Kent and Medway ICB Stage 2 NHS England Assurance Review Response

24/04/2023

Contents

0. Document Control

0.1 Version Control

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0.3 Approvals/Sign off

Name	Organisation	Role	Date
Taps	KMPT	Director of Adult MH System Collaboration	

1. Introduction

Document Purpose:	The purpose of this document is to: • Respond to the KLOE's from the Stage 2 NHS England Assurance Review.

2. Best Practice Test 1: Strong Patient Engagement

Add an addendum to the Engagement & Communications Plan that details the approach to engagement & communications, the range of engagement activities completed, the groups that were targeted in particular hard to reach groups.

Ensure details of the number of stakeholders engaged with (including those that are hard to reach), key emerging themes from feedback and how these will be fed into the decision-making process.

The DMBC will include the addendum to the communications plan that describes the early approach to engagement and communications and details the range of engagement activities that have taken place including groups and hard to reach groups that were targeted.

The document identifies that throughout the engagement Kent and Medway ICB have engaged with:

- 11 focus Groups
- 5 Meetings with Megan CIC
- 1 interview with a carer
- A range of meetings/ workshops involving 185 directly
- 1450 staff and stakeholder through wider communications

Historical engagement information was also used to inform the project. Information from the Kent listens project included in-depth conversations with 1356 individuals (from 57 different self-identified ethnicities who spoke 30 different first languages). We have also benefitted from colleagues across the system, including Healthwatch, Young Adults Involvement Project at Porchlight, and the Suicide prevention network, who have shared existing reports and research.

Key feedback has been shared with the Programme Director, Mental Health Urgent and Emergency Care and partner organisations to support and inform the decision-making process. To provide an unbiased review of the consultation an independent company has been procured to collate the feedback this information will be used to inform the Decision-Making Business Case (DMBC) and shared as part of the decision-making process.

3. Best Practice Test 2: Consistency with current and prospective need for patient choice

Recommended more detailed post code mapping is undertaken to assist with providing the impact on patient anxiety, stress, and recovery.

As part of the stage two assurance process a recommendation was made to undertake a detailed postcode mapping exercise. We were not able to do this due to KMPT's Information Governance Team advising that this was Patient Identifiable Data. Further, Postcode level detail would does not show a true representation because people detained under a section 136 are detained in public places (as opposed to home address) and therefore it is highly unlikely that the patient would be transferred from their local post code. It was decided therefore that the best way to approach the travel analysis was:

- Firstly, identify how many people were detained within each of the residential localities within Kent and Medway
- Assign a prominent town centre postcode as a point of reference for each of the localities.
- Calculate the distance in miles and minutes to the three current HBPoS from those points.
- Calculate the same journeys if the proposed centralised HBPoS was in place.

The two data sources were then compared to show the impact on patients traveling from the areas in and around Kent and Medway. Overall, journey lengths and time were reduced. There are some areas that would see a slight increase however this is balanced with the added benefits of the proposed centralisation (through improved access to a therapeutic environment, reduction in length of detention and assessment time, robust staffing, and support) and overall improvements to patient experience.

To ensure that patients are supported at the point of discharge Kent and Medway ICB have commissioned a private mental health ambulance service, this has been in place for 14 months. This service was implemented after feedback from patients and our voluntary support services. This ensure patients are supported on the transition back to their residence and no anxiety or worry is added to the patients at the point of discharge. The feedback since implementation from patients has been positive, this feedback is collected by the new commissioned service.

To support the understanding the journey for patients who are admitted due to being detained under a section 136 a further analysis was undertaken. This analysis showed that for the months from April 2022 to March 2023 of the 682 patients that were detained under a section 136 and taken to a HBPoS 134 patients were admitted to inpatient services. Of the 134 patients, 109 were sectioned and 25 were admitted informally.

The table below shows the number and percentage of people that were admitted within their local residential area and those admitted outside their local residential area.

Table 1 - Admission information

Admission post HBPoS	No of patients sectioned	% of patients sectioned	No of patients informally admitted	% of patients informally admitted
Ward local to residence	40	37%	9	36%
Ward not local to residence	46	42%	14	56%
Other (PICU/Out of County)	23	21%	2	8%

Of the 109 patients that were sectioned 40 patients 37% were admitted within their local residential area and 46 patients 42% were admitted outside of their local residential area. Of the 25 that were informally admitted 9 patients 36% were admitted within their local residential area and 14 patients 56% were admitted outside their residential area and only 1 patient out of the 14 was transferred during their stay to their local residential area.

KMPT have been working on improving the quality, safety, and the gender separation (single sex accommodation) across their inpatient provision, to improve the overall patient experience and outcomes. In doing so, the configuration of beds per inpatient site does mean that admission to an inpatient unit may not be the unit immediately closer to home. This notwithstanding, admission will be to a bed within Kent and Medway and there is robust integrated working between the community and inpatients nursing teams ensuring continuity of care provision. Further KMPT offer flexible visiting hours to facilitate Carer and Family access and there is also a voluntary driving service available to transport carers and families. Virtual visiting is also supported throughout the trust to ensure that patients feel supported if their families are unable to visit in person.

Evidence of any impact assessment on equalities and interpreting services to also be included.

KMPT is committed to providing interpretation services for those whose first language is not English. Guidance to staff is provided through the interpretation and translation policy to support teams in accessing the right support and services. HBPoS have used these services and will continue in the proposed new HBPoS to support patients. This policy is also used to support patients that have other language requirements such as access to sign language services.

Best Practice Test 3: Clear Clinical evidence base

It is recommended that consideration be taken in relation to S140 bed capacity and highlight what the current occupancy of the HBPoS is and how often patients are diverted to A&E.

HBPoS

To look at the demand on the HBPoS rooms over a 12-month period (01/12/2021 to 30/11/2022) we pulled raw data of all the 136 detentions at each site. The 12 months were broken down into 30 min slots creating 17568 slots over the period. The room data was then allocated against the correct site, date and time using 30 min time slots. When all the information was plotted, an analysis was undertaken to show how many rooms were occupied at each 30 min slot throughout the year.

As detailed in the original PCBC the Dartford HBPoS was closed from 02/03/2020 until 01/04/2022, to show the impact of this closure a summary was created including the closure within the occupied rooms and then excluding. A summary of the information is shown in the tables below.

The tables below show the number of 30 min slots and % of time that the rooms were occupied over the 12 months.

Table 2 includes the closure of the Dartford site which provides a true picture of the impact on patients and the KMPT partners over the 12 months.

Table 2 - HBPoS usage including Dartford closure (01/12/2021 - 30/11/2022)

Table to show occupation of HBPoS rooms over 12 months (including Dartford closure counted as occupied)						
Number of rooms	0	1	2	3	4	5
Total 1/2-hour slots rooms occupied over 12 months	1378	3703	5462	4385	2161	479
Total hours rooms occupied over 12 months	689	1851.5	2731	2192.5	1080.5	239.5
Total hour % slots rooms occupied over 12 months	7.84%	21.06%	31.06%	24.93%	12.29%	2.72%

The second table below shows the same time excluding the closure of Dartford which probably provides a more realistic view of what the usage would have looked like if the centralised HBPoS were in place over of the 12 months, assuming that all five rooms would be available.

Table 3 HBPoS usage excluding Dartford closure (01/12/2021 - 30/11/2022)

Table to show % occupation of HBPoS rooms over 12 months (excluding Dartford closure)						
Number of rooms	0	1	2	3	4	5
Total 1/2-hour slots rooms occupied over 12 months	2333	4465	5519	3682	1381	188
Total hours rooms occupied over 12 months	1166.5	2232.5	2759.5	1841	690.5	94
Total hour % slots rooms occupied over 12 months	13.27%	25.39%	31.38%	20.94%	7.85%	1.07%

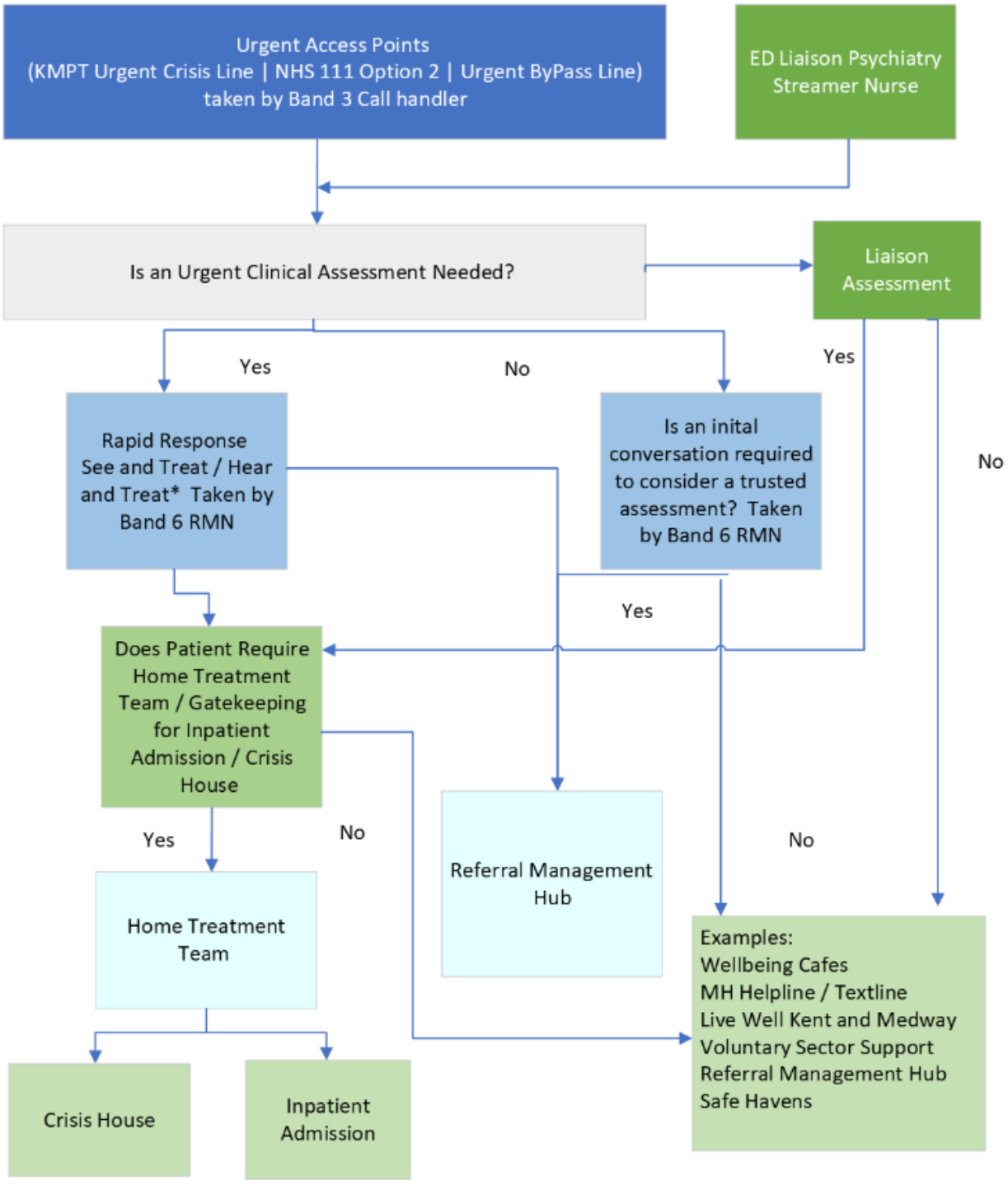
Data around patients taken to A&E prior to HBPoS unfortunately is not reliable due to how the information is recorded. This was identified during the course of the PCBC and is being remedied with some early improvement seen however further work is required to prevent duplication of entries. What we have been able to identify is that in the last 12 months 10 patients were diverted to A&E due to a HBPoS being closed due to damage.

Recommended that emphasis is placed on prevention & avoidance and the whole crisis pathway in the DMBC. (Further recommendations may result once the clinical senate has completed their final report.

The entire Mental Health Urgent and Emergency Care Pathway and Community Mental Health Framework are currently being reviewed. The proposed UEC Mental Health Crisis pathway can be seen below in fig1. The DMBC will provide detailed information in relation to this.

NHS Kent and Medway currently commission and are in the process of commissioning a range of community crisis alternatives for individuals in or at point of mental health crisis and/or experiencing acute mental illness, in partnership with the VCSE and KMPT. The focus is on early intervention and timely crisis de-escalation and provision of several alternative safe spaces (for example Safe Havens and crisis cafes. When a patient is in mental health crisis and referred to the mental health services, they are provided with information of services that they can access in times of distress and need. This will include the information on the increasing range and breadth of services available in the community with the aim to reduce the need for inpatient stays. Examples include Crisis House provision, revised Safe Haven model, Enhanced Home Treatment (virtual ward in the community), Peer Support Crisis Workers, expansion of Talking Therapies, 7 day working Crisis and Well Being Cafes and Service User Network (SUN).

Figure 1 -The Mental health pathway



*4hr response (but 1 hr response to Police and SECAMB)

4. Best Practice Test 4: Support from Commissioners

The stage 2 assurance team were assured of this test being covered.

5. Best Practice Test 5: Bed Test

The stage 2 assurance team were assured of this test being covered.

6. Best Practice Consideration: Finance and Affordability

Centralisation of section 136 Health Based Places of Safety (HBPOS) in Kent and Medway

Supplementary Detail – Financial Position

The detail below should be read in conjunction with the overall pre-consultation business case and public consultation. The financial case has been prepared on the basis of a centralised service; however, this is subject to consultation. The modelling will be updated following the outcome of that process and doesn't look to prejudge any outcome.

Financial Case (Expanded)

The purpose of the financial case is to set out the impact of the preferred way forward on the financial performance of the Kent and Medway health system. This is important as it demonstrates the option being considered for consultation is financially viable.

The preferred option was the only option on our shortlist to pass all the hurdle criteria, and therefore the only option to be evaluated financially in this pre-consultation stage. Other options considered did not meet the minimum criteria to be developed in any meaningful way, so revenue and capital consequences have not been explored.

As described in chapter 7 (pre-consultation business case), should a viable alternative option or options be put forward as a response to the consultation process, they would be assessed against the scheme objectives and the deliverable criteria outlined. This does not impact on the assessment of financial affordability, value for money and key financial risks, which has been undertaken for the preferred option.

Key Planning Assumptions

Table 4 - Planning assumptions

Category	Inputs	Assumptions
Programme	Signed Memorandum of Understanding (MOU) confirming national funding	Funding is fixed and must be drawn in line with phasing outlined in the MOU. Approvals are achieved with the timescales anticipated.
Inflation	8.98%	Based on industry standard BCIS All-in Tender Price Indices (TPI) and Cost Indices.
Land	Included	The land is already owned by the trust so is not considered in this case
Disposals receipts	Nil	There are no property sales as part of this project.
Capital costs (construction)	All-in-Capital Cost £3.864m	The cost estimates have been provided by the trust Cost Consultant based on a schedule of accommodation and benchmarked costs. This includes Contingency, Inflation and VAT.
Equipment costs	Included in Capital Cost	An equipment allowance of 3.5% has been included.
Digital costs	Included in Capital Cost	All IT infrastructure has been included in the overall capital cost
Income	Currently paid under block contract	Continuation of existing block contract – no change of bed occupancy anticipated as a result of this project. Additional two beds included in build but assuming these are for future opportunities rather than base capacity at this stage.
Pay costs		As per current rota and potential future model, no agency premium included. At this stage no displacement costs included but would need confirmation of risk. Assumed go live of model May 2025
Non-pay costs	Property Cost – Capital Charges - £0.2m per annum	One site so assumed a higher level of minor works due to urgent repairs will be required. Need to understand what will happen to sites currently being utilised for current model

Key Activity Planning Assumptions

The current HBPoS have 5 assessment spaces across three sites. A review of this capacity, against the expected growth within Kent and Medway, is being undertaken to understand if this level of capacity is still required, given the sustained reduction in 136s over the last 12-18 months.

There have been some challenges to undertaking the demand and capacity understanding as if the current rooms are out of action or full, patients are taken to a HBPoS at an Emergency department and this information isn't currently captured accurately. Work is

being undertaken within the system to better understand the numbers of patients that are detained in the Emergency departments, either for part or all their detention.

The population in the Kent band Medway is expected to grow by another 200,000 by 2041, meaning an extra 104 patients that would be seen through the HBPoS (assuming the same percentage of people to the overall population require the service). The proposal therefore is to maintain the current level of capacity however centralise creating a robust staffing and an improved quality of care.

If at any time the demand drops, and information is more robust to enable full capacity and demand modelling then a further review would be undertaken to ensure the right level of capacity remains within the HBPoS.

Capital Case

Cost of the scheme

The total capital cost for the scheme is £3.864m. This has been calculated from schedules of accommodation that were developed and costed by McBains, expert advisors on cost reporting and project management.

A contingency balance has been included within the latest cost report of 15% to cover planning, design, and pricing risk. In addition, a 17% allowance has been included for optimum bias.

These assumptions are in-line with a typical scheme of this nature; and in-line with Department of Health expectations.

Capital Funding

Following the publication of the NHS Long Term Plan, the Department of Health and Social Care is providing £150m of capital funding to the Mental Health sector to support Integrated Care Systems (ICS) with pressures on the urgent and emergency mental health care pathway. This is part of wider programme of transformation to provide rapid access to care for people in crisis, thereby reducing avoidable hospital admissions and attendances at ED, increasing appropriate local alternatives, and improving patient experience and outcomes.

KMPT/ICS applied for capital funding under this initiative and was successful in securing funding to the value of £3.785m, supplied via public dividend capital (PDC).

The ICS recognises the current financial uncertainties, especially around prevailing rates of inflation. This case has support for additional capital funding from the system allocation if the project should be impacted by this. This position has been confirmed and is supported by the ICB.

The agreed profile of the capital funding is outlined below. This is reflected in the Memorandum of Understanding and cash will be drawn from the Department of Health and Social Care on this basis.

Table 5 - Capital funding

Financial Year	Value (£'m)
2023/24	1.077
2024/25	2.708

The impact on the revenue case is considered within the revenue modelling (section 3)

Revenue Impact

The Trust presently runs three Places of safety across Kent and Medway. This expertise has been used in modelling the impact of a single site model. This includes the staffing impact from the change to a single site model (Workforce Plan 12.1 Pre-Consultation Business Case).

The consolidation of services to one site is expected to deliver a cost reduction of £0.61m over 15 years. This saving will form part of ICS discussions around reinvestment/ efficiency.

Staff Impact

Workforce

The Trust is presently running three places of safety; as part of the proposed centralisation of the service, a review has been undertaken to ensure that a robust workforce is in place to support the services. These details are set out in the Pre-Consultation Business Case (Section 12.1), with the expected impact set out below.

Table 6 - Workforce model and financial impact

	Present Staffing (WTE)	Centralised HBPoS (WTE)
HBPoS team manger	1.00	1.00
Senior Staff Nurse	6.00	4.48
Registered nurse	8.25	4.48
Health care workers	23.77	17.92
Total Workforce	**39.02**	**27.86**
Financial Impact	**£1,721k**	**£1,340k**

The reduction in workforce reflects the economies of scale from centralising the resource on one site. This is expected to reduce workforce costs by £381k pa. Due to the trust's vacancy position this change is not expected to adversely impact on any substantive staff.

Medical Workforce

Due to the spread across the sites, there is no assigned doctor to cover the s136 patients within the present medical model. The current practice is that the doctor supporting the wards also supports the HBPoS on that site. This has created delays in the past to the Mental Health Act assessment being completed within the Kent and Medway Crisis Care standard of 4 hours due to competing needs on the wards.

With the centralisation of the HBPoS the expectation is that the medical rota that will see a designated doctor assigned to the centralised HBPoS. This is anticipated to be covered from

existing workplan; however, part of the contingency has been assigned to mitigate any potential impact of changes to the medical rota.

AMHP Teams

The HBPoS within Kent and Medway is supported by separate AMHP teams. The location of services to one site is anticipated to improve coverage, with AMHPs presently required to travel to all three sites and the rest of the county in other settings. The present design work is looking at the possibility of creating a space at the new centralised HBPoS for the AMHP to be based, providing a higher chance of an AMHP being available at the point a patient is detained in the centralised HBPoS.

Non-Pay Costs
Recurrent

The centralisation to one site is anticipated to have minimal impact on the service's non-pay expenditure. The service spend is low and the as set out in 1.14 of the Pre-Consultation Business Case the travel time is expected to reduce from the centralised proposal.

The impact on costs is therefore anticipated to be non-recurrent in nature and linked to staff travel (due to a change in base), and site costs relating to the change in use. These are considered further within the Transitional Costs.

To note, South East Coast Ambulance NHS Foundation Trust (SECAmb) is engaged in this programme through the Key Interest Group of system partners (referred to more in chapter 14 on implementation). Discussions are underway with SECAmb to ascertain what, if any, material impact the proposal to relocate Ruby Ward from Gillingham to Maidstone would have on ambulance conveyance time and subsequent resourcing. The number of patients arriving by ambulance across the year are relatively small, but it is important to consider the extent of any potential impact and work together to ensure mitigations are in place. This is part of our ongoing implementation and system resource planning.

Transitional costs

There are several revenue implications of the relocation that are non-recurrent. These include,

- Travel costs for staff to cover additional mileage for a fixed period of time.
- Site related expenditure for the vacate property whilst the estate is reviewed and utilised for further service provision.

The net impact of all of these charges is estimated to be minimal. KMPT is confident these charges can be managed within existing contingency provisions.

Capital Charges

KMPT does not have the necessary level of capital reserves to fund the investment in this project. Investment will come from central government allocation under the Centralised Health-Based Place of Safety Programme. Funding of this nature carries a public dividend capital charge of 3.5% per annum after depreciation.

Financial modelling has been used to calculate the impact of PDC on the trust's financial position and included in the revenue impact above. The agreed profile of the capital funding is set out in section 2 above.

Table 7 – Financial impact

Financial Impact/ Value for Money Assessment

£'000s	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	35/36	36/37	37/38
Net Operating Costs	0	0	(245)	(267)	(267)	(267)	(267)	(267)	(267)	(267)	(267)	(267)	(267)	(267)	(267)
Depreciation	0	0	74	99	99	99	99	99	99	99	99	99	99	99	99
PDC dividend	19	86	134	131	127	124	121	117	114	110	107	103	100	96	93
Incremental impact on I&E (surplus)/deficit	19	86	(37)	(37)	(41)	(44)	(48)	(51)	(55)	(58)	(62)	(65)	(69)	(72)	(76)

The present proposal delivers a £610k saving over a 15-year period. This is after the impact of capital charges, offering the taxpayer a return on their investment in excess of 3.5%.

The proposal includes an element of contingency (5%), which will be used to offset the likely risks identified below.

Any underspend will be made available for system level discussions around efficiency/ reinvestment. This follows the principle of the Mental Health Investment Standard.

Financial Risks

There are a number of financial risks in undertaking this project. These are being monitored closely as part of the build project and are being mitigated via value engineering exercises to ensure effective cost control.

Capital overspend

The current economic climate has had a significant impact on availability of materials and prices in the construction industry both for labour and materials. The inclusion of a contingency in the latest costs should provide some mitigation against this, but as more detailed surveys are carried out to assess site requirements this may put pressure on the budget. KMPT will do all it can to mitigate any cost pressures related to a rise in material costs or supply issues through the careful monitoring by its cost advisors.

The present capital case includes a 17% optimism bias, and a 15% contingency. The ICS has agreed to support any further overspend through its system capital. The revenue position could support an increase in capital costs of a further 2.5% overspend and still achieve breakeven.

Expenditure changes in excess of this will require a call on contingency in the first instance, and then a wider discussion with the ICB about appropriate support through the use of the Mental Health Investment Standard funding.

Impairment

As with all refurbishments there is a likelihood of an impairment upon completion. Whilst this would be a departmental expenditure limit (DEL) impairment and excluded from control total calculations for NHS reporting, this would still be a charge on KMPT's annual accounts statement of comprehensive income in the year of completion.

KMPT makes an annual assessment on the value of its estate and whilst the impact of the development is difficult to predict, it is anticipated that this approach should minimise the impact.

Revenue Impact

The Trust's financial case has been built of anticipated changes to the staffing model through the consolidation to one site. The staffing model represents c87% of the total direct and indirect costs of the service. Given the Trust's experience in service provision the likely risk of unidentified costs is felt to be minimal.

To mitigate the risk the Trust is holding a 5% contingency to cover potential changes in the medical, staffing and the trust's cost base.

7. Options Development

Addendum that describes the options appraisal workshop with ICB, KMPT, Police, Ambulance and other key stakeholders and the process of assessing each option adopted. This also needs to clearly set out why there is only one option for consideration and the reasons that the other options were withdrawn. The option also needs to demonstrate value for money.

Due to the narrow timescale for submission of the bid for National urgent and emergency care pathway capital funding, Kent and Medway ICB and KMPT reviewed the strategic planning that was undertaken with partner organisations in 2019. This review identified that back in 2019 the Section 136 service had been under consideration and review for how services might be improved. Outline plans for those improvements had been developed and included reducing the number of sites for Health-Based Place of Safety (HBPoS) to optimize the benefits from those improvements. Indeed, the KMPT "Improving Mental Health Services (IMHS)" capital development program included a plan for a new, single, "centralised" HBPoS in 2019. These plans hadn't however progressed to wider consultation due to lack of capital.

This formed the basis of the submission for funding; a brief 'touch base' with all partners (Kent Police, AHMP Kent and Medway, SECAmb, Lived Experience Expert) prior to submission was all that could be facilitated, however. Following approval of the funding further pre-consultation engagement took place to ensure that proposed centralisation of the HBPoS was still the preferred option and gave the best value for money.

This engagement was done through several workshops that took place with all system partners represented as follows:

- 21st June 2022 UEC Mental Health Pathway Transformation Workshop

- 11th July 2022 Community Crisis Alternatives Stakeholder Workshop 1
- 11th August 2022 Community Crisis Alternatives Stakeholder Workshop 2
- 24th August 2022 Community Crisis Alternatives Stakeholder Workshop 3
- 13th December 2022 – review of options, objectives, and benefits
- 13th January 2023 – Section 136 Pathway & HBOS Stakeholder Workshop
- 24th February 2022 – Mental Health Crisis Alternatives Stakeholder Workshop
- 28th April 2023 – consultation timeline, KPI and data points, dual delivery

In the initial workshops a variety of options and considerations were discussed and identified. Information was received from all partners around the strengths, weaknesses, opportunities, and threats of each option identified and each option was assessed using the HM Treasury long list options framework to identify the preferred way forward under:

- Service Scope – the what
- Service Solution – the how
- Service Delivery – the who
- Implementation – the when
- Funding – the funding

The preferred way forward and 3 other options including BAU were taken forward. Further analysis took place on how each of the options achieved and supported the spending objectives, critical success factors and finally affordability (costing estimates – costed by McBains) of each option.

This information was reviewed in later workshops with the joint consensus amongst all partners being that only one option - the final preferred option met all the criteria (financial, spending objectives and the critical success factors).

The value for money assurance was given through several benefits identified in the PCBC and the table below.

Table 8 - Benefits table

	Direct public sector	Indirect public sector	Wider benefits to UK society
Cash releasing	Circa - £381k pa reduction in staffing costs.	N/A	N/A
Non-Cash releasing	N/A	AMHP time released to support other areas. Kent Police and SECAmb time released to support other areas.	N/A
Quantifiable	Robust staffing and environment	Reduced time and travel commitment to	Reduced CO2 emissions.

	within the new HBPoS	SECAmb, Kent Police and AMHP.	
Qualitative	Reduced time for assessment. Improved patient experience. Improved staff work life. Meet the Kent and Medway Crisis care section 136 pathway & Royal College of psychiatry standards.	Improved partner relationships. Improved staff work life.	N/A

The driving force for this change was not financial and focused on the quality, safety, and patient experience.

The centralised HBPoS at Maidstone option was taken to public consultation with the premise that if any other options were identified as part of the public consultation these would go through the same appraisal process to ensure that the option that is progressed will achieve all the criteria and offer the best value for money.

8. System Strategy

The stage 2 assurance team were assured of this test being covered.

9. Senate Review

Clinical Case for Change

R1

The clinical case for change is compelling; the Kent and Medway ICB proposal would benefit from a greater emphasis on the clinical case in the business case.

The clinical case for change was multifactorial and a key driver for the proposed change.

The current services are delivered across three separate sites; these sites are supported through three individual site-based teams which creates a number of staffing challenges, leading to site HBPoS closures due to lack of staff availability.

The differing layouts and facilities see an unequitable service being delivered to patients, for example access to fresh air, de-escalation space, enhanced privacy and dignity. The physical fabric of the facilities are old and outdated and lack resilience. They do not meet current standards and often closed due to damage from patients.

When sites are closed patients are taken to the A&E department which is an environment not conducive to supporting a patient in crisis and which exacerbate symptoms and behaviours and does not have immediate access to trained mental health clinicians.

The current service has support from doctors however due to the split locations this is not a dedicated resource which means patients can have prolonged waits for a doctor to be free to undertake a review.

Kent and Medway AMHP's can be called to undertake assessments on any site this can also extend the wait for patients due to travel and availability of the AMHP's.

Due to prolonged waits patients can become more agitated, anxious and at times may require sedation which can further prolong the wait for assessment and impact on their overall recovery time making inpatient admission unavoidable with an additional impact upon inpatient bed occupancy.

South London and Maudsley NHS Foundation Trusts (SLaM) where centralised services have already been implemented has provided evidence to support the centralisation of HBPoS. The evidence has shown that onward inpatient admissions are reduced (13%).

A smoother and timelier assessment pathway, combined with a fit for purpose physical environment lends well to improving clinical outcomes and experience for patients.

Centralisation of HBPoS

R2

Inclusion of data in answer to the questions posed above to further strengthen the case is recommended.

Within the DMBC current data will be provided to outline the current situation to create baseline data for the areas that the team will monitor if the proposal is approved. This data will range from the number of patients requiring onward admission, to the improved output from the AMHP and the rest of the benefits that were outlined in the PCBC.

The improvements seen through different trusts that have implemented a centralised service will be shared and Kent and Medway if approved will monitor the expected benefits against the Kent and Medway baseline data and the results from trusts who have already implemented the proposed changes.

R3

The SLaM evaluation suggests the potential for clinical benefit of a single site, albeit in a smaller geographical area with better road transport compared to Kent and Medway. The

Senate panel recommend incorporating clinical evidence from comparable geographies such as the southwest centralisation. Conversations with in-region colleagues with regards to the Surrey centralisation may also yield further insight (introductions can be made via the Senate management team if desired).

As part of the building of the case the evaluation of South London and Maudsley NHS Foundation Trusts centralised HBPoS paper was taken into consideration[1]. The paper outlines several benefits that were seen within the first 7 months of implementation.

Key benefits that Kent and Medway took from the report were.

- A 13% reduction in patients requiring an admission due to a dedicated staffing team with an identified saving of £1.2M.
- A reduction in patients taken to A&E due to the improved physical health capabilities of HBPoS team.
- Improved partnership relationships and working
- Reduction in closure – due to staffing and vandalism

A meeting has also been arranged with Surrey to understand the benefits and learning they have seen since implementation. The SLaM and Surrey information will be used to Strengthen the DMBC.

Inpatient capacity and patient pathways

R4

Consideration of the risks posed, and the operational leadership required when there is lack of inpatient capacity need to be explored and clearly articulated in the future business case.

In line with recommended standards, the aim within KMPT is to achieve an average of 85% bed capacity and 32-day Average Length of Stay. The table below shows an average of around 95.9% capacity, with LoS averaging at 34 days.

Table 9 - Bed capacity 04/22-03/23

Total KMPT younger and older adult bed capacity and demand for the last 12 months broken down by month													
Bed Occupancy													
Inpatient	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2023-01	2023-02	2023-03	2022/23
YA	96.1%	98.1%	96.1%	95.9%	97.9%	96.6%	97.2%	95.7%	95.2%	94.2%	95.8%	92.9%	96.0%
OA	90.9%	92.4%	97.2%	95.2%	97.6%	95.1%	94.8%	97.5%	94.6%	98.0%	96.8%	97.2%	95.6%
Average	94.4%	96.1%	96.5%	95.6%	97.8%	96.1%	96.4%	96.4%	95.0%	95.6%	96.2%	94.5%	95.9%

KMPT is benchmarked nationally as being in the lowest quartile for commissioned bed days. This combined with a number of inpatients medically fit for discharge but whose discharge is delayed due to waiting for Residential Home or Supported Living accommodation poses significant challenges for effective patient flow and timely access to inpatient beds. Consequently, bed occupancy is consistently above recommended levels and access to inpatient beds can be delayed. Access to inpatient beds by patients requiring inpatient

[1] SLaM-Centralised-Health-Based-Place-of-Safety-Evaluation-Nov-2017.pdf (transformationpartnersinhealthandcare.nhs.uk)

admission from the HBPOS (22%) can be delayed due to prioritisation being given to patients waiting in the community, given that the HBPOS is a safer environment to wait for a bed.

In line with the NHSE 100 day discharge challenge, and recently produced NHSE Draft Inpatient Guidance, NHS Kent and Medway are working with System Partners, including KMPT, Social Care Partners, Ambulance Trust and VCSE providers to improve flow and capacity with focus on admission avoidance and alternatives, meaningful and therapeutic inpatient stays/reduced Length of Stay, and with Social Care commissioners to widen and stimulate the provider market. Work is underway on improving the 'inpatient journey' and ensuring early identification of barriers to discharge.

To support admission avoidance and facilitate earlier discharge the following support services are offered:

- Rapid response Service for timely mental health assessment
- 24/7 VCSE delivered Mental Health Crisis Line
- Crisis Peer Support Discharge workers
- Safe Havens
- Crisis and Well Being Cafes
- Home Treatment

As viable alternatives to inpatient admission, NHS Kent and Medway are currently procuring:

- Revised Save Havens enabling increased access to 24/7
- Crisis Houses

They are also working with KMPT to ensure the functions of Crisis Resolution and Home Treatment are resourced and functioning in line with best practice to ensure optimal utilisation of home treatment.

R5

The Senate panel recommend the consideration of the Kent and Medway ICB bed commissioning policy relating to sec 140 MHA to the proposals.

The KMPT Section 140 policy document highlights the process for referral and allocation of beds where:

- An AMHP from KCC or MC has been requested to undertake an MHA assessment.
- The AMHP believes that an admission of 'special urgency' applies.
- There are no immediately available beds at the time the MHA assessment is requested or completed.

The policy also outlines the provider collaborative beds timescales:

- Referrals are reviewed and responded to within 4 hours.
- An emergency assessment must be offered within 12 hours followed by an admission within 24 hours if needed.
- Urgent Referrals 48 hours
- Routine referrals: 1 week

It is recognised within KMPT that current capacity issues mean that achieving these timeframes is a constant challenge and for this reason much of the focus of the Kent and Medway Urgent and Emergency Care Pathway is on alternatives to inpatient admission.

This includes provision of VCSE delivered Crisis Houses; it has been identified that approximately 30% of KMPT bed days could be saved which will have a positive impact upon inpatient bed capacity.

Recent transformation to the KMPT Crisis Resolution and Home Treatment functions has involved disaggregating the 'unplanned' urgent assessment response, from the 'planned' home treatment response. This has enabled the Home Treatment function to employ a wider and more diverse skill mix which will enable an improved Home Treatment offer as a true alternative to inpatient admission.

KMPT are signatories to NHSE London, and surrounding counties compact, offering and benefitting from mutual aid with neighbouring systems to support timely access to inpatient provision and effective flow.

Recommendations arising from the recently published Draft Acute Inpatient Guidance will be rolled out across KMPT, which alongside the Therapeutic Adult Mental Health Inpatient Care mental health investment standard will see a further reduction in the Length of Stay across the inpatient wards.

Nationally there is a patient flow challenge across the majority of acute mental health inpatients services whereby increasing numbers of inpatients are medically fit for discharge however their discharge is delayed due to lack of access to social care funded supporting living and residential placements. As aforementioned the Kent and Medway System is grappling with this challenge with between 15-20% of inpatients on KMPT wards delayed from being discharged. The Kent and Medway ICS partners are working collaboratively to resolve this.

R6

Clarity on location of inpatient admissions from the proposed centralised unit and exploration of the wider impacts on service users and their families of admission further from home is necessary.

The tables below give an overview of patients between April 2022 to March 2023 of the 682 patients that were detained under a section 136 and taken to a HBPoS 134 patients were admitted to inpatient services. Of the 134 patients, 109 were sectioned and 25 were admitted informally.

The table below shows the number and percentage of people that were admitted within their local residential area and those admitted outside their local residential area.

Table 10 - locality of Admission

Admission post HBPoS	No of patients sectioned	% of patients sectioned	No of patients informally admitted	% of patients informally admitted
Ward local to residence	40	37%	9	36%
Ward not local to residence	46	42%	14	56%
Other (PICU/Out of County)	23	21%	2	8%

Of the 109 patients that were sectioned 40 patients were admitted within their local residential area and 46 patients were admitted outside of their local residential area. Of the 25 that were informally admitted 9 patients were admitted within their local residential area and 14 patients were admitted outside their residential area and only 1 patient out of the 14 was transferred during their stay to their local residential area.

KMPT have been working on improving the quality, safety, and the gender separation (single sex accommodation) across their inpatient provision, to improve the overall patient experience and outcomes. In doing so, the configuration of beds per inpatient site does mean that admission to an inpatient unit may not be the unit immediately closer to home. This notwithstanding, admission will be to a bed within Kent and Medway and there is robust integrated working between the community and inpatients nursing teams ensuring continuity of care provision. Further KMPT offer flexible visiting hours to facilitate Carer and Family access and there is also a voluntary driving service available to transport carers and families. Virtual visiting is also supported throughout the trust to ensure that patients feel supported if their families are unable to visit in person.

Community Services and Prevention

R7

Further articulation in subsequent business cases regarding the preventative offer and its effects on the s136 pathway.

A range of community crisis alternatives are being commissioned via both the Community Mental Health Transformation Programme and the Mental Health Urgent and Emergency Transformation Programme.

An area of focus is on crisis prevention through the bolstering of mental health provision within Voluntary and Charitable Social Enterprise provision, for example the Service User Network Model (SUN) and Peer Support Services, and primary care provision (recruitment to 40+ Mental Health ARRs (Assisted Roles and Responsibilities) clinicians.

Additional focus is placed on early crisis intervention and timely de-escalation. VCSE Well-being and Crisis Cafes have received recent investment enabling 7 day opening in some

areas. There are also 5 VCSE delivered Safe Havens spread across the County and open out of hours and at weekends.

In response to the low conveyance rates to the Safe Havens by Police and SECAmb, who lack confidence in handing over risk to the VCSE, plans are in place to commission a further 4 Safe Havens, three of which will be collocated with an Acute Hospital with clinical input to further encourage SECAmb and Police confidence in utilising non-clinical community crisis alternatives.

Recent transformation to the KMPT Crisis Resolution and Home Treatment functions has involved disaggregating the 'unplanned' urgent assessment response, from the 'planned' home treatment response. This has enabled a more rapid response to requests for urgent assessment 24/7.

Kent and Medway have also implemented the NHS 111 Select 2 for mental health pathway in March 2023, providing members of the public with urgent access to mental health support via KMPT's Urgent Crisis Line who can then arrange for an urgent Face 2 Face mental health assessment within 4hrs.

Workforce

Workforce Planning

R8

Detail on current and proposed workforce models for all staff groups in future documents is required to fully assess the safety and effectiveness of the proposed model.

KMPT is presently running three places of safety; as part of the proposed centralisation of the service, a review has been undertaken to ensure that a robust workforce is in place to support the services. These details are set out in the Pre-Consultation Business Case (Section 12.1),

Table 11 - HBPoS workforce

	Present Staffing (WTE)	Centralised HBPoS (WTE)
HBPoS team manger	1.00	1.00
Senior Staff Nurse	6.00	4.48
Registered nurse	8.25	4.48
Health care workers	23.77	17.92

Financial impact of this is considered in section 6 - Best Practice Consideration: Finance and Affordability.

Within KMPT The workforce for the proposed HBPoS is still being reviewed however the money that has been allocated creates a level of flexibility in how the workforce is modelled, the operational team recognise there is an opportunity to create a Multidisciplinary diverse team working to benefit the overall therapeutic experience of patients. One option that is currently being discussed is the inclusion of OTs within the HBPoS staffing budget. There are plans for the consultant rota to be reviewed with the intention of providing a dedicated

doctor to support the proposed centralised HBPoS. With regard to the AHMPs that support the HBPoS, the plan within the proposed design is to provide on-site accommodation for a dedicated AMHP. This space will improve integration with the HBPoS team and provide space for the background work required prior to the mental health assessment.

Through delivery of dedicated resource on site from the supporting teams this will support a faster more efficient Mental Health Assessment and reduce the overall time spent within the HBPoS.

Training and Development

R9

Meeting staff skills and physical health competencies require further consideration and greater articulation in the PCBC.

The proposed centralised HBPoS will support creating a workforce that allows a diverse range of skills and knowledge within the team. The Kent and Medway Section 136 Pathway Standards and Health Based Place of Safety Specification outline the Physical Healthcare Competencies for staff working in the 136 Health based Place of Safety (including both nursing and medical staff) who will have the following physical health competencies to prevent unnecessary A&E referrals:

Provide monitoring and basic physical interventions e.g., hydration to support basic physical health status.

Safely administer and monitor medication used or rapid tranquilisation.

Be able to provide basic life support.

Recognise and refer on the acutely deteriorating patient providing initial supportive treatment, including seizures, chest pain, breathlessness, lowering of consciousness.

Manage simple superficial wounds.

Screen and respond to non-acute illness including management of co-morbid infection and identification and onward referral for chronic stable disease.

Perform basic lifestyle screen assessment.

Screen for, prevent and manage uncomplicated alcohol or substance (including nicotine) withdrawal.

Provide full medical examination and systems review (and if appropriate blood tests) to screen for co-morbid physical health conditions to support onward referral if appropriate.

Travel and Transport

R10

The senate panel recommends consideration of the commissioning arrangements that are or will be in place with SECAmb to transport patients to Maidstone rather than the closest

emergency department that includes the exploration of a commissioned service for HBPoS conveyances that negates the need for a frontline ambulance.

SECAmb will always take to a KMPT provided Health Based Place of Safety rather than an Emergency Department (unless medical treatment is indicated or there is no space at the MH HBPOS) and currently convey from one end of the County to the other.

As part of the travel analysis, it was identified that the SECAmb would likely have a reduced travel time over the twelve months due to less journeys being required from one end of the county to the other. This will mean that crews will remain more centralised and less chance of them being pulled to cover calls outside of their normal designated area.

An additional positive impact upon SECAmb will be realised by access to a dedicated robust team at HBPOS ready to receive new patients and thus a reduction in the handover time enabling police and crews to return to other duties quicker than under the current system.

A Mental Health Ambulance conveyance service is currently being re-procured however in line with the MHA Code of Practice, Police will always call for a SECAmb Category 2 response when using their powers of detention to ensure that physical ill health is ruled out and as a protective patient measure if the Police have had to use physical restraint.

R11

The Clinical advice service for Kent Police is to be applauded and this service should be extended to include SECAmb if it doesn't already do so.

SECAmb already employ mental health clinicians within their own Clinical Advice Service, and area also provided with an Urgent Bypass Telephone Advice service that enables them direct access to a KMPT Mental Health Clinician for advice.

The latter is currently only available between 0800hrs-2000hrs. Mental Health Investment Standard funding has been ringfenced to provide 24/7 access to Mental Health Clinicians who will provide a 'hear and treat, or a 'see and treat' convergence on scene with paramedics for implementation Q1 24/25.

R12

Clear articulation in the PCBC of how increased transfer times for SECAmb may be mitigated is required. For example, how the centralisation of the HBPoS will result in decreased handover times.

As part of the travel analysis, it was identified that the SECAmb and Kent police would likely have a reduced travel time over the twelve months due to less journeys being required from one end of the county to the other. Meaning that police and crews will remain more centralised and less chance of them being pulled to cover calls outside of their normal designated area.

There is also the impact that having a dedicated robust team ready to receive new patients reducing the handover time and help patients de-escalate enabling police and crews to return to other duties quicker than under the current system.

R13

The challenges of repatriating patients after discharge from the centralised HBPoS need to be acknowledged and mitigation plans require describing in the business case.

Patients at the point of discharge from the HBPoS are provided with transport to get home Kent and Medway ICB through a dedicated commissioned Mental Health private ambulance. Patients are currently placed in the next available bed around the county as the figures mentioned in chapter 3 outline.

As mentioned in R6, KMPT have been working on improving the quality, safety, and the gender separation (single sex accommodation) as this will improve the overall patient experience and provide improved outcomes. Due to the constraints around space and demand this wouldn't be possible to deliver across all the sites in all localities, however there is robust integrated working between the community and inpatients nursing teams that provide continuity of care, KMPT also offer flexible visiting hours to facilitate patients cares and family's access, within Kent and Medway Families can also access a voluntary driving service to support visiting. Virtual visiting is also supported throughout the trust to ensure that patients feel supported even if their families are unable to visit in person.

As part of the wider 136 pathway all patient journey's, wards and visiting are being reviewed and any improvements identified and implemented where practically reasonable to create the best possible experience not only for patients but their families, friends and the staff that support them.

Engagement

Clinical Engagement

R14

Impacts of the proposed change on staff require further exploration and evidence in the PCBC.

ON the 11th January 2023 the first formal staff engagement session took place this was attended by 21 individuals out of the 25 members of the team currently employed, this equates to 84% of the workforce. At this meeting the feedback was resoundingly positive with around 85% of the team being really excited around the changes and 15% happy and able to see the benefits for both patients and them as a group.

The identified benefits from the team ranged from improved work life balance as less unsociable shifts, improved supervision, career progression and larger support group as all based on one site.

One surprise from the management team was that not one member of the team raised any concerns around the impact on their travel, however it is realised that this could be as, yet this is a proposal and if approved will become more real over the coming months to the team.

The service manager for the HBPoS has added the proposed centralisation to a rolling agenda item on the team meetings to enable any questions to be asked and give any updates as the proposal progresses. Formal consultation with KMPT staff will take place only if the proposal is agreed and when the implementation is closer.

To support the communication and engagement with the HBPoS team some of the team will be invited to support the design work of the proposed HBPoS if the proposal is approved.

R15

Further engagement with key stakeholders such as SECAmb and emergency departments is strongly recommended. Letters of support from SECAmb and impacted urgent and emergency care services in the region would undoubtedly strengthen the business case.

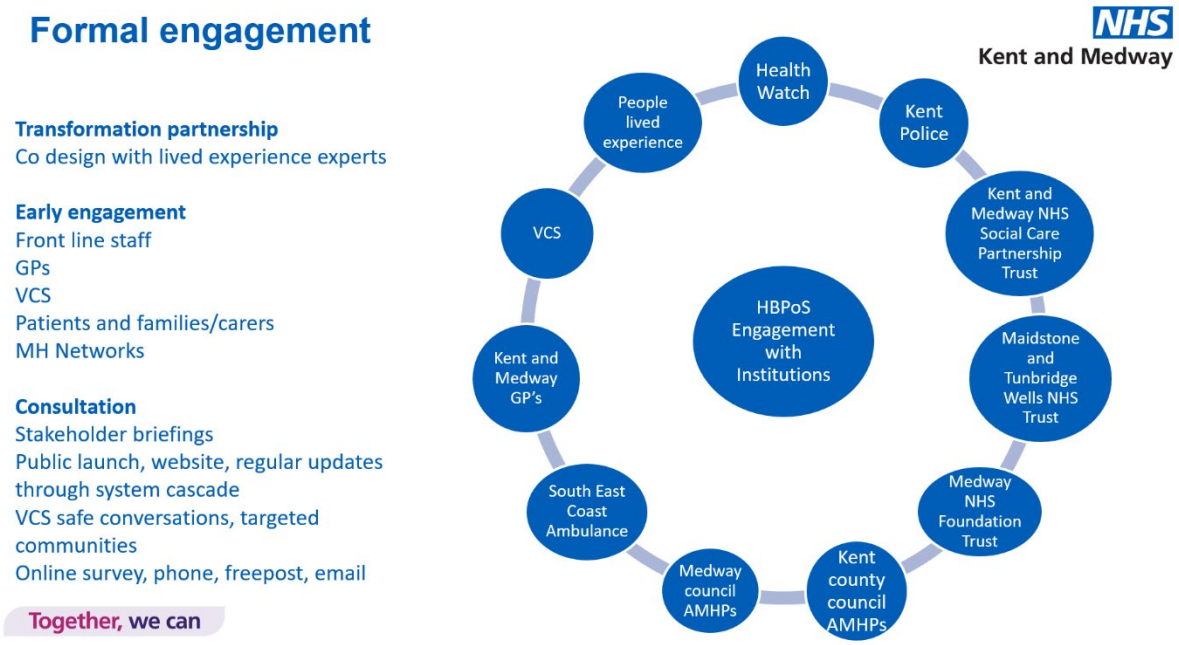
The robust engagement and consultation that has been undertaken with SECAmb and Kent Police is previously described. Both organisations are preparing letters of support that will be included in the DMBC.

R16

Inclusion in business case proposals of the verbalised engagement that has taken place.

Form the initial concept of the centralisation of the HBPoS Kent and Medway ICB and KMPT have ensured that engagement with stakeholders has been at the heart of the activities. The figure below shows the external engagement that has taken place.

Figure 2 - Formal engagement



R17

The opportunity should be taken to build on the consultation feedback received from staff, service users and their families to ensure a level of co-creation and true engagement in developing the service to be the best it can be.

The DMBC will include information the feedback that Kent and Medway ICB have received back from all stakeholders through the consultation. To provide an unbiased review of the consultation an independent company has been procured to collate the feedback from the consultation. This document will be attached to the DMBC as well as information pulled out and used within the DMBC.

The DMBC will also include an addendum to the communications plan that includes the early approach to engagement and communications, this details the range of engagement activities that have taken place including groups and hard to reach groups that were targeted.

The document identifies that throughout the engagement Kent and Medway ICB have engaged with:

- 11 focus Groups
- 5 Meetings with Megan CIC
- 1 interview with a carer
- A range of meetings/ workshops involving 185 directly
- 1450 staff and stakeholder through wider communications

Past engagement information was also used to inform the project this involved information from the Kent listens project that had in-depth conversations with 1356 individuals (from 57 different self-identified ethnicities who spoke 30 different first languages). We have also benefitted from colleagues across the system, including Healthwatch, Young Adults Involvement Project at Porchlight, and the Suicide prevention network, who have shared existing reports and research.

Key feedback has been and will continue to be shared with the Programme Director, Mental Health Urgent and Emergency Care and partner organisations to support and inform the decision-making process.

Public and Patient engagement

R18

The business case needs to include descriptions, data and documented feedback from the extensive engagement work verbalised.

Please see information in R17once the independent review and report is completed the feedback from the consultation will be documented in the DMBC, with you said we have listened and done type of responses from the ICB and its partners.

R19

The voice of carers and families need to be well documented in the proposals.

Please see information in R17 once the

Population Health and Inequalities

R20

The current EQIA is limited and would benefit from further development. It does not include details normally seen for such a business case. There is evidence of data for some of the protected characteristics such as age and gender that could be included. The Senate panel recommend the current EQIA is updated and expanded.

Please see attached updated EQIA is appendix 4 in the report

R21

More detailed analysis of s136 detentions, such as the higher incidence of women detained, is recommended as it may have subsequent service planning implications.

KMPT and Kent Police produce monthly intelligence reports, the reports shows that over the 12 months from April 2022 to the end of March 2023 that the gender split of people detained under section 136 is 52.2% female, 47.6% male and 0.2% X.

Table 12 Section 136 by gender per month 04/22-03/23

Gender	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2023-01	2023-02	2023-03	Total S136
F	32	35	24	38	35	32	35	31	22	20	28	24	356
M	37	37	33	31	18	22	23	24	31	29	23	17	325
X			1										1
Total S136	**69**	**72**	**58**	**69**	**53**	**54**	**58**	**55**	**53**	**49**	**51**	**41**	**682**

The design of the proposed Centralised HBPOS work will commence if/and when the Decision-Making Business Case is approved, and as such the PCBC was not able to provide detail. This notwithstanding key to the proposed design of the centralised HBPoS is accommodation that ensures privacy and dignity to all patients through provision of single sex accommodation and individual rooms each with ensuite bathroom facilities and facilities. There will be communal areas, for example a lounge and outside space, and the flexibility to provide a female only communal area also.

Another area that needs consideration within the design will be the number of young adults that are transitioning from Children and Younger Persons (CYP) services, specifically the cohort of individuals that fall within the 18-25 bracket. An analysis of the same time from 04/2022 to 03/2023 identified that 190 young adults had been sectioned so around 28% of the total of people detained under the S136. Consideration with regards to workforce skills and experience and the physical layout of the HBPOS will be factored into the design with the support of lived experience experts and input from the CYP Services.

R22

NHS England 2023/4 priorities and operational planning guidance23 has prevention and health inequalities as a key objective. The Core20PLUS5 approach to tackling healthcare inequalities lists mental health as one of its 5 targeted areas. Some of the areas impacted by

the proposals are the most deprived in Kent.24 The Core20PLUS5 approach enables the biggest impact on avoidable mortality in the most deprived populations and contributes to an overall narrowing of the health inequalities gap. It would be helpful to be able to see how the Kent and Medway's understanding of its Core20PLUS population feeds into the centralisation of HBPoS proposals.

The Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both the National and System level. The approach defines a target population cohort - the 'Core20PLUS' (The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD)), and identifies '5' focus clinical areas requiring accelerated improvement:

- **Maternity:**
- **Severe Mental Illness (SMI):**
- **Chronic Respiratory Disease:**
- **Early Cancer Diagnosis:**
- **Hypertension Case**

One of the five clinical areas relates to ensuring equity of physical health monitoring for Mental health service users with SMI and this is focused on ensuring annual health checks. The proposed centralisation of the HBPoS will complement this as the requirement within the HBPoS will be physical health assessment of individuals detained under 136, some of whom will likely fall under the category of having SMI.

Sustainability

R23

To demonstrate how the centralisation proposals will address healthcare sustainability and involve the ICB Greener NHS team in assessment of the proposals.

The HBPoS will address healthcare sustainability as the centralisation of the HBPoS will create a robust workforce with greater access to development and training improving the capabilities of that workforce. The environment will be fit for purpose and the construction work will wherever possible use modern methods of construction.

The space freed up from the proposed centralisation of the HBPoS will be reutilised to support other services, creating much needed space on sites where there is limited space and no options for expansion/extension.

We have invited the ICB's greener NHS lead to support the design and implementation of the proposed HBPoS.