Council has delegated the function of health scrutiny to the Health and Adult Social Care Overview and Scrutiny Committee and the Children and Young People Overview and Scrutiny Committee. This includes the power to report contested NHS service reconfigurations to the Secretary of State.
- 1.2. The Kent and Medway Joint Health and Overview Scrutiny Committee, rather than the individual KCC and Medway HOSCs, has been consulted by the NHS on the redesign of acute mental health services. This is because where the NHS is required to consult more than one local authority on any proposal for a substantial development or variation of the health service those local authorities must appoint a Joint Committee for the purposes of the consultation and only the Joint Committee may make comments, require information and the attendance by the NHS to answer questions.

- 1.3. As Kent County Council and Medway Council have not delegated authority to the Joint HOSC to exercise the power to report contested service reconfigurations to the Secretary of State this Committee and the KCC HOSC each preserve the power to make a report on this matter, subject to meeting the requirements for reporting.

## **2. Background**

- 2.1 Appendix A to this report provides an overview of the statutory consultation undertaken by the NHS with the Kent and Medway Joint HOSC on the proposed reconfiguration of acute adult mental health care in Kent and Medway and associated discussions by the PCT Cluster Board (as Commissioner) and KMPT Board (as Provider) during this period.
- 2.2 Appendix B sets out questions and concerns raised by Medway members at the Joint HOSC meeting in February 2013 and the NHS response on each issue.
- 2.3 Appendix C is an expert opinion commissioned by the Joint HOSC from James Fitton of Mental Health Strategies. This was considered at the last meeting of the Joint HOSC on 30<sup>th</sup> July 2013.
- 2.4 Appendix D is the briefing paper provided by the NHS to the Joint HOSC on 30<sup>th</sup> July setting out the background to the review, the proposals, consultation process and outcome of subsequent review by the Joint HOSC, progress on actions agreed in March by the PCT Cluster Board and the impact of the Keogh review into quality of care and treatment provide by 14 hospital trusts in England. The paper also sets out an NHS response to Medway specific needs and proposes a way forward.
- 2.5 On 30 July at the Joint HOSC meeting Medway members proposed and seconded the following motion:

That the Joint HOSC should recommend the Kent and Medway Health Overview and Scrutiny Committees to refer this service change to the Secretary of State on the basis it would not be in the best interests of the health service in Kent and Medway to make changes to acute beds until confidence in the information provided by the NHS is restored, reasons for high levels of out of area placements are resolved and sustained evidence of improved community based services is available, plus guarantees of the implementation of James Fitton's recommendations. This was lost when put to the vote

- 2.6 At the meeting on 30 July, after the motion proposed and seconded by Medway members was lost, KCC members proposed the following:

That the Committee supports the NHS proposals and asks that the report and recommendations of the independent report commissioned

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

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

This motion was carried when put to the vote (with Medway members abstaining) and the decision has been communicated to Ian Ayres, the Chief Officer of NHS West Kent CCG, the lead CCG for commissioning of Kent and Medway mental health services.

2.7 This means that the lead Commissioner has been authorised by the Joint HOSC to make the following recommendations to CCGs for approval in August 2013:

- KMPT commence enhancement of Crisis Resolution and Home Treatment teams and psychiatric intensive care outreach to provide increased and improved alternatives to admission for appropriate patients and facilitating timely discharge.
- KMPT commences implementation of the changes to acute beds in Kent (Canterbury and Maidstone) to improve the levels of care provided, especially in the East of the area.
- In the light of the requirement to vacate A Block (enabling Medway hospital to improve acute services), KMPT commences rapid development of alternative provision for acute beds at Dartford, Maidstone and Canterbury, based on a total current Kent and Medway-wide possible requirement for 174 beds.
- CCGs working with local authorities and KMPT commence work to develop detailed implementation plans for local, multi agency urgent care mental health pathways.

2.8 The CCGs will also be provided with a copy of the report produced by James Fitton and should be advised of the requests from the Joint HOSC as set out in the bullet points in paragraph 2.6 above. The Chief Officer/Accountable Officer of NHS West Kent CCG (the CCG with lead commissioning responsibility for mental health services) has confirmed the requests from the Joint HOSC will be acceptable to the NHS.

### 3. Advice and analysis

3.1 The Committee should note the following key points in relation to the current position on the proposed reconfiguration of acute mental health care:

- a) after Medway members formally sought assurances about data quality via the Joint HOSC, in response to representations by the families of two acute inpatient service users, a bed sensitivity analysis was commissioned by the NHS. This generated an acceptance that the data on which the proposed reconfiguration and consultation exercise were based was flawed. The original proposal was for a reduction from 160 acute inpatient beds to 150 (and a reduction from 20 Psychiatric Intensive Care Unit (PICU) beds to 12). The proposal following the bed sensitivity analysis is for an increase from 160 acute beds to 174, configured as set out below. The NHS reported to the Joint HOSC on 30 July that 8 beds still had to be found:

	Current 12/13-12	Proposed Consultation changes	Revised Proposal	Summary Change in April 14
St Martins Canterbury	59	68	72	3 wards @ 18 beds + 1 ward @ 18 beds (1 extra ward then current)
A-Block Medway	35	0	0	No beds at Medway (2 less wards than current)
Priority House Maidstone	34	34	46	2 wards @ 17 beds + 1 ward @ 10-12 beds (1 extra ward than current)
Little Brook Dartford	32	48	48	3 wards @ 16 beds (1 extra ward than current)
Yet to be identified			8	
<b>Acute Younger Adult Total</b>	<b>160</b>	<b>150</b>	<b>174</b>	
PICU - St Martins	8		0	No PICU at Canterbury (now Acute ward 14 bed)
PICU – Little Brook	12	0	12	1 ward @ 12 bed
<b>Total</b>	<b>20</b>	<b>12</b>	<b>12</b>	

- b) KMPT, in partnership with Commissioners, have reviewed the original model and the particular needs of Medway. As a consequence the following is proposed:
- (i) Developing 8-10 intermediate care beds and day care intensive treatment service for patients with Personality Disorder (through capital investment).
  - (ii) Establishing a recovery house model in partnership with a third sector provider where 8-12 people would be able to be supported in supervised accommodation with intervention/input from mental health professionals.

- (iii) Developing 12 extra acute beds within Maidstone as added capacity in addition to the proposed additional beds at Dartford.
- (iv) Changing the function of and extending Dudley Venables House to allow the provision of an additional 8-10 acute beds in Canterbury.

The NHS say these resources will provide local and immediate support to patients who cannot be safely looked after at home in addition to (and working with) the original proposals of intensive home treatment which would significantly reduce the number of people requiring acute admission, and support more timely discharge.

- 3.2 The NHS reported to the Joint HOSC that Medway Hospital Foundation Trust is one of 11 hospitals put into special measures as a result of a review by Sir Bruce Keogh. The Joint HOSC was advised that the recovery plan agreed by the review team and the FT requires the Trust to make significant changes to the layout of its services in order to improve clinical safety, effectiveness and patient experience. To achieve this the Trust requires KMPT to vacate A Block. KMPT have indicated this will take 45 weeks to achieve so they will continue to be providing services in A block through next winter.
- 3.3 The Medway Councillors who were members of the Joint HOSC Committee and attended the meeting on 30 July 2013 have asked that this Committee should be informed of their concerns as set out below:
  - a) the James Fitton report states that Kent and Medway have few acute beds and only about average levels of crisis resolution home treatment services compared with other places; at 12% below the average. James Fitton also says existing acute inpatient services and community alternatives in Kent and Medway have been operating at or close to full capacity. He advised that overspill beds in other areas should only be sought in unusual circumstances. The bed sensitivity analysis, based on a review of historic bed usage, has produced a requirement for 24 more acute beds than the 150 originally proposed, (or 14 more than current level of 160 beds). This is at a time of unprecedented and inexplicable reliance on out of area placements both nationally and locally. It has been suggested that expenditure on out of area placements by KMPT is set to rise from £1.2 million in 2012/13 to £3 million in 2013/14. Medway members believe the Joint HOSC should have asked for more assurances about the reasons for these pressures and the methodology used for determining bed numbers before signing off the reconfiguration. Members felt the proposed configuration of 174 beds as set out in paragraph 3.1 (a) above lacked detail and appeared to be “cobbled together” in a last ditch attempt to persuade the Joint HOSC to approve the proposed reconfiguration. Medway

members remain to be convinced that historic bed usage is the most appropriate tool to gauge future need.

- b) whilst James Fitton echoes the widely held view that A block is no longer fit for purpose and, on that basis, recommends that the proposed reconfiguration of acute beds to three centres of excellence should be supported by the Joint HOSC he also points out that other comparable places have their acute mental health facilities closer to their most deprived communities than is being proposed for Kent and Medway. He concludes that the proposed changes will bring about a pattern of sites, which is more distant from centres of deprivation than is typical for this comparator set. This undermines the capacity to truly integrate health and social care locally in Medway as envisaged in the Health and Social Care Act 2012 and articulated in the Joint Health and Wellbeing Strategy. Members believe acute mental health beds should be provided for Medway patients in Medway given the size of the population and levels of deprivation. Further they are concerned that the NHS proposals are driven by property considerations rather than community need. Members are also concerned that James Fitton could find no expression or understanding of what a centre of excellence should look like during his review. Members remain unconvinced that an affordable facility providing acute beds in Medway cannot be found;
- c) a further compelling submission has been made to Joint HOSC members by a family member of a service user referring to research published by Manchester University that has shown in recent years there have been more suicides under home treatment or crisis resolution than under in-patient care. James Fitton heard from several well-placed stakeholders that existing crisis resolution home treatment (CRHT) team are often too stretched to provide home treatment which could otherwise be safely offered. He also notes the inequitable size of existing CRHT services across Kent and Medway. These observations underpin concerns raised by Members about the need for more qualified community based staff. This Committee also raised concerns with KMPT about patient experience in October 2012 when it withheld support for KMPT's application for Foundation Trust status. The Trust has not yet reported back to show sustained and ongoing improvements in patient experience as requested by the Committee at that time;
- d) Whilst it is encouraging to note that the new lead commissioner for mental health services (NHS West Kent CCG) has proposed a number of actions to address need in Medway, Members have expressed an underlying loss of confidence and trust in KMPT, as the provider of the service, generated by the experience of this review and the recent judgement of the Council that social care needed to be taken back in-house to improve outcomes for service users. Members have no confidence the proposed actions

in the report to the 30 July 2013 Joint HOSC will be delivered with measurable improvements to patient and service user experience

- e) The Medway Members on the Joint HOSC believe this Committee should report to the Secretary of State on the basis the proposed service reconfiguration would not be in the interests of the health service in Medway, is based on flawed data and that the consultation did not adequately consider the feedback of service users and their family carers in reflecting local services for local need.

#### **4. Financial and legal implications**

##### **4.1 Financial implications**

The cost of the expert opinion commissioned by the Joint HOSC was £18,750. KCC only contributed £2, 500 towards this expenditure. The balance was met from within Medway Council's adult social care budget.

##### **4.2 Legal implications**

- a) Under *The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (SI 2013/218)* (which came into force on 1 April 2013 and revoked the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (S.I. 2002/3048) local NHS bodies must consult local authorities over any proposals "for a substantial development of the health service in the area of a local authority, or for a substantial variation in the provision of such services."
- b) Where more than one local authority is consulted on a substantial variation of service, "those local authorities must appoint a joint overview and scrutiny committee for the purposes of the consultation."
- c) These regulations mean that where a service change is proposed that affects an area covered by more than one local authority, and where both consider the change to be a "substantial development or variation," then a Joint HOSC must be established for the purposes of the consultation. Only the Joint HOSC may make comments on the proposal, require information from the NHS and attendance by the NHS to answer questions in connection with the consultation.
- d) Kent County Council and Medway Council have not given authority to the Kent and Medway Joint HOSC to exercise the power to report contested service reconfigurations to the Secretary of State. (Had this been the case then only the Joint HOSC could take a decision to make a report). This means that either or both the KCC and Medway HOSCs may independently

exercise the power to report to the Secretary of State on any service reconfiguration which has been the subject of statutory consultation by the NHS with the Joint HOSC.

- e) On 9 March 2012 the Health Overview and Scrutiny Committee at Kent County Council determined that the proposals for a review into adult mental health inpatient services in Kent and Medway constituted a substantial variation of service. On 27 March 2012 the Health and Adult Social Care Overview and Scrutiny Committee at Medway Council made the same decision.
- f) The Joint Committee consists of 12 Members: 8 from Kent County Council and 4 from Medway Council.
- g) At the Joint HOSC meeting on 30 July 2013, a number of options were available to the Committee. These included:
  - (i) Support the NHS proposals.
  - (ii) Support the NHS proposals with comments.
  - (iii) Support the NHS proposals with a recommendation.
  - (iv) Reject the NHS proposals.
  - (v) Reject the NHS proposals with comments.
  - (vi) Reject the NHS proposals with recommendations
  - (vii) Propose a vote on the option of recommending the KCC and Medway HOSCs to refer the proposals to the Secretary of State for Health
- h) There are two routes for reporting a contested service reconfiguration to the Secretary of State:

Either Option 1

- to comment **and** make a recommendation . If the NHS disagrees with a recommendation it must tell the respective HOSC(s) and then steps must be taken to try and reach an agreement on the subject of the recommendation before a report can be made to the Secretary of State or

Option 2

- to decide not to comment or to comment but with no recommendation in which case a decision could be made by the HOSC (s) with power to refer to **either** notify the NHS that a report is to be to the Secretary of State and the date it is



intended to make the referral **or** notify the NHS of the date by which it is intended to make a decision to refer.

- i) ***A report to the Secretary of State for Health can only be made, on the following grounds:***
  - (i) ***The local authority is not satisfied there has been adequate consultation with the relevant HOSC or Joint HOSC in terms of content or time allowed***
  - (ii) ***Where a consultation was not possible because of a risk to the safety of welfare of patients or staff, it is considered the reasons given for the lack of consultation were inadequate.***
  - (iii) ***The local authority considers that the proposal would not be in the best interests of the health service in its area***
- j) Any report to the Secretary of State for Health must include:
  - (i) an explanation of the proposal to which the report relates;
  - (ii) where appropriate, the reasons why either members are not satisfied that consultation with the local authority has been adequate or with the explanation given for no consultation taking place because of a risk to the safety or welfare of patients or staff and evidence to show that steps have been taken to try and reach agreement on the areas of concern;
  - (iii) a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area of the local authority where referral is on the grounds that the proposed reconfiguration would not be in the interests of the health service in the area;
  - (iv) in a case where there has been a failure to reach agreement on local authority recommendations, an explanation of the steps that have been taken to reach an agreement locally within a reasonable period of time;
  - (vi) an explanation of the reasons for the making of the report; and
  - (vii) any evidence in support of those reasons.
- k) In addition, any health service reconfiguration is subject to the following four tests, set out by the Secretary of State for Health in 2010:
  - (i) Support from GP commissioners;

- (ii) Evidence of public and patient engagement;
- (iii) Clarity about the clinical evidence base; and
- (iv) Proposals must take into account the need to develop and support patient choice.

## 5. Risk management

<b>Risk</b>	<b>Description</b>	<b>Action to avoid or mitigate risk</b>
Loss of 35 mental health acute beds in Medway	The NHS are proposing a reconfiguration which involves the loss of 35 acute mental health beds in Medway and a requirement for Medway patients and their families and carers to access beds elsewhere in Kent	The Committee is considering whether to report the proposed reconfiguration to the Secretary of State on the grounds it would not be in the interests of the health service in its area. The Secretary of State may then make a final decision on the proposal or give directions to the NHS.

## 6. Recommendations

The Committee is asked to consider the report and either:

- a) agree to note the decisions of the KCC and Medway Joint HOSC  
or
- b) decide to exercise the power to report to the Secretary of State about the proposed reconfiguration of acute mental health services on one or more of the permitted grounds set out in paragraph 4.2 (i) as highlighted in bold above , specify the reasons for this and what action the Committee is seeking from the Minister, and delegate authority to the Deputy Director , Customer Contact, Leisure, Culture, Democracy and Governance, (who is the Council's Designated Scrutiny Officer) to take the necessary steps to make the report in consultation with the Chairman and Opposition Spokespersons of this Committee and
- c) to notify the West Kent CCG of the decision to report to the Secretary of State and the date by which it proposes to make the report

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**Background papers**

Agenda and minutes of the Kent and Medway Joint HOSC 2012-2013



## SCHEDULE OF DECISIONS TIMELINE– JOINT HOSC ON ACUTE ADULT MENTAL HEALTH INPATIENT BEDS REVIEW

<b>Date</b>	<b>Meeting</b>	<b>Decision</b>
9.3.12	KCC Health Overview and Scrutiny Committee	RESOLVED that the Committee agrees the proposals constitute a substantial variation of service and that a Joint Health Scrutiny Committee with Medway Council be constituted should this be necessary.
27.3.12	Health and Adult Social Care O&S Committee	It was agreed that the review of acute inpatient mental health beds is a substantial variation for the purposes of convening the joint HOSC (health scrutiny committee) with Kent County Council.
3.7.12	JHOSC first meeting	RESOLVED that the Committee approves the NHS decision to take the proposals in the report to three months public consultation between late July and late October 2012 and looks forward to a consultation document which will take into account the concerns expressed at this meeting and that these concerns will also be addressed by the further information to be provided and the further site visits to be arranged.
13.2.13	JOHSC second meeting	RESOLVED that the Committee convene another meeting in the near future to receive responses to the questions raised by Members
20.2.13	NHS Kent and Medway cluster board meeting	The NHS Kent and Medway PCT Cluster Board endorses the model of care which improves service for people who have acute mental health problems by:- <ul style="list-style-type: none"> <li>- extending psychiatric intensive care outreach services to Medway and East Kent where it</li> </ul>

		<p>is currently unavailable</p> <ul style="list-style-type: none"> <li>- strengthening crisis resolution home treatment services</li> <li>- developing centres of excellence for the most unwell in line with national best practice</li> <li>- consolidating inpatient psychiatric care as proposed in the paper</li> </ul> <p>As part of the recommendation the Board supports the implementation of option A subject to the following requirements being met:-</p> <ul style="list-style-type: none"> <li>- that the bed number sensitivity analysis was undertaken and are confirmed as being in line with best practice evidence for the size and type of population in Kent and Medway within this model of care</li> <li>- that sequencing of implementation was undertaken to introduce CRHT in advance of bed changes, we would recommend that CCGs consider this in how they use their transition non-recurrent resources during the period of implementation</li> <li>- that a Quality Impact Assessment is undertaken and clear benefits identified to form Key Performance Indicators</li> <li>- that the transport plan is completed and any remaining gaps in transport provision were closed</li> </ul> <p>The governance process would be</p> <p>These tasks should be completed and considered for approval by the CCG and cluster board meetings by March if the work could be completed to this timetable. If not that these should be taken to CCG boards and confirmed by the Area Team of the NHS Commissioning Board as part of their ensuring that the CCG have clear and credible plans for health services in Kent and Medway for the future.</p>
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19.3.13	JHOSC third meeting	<p>RESOLVED that:</p> <ul style="list-style-type: none"> <li>i. the outcome of the bed sensitivity analysis and Quality Impact Assessment should be reported to the Joint HOSC before it takes a final view on the proposed option for reconfiguration of adult mental health inpatient services and before the CCGs meet in May:</li> <li>ii. the NHS should meet with Medway Council to informally discuss options for local bed provision and</li> <li>iii. simultaneously the advice of an independent expert be sought on the review of adult mental health inpatient services and the proposed option for reprovision</li> </ul>
20.3.13	NHS Kent and Medway final Board meeting	<p>Extract from discussion:</p> <p>Helen Buckingham commented that the paper was for noting in terms of papers that went to the Joint HOSC meeting held on 19 March 2013 and in terms of the actions taken forward from the cluster board meeting held on 20 February 2013. Adrian Hosford commented that on listening to the discussions he was left with a feeling that something might happen to delay the decision again in May and that this would be pushed into the long grass. He added that the feeling was that this hasn't progressed over last several board meetings. Felicity Cox commented that she thought that there was a real will amongst the JOSC to move to a decision and a real recognition that there was a need to resolve issues for the quality of the service for patients across Kent and Medway and that rather than move forward for the want of some additional information move to a decision in May. She added that the danger of not moving to a decision in May would lead to the risk of emergency closures and that with the additional serious incidents and the issues of recruiting staff KMPT had had to close beds in the A Block unit. We were now at a stage where attrition would tip the service over and therefore was imperative that a decision be made. Colin Tomson wished CCGs leadership luck in moving to the next stage and that the CCG Governing Body Boards in May 2013 may help to move this on.</p>

28.3.13	Kent and Medway NHS and Social Care Partnership Trust	<p>The Board <b>AGREED</b> in principle to proceed to implementation of option A. The Board recognised the work to be done on the bed sensitivity analysis and when that work had been completed this would be submitted to the Board for ratification.</p> <p>The Board:</p> <p>1.</p> <p><b>AGREED</b> in principle to proceed to implementation of option A.</p>
26.06.13	NHS Medway Clinical Commissioning Group governing body meeting	<p>The Governing Body received a verbal update on acute mental health.</p> <p>Peter Green reported that a report on the review of acute mental health beds had been presented to the last meeting of the Cluster Board, which had been approved with caveats. This had also been presented to the Joint Adult Health and Overview Scrutiny Committee (HASC). Work is underway to address the concern raised and this is then due to go back to the Joint HASC. The team were also looking at a recovery house service that would be in addition to the mental health beds, recovery houses were normally outside of the NHS and allowed people with mental health conditions to live and be supported outside of a mental health environment.</p>
24.07.13	NHS Medway Clinical Commissioning Group governing body meeting	<p>Angela McNab, Chief Executive of Kent and Medway NHS and Social Care Partnership Trust introduced a report setting out the briefing paper for the Kent and Medway JhoSC on 30 July 2013. No minutes of the meeting are yet available.</p>
30.7.13	JHOSC fourth meeting	<p>The Committee supports the NHS proposals and asks that the report and recommendations of the independent report commissioned by the Joint HOSC be presented to the CCGs when they are asked to consider next steps set out in the NHS briefing paper on page 21 of the agenda. In particular the Committee asks for, in line with the independent report:</p> <ul style="list-style-type: none"> <li>• a significant increase in the retention for reinvestment, to be spent on further increases in crisis resolution and home treatment and a small number of additional acute beds</li> <li>• a clear plan being developed for the delivery of the elements of genuine centres of excellence in the three remaining sites</li> <li>• an action plan to be prepared within three months to be overseen by NHS England, Kent County Council and Medway Council HOSCs and</li> <li>• regular monitoring of performance to be undertaken in light of experience as changes</li> </ul>



		progress
20.8.13	HASC Overview and Scrutiny Committee	



## NHS Kent and Medway and KMPT responses to the concerns and questions raised by Medway Council from the Joint Kent and Medway Health Overview and Scrutiny Committee held on the 13 February 2013

Question raised by Medway Council	Response
<b>Access and Transport</b>	
<p>1, When will a final Transport Plan be in place with confirmed and definite arrangements dealing with transport links, costs, new signage, information and out of hours access?</p>	<p>The KMPT transport plan will deliver a range of initiatives to support service users, carers and families' access to and from hospital sites.</p> <p>The transport plan is complete and will be signed off at the Acute Service Line Programme Board on the 23<sup>rd</sup> April 2013. Progress on the delivery and milestones of the plan will be undertaken by the Transport Sub-Committee, which reports to the Programme Board that will monitor and oversee implementation.</p> <p>We have engaged with experts by experience to test out public transport options for people in Medway and Swale accessing Dartford, Maidstone and Canterbury. This information has aided the development of the transport plan. We have also conducted two snapshot audits of those visiting our inpatient facilities to gain an understanding who, when and by which mode of transport access our inpatient units. We are also in the process of conducting a questionnaire utilising the patient experience group seeking specific views from those visiting A Block, Medway; re the concerns they have and the types of support they would like to see if proposed changes occur. This information will be considered by the transport group and aid the further development and implementation of this plan.</p>
2, Will the secure transport to be used for patients be an	We also work closely with the Police and Ambulance service in

ambulance equipped to the right standards?	<p>emergencies, and with our PTS partners to support the safe transport of patients to and from hospital. The type of vehicle used for transporting a patient is based on a risk assessment taking into account all the patient's assessed needs.</p> <p>If a patient has a high level of physical health need they will be transported in a traditional ambulance supplied through our contract with the patient transport service. If someone had both a high level physical and mental health needs the decision would be made as to where care is best delivered transferring only when all parties agreed that it was in the individual's best interest. The secure transport will not be equipped as a traditional ambulance for physical health care but as a secure vehicle for someone presenting with a high level of risk to others in the context of their mental health care.</p> <p>The secure transport vehicle has been purchased to the required specification and is due to arrive in the KMP Trust by the end of March. This will be used predominately for inter ward transfers.</p>
3, What help will there actually be for people in meeting the cost of travel to Little Brook Hospital from Medway?	<p>This is being carefully considered by the Transport Sub-Committee. A preliminary budget of £10,000 has been set aside to support the extension of the voluntary transport scheme to Medway.</p>
4, Bearing in mind the journey on foot is difficult in an unlit environment with no signage to Little Brook Hospital what are the plans to improve this situation?	<p>A meeting is already planned between the site manager for Little Brook; senior KMPT staff David Tamsitt and Philippa MacDonald with Dartford council to highlight this situation and to agree a resolution.</p> <p>The noticeboards across the Little Brook site already have the information on travel with details of public transport. And the site manager has asked for quotes from spectrum signs to direct patients and visitors to bus stops.</p>
5, What arrangements have been put in place for transporting people to A&E from Dartford speedily?	<p>If it was an emergency then the response would be via 999 working with the ambulance trust or police as appropriate. We have close working</p>

## Kent and Medway

	<p>relationships with both organisations and established protocols in place to facilitate smooth support for patients.</p> <p>A&amp;E transport.....Non emergency transfers would receive a nursing escort to Darenth Valley Hospital using our contract taxi provider. We also have in place a protocol with the acute trusts to provide a consultant opinion at the mental health for physical conditions in circumstances where that would be appropriate.</p>
<b>Data quality/accuracy</b>	<p>An assessment of the demand for beds was in the paper considered by the PCT cluster Board in July and provided to the first JHOSC meeting. The method used to calculate the number of beds needed was covered in Appendix C of the July Board paper; and responses to questions raised by members of the public during the subsequent consultation process were set out in Appendix 2 of the February JHOSC and PCT cluster Board papers. The method was based on historical bed usage and described in a narrative form in Appendix C of the July Board paper.</p> <p>The PCT cluster has committed to undertaking both a sensitivity analysis of bed number estimates and modelling to estimate the likely impact of the services changes proposed in the Review, e.g. enhanced Crisis Resolution and Home Treatment staffing, acute inpatient beds consolidated on three sites, and improved integration of acute and community mental health services.</p> <p>Additionally, the PCT cluster is exploring what is happening in other parts of the country. Dr Pete Sudbury from the National Clinical Advisory Tea informed the February JHOSC meeting that most areas are moving to have fewer specialist units / Centres of Excellence.</p>
6, Is the method used to calculate future number of in-patient beds requirements robust? It seems that only four data points have been used to produce a linear trend in the redrawn figure 2 in Appendix 2. Projecting forward two years is not well supported by such a small number of past observations. Furthermore a linear model is not generally appropriate where projections suggest zero or negative number of beds in the near future.	<p>As explained in Appendix 2 of the paper presented to the JHOSC on 20.2.2013, the data set analysed was bed usage over four years available from recent service information when the Crisis Resolution and Home Treatment service was in place</p>
7, It would seem more appropriate to use the full dataset available for the last six years. The NHS Kent and Medway paper refers on page 2 to the fact that successful alternatives	

to inpatient treatment have been established in the community since 2004 so it is hard to see why data from 2006/7 and 2007/8 cannot be used which would make the picture quite different.	and starting to show an effect on hospital stays. The data is being rechecked by the PCT cluster as part of the sensitivity analysis, and is we understand to be independently analysed by Medway Council.
8, The report recognises that inpatient beds will always be required for some mental health patients but it is important to try and provide an estimate of the size of this sub-group and therefore the required bed count to meet expected demand. How can the report authors be confident that the optimum bed count lower threshold has not already been reached especially as bed provision is already low with respect to the national benchmarking?	<p>The PCT cluster is modelling the impact of the proposed services changes in order to address any uncertainty around the increased availability of beds. Public Health will work with Commissioning, Performance Intelligence and KMPT to quantify the changes described in the Review, seek input to ensure that all proposed changes have been included, and then create a model that describes how the change will affect bed availability across KMPT.</p> <p>Quantifying each element will also provide metrics for monitoring the implementation of the redesign and alerts if changes do not result in the expected efficiencies.</p>
9, The reduction in beds was not entirely based on the trend analysis, but as the original paper says the actual proposed bed reduction was based on other factors also particularly the strengthening of other services to enable the bed reduction and therefore is considerably more conservative than the trend analysis alone would suggest. However if the trend analysis has weaknesses and the size of the possible bed reduction cannot be based on this, the case needs to be very clearly spelt out how the additional resourcing for Centres of Excellence and CRHT provision will provide sufficient resource to support the specific bed number reduction proposed.	The impact of service changes on bed requirements is being factored into the PCT cluster modelling work.
10, We are asking the Joint Committee to agree to seek a delay in any decision –making by the PCT Cluster Board until the outcome of the external independent validation commissioned by Medway is available.	A letter sent to JHOSC on 20.2.2013 by Felicity Cox explained the decision taken in principle by the cluster Board and is part of the papers being considered by the JHOSC.
<b>Estates Strategy/acute bed provision in Medway</b>	
11, How were decisions not to invest in acute in-patient	The JHOSC have had two previous briefings on the attempts to pursue an

## Kent and Medway

<p>provision in Medway reached in the context of the overall KMPT Estate Strategy and priorities over the last ten years?</p>	<p>alternative to A Block in Medway (included in these papers) and the stakeholders and public had a briefing providing them with the information at each public meeting. We have considered other site options over the years to find a local solution for Medway and in the main the reasons for ruling these out have been due to either lack of suitability re environment or due to viability.</p> <p>The business case for capital investment to provide inpatient services at a block was discussed at the first board meeting of the new trust (2007) – The cost did not include a significant financial contingency for the project which had the potential to add significant cost to the scheme. A number of surveys had taken place which had identified the need for all main utilities to be addressed together with a risk of ‘floating foundations’ which had the potential to generate significant additional cost in the reconstruction of the site.</p> <ul style="list-style-type: none"> <li>• The Strategic Health Authority- had asked why as a tenant for the site   KMPT was considering capital spend – the recommendation was that Medway Hospital should spend the capital. There were new rules about capital expenditure coming into play from the Department of Health and of course Medway was looking to become a Foundation Trust.</li> <li>• KMPT Board wanted to review and set out an Estate Strategy that was Kent and Medway wide and not simply adopt the strategies of the two former organisations.</li> <li>• The co-dependencies with Medway Trust who were at the time planning a new A and E were also fundamental concerns.</li> </ul> <p>As an organisation we are committed to improving quality and it is a key strategy to invest in premises that raise quality standards and provide better</p>
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	environments in inpatient units and community. There are plans to upgrade Canada House - the community base for Medway.
12, What are the plans for patients accommodated in Ruby Ward at "A" Block if the other two wards are to be closed?	KMPT are engaging with Commissioners (CCGs and the Commissioning Support Team) and partner organisations in Medway (Medway LA and MCT) to consider alternatives for a number of patient and rehabilitation services for older adults in Medway, which includes the possibility of co-location on the Medway Hospital site. The strategy is in the early stage of development and is being led by the Commissioning Team. KMPT are working with MCT to describe 'Intensive Dementia Care Solutions' and alternatives to hospital admissions. The outcomes from this strategic work is not dependent on the future provision of Adult Acute Services currently provided on A Block.
<b>Quality and levels of staffing for the CRHT team in Medway</b>	
13, What is being put in place to ensure there are sufficient numbers of qualified and experienced CRHT staff in Medway to cover and above Support Time Recovery Workers to deal with the complex nature of decisions and risk assessments needed on behalf of vulnerable clients and their families?	<p>There is a multidisciplinary team in Medway both in acute services and in community recovery services, we will be enhancing that local provision to strengthen the service further.</p> <p>We have listened to users and carers and will be providing an enhanced role for STR workers that links with our commitment to recovery.</p> <p>The planned additional investment in CRHT in Medway will be the investment in STR workers. The majority of staff within the Medway Swale CRHT at present are experienced qualified staff, the decision to use the investment for STR workers was in response to frequent feedback from service users and carers that this level of practical and social support, as well as support for carers was what was missing within the current provision. This will give qualified nursing staff more time to support service users and carers to best effect.</p> <p>As part of the planning following the consultation outcome we are committed to review staffing requirements as a result of team changes and in particular</p>



	the impact of Swale being located elsewhere.
14, What consideration has been given to staffing levels for escorted leave and the accessibility of the home area for periods of section 17 leave to support a phased return home?	<p>If escorted leave is required then staffing to support this is obtained.</p> <p>Regarding Section 17 leave, each case is reviewed and arranged on an individual basis; depending on the individual's needs, care treatment plan and duration of leave. This may involve utilising the voluntary driver scheme, STR support, or possibly use of public transport. The individuals centred care plan will determine the type of support required. We are fully committed to achieving the best outcome and support to this leave is important.</p>
15, What assurances do we have that the very important social care elements of care and support in mental health will be addressed in the new system?	<p>Mental Health commissioners have long established partnership of working with fellow commissioners in social care. Operationally across Kent health and social care, clinical commissioning groups and colleagues in social care and community services are establishing integrated work programmes to improve coordination and delivery of care and support to patients and carers.</p> <p>A Discharge coordinator role has been developed and piloted in east Kent, which will ensure links are made and maintained with various partners including social care and housing. This means</p> <p>Support around timely discharge will be provided as part of the acute pathway, utilising support from Support Time and Recovery workers to aid that transition.</p> <p>Also Care co-ordinators within the community team remain involved throughout an individual's time in acute care and will be part of the team that considers what care and support is required both as an inpatient and on discharge home.</p> <p>We will be working closely with our Medway Social Care colleagues to</p>

	ensure that plans are agreed with colleagues, users and carers.
16, The Care Quality Commission recommend having access to psychological support at an inpatient unit. What plans are there to fill the vacant Psychologist post for Little Brook Hospital?	Interviews for this Band 7 post were held on the 5 <sup>th</sup> March 2013 and a suitable applicant has been offered the position.
17, What verifiable progress has been made to improve patient experience of CRHT services in Medway since concerns were raised with KMPT by the Medway Health and Adult Social Care Overview and Scrutiny Committee last October?	<p>KMPT have increased staffing at night to support access to out of hours support.</p> <p>Previously the Team had 2 staff at night, which meant that when a Section 136 assessment or A&amp;E assessment came in no-one could receive an assessment at home. The staff rotas have been increased to 3 in order to support improved access, safety and responsiveness.</p> <p>A Senior SRT worker and two STRs have been recruited into the Crisis Team and they are now fully engaged in providing planned enhanced support to patients and their families.</p> <p>We have also agreed a CRHT survey, which will be rolled out imminently to ensure we can act on feedback from service users.</p> <p>The CRHT regularly meet with the Medway Carers Group and there has recently been positive feedback about the impact of the additional interventions the STR support has been able to make.</p>

# **Kent County Council/ Medway Council**

## **Independent evaluation of proposed reconfiguration of adult acute mental health inpatient beds - project report**

July 2013

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### **Appendix One – Documents received**

## **SUMMARY**

This report is the result of a brief independent evaluation of proposals to change acute mental health care in Kent and Medway. These proposals would see acute mental health wards being concentrated into three “centres of excellence” in Canterbury, Dartford, and Maidstone; psychiatric intensive care would be provided at Dartford only, with inreach services to the other sites. The total number of beds in the services affected would fall from 180 to 162, with some of the money saved spent on increases in community services.

These proposals are now being considered by the Joint Health Overview and Scrutiny Committee (JHOSC) of Kent County Council and Medway Council. The JHOSC has the responsibility to review proposals for significant changes in local NHS services. In this case, the JHOSC wished to help its task by seeking independent expert advice. Mental Health Strategies, a specialist independent consultancy, were appointed to do this.

During the review, we have looked at local documents, met and discussed the proposals with local agencies, visited the hospital sites, and carried out data analysis. Our main findings are:

### ***Comparisons of Kent and Medway with other places***

Compared with other similar places in England, Kent and Medway already provide few acute inpatient beds. The level of crisis resolution home treatment is about average. The number of mental health inpatient beds for older people is also about average. There are more rehabilitation beds for adults of working age than average. In Kent there is a high level of home care for people with mental health problems, but much less day care. In Medway this is has been the other way around.

As regards the location of beds, other comparable places have their acute mental health facilities closer to their most deprived communities than is being proposed for Kent and Medway.

### ***Local data analysis***

The clear and reliable messages from local data analysis are:

- Existing acute inpatient services have been operating at or close to full capacity
- There is a clear picture of pressure being higher in East than in West Kent, across inpatient and community-based services for acute mental health problems
- Delayed transfers of care (people fit for discharge, but not able to be discharged, because of some gap in community services) are contributing only to a very small extent to these pressures

### ***Local stakeholder opinion***

The main things we heard in talking to people involved in local services were:

- A low level of confidence that the proposals will in fact provide sufficient beds
- Almost everyone agrees that the mental health facilities at A block in Medway Maritime Hospital are not acceptable, and should close
- The strong wish of people in Medway to keep an inpatient mental health service in the area; a wish which is largely not supported outside Medway

### **Site visits**

The difference is striking between the quality of facilities available across the four acute sites in Kent and Medway. The new wards at St Martin's Canterbury are excellent. Priority House in Maidstone and Little Brook Hospital at Dartford have good facilities. The wards at Medway Maritime hospital are, in our view, very poor in design and location, and should definitely close.

On balance, and after careful consideration of all of the evidence and options this review supports the proposal to concentrate acute inpatient beds at Dartford, Maidstone, and Canterbury. This seems the most realistic way of quickly closing the Medway Maritime wards. It also creates an opportunity to improve the quality of inpatient care, with improvements to staffing levels, therapies, staff cover arrangements, research opportunities, specialist services, and the management of risk. On the other hand, this will increase travel times for a number of patients, visitors and staff, but thought does appear to have been given to supporting the question of travel and access.

We think more planning should be done, and better explained, about how the three remaining sites can really become "centres of excellence." The opportunity is there, but there needs to be a clearer plan to make it happen.

We also think, on balance, that the proposals are taking too much money out of acute mental health services. We would hope to see more of the money saved by closing A block spent on improving other parts of the local acute mental health system. This could mean bigger crisis resolution/home treatment teams – above the increases already proposed. It could mean a small number of additional acute beds being retained.

We hope that it is possible for the work required to develop clearer plans for the "centres of excellence" and for some additional reinvestment to be taken forward rapidly, and in parallel with the practical plans for the closure of the A block acute service.

We therefore recommend that the JHOSC support the proposed changes to acute mental health inpatient services in Kent and Medway, subject to:

- A significant increase in the retention for reinvestment, to be spent on further increases in crisis resolution/home treatment and/or a small number of additional acute beds
- A clear plan being developed for the delivery of the elements of genuine centres of excellence in the three remaining sites

## 1. INTRODUCTION

### 1.1. Purpose of report

This report is the result of a brief independent evaluation of proposals to reconfigure acute mental health care in Kent and Medway.

Work to review acute mental health services in Kent and Medway has been under way for several years. This work culminated in 2012 in formal service reconfiguration proposals, and a countywide consultation process. The proposals would see acute mental health admission wards being concentrated into three “centres of excellence” in Canterbury, Dartford, and Maidstone; psychiatric intensive care would be provided at Dartford only, with inreach services to the other sites. Current adult acute bed numbers available are, we understand, as follows:

Area	Beds
<b>East Kent</b> St Martins Hospital, Littlebourne Road, Canterbury, CT1 1AZ	59
<b>Dartford</b> Little Brook Hospital, Bow Arrow Lane, Dartford, DA2 6PB	32
<b>Maidstone</b> Priority House, Hermitage Lane, Maidstone, ME16 9PH	34
<b>Medway</b> A Block, Medway Maritime Hospital, Gillingham, ME7 5NY	35
<b>Total</b>	<b>160</b>
<b>PICU - East Kent</b> St Martins Hospital, Littlebourne Road, Canterbury, CT1 1AZ	8
<b>PICU - Dartford</b> Little Brook Hospital, Bow Arrow Lane, Dartford, DA2 6PB	12
<b>Total</b>	<b>20</b>

If the current proposal is implemented as currently proposed, we understand that this will change to:

Area	Beds
<b>East Kent</b> St Martins Hospital, Littlebourne Road, Canterbury, CT1 1AZ	68
<b>Dartford</b> Little Brook Hospital, Bow Arrow Lane, Dartford, DA2 6PB	48
<b>Maidstone</b> Priority House, Hermitage Lane, Maidstone, ME16 9PH	34
<b>Total</b>	<b>150</b>
<b>PICU - Dartford</b> Little Brook Hospital, Bow Arrow Lane, Dartford, DA2 6PB	12
<b>Total</b>	<b>12</b>

These proposals are now being considered by the Joint Health Overview and Scrutiny Committee (JHOSC) of Kent County Council and Medway Council. The JHOSC is seeking to reassure itself that the reconfiguration of acute adult mental health inpatient services is in the best interests of the residents of Kent and Medway; the JHOSC wished to do this by procuring impartial independent expert advice, following a robust review of the evidence. Following a competitive process, Mental Health Strategies were appointed to conduct this independent review; its objectives were agreed to be the provision of:

- a) An independent review of the robustness of the reconfiguration proposals
- b) An analysis of the views of key local stakeholders about those proposals
- c) Recommendations as to whether the proposals should be:
  - a. Supported
  - b. Supported with requested amendments
  - c. Not supported

This report sets out the results of that review.

## **1.2 Structure of report**

Following this brief introduction, the report is structured in three main sections:

- Section 2 provides details for reference of the methods used to carry out the review
- Section 3 provides the review's findings, in terms of both the quantitative analysis, and the meetings and interviews conducted
- Section 4 presents the review's conclusions



## 2. METHOD

This was a brief and focussed project, with only 5 weeks from initiation to completion. During this time, we have worked to review existing local documentation, meet and discuss the proposals with local agencies, visit existing acute service sites, and undertake data analysis. This section provides more detail on the work we have done, and which has informed our conclusions.

### 2.1 Documents received

A substantial quantity of written documentation has been made available to us. This began with two folders of materials made immediately available at the project's initiation meeting; a substantial range of further materials were gathered during the review process, including the full pre-consultation business case for the proposed reconfiguration. All of these materials have been reviewed in preparing this report.

We also asked to have sight of any report which had been prepared by the National Clinical Advisory Team, following what we understand to have been the referral of this issue to NCAT. We have not received any such report, but we have seen the webcast participation of Dr Peter Sudbury, who we understand was appointed for this purpose, to a meeting of the Health Overview and Scrutiny Committee in February 2013.

Appendix One provides a full list of the documents received by this review.

### 2.2 Meetings and interviews

We have met directly and/or interviewed the following:

Richard Adkin	Principal Officer, mental health, Medway Council
Antonios Antoniou	Carer
Ian Ayres	Accountable Officer, West Kent CCG
Brian Clarke	Carer
Louise Clack (and various colleagues met during site visit)	Service Manager, Medway acute mental health unit
Geri Coulls (and various colleagues met during site visit)	Service Manager, Maidstone acute mental health unit
Mark Devlin	Chief Executive, Medway Foundation Trust
Martine Fante (and various colleagues met during site visit)	Ward manager, Littlebrook Hospital, Dartford
Dick Frak	Mental Health Social Care Commissioning Manager, Medway Council
Peter Green	Accountable Officer, Medway CCG
Rosarii Harte	Consultant Psychiatrist, Clinical director for acute mental health services, KMPT
Sarah Holmes-Smith	Assistant Director KMPT
Lauretta Kavanagh	Partner, KMCS strategic services

Karen MacArthur	Consultant in public health, Medway council
Steve Morris	Interim Operational Services Manager, Medway Council
Jason Seeze	Director of Strategy, Medway Foundation Trust
Kim Solly	Head of mental health commissioning support, KMCS
Penny Southern	Director mental health / learning disabilities, Kent County Council
Sue Scamell	Commissioning manager mental health, Kent County Council
Maria Stafford (and various colleagues met during site visit)	Service Manager, Canterbury acute mental health unit
David Tamsitt	Director of Acute Services, KMPT
David Whiting	Senior public health intelligence manager
Oena Windibank	Operations director, Medway Community Health

We also wrote to a range of further contacts identified to us, and offered the opportunity for evidence to be submitted. This received responses only from the following:

Tracey Jones / Catherine Morgan	Medway Engagement Group and Network CIC
David Wildey	Chair of Health and Adult Social Care Overview and Scrutiny

## 2.3 Site visits

During the review period, we visited the four existing sites for acute mental health care in Kent and Medway:

- St Martin's Hospital, Canterbury
- Littlebrook Hospital, Dartford
- Priority House, Maidstone
- A block, Medway Maritime Hospital

During the visits, we saw the existing ward facilities at each hospital, and took the opportunity to discuss views of those facilities, and of the reconfiguration proposals with staff of the services.

## 2.4 External data

We wished to place the situation in Kent in the context of arrangements in similar counties and areas; not because such benchmarking data can ever provide a clear “answer” as to what should be done, but because it provides an additional source of evidence alongside local data and opinion. We therefore brought together, from public domain data sources:

- Benchmarking data as to the level of provision and cost of acute inpatient services
- Benchmarking data as to the level of provision and cost of associated community-based services on the acute care pathway; and of associated older people's services

Given the particular questions which have arisen in Kent and Medway, we also wished to prepare a fully up-to-date benchmarking analysis of the size and location of inpatient services relative to centres of population and deprivation. We contacted a series of comparator Trusts to enable this to be done; unfortunately, several insisted on a formal Freedom of Information request, which we submitted in all cases. We have included the up-to-date data from those comparator Trusts which replied within the project period; some did not meet the requested FoI deadline.

## **2.5 Internal data**

We also wished to do our own analysis of bed and service use in Kent and Medway in recent years. We therefore sought, and were willingly provided with, an anonymised feed of patient activity at the individual episode level, directly from the Kent and Medway NHS Partnership Trust. The presentations in section 3.2 below are based on this data, not on any data analyses prepared for any previous internal or external reports.

### **3. FINDINGS**

#### **3.1 Benchmarking perspectives**

##### **3.1.1 Reference cost analyses**

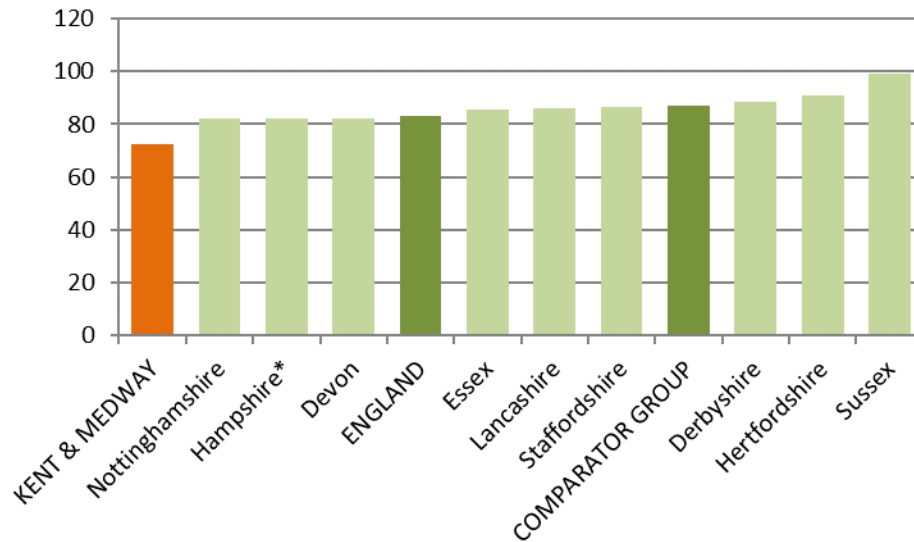
The first set of analyses in this section are based on 2010/11 reference costs, as the most recent set of comparable national data. (Section 3.1.3. below uses more recent data gathered specifically for this review.) In each case, the situation in Kent and Medway is compared with the ten most similar places in England, and with all-England data. Hampshire's data is asterisked as services in that area have been reconfigured since this dataset was compiled, and are no longer provided by the same structure of Trusts.

Populations served are based on 2011 census data, and have been weighted for morbidity in accordance with the method used by the Department of Health for mental health need introduced for the 2011-12 Resource Allocation Exposition Book. This model is based upon work carried out by the Resource Allocation for Mental Health and Prescribing (RAMP) Project.

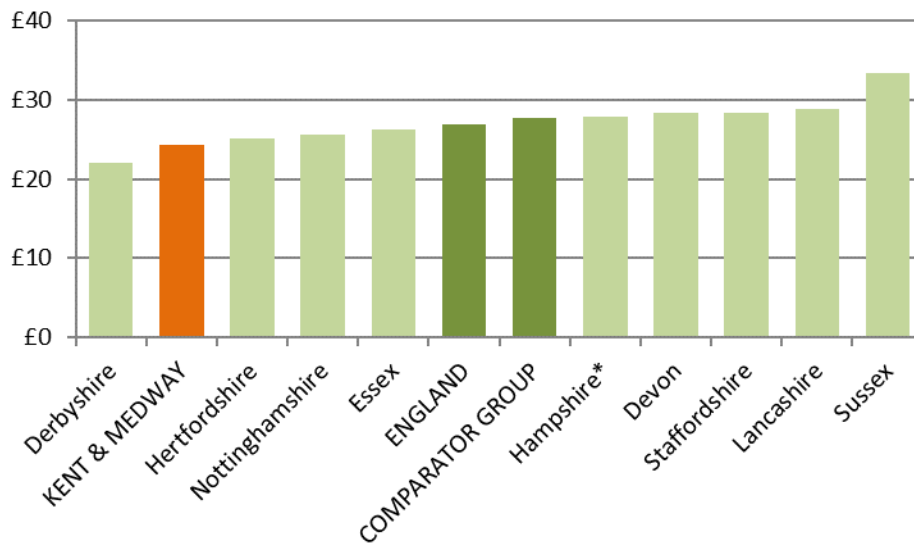
Reference cost data is always susceptible to challenge on the grounds that things are counted differently in different places. It is however a reasonably complete source available of comparative data about patterns of spending, and has, up to and including 2010/11, used an established method.

Although 2011/12 reference cost information is available, it is the first year of using Payment by Result Cluster costings, and many trusts were only able to submit information for a small proportion of clustered service users. We are aware that trusts' approach to clustering is not yet stable, and consequently comparisons of costs by service have the potential to be misleading.

**Figure 3.1 - Own only – Occupied Bed Days per 1,000 weighted adults for 'Mental Health Inpatients' : 'Adult : Acute Care'**



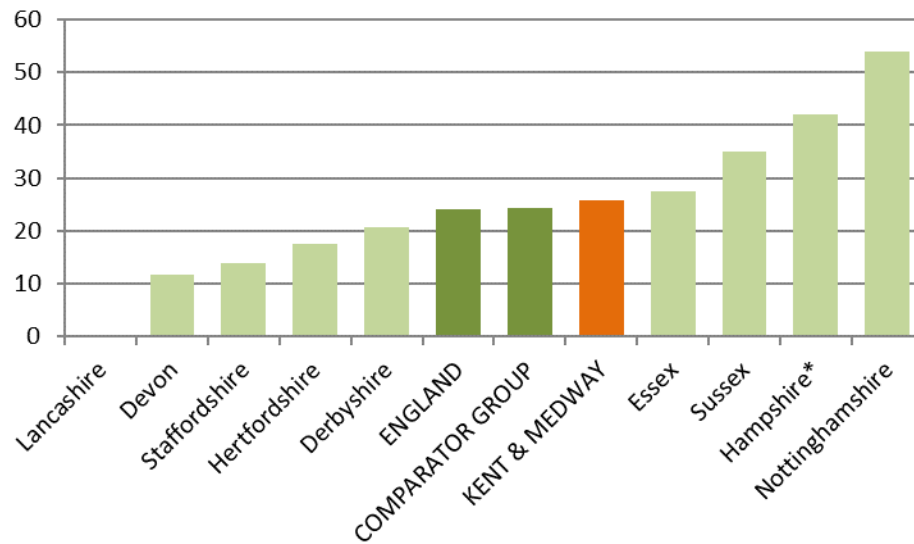
**Figure 3.2. Own only - Adult Acute Inpatients - spend per weighted head (£)**



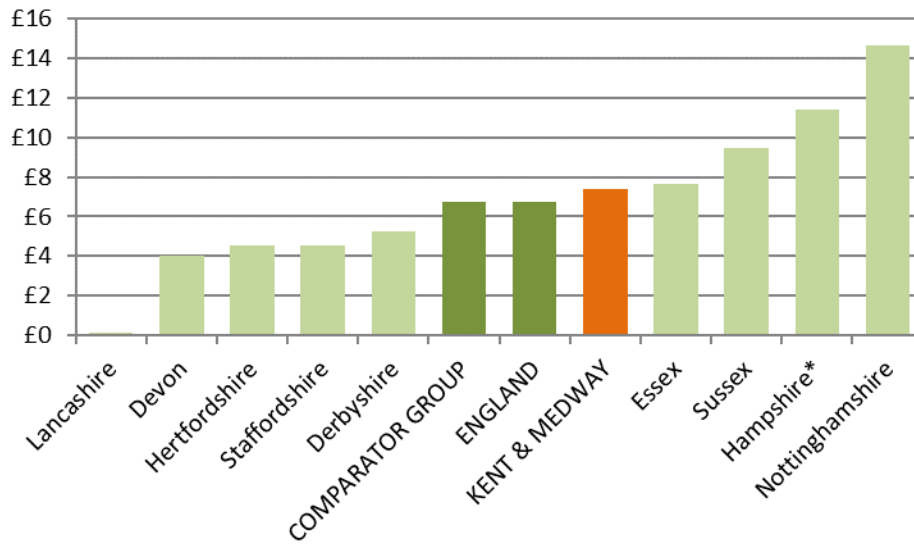
Figures 3.1. and 3.2. above show that Kent and Medway both spends and provides a relatively low amount on acute inpatient care, below both the national and the comparator group average.

Figures 3.3 and 3.4 below show, however, that the position for rehabilitation beds is more typical, with both spend per head and level of activity close to the average levels.

**Figure 3.3. Own only - OBDs per 1,000 weighted adults for 'Mental Health Inpatients' : 'Adult : Rehabilitation'**

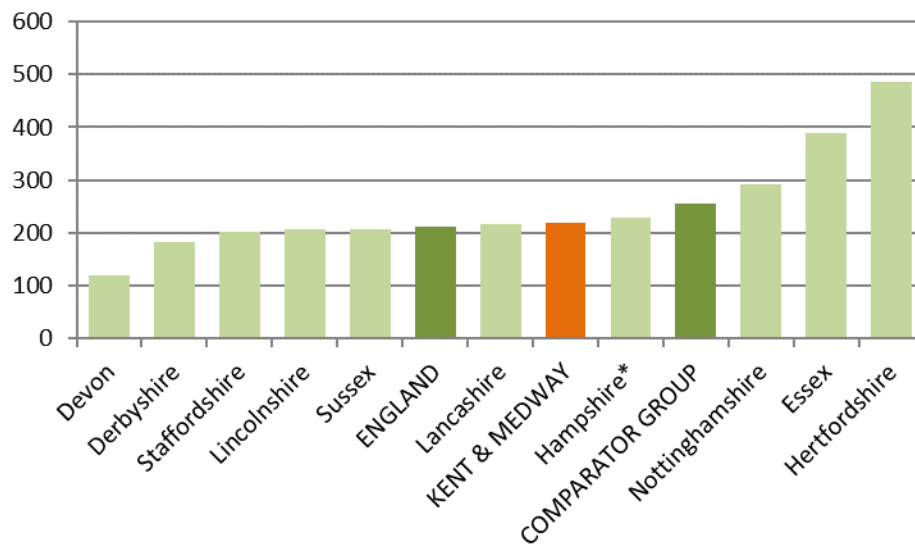


**Figure 3.4. Own only - Adult Inpatients - Rehabilitation - spend per weighted head (£)**

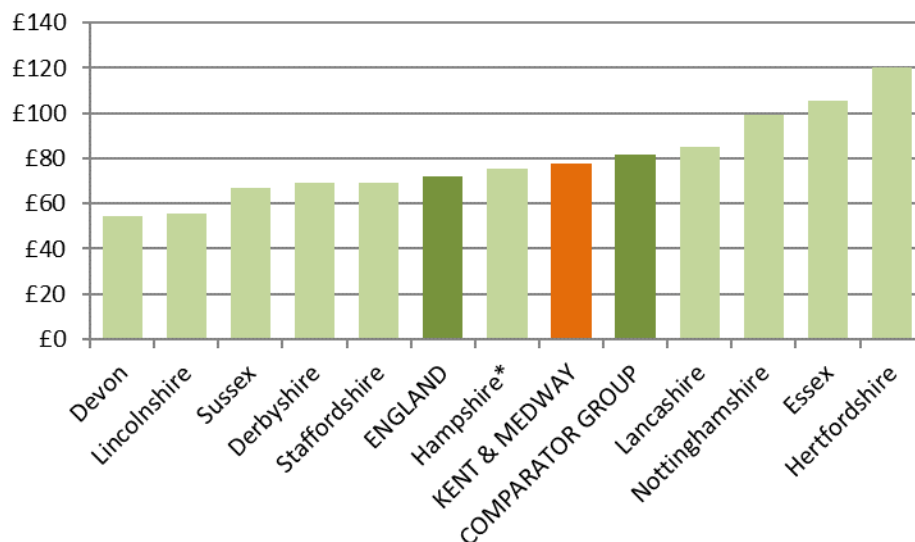


Figures 3.5 and 3.6 below give the comparable position for older adults. This is useful as context, as the overall provision can sometimes be distributed in unusual ways between age groups. The level of provision and spend in Kent and Medway appears around the average, which is consistent with local comments which have focussed on concerns about adults of working age much more than on services for older people. Comparable data for children's inpatient services is not robust: the numbers are very small, and provider arrangements span counties and districts which make it difficult to distinguish locally available services from this source.

**Figure 3.5. Own only - OBDs per 1,000 weighted older adults for 'Mental Health Inpatients' : 'Elderly'**



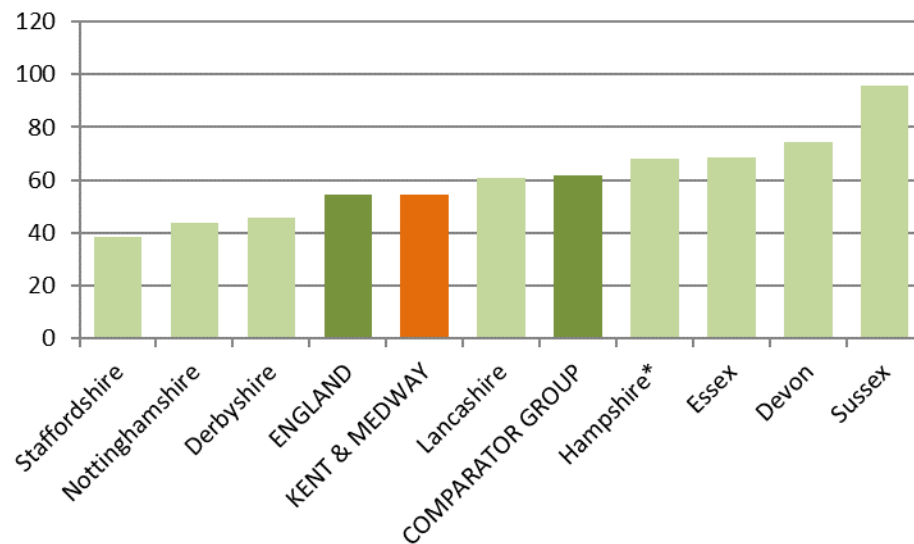
**Figure 3.6. Own only - Elderly Inpatients - spend per weighted head (£)**



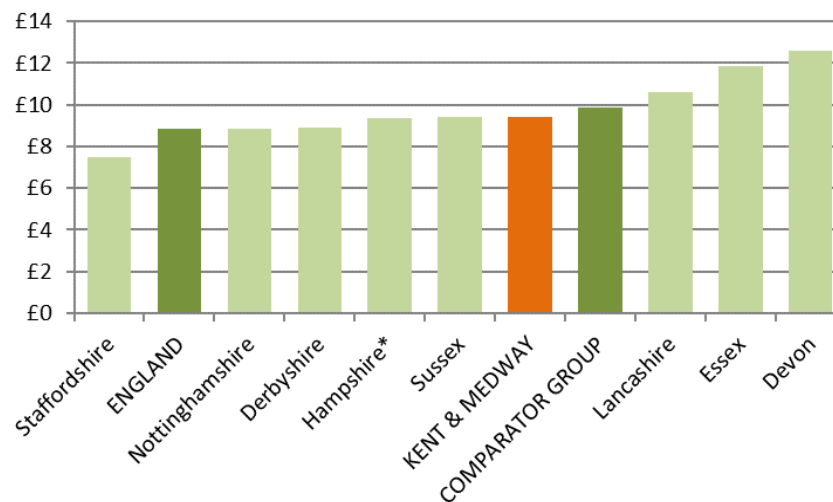
Lastly in this section, figures 3.7 and 3.8 below show the comparable position for crisis resolution home treatment services. Here, local levels of spending and activity appear within the typical range, slightly above the England average, but slightly below the average for the comparator group.

Considering the data on acute inpatient and crisis resolution services together, local spending on acute inpatient care is 12% below the average for the most comparable places in England; Kent and Medway have the second lowest level of spending in that comparator set. For local spending on crisis resolution home treatment to reach a level 12% above average (as a very rough proxy for compensatory spending on community alternatives to admission) a further £1.4 million would have to be spent. To match the spending of the second highest comparator on these services, a further £2 million would have to be spent.

**Figure 3.7. Own only - Contacts per 1,000 weighted adults for 'Mental Health Specialist Teams Adult: 'MHST: Crisis Resolution Home Treatment Teams'**



**Figure 3.8. Own only - Adult CRHTs - spend per weighted head (£)**



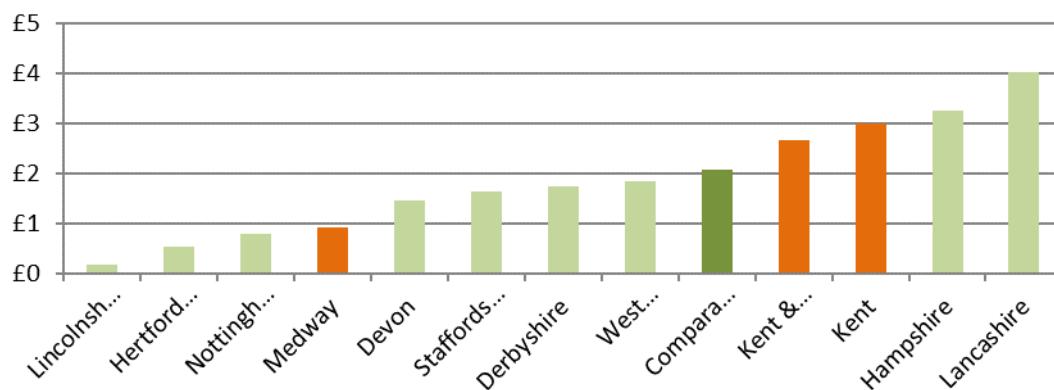


### 3.1.2 Social care indicators

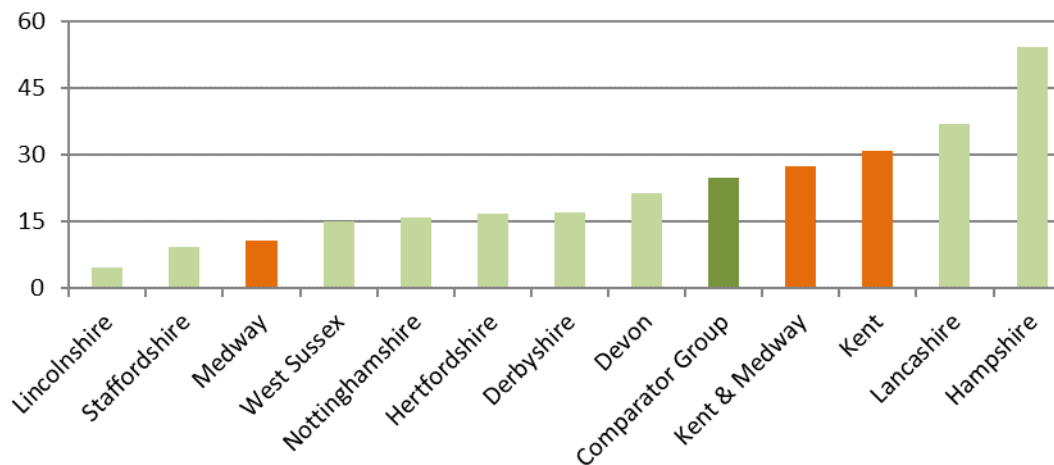
To give additional context to the NHS data above, we have also drawn out a set of data about social care investment and activity in mental health services. The data is taken from the most recently available national returns for Personal Social Services: Expenditure and Unit Costs and is for the year ended March 2012. Comparators and the population base are as in section 3.1.1 above.

Figures 3.9-3.12 reveal very different service models in Kent and Medway. Kent invested in a high level of home care for people with mental health problems; Medway much lower. But, in reverse, Medway invested in a high level of day care for people with mental health problems; Kent much lower. We are aware that, since these data were published, there has been reduction in day care investment in Medway, with a proportion of reinvestment into other social care services. This is the most recent comparable dataset.

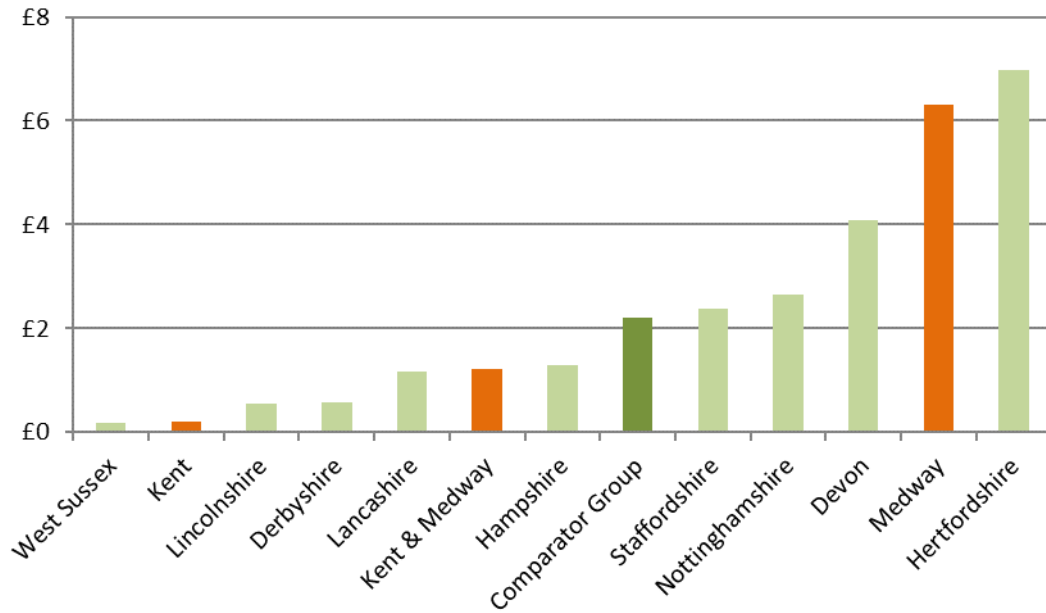
**Figure 3.9. Gross total cost for home care to adults aged under 65 with mental health needs per weighted head**



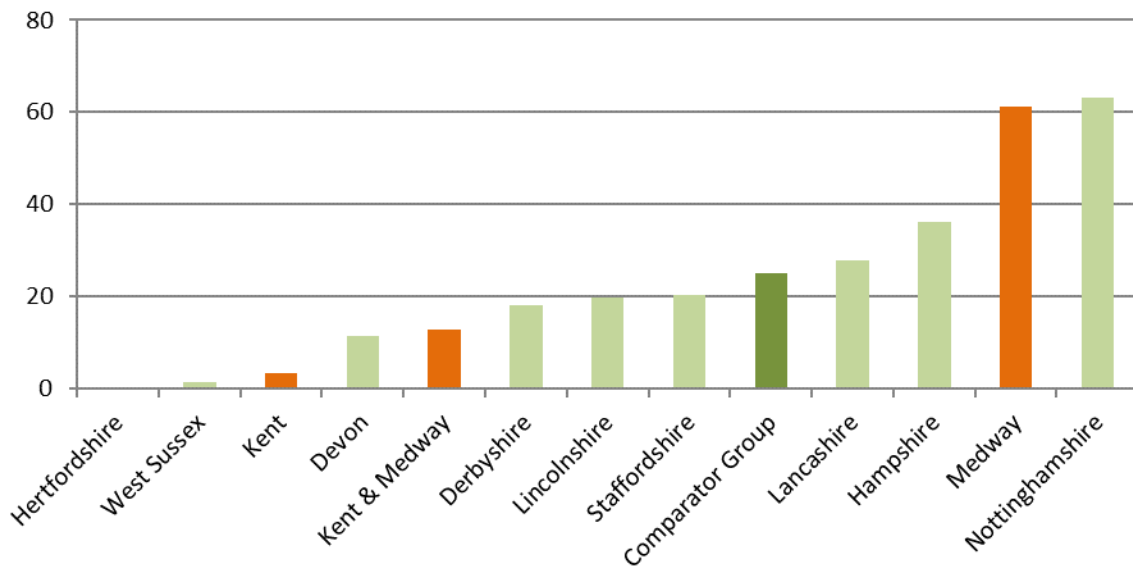
**Figure 3.10 Number of adults aged under 65 with mental health needs receiving home care at 31 March 2012 per 100k weighted population**



**Figure 3.11 Gross total cost for day care or day services for adults aged 18-64 with mental health needs per weighted head**

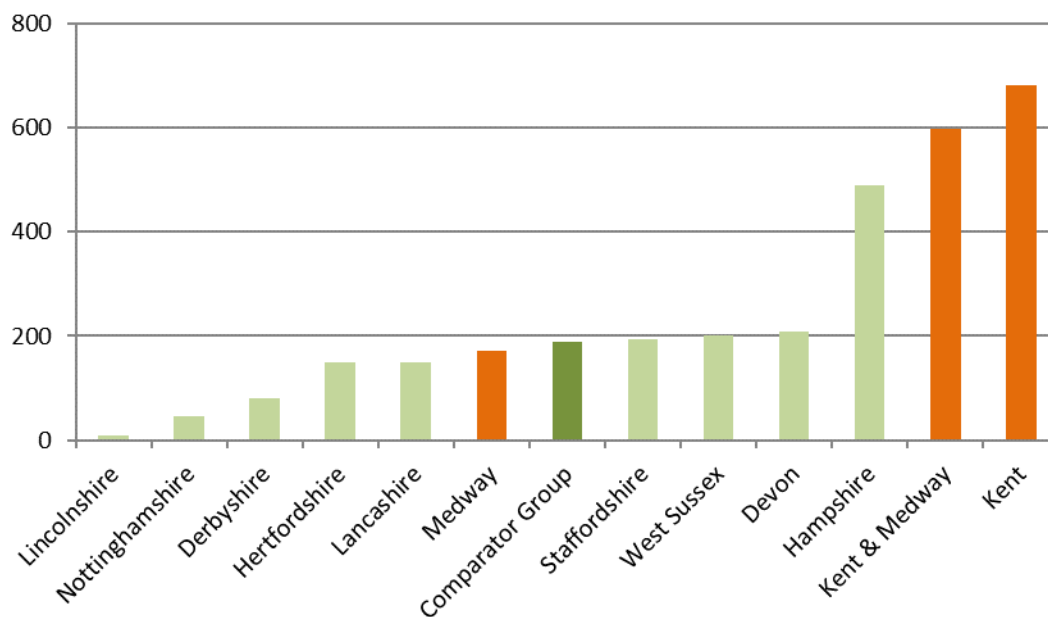


**Figure 3.12 Average number of clients of day care or day services for adults aged 18-64 with mental health needs per weighted head**

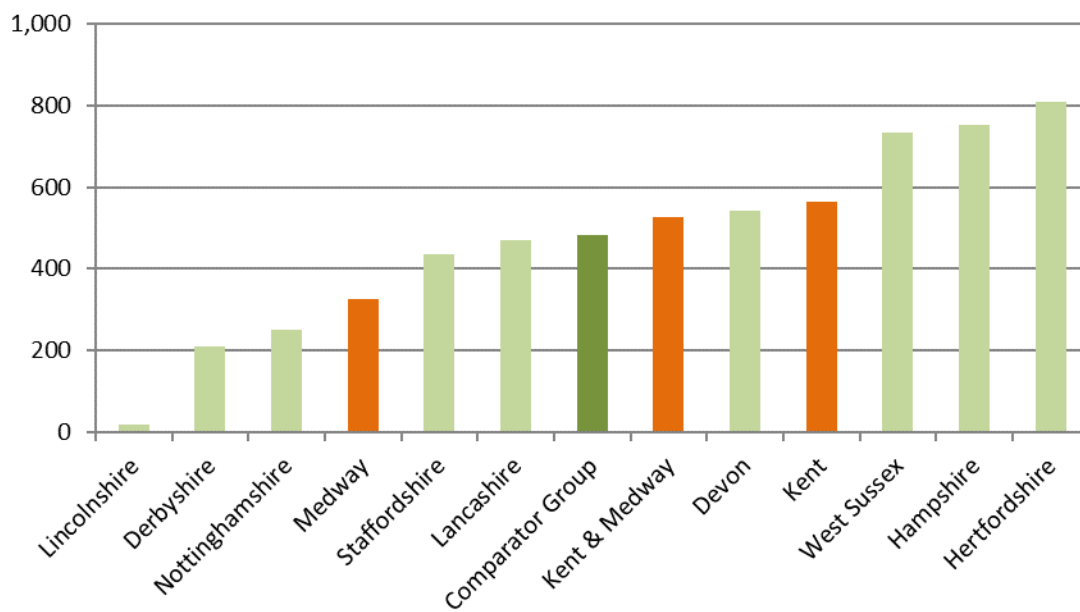


Figures 3.13-14 show further local differences, with the level of mental health assessments and reviews being strikingly higher in Kent than in Medway during this period.

**Figure 3.13 Completed mental health assessments per 100,000 weighted population**



**Figure 3.14 Mental health reviews per 100,000 weighted population**

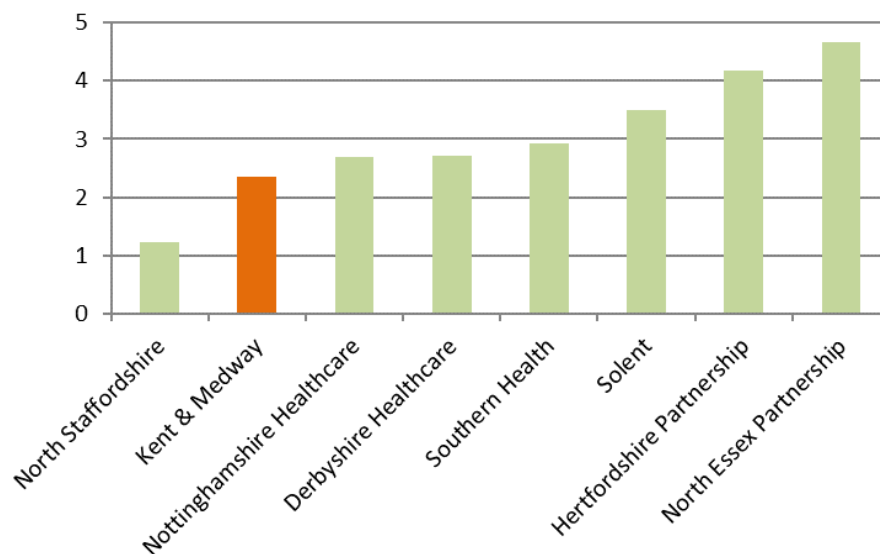


In considering this dataset alongside the NHS data, it is very difficult to discern a clear pattern. It is certainly not the case that high social care investment appears to be associated with either high or low NHS investment. What we are more plausibly seeing is the result of a series of local historic investment and planning decisions, with service models and levels of investment evolving in very different ways in different parts of the country.

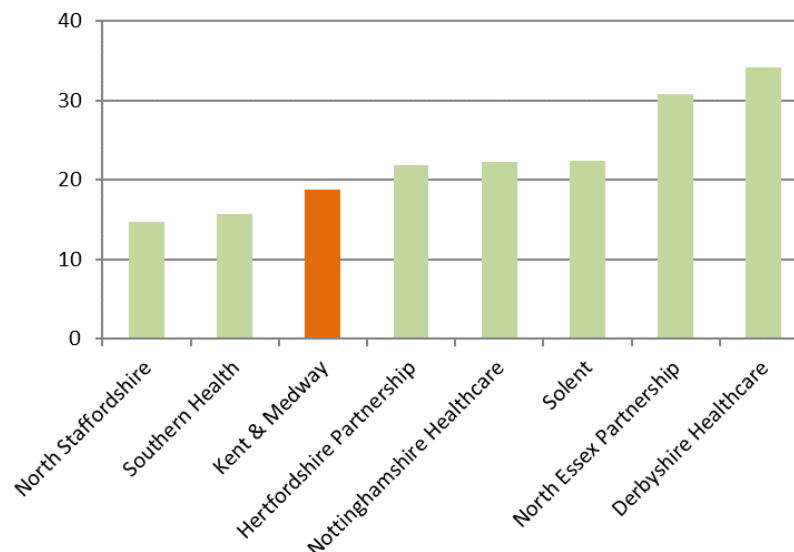
### 3.1.3 Geographic analysis

This section is based on the data supplied to us by those seven comparator Trusts who were willing and able to share an up-to-date breakdown of their acute inpatient beds by site and postcode within the project period for this review. In firstly comparing the numbers of sites and of beds, Kent and Medway appear already to have a relatively low number of both. Figures 3.15 and 3.16 are both based on the current actual position, not on the proposed changes.

**Figure 3.15 Adult acute sites per 500,000 needs weighted population**



**Figure 3.16 Adult acute beds per 100,000 needs weighted population**



We then worked to compare the location of sites for these comparators so as to determine the distance between centres of deprivation and acute mental health inpatient units. We defined a “centre of deprivation” as being a Middle Super Output Area (IMD 2010) in the most deprived quintile for the area under consideration (i.e. not necessarily in the nationally most deprived quintile, given that each area can only consider this question in terms of the local siting of facilities.) We then calculated the mean distance from the centre of population of each of these most deprived MSOAs to the nearest in-area acute mental health unit. The table below shows the mean distance from the most deprived quintile to the nearest local unit, based on the proposed change option.

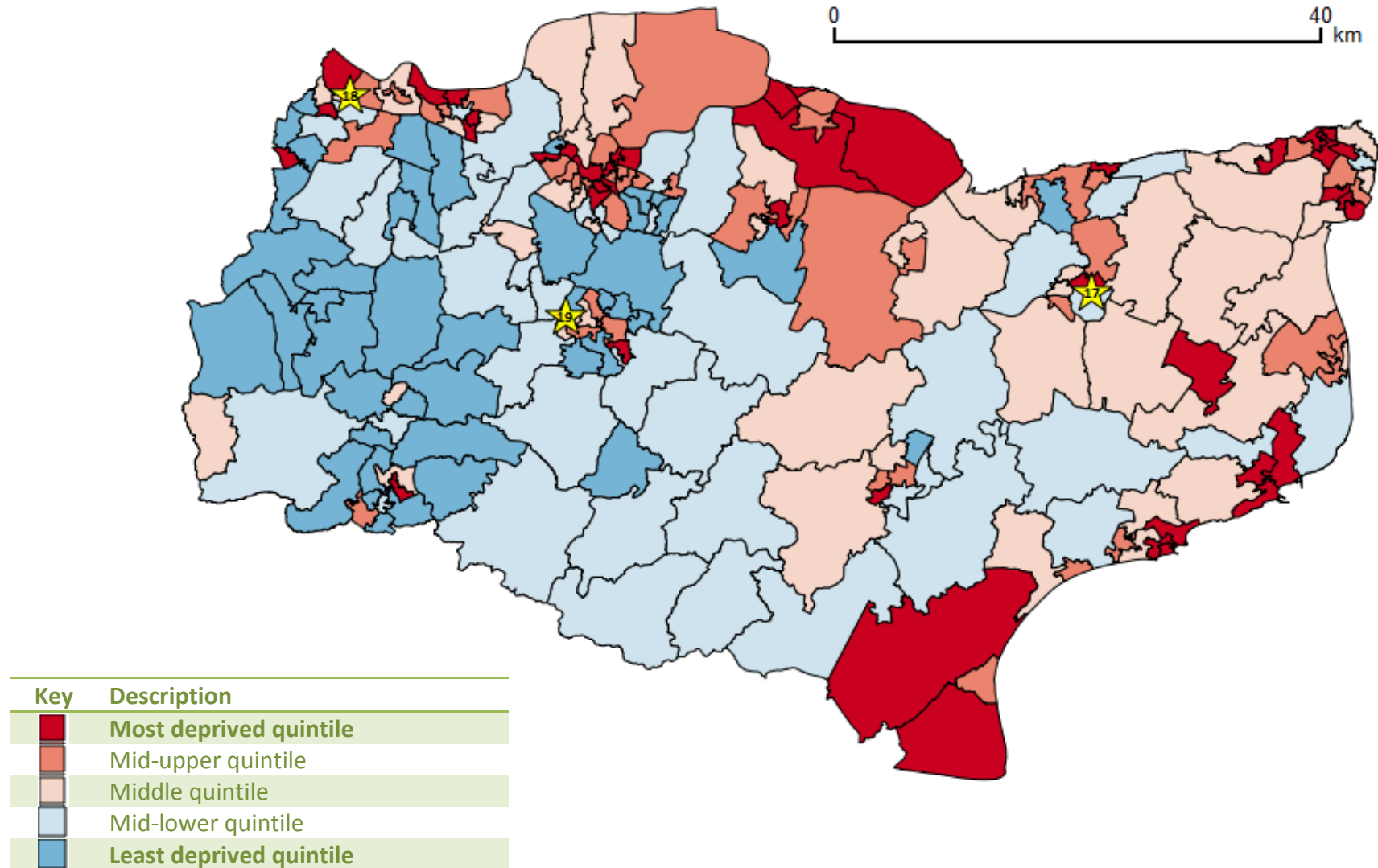
<b>County / Area</b>	<b>Mean distance (miles)</b>
<b>Nottinghamshire</b>	1.91
<b>Hampshire</b>	3.37
<b>North Essex</b>	3.66
<b>Hertfordshire</b>	3.94
<b>Staffordshire</b>	4.87
<b>Derbyshire</b>	5.41
<b>Kent and Medway</b>	<b>10.64</b>

We then calculated the impact of various other site options for a reduction from 4 sites to 3 in Kent and Medway:

<b>Option</b>	<b>Mean distance (miles)</b>
<b>Canterbury, Dartford and Medway</b>	9.12
<b>Canterbury, Maidstone and Medway</b>	9.97
<b>Canterbury, Dartford and Maidstone</b>	10.64
<b>Dartford, Maidstone and Medway</b>	18.28

On this analysis, it appears that the proposed changes will bring about a pattern of sites which is more distant from centres of deprivation than is typical for this comparator set. With the exception of a closure of the Canterbury site (which no-one is proposing locally), the difference between other 3-site options is however small. The map below illustrates the distribution of sites and most deprived MSOAs in Kent and Medway. (For the purposes of this analysis, we have also prepared similar maps for each of the comparator areas - these are available from the authors on request.)

Figure 3.17 Kent and Medway – proposed three site model



### 3.2. Local data analysis

This section presents analyses from the patient-episode data supplied to us by Kent and Medway Partnership Trust.

#### 3.2.1 Acute inpatient activity

We first wished to consider the evidence as to bed use and local bed pressures. The raw occupancy rate picture is as in figure 3.18 below:

**Figure 3.18 Acute inpatient units occupancy rates (excluding leave) Q1 2011-12 to Q2 2012-13**

Quarter	Little Brook	Medway Maritime	Priority House	St Martins	Thanet MH Unit	William Harvey
2011-12 Q1	95%	96%	98%	102%	122%	102%
2011-12 Q2	99%	101%	101%	104%	108%	101%
2011-12 Q3	96%	98%	96%	100%	97%	94%
2011-12 Q4	98%	100%	97%	103%	93%	96%
2012-13 Q1	97%	98%	97%	103%	96%	97%
2012-13 Q2	93%	94%	95%	97%	100%	93%

All of these services were therefore effectively operating at full capacity over the data period. We also wished to gain an additional perspective on this capacity data. We have done this using a “diversity index” which calculates how diverse the profile of admissions/bed days/caseload days are for each Local Authority District. Values close to 100% indicate that almost all of the admissions/bed days/caseload days can be attributed to a single unit. In each case, the minimum possible value would be 17% (100% divided by 6 units). Values close to 17% would indicate a uniform distribution of activity between all 6 units. (There are 6 units in the dataset as the data includes admissions from the now-closed units in Ashford and Thanet.) The indicator value can be understood as the probability that two independently selected values from the distribution of activity (for that district) are attributable to the same unit.

The source district for the admission is determined by the patient’s postcode; we have included within the “admissions” dataset, ward transfers.

The thinking behind the prime use of this index in this context is as follows. Raw numbers of admissions are a poor indicator of demand, as they are so heavily influenced by the simple availability of beds, either in terms of overall supply, or at the time of the decision to admit or to attempt community management. Likewise, out-of-area placements, as they incur an additional cost, may be influenced by financial as well as care-needs-based decision-making. However, within a multi-site acute care system, the level of overspill from the “local unit” to other units is, we would suggest, a useful proxy indicator for the level of pressure being experienced by that unit. The pattern in Kent and Medway is set out in figures 3.19 and 3.20 below, comparing the first quarter data for each of the last two years for which data has been made available.

Figure 3.19 Inpatient admissions profile – Q1 2011/12

Unit admitted to:	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Medway	Sevenoaks	Shepway	Swale	Thanet	Tonbridge and Malling	Tunbridge Wells
Little Brook	9%	11%	88%	20%	69%	4%	18%	20%	17%	13%	9%	18%	0%
Medway Maritime	9%	4%	1%	2%	4%	8%	72%	10%	10%	65%	11%	5%	17%
Priority House	19%	1%	9%	5%	27%	86%	8%	70%	7%	23%	8%	75%	83%
St Martins	17%	41%	1%	5%	0%	0%	1%	0%	14%	0%	39%	2%	0%
Thanet MH Unit	0%	3%	0%	2%	0%	0%	0%	0%	0%	0%	0%	0%	0%
William Harvey	47%	39%	0%	66%	0%	2%	1%	0%	52%	0%	33%	0%	0%
<b>Diversity Index</b>	<b>30%</b>	<b>34%</b>	<b>78%</b>	<b>48%</b>	<b>55%</b>	<b>75%</b>	<b>55%</b>	<b>54%</b>	<b>33%</b>	<b>48%</b>	<b>29%</b>	<b>60%</b>	<b>72%</b>

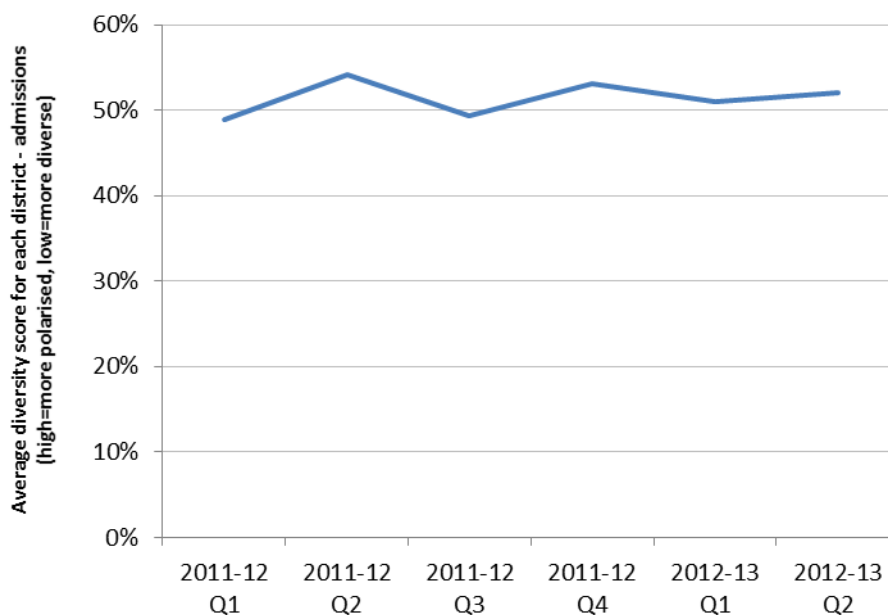
Figure 3.20 Inpatient admissions profile – Q1 2012/13

Unit admitted to:	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Medway	Sevenoaks	Shepway	Swale	Thanet	Tonbridge and Malling	Tunbridge Wells
Little Brook	9%	7%	85%	0%	69%	14%	14%	14%	4%	6%	9%	14%	0%
Medway Maritime	9%	11%	3%	3%	6%	3%	70%	7%	8%	78%	6%	3%	0%
Priority House	21%	18%	10%	11%	25%	81%	13%	79%	12%	17%	16%	83%	100%
St Martins	16%	24%	0%	16%	0%	0%	0%	0%	15%	0%	20%	0%	0%
Thanet MH Unit	0%	8%	0%	8%	0%	0%	2%	0%	0%	0%	10%	0%	0%
William Harvey	44%	31%	1%	63%	0%	2%	2%	0%	62%	0%	40%	0%	0%
<b>Diversity Index</b>	<b>28%</b>	<b>21%</b>	<b>73%</b>	<b>44%</b>	<b>54%</b>	<b>68%</b>	<b>53%</b>	<b>64%</b>	<b>42%</b>	<b>64%</b>	<b>25%</b>	<b>71%</b>	<b>100%</b>

This analysis confirms that there is a substantial difference over the period from district-to-district. In overall terms, there is a clear gradient from more Western parts of Kent and Medway, with high indices (as high as 100% for Tunbridge Wells during the second data period), to the East of the area, with low indices for Canterbury, Thanet and Ashford in particular. Figure 3.21 below shows the overall trend for this analysis over this full period, which shows little overall change, suggesting little change in overall bed pressures over the period.



Figure 3.21 Overall admission diversity index Q1 2011-12 to Q2 2012-13



Figures 3.22 to 3.24 below repeat the analysis of figures 3.18-3.20, but using occupied bed days, rather than admissions, to allow for any effect of short outplacements and retransfers.

Figure 3.22 Inpatient OBDs profile – Q1 2011/12

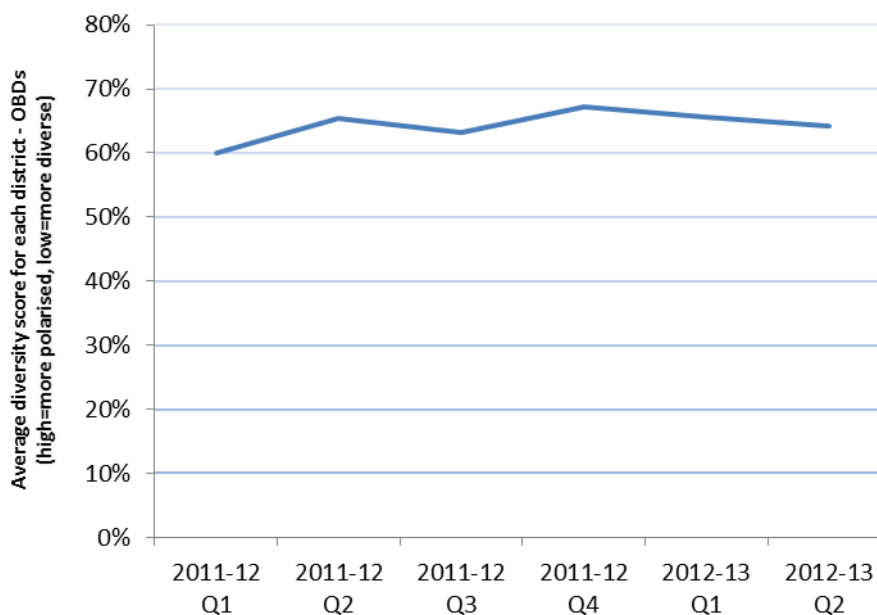
Unit admitted to:	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Medway	Sevenoaks	Shepway	Swale	Thanet	Tonbridge and Malling	Tunbridge Wells
Little Brook	9%	11%	88%	20%	69%	4%	18%	20%	17%	13%	9%	18%	0%
Medway Maritime	9%	4%	1%	2%	4%	8%	72%	10%	10%	65%	11%	5%	17%
Priority House	19%	1%	9%	5%	27%	86%	8%	70%	7%	23%	8%	75%	83%
St Martins	17%	41%	1%	5%	0%	0%	1%	0%	14%	0%	39%	2%	0%
Thanet MH Unit	0%	3%	0%	2%	0%	0%	0%	0%	0%	0%	0%	0%	0%
William Harvey	47%	39%	0%	66%	0%	2%	1%	0%	52%	0%	33%	0%	0%
Diversity Index	30%	34%	78%	48%	55%	75%	55%	54%	33%	48%	29%	60%	72%

Figure 3.23 Inpatient OBDs profile – Q1 2012/13

Unit admitted to:	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Medway	Sevenoaks	Shepway	Swale	Thanet	Tonbridge and Malling	Tunbridge Wells
Little Brook	2%	5%	96%	2%	88%	9%	7%	6%	3%	1%	7%	9%	0%
Medway Maritime	2%	8%	0%	2%	1%	2%	84%	6%	3%	91%	5%	13%	0%
Priority House	15%	16%	4%	8%	11%	88%	5%	88%	4%	7%	12%	78%	100%
St Martins	10%	24%	0%	27%	0%	0%	0%	0%	13%	1%	22%	0%	0%
Thanet MH Unit	0%	9%	0%	1%	0%	0%	1%	0%	0%	0%	15%	0%	0%
William Harvey	70%	37%	0%	60%	0%	0%	3%	0%	77%	0%	40%	0%	0%
Diversity Index	53%	24%	92%	44%	78%	79%	72%	79%	62%	83%	25%	63%	100%

These show a very similar picture, with a similar gradient from West to East Kent, and also little change over the data period.

Figure 3.24 Overall occupied bed day diversity index Q1 2011-12 to Q2 2012-13



Lastly within the analysis of inpatient data, we wished to draw out any potential impact of delayed transfers of care (patients identified as medically fit for discharge, but not able to be discharged for want of some form of community-based provision.) This suggests that, over the 2-year period, 4 beds at any one time were typically occupied by people medically fit for discharge. The numbers are small, so it is difficult to draw any useful inference as to the differences between localities within Kent and Medway.

**Figure 3.25 Bed days attributable to DToC - 2011/12 and 12/13 financial years, broken down by unit**

Unit	OBDs	As % of overall delay
Little Brook	1,373	48%
Medway Maritime	500	17%
Priority House	598	21%
St Martins	309	11%
Thanet MH Unit	49	2%
William Harvey	61	2%
<b>Total</b>	<b>2,890</b>	<b>100%</b>

**Figure 3.26 Bed days attributable to DToC - 2011/12 and 12/13 financial years, broken down by reason for delay**

Unit	OBDs	As %
Awaiting further (non acute) NHS care	846	29%
Awaiting residential home placement	696	24%
Housing-clients not covered by NHS & CCA	529	18%
Awaiting public funding	207	7%
Awaiting completion of assessment	194	7%
Awaiting care package in own home	107	4%
Awaiting community equipment/adaptation	98	3%
Awaiting Public Fund	81	3%
Awaiting Comm Equipt	36	1%
Disputes	34	1%
Housing	28	1%
Awaiting Further NHS	27	1%
Awaiting Home Care	7	0%
<b>Total</b>	<b>2,890</b>	<b>100%</b>

### 3.2.2. Crisis resolution home treatment

We also wished to place this inpatient analysis in the context of data about the crisis resolution home treatment teams' size and activity. The following are the current maximum optimum caseloads which we understand to have been agreed per team

Medway/Swale	25
North East Kent	25 increasing to 30 with new STR recruitment
South East Kent	16 increasing to 21 with new STR recruitment
Dartford, Gravesham and Swanley	16
Maidstone/South West Kent	25

The following funded establishments are taken from current budgets but do not include the proposed new STR workers within East Kent.

CRHT Team	Agreed Funded establishment (early, late, night)	Qualified staff within funded establishment
Medway/Swale	6, 6, 3*	4, 4, 2
North East Kent	6, 6, 3 (2) extra night STR alternating with SEK	5, 5, 2
South East Kent	5, 5, 2 (3) extra night STR alternating with NEK	4, 4, 2
Dartford, Gravesham and Swanley	5, 5, 2* (night band 2 NHSP on the ward to cover S136)	3, 3, 1
Maidstone/South West Kent	6, 6, 3	5, 5, 2

Figure 3.27 below calculates the level of qualified CRHT staff available on the main early and late shifts per 100,000 working age adult population. Medway and Swale, and Maidstone/SW Kent appear to have low levels of cover, compared to the rest of Kent and Medway

**Figure 3.27 Qualified CRHT staff (main shifts) per 100,000 working age adult population, as at July 2013**



Figures 3.28 to 3.30 below present an activity and diversity analysis for CRHT caseloads similar to that which we have prepared for inpatient activity. The available caseload data for CRHT is somewhat more up-to-date than that for inpatients; we have therefore been able to present a slightly more up-to-date picture. Please note therefore that direct comparisons should not be made between the inpatient and CRHT datasets. Please note also that Maidstone and South West Kent CRHT data includes the caseloads of the two constituent teams prior to their merger.

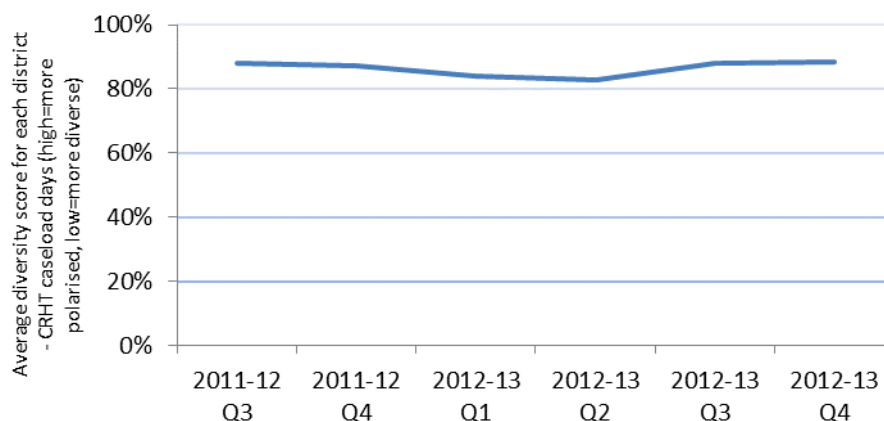
This analysis indicates that the CRHTs are largely geographically self-contained, with the exception of services for the Ashford district.

**Figure 3.28 CRHT caseload days profile – Q3 2011/12**

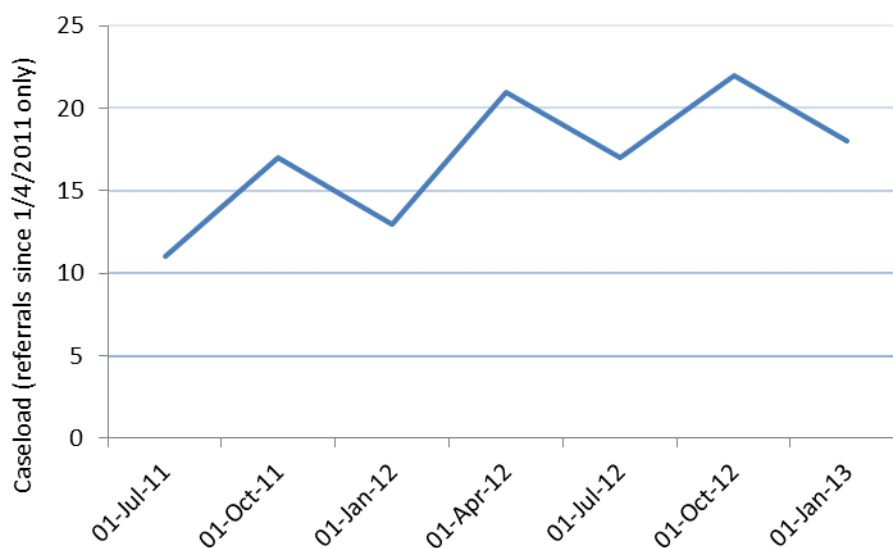
Team referred to	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Medway	Sevenoaks	Shepway	Swale	Thanet	Tonbridge and Malling	Tunbridge Wells
DGS CRHT	0%	0%	98%	0%	92%	2%	0%	0%	0%	0%	0%	0%	0%
Maidstone and South West Kent CRHT*	11%	0%	1%	0%	8%	89%	1%	100%	0%	0%	0%	100%	100%
Medway SW CRHT	0%	2%	1%	0%	0%	5%	96%	0%	0%	95%	0%	0%	0%
NE KENT CRHT	18%	94%	0%	18%	0%	3%	3%	0%	6%	4%	100%	0%	0%
SE KENT CRHT	70%	4%	0%	82%	0%	2%	0%	0%	94%	1%	0%	0%	0%
Diversity Index	54%	88%	95%	71%	85%	79%	92%	99%	89%	91%	99%	100%	100%

**Figure 3.29 CRHT caseload days profile – Q3 2012/13**

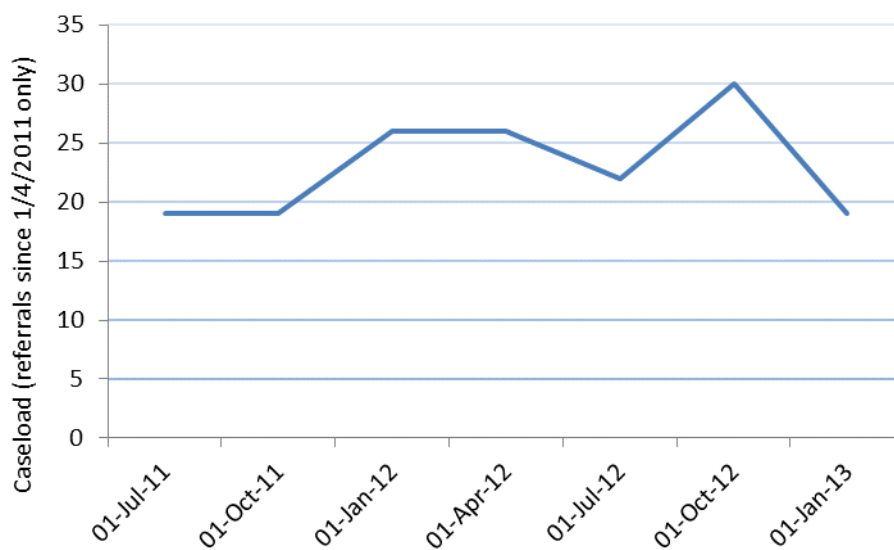
Team referred to	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Medway	Sevenoaks	Shepway	Swale	Thanet	Tonbridge and Malling	Tunbridge Wells
DGS CRHT	0%	0%	97%	3%	88%	0%	1%	1%	0%	4%	0%	0%	0%
Maidstone and South West Kent CRHT*	27%	0%	3%	0%	9%	98%	2%	99%	0%	1%	0%	99%	100%
Medway SW CRHT	0%	1%	0%	0%	3%	1%	96%	0%	2%	94%	0%	0%	0%
NE KENT CRHT	13%	95%	0%	15%	0%	0%	0%	0%	0%	2%	98%	0%	0%
SE KENT CRHT	60%	4%	0%	82%	0%	0%	0%	0%	98%	0%	2%	0%	0%
Diversity Index	45%	91%	94%	69%	78%	97%	93%	99%	96%	88%	96%	98%	100%

**Figure 3.30 Overall CRHT caseload day diversity index Q3 2011-12 to Q4 2012-13**

Figures 3.31 to 3.34 below show the caseloads of each crisis team on the first day of the quarter. Note that Maidstone and South West Kent CRHT graph includes the caseloads of the two constituent teams prior to their merger. These suggest that, notwithstanding their relatively generous size compared to the rest of Kent, the teams covering East Kent have been operating over their currently agreed caseload capacity for almost all of the data period; as has the team covering Dartford, Gravesham and Swanley.

**Figure 3.31 CRHT caseload July 2011 to January 2013 – Dartford, Gravesham and Swanley**

**Figure 3.32 CRHT caseload July 2011 to January 2013 – Medway and Swale**



**Figure 3.33 CRHT caseload July 2011 to January 2013 – North East Kent**

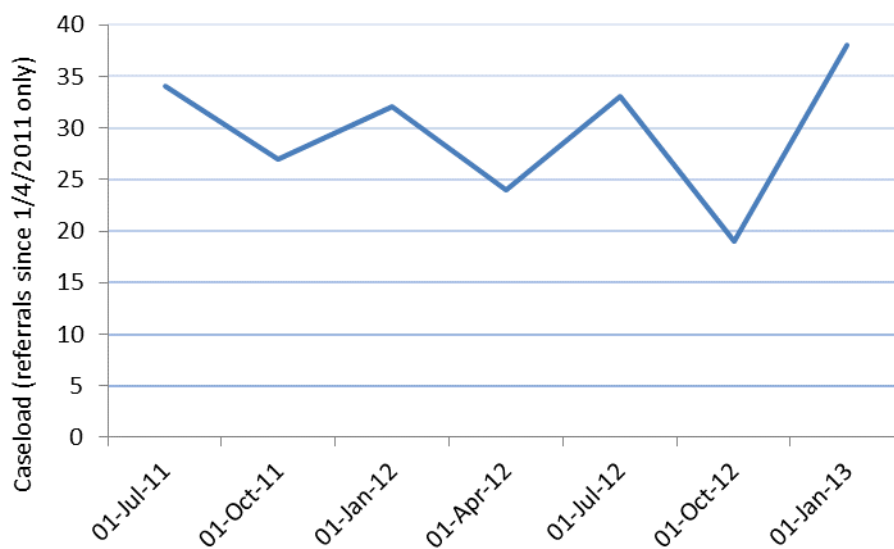


Figure 3.34 CRHT caseload July 2011 to January 2013 – South East Kent

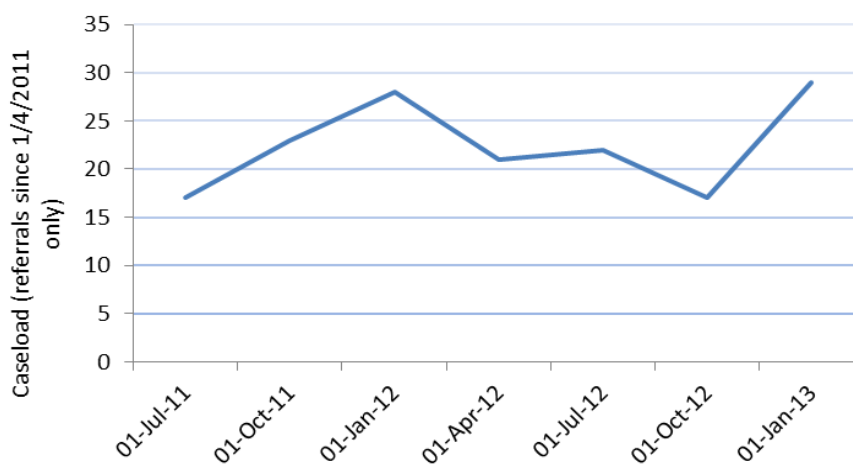
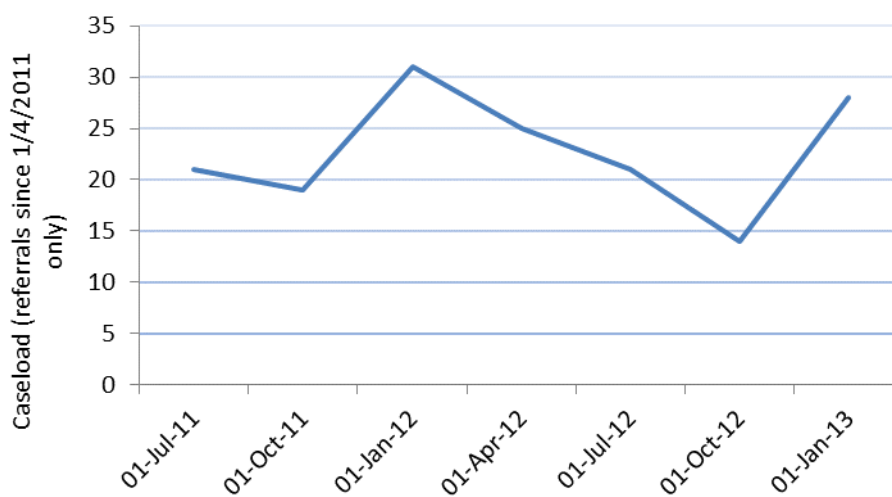


Figure 3.35 CRHT caseload July 2011 to January 2013 – Maidstone and South West Kent





### 3.3 Perspectives from local visits and interviews

In our discussions with local stakeholders, we focussed on three main questions:

- The number of acute inpatient beds which should be available in Kent and Medway
- The number of sites from which those beds should be provided
- The location of the sites

This section presents a summary of the opinions which we heard. This section should therefore not be read as representing the views of this report's authors, which are given in section 4 below. It attempts to explain the balance of opinion as it was given to us, for each of these three main questions in turn:

#### ***The number of acute inpatient beds which should be available in Kent and Medway***

We heard a significant level of concern that the planned reduction in inpatient beds might be too great, and not in fact safely achievable; only a small minority of our interviewees felt confident that the currently planned numbers would prove safe and sufficient. The majority view was based on three fundamentals:

- Awareness that there had been a number of errors in the data analysis supporting the case for 150 acute beds + 12 PICU beds
- Awareness that, since the publication of the paper "Achieving Excellence in Mental Health Crisis Care" in June 2012 (which contained the 150+12 proposal), demand for acute mental health services had been consistently higher than anticipated
- A lack of confidence that the proposed changes to the service model (most notably increased investment in crisis resolution home treatment, a small increase in PICU outreach, and planned reduced use of home leave) would in fact be sufficient to reduce the pressure on acute beds to a level within which the 150+12 option would be achievable

However, this majority view did not necessarily translate to a wish to see more investment in acute inpatient beds, as opposed to more investment in the acute care pathway. Some interviewees did clearly wish to see more beds retained within any reconfigured model; others would prefer to see some or all of any additional money to be invested in alternatives to admission, including crisis resolution home treatment teams, and sub-acute "crisis houses" for people who cannot appropriately be managed at home.

#### ***The number of sites from which those beds should be provided***

There are clear differences of opinion on this issue. Some interviewees felt strongly that four sites should be retained, possibly even that this number should increase, arguing that local access and community links should weigh most heavily in planning and decision-making. Others felt equally strongly that the number of sites should reduce to three, possibly even that this number should fall to two in due course, arguing that concentration of specialist expertise should weigh more heavily.

***The location of the sites***

Here too, as to the general principle, there were clear differences of opinion. Interviewees from Medway wished to see some form of inpatient service retained in Medway; those from outside Medway did not consider this as good a site as Maidstone. Even when this was considered as a “blank sheet of paper” question (i.e. if a wholly new service were being designed, disregarding the number, size, location and condition of existing facilities) there was little support outside Medway for Medway as a service site.

When the question was considered with regard to actual current facilities, there was a greater measure of consensus, in that no interviewee considered the current A block facilities at Medway Maritime hospital to be suitable for acute psychiatric care, and almost all interviewees did not consider it realistic for any form of refurbishment to be possible, for those facilities to be brought up to modern standards.

Efforts to find an alternative site in Medway were considered to have been thorough by those who did not support the continuation of inpatient services in Medway, and insufficient by those who wished to see those services retained somewhere in Medway. We were advised that, even if a suitable site could be found, there is currently no capital available for a substantial development in Medway, although the exact potential cost of such a development is clearly somewhat disputed.

Across all of these questions, there was a widespread sense of frustration at the length of time during which they have been under discussion, and with the nature of much of that discussion. There was also, between some parties, a significant measure of distrust of others’ actions and motivations.

## 4. CONCLUSIONS

### 4.1 Introduction to conclusions

Planning provision of acute psychiatric beds for adults of working age is a complex task. The range of factors potentially to be taken into account is very wide:

- The expected incidence of serious mental crises within the community to be served
- The balance of provision desired between community-based and hospital-based crisis services
- The effectiveness of current services in gatekeeping access to beds, in managing community-based home treatment, and in managing inpatient episodes
- The levels of provision of services for other age groups
- The levels of follow-on service provision: rehabilitation and recovery services of various types
- The pattern of existing facilities
- The ability to attract, retain and provide safe levels of skilled staffing
- The desired approach to specialism within services
- Geographic access to services for local communities
- The extent to which “overspill” placements to manage spikes in demand are locally feasible and considered locally acceptable

***It is therefore important to stress that there is no formula into which data about these factors can be entered, and which can produce the “right” answer as to the numbers of beds required, or where they should be located.*** Considerable debate within Kent and Medway has focussed on statistical evidence as to use of beds and of community alternatives: whether it is accurate, whether it provides evidence of changing patterns of demand or simply changing patterns of supply, whether historic trends can sensibly be projected into the future. These statistics and the debate around them do matter, but they cannot and should not be used as the sole basis for decision-making. Historical resource use statistics will not bear that weight. Nor do such statistics properly reflect the extent to which decisions about acute inpatient care are as much policy decisions as statistical decisions, in that they represent a decision as to the balance of ways in which people in acute mental health crisis should be cared for.

Decisions to admit people to psychiatric inpatient care are very often not clear-cut. There are some situations where almost every professional and family would want an admission (even if that means admission to a bed some distance from home); there are others where almost every professional and family would agree that the person can and should be safely managed at home. But there are many situations which fall in a “grey area” on this spectrum; situations where the availability of a local bed, the availability and effectiveness of local alternatives to admission, and the preferences and judgement of professionals, family members, and the patient will all play a part.

There is therefore a substantial element of judgement, not only in these individual decisions, but in the overall decision of those charged with planning and providing health and social care as to how many acute beds should be provided, and where they should be.

***In asking us to review local reconfiguration proposals, you have essentially asked us for our judgement: what we would do if we faced the decisions and responsibilities which you now face. We have worked to do this in as evidence-based a way as possible, but we wholly accept that others will come to different conclusions, based on this evidence. What follows is our judgement, based on the available evidence.***

## **4.2 What does good look like?**

In reaching this judgement, we have had regard to guidance as to what a good acute inpatient service should look like. In terms of general policy, the national policy guide on these services explains:

*“The purpose of an adult acute psychiatric inpatient service is 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. It should be for the benefit of those service users whose circumstances or acute care needs are such that they cannot at that time be treated and supported appropriately at home or in an alternative, less restrictive residential setting.”*  
(Department of Health, policy implementation guide)

This definition is, in our view, worthy of detailed consideration. The overall purpose of acute inpatient care should be:

- *to provide a high standard of humane treatment and care in a safe and therapeutic setting*, emphasising the need for skilled and compassionate staff, and good physical facilities
- *....in the most acute and vulnerable stage of their illness*, noting that inpatient care should be used for people who are seriously mentally unwell
- *.....such that they cannot at that time be treated and supported appropriately at home or in an alternative, less restrictive residential setting*, indicating that care should be provided outside inpatient settings whenever possible but that it should be available when home or alternative care is not considered safe.

In further detail, the Royal College of Psychiatrists (2011) have identified that good inpatient services should deliver:

1. Bed occupancy of 85% or less
2. A maximum of 18 beds
3. A physical ward environment which is fit for purpose
4. A therapeutic space, with a programme of activities, and a holistic approach to healthcare
5. A proportionate approach to issues of risk and safety within the ward
6. Information sharing and involvement in care planning
7. Good links with other services and other agencies
8. Access to psychological therapies
9. Adequate skilled staffing, enabling regular 1-1 contact
10. Socially and culturally sensitive care

We would add to this a principle about overall provision, which we are aware has also been considered locally: that “normal cause” variation in demand for beds should be manageable within the local bed stock i.e. overspill beds in other areas should only be sought in exceptional circumstances.

In considering the issue of the number and location of beds, we have kept these principles in mind, and sought the configuration which appears to us most likely to deliver services consistent with these standards. We have also kept in mind the principle that community alternatives should be considered prior to admission.

### 4.3 What does the evidence suggest?

In reaching the conclusions presented here, we have considered the evidence from national benchmarking, from local data analysis, and from the opinions of key local stakeholders – as well as our own experience of visiting the four acute sites.

These four sources of evidence seem to us, in summary, to say the following:

#### ***National benchmarking***

Compared with other similar places in England, Kent and Medway already provide few acute inpatient beds. Levels of provision of crisis resolution home treatment are typical of the comparator set; inpatient beds for older people are also provided at a typical level. The only service examined in this review which appears to be provided at a level slightly above what would be expected is rehabilitation beds for adults of working age. Social care models appear very different across Kent and Medway, but there is no clear pattern between comparators to enable clear conclusions to be drawn as to the potential implications of these differing models.

As regards the location of beds, the comparator data we have assembled and mapped do appear to confirm a typical pattern of acute mental health services being distributed across a greater number of sites, and closer to centres of deprivation, than is proposed for Kent and Medway. The choice of a Canterbury-Maidstone-Dartford 3-site pattern creates a service on average 1.5 miles more distant from centres of deprivation than would a Canterbury-Medway-Dartford pattern.

#### ***Local data analysis***

The clear and reliable messages from local data analysis are:

- Existing acute inpatient services have been operating at or close to full capacity
- There is a clear picture of pressure being higher in East than in West Kent, across inpatient and community-based acute elements of the acute care pathway
- Crisis resolution home treatment services are not provided equitably across the area
- Delayed transfers of care are contributing only to a very small extent to these pressures

#### ***Local stakeholder opinion***

This opinion very much matters. Local people involved in planning and providing services are very considerably more familiar with the reality of those services than our independent perspective. We were therefore particularly struck by:

- The widespread lack of confidence that the 150+12 proposal will in fact provide sufficient beds
- The very substantial consensus that the facilities at A block in Medway Maritime are not acceptable, and should close
- The strong wish of people in Medway to retain an inpatient mental health service in the area; a wish which is largely not supported outside Medway

- The very unfortunate level of mutual distrust, between some parties in this process, which may have hampered efforts to find a consensual solution

In this context, we think it is regrettable that the formal public consultation document for this reconfiguration, although it did explain the deficiencies with A block, did not explain why there was no option for the service to be relocated within Medway. We agree that there is no expectation to include options which cannot in fact be delivered, but we think this omission may have contributed to a lack of clarity about the status and potential of the option of relocation within Medway.

#### **Site visits**

The difference is striking between the quality of facilities available across the four acute sites in Kent and Medway. The new wards at St Martin's Canterbury are of an excellent quality, with individual rooms, a good range of internal and external space, room for activities and therapies, and good staff and clinical accommodation. The newly refurbished ward on this site lacks full ensuite facilities, but is otherwise a very good ward facility. The grounds are spacious and pleasant.

Priority House in Maidstone also offers a very good standard of accommodation for acute psychiatric care, not quite as modern as the newest facilities at St Martin's, but well-designed and well-maintained. The acute wards at Little Brook Hospital, Dartford, are somewhat less modern in design, with somewhat less space, but also offer a good standard of accommodation.

However, the differences between these three facilities are small compared to the difference between all three and the wards in A block at Medway Maritime Hospital. We concur completely with the clear local view that these wards are unacceptable for modern mental health care; we think it is regrettable that the protracted nature of local planning and discussions have resulted in these wards remaining in use for as long as they have. If these wards were not currently in use for psychiatric care, it seems to us certain that a proposal to use A block for such services would be dismissed by all parties as ill-conceived and indeed somewhat bizarre.

We are also not convinced that any refurbishment of the A block area could produce a service of an acceptable standard. The template of these wards is such that it will simply not be possible to secure the provision of individual ensuite rooms as well as an acceptable level of other internal and external spaces; however imaginatively refurbished, the wards would remain spread across the main corridor of a general hospital, and would struggle to offer a safe and suitable environment for the care of acutely unwell people.

#### **4.4 Recommendations**

This is not a straightforward decision. We entirely understand the wish to retain services as locally as possible, and concerns about issues of travel and access. We are also conscious of concerns about the various ways in which local debates about this issue have been framed, and regrets that we are starting from the pattern of services as they currently are. However, solutions which presume "blank sheets of paper", or a different starting point than current reality, are of only theoretical value, and both our and the JHSOC's task is to consider options which are actually available, either now or in a plausible future.

On balance, and taking all of the above into account, we support the proposal to consolidate acute inpatient beds at Dartford, Maidstone, and Canterbury. The principal driver of this view is the very poor quality of the A block wards at Medway Maritime hospital. Notwithstanding the various caveats below, it seems to us that all of those involved in the planning, commissioning and oversight of local health services – and ourselves, as providers of an independent opinion – would be failing in our responsibilities if we allowed other considerations to mean that people continued to be admitted to these facilities for any significant additional time. These wards should cease to provide mental health care as soon as practically possible.

The consolidation option appears to us therefore to offer:

- The most plausible early means of moving out of the unacceptable facilities at A block in Medway
- An opportunity to consolidate services and expertise in a way which could improve the quality of care provided

Although we understand the motivations behind this idea, and we expect that a site could in fact be found, we are not convinced that there is real merit in trying to seek an alternative site in Medway. A freestanding unit of this nature would remain a small and relatively isolated mental health facility. If capital on this scale is in fact available (and we have been clearly informed that it is not), it would be far better used in upgrading and/or extending existing facilities than in a new-build project in Medway.

We acknowledge that this will increase travel times for a number of patients, visitors and staff, but thought does appear to have been given to supporting the issue of travel and access both practically and financially, and we do not think that this issue should weigh more heavily in the balance than the quality of facilities and of the patient care actually provided. We also acknowledge that this solution is slightly less ideal in terms of siting of services near centres of deprivation than would be a Dartford – Medway – Canterbury pattern. However, we judge that the, on average, 1.5 more miles between those centres of deprivation and the facilities is an acceptable amount, given the very significant difference in quality of facilities. We note that the NCAT appointed Consultant Psychiatrist supported the reduction from four sites to three, and even proposed that there should be a longer-term aim of reduction to two sites.

In the medium to long-term, the design life of the current facilities at Maidstone will of course come to an end. It may be that future planners will wish to consider at that point the option of relocating this service to Medway. However, this is not at all imminent, and many other currently unforeseeable events will happen in the meantime. As things currently stand, it would be extremely hard to justify the closure of good quality facilities in Maidstone, taking the whole Kent and Medway community into consideration.

In making this recommendation, we are not however convinced that the concept of “centres of excellence” has been sufficiently well articulated locally. The consolidation of services on to a smaller number of sites clearly does offer the opportunity to improve staffing levels, therapies, cover arrangements, research opportunities, specialist service offerings, management of risk, cultural sensitivity and so on – to demonstrate that the characteristics of a good inpatient service are not just more likely to be met, but will tangibly improve. We gained however insufficient sense of a clear plan to deliver these improvements, or that

such a plan was understood and “owned” across current acute care staff; we would encourage both more planning to be done, and better communication of the results of that planning, so that the benefits of this change can be understood as actual, rather than theoretical, and so that their delivery can be implemented and monitored in practice.

We are also very hesitant indeed about the issue of bed numbers. The current proposals would appear to place Kent very low on the spectrum of provision, when compared with other similar places. It is important to stress that this is not necessarily a bad thing; there is nothing inherently desirable about being in the middle or upper end of this spectrum, given the principle of community-based management as the preferred option, where safely possible. However, for the proposals at this level to be realistic, we would expect to see:

- High investment in services designed to avoid admission, such as crisis resolution/home treatment or crisis house-type accommodation, with local confidence as to their effectiveness
- High levels of aftercare/rehabilitation/recovery services
- High ability to contain admissions within the designated catchment service
- Evidence of a good ability to manage existing beds within acceptable occupancy ranges, ideally at or around 85%
- Good local confidence, across a range of agencies, that the low bed numbers could prove sufficient

None of these appear currently to be the case; although we do note that delayed transfers of care are at a low level in Kent and Medway, and that throughput does not appear to be significantly delayed for want of places to discharge people.

We are conscious that there is a risk of a circular argument here, in that both confidence and evidence that a proposal is realistic can sometimes only be fully available once the proposal has in fact been implemented; this is particularly the case as regards reductions in established service models. But we do think there is a good case that the proposed level of disinvestment from the acute care pathway may be greater than the local system can currently safely manage.

This should not, however, be read as a recommendation that more acute beds are necessarily needed. This should instead be read as a recommendation that a greater proportion of the savings released from the closure of A block should be reinvested elsewhere in local acute care. This could be in additional crisis resolution/home treatment services; or in additional services designed to facilitate and support discharge and rehabilitation; it could also be in at least some additional beds, over and above the 150+12 option.

It is very difficult to recommend specific numbers, although we are conscious that local analysis is continuing to attempt to estimate the right numbers. We have heard from several well-placed stakeholders that existing crisis resolution home treatment services are often too stretched to provide home treatment which could otherwise safely be offered, and that unnecessary admissions can be the result. We also note the inequitable size of existing CRHT services. We understand that the actual proposed reinvestment in crisis resolution services has been set at £297,000 (with a small further investment in PICU outreach.) Our view is that there is potentially a substantial gap between the amount of reinvestment proposed, and the level of reinvestment which could perhaps create the real momentum for a changed service model which is being sought, and offer reassurance that safe levels of service will



continue to be available. A financially neutral plan, in which all of the money saved is reinvested, would not appear to us to represent an excessive spend on acute mental health care.

This review has been brief; we do not have an overview of the local financial situation, and therefore the practicality of increasing the level of reinvestment and/or redirecting investment from other services into acute care; choices as exactly to how to balance the spending of any additional reinvestment warrant proper local discussion, not simply external recommendation from so short a process. We would urge all local parties to consider this question together as soon as possible.

We have however no wish whatever for any action arising from these recommendations to be the cause of A block remaining in use for any longer than immediately necessary; this process has already been protracted enough. We hope that it is possible for the work required to develop clearer plans for the “centres of excellence” and for some additional reinvestment to be taken forward rapidly, and in parallel with the practical plans for the closure of the A block acute service.

In summary, we therefore recommend that the JHOSC support the proposed reconfiguration of acute mental health inpatient services in Kent and Medway, subject to:

- An increase in the retention for reinvestment, at as high a level as possible, to be spent on further increases in crisis resolution/home treatment and/or a small number of additional acute beds
- A clear plan being developed for the delivery of the elements of genuine centres of excellence in the three remaining sites

## **APPENDIX ONE – DOCUMENTS RECEIVED**

### **FOLDER ONE**

1. November 2010. Review of Compliance - Care Quality Commission.
2. November 2011. Kent and Medway Key Risks summary paper to the Board.
3. 30 November 2011. Meeting Trust Board Part 1 re Governance and Risk Report.
4. 21 December 2011. KMPT Chief Executive's and Executive Team's Report.
5. 22 December 2011. Letter from Bob Deans, Chief Executive, to Katie re Mental Health Services.
6. 9 March 2012. Kent HOSC - Minutes re meeting.
7. 27 March 2012. Medway Council re Meeting of Health and Adult Social Care Overview and Scrutiny Committee – Inpatient Bed Review.
8. 22 June 2012. Emails re briefing note for Councillors.
9. 25 June 2012. Site visits for JHOSC A Block and Little Brook, Dartford.
10. 26 June 2012. Kent and Medway – Achieving excellence in Mental Health Crisis Care – Briefing.
11. 28 June 2012. Letter from Angela McNab, Chief Executive, Kent and Medway NHS to Councillors, Joint Health and Overview Scrutiny Committee, Kent and Medway re Service Visits Monday 25 June 2012.
12. 3 July 2012. Kent and Medway NHS Joint Overview and Scrutiny Committee – first meeting. Agenda/Minutes.
13. 10 August 2012. Email from Sue Brown to Tristan Godfrey re Acute mental health review – JHOSC meeting actions and responses.
14. 21 August 2012. Health and Adult Social Care Overview and Scrutiny Committee work programme – update on progress.
15. December 2012. Independent Analysis of public consultation.
16. 6 December 2012. Emails from Sue Brown to Tristan Godfrey re Point 5 – Alternative Sites.
17. 7 December 2012. Emails from Rosie Gunstone to Julie Keith re Point 5 – Alternative Sites.
18. 18 December 2012. Email from Sue Brown to Rosie Gunstone re Acute mental health services review update.
19. 21 December 2012. Emails from Sara Warner to Julie Keith re Point 1 - Alternative Medway Options. Point 2 – Information on Medway residents accessing acute mental health services outside of Medway. Point 3 – Details of staffing at Medway A Block. Point 4 – CQC Reports of all sites involved in the proposals.
20. 7 January 2013. Email from Sue Brown to Julie Keith re A Block – Alternative Sites.
21. Report re work undertaken in 2011 to find an alternative solution to Medway A Block.
22. 8 January 2013. Emails re A Block Medway Hospital, alternative sites.
23. 8 January 2013. Emails re Admissions.
24. 29 January 2013. Emails re acute beds. Rosie Gunstone/Tristan Godfrey/Julie Keith.
25. 30 January 2013. JHOSC Supplementary Information.

## **FOLDER TWO**

1. July 2012. The University of Manchester - Annual Report of National Confidential Enquiry into Suicide and Homicide.
2. 3 July 2012. Minutes. Kent and Medway NHS Joint Overview and Scrutiny Committee.
3. 2013-14 Patient Safety Priority 2.
4. 9 January 2013. Letter from Wendy Purdy, Vice-Chairman, Kent and Medway NHS Joint Overview and Scrutiny Committee Medway Council and Kent County Council to Angela McNab, Chief Executive, Kent and Medway NHS and Social Care Partnership Trust.
5. 21 January 2013. Confidential briefing for Medway Members of JHOSC and Chair of HASC on adult mental health inpatient beds review.
6. 22 January 2013. Visit to Little Brook Hospital, Dartford.
7. 30 January 2013. JHOSC Supplementary Information.
8. 30 January 2013. Appendix 2. Issues of detail and data raised in the consultation and the review team's response.
9. 5 February 2013. Agenda from Peter Sass, Head of Democratic Services, Kent County Council.
10. 13 February 2013. Kent and Medway – B023/13 Acute Mental Health Services.
11. 13 February 2013. Minutes re Kent and Medway NHS Joint Overview and Scrutiny Committee Meeting.
12. 13 February 2013. Proposal from Medway Councillors.
13. 19 February 2013. Letter from Cllr Wendy Purdy to Felicity Cox re Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) – Adult Mental Health Inpatient Services Review.
14. 20 February 2013. Letter from Felicity Fox, Director of Kent and Medway NHS Commissioning Board to Chris Smith, Chairman, Kent and Medway NHS Joint Overview and Scrutiny Committee. Re PCT cluster Board Met 20 Feb to discuss options for acute mental health services in Kent and Medway
15. 20 February 2013. Minutes of the Kent and Medway Cluster Board meeting.
16. 20 February 2013. Agenda re Kent and Medway Cluster Board meeting.
17. 20 February 2013. Report 'Achieving Excellence in Mental Health Crisis Care recommendations'.
18. 28 February 2013. Letter from Cllr Wendy Purdy to Felicity Cox re Kent and Medway NHS Cluster Board Meeting – Adult Mental Health Inpatient Services Review.
19. 11 March 2013. Agenda re Kent and Medway NHS Joint Overview and Scrutiny Committee Meeting.
20. 11 March 2013. Email from Tristan Godfrey on behalf of Mr Antonios Antoniou circulated to Members of the JHOSC re Supplement Paper for JHSOC (A Block) member meeting on 19.03.13.
21. 13 March 2013. Letter from Felicity Fox to Cllr Purdy.
22. 19 March 2013. Kent and Medway NHS Joint Overview and Scrutiny Committee Meeting.
23. 19 March 2013. Minutes re Kent and Medway Committee Meeting.
24. 19 March 2013. Kent County Council. Report re Kent and Medway NHS Joint Overview and Scrutiny Committee Meeting.
25. 19 March 2013. Joint HOSC Meeting: Alternative Proposals.
26. 19 March 2013. Email from Julie Keith to Felicity Cox re letter to Cllr Purdy dated 13 March.

27. 20 March 2013. Board Meeting.
28. 20 March 2013. Kent and Medway Cluster Board Minutes.
29. March 2013. Progress Update on Achieving Excellence in Mental Health Crisis Care.
30. 20 March 2013. Email from Rosie Gunstone to Julie Keith re Draft decision from JHOSC for urgent comments. Email returned from Julie Keith to Rosie Gunstone with comments.
31. 28 March 2013. Kent and Medway Trust Board Meeting.
32. March 2013: A critical analysis of the data presented in the KMPT acute service review and redesign 2012. Stephen Allan, University of Kent.
33. 9 April 2013. Email from Angela McNab, Chief Executive, Kent and Medway Trust, to Cllr David Brake re Acute Care Review.
34. 16 April 2013. Email from Cllr David Brake to Angela McNab re Kent and Medway NHS Cluster Board Meeting – Adult Mental Health Inpatient Services Review.
35. 19 April 2013. Emails between Rosie Gunstone and Tristan Godfrey.
36. 23 April 2013. Community Care articles website.
37. 1 May 2013. Email from Cllr Wendy Purdy to Angela McNab re Kent and Medway NHS joint overview and scrutiny committee (JHOSC) Adult Mental Health Inpatient Services Review.
38. 1 May 2013. Email from Rosie Gunstone to Angela McNab re acute beds mental health redesign.
39. 24 May 2013. Letter from Marie Dodd, Deputy Chief Executive, Kent and Medway NHS to Councillor Wendy Purdy, Democratic Service re demand for acute care and bed pressures.
40. 12 June 2013. Email from Rosie Gunstone, Democratic Services Officer, Medway Council to Tristan Godfrey, Kent, re Independent experts – Medway's view.

#### **ADDITIONAL MATERIALS GATHERED DURING REVIEW**

1. Dossier of comments and analyses prepared by Antonios Antoniou
2. "Achieving excellence in mental health crisis care" – papers submitted to KMPT Trust board on 28<sup>th</sup> June 2012, with full appendices
3. Analytical review and sensitivity analysis of bed number estimates prepared in draft by David Whiting
4. KMPT acute service line performance management meeting dashboard for period March 2013 to May 2013
5. Review and redesign of acute mental health services – workshop notes and supporting papers prepared by Medway mental health service user engagement project May 2012
6. List of 10 bed availability issues prepared by Medway Approved Mental Health Professionals between February and April of 2013
7. Crisis resolution home treatment caseload management data
8. Notes of two meetings that brought together senior practitioners from across health and social care with local managers from the acute service and recovery service to discuss acute pressures
9. Medway mental health social work governance arrangements

**Achieving Excellence in Mental Health Crisis Care  
Adult Mental Health Acute Inpatient Services Review**

**Briefing Paper for the Kent and Medway Joint Health and Overview and  
Scrutiny Committees – 30th July 2013**

**Introduction**

This briefing paper has been prepared for the Kent and Medway Joint Health and Overview and Scrutiny Committee (JHOSC) meeting on 30<sup>th</sup> July 2013.

It summarises:

- The background to the review
- The proposals, consultation process, and subsequent review by the JHOSC
- Progress on actions agreed at March 2013 NHS Kent and Medway Primary Care Trusts (PCT) Cluster Board
- Impact of the Keogh review into quality of care and treatment provided by 14 hospital Trusts in England
- Next Steps

**Background**

Since 2011 NHS Kent and Medway PCTs and subsequently the eight Clinical Commissioning Groups (CCGs) have been reviewing acute mental health care in collaboration with Kent and Medway NHS and Social Care Partnership Trust (KMPT).

In Spring 2012 proposals were developed with the help of clinicians, service users, carers and stakeholders which focused on developing a new model to address:–

- The increasing need to enhance staffing and improve the service delivered by Crisis Resolution and Home Treatment teams following the success of this community-based alternative to hospital admission.
- Very different levels of psychiatric intensive care support between the East and the West of the area.
- Inequitable distribution of hospital beds for Kent and Medway people who are acutely mentally ill and the imbalance in capacity across the area.
- Long standing concerns about the poor quality therapeutic environment at Medway's A Block, including inadequate privacy and dignity on offer and therefore the sustainability of clinical safety. – This is brought into sharper focus by the Keogh review into the quality of care and treatment provided by 14 hospital trusts in England which has given an increased focus on delivering

services that are clinically effective, safe, and give a positive patient experience.

## **Proposals, consultation process, and subsequent review by the JHOSC**

The proposal is for:

- An increase in Crisis Resolution and Home Treatment teams' staffing to enhance the primary alternative to admission for appropriate patients and facilitate a timely discharge by offering more intensive support.
- A reconfiguration of acute beds to provide centres of excellence in Dartford, Maidstone, and Canterbury for individuals requiring admissions. These will enable medical cover and expertise to be focused - driving up quality of service, care, and patient experience.
- A consolidation of psychiatric intensive care beds in Dartford and establishment of a psychiatric intensive care outreach service in East Kent.

A reconfiguration of acute beds to provide centres of excellence in Dartford, Maidstone, and Canterbury for individuals requiring admissions. These will enable medical cover and expertise to be focused - driving up quality of service, care, and patient experience. Consideration was given to a range of options for the locations of centres of excellence, including the potential for a centre in Medway. However, it was not possible to identify an affordable or feasible option in Medway.

The National Clinical Advisory Team examined the clinical case for change. Their assessment concluded that proposals and direction of travel were clinically sound and should deliver reduced need for admissions and duration of inpatient stays.

Proposals were submitted to the Kent and Medway PCT Cluster in June 2012.

In July 2012, the PCT Cluster Board and the Joint Health Overview and Scrutiny Committee agreed to conduct a public consultation. The consultation ran between 26 July 2012 and 26 October 2012. The consultation responses and process were assessed by the University of Greenwich and the University's findings were reported to the Joint Health and Overview Committee meeting in February 2013.

Overall responses to the consultation were:

- Support for the need to improve services, including a recognition that Medway A Block is not fit-for-purpose.
- Support for enhancing Crisis Resolution and Home Treatment teams' staffing and psychiatric intensive care outreach.
- Concern that the number of acute beds proposed was not sufficient to meet demand.
- Concern about Medway residents needing a bed having to travel to Dartford.

The Kent and Medway Cluster PCT Cluster Board met in March 2013, reviewed the results of consultation, endorsed the model of care and supported the implementation of Option A subject to undertaking the following work:

- A bed sensitivity analysis to test the proposed bed numbers
- Completion of a travel plan covering gaps in transport provision
- Quality impact assessments to be undertaken
- Enhancement of Crisis Resolution and Home Treatment teams' staffing and psychiatric intensive care outreach in advance of any change to beds.

The JHOSC met in February 2013 and March 2013 to consider the proposals and raised questions, in particular about the effects of the proposals on Medway people.

### **Progress on actions agreed at March 2013 NHS Kent and Medway Primary Care Trusts (PCT) Cluster Board**

#### Bed Sensitivity Analysis

The Public Health Directorate in Medway Council was commissioned to:

- Review the original calculations of bed numbers
- Develop a more needs based approach to estimating the number of beds needed taking account of the relationship between local and out of area beds, and the impact of the requirement for beds as a result of the proposed improvements to out of hospital services.

The results of the review of the original calculation is that the original figure of 150 acute beds being sufficient for Kent and Medway is no longer supported by the data. The calculation of beds needed, using correct, up to date data is 174.

Development of a more needs based approach is almost complete.

Attachment 1 is the latest draft paper setting out in detail the results of this analysis. A final version will be available by the end of July 2013 and will be circulated to JHOSC members.

KMPT, in partnership with Commissioners, have reviewed the original model and the particular needs of Medway. This review has considered:

- The longstanding need for the development of supported living and recovery house models to support patients requiring short term enhanced support during a crisis.
- The high number of people with a personality disorder within Medway who are recognised to not do well in an acute setting but who in a crisis need immediate intensive support tailored to their need.

In light of this further review in line the clinical strategy and acknowledging the specific needs of the population of Medway, KMPT proposes the following:

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

These resources will provide local and immediate support to patients who cannot be safely looked after at home in addition to (and working with) the original proposals of intensive home treatment which would significantly reduce the number of people requiring acute admission, and support more timely discharge.

### Travel Plan

A travel plan has been developed and is being implemented. This is included as attachment 2.

### Quality Impact assessments

Quality impact assessments have been developed for the proposed changes and for maintaining the existing arrangements. These are included as attachment 3.

### Development of Crisis Resolution and Home Treatment teams and psychiatric intensive care outreach

Agreement has been reached with the CCGs and with NHS England for KMPT to commence further investment in Crisis Resolution and Home Treatment teams and psychiatric intensive care outreach ahead of any changes to acute beds configuration and additional funding will be provided to fund any double running costs incurred.

### **Impact of the Keogh review into the quality of care and treatment provided by 14 hospital trusts in England**

Overall the Keogh review has strengthened the pressure for the NHS to take rapid action to improve clinical safety, effectiveness and patient experience in areas where there are concerns.

Medway NHS Foundation Trust was one of the 14 hospitals reviewed by Sir Bruce Keogh and is one of the 11 hospitals put into special measure as a result of the review. The recovery plan agreed by the review team and the trust requires the trust to make significant changes to the layout of its services in order to improve clinical safety, effectiveness and patient experience. To achieve this the trust requires KMPT to vacate the site so that the space currently occupied by them in A Block can be used to improve the quality of acute care.



Whilst this does not change the direction of travel for these services it imposes the need to make rapid progress.

KMPT have undertaken contingency planning to establish how soon they could vacate the site which indicates that this work could take 45 weeks to achieve. This means that they will continue to be providing services in A Block through next winter which presents a continuing significant risk to the clinical safety, effectiveness and patient experience of acute services provided at Medway hospital.

### **Next Steps**

The work that has been undertaken since March 2013, as described in this paper, will be taken to CCGs for consideration in the next month . It is proposed to make the following recommendations for CCGs to approve.

- KMPT commence enhancement of Crisis Resolution and Home Treatment teams and psychiatric intensive care outreach to provide increased and improved alternatives to admission for appropriate patients and facilitating timely discharge.
- KMPT commences implementation of the changes to acute beds in Kent (Canterbury and Maidstone) to improve the levels of care provided, especially in the East of the area.
- In the light of the requirement to vacate A Block (enabling Medway hospital to improve acute services), KMPT commences rapid development of alternative provision for acute beds at Dartford, Maidstone and Canterbury, based on a total current Kent and Medway-wide possible requirement for 174 beds.
- CCGs working with local authorities and KMPT commence work to develop detailed implementation plans for local, multi agency urgent care mental health pathways.

## **Adult Mental Health Review – Position Paper for the Kent and Medway Joint Health and Overview and Scrutiny Committees**

### **Analytical review and sensitivity analysis of bed number estimates**

**This report is set out in 4 parts**

1. Introduction and Context
2. Sensitivity analysis: review of bed number estimates and updated numbers
3. Project plan for future work
4. Re-modelling of bed numbers; approach used and initial progress report

#### **1. Introduction**

The Adult Mental Health Review was submitted to the June 2012 Kent & Medway Cluster PCT board proposing a reconfiguration of inpatient mental health services. The review argued that a reconfiguration of acute bed capacity was necessary in order to address undersupply in East Kent, close facilities which are not fit for purpose and expand the Psychiatric Intensive Care (PIC) Outreach service to cover the whole of Kent and Medway in order to concentrate services in three centres of excellence.

This has generated a number of questions both internally and externally, some of which were to do with the methodology for estimating bed numbers and the data produced for this. This report deals only with this methodology and the data issues. The quality arguments for change are not the subject of this report.

In order to ensure that we can be confident in our analysis, we have reviewed both the methodology used and tried to make any methodological issues and uncertainties explicit.

We have re-run the analysis completely from raw data to identify any issues in the original implementation of this approach and updated it to reflect more recent data to see if this affects the proposed changes.

The first concern of all involved in this process is patient safety and welfare and we therefore consider it healthy to question ourselves and listen to concerns continually in order to make sure that any actions we take are based on robust evidence.

#### **2. Estimating the number of beds needed**

The argument for the number of beds needed is based on three elements:

- 1) Average bed use over the year 2011/12 with adjustments (see below for details)
- 2) A decreasing trend in bed use over the previous four years to provide confidence that the proposed reduction in the number of beds is conservative
- 3) A reduction in the number of beds needed as a result of expansion of Crisis Resolution Home Treatment and improvements in community mental health services.

These three elements are considered in turn below.

### Element 1: The number of beds needed

Most of the description of the method used to calculate the number of beds needed is covered in Appendix C of the Review (page 35). The method is described in a narrative form and can be summarised as consisting of the following components:

- The average daily bed use in 2011/12;
- The average number of PICU beds used in 2011/12 by patients who should be in an acute ward;
- An allowance for within-year variation;
- The average net use of out of area beds in 2011/12, i.e. the average of the number of out of area beds used by KMPT patients minus the number of KMPT beds used by patients from other areas.

The values for these four components were calculated in the Review as follows:

**144** average daily bed use (shown in Appendix B) plus  
**7** PICU beds, on average, currently used for acute patients plus  
**7** for within-year variation plus  
**2** average net daily use of out of area beds

i.e.  $144 + 7 + 7 + 2 = 160$

Then on page 20 the Review states that “*addressing [...] the continued high use of non-same-day ward leave, alongside many other factors that affect demand, should result in an average of at least 10 more available beds across KMPT.*”

Therefore the complete formula for calculating the number of beds needed is:

$144 + 7 + 7 + 2 - 10 = \mathbf{150 \text{ beds needed}}$

Re-examination of the data used to produce Appendix B in the Review has now shown that there was an error in the analysis that particularly affects the year 2011/12. Correcting that error shows that the average bed use in 2011/12 was actually 168 (not 144). Using the same logic for the calculation of the number of beds with this revised average use in 2011/12, the number of beds needed is:

$168 + 7 + 7 + 2 - 10 = \mathbf{174 \text{ beds needed}}$

### Element 2: Linear trend shows that a reduction to 150 beds is conservative

The Review uses the linear trend to demonstrate that the reduction to 150 beds in the redesign is conservative. This happens in several places:

- The review states that over the last four years there has been a reduction in demand (pages 4 and 9). For clarity it should be noted that the data are in fact for bed *use*, not *demand*.
- The Review states that rather than following this decline the reduction to 150 beds is conservative (pages 10, 20 and 34) because the linear trend shows that over two years 32 beds could be removed (pages 10 and 20)

- There are three more references to the trend supporting the reduction in Appendix C (page 34)

The linear trend raises two issues: 1) is it appropriate to use a linear trend and project is further into the future?; and 2) has the trend been calculated correctly?

How valid is the linear trend modelling as a basis for reducing bed numbers?

- 1) We have looked at this again and feel we have identified significant concerns that the linear trend modelling approach used to estimate the number of beds that will be required in the next two years is not sufficiently robust as a basis for a decision on bed reduction.

The approach taken in the Review uses a linear trend to project forwards for two years. We do need to make clear that there is considerable uncertainty around the use of such a trend line and that this should be made more explicit. There are four main reasons for this.

- i. It is unlikely in the real world that change of this nature will continue in a straight line for even two years.
- ii. It is also likely that there will be still be a number of people whose mental illness will need inpatient treatment even as community services are increased so at some point the trend may level off. We need to be aware of this and so be constantly checking with real time data what is happening rather than putting much reliance on forecasts which are subject to uncertainty.
- iii. Bed usage and bed closures have a complex relationship but it is clear to a significant extent bed usage figures are influenced by bed closures. Consequently there can be a circular argument in that when you close beds demand appears to go down rather than this being driven by a reduction in underlying need. This is explored more fully in Appendix 2 but again gives a reason why we need to be cautious about bed use as the main basis for predicting future need.
- iv. Even if the linear trend method is used, how accurate are the numbers and estimates and what level of uncertainty do we need to recognise?

On completely re-analysing the raw data, some previous analytical errors have been identified which mean that the rate of decrease in the number of beds assumed in the Review may have been considerably over-estimated. As noted above (Element 1), this has a small effect on 2008/9 to 2010/11, however the figures for 2011/12 show a larger difference (168 as opposed to 144).

This has an impact on any projections made. See Table 1 for the differences in numbers and Figure 1 for the effect this has on predictions.

**Table 1: Average daily bed use on adult mental health acute wards in Kent & Medway by financial years**

Financial year	Average daily bed use	
	Original (Mental Health Review)	Recalculated (this report)
2006/07	-	207
2007/08	-	192
2008/09	207	210
2009/10	196	200
2010/11	184	188
2011/12	144	168

*Source: Excerpt from Appendix B, Adult Mental Health Review and NHS Medway Public Health Intelligence Team*

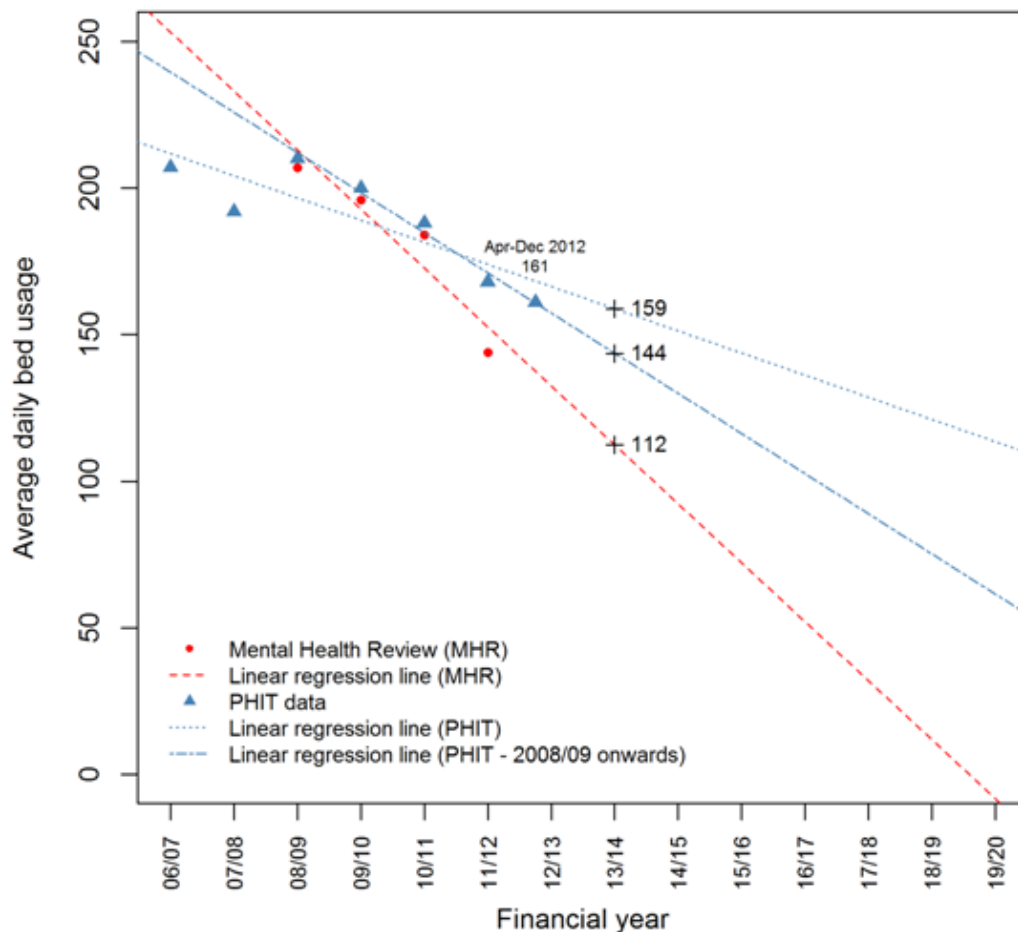
We conducted a sensitivity analysis using the six years data available for Community-based Crisis Resolution and Home Treatment episodes and bed usage in addition to the four years data that was used in the Review. There have been concerns raised that using six years data was more appropriate and we recognised that carrying out a sensitivity analysis using six years would give us greater assurance as to the robustness of our numbers. We have also obtained more data, covering the period April to December 2012.

Using six years of data, ensuring that all the data for 2011/12 are included and adding the new data from April to December 2012 the linear trend shows that rather than falling to 112 beds in 2013/14 as shown in Appendix B in the Review (red line in Figure 1), bed use would fall much more slowly, reaching 159 beds in 2013/14.

Using the complete data for 2011/12 and the new data for April to December 2012 and taking the trend from 2008/09 as per the Review, the projection to 2013/14 is (coincidentally) 144 bed, 32 higher than 112 show in the Review. Note that this is a linear projection and this number may not be reached.

The Review did not use such a projection to estimate the number of beds needed, it used the projection to show that the reduction was conservative.

**Figure 1: Average bed use on acute ward in Kent & Medway by financial year with linear regression lines**



Source: Excerpt from Appendix B, Adult Mental Health Review and NHS Medway Public Health Intelligence Team

Looking more widely, we are aware that we have no reason and no evidence to lead us to believe that mental health need in the population is decreasing. This again reinforces that the primary rationale for decision making on the reduction of bed numbers needs to be based on clarity that the proposed service changes will sufficiently meet the presenting needs for acute care, rather than on this trend analysis. Further consideration also needs to be given to whether underlying need may be captured more accurately.

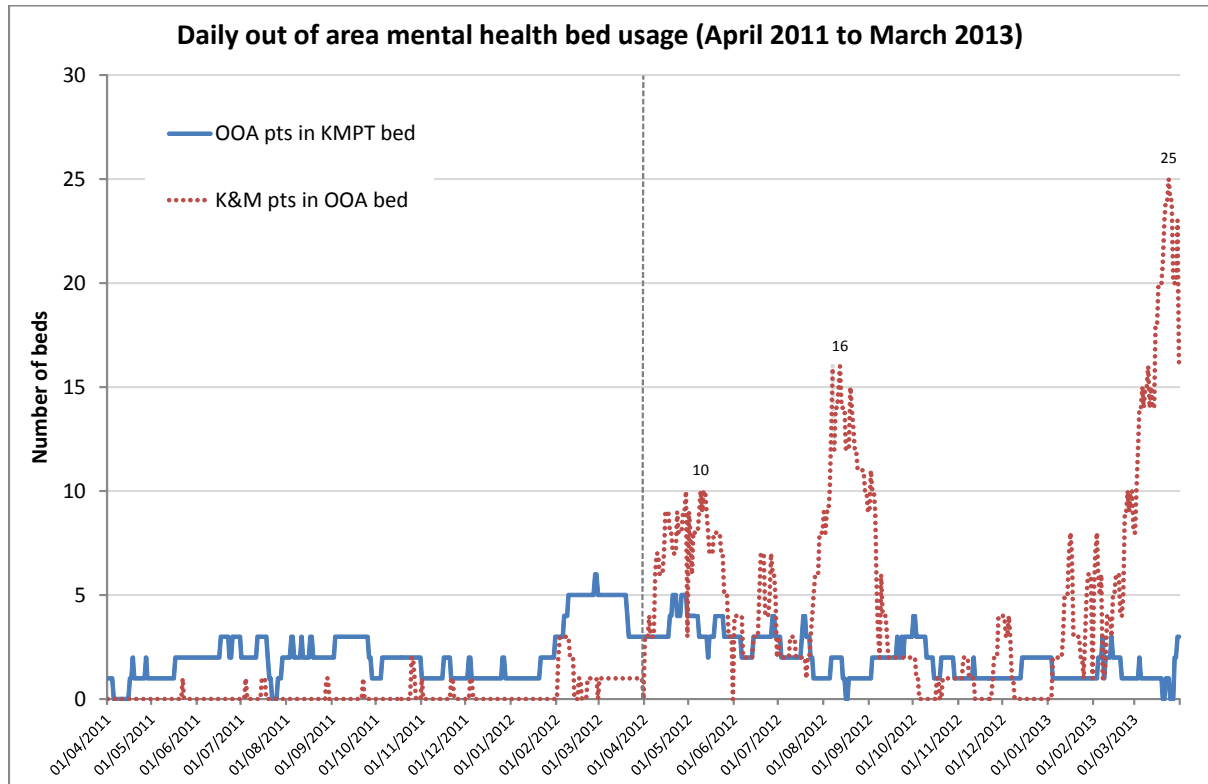
### **Element 3: Reduction in bed use as a result of reduced demand**

Page 20 of the Review states that “addressing [...] the continued high use of non-same-day ward leave, alongside many other factors that affect demand, should result in an average of at least 10 more available beds across KMPT.”

This reduction bed use is used in Element 1, however, we feel that more work needs to be done to make explicit how these changes will lead to proposed bed reduction.

#### Element 4: Increase in out of hours area bed usage

In addition we have done some more work looking at out of area bed usage which is shown below. This also indicates the need to review our previous estimates.



Source: Kent & Medway Social Care Partnership Trust (KMPT)  
Analysed by: Medway Public Health Intelligence team (PHIT)

The data presented here is total ward stays and does not reflect any periods of ward leave. It has been assumed that ward stays relating to Kent and Medway patients being placed in an out of area bed, does not include any kind of ward leave.

Please note: KMPT provided the following explanation for the three peaks observed in 2012/13:

- *May 2012 - There was a reduction of 3 beds due to the decant of Anselm Ward to enable work of new wards at Canterbury, this remained in place until November.*
- *August 2012 – There was a dramatic increase in demand for Acute care, this was also experienced elsewhere in the country (as there was difficulty in finding beds with Private Providers).*
- *March 2013 – Emerald ward was reduced by 2 beds due to maintaining a safe environment. 1 bed remains temporary out of use at Canterbury due to a fire in January. Net effect of 3 beds removed following changes to Woodchurch ward.*

For the most recent financial year (April 2012 to March 2013) there were 741 more bed days involving a Kent & Medway patient using an out of area bed compared to out of area patients using a KMPT bed. The average daily figures are 4.5 and 2.5 respectively (table 1).

**Table 1: Summary of bed use statistics**

	<b>OOA pts in KMPT bed</b>	<b>K&amp;M pts in OOA bed</b>
Total bed usage (2012/13)	921	1,266
Mean bed usage (2012/13)	2.0	5.5
Daily max (2012/13)	5	25

### **Conclusions from sensitivity analysis**

Having checked the data and assumptions again, the basis for 150 acute beds being sufficient for Kent and Medway is no longer supported by the data. The calculation of beds needed, using the approach in Appendix C of the Review, now works out at 174, and the linear trend that was used to provide confidence that a reduction to 150 was conservative no longer provides such assurance. The reduction in the number of beds needed through improvements has not been quantified sufficiently and assumptions need to be made more explicit.

The numerical estimates therefore do not now give us sufficient assurance on bed reductions in order to use them confidently to inform decision making therefore further work needs to be undertaken.

### **3. Project planning for the future**

Following the work undertaken above a project plan has now been developed to take this work forward which is attached as Appendix 3.

### **4. Approach and progress to date on modelling estimated numbers needed**

#### Introduction

The ideal way to estimate the number of beds needed (i.e. demand) is to have a means of estimating the number of people in the population who have acute mental health problems that require admission, and the frequency and duration of those admissions. As far as we are aware there is no recent robust tool for generating such estimates based on current practices of care. We must therefore use proxy estimates of need that are based on previous bed use as indicated above and in the original Review. Bed use is driven to some extent by bed availability and this is therefore hard to interpret when wards are being closed. During the year 2012/13 no wards were closed which means that the 2012/13 year provides a more stable set of data with which to model the estimated number of beds needed.

#### Approach

The approach taken here is in two parts. The first is to demonstrate how often a given number of beds would provide enough beds on each day of the year, and from this to work out how often, and how many, out of area (usually private provider) beds would be needed. As there is variation in bed use (both seasonal and random) a



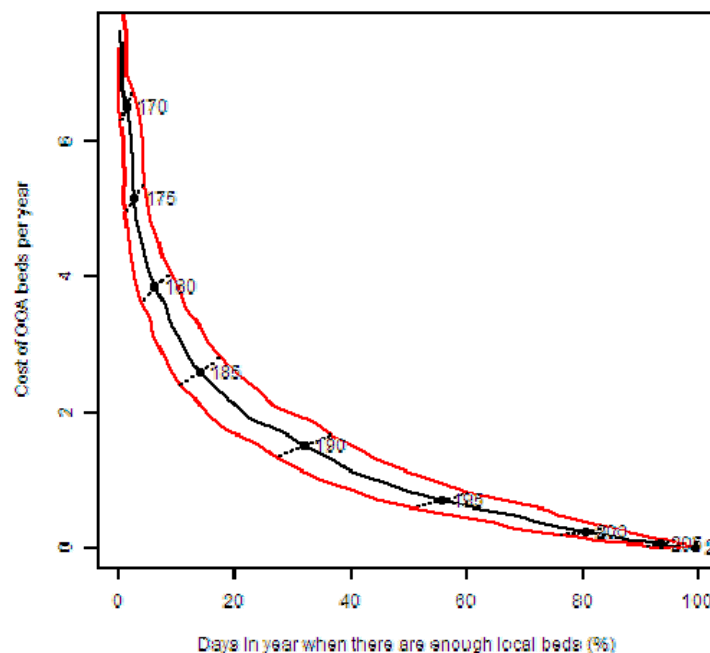
technique known as boot-strapping<sup>1</sup> is used to provide ranges around the most likely values. Using estimates of the average cost of an out of area bed it will be possible to show on one plot for a given number of beds what percentage of days in the year there will be enough beds, and what the expected cost of out of area beds will be.

The second part of the approach is to model the proposed changes to see what effect these are likely to have on the expected bed use. These will be modelled using estimates of the most likely effect of the changes, with ranges around those estimates demonstrating explicitly that we cannot be certain of the exact effect size.

### Results so far

The approach involves developing analytical code that is run many times. The code is almost ready and the figures below illustrate the types of output that will be produced. **Please note that these are for illustrative purposes only and that these numbers should not be used.**

**Figure 1 Example of the type of curve that will result from the analysis**

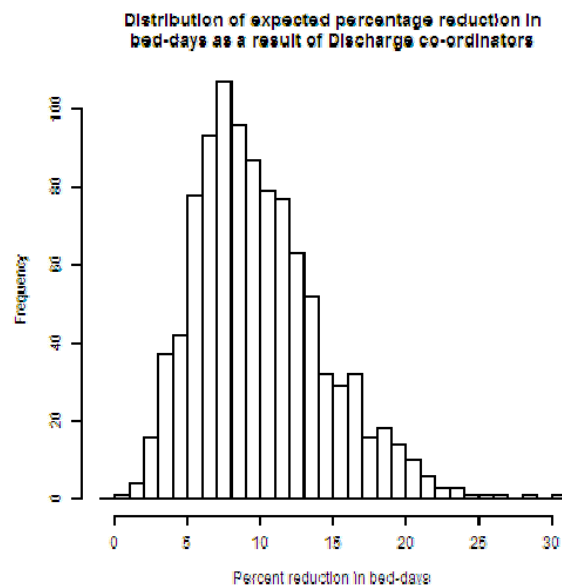


Part 1 of the model: In Figure 1 the number of beds is indicated on the curve line itself, the x-axis shows the percentage of days in the year when there will be enough local beds (assuming no change in need and no change in length of stay as a result of improvements). The y-axis shows the cost of out of area beds (currently this has no units as this is for illustrative purposes only). The red lines show the 95% confidence intervals, and the dashed lines show the confidence intervals for a given number of beds.

<sup>1</sup> Boot-strapping is a statistical technique that involves repeatedly sampling from the data to show which values are very likely to happen and which are much less likely. The approach creates 95% intervals around the estimate. For example, it might say that when there are 165 beds there will be enough beds for 75% of the days in the year, with a confidence interval of 71% to 77%. This means that it will most likely be 75% and we are pretty sure that most of the time it will not be lower than 71% or higher than 77%.

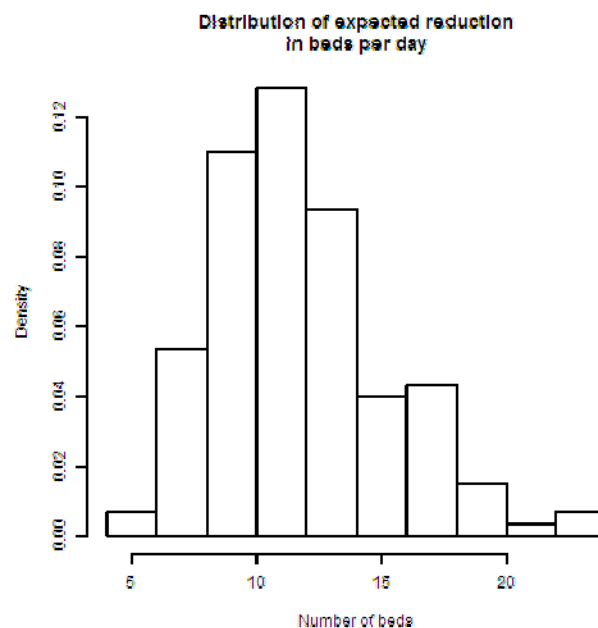
Part 2 of the model: Modelling of the improvements, i.e. reduction in length of stay as a result of STR workers and discharge co-ordinators, is also underway. An example of how the expected effects of the improvements in care will be considered is shown in Figure 2. In this example the discharge co-ordinators are expected to reduce the length of stay by 10%, with a range of 5% to 20%. This information is used to create a distribution of the effect, as shown in Figure 2. This distribution is used in the model so that sometimes the effect may be 10%, other times 5%, others 15%, etc., with 10% being more common than 20%.

**Figure 2 Example of the distribution of expected reduction in bed-days assuming a 10% reduction with a range of 5% to 20%**



A similar approach is used for the other service improvements and these are combined to calculate a distribution of the overall reduction in length of stay and occupied bed days. This will be shown as a distribution, as shown in Figure 3.

**Figure 3 Example of the distribution of expected reduction in beds per day as a result of all of the service changes**



How will this information be used?

Once all of the changes have been modelled and the code run several thousand times, the resulting figures will show how often commissioners can expect there to be enough beds for a given number of beds, and the likely cost implications of out of area beds when there are not enough local beds. It will also show the likely effect of the planned improvements. These will be shown as ranges, e.g. with 170 beds there will be enough local beds for 70% of days (range 65% to 75%), it will cost £XX (range £YY to £ZZ) in out of area beds and the changes are likely to reduce the use of beds by 10 beds per day (range 5 to 20).<sup>2</sup>

Combining this information it will be possible to create a table similar to the one shown below. In this table it is assumed that we want to have enough in-area beds for 70% of the days in the year, and that the ranges around bed use and effect of service improvements are as described above. The shaded area shows the number of beds needed minus the reduction as a result of service improvements, with the most likely scenario being 165 beds.

Table 1: Example showing the number of beds needed to cover 70% of days after the effect of service improvements (for illustrative purposes only, please do not use these estimates)

		Service improvements (reduction in bed use per day)		
		Worst case scenario	Most likely scenario	Best case scenario
Enough local beds for 70% of days		5	10	20
Worst case scenario	176	171	166	156
Most likely scenario	175	170	165	155
Best case scenario	174	169	164	154

<sup>2</sup> These ranges will be 95% confidence intervals

**Appendix 1: Methods used for re-calculating the bed numbers Methods**

Analysis was based on the same raw ward stay data files used to produce the mental health review. Prior to work starting, clarification on the search criteria applied to the patient administration system (PAS) was sought from the analyst at Kent and Medway Social Care and Partnership Trust (KMPT) who supplied the original data. Clarification was also sought regarding the history of modifications to the extracted data from the data analyst in the PCT Cluster, who produced the tables and figures in the review, to enable the outputs in the June 2012 document to be recreated independently.

The raw data contains rows of separate ward stays with multiple variables including a start and end date covering the period from 01/04/2006 to 31/03/2012. Multiple ward stays can make up a 'spell' of treatment if the patient is transferred from one ward to another and each patient can have multiple spells. Other key variables are the Ward name, Ward type (Acute Ward, Acute Older People Mental Health, Psychiatric Intensive Care Unit), Postcode and Age at start of stay.

The data was submitted by KMPT in two batches. The first file contained 19,084 rows and included ward stays during the period 01/04/2006 to 09/02/2012. The second file contained 956 rows and included ward stays during the period 01/01/2012 and 31/03/2012. The datasets were combined and 440 duplicates were removed (retaining the most recent version) which left 19,600 rows of data for further analysis.

First, the data were examined for completeness. Plots of bed occupancy by day, month, quarter and financial year were produced for each ward over the six year period using the R statistical programming language<sup>3</sup>. Re-naming of wards, closures and reclassifications from one type to another were identified. The wards were mapped to the six Mental Health Units (MHUs) in order to take account of possible transfer of patients between wards within the same site and the same analysis was repeated. The plots were annotated with details of changes to the wards in each MHU.

The numbers of younger adults (aged under 65) placed on Older People's Mental Health wards was examined as well as the age profile of patients placed on acute wards. To check data quality, the age distribution of new spells on an acute ward was examined.

Lastly, the number of new spells and average length of stay on acute wards was calculated for each MHU.

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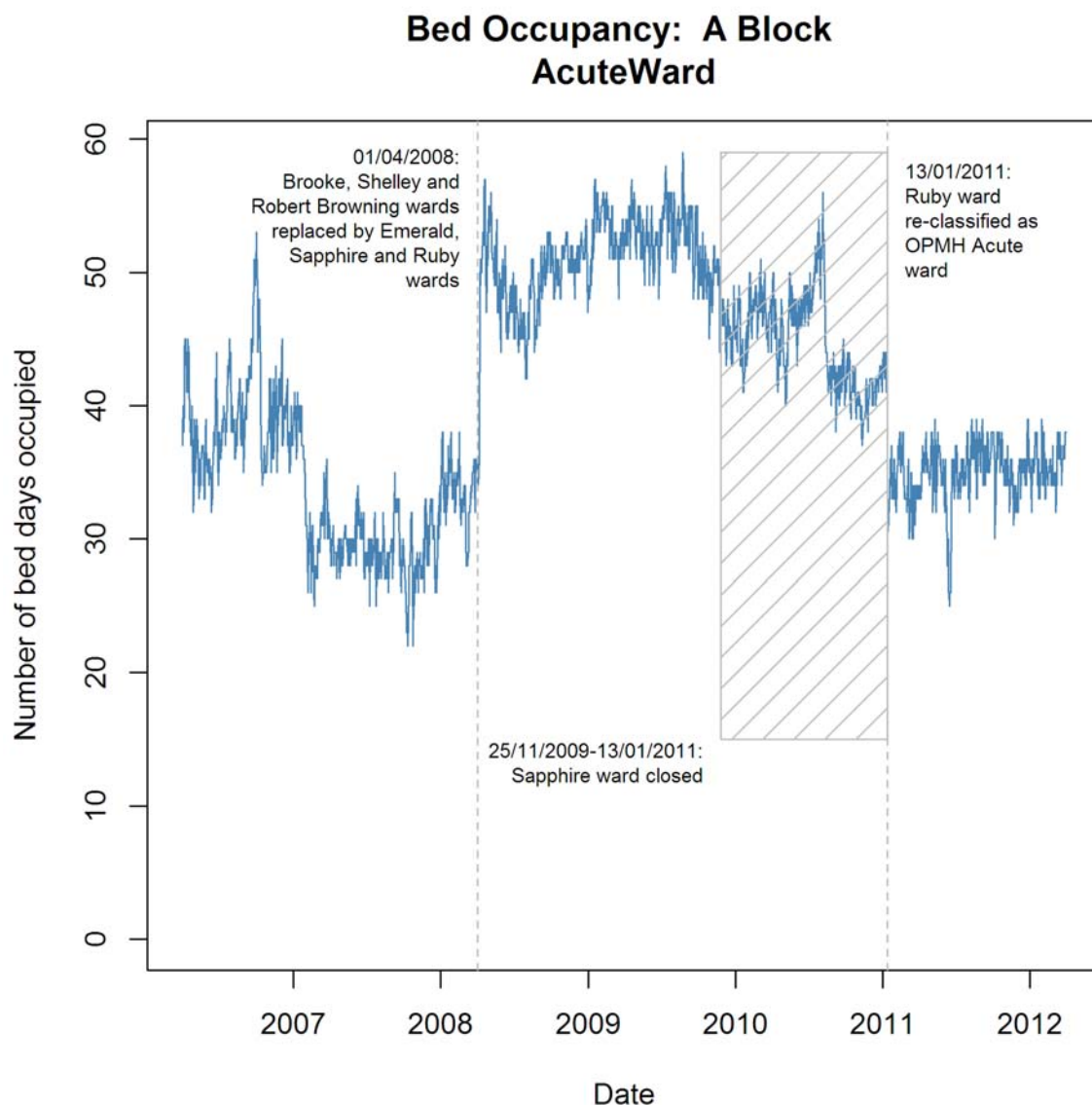
<sup>3</sup> R Core Team (2012). R: A language and environment for statistical computing. R Foundation for statistical Computing, Vienna, Austria. ISBN 3-900051-07-0, URL <http://www.R-project.org/>.

## Appendix 2: Bed usage and bed closures

Figures 2-7 show the daily bed occupancy trends for the six mental health units across Kent and Medway which at some point included wards classified as 'acute' for younger adults. They have been annotated with details of when wards have been opened, closed or re-classified. Figure 8 shows all the known changes annotated on one plot. These show the links between bed closures and bed usage.

In the case of A Block at Medway Hospital, Arundel Unit at William Harvey Hospital, St Martin's Hospital in Canterbury and Thanet Mental Health Unit, it is clear that daily bed occupancy suddenly changes corresponding to changes to the wards.

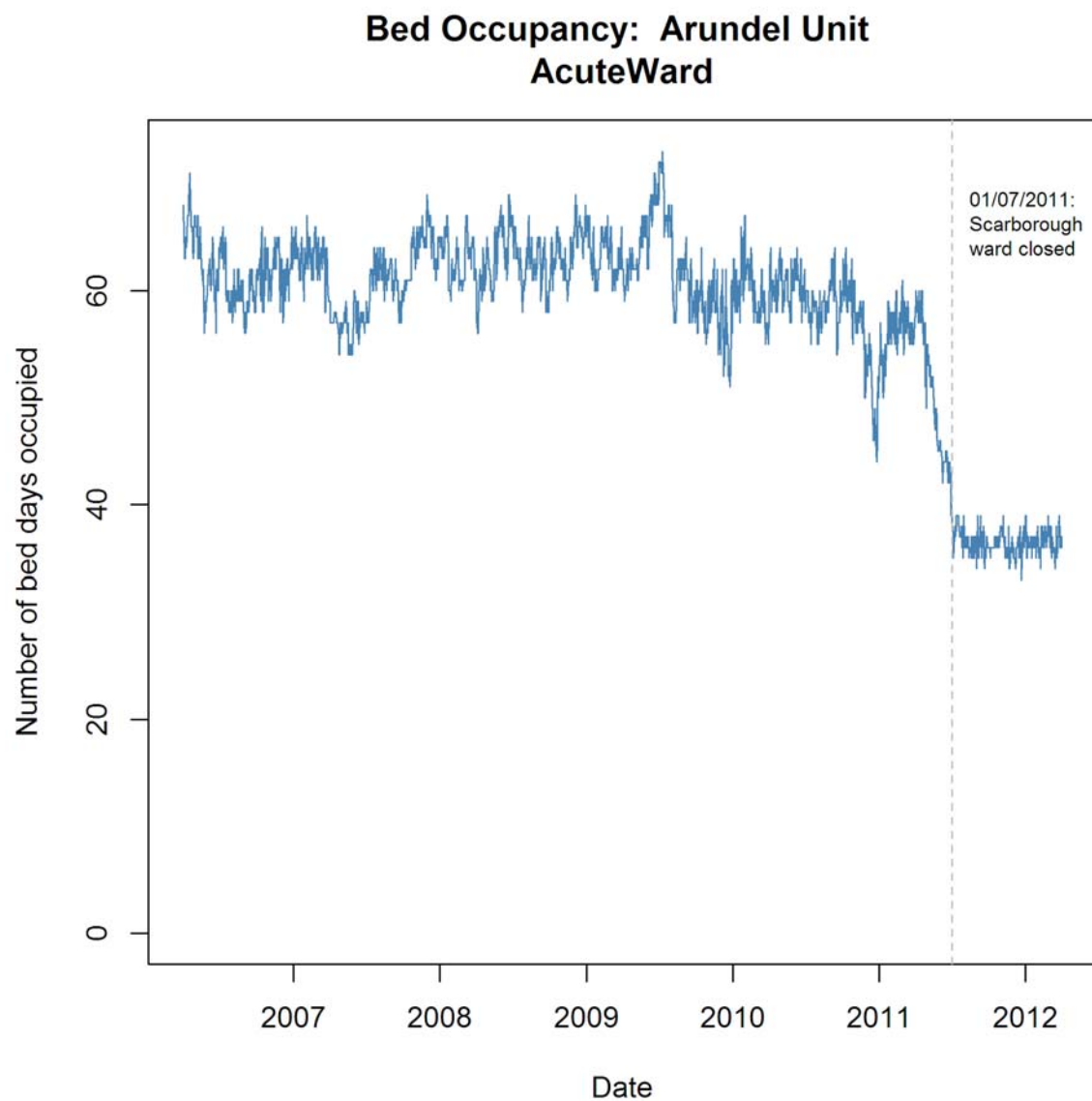
**Figure 2: Daily bed occupancy on an acute ward at A Block (Medway Hospital)**



Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

At A Block, bed occupancy rose sharply in April 2008 but this could be due to an increase in bed capacity not known at the time of writing this report. Sapphire ward was closed between 25<sup>th</sup> November 2009 and 13<sup>th</sup> January 2011 (indicated by the shaded box). It is evident that Bed occupancy was level or increasing when Sapphire ward was in use.

**Figure 3: Daily bed occupancy on an acute ward at Arundel Unit (William Harvey Hospital)**

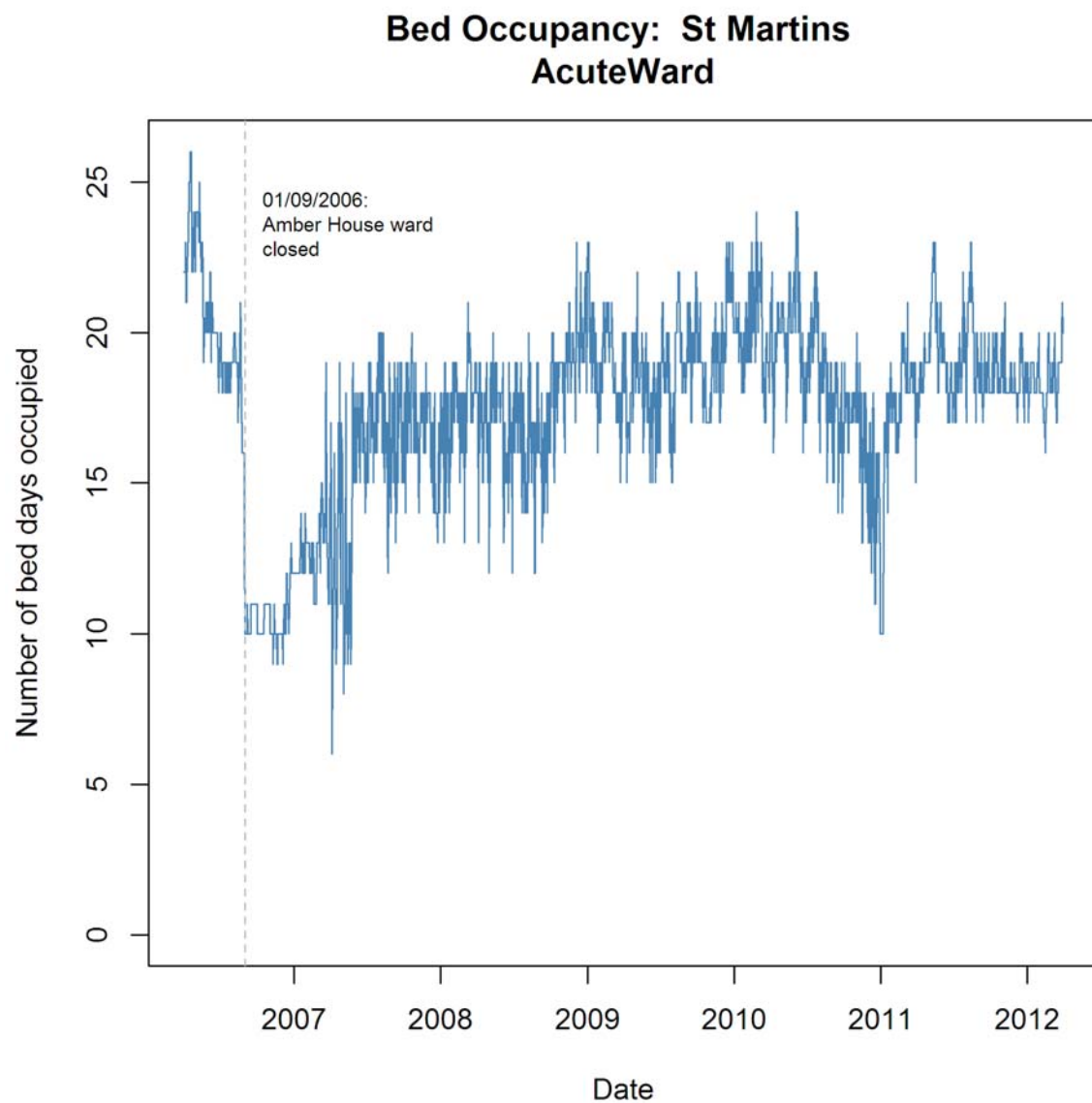


Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

At the Arundel Unit (Figure 3), Edgehill and Newington wards have subsequently been moved to St Martin's with effect from 01 November 2012.

Prior to Scarborough ward being closed there is evidence of a slight reduction in bed occupancy.

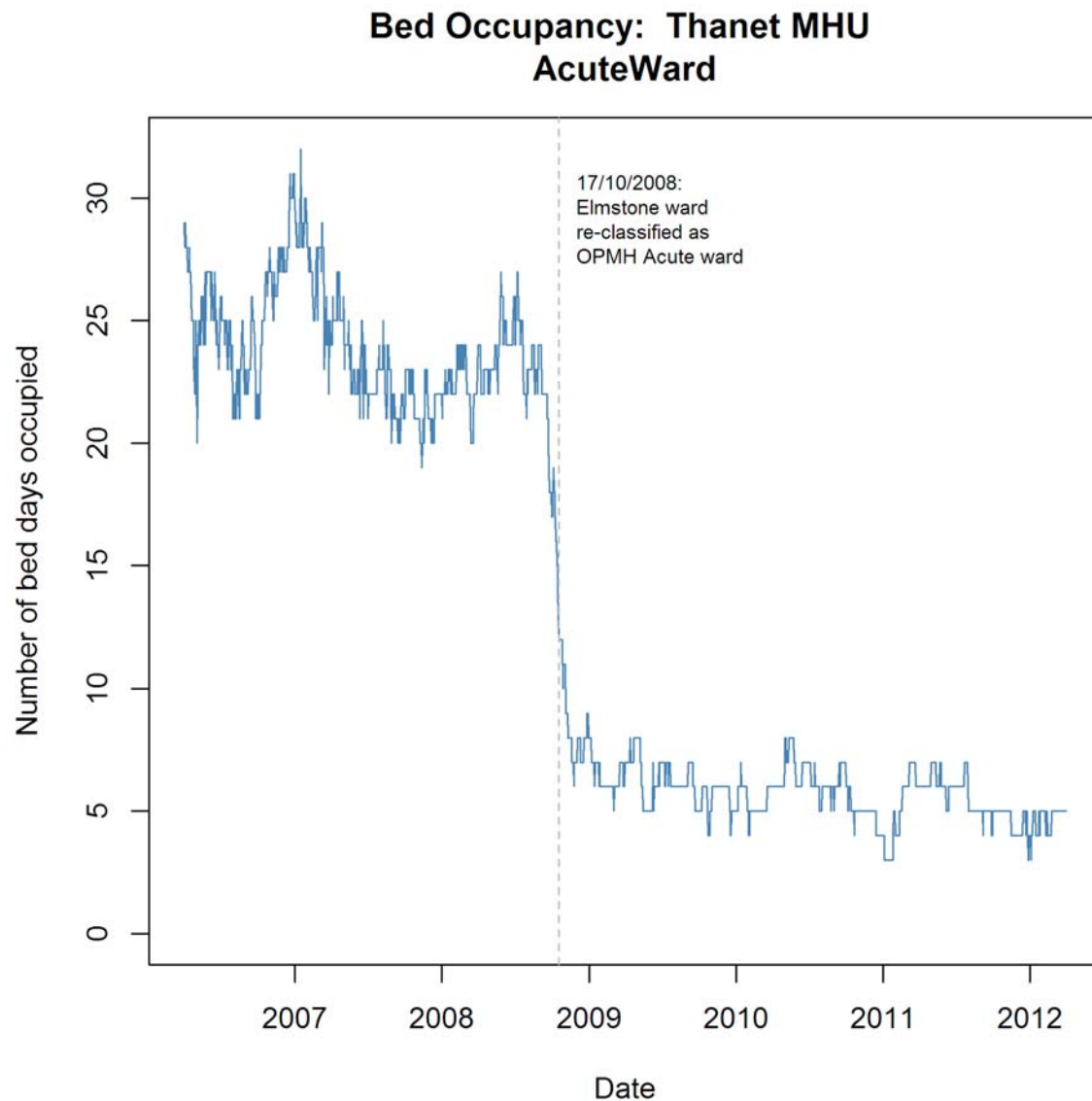
**Figure 4: Daily bed occupancy on an acute ward at St Martins Mental Health Unit (Canterbury)**



Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

At St Martin's Hospital, bed occupancy has remained level over recent years with the exception of a brief dip in late 2011 (reason unknown).

Figure 5: Daily bed occupancy on an acute ward at Thanet Mental Health Unit

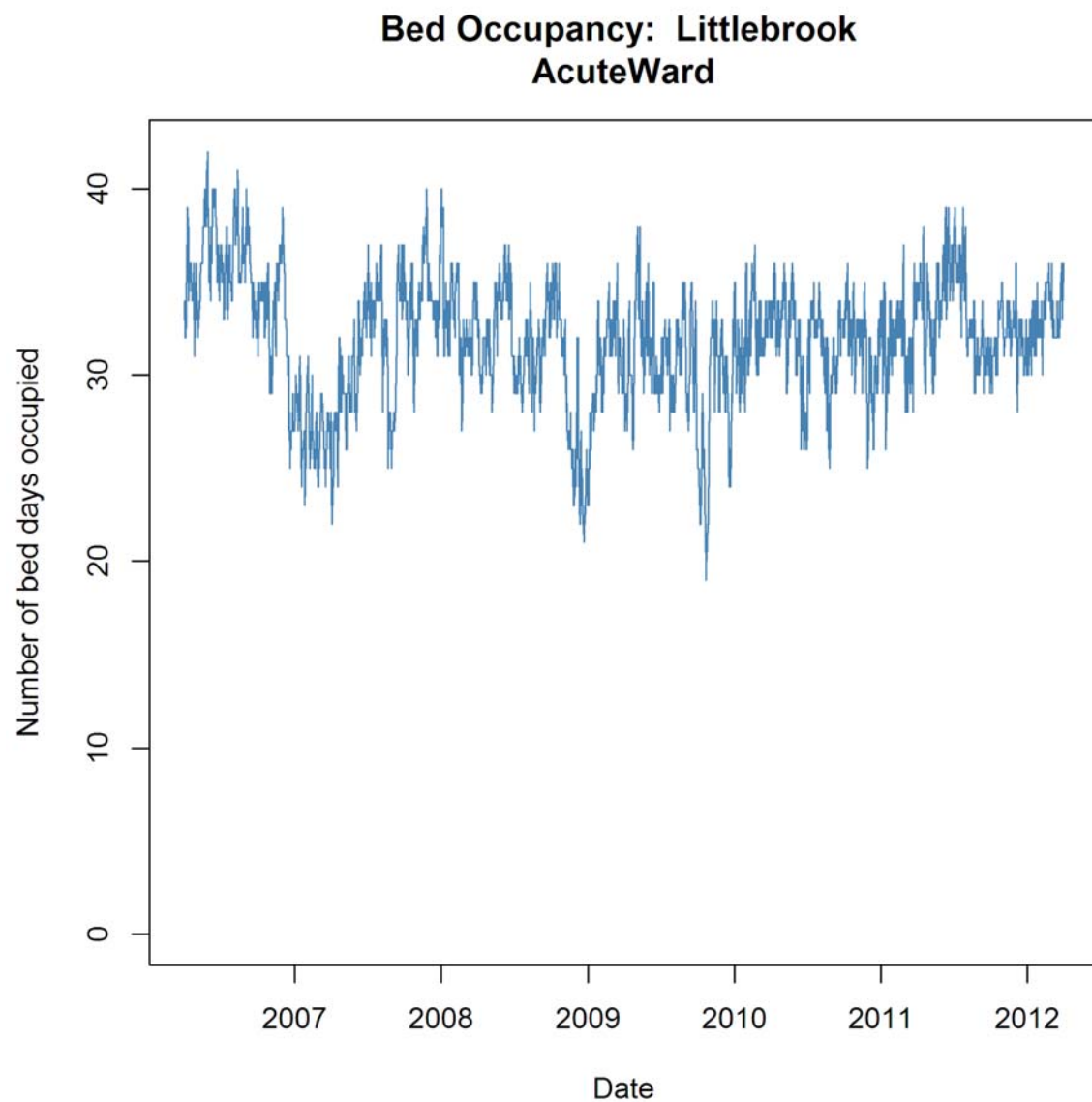


Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

The Mental Health Review refers to five beds on an Older People's Mental Health ward at Thanet Mental Health Unit being used for younger adults. This is evident in Figure 5.



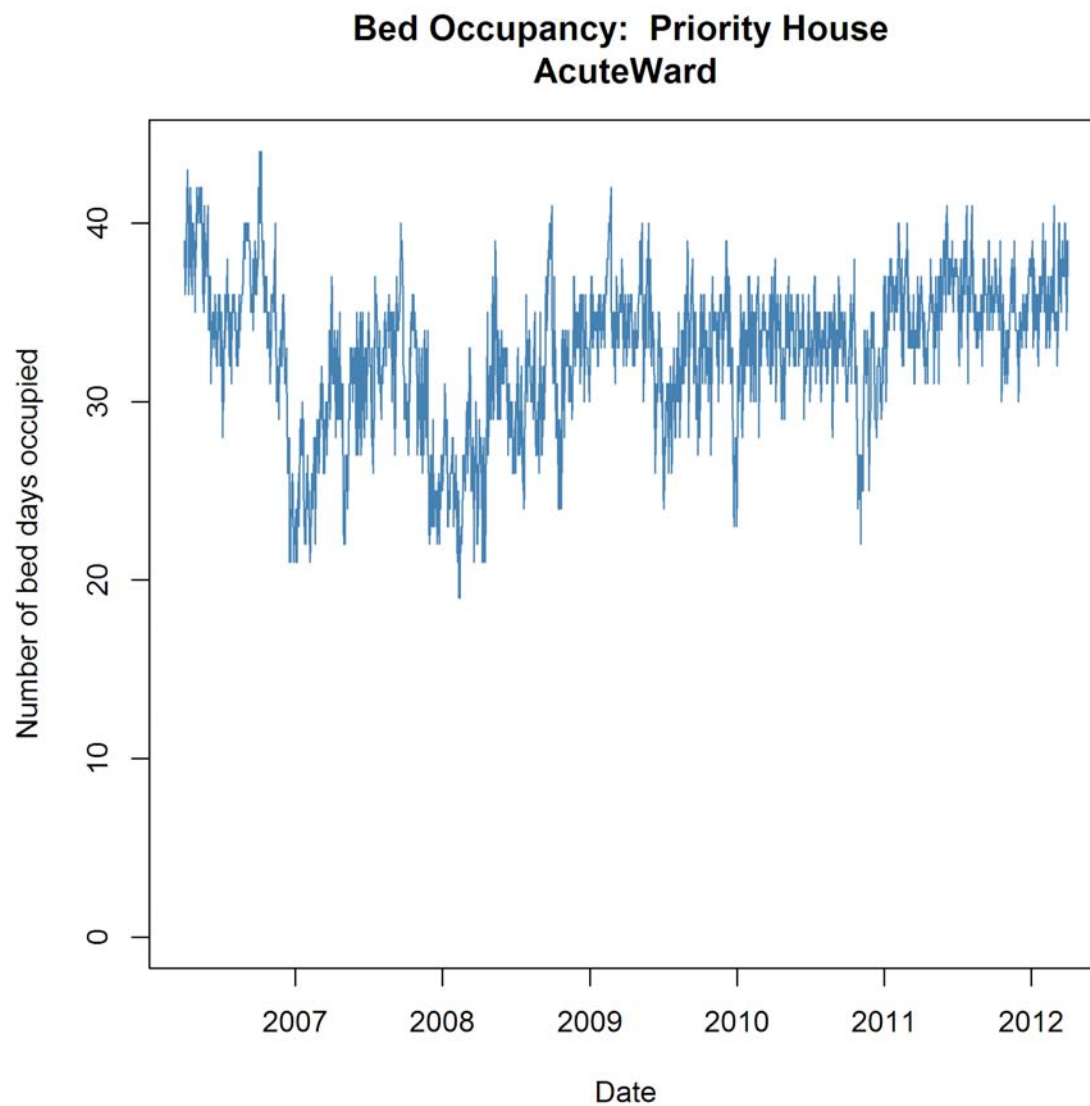
**Figure 6: Daily bed occupancy on an acute ward at Littlebrook Hospital (Dartford)**



Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

Bed occupancy at Littlebrook Hospital, Dartford has, on average, remained constant over time.

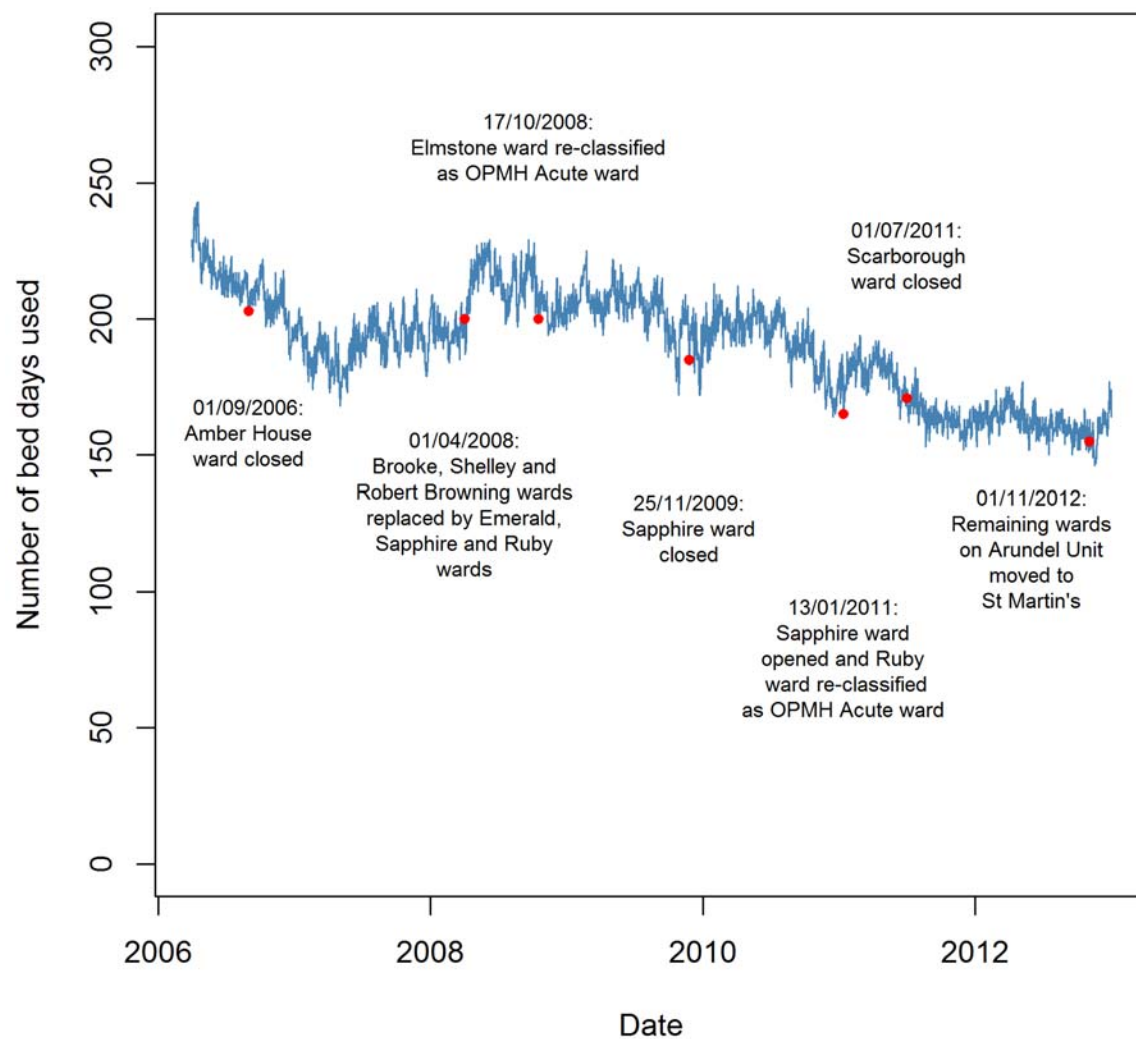
**Figure 7: Daily bed occupancy on an acute ward at Priority House Mental Health Unit (Maidstone Hospital)**



Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

Bed occupancy at Priority House has increased gradually since 2008.

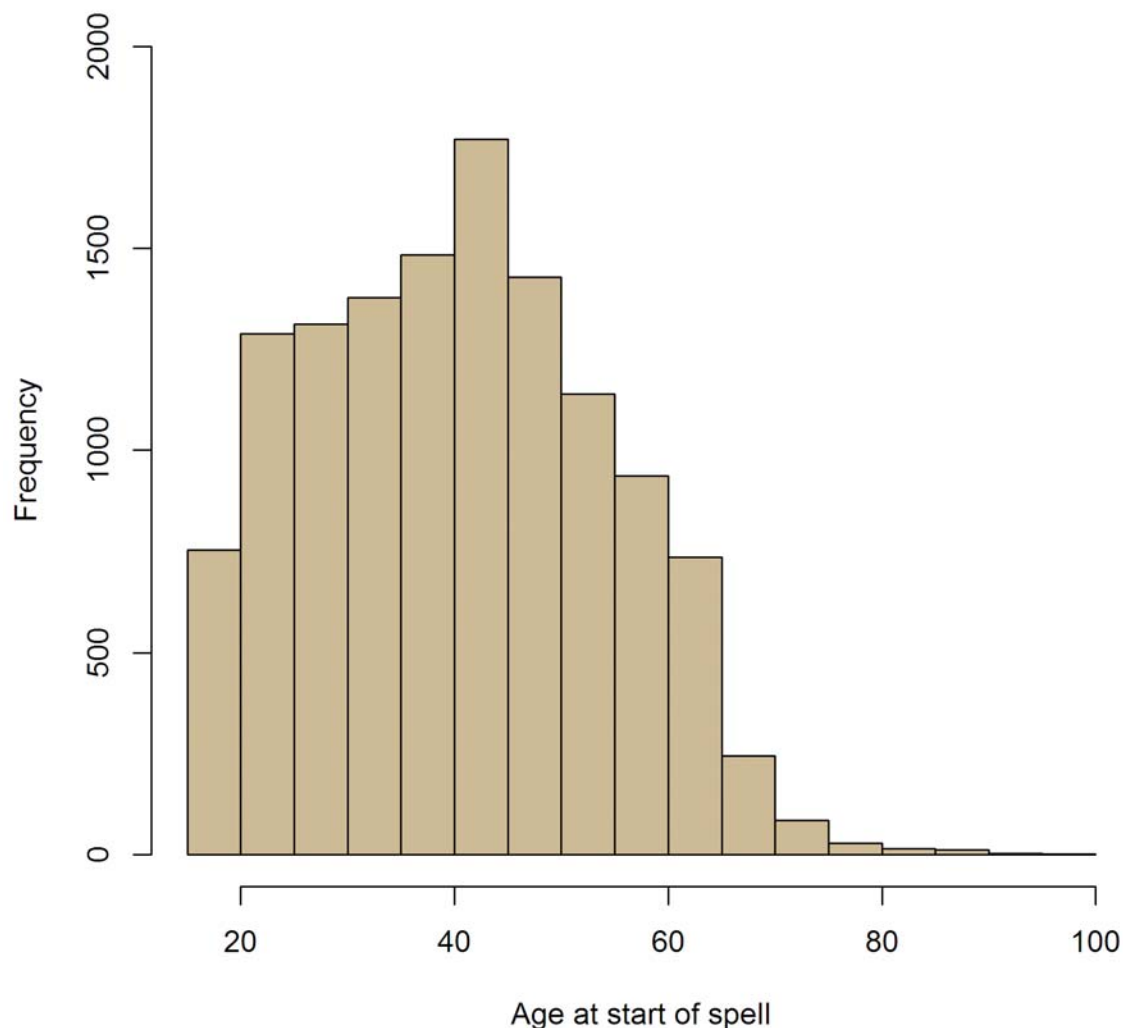
Figure 8: Daily bed occupancy on an acute ward at all sites



Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

In Figure 9 it can be seen quite clearly that the vast majority (97%) of patients on an acute ward are aged 65 years or under.

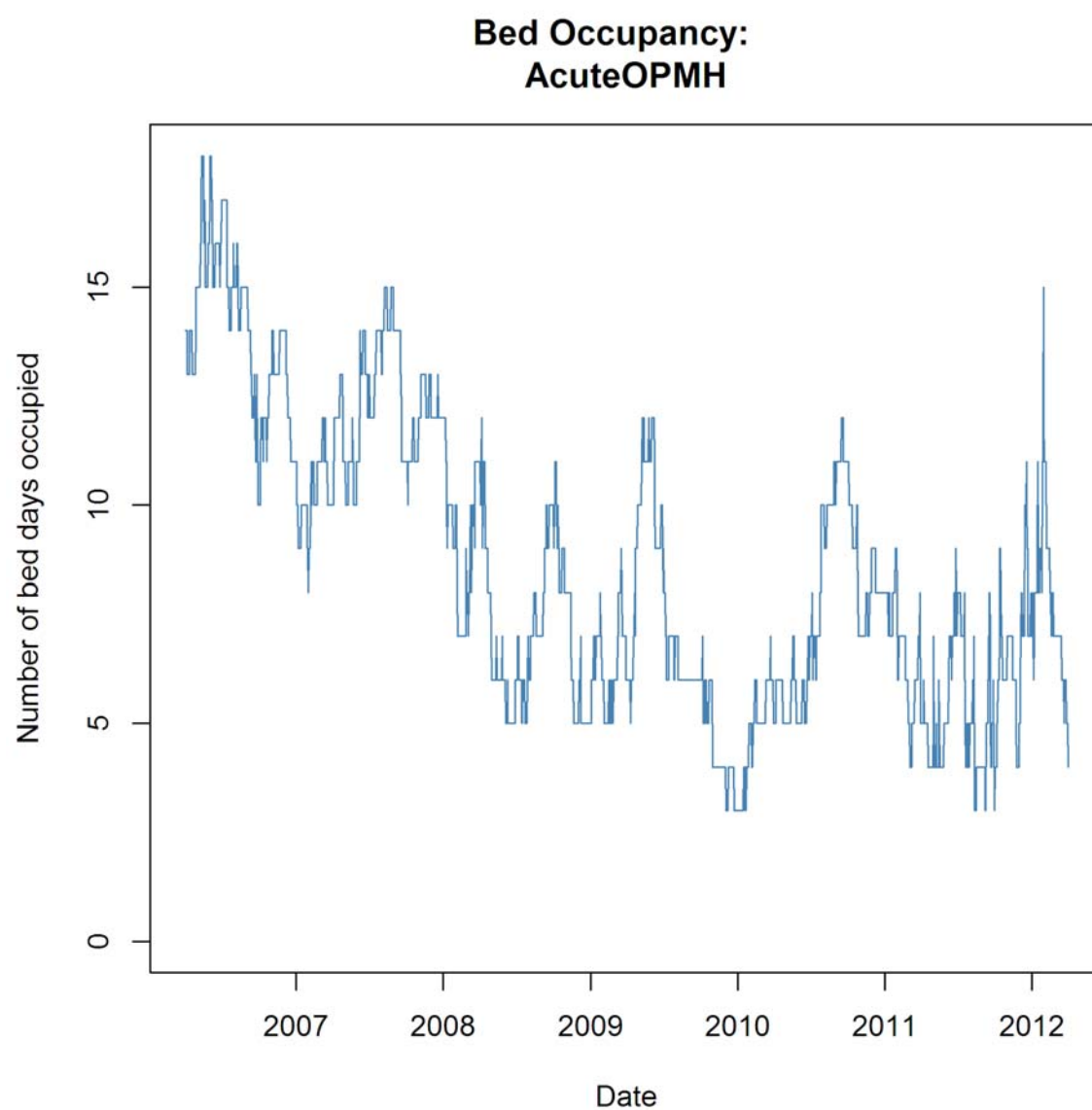
**Figure 9: Age distribution of patient spells on an acute mental health ward, April 2006-March 2012**



Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

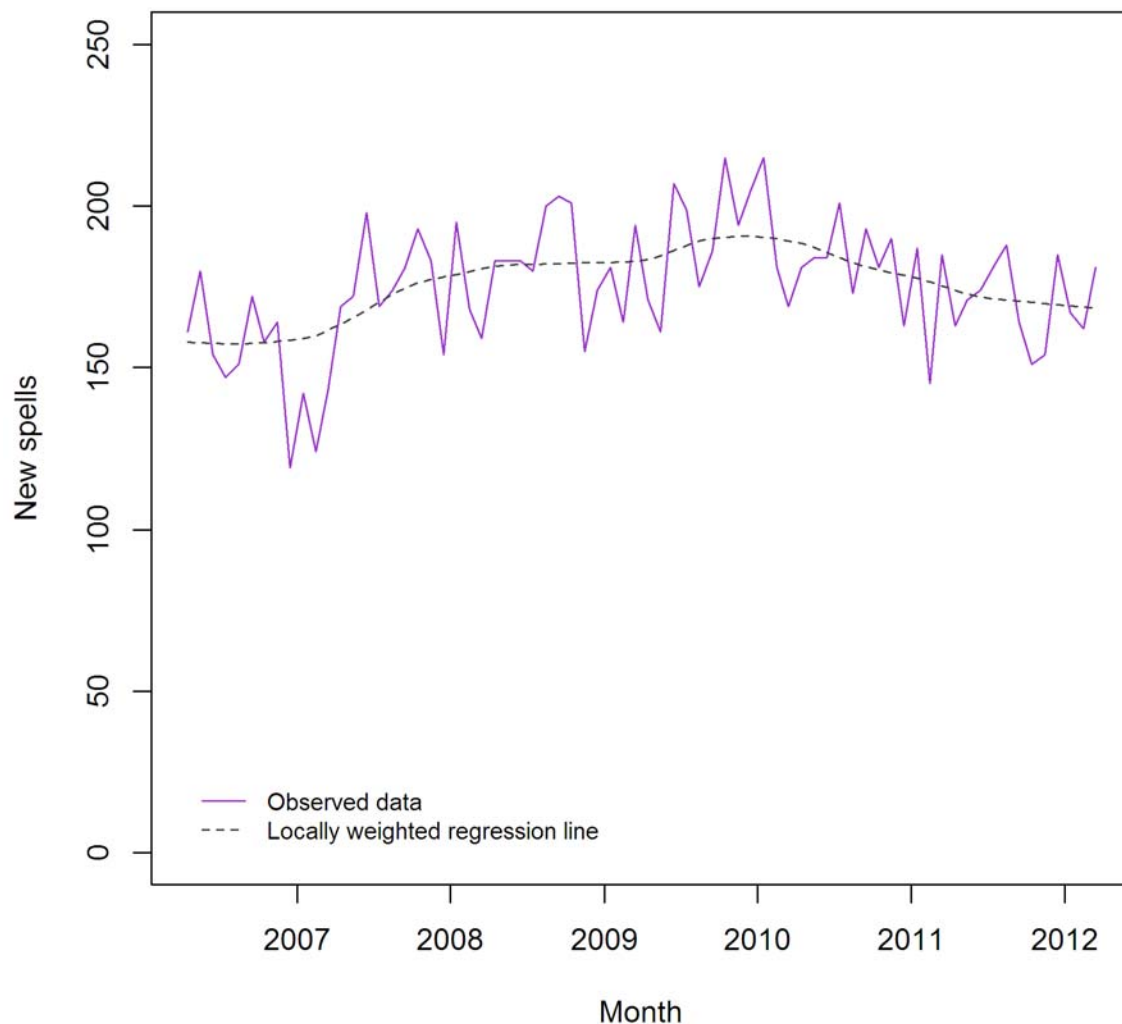
The review states that in some instances it is clinically appropriate to place younger adults (aged under 65) on an older people's mental health ward if they have Dementia. Figure 10 shows the daily bed occupancy of younger adults on older people's mental health wards. This has reduced from around 15 beds per day in April 2006 to around 5 in March 2012 but has spiked over that period in particular between 10 and 15 in late January and early February 2012. A closer analysis of the 190 separate spells over this period reveals that around half (93) have a primary diagnosis of Dementia. Of the 97 spells without a diagnosis of dementia, of which 26 are at Thanet Mental Health Unit which has five beds set aside for younger adults and the rest are in wards not intended for younger people.

**Figure 10: Daily bed occupancy on an older people's mental health ward at all sites**



Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

**Figure 11: New spells starting on an acute mental health ward at all sites by month**

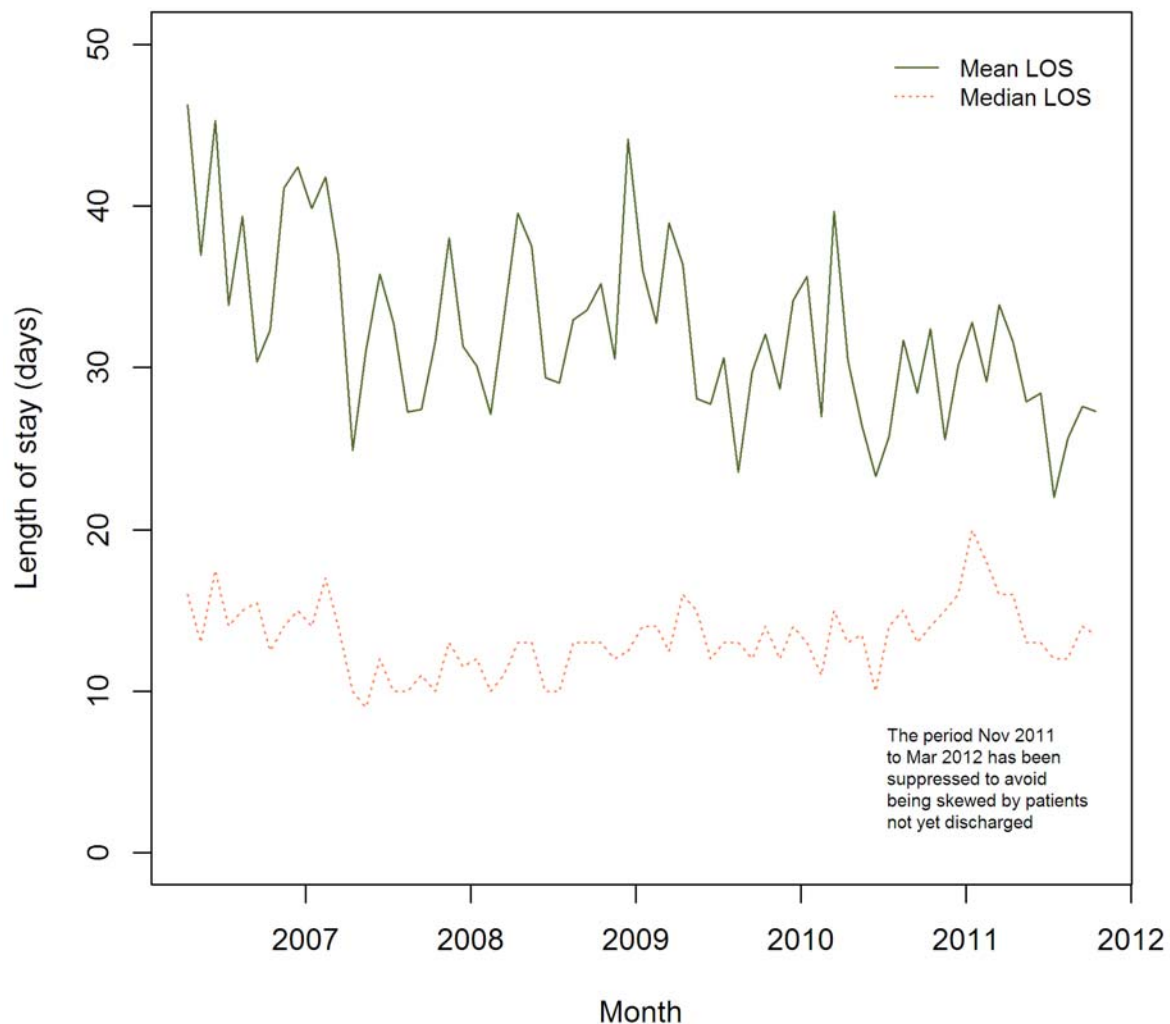


Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

Figure 11 shows that the number of new inpatient spells on an acute mental health ward has reduced since 2010. It is not possible to disaggregate by MHU as patients are often transferred between sites in the course of a single spell so the Kent and Medway total has been presented as one series.

The average length of stay (LOS) has been measured by using the arithmetic mean and median (middle value). In Figure 12 it can be observed that the mean LOS has fluctuated and generally reduced. Some patients stay on a ward for an extremely long time. Over the entire period, 2,145 spells (17%) lasted more than 50 days, 2.5% lasted more than 200 days and 0.6% lasted over 1,000 days. The median LOS has remained fairly constant between 10 and 15 days except for a peak between December 2010 and February 2011.

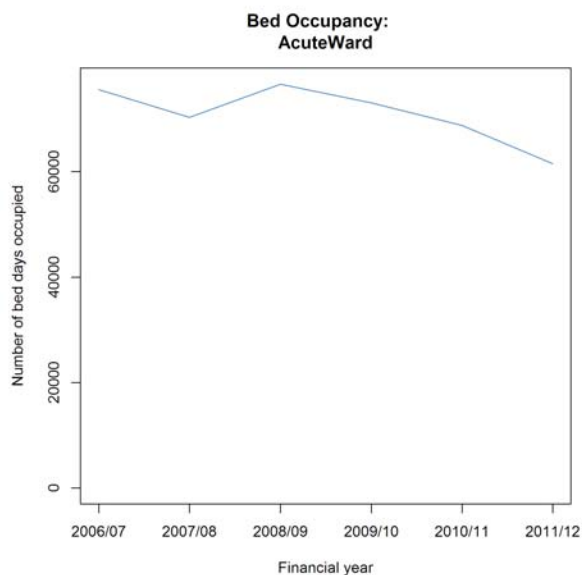
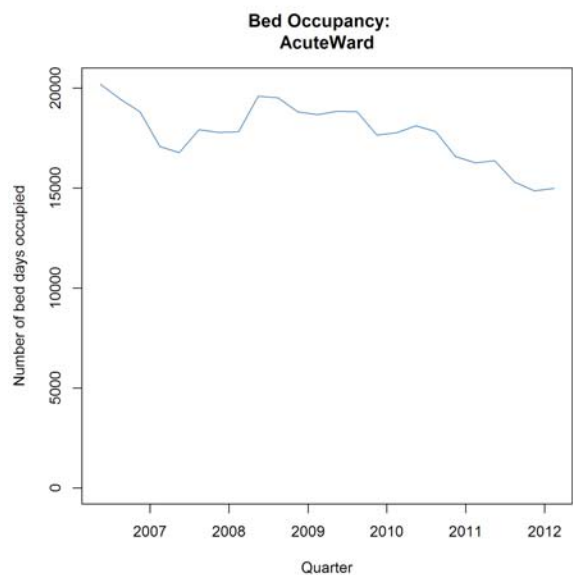
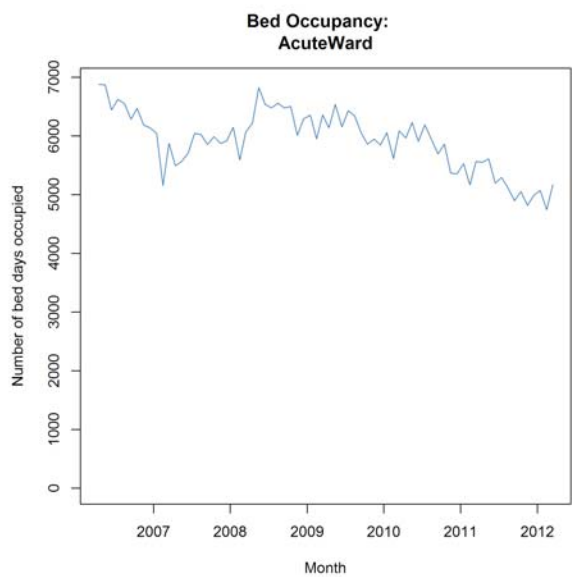
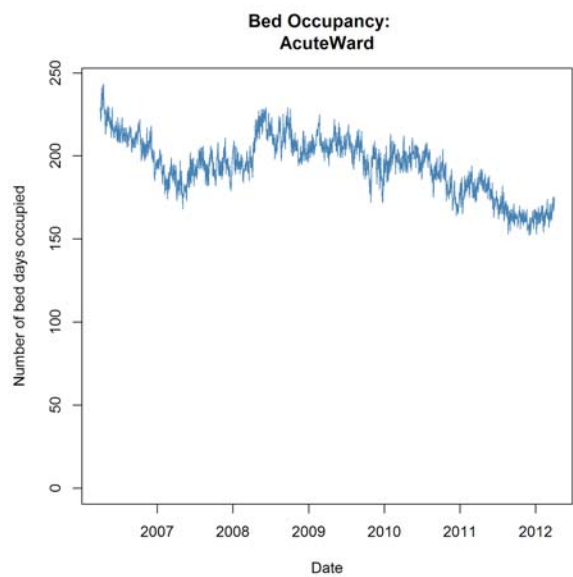
**Figure 12: Average length of stay on an acute mental health ward at all sites by month**



Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

The June 2012 paper does not attempt to model the effect of changes to the service. Creating a model around the proposed service changes would be informative because it would require explicit specification of the parameters and enable the testing of scenarios. This would not on its own determine the actual need for beds, ideally a clinical review is required to do this.

Appendix A





## **Review and sensitivity analysis of mental health bed redesign: work completed and project plan going forward**

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### **1. Work completed as of 01/05/13**

- (i) Model used to calculate bed numbers reviewed and rerun, accuracy of calculations assessed and update
- (ii) Trend analysis reviewed, accuracy of calculation assessed and updated. Sensitivity analysis carried out to see the effects of 4 and 6 years data
- (iii) Out of area bed numbers reviewed and updated

### **2. Project plan going forward**

- (i) Probability curves for out of area beds
  - Create probability curves with number of beds on x-axis and probability of needing out of area beds on y-axis. Use data on historical use of mental health beds in KMPT.
  - Include a check of the use of out of area beds when the use of in-area beds was low. At the moment we are not able to explain why out of area beds were used when in-area beds were available.
- (ii) Document the effect of proposed changes
  - KMPT to list the proposed changes and specify which relate to quality of care and which are expected to have an effect on beds days. For those that are expected to affect beds days, specify the expected effect, and define a range for that effect. E.g. STR workers are expected to lead to a 5% reduction in total bed days, with a range of 1% to 10%.
- (iii) Model the probable effect of the proposed changes

- Use the information provided by KMPT to model the probable effect on the number of beds used resulting from the proposed changes in the service reconfiguration. Combine this with the probability curves to determine the probability of needing out of area beds after the reconfiguration.
- (iv) Review other methods for determining need for mental health care to assess if applicable
- Review needs assessment work done in other areas to see if other methods used may be more appropriate.
  - Review local measures of mental health need.
- (v) Review other models of community services
- KMCS to review good practice in areas with high satisfaction ratings with mental health services with respect to bed ratios and community mental health services design.
- (vi) Review proposed distribution of beds across Kent and Medway
- With updated demand and need information review proposed distribution of beds across Kent and Medway

## Timescales and Responsibilities

Overall project plan: KMCS, Head of Mental Health Commissioning: Kim Solly

[illegible]

**Travel Plan Update: July 2013**

The following table summarises progress to date with the travel plan in relation to the proposed acute mental health service redesign. The Travel Steering group are due to meet on the 22<sup>nd</sup> July, 2<sup>nd</sup> October and 4<sup>th</sup> December and will provide monitoring and oversight of plan as service redesign is implemented.

RAG Rating:

 Red: at risk either of slippage or in delivery;  Amber: in progress/on target;  Green: completed

 White: not started

Area	update	Lead Organisation – Responsible Officer	Further actions required	Milestone/T imeframe	RAG
Signage - internal	All internal signage in place at the Littlebrook site providing directions to the inpatient unit and to local public transport routes.	KMPT	KMPT to consider adding directions from Bluewater Shopping Centre to Littlebrook Hospital on their Internet site.	End August 2013	(A)
Signage - external	Advice has been sought with view to signage on external roads/ motorway; we are currently awaiting feedback and will formulate plan/provide further update when we are in receipt of this information.	KMPT	To explore possibility of Bluewater SC providing signage to Littlebrook Hospital on their site.	End August 2013	(A)





Transport information	Information on public transport is available at main entrances at each acute inpatient site.	KMPT	Review current availability of travel to KMPT sites information on Trust Web site to ensure it is robust and up to date. Review information held at each acute in-patient site to ensure that it is easily found and is 'user friendly'	End August 2013  End August 2013	(A)
Secure Transport	Secure vehicles have now been delivered and are available for the internal transfer of patients.	KMPT		Completed	(G)
Voluntary transport scheme	Plans in place to extend the voluntary transport scheme which is present in Maidstone/SWK. Guidance and policy to be reviewed to reflect extension of the scheme.	KMPT	Plans in place to provide this scheme for three main acute in-patient sites.  Voluntary transport scheme to be in place to support all three main acute in-patient sites.	End September 2013  End March 2014	(A)
Visiting times	Wards have protected times to ensure patients	KMPT	This information to be included on Trust web	End August 2013	(A)

	have opportunity to eat uninterrupted, and to engage in therapeutic interventions/ treatment. However flexible visiting can be requested should a carer/close family member be unable to visit within set hours due to distance, public transport restrictions; the wards will accommodate requests in those circumstances.		site in relation to all wards.  KMPT to ensure that all acute in-patient wards fully implement this initiative.	End August 2013	
Visitor Audit	Further audit was completed seeking views of those visiting Medway A Block. Findings and implications of this audit are to be reviewed at the July steering group	KMPT	Update on July Steering Group review required.  Actions in relation to findings to be developed and action plan with milestones/timeframes to be developed.	End August 2013  End September 2013	(A)
Technology	All wards have access to spider phones to facilitate clinical engagement with community colleagues (secondary and primary	KMPT	Completion of protocols and guidance notes required.	End September 2013	(A)

	care) around an individual's treatment plan. Patient Internet Access has been established and SKYPE is now available. Final protocols and guidance notes are being developed.				
Guidance notes and policies	Existing policies and guidance notes have been collated from current voluntary transport scheme. Steering group will allocate a small working group to review and amend so meets need for an extended service.	KMPT	Working Group to be established.  Complete work required.	End September 2013  End December 2013	(A)





# KMPT Quality Impact Assessment

## Achieving Excellence in Mental Health Crisis – Do Nothing

<b>KMPT</b> <b>Quality Impact Assessment</b>		Scheme number: Date of QIA:		
		14.03.2013		
Scheme Name	Achieving Excellence in Mental Health Crisis - Do Nothing			
Benefits for patients	This option is based on the outcome of the consultation not being supported and the status quo re current acute care provision being maintained. Reduced travel as individuals accessing inpatient care from Medway & Swale can continue to access inpatient care from within A Block Medway.			
Clinical Lead	David Tamsitt/ Rosarii Harte	Service line	Acute	
Quality Indicator(s) - consider Performance Management Framework PAF KPIs	Length of stay; Delayed Transfers of care; Occupancy Patient Satisfaction; Staff Survey; Home treatment episodes per locality; admissions per locality CQC standards; PEAT scores			
Risks to Patient Safety	<b>Details (include mitigation)</b> Fixtures & Fittings and poor sight lines inherent within the building design in A Block Medway. The current environment increases risks of incidents occurring which impact on the well being of all patients. Increased incidents, staff sickness, poor retention and recruitment has a direct link to patient safety. The service has sought to mitigate these risks as far as possible however the issues listed above remain.	<b>Consequence</b> 4	<b>Likelihood</b> 4	<b>Score</b>  16 (R)
Risks to Clinical Effectiveness	<b>Details (include mitigation)</b> Increased sickness rates, poor retention and recruitment impacts on ability to provide continuity and monitoring of best practice with increased dissatisfaction from patients, carers and staff as a result. The lack of easy access to outside space hinders the therapeutic environment available to service users on Sapphire Ward and increases frustrations leading to an increase in incidents.	<b>Consequence</b> 4	<b>Likelihood</b> 4	<b>Score</b>  16 (R)
Risks to Patient Experience	<b>Details (include mitigation)</b> Incidents of violence and aggression are higher than other environments and this and other environmental issues such as lack of outside space, single rooms have resulted in the poor surveys and complaints. The accommodation within Medway limits choice regarding single rooms, access to en suite facilities and access to external space.	<b>Consequence</b> 3	<b>Likelihood</b> 5	<b>Score</b>  15 (R)
Overall Risk Score (highest from above quality domains)		 16		
Date approved by Service Line Director	15/03/2013			
Date approved by Medical Director				
Date approved by Executive Nurse	15/03/2013			

# KMPT Quality Impact Assessment

## Achieving Excellence in Mental Health Crisis – Option A

<b>KMPT</b> <b>Quality Impact Assessment</b>		Scheme number: _____ Date of QIA: 14.03.2013		
Scheme Name	Achieving Excellence in Mental Health Crisis (development 3 centres of excellence, PIC Outreach, development of CRHT; Option A preferred outcome of consultation - relocation of inpatient services Medway to Dartford; Swale to Maidstone & centralised PICU)			
Benefits for patients	Delivering acute care services within Kent and Medway from three centres of excellence will optimise care within purpose built accommodation and provide opportunity for staff to share of experience, knowledge and best practice. This will also optimise productivity. There will be an improved environment for patients, Staff and visitors. The accommodation within the three centres reduces ligature risks that are present within current environment in Medway. This will also provide a critical mass of staff and optimises skill mix. Supports the delivery of the acute care pathway. The scheme addresses inequality of inpatient environment, reduces ligature risks, addresses concerns relating to privacy and dignity, reduces the likelihood of out of area placements. Improved environments have a positive impact on incidents of violence and aggression, recruitment and retention of staff, reduced sickness.			
Clinical Lead	David Tamsitt/ Rosarii Harte	Service line	Acute	
Quality Indicator(s) - consider Performance Management Framework PAF KPIs	Length of stay; Delayed Transfers of care; Occupancy Patient Satisfaction; Staff Survey; Home treatment episodes per locality; admissions per locality CQC standards; PEAT scores			
Risks to Patient Safety	<b>Details (include mitigation)</b> This will have a positive impact on patient safety. The development of the three centres of excellence will mitigate against the current and inherent risks present in Ablock, Medway.	<b>Consequence</b> 1	<b>Likelihood</b> 1	<b>Score</b>  1 (G)
Risks to Clinical Effectiveness	<b>Details (include mitigation)</b> This will have a positive impact on clinical effectiveness. The three centres of excellence will enable shared learning and opportunities for shadowing and coaching which in turn will improve the quality of care delivered. Skill mix and expertise will be optimised across the pathway. The scheme will also support robust clinical leadership and consistency to the leadership provided across all aspects of acute care. It supports the delivery of the acute care pathway and supports /encourages the implementation of audit and peer review.	<b>Consequence</b> 1	<b>Likelihood</b> 1	<b>Score</b>  1 (G)
Risks to Patient Experience	<b>Details (include mitigation)</b> Overall we anticipate improvement to the patient experience. The scheme delivers improved inpatient environment, ability to have own room when an inpatient and access to external space both of which are limited in Medway. The development of the acute care pathway supports and actively promotes individualised care. The consolidation of staff onto 3 centres also improves level of expertise and skill mix available. However the scoring noted reflects for some this may have a negative impact regarding the proximity to friends family and carers to the inpatient facilities and their ability to visit. A transport plan has been developed to aid mitigation of this, and provide support where applicable. Concerns remain regarding sufficient bed capacity due to unprecedented increased demand for acute inpatient care over the past year. Further sensitivity work is being undertaken to review bed capacity. This will inform final decisions regarding the redesign and bed requirements.	<b>Consequence</b> 3	<b>Likelihood</b> 3	<b>Score</b>  9 (A)
Overall Risk Score (highest from above quality domains)		 9		
Date approved by Service Line Director				
Date approved by Medical Director				
Date approved by Executive Nurse				