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Dear Member

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE - TUESDAY, 19 MARCH 2013

I am now able to enclose, for consideration at next Tuesday, 19 March 2013 meeting of the Kent and Medway NHS Joint Overview and Scrutiny Committee, the following report(s) that were unavailable when the agenda was printed.

Agenda No	Item
5	**Adult Mental Health Inpatient Services Review (Pages 1 - 74)**

Yours sincerely

Peter Sass
Head of Democratic Services

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Kent and Medway NHS
NHS and Social Care Partnership Trust

NHS
Kent and Medway

Achieving Excellence in Mental Health Crisis Care

1. INTRODUCTION

1.1 This paper reports on Kent and Medway residents' responses to the public consultation on Achieving Excellence in Mental Health Crisis Care, held for 13 weeks between 26 July and 26 October 2012.

1.2 The proposals were developed with the help of stakeholders in Spring 2012 as a result of significant concerns about

- Inequitable distribution of hospital beds for Kent and Medway people who are acutely mentally ill
- The long standing concerns about shortfalls in the therapeutic environment at Medway's A Block, including the inadequate privacy and dignity on offer and therefore the sustainability of clinical safety.
- The increasing need to enhance staffing and improve the service delivered by Crisis Resolution and Home Treatment (CRHT) 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

1.3 The year-long discussions about how to improve the situation and raise the standards of care to appropriate and equitable levels across the area have naturally caused some anxiety for service users and carers and for staff facing uncertainty about their futures.

1.4 Medway's A Block, which already had significantly more violent and aggressive incidents than any other unit in Kent and Medway and which is listed in the local NHS Risk Register for this reason, has seen a further eight such incidents at Medway, in a period when there have been none at either Dartford or Maidstone. Inevitably, the situation becomes more untenable the longer it remains unresolved.

1.5 This paper reports on the independent analysis of the consultation responses and the independent assessment of the consultation process. It sets out how the points raised by the respondents are being addressed and includes further information requested by, and supplied to, Kent and Medway Joint Health Overview and Scrutiny Committee (JHOSC).

1.6 Seven Clinical Commissioning Groups have considered the response from the consultation, the proposed actions to address points raised within consultation and the implementation plan, and offered their support, the eighth CCG is due to respond shortly.

1.7 All of this, together with views expressed by the Kent and Medway JHOSC, will be reported to the PCT Cluster Board and the Kent and Medway NHS and Social Care Partnership Trust Board (KMPT) towards the end of February when next steps will be decided.

2. BACKGROUND

2.1 The service review

2.1.1 The public consultation, which all the Kent and Medway Clinical Commissioning Groups (CCGs) supported, was approved by the Cluster Board in July 2012, following a review of current services that found:

a. **Reducing hospital bed use** over four years, due to successful alternatives established in the community, particularly since 2004

b. **Too few acute beds** in east Kent and too many in west Kent, with people often placed out of the area covered by their community-based Crisis Resolution and Home Treatment (CRHT) team, a situation that prevents seamless care and creates delays

c. **Long-standing concerns** about the quality of the environment in A Block at Medway Maritime Hospital, the inpatient unit for people from Medway and Swale, despite considerable previous effort to identify a local inpatient alternative

d. **Psychiatric intensive care** is supported in west Kent by a very effective acute ward outreach service (PICO), not currently available for east Kent.

2.1.2 The review analysed four years of bed usage data, leading to the conclusion that, allowing for the usual variations and the seasonal peak between January and March, 150 beds would be required (rather than the current 160), plus 12 in one psychiatric intensive care unit (PICU) supported by an outreach service across the whole of Kent and Medway, rather than 20 in two such units with only some places having the outreach service. The 150 beds will be allocated proportionately to match actual demand, with each service locality allocated to a specific inpatient ward and an aligned Crisis Resolution Home Treatment team.

2.2 Proposals for consultation

2.2.1 With the approval of all CCGs in Kent and Medway, the Cluster Board sought and gained JHOSC support for consultation on the review's proposals for future services that will deliver

- more equitable access to high quality hospital wards
- strengthened acute services delivering more care in people's homes
- better recovery outcomes for those receiving acute treatment

2.2.2 The proposals are designed to:

a. **Strengthen the Crisis Resolution Home Treatment teams** so they can provide more support to service users and their carers, including practical help and respite to support families

b. **Develop three hospital Centres of Excellence for the most acutely unwell**, each providing:
   - Faster and more complete recovery for service users
   - Patients reporting a better experience including feeling safe and being able to see the progress they have made in improving their mental health
   - An excellent acute inpatient mental health service in itself, delivered by highly effective staff who are well supported and able to deal with any crisis
   - Opportunities for therapeutic interventions at weekends and into the evening
   - Purpose built accommodation for safe care and the promotion of recovery.
   - Hubs of good practice with a research programme that attracts and retains highly qualified, expert and motivated staff.

c. **Expand the psychiatric intensive care outreach service** to cover the whole of Kent and Medway, providing support to staff in the Centres of Excellence so that the need to transfer patients to a psychiatric intensive care unit is reduced

d. **Consolidate inpatient psychiatric intensive care in one place**

2.2.3 They would mean:

- **Recruiting 26 Support Time and Recovery workers to the CRHT teams offering practical support to service users and carers**
- **Opening an additional acute ward at Dartford**'s Little Brook Hospital
- **Opening eight additional acute beds at Canterbury**'s St Martin's Hospital
- **Moving out of the two wards in Medway Maritime Hospital's A Block**
- **Basing the psychiatric intensive care unit at Little Brook** and extending the outreach service to cover East Kent

2.2.4 In developing the proposals, KMPT made clear it was committing to creating Centres of Excellence to drive quality, breadth of services and interventions offered. The opportunity for research and development alongside academic partners enables greater consistency of practice and outcomes to be achieved and shared. KMPT described its Centres of Excellence (CoE) model as:

> *"A service that is delivered to a recognised high (national or world class) standard, in terms of measurable results and innovation, so that, in addition to performing its own core work very effectively, it has an additional role in improving its practice expertise and knowledge resources. The centre can then, in turn, assist other parts of its service system to improve continuously and work collaboratively. The defining features of a CoE are therefore: A critical mass of specialist staff organised around one locus; an ability to integrate complementary multidisciplinary skills; evidence-based research and knowledge management capabilities; and the capacity and stability to attract, retain and exchange a skilled workforce."*

2.2.5 The Centres of Excellence, together with strengthened CRHTs, will ensure service users and carers:

a. **Receive more cohesive and complete care and support through a crisis**

b. **Have more opportunities to choose home care and treatment**

c. **Have equal access to a hospital bed in a high quality centre designated for their locality** which is known to reduce the risk of delayed discharge, helping people return to their home environment and daily routine as soon as possible.

d. **Benefit from investment in greater support from their locality's CRHT:**
   - Around 160 additional care packages are expected to be delivered across Kent and Medway in a year
   - Around 3,600 extra home visits will be delivered, giving practical help to service users and their carers.

2.2.6 Three options for the allocation of service localities to inpatient wards were consulted on. In all of them, people from Medway would be treated at Little Brook Hospital, Dartford, when they need a hospital stay. In options A and C, Medway would have its own CRHT and in Option B, it would share one with Swale.

2.2.7 For people from Swale (excluding Faversham)
- Option A would mean hospital stays in Priority House, Maidstone
- Option B would mean hospital stays in Little Brook Hospital, Dartford

- Option C would mean hospital stays in St Martin's Hospital, Canterbury

2.2.8 For people from Swanley, Option B would mean hospital stays in Priority House, Maidstone.

2.2.9 In each option, the CRHT teams are to be aligned so that they have a base and strong working links with the Centre of Excellence serving the same area of Kent and Medway as they do, to ensure seamless care. The CRHT staff will be spending most of their time out and about on their 'patch', providing home treatment and support to service users.

2.2.10 The proposed new arrangements fit with the range of improvements to mental health services made in the last few years. These include:-

- **A clear pathway** for patients via their local Access Team (8am to 8pm) and Crisis Resolution and Home Treatment Services (8pm – 8am), either directly if they are already known to mental health services or through being referred by their GP
- **A liaison psychiatry team** at the general hospitals and a protocol so that general hospital staff can access advice about working with patients who have mental health issues and secure appropriate mental health care when their patients need it
- **Psychiatric nurses at the custody suites in main police stations** providing swift assessment and diversion where appropriate
- **A suicide prevention training** package and protocol for Kent Police;
- **A protocol with South East Coast Ambulance** Service to ensure people with mental health problems are taken to the most appropriate place
- **An Assertive Outreach team** to engage with people who might otherwise be at risk of losing contact with services
- **Increased investment in early intervention** services for people experiencing a first episode of psychosis

3 ENGAGEMENT AND CONSULTATION

3.1 Pre-consultation

3.1.1 From February to June 2012 there was extensive engagement with stakeholders, staff, service users and carers to ensure their views were able to influence the review. The review met the requirements of the four tests set out by the Department of Health in relation to service configuration as outlined below:

- **Support from GP commissioners**
  All eight of the Clinical Commissioning Groups reviewed the evidence presented by the Acute Mental Health Board, and clinical leads from each locality were involved throughout the development of the options.

- **Strengthened public and patient engagement**
  The Commissioners and the Trust have several ways in which they regularly talk to their service users and carers including: patient consultative committees, nine Locality Planning Meeting Groups twice in March and May/June, Performance meetings and Joint Commissioning Boards. The commissioners and Trust senior staff used all of these meetings to ensure that service users and carers were involved from the outset in developing and commenting on the proposals for achieving excellence in a mental health crisis.

  Service users, carers, council members and clinicians all took part at options appraisal in February, there were several further meetings with service users, staff, clinicians, GPs and carers to finalise the options to be taken forward including a workshop with Kent LINk's mental health network.

- **Clarity on the clinical evidence base**
  A wide range of stakeholders: GPs, clinicians, service users, carers, councillors and partner organisations were invited to a stakeholder option appraisal event in February to consider eight potential options and reduce these to a short list of robust, viable options to take forward.

  Following this, a series of meetings was held with mental health clinical staff and the clinical commissioners (CCGs) to test the short listed options and ensure that all aspects of the proposed clinical pathway were robust and supported by front line staff as well as senior staff.

  The clinical case for change was reviewed and supported by the National Clinical Advisory Team in July 2012, and the SHA service reconfiguration team.

- **Consistency with current and prospective patient choice**
  Each of the options for change retains choice of home treatment from the CRHT or inpatient treatment if appropriate. The core proposal is for relocation of acute services in Medway following clinical opinion that there was a need to resolve the problems with A Block after a 10 year pursuit of local alternatives.

3.1.2 Throughout the review the team has worked closely with the Medway and Swale advocacy project to ensure those service users most affected by the changes would be able to influence the plans. Travel and transport for carers, family and friends was a major concern so staff worked with the Medway and Swale service user group to test the public transport available to reach the centres of excellence from Medway, and Sittingbourne and Sheppey. The information they found was fed into the plans and information provided during the wider consultation.

3.2 Regular communication and information

3.2.1 Key stakeholders such as MPs, local authorities and other partner organisations were also briefed and asked for their input through their regular working meetings, or via meetings with senior staff to ensure they were kept abreast of developments and were aware of the early thoughts and plans.

3.2.2 Both scrutiny committees in Kent and Medway were given an early briefing in which the potential requirement for a Joint Health Overview and Scrutiny Committee (HOSC) was highlighted. Both Kent and Medway HOSCs agreed to form a JHOSC using the existing agreement for how this would be set up.

3.2.3 The Members of the JHOSC and their support staff were invited to visit two of the key sites affected by the proposals being developed.

3.2.4 The PCT featured the review in two issues of the award winning *Your Health* magazine, 50,000 copies of which are distributed through GP practices, hospital waiting areas, supermarkets, libraries and community centers, as well as in hairdressers and other outlets to ensure the wider community was aware of, and able to be involved in the review.

3.2.5 The local media have also been regularly updated with press releases and news statements. Both the broadcasting media and local newspapers have featured the review.

3.2.6 A dedicated page on the KMPT website was set up and two consultation documents written.

3.2.7 In June and July the JHOSC and the two NHS Boards met to agree and approve the proposals and the plans for formal consultation with the wider public, following approval from all the 8 clinical commissioning groups across Kent and Medway.

3.3 Independent assessment of the clinical case for change

3.3.1 The National Clinical Advisory Team examined the clinical case for change before the consultation was launched and said:

> *"The clinical case for change is sound, and this overall is an outstanding piece of work.....The paper has a really impressive and well worked-through set of interventions and service changes which should reduce both admissions and length of stay."*

3.4 Consultation methods

3.4.1 The formal consultation ran from 26 July until 26 October and a range of methods were used to promote the process:

- The public consultation document and summary was written and tested with various stakeholders, including non-executive directors, staff, and service users, to ensure it was clear, easy to understand and provided sufficient information without overwhelming the reader with details. It was successfully launched on 26 July 2012 and over 200 individuals, staff, service users and carers responded.

- The engagement team sent out 966 invitations, with a link to the website and the electronic versions of the document, to organisations and individuals with an offer to attend any meetings or events where people were interested in the review to provide further information and listen to what people thought of the plans. The Commissioning team and KMPT also sent the document out to key stakeholders, organisations, over 3,000 Foundation Trust members, and staff. Also the VCS organisations which support service users and carers and are interested in mental health, cascaded the information to their members – for instance, 575 individuals registered with MIND for the LPMGs

- The engagement team booked six venues to cover each area, holding the Public Consultation meetings at a range of times in accessible and well used venues, and wrote to all known service user and carer organisations with the offer of being involved in focus groups or the engagement team coming to their meetings to provide some information and raise awareness of the consultation. A further two public meetings were added at the request of stakeholders. Over 180 people attended these eight meetings and a few carers attended several meetings.

- KMPT had a specific page on their website, with information available and suitable links on the three PCT websites, the *live it well* website and from partners in social care. The website and Intranet contained supporting documents of the Review including:

  - Online Consultation Response Form
  - Full Public Consultation Document and Consultation Response Form and Summary Consultation Document
  - Easy Read Consultation Document and Easy Read Consultation Response Form
  - Large Print Consultation Document and response form

  Background papers were also available online, including:

  - Full Board papers
  - Summary Board papers

- Non-financial appraisal
- Risk appraisal
- Risk scores for Appendix B of the full Board paper
- Right care, right time, right place document
- Equalities Impact Assessment

The consultation was also accessible through social media such as Facebook and Twitter.

- The communications teams distributed 3,000 Public Consultation Documents and 15,000 summary documents to over 700 organisations in Kent and Medway: GP practices, libraries, voluntary organisations and community centres, KMPT trust community buildings, pharmacies, opticians, hairdressers, job Centres, fitness centres, citizens advice and volunteer bureaus.

- The review and consultation also featured in *Your Health* and *Medway Matters,* the NHS magazines with a circulation in excess of 50,000. The information was also placed with local councils known to publish residents' papers in Medway and Swale, the LINk and Kent Community Action Network.

- Press releases were issued to raise awareness and promote the consultation and specific releases went out before and after each public event.

- The PALS phone number and email address was offered for any individuals wishing to comment or request more information.

3.5 Public meetings

3.5.1 Many of the eight public meetings in the consultation were chaired by an independent person from one of the local VCS support organisations to ensure that service users and carers felt comfortable and confident to contribute their views.

3.5.2 At these three-hour public road shows, a panel of clinicians and commissioners presented information on the review, the reasons why it was necessary, the outcome expected of the review, the steps taken during the review, the options arrived at and what would happen following the consultation. There was also a film of a service user's story so that people could hear how the Crisis Response and Home Treatment service worked to treat people at home. A quick question and answer session was followed by an hour of round table discussions to ensure that everyone present was able to give their views. Then, finally, a further open question and answer session and those present were asked to evaluate the events so we could ensure they worked.

3.5.3 184 people attended the eight meetings: there was a good mix of service users and carers, support organisations, NHS and social care staff and some local councillors. It had been anticipated that the numbers attending wouldn't be high due to the specialized nature of mental health crisis care and also, partly, to consultation fatigue. A number of people commented upon the high level of changes happening across the public sector. The NHS is grateful for the contributions of all those who took part.

4 CONSULTATION RESPONSES

4.1 Public response

4.1.1 An independent University of Greenwich research team analysed all the responses to consultation made through surveys, focus groups, public meetings, road shows and individual letters, emails and telephone calls. The team's detailed report is attached as Appendix 1 to this report.

4.1.2 25 queries or comments were received directly from the public in the form of letters, faxes and emails.

4.1.3 207 surveys (120 paper versions and 87 submitted online) were sent to a research team at the University of Greenwich for analysis.

4.1.4 133 people attended 13 Focus Groups, including 66 service users, 41 carers, 2 volunteers, 3 workers and 21 members of the public.

4.1.5 In addition to this, the engagement team and KMPT staff attended 15 other events with 290 attendees, including holding road shows at three shopping centres in the Medway towns to raise awareness and share the information.

4.1.6 The media took an interest in the consultation. 19 articles were written in local papers and published online with various circulation figures totalling approximately 447,604.

4.1.7 One correspondent attended seven of the eight meetings and approached various senior managers and GP commissioners to discuss his concerns. He raised a number of issues of detail and identified some errors in the review data, which the review team has now corrected. The review team also gave him a detailed response to his concerns, none of which have a substantial impact on the overall clinical case for the proposed changes. A summary of this detailed response from the review team is attached to this paper as Appendix 2.

4.2 High level feedback

4.2.1 The University of Greenwich reports there was strong agreement with the aims of the review:

- Over 80% of respondents strongly agreed everyone should have the same high quality of care and hospital facilities.
- 70% strongly agreed that people with mental health problems make a better and faster recovery in a calm environment
- 62% strongly agree crisis treatment at home should support carers as well as service users.

4.2.2 The strength of support was less when considering whether quality of care was more important than the distance travelled to reach it but, even on this point, over 50% strongly agreed or agreed.

4.2.3 Concern over travel and transport was clearly a major issue for many people and, when asked about the kind of support that would be most helpful, people were strongly in favour of the volunteer driver scheme, clear information and better signage. They also suggested support with payment of fares, a subsidized shuttle service and working with the Medway Foundation Trust or the local council to pursue a cheaper public transport solution.

4.2.4 When asked about their priorities, the themes were:

- **Access** (including, coverage, amount of travel, how local the service was and how quickly the service could be accessed)
- **Greater resources**
- **The quality of individual care** (including the family and more personalized care) and
- **The quality of service provision** (organisational improvements, multidisciplinary teams, transition between services, more and better services)
- **Community provision** summed up by this quote: “Priority should be to give prompt, effective and satisfactory home treatment to patients and carers of the mentally sick to prevent relapse and minimise recurrent hospitalization.”
- **Compound impact of changes** – Mental Health service users made the point that they were being affected by several changes to public services including the changes to the benefit system, supported housing and charges being introduced for some social care services.

4.2.5 What people want from centres of excellence are: a better patient experience, a better range of staff 24/7, more personal service. They expect them to provide a high quality environment, better resources, and appropriate treatment. People welcomed the idea of calm environments with better personal facilities. They also asked that staff provide a response to questions raised and work better with carers by giving more practical advice and information so that both service users and carers could understand and receive the support they need from this complex system. This was, they said, particularly necessary when service users were being discharged.

4.2.6 In terms of CRHT they would like an improvement in the quality and availability of support, more personalised care, better staffing, information and continuity.

4.2.7 The support for plans for Psychiatric Intensive Care were less clear cut with just over a third agreeing, a third disagreeing, and just under a third unsure.

4.2.8 In terms of options for Swale service users, 141 respondents chose an option with 66 not indicating a preference.

- 62% chose Option A Priority House
- 11% chose Option B Littlebrook Hospital
- 27% chose Option C St. Martin's Hospital

4.3 Profile of survey respondents

4.3.1 The final section of the survey tells us about the respondents :

- 39% were service users
- 13% carers
- 11% members of the public
- 11% health and social care staff
- 17% felt they represented a combination of the above
- 6% fitted none of these categories
- 3 % were organisational responses.

4.3.2 In geographical terms:

- 34% came from the east Kent catchment area,
- 27% from Medway and Swale,
- 12% from the Priority House (west Kent) catchment area and
- 9% from north Kent the Dartford, Gravesham and Swanley area, with
- 13% of respondents did not provide a postcode.

4.4 Evaluation of the consultation process

4.4.1 The University of Greenwich research team also independently evaluated the consultation process undertaken. Its findings are shown in Table 1 below.

Issue	Evaluation
Public consultation processes are governed by legislative requirements	Based on the evidence received to date... this requirement is fully met
The 'Strengthening public and patient engagement' element of the four tests for NHS Reconfigurations	Evidence is provided of strengthening public and patient engagement in the report. The full consultation document describes the process used to solicit early views and what these were and how they informed the development

	of options. Based on this evidence the criterion has been met.
The seven criteria of HM Government Code of Practice on Consultation 1. When to consult – Formal consultation should take place at a stage when there is scope to influence the policy outcome	The mental health acute crisis care review timetable allows for reporting on the results from the public consultation, before recommendations are made by KMPT to the NHS Cluster board who are the decision making organisations, hence there is sufficient time for the public viewpoint to be fed in to the decision making process. The survey document stated that: "No decisions have been taken yet and your views are important in helping us make the right ones" Based on this evidence the criterion has been met.
2. Duration of the Consultation – Consultations should normally last for at least 12 weeks with consideration given to longer timescales where feasible and sensible.	The public consultation began on 26th July 2012 and ended on 26th October 2012, which is a total of 13 weeks. Based on this evidence the criterion has been met.
3. Clarity of Scope and Impact – Consultation documents should be clear about the consultation process, what is being proposed, the scope to influence and the expected costs and benefits of the proposals	A consultation document was provided, which explained the process and proposals, and gave the respondents the opportunity to comment on the advantages and disadvantages of the options proposed. Affordability is discussed but costs for each option are not included. The full financial consequences of the redesign will only be known when the decision is made. Based on this evidence the criterion has been largely met.
4. Accessibility of consultation exercises – Consultation exercises should be designed to be accessible to, and clearly targeted at, those people the exercise is intended to reach	This criterion is evaluated in the reach and range section of this report. See below for further detail. Based on this evidence the criterion has been met.
5. The burden of consultation – Keeping the burden of consultation to a minimum is essential if consultations are to be effective and if consultees' buy-in to the process is to be obtained.	The consultation document is 31 pages in length, presented in colour with photographs as well as text. Sections include: the reasons for change, the proposals, what the options are, frequently asked questions and a summary. There is also a 12 page summary document. The survey was eight pages in length with 17 closed questions, seven open ended questions and three questions with both open and closed components. The survey was also available online. Other ways of the public providing feedback included emailing comments, attending public meetings, outreach events or focus groups. There were multiple ways of accessing information and responding. Based on this evidence the criterion

6. Responsiveness of consultation exercises – Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation.	has been met. Consultation responses were independently analysed and reported by the University of Greenwich Centre for Nursing and Healthcare Research, to KMPT and NHS Kent and Medway, taking into account the public view. Based on this evidence the criterion has been met. At this stage, we are currently unable to assess the participant feedback mechanisms as this aspect of the consultation process is still pending.
7. Capacity to consult – Officials running consultations should seek guidance in how to run an effective consultation exercise and share what they have learned from the experience.	The consultation exercise was instigated by KMPT and conducted by the Assistant Director of Citizen Engagement, a role which specialises in communications with the public for the NHS Kent and Medway. The commissioning brief was also informed by the Requirements under section 242 and 244 of the Public Involvement in Health Act 2007 suggesting national guidance had been sought and followed. Based on this evidence the criterion has been met.
Consultation documents were available in different formats	Paper versions of the full and summary consultation documents were offered in Polish, Czech, Chinese, Romanian and Slovak. Accessibility was provided with Braille, easy read paper or audio versions. All of these could be obtained by telephone or email.
Consultation documents and surveys were widely distributed	The survey and consultation document were sent to, for example, the Ethnic Minority Independent Council with 10 copies each of Czech, Nepalese and Chinese documents. Paper copies of the consultation document and surveys were handed out at the outreach events.
Taking public views	Public meetings were held in all catchment areas of Kent and Medway, in all the main towns and cities. Each meeting began with an explanation of the consultation and survey by a representative from KMPT involved in the service redesign. All emails, letters, calls and petitions were recorded and responded to.

Table 1: Independent University of Greenwich evaluation of the consultation process

4.4.2 The University team highlighted a number of learning points, mostly related to ways of improving the survey design, its questions and the data collection tools, which would have facilitated the analysis of responses. They also said the consultation documents in paper and electronic formats were in a "well presented and user friendly format" and that "other consultations would benefit from using a similar format".

4.5 Health Gateway Review

4.5.1 In the last three days of the consultation period, a team of three provided by the Department of Health conducted a Health Gateway Review 0 : Strategic Assessment, centred around the implementation phase of the programme. They interviewed 15 members of the programme team and a small number of key stakeholders and reported to David Tamsitt, KMPT's Director of Acute Services on 26 October.

4.5.2 The purposes were to

- Confirm the programme's outcomes and objectives (and the way they fit together) make the necessary contribution to the overall strategy of the organisation and its senior management
- Ensure the programme is supported by key stakeholders
- Confirm the programme's potential to succeed has been considered in a wider context
- Review arrangements for leading, managing and monitoring the programme and its main risks
- Check that the programme is resourced and that plans for the next stage are realistic and feasible and join up with other programmes (internal and external) and
- After the initial review, check progress against plans and expected achievement of outcomes.

4.5.3 The review team made six timely recommendations, shown in Table 2.

Recommendation	Timing	Action
1. The Programme Team should continue to develop a detailed response to the emerging findings from the consultation to fully support the final submissions to the approving bodies.	Do Now	Done – see sections 5 and 6 of this paper and ongoing discussions with stakeholders
2. The Programme Team should identify the main initiatives required to achieve the anticipated outcomes and put in place a performance framework to assure delivery.	By Jan 2013	Done – marked in Implementation Plan see Appendix 3
3. The Programme Manager should implement a comprehensive risk and issues management process and produce and maintain an updated risk register to reflect the current status of the Programme.	By Nov 2012	Done – reported to KMPT Board in January 2013
4. The Programme Team should produce contingency plans to address the risks associated with challenge and delay in order to maintain momentum in seeking better patient outcomes and increased efficiencies.	By Nov 2012	Done – reported to KMPT Board January 2013
5. The Programme Team should prepare a detailed implementation plan which captures all of the activities, dependencies between all of the workstreams and which identifies the critical path.	By Nov 2012	Done – attached to this paper at Appendix 3
6. The SRO should review and implement new governance arrangements to ensure clear reporting and accountability lines for performance and delivery.	Do Now	Done – KMPT NED, Medway/ Swale CCG GPs and service user on Programme Board

Table 2: Health Gateway Team recommendations to KMPT

4.6 Important additional information

4.6.1 In November 2012, the independent Schizophrenia Commission established by Rethink Mental Illness published its report *The Abandoned Illness* following a year of research by its 14 experts. Their work focused, in particular, on the delivery of adult mental health services. It is especially interesting that this was being undertaken at the time of the Kent and Medway review and redesign programme and its formal public consultation process.

4.6.2 The Commission's work involved six formal evidence-gathering sessions from 80 people who have lived with schizophrenia or psychosis, family members and carers, health and social care practitioners and researchers. 2,500 people responded to the Commission's survey online.

4.6.3 Their report makes a number of crucial points about healthcare offered to adults with severe mental illness and says: "Ensuring good quality acute services are in place must be a top priority for the commissioners and providers of mental health services. "

4.6.4 It calls for "a radical overhaul of poor acute care units" and says: "Recovery houses can offer an alternative to an acute admission or be a half-way house back to the community after time on an acute ward." In the same section it says: "Alternative providers such as voluntary organisations and charitable housing associations should be involved in discussions about expanding this provision. We recommend that Clinical Commissioning Groups and providers explore alternatives to admission as part of their plans for the development of acute care and crisis services."

4.6.5 The report, which makes 42 recommendations, says: "We found broad agreement about the changes that need to be made to transform the lives of those with schizophrenia or psychosis and of their families. Encouragingly, we also had support from a range of organisations and practitioners for our approach."

4.6.6 It adds: "There are things we can build on. In the last 20 years much progress has been made in understanding schizophrenia and psychosis. There have been many positive developments including the growth of the service user movement, initiatives like crisis resolution teams and early intervention in psychosis services, exercise prescriptions, investment in new IT systems and direct payments. There are now more single sex acute care units with individual rooms, flexible day centre provision and multi-disciplinary team working."

4.6.7 It also says: "We...commend the innovative and progressive mental health services that are being delivered in some areas as well as the Government Strategy *No Health without Mental Health* which provides a good foundation for building the attitudes and values that we need. We are hopeful that outcomes can be improved for everyone affected by severe mental illness. But it will require a radical overhaul of the system including

an integrated approach with health and social services working together, a greater emphasis on patient preferences and a widespread application of flexible and innovative solutions. We do know what works – let's apply it."

4.6.8 The charity Mind produced *Mental health crisis care: commissioning excellence,* a briefing for Clinical Commissioning Groups in November 2012, highlighting the uneven provision across the country. Following a Freedom of Information request to mental health trusts around the country, Mind established that referrals to crisis care ranged from 42-430 per 10,000 population. KMPT receives 147, above the average of 107. It visits service users in crisis an average of 14 times. The range across the country is 1-23 visits and the average is 8.

4.6.9 The briefing points out that having a range of alternatives to hospital admission facilitates service user choice, meets a diversity of needs and helps CRHTs work more effectively. Examples include:

- Crisis houses, sanctuaries and recovery houses
- Retreats/respite care
- Peer/survivor-led services
- Host families
- Crisis-focused therapeutic programmes

4.7 Conclusions

4.7.1 Based on all the above consultation and engagement, the following conclusions are drawn:

a. The work on which the consultation was based has been examined independently and found to be clinically sound and of high quality.

b. The independent research team analysing the consultation responses is clear that the consultation has been properly conducted.

c. Stakeholders strongly supported the consultation's aims

d. Two-thirds of respondents supported the proposals in Option A, giving a clear mandate to proceed

e. A number of key issues raised in the consultation need to be addressed to facilitate establishing and embedding the proposed changes

f. None of these issues is of sufficient substance reasonably to prevent the proposed changes going ahead

g. The proposed centres of excellence are the kind of acute units that the Schizophrenia Commission wants to see established.

5 ADDRESSING THE POINTS RAISED IN CONSULTATION

5.1 Travel and transport

5.1.1 KMPT staff are expanding the volunteer driver scheme and preparing clear travel information for CRHTs and Centres of Excellence to hand out, as well as making it available on the Trust website.

5.1.2 Carers from Swale and Medway are involved with staff from KMPT in a group preparing the transport plan to support visitors to patients from these two areas to their new acute units . This group is considering all the issues outlined in the consultation document including:

- Estimating the funding needed to cover higher fare repayments for claimants
- Exploring use of hospital transport economies of scale with acute providers
- Checking that bus times work well with end of ward visiting times: at Little Brook Hospital, Dartford, visiting times are currently 3pm - 5pm and 6pm - 8pm, Monday to Friday and flexible at weekends and Bank Holidays; at Priority House, Maidstone, visiting times are currently 4pm – 8pm except during the 6-6.30pm protected meal time, and at weekends and Bank Holidays 2pm-8pm except during the 6-6.30 protected meal time. There is always flexibility in difficult circumstances, and that judgment is made by the ward manager/nurse in charge. No-one wants people to have a long wait for a bus if they stay to the end of the ward day
- Voluntary transport/'buddying' for service users and carers from localities affected
- Secure transport for the safe transfer of patients between sites and PICU
- Liaising with the Police to ensure best use of Section 136 admission
- Use of web technology (e.g. Skype) to support community team-ward/patient liaison
- Service user forum based web technology to support family/carer communications
- Further integration of CRHTs and acute ward resources for service users' benefit
- A week-long audit of transport used by visitors, which was done in the summer, showing that most used their own transport whichever unit they were visiting.

5.2 Service user priorities expressed in the consultation

5.2.1 Access:

a. Sheppey service users were clear in the consultation that they want access to some crisis care on the island. The CCG and KMPT will

discuss the feasibility of this and whether it could be aligned with the walk-in centre at Sheppey Hospital.

b. Medway service users were clear in the consultation that they want to see another alternative to admission available in Medway. KMPT is looking into whether the local CRHT base in Medway could be with the Liaison Psychiatry Service at Medway Maritime Hospital, so service users have a clear place to go when necessary.

c. Medway councillors also expressed disquiet at the relocation of services. In view of the campaign by Rethink and Mind, possibly Medway Council could discuss with the voluntary sector the feasibility of establishing and running a Recovery House in Medway to provide an alternative to hospital admission and to ease people's return home from a hospital stay.

5.2.2 Greater resources:

a. Three STR workers have already been appointed in Medway to work with the CRHT to ensure more continuity of care for service users, more time, and practical support for carers and service users.

b. 11 STR workers were recruited in East Kent in December

c. 11 STR workers will be recruited in West Kent once the ward changes have taken place and the funding is released.

5.2.3 The quality of individual care and the quality of overall service provision is being improved by

a. **The addition of STR workers** who provide respite for carers and additional support to service users

b. **A more consistent approach to care across the area** - KMPT is working to ensure the CRHTs across Kent and Medway work consistently with clients wherever they live in the area. It is also monitoring the impacts from initiatives to develop alternatives to hospital admission and will report publicly on the emerging picture in March 2013 after its acute care clinicians have examined the situation

c. The role of the **Discharge Co-ordinator** provides service users with practical support removing barriers to discharge such as problems with housing or utilities. It has been piloted in East Kent and reviewed in November 2012, when it was found to have achieved a significant reduction in out of area placements, which were down from 35 in August to just four in October. This resulted in savings as well as improved support for service users so KMPT proposes to appoint Discharge Co-ordinators in Dartford and Maidstone too. At the same time, KMPT is overhauling its protocols and practice

throughout the acute care pathway and this work is expected to be completed by March 2013

d. **Therapy at evenings and weekends too** - In preparing for Payment by Results, KMPT's acute service has developed packages of therapeutic interventions for service users in hospital which are based on NICE standards and best practice and will make those available in the centres of excellence in the evenings and at weekends as well as during the day. This means the overall service is better and individuals will have more support in reaching their care plan goals.

e. **Peer support workers** - Research evidence from Recovery Scotland indicates that peer support workers – people who are themselves in recovery from mental illness – are a valuable addition to the multi-disciplinary team supporting service users. This approach is being introduced by KMPT in December 2012 at Little Brook Hospital, Dartford, and at St Martin's Hospital, Canterbury, and at Priority House, Maidstone, in May 2013. It will be evaluated in June and, if the achievements are sufficient, a plan to expand it to CRHT work will be prepared in July.

f. **Working better with protected groups** – a conference involving service users, carers and agencies representing older people, younger people, those with disabilities, gay, lesbian, bisexual and transgender groups, parents, those of different races, men and women and people of different faiths considered the consultation document and commented on how the proposals could affect them. The Trust is working hard to improve its connections with the communities it serves, and will build upon the local knowledge of the community and voluntary sector to support people.

6 NEXT STEPS

6.1 Implementation Plan

6.1.1 The Implementation Plan has been developed, following the closure of the consultation and submission of the analysis of responses by the University of Greenwich. The planning is being undertaken with input from clinicians, KMPT Acute Service Line leadership and managers and Kent and Medway NHS commissioners. The plan appears at Appendix 3. Key stakeholders will continue to be briefed regularly as the next steps are taken.

6.1.2 The planning includes draft timelines that will apply if the cluster board approves the recommendations at its meeting on 20 February 2013 but no action will be taken until that approval is given.

6.1.3 The plan includes:

- **Staff consultation** about the re-aligned jobs resulting from the changes between 1 and 30 March 2013, with interviews in April/May and staff in their new roles by July

- **Psychiatric Intensive Care**
  - Two Band 6 psychiatric nurses to provide Psychiatric Intensive Care Outreach support to the East Kent centre of excellence from May 2013. They will have a base at St Martin's, Canterbury, but be managed from the PICU at Dartford. They will support staff in the East Kent centre of excellence with strategies to work with patients who are particularly unwell, so that fewer of those patients need to be transferred to PICU than in the past.

  - All Canterbury-based Psychiatric Intensive Care patients to move to the Willow Suite in Dartford by 30 April 2013

- **East Kent centre of excellence** A £400,000 redesign and refurbishment of Dudley Venables House on the St Martin's, Canterbury, site to convert the building from a Psychiatric Intensive Care Unit to a modern, light and airy therapeutic acute unit space is expected to be completed by 1 August 2013. The work will involve establishing a new dedicated de-escalation suite where staff can take patients who need to calm down away from the busy-ness of the whole unit. A total of 14 bedrooms will be created with modern toilet and bathroom facilities for patients to share in segregated male and female areas.

- **West Kent centre of excellence**
  - Sittingbourne and Sheppey patients to routinely use the acute unit at Priority House, Maidstone, from August 2013

  - Around £40,000 to be spent on improving the Section 136 suite at Priority House, used for people with apparent mental health problems who are brought in by the police for assessment The work should be completed by August 2013

  - Plans to upgrade the accommodation in Priority House are being drafted, with a capital bid due to be submitted in January 2013 and the work completed by August.

  - The Crisis Lounge being piloted in Maidstone will be evaluated in July.

- **North Kent centre of excellence**
  - Medway patients to begin routinely using the acute unit at Dartford from August 2013, once Birch Ward in Dartford has been refurbished and prepared for its new role.

  - Medway CRHT is being strengthened by 3 STR workers, currently being recruited to offer crisis day care in the Medway towns. If Option A goes ahead, Medway will recruit a further 4 STR workers.

7 RECOMMENDATIONS

The CCG/KMPT/Cluster Board is recommended to

a. Approve the implementation of Option A in line with the plan at Appendix 3

b. Approve the actions in response to the points raised by respondents to the consultation

c. Endorse the Implementation Plan

d. Encourage the establishment of a Recovery House in Medway

A Block: efforts to relocate to date

Previous attempts to resolve the issues of A Block have all been foiled by a lack of capital funding and it is not acceptable for the people of Medway and Swale (excluding Faversham) to be subjected to an inpatient environment that is so inequitable with that provided for residents of the rest of Kent. Those previous attempts were:-

1. Between 2004 and 2006, West Kent Health and Social Care NHS Trust invested £160k in a business case for the wholesale refurbishment and redesign of A Block. With initial estimated costs of £5.7m, the project was agreed by that Trust's Board and the Kent and Medway Strategic Health Authority (SHA) in 2005.

   When the Full Business Case was considered by the newly-formed KMPT Board in December 2006, estimated costs had risen to £7.1m and were expected to increase as more design work was needed. A comparative new-build solution was costed at £13m.

   The Board asked its Major Projects Committee to address concerns about cost, affordability, model of care, and the source of capital. In the end, these concerns and the unavailability of strategic capital funding rendered the project unviable.

2. In 2008/09, KMPT tried again to develop a business case and looked at a range of options, including conversion of A Block, new-build elsewhere on the Medway Maritime Hospital site, use of existing KMPT facilities in Dartford and Maidstone and conversion of Southlands Hospital.

   Again, the Trust was concerned at the potential capital cost and the unsuitability of facilities which had not been purpose built and designed. The Trust and PCT agreed a public consultation would be needed. Preparations began but the main feedback from the service users, carers and clinicians in Medway, Sittingbourne and Sheppey was that improvements were needed to community services. The PCT and KMPT decided to focus on making these improvements, rather than launching public consultation.

3. In May 2011, KMPT again revisited the draft business case, this time considering seven local Medway options with the PCT. Four of the buildings were not big enough and two were in unsuitable locations, with site constraints and neighbouring issues.

That left, once again, only A Block. The Trust spent £10k on a feasibility study for converting A Block into three fit-for-purpose wards. The cost was estimated at £7.2m and, again, the scale of capital investment was the major obstacle along with the constraints implicit in the layout of A Block in the lack of easy secure access to outdoor space.

4. In July 2011, following negotiations between the PCT, Medway NHS Foundation Trust, Medway Community Estates and KMPT, Medway Community Estates proposed two possible options on the Medway Maritime Hospital site. One of these, between the laundry and perimeter fence was discounted because of boundary and planning issues. The other, a part new-build/part extension next to the Post Graduate centre was considered in detail. A preliminary design was costed at around £6m.

   This proposal was rejected due to the unavailability of capital and because the design was not suitable for acutely unwell mental health service users. There were also concerns about “landlocking” a mental health unit into such a small area in the heart of the general hospital, which is not particularly conducive to mental health recovery.

Background

The following report reflects work that was undertaken in 2011 to find an alternative solution to Medway A Block.

The review of options and consideration of the estate options was largely based on dialogue between KMPT, the Medway Foundation Trust and Medway LIFTco, with some input from the PCT.

KMPT has no suitable accommodation in the area so the main options were:

- Sites based on the Medway Maritime site - existing A Block, the Disablement Services Centre site and a further alternative option at the rear of the hospital site.
- the PCT's identification of potential sites at Darland House, St Barts and Canterbury Street, and
- Medway LIFTco's identification of sites at Darnley Road and Woodlands Road.

A desk top review of the key features of sites allowed KMPT to rule out the Woodlands site on the grounds of its proximity to schools and the extreme unlikelihood of planning consent, in conjunction with the likely order of cost.

All the other options were reviewed by the Trust's Head of Estates and, in the case of A Block, with additional technical input from Pick Everard. The exercise therefore represents the most thorough estates review to date of the options available for addressing the short-comings of the A Block site.

Context

KMPT considered seven possible sites and worked on two possible ground-floor bed configurations:

a) 2 x 18 bed units
b) 3 x 18 bed units

This approach reflects the potential for Older People's Mental Health units and Young Adult units to be co-located. The sites under consideration were:

1. A.Block at Medway Maritime Hospital, Gillingham
2. Darland House Nursing Home, Darland Avenue, Gillingham.
3. St Barts Hospital, New Road, Chatham.
4. Canterbury Street site, Gillingham
5. Darnley Road site, Strood

6. Disablement Services Centre at Medway Maritime Hospital, Gillingham
7. Transport/SSD site at Medway Maritime Hospital, Gillingham

Initial site feasibility

This section considers the main advantages and disadvantages of each option in terms of the built environment and costs, and concludes with an appraisal as to whether the option is worthy of further consideration, or has been discounted at this stage.

Where relevant, the option to provide a new build for each site was considered against the design footprint for the new St Martin's Younger Adults Inpatient unit at Canterbury. This is a single storey building footprint of approximately 2500 square metres set in a site of approximately 7750 square metres (1.91 acres or 0.78 Hectares). This enabled a comparable consideration to be made in each case for whether a new build option was suitable and practical.

Sites investigated

1. A Block, Medway Maritime Hospital

Description

A Block is embedded on the eastern end of the Medway Maritime Hospital site. It is a 2-storey building and comprises a steel frame and brick built construction under a sloping roof. Floors are solid screed/concrete beam and ceilings generally comprise traditional suspended grid ceilings with a service void above. Windows are metal frame double glazed. Access to the building is via the pathways and access roads within the hospital site. The building can be approached from either the main entrance at the east end of the site or via the main hospital street access through the central hospital main entrance. Car parking for staff, users and visitors is limited to the available 'pay and display' facilities on the site.

The occupancy of each floor is as follows:

Ground floor: Administration, Inpatient ward (Emerald), Acute Consultant Psychiatrists, Service Manager, Health and Safety Manager, Pharmacist and Technician, Tribunal room, hot desk/interview room, Housekeeping team, KMPT Chaplaincy, Psychology Consultant, Day Therapy service (Christina Rossetti).

First Floor: Two inpatient wards (Ruby and Sapphire), 136 suite.

NOTE 1: The current inpatient provision is predominantly through 4 and 6 bed dormitories with some single bed provision.

NOTE 2: A proportion of the ground floor area adjoining the mental health area entrance is currently used by the PCT (Chaucer Children's Therapy). Any future

review of mental health services in A Block would be dependent on this area being made available to KMPT.

The area utilised by KMPT is leased from Medway Foundation Trust (MFT) on a 60 year lease which commenced in 1995. Services provided by MFT under the current SLA include Estates Maintenance, Hotel Services and Portering/security.

Main advantages

The main advantages of remaining on the A Block site and reconfiguring the existing available building layout are:

- Provision of an environment more fit for purpose
- Location on an acute hospital site provides immediate access to accident and emergency facilities
- Provision of ground floor ward access to inner courtyards
- Better control of security and access to the units
- Ensure enhanced privacy and dignity for the service users meets the requirement for single room and ensuite accommodation
- Potential for more individualised care through better staff to patient ratios
- Provision of 136 suite on the ground floor – improved access and arrangements for Police
- Rationalisation of inpatient support services such as Crisis Resolution Home Treatment and 136 suite adjacent to the mental health wards

Main disadvantages.

The main disadvantages of remaining on the A Block site and reconfiguring the existing available building layout are:

- High level of investment needed to convert/ reconfigure and upgrade the existing facility to ensure it meets current criteria and is fit for purpose
- Inherent lack of parking availability adjacent to the building
- On-going issues with 136 suite arrivals
- Inherent constructional issues with providing ensuite arrangements (cost impact)
- Juxtaposition of MFT neurology and older people's services administration onto inner courtyards at ground floor level.
- Requirement for Chaucer Children's Day Therapy to relocate
- Requirement to relocate League of Friends shop and store
- On-going issue with hospital street dividing the mental health ward areas

Costs

An initial space assessment was carried out in order to define the existing available area for KMPT use. A further feasibility study was undertaken for the reconfiguration of the available space to provide two or three 18 bed ward areas and supporting facilities.

The initial feasibility study indicated that it is possible to fit two 15 to 16 bed mental health wards into the available space on the ground floor.

The outline cost for this reconfiguration was estimated in 2011 to be £5.5M including vat risk contingency of 10%, group 1 & 2 equipment, professional and developmental fees @15%, construction and engineering costs.

Conclusion

In 2011 it was felt that this option was worthy of further consideration and development of a more detailed feasibility study. This further feasibility study, which cost £10,000, was undertaken by KMPT. The study focussed on examining how A Block could be converted into three 'fit for purpose' wards. The cost was estimated at £7.2m and, the scale of capital investment was the major obstacle along with the constraints implicit in the layout of A Block in the lack of easy secure access to outdoor space.

2. Darland House Nursing Home, Darland Avenue, Gillingham

Description

The building is located on Darland Avenue, Gillingham in a predominantly residential area. The boundaries to the north, east and south lead onto sports fields and an associated access road. The building is located in a plot of approximately 6,000 square metres (1.48 acres or 0.6 Hectares) and the existing building comprises approximately 1,100 square metres as a base building footprint. (Overall gross internal areas is 2,235 square metres over two floors)

The building itself is - a two storey brick built construction with solid floors under a tiled pitched roof. The building was constructed in 1995. The current use is for continuing care services for older people provided by Medway Community Care. The building is configured to deliver this service via four ten bed units two units on each floor. Each bedroom has an ensuite toilet area and bathing facilities are delivered via assisted bathroom areas centrally located in each ten bed wing. An assessment of the space in each ensuite area indicated that there was potential for the addition of a shower tray. Each ten bed wing comprises ten single bedrooms, activity/day space and dining/sitting room areas.

The building has a central kitchen, laundry facilities, reception area and is covered by a standby generator. The floors are served by a single lift.

Car parking is limited to 21 on site spaces. There was some scope to provide approximately ten additional spaces with the surrender of some green space to the front of the building. The site is approximately 1.7 miles from the Medway Maritime Hospital.

Main advantages

- Located on good public transport routes and close to A2.
- Relatively modern build
- Self-contained site and services.

Main disadvantages

In terms of site redevelopment:

- Site size was an issue as there is insufficient site space for a new build of 2,500 square metres at ground level.
- Site shape was an issue as the site tapers towards the southern end and restricts development into the far end of the site

In terms of extending the existing building:

- Lack of space on the existing ground floor of the building to provide two or three 18 bed units.
- Existing room layout and building configuration/ orientation did not lend itself to the provision of distinct 18 bed units.
- Requirement to upgrade en suite areas
- Requirement to retain some in patient areas on the first floor
- Significant works were required to low suspended ceiling areas and general upgrade to mental health standard environment.

In general terms:

- Local residential opposition towards any planning application to redevelop the site for either an extension or new build for mental health was likely.

Costs

An extension of the building was not seen as an option for reasons highlighted above and in the following conclusion.

If it were possible to fit a suitably sized building on the site the cost of rebuilding the service on the site was likely to be similar to the cost for the Younger Adults Mental Health development at St Martins Hospital, Canterbury which was approximately £10 million.

Conclusion

Initial investigations into the building layout and the potential for additional bedded space indicated that it would be difficult to create two dedicated 18 bed units on the ground floor due to site boundary constraints, the building configuration and the lack of space to provide the necessary consulting and adequate day spaces for a mental health unit. The building fits tightly into the site and any extension to the layout would

result in unacceptable restrictions on external areas and extensions very close to boundaries which might not be acceptable to the planning authorities.

Other issues with the existing building related to the need to carry out extensive ceiling upgrade and anti - ligature works if the existing building was retained. Also a wholesale review of the site and building security arrangements would need to be undertaken. The ceilings were relatively low and it would be likely that all suspended ceilings would require replacing with a solid type. In addition a wholesale replacement of lighting was necessary as existing fittings did not comply with mental health environment requirements.

The ultimate solution of a new build was not deemed suitable as the site size was insufficient.

As a result of the above, the Darland Avenue option was deemed not worthy of further consideration.

3. St Bartholomew's Hospital, New Road, Chatham

Description

St Barts is a multiple building site comprising single to 4/5 storey brick built, slate and flat roof buildings of varying ages from 1880 to 1980. The site is steeply inclined on the Medway Basin escarpment to the River Medway and as such is terraced in nature. Approximately 25% of the site is derelict. The site area is approximated at 10,000 square metres (2.47 acres or 1.0 hectare) and the building base footprint is approximated 3,000 square metres. Total site GIA for all floors is approximately 8500 square metres.

The site shape and topography is complex with terraced car park areas and main vehicular access is from the rear of the site from the main high street. Part of the site is Grade 2 listed (Path lab/mortuary). The site boundaries are largely residential. Part of the site borders on a cemetery, a public area onto the high street which is owned by the PCT but subject to local authority conservation constraints, and British Rail property. The main line train service passes close to the west boundary of the site (tunnel). The site is approximately 2.1 miles from the Medway Maritime Hospital.

Main advantages

- Centrally located in Medway
- Close to all public transport routes

Main disadvantages

In terms of use of the existing buildings:

- Existing buildings are unsuitable for mental health reconfiguration
- Backlog maintenance costs approximated at in excess of £3million

In terms of the redevelopment of the site:

- Site topography, shape and boundaries preclude any consideration for redevelopment for a mental health unit as preference is for a level site with good access.
- Part listed building status precludes demolition considerations to clear site
- Prohibitive cost of demolition.
- Additional cost to provide split level buildings
- Located in a residential area – opposition to any redevelopment is likely

Costs

Any consideration for a redevelopment of the site would attract a cost well in excess of the St Martin's model costs of £10million. The cost of the demolition of the existing buildings (if this is possible and permitted) would be in the region of over £2 million.

Conclusion

The uplift to the construction costs would be significant due to access issues, adjacency to residential areas, boundary reinstatements to some areas and retention of the listed part of the site.

These issues would preclude this option from any further consideration.

4. Canterbury Street site, Gillingham

Description

This was open site of approximately 1,600 square metres (0.4 acres or 0.16 hectares) located near to the Jezreels junction of the A231 and the A2 in Gillingham. The site was split level (approximately 1.0m) and borders on to residential areas and adjacent derelict industrial buildings. Access to the site was via a shared road which also served nearby commercial units. The site was approximately 0.7 miles from the Medway Maritime Hospital.

The site is currently used by Medway PCT for a temporary GP and day service.

Main advantages

- Excellent public transport access.
- Located centrally in Medway.
- Relatively close to the Medway Hospital A&E facility

Main disadvantages

- Site is not large enough for the provision of a single storey Mental Health unit similar to the St Martins Model
- Local opposition is likely due to nearby residential area.

Costs

The site was valued at £1.2million in 2007.

Conclusion

This site was not deemed a suitable option for consideration due its size.

5. Darnley Road Site, Rochester Strood

Description

This site comprises a redundant day centre and hostel. It is currently owned by Medway Council and has been declared surplus to their requirements. It has a site area of 10,172 square metres (approximately 2.5 acres or 1.0 hectare). The Council had already tried to dispose of this site, to no avail, and was working on a planning brief to make the site more attractive to potential purchasers.

The buildings on the site were thought to be circa 1970 - 80's construction, and are a mix of single storey and three storey, brick built under a mix of flat and tiled, pitched roofs. An opinion was expressed by a council representative that some of the existing buildings may have the potential for retention and redevelopment. The buildings footprint on the site was approximately 1,800 square metres.

The site itself was sloping and therefore terraced and split level. The site was elongated in nature and lent itself to the provision of two distinct areas of building with linkages between. It was embedded in a residential area and the majority of the boundaries backed onto rear gardens, and also onto a Clinic. The site was approximately 4.8 miles from the Medway Maritime Hospital and the quickest route was through the Medway town centre areas.

Main advantages

- Located in the Medway area.
- Good public transport routes (buses).
- Low cost of purchase (estimated at £0.5 million).

Main disadvantages

- Local opposition is likely due to nearby residential area.
- Sloping nature of site – little opportunity for buildings on same level and need for consideration of two storey buildings.
- Proximity to rear gardens on boundaries will inhibit the opportunities for external patient garden areas outside of the building.

Costs

Although an opinion was expressed that some of the existing buildings could be reused it was felt that this would lead to unnecessary compromises against the requirements of Health Building Note (HBN) 35.

The services required need to be modern and the reuse of the Day Opportunities Centre and/or the Greatfield Lodge hostel buildings were not desirable due to difficulties in complying with HBN 35 in terms of proximity to boundaries, building layout and content, relationships between buildings and staff coverage.

The only realistic option was for wholesale redevelopment of the site. Using the St Martin's redevelopment cost template, the costs would be in the region of £10 million plus an additional premium to deal with the fact that the site topography precludes the provision of a single building on one level. Added to this was the requirement for additional costs to level the site. Further development and feasibility work would be required in order to assess the overall impact of the site shape, size and location on the overall costs of a scheme at Darnley Road.

Conclusion

This option was not seen as viable due to the above costs, the locality issues regarding the proximity to back gardens (potential planning risk due to objections), and also the distance from the Medway Hospital A&E..

6. Disablement Services Centre, Medway Maritime Hospital.

Description

This site comprises a two storey building located in approximately 3,400 square metres (0.847 acres or 0.343 hectares) of land which is embedded in the south east corner of the Medway Maritime Hospital. It is currently owned by the Medway Foundation Trust and leased to KMPT on a 60 year lease which commenced in 1995. The building mainly houses services for wheelchair assessment and for the manufacture and provision of prosthetic limbs.

The site is located adjacent to the boundary of the hospital site outside of which is a residential area. The site has a dedicated car park area of approximately 20 spaces which is reserved for service users and is relatively level. The building was constructed circa 1969 and the footprint is approximately 1,400 square metres. The overall GIA is 1,789 square metres.

The building is not suitable for any redevelopment and as such the only option would be in terms of a demolition and redevelopment of the site.

The site size is in itself the main issue with this option. The site is not large enough to support the redevelopment for a new mental health unit of the size and layout of the St Martin's. The option to push administration and other non-clinical functions on to first floor accommodation was limited, and would have implications for the effective operation of the building and, above all, will have planning implications.

Main advantages

- Location on an acute hospital site provides immediate access to accident and emergency facilities
- Good public transport routes (buses).
- Good access from local road network

Main disadvantages

- The site is not adequate for the provision of a new unit.
- Opposition to a planning application would be an issue due to nearby residential area.
- KMPT would need to purchase this site. (Likely cost is approximately £480k*)
- Lack of space would displace the car parking provision onto the MFT site causing additional stress on the car parking infrastructure on the site.
- Lack of space would inhibit the provision of adequate external patient areas.

Conclusion

This option was not deemed to be viable due to the size of the site against the St Martin's template and the cost of purchasing the site from MFT plus the cost of building demolition to clear the site.

(* Land purchase cost based on District Valuer's Report 2010 - Residential Building Land Market (year to January 2010). South East, Medway Towns area - rated at £1,4M/Ha)

7. Transport and Sterile Services Department site, Medway Maritime Hospital

Description

This site comprises a mix of single and two storey buildings located in approximately 4,500 square metres (1.1 acres or 0.45 hectares) of land which is embedded in the North West corner of the Medway Maritime Hospital. The site and buildings are currently owned by The Medway Foundation Trust and house transport and sterile services departments.

The site is located adjacent to the boundary of the hospital site close to a main access point from Marlborough Road. The north boundary is alongside York Road which is a residential area. The overall footprint of the existing buildings is approximately 1250 square metres. The buildings were not suitable for any redevelopment and as such the only option would be in terms of a demolition and redevelopment of the site.

The site size was the main issue with this option. The site was not large enough to support the redevelopment for a new mental health unit of the size and layout of the St Martin's re-provision. The option to push administration and other non-clinical

functions on to first floor accommodation is limited; it will have implications for the effective operation of the building and, above all, will have planning implications.

Main advantages

- Location on an acute hospital site provides immediate access to accident and emergency facilities
- Good public transport routes (buses).
- Good access from local road network

Main disadvantages

- The site is not adequate for the provision of a new unit.
- Opposition to a planning application could be an issue due to nearby residential area.
- KMPT would need to purchase this site. (Likely cost is approximately £630k*)
- Lack of space would displace the car parking provision onto the MFT site causing additional stress on the car parking infrastructure on the site.
- Lack of space would inhibit the provision of adequate external patient areas.

(* Land purchase cost based on District Valuer's Report 2010 - Residential Building Land Market (year to January 2010). South East, Medway Towns area - rated at £1,4M/Ha)

Conclusion

This option is not deemed to be viable due to the size of the site against the ST Martins template and the cost of purchasing the site from MFT.

8. Summary of initial findings in 2011

Four of the seven estate sites were ruled out on insufficient space/restricted orientation to accommodate a minimum of 2 ground-floor wards of 18 beds. These were Darland House, Canterbury Street, the Disablement Services Centre, and the Transport and Sterile Services Department site.

It was felt that Darnley Road and St Barts had potential to meet the capacity requirement but would be very poor value for money for the reasons described above. There would also have been significant costs associated with fully establishing the capital cost.

The preferred option was to explore the redesign of A Block which, at the time of the sites appraisal report provided the best value for money option, as well as meeting the specification. However, a further feasibility study concluded that the cost to achieve a fit for purpose facility would cost approximately £7.2 million. This capital investment together with the existing physical constraints A Block presents, e.g. lack of secure access to outdoor space, means that redeveloping this facility is not a viable option.

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Appendix 2 – 30.01. 2013

Issues of detail and data raised in the consultation and the review team's response

We welcomed the sometimes lively debate and the frank exchange of views in the *Achieving excellence in mental health crisis care* public consultation between August and October 2012.

A number of challenging questions were asked about the detail of the case for change so we re-visited a number of issues to check our accuracy, which was sound in most cases. In a few instances, mostly raised by one individual who attended all but one of the consultation public meetings, some small amendments have been made to graphs and data that had been published in the detailed pre-consultation Board paper on which the decision to consult was based, which was shared on the consultation web page at http://www.kmpt.nhs.uk/acute-mental-health-review. These do not substantively affect the clinical case.

We believe that, in the interests of transparency, it is important to share this material more widely since many of the questions were raised at public meetings, so we felt people might be interested in the responses made and actions taken. We feel this challenge and response has enhanced the whole process of considering our plans for the future.

The material published here demonstrates that the points have been responded to appropriately and that none of them was large enough (either separately or when added together) to indicate that the consultation should not be held or that the options being consulted upon should be changed.

For the sake of clarity and to aid understanding we are including both the information we originally published and the amended information.

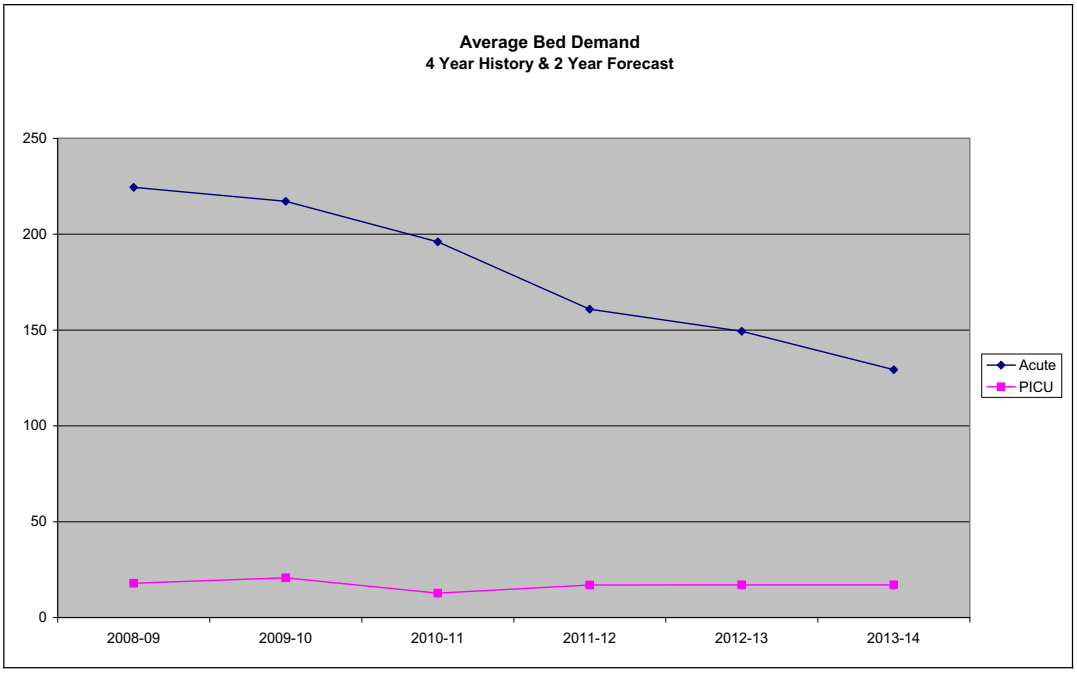
1. Falling demand for beds shown in Figure 2

a. Question: Why are the numbers in Figure 2 graph on page 9 of the July Board report higher than those in Appendix B, when both purport to show the same information?

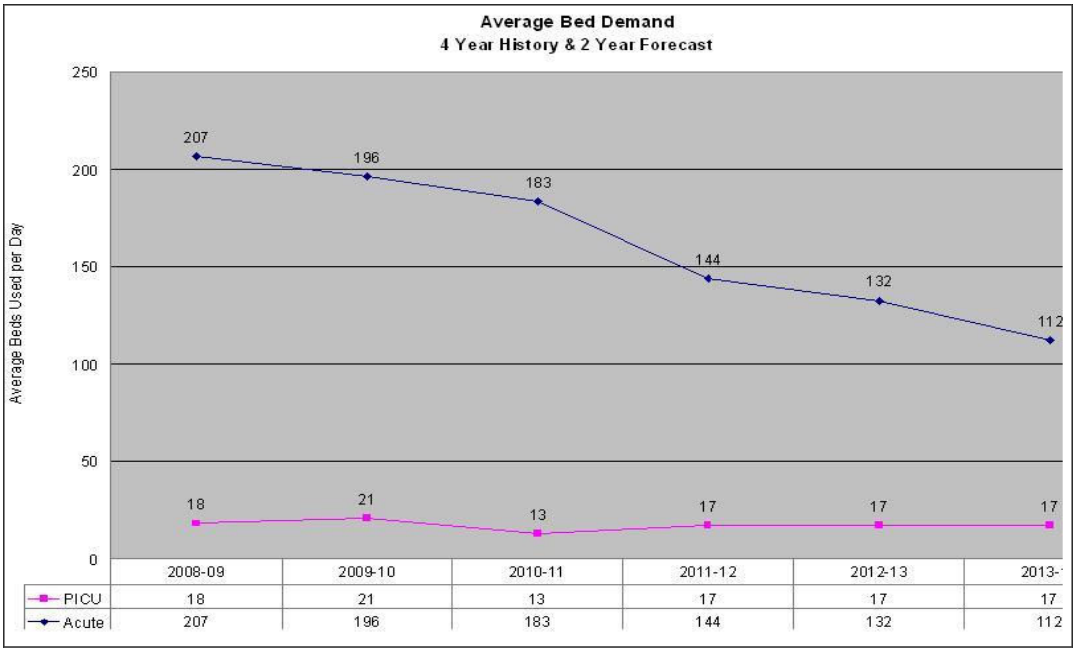
Response: The data in both places accurately reflects the activity recorded in those years. The graph shows one line indicating the PICU bed usage and another indicating the *total* adult acute bed usage (the number of ordinary acute beds *plus* the number of PICU beds). We recognise this is not as clear as it should be and a further line showing the number of ordinary acute beds alone would have been helpful. This would have matched the numbers in Appendix B. We have since drawn this line and the graph displays the same shape and meaning as in the original.

We made two descriptive mistakes: first, the title in the graph should have read *Reducing bed demand over the last four years extrapolated as a forecast to 2013-14*; and secondly, the scale of the graph in the Board report was formatted for a stacked rather than a non-stacked chart in Excel, which resulted in the two figures, for acute beds and for PICU, being added together automatically. Thus, the top line of the graph included not just acute inpatients but also the bed days of people in PICU (between about 17- 20 beds). When we drew this line, it had the same trend as the original.

i) **Graph published in the pre-consultation Board paper where it was entitled *Fig 2:*** *Reducing bed demand over the last four years extrapolated as forecast to 2014-15*



ii) Redrawn Fig 2, with values on the data points and the data table it is taken from. Its correct title is: *Reducing bed demand over the last four years extrapolated as a forecast to 2013-14*



b. Question: Why is the number of adult acute beds indicated in Appendix B as 207 in 2008-9 when there were only 190 beds available?

Response: The 190 is counting the supply – that is, the number of beds we actually had set up in the acute mental health wards. The figure of 207 is counting the demand – that is, the number of adults wanting an acute mental health bed. About 10 per cent of the 207 were patients on home leave, who were not actually using a hospital bed allocated to them. These beds were therefore available for other patients who were in hospital. It also included use of beds by adults who were in hospital for their acute mental health problems but who were on other wards (e.g. older people's wards, and historically, some mixed wards). We have re-checked the underlying ward stays data for 2011-12 and can confirm that bed demand was just as we stated in Appendix B.

2. CRHT treatment data shown in Figure 3

Question: What CRHT activity does the Figure 3 graph on page 10 of the July Board report show? It stops at June 2011 – and doesn't it give a different picture from the data KMPT has from July 2011 to September 2012 when the activity showed a sudden dip? If this is down to computer error, will the hospital bed days data have been similarly affected?

Response:

iii) The title published in the pre-consultation Board paper was *Fig 3: Increasing CRHT episodes of care over the last four years to 2012-12* – It should have read:- *Fig 3: Increasing CRHT episodes of care over the five and a quarter years to 2011-12*

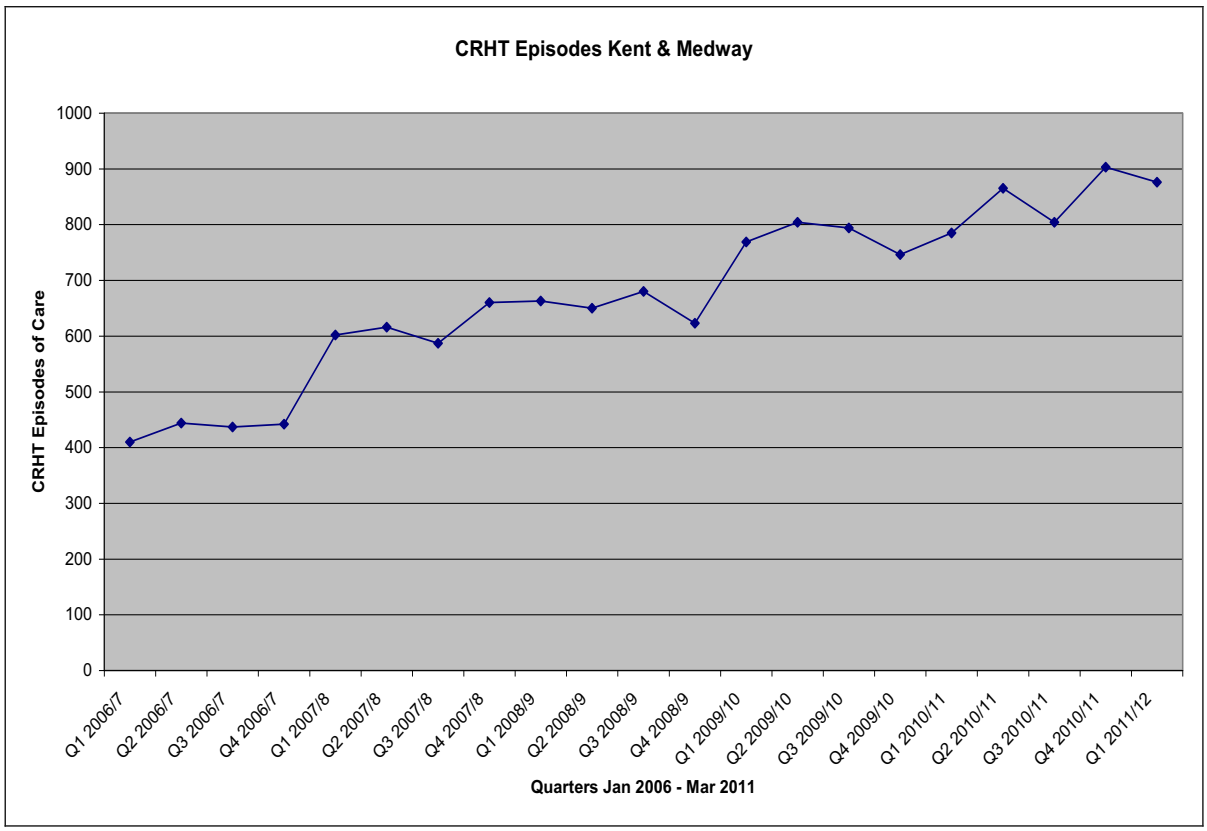


Figure 3 shows episodes of care delivered by KMPT's CRHT teams. An episode of care is the series of visits made by a CRHT team to an individual following a particular referral and covers the care package the CRHT team delivered to that person at this stage of their illness. A service user may have several referrals in a single year, only one, or none at all. Each referral will result in a care package or episode of care that might last for a few days or a few weeks before the service user is transferred back to the care of the Community Mental Health Team. It is these referral-based episodes of care that are counted and reflected in the graph that is Figure 3 in the Board report.

KMPT knows that the CRHTs have been delivering increasing numbers of episodes of care in people's own homes every year while the numbers of hospital admissions and occupied bed days have been falling because that has been a deliberate policy across the country and is supported by organisations like Mind and Rethink who champion service users and their families. This is clearly reflected in the data to June 2011, which was collected on a patient administration system called ePEX. The code for episodes of care on ePEX included single-contact support given by the CRHT team to individual service users as well as full episodes of care lasting days or weeks.

When this review of acute mental health beds began, the Trust was only just changing to a new patient administration system called RiO. Trust staff soon spotted that the CRHT work was being reflected differently by RiO than the previous system, ePEX, but did not then fully understand exactly why. The Acute Service Line knew there had been no dramatic change to CRHT work, so the review based its calculations on the ePEX data, drawing a line at the changeover to RiO, so that the data it was based on was consistent. We did make a tiny mistake in the description of Figure 3 in the Board paper, which mentions four years of data when it quite clearly covers five and a quarter years.

The new patient administration system introduced in April 2011, called RiO, is designed to give the trust more detailed management information. It has two codes where ePEX had only one: episodes of care are counted only when they last for more than a single contact, with single-contact support having a separate code. This takes all the single-contact support away from the episodes of care that ePEX counted and makes it look, when ePEX and RiO data is plotted in a single line, as though CRHT activity has dropped dramatically when it has actually continued to rise as the graph shows, but also beyond June 2011. We stopped at this point because we didn't want to display confusing data and needed to address the coding practice first.

The RiO data still shows a steady increase in CRHT episodes of care, balancing the reduction in occupied bed days in line with national and local policy. This policy is evidence based because it is now known that people experiencing a mental health crisis recover better and faster in their own home, in touch with family and friends and all the key features of their life. Hospital is becoming increasingly a last resort for those who are so unwell that they are a danger to themselves or others.

3. Medway bed stays

Question: Why does Medway's bed stay profile drop so sharply and in an unusually straight line over the four years of data behind the review? Why choose to move all beds out of Medway, the most populous locality in the KMPT area?

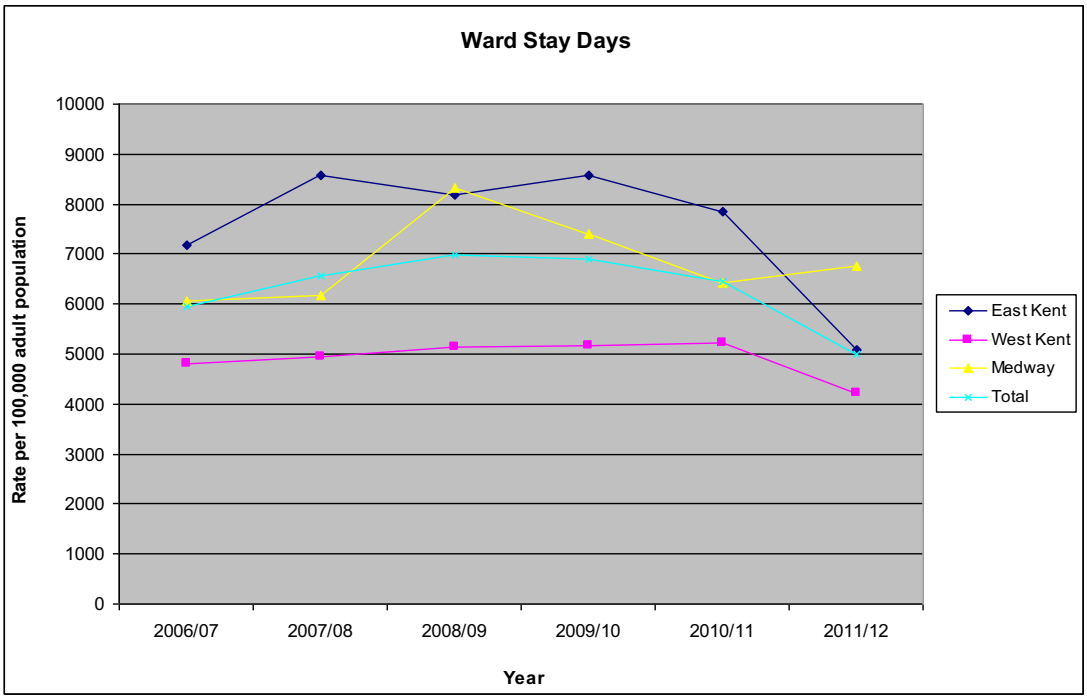
NB: We have placed the relevant graphs at the end of this response as there are so many of them and we think they are easier to understand when seen together and when their relevance has been explained.

Response: The impact of a policy (in this case, admitting fewer people to hospital for less time and providing more crisis resolution home treatment) is bound to show up more dramatically in Medway than in smaller areas. There are a number of local teams working in different areas of Medway and by aggregating their results; any unevenness in the profile will be smoothed out. Using only four (whole year) data points would also have this effect. Other localities should be asked how their particular patterns of reducing bed use could become more consistent.

The reason for closing the beds in Medway Maritime Hospital's A Block is that these wards are not able to provide the calm, therapeutic environment that patients need to help them overcome the mental health crisis that led to their hospital admission. Funding for a purpose-built unit is not available and we already have the right kind of unit available now in Dartford.

The key finding of the review is that we need three centres of excellence for the Kent and Medway population, not more. Inevitably, that means that some people have to travel to reach them. Consolidating the staff in three centres means there will be better Consultant cover available 24/7, unaffected by staff leave or illness in a way that has not been possible until now. Having three centres also means that the service can expand the range of therapeutic staff available and that they can be available at evenings and weekends, which, throughout the consultation, service users have said they want.

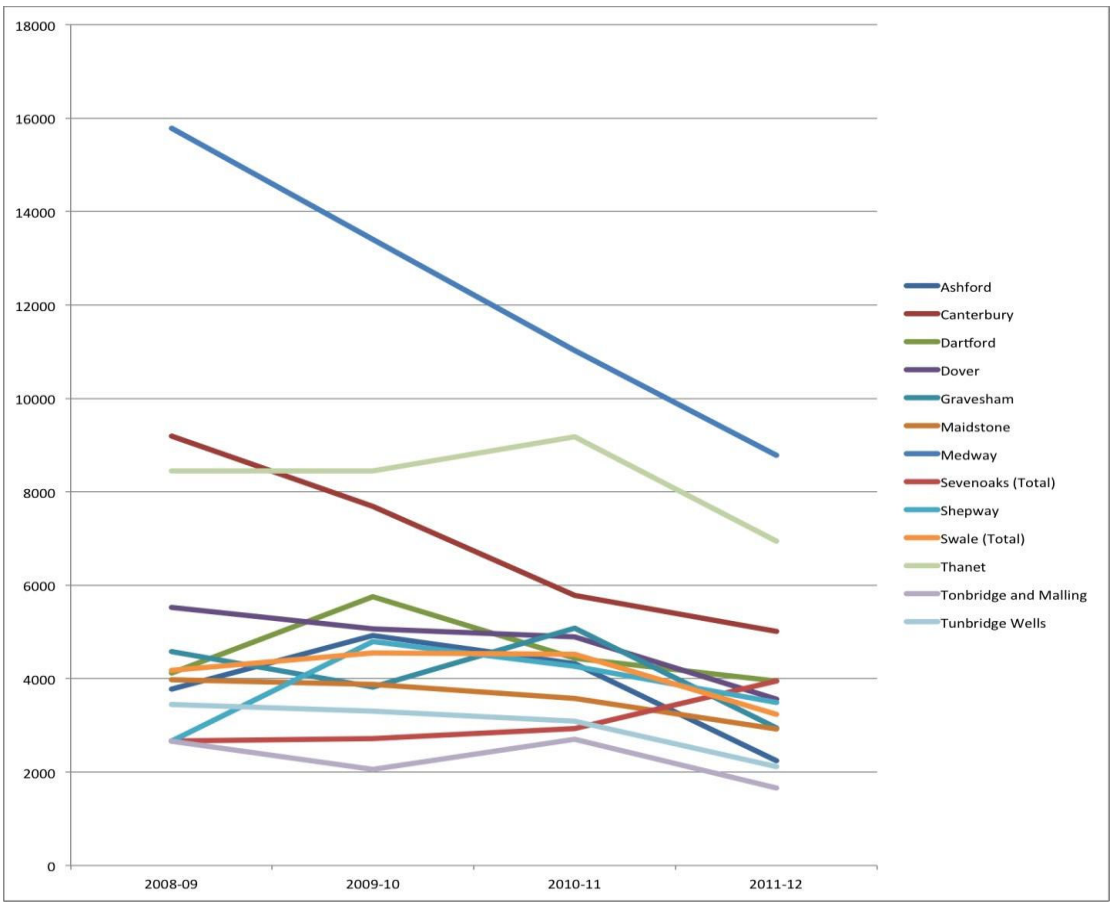
iv) **This graph was published as *Appendix E: Service Area Demand per 100,000 Population* in the pre-consultation Board paper. The purpose was to check that demand relative to population was generally highest in East Kent and higher in Medway, than in West Kent (which was and is still the case) and thus to validate our main method of using relative demand as a proxy for need in allocating hospital beds. Yet there seemed to be a contradiction between the absolute demand data for Medway in Appendix B (see v) below) and this four year graph that is showing a slight rise for Medway in 2011/12, which could not be explained by population alone.**



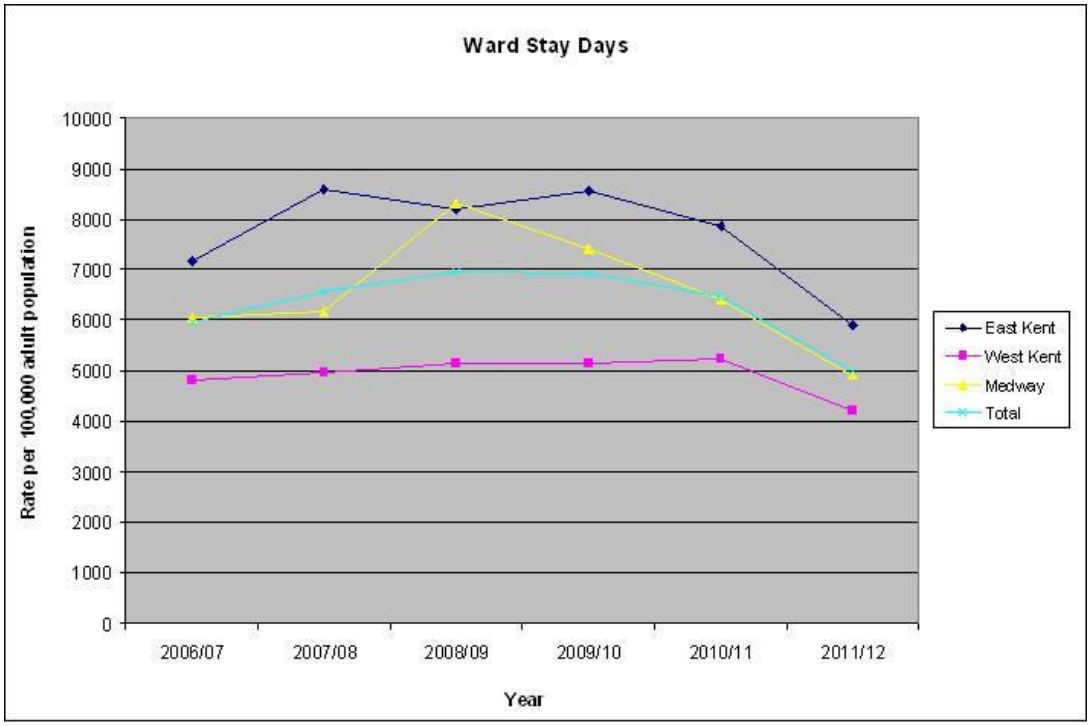
v) Appendix B: Four Year Drop in Inpatient Bed Demand

Acute Ward Stay Days by Financial Year and Local Authority

	4 Year History				Trend Forecast	
Local Authority	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**
Year	1	2	3	4	5	6
Ashford	3771	4918	4325	2241	2518	2000
Canterbury	9195	7692	5778	5012	3304	1857
Dartford	4121	5749	4442	3946	4107	3923
Dover	5518	5066	4897	3559	3249	2644
Gravesham	4578	3822	5074	2945	3193	2828
Maidstone	3974	3871	3570	2922	2720	2374
Medway	15784	13400	11023	8782	6402	4063
Sevenoaks (Total)	2665	2720	2931	3949	4082	4488
Sevenoaks - DGS	1615	1335	1609	2181	2178	2375
Sevenoaks - South West Kent	1050	1385	1322	1768	1904	2113
Shepway	2665	4792	4268	3492	4294	4489
Swale (Total)	4175	4553	4517	3236	3407	3122
Swale - East Kent	1183	1260	1057	746	683	532
Swale - Medway	2992	3293	3460	2490	2724	2590
Thanet	8452	8441	9171	6944	7304	6924
Tonbridge and Malling	2659	2051	2705	1660	1683	1449
Tunbridge Wells	3443	3298	3096	2117	1944	1526
East Kent	**30784**	**32169**	**29496**	**21995**	**21351**	**18447**
West Kent	**21440**	**21511**	**21818**	**17543**	**17732**	**16594**
Medway	**18776**	**16693**	**14483**	**11272**	**9126**	**6653**
Unknown (address or responsibility)	**4398**	**1326**	**1135**	**1712**	**81**	**0**
Grand Total	**75398**	**71699**	**66932**	**52522**	**48289**	**40950**
Average Bed Use (No PICU/O changes)	207	196	183	144	132	112
Average Bed Use (PICU/O proposal implemented)						119



vi) During the consultation this was rechecked and the formula corrected. In the new graph shown here, we can see a decrease for Medway in 2011/12 that complements the absolute demand data illustrated. This mistake had also affected the East Kent figure, which now shows a smaller decrease.



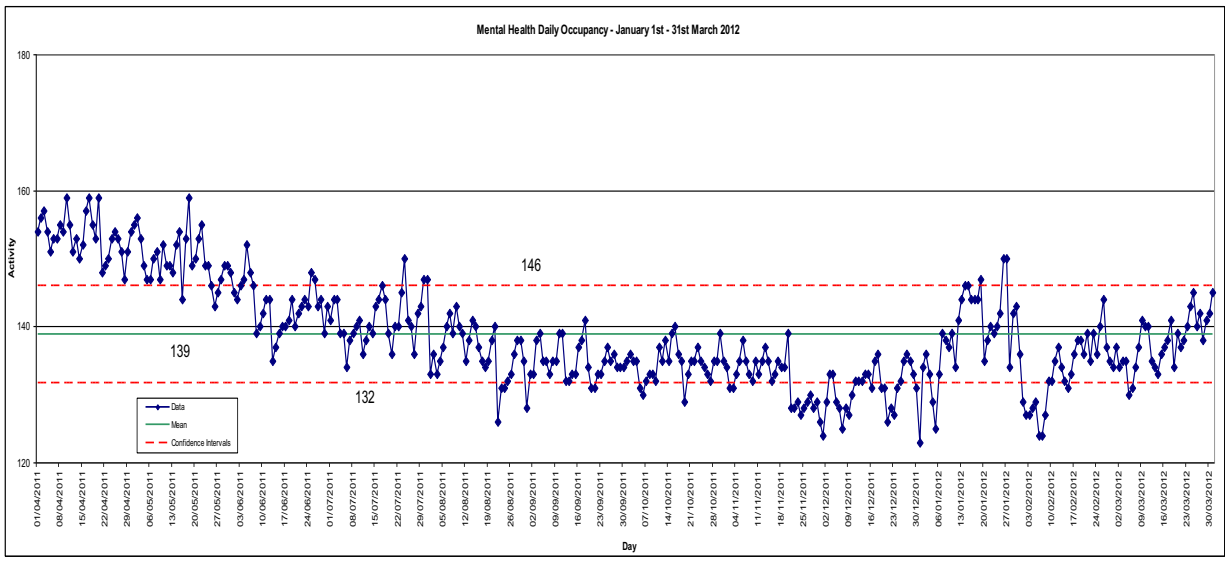
4. Variations in demand

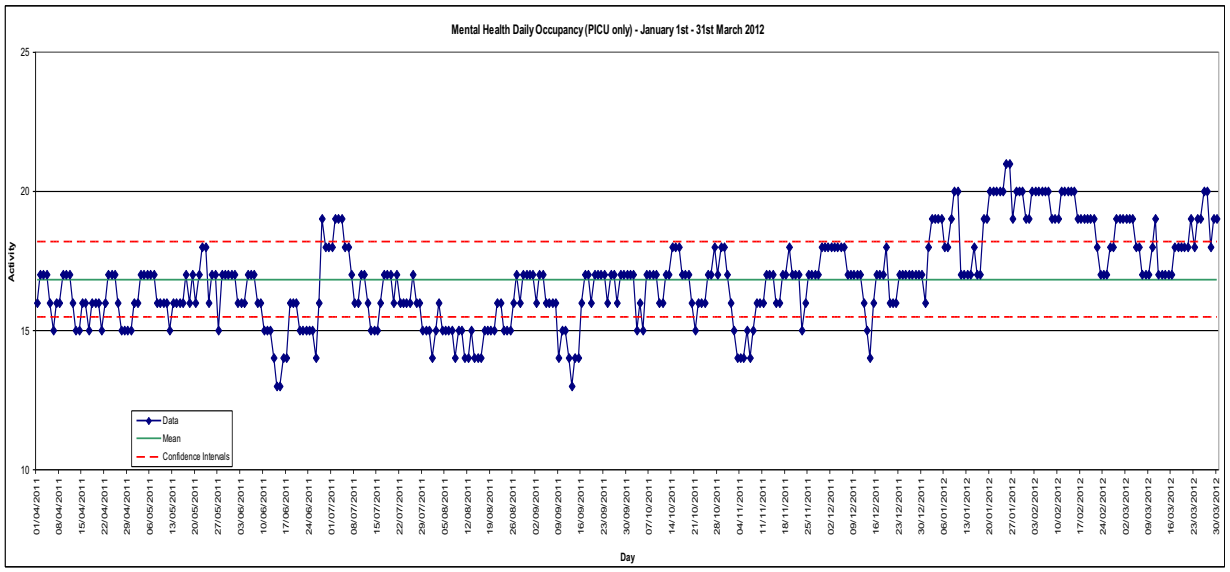
Question: In the first two graphs of Appendix H, why is the 2011/12 acute bed average 139 and not 144 as in Appendix B; why does the line not go over 160 if non-KMPT beds were used; and isn't it weekly rather than daily bed use that is shown? Why is the third seasonal variation bar chart not consistent with acute bed use variation and occupancy data?

Response: The variation analyses were done to estimate confidence intervals in the demand for hospital stays that KMPT is fully responsible for. We did this so that we could add the difference (variation) to the estimated average demand, including the small demand from KMPT patients treated outside the Trust. That total helps us ensure that, in future, beds can be found in KMPT, in the correct hospital ward for a given locality.

Appendix B included data for people "not a KMPT responsibility or unknown" and Appendix H did not. We have revised the graphs to include them.

vii) These two graphs were in the pre-consultation Board paper as *Appendix H: Variations in Demand - Confidence Intervals and Seasonal Effect*



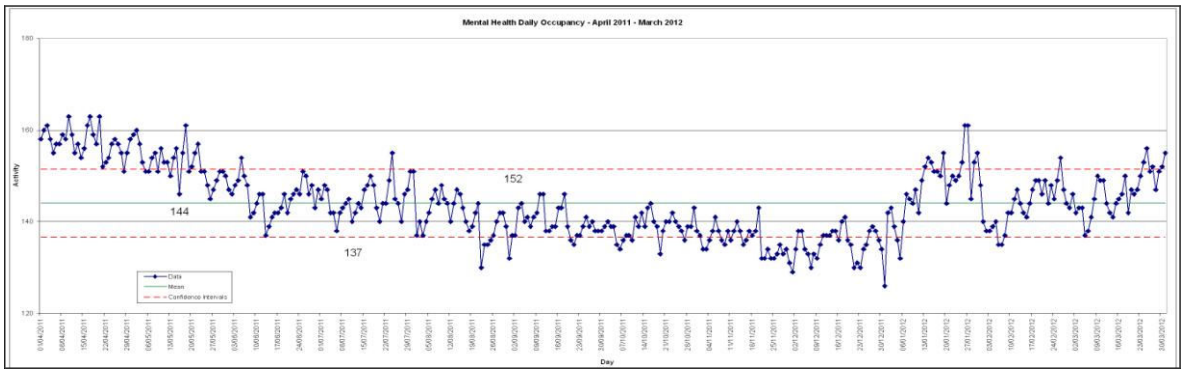


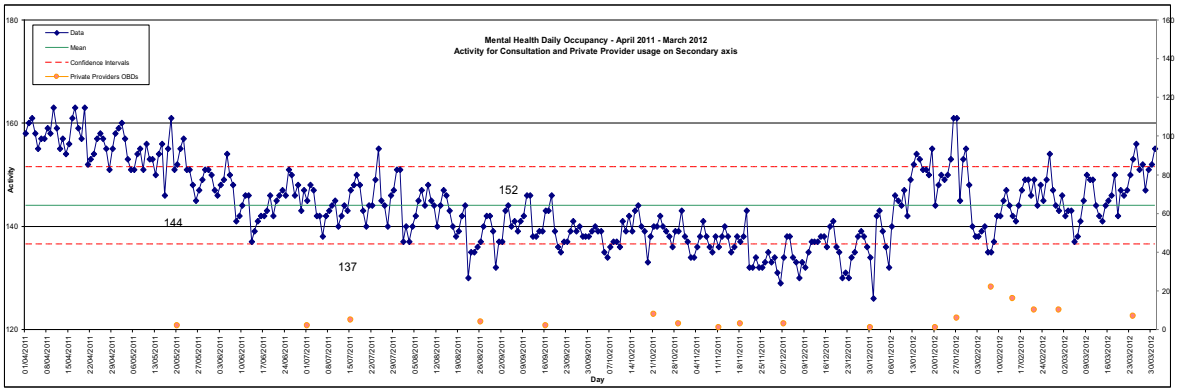
viii) The graphs below show a revision to Appendix H. They include the data about patients who are "not a KMPT responsibility or unknown" – that is, those from outside Kent and Medway. They show a 144 average in 2011-12 and the line going above 160, without counting patients placed outside KMPT. The title on the graph should read April 2011- Mar 2012. The data is correctly described as daily, with 365 data points, although the axis text can only print the weekly dates.

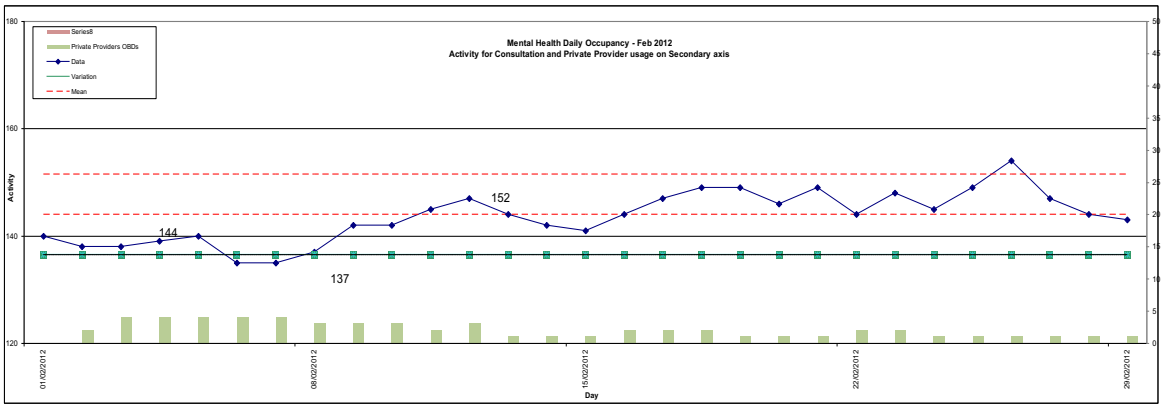
We include an extra version of the chart (the second below) showing where any patient was placed outside KMPT as a dot near the horizontal axis.

The third chart shows the February information (average of 144 beds and higher [58-days] usage of private provider beds) in more detail. This data relates to seven people, mostly at the start of the month. There had been high usage and bed occupancy in KMPT at

the end of January 2011. Patients placed outside KMPT in such circumstances are brought back to KMPT as soon as clinically appropriate







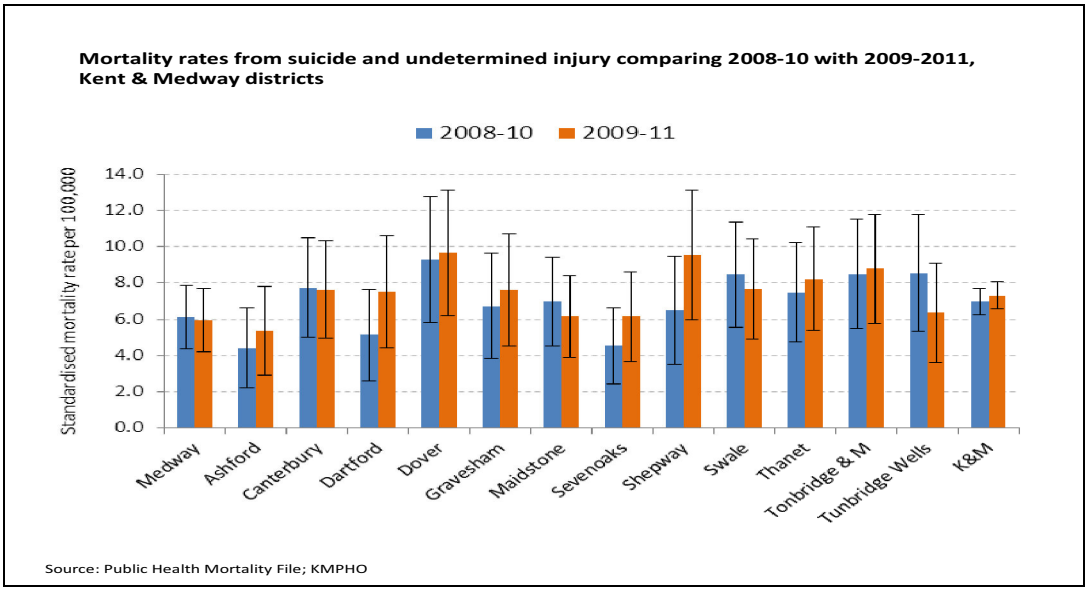
5. Reducing bed supply and suicide rates

Question: There seem to have been more suicides when more service users are placed out of their local area. Doesn't this mean that closing more beds should be avoided? Why was there not more attention in the redesign to any correlation between suicides and inpatient beds?

Response: Colleagues specialising in Public Health have been looking at suicide rates and their data does not indicate that reducing bed supply has any correlation with a higher suicide rate. If there was a link between local mental health activity and suicides, this would be more likely to involve the access and recovery services in the community than the hospital service:

people in hospital are seen to take their medication and they are supported by the staff who are working with them towards recovery, so suicide in hospital is much more infrequent than in people who may, as part of their condition, not take their medication appropriately. Kent and Medway's suicide numbers are so small that, even if "undetermined injury" deaths are included, no statistically valid correlations would be possible. Of course, there are many different variables that contribute to suicide so looking at the numbers of suicides and beds cannot amount to cause and effect, nor can it account for other external factors, such as unemployment, that might underlie both increasing demand for the whole range of mental health services and any rise in suicides.

ix) This graph has been produced by public health colleagues, showing deaths from suicide and undetermined injury, in two consecutive two-year periods.

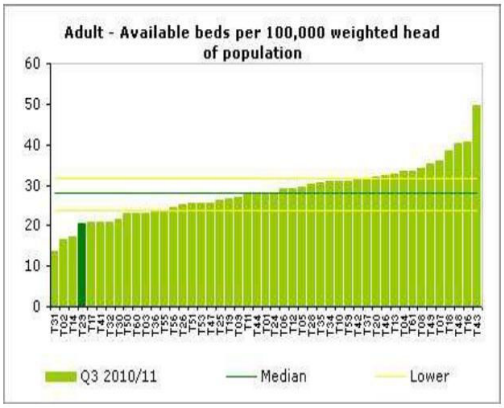


6. Benchmarking of KMPT acute bed supply with other Trusts by weighted population

Question: Why is there a proposal for a further reduction in bed supply when KMPT is already in the bottom quartile of Trusts?

Response: The National Clinical Advisory Team endorsed our proposals after considering, among other things, the Audit Commission benchmarking shown on the next page). Our review took on board the views from many stakeholders, especially service users, that any resources that could be found to expand or strengthen home treatment would be a good outcome. We also know that most mental health Trusts in England are also moving towards using beds for higher risk inpatients, even though they use different supply definitions. Bed need cannot be estimated without taking account of a Trust's acute service practices, access thresholds and the alternative care it makes available.

x) Audit Commission benchmarking of mental health Trusts' bed supply



Benchmarking shows KMPT with a low number of beds per 100,000 weighted head of population. This needs to be taken into account with regard to any consultation around future bed provision.

7. Checking the data

Question: Were figures checked and have there been computer errors? Why are you not looking at all the last six years and at the emerging data in the current year, as well as the four specific years you chose for the review?

Response: There has been extensive checking of data. Two comprehensive fresh analyses were undertaken, in February and April 2012, each compiling the data up to those dates in a different way, and they validated each other. There has been learning and sharing of these findings with stakeholders as the work has progressed. We found only one actual data error, in a graph in the July Board report's Appendix E, which was only used to validate the population's need for acute beds, and not as part of the core analysis of service demand. This error was recognised and corrected. Both the original and new versions show the expected demographic differences between areas and clearly support the clinical case for change and the proposals for the future.

The data analysed was the record of Trust activity made by its staff and this told a consistent story. The only peculiarity showed up when the Trust moved from ePEX to RiO, as described in item 2 above.

The approach of analysing data in April 2012 from a number of whole financial years to 2011/12 was agreed with stakeholders in February 2012. The most recent years were used for the main estimation of locality demand. Six years' data was initially examined but only used in the Board report when necessary to get enough useful data for variations, such as for seasonality. It is always better to use recent data. In this case, we had four whole years' data available during the time when the practice of using CRHTs in place of hospital stays was already taking effect. There is no reason to extend this to other years.

The data published in July 2012 has been subjected to a very thorough scrutiny during the consultation and we have re-examined every discrepancy that has been brought to our attention. This paper makes public any corrections made – and makes it clear that these corrections have been points of detail and are not substantial enough – either separately, or together – to warrant changing the proposals consulted on.

Kent and Medway mental health stakeholders have awaited the redesign outcome for a year. We believe the proposals set out offer the best way forward for everyone and that further delay only perpetuates the disparity between the current services and the imbalance in the capacity.

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JHOSC Supplementary Information: 30.01.2013

1. **Updated information on the numbers of Medway residents accessing acute mental health services outside Medway, and the associated costs, over the last four years:**

Patients staying in the KMPT area

1.1 As acute mental health services have been commissioned jointly from KMPT by Medway and Kent PCTs/CCGs throughout this period, there are no additional costs to either of them when their residents are treated in any KMPT unit, whether it is in their home area or not.

1.2 Increasing numbers of patients have been crossing the boundary between the two council areas in the last couple of years as a result of the imbalance in bed distribution. The proposals we have been consulting on are designed to address this because it is much better for service users and their carers if the local Crisis Resolution Home Treatment team (CRHT) has strong links with the hospital unit serving their area.

1.3 The situation was aggravated when the CQC required four High Dependency beds in the East Kent Psychiatric Intensive Care Unit to be removed in 2010/11 and the impact is clear in Table 1, which shows sharp increases in the percentages of Medway patient ward stays at non-Medway wards. The CQC requirement meant that more East Kent patients have been treated in Medway since then and, consequently, more Medway patients have been treated in Maidstone and Dartford and the balance of bed usage and its management has been upset.

Patients placed outside the KMPT area

1.4 Kent and Medway patients sometimes have to be placed outside the KMPT area (when they need the level of services that KMPT normally provides) when all KMPT's beds are occupied. When this happens, KMPT has to pick up the bill and make its accounts balance: so the issue becomes a cost pressure within KMPT. These costs do not impact on local health expenditure. There were no such placements from Medway in 2009/10, 20010/11 or 2011/12. But in the first nine months of 2012/13, 16 Medway patients were treated outside KMPT and the related cost pressure is £110,348.

1.5 Trusts from many different areas of England have been reporting similar sharp rises in Out of Area Placements between January and October 2012 but the increase is too recent for there yet to be any clear understanding of why this has been happening. Acute care Hospital Trusts also reported seeing a peak of admissions during this period.

1.6 KMPT addressed this situation by introducing a discharge co-ordinator in east Kent and this has been successful in helping patients with the practical aspects of returning home, reducing delayed discharges and supporting patients' timely transition from acute inpatient care to

community/treatment at home. This improvement has also had a positive impact on bed management in Medway and west Kent.

1.7 It is perhaps worth noting that all acute mental health services have seen an increase in their work in the last few years, apparently linked to the impact on individuals of the global economic situation. This has put Community Mental Health Teams and the CRHT teams, who have been treating many of these people, under some pressure, which the current proposals are also designed to alleviate.

Out of Area clinical specialisms

1.8 Each year, a very small number of Medway patients have needed highly specialist treatment in other parts of the country. Examples include specialist treatment for eating disorders and for individuals with learning disabilities and an unusually high degree of challenging behaviour. These so-called Out of Area Placements are only made when clinically necessary, i.e. when the complexity of the individual's needs is beyond the scope of non-specialist units, either because they need higher levels of staffing or specific staff skills.

Data

1.8 **Table 1** below shows the number and percentages of Medway patients staying at KMPT units outside Medway and at specialist units outside KMPT since April 2008.

	2008/9	2009/10	2010/11	2011/12	*Apr – Dec 12
Medway patients ward stays (total)	15784	13400	11023	8782	6791
Medway patients ward stays at non Medway wards (total)	2144	1162	1374	1529	1005
% of Medway patient ward stays at non Medway wards	13.6	8.7	12.5	17.4	14.8
Medway patient ward stays non KMPT (total)	N/A	0	0	0	167
% Medway patient ward stays at non KMPT wards	N/A	0	0	0	2.5
Medway patients (number of individuals)	269	277	273	283	317
Medway patients at non Medway wards (number of individuals)	67	83	95	94	79
% of Medway patients staying at non Medway wards (within KMPT)	24.9	30.0	34.8	33.2	24.9
Medway patients at non KMPT beds	N/A	0	0	0	16
% of Medway patients staying at non KMPT wards	N/A	0	0	0	5%

Table 1: Medway patient ward stays outside Medway 2008/9 – December 2012

**Note: data for April – Dec 2012 cannot be used for year on year comparison.*

1.10 **Table 2**, also below, shows the KMPT patients resident in east and west Kent who stayed in Medway's A Block in the current year.

West and east Kent patient ward stays in Medway (total)	1405
Patient overspills within KMPT bed stock by East and West Kent into Medway (total)	88
East Kent patients staying in Medway wards	59
% of East Kent patients bed days staying in Medway wards	13.92%
West Kent patients staying in Medway wards	29
% of West Kent patients bed days staying in Medway wards	3.54%
% of Medway patients bed days staying in east Kent wards	2.12%
% of Medway patients bed days staying in west Kent wards	14.03%

Table 2: Residents from East and West Kent treated in Medway's A Block between April-Dec 2012

2. **Details of the levels of staffing at Medway A-block over the last four years along with an analysis of the changes, which could have affected demand:**

2.1 Staffing levels for each KMPT ward are set in line with the number of beds/patients to be cared for. A consistent policy is applied across every KMPT facility ensuring parity, based upon national practice and in line with other mental health inpatient units. The staff ratio on all acute inpatient wards in KMPT is 6:6:3. (Early: Late: Night shifts).

2.2 However, staffing is increased when patients' acuity and the needs of individual patients within the ward increases, such as a number of patients requiring 1:1 observations.

2.3 Overall, staffing at Medway's A Block has increased in the last three years, the skill mix has been enhanced and the number of senior staff has gone up significantly since 2010. This is because those admitted to A Block now are more acutely ill than they might have been when admitted there in the past, due to the successful support now given to service users at home by the Crisis Resolution Home Treatment team.

2.4 **Table 3** shows the detailed breakdown of staff changes in Medway's A Block over the last four years. The differences between the numbers of budgeted posts and staff actually in post are due to vacancies, which are covered by locum staff so that the service is delivered.

2.5 The figures for 2009/10 reflect a time when ward sizes varied because the service was run for all ages together, rather than separating mental illness from dementia as now, and there was a high vacancy rate.

2.6 Vacancies are peaking again now, due to the uncertainty caused by the year of discussion and debate preceding a decision about Centres of Excellence.

Sapphire ward establishment

Budget:

Position	2009/10 (March 10)	2010/11 (March 11)	2011/12 (March 12)	2012/13 (Dec 12)
Ward Manager	1:00	1:00	1:00	1:00
Deputy Ward Manager	2:00	2:00	2:00	2:00
Senior staff nurse	0.80	0.96	0:00	0:00
Staff nurse	9.33	8.74	6.87	10.13
Healthcare assistant	6.67	9.77	12.13	10.27
Total	19.80	22.47	22.0	23.40

In Post

Position	2009/10 (March 10)	2010/11 (March 11)	2011/12 (March 12)	2012/13 (Dec 12)
Ward Manager	1.00	1.00	1.00	1.00
Deputy Ward Manager	0.91	2.00	2.00	2.00
Senior staff nurse	0.00	1.00	1.00	1.00
Staff nurse	3.99	8.47	7.41	6.41
Healthcare assistant	2.80	10.40	8.00	8.00
Total	8.70	22.87	19.41	18.41

Emerald Ward establishment

Budget:

Position	2009/10 (March 10)	2010/11 (March 11)	2011/12 (March 12)	2012/13 (Dec 12)
Ward Manager	1.00	1.00	1.00	1.00
Deputy Ward Manager	2.00	2.00	2.00	2.00
Senior staff nurse	2.00	0.96	0.00	0.00
Staff nurse	6.80	8.74	6.87	10.13
Healthcare assistant	10.53	9.77	12.13	10.27
Total	22.33	22.47	22.00	23.40

In Post

Position	2009/10 (March 10)	2010/11 (March 11)	2011/12 (March 12)	2012/13 (Dec 12)
Ward Manager	0.00	1.00	1.00	1.00
Deputy Ward Manager	2.00	1.91	1.91	1.91
Senior staff nurse	0.00	0.00	0.00	0.00
Staff nurse	5.20	7.80	9.60	7.20
Healthcare assistant	12.80	8.80	9.80	7.20
Total	20.00	19.51	22.31	17.71

Table 3: Breakdown of staffing in Medway's A Block over the last four years

The difference between budgeted posts and staff in post reflects vacancies, which are covered by locum staff. KMPT has worked to gain consistency in both staff numbers and skill mix in all its wards. The posts for qualified staff have increased to cater for the more acute and complex needs of patients admitted to hospital these days.

2.5 **Table 4** below illustrates the bed base of the wards in Medway's A Block over the past four years, demonstrating that the staff to patient ratio has been further increased than Table 3 indicates, due to a reduction in beds and therefore in patients requiring care at any one time..

ward	Number of beds 2010	Number of beds 2011	Number of beds 2012	Number of beds 2013
Sapphire	16	16	16	16
Emerald	21	19	19	19

Table 4: Beds in the wards in Medway's A Block over the last four years

3. Details of the staffing of the different CRHTs across Kent and Medway, with the location of the new and proposed Support Time Recovery Workers indicated clearly:

3.1 In addition to investing in more ward staff, KMPT has also strengthened its community-based services Crisis Resolution & Home Treatment (CRHT) Teams and Liaison Psychiatry teams.

3.2 Liaison Psychiatry is based at Medway Maritime Hospital, providing support to staff in A&E and on general wards when they are dealing with patients who are service users or who appear to have mental health problems as well as any physical health issues they may be at the hospital for. This service is not affected by the proposals in the public consultation and will continue to be provided at the hospital.

3.3 Medway CRHT will, as now, be based with the Medway inpatient facilities because close links between ward staff and CRHT ensure a proven better service to users and their carers. If Option A is put in place, for example, Medway CRHT would have their base in Dartford – but they would also have a presence in Medway and spend much of their time working in Medway. KMPT is also exploring a satellite crisis presence/team in Medway.

3.4 Community mental health services, for those not in an acute phase of illness, which are used by the vast majority of mental health service users will continue to be based in Medway. They will be in a new base at Canada House in Gillingham, with Recovery and Access services co-located for the first time.

STR workers

3.5 A dozen Support Time and Recovery staff are currently being recruited to the two CRHTs in East Kent and three are being recruited to Medway as part of the re-enablement project.

3.6 If Option A is implemented, a further 11.36 WTE STR workers will be recruited for teams in West Kent and Medway. Four of these will be in Medway, in addition to three being recruited at the moment – an increase of seven full-time staff spending most of their time in Medway working with the area's service users as part of Medway's CRHT – along with four more in Maidstone and South West Kent and three in Dartford. Should future demand analysis demonstrate greater need in a particular locality, KMPT will adjust the allocation of STR workers accordingly.

3.7 **Table 5** below shows the current and future CRHT staffing across Kent and Medway.

Staff Type	Dartford	Medway	Maidstone / SWK	North East Kent	South East Kent
CURRENT					
Team Leader	1.00	1.00	2.00	1.00	1.00
Qualified Nursing/OT	11.67	19.39	21.27	22.46	14.80
Unqualified Nursing/OT	3.60	3.47	1.00	11.69	11.44
STR Worker	0.00	0.00	6.73	0.79	0.79
Social Worker	0.00	0.00	1.00	1.00	0.50
Current Total	**16.27**	**23.86**	**32.00**	**36.94**	**28.53**
ADDITIONAL STAFF CURRENTLY BEING RECRUITED					
STR Worker	-	3.00	-	6.00	6.00
ADDITIONAL STAFF IN OPTION A					
STR Worker	3.36	4.00	4.00	-	-
Future Total	**19.63**	**30.86**	**36.00**	**42.94**	**34.53**

Table 5: current and future CRHT staffing across Kent and Medway

4. Travel plan – progress to date:

4.1 From the feedback during the early stages of the review and consultation we know there are concerns about travel, particularly for family and carers visiting inpatient facilities out of their local area. We have established a transport group which includes a service user to oversee the development of the transport plan.

4.2 The plan includes the following elements:

- **Understanding current access to inpatient wards:** We audited the number and types of transport used by visitors to our acute inpatient services. This snapshot taken in the summer indicated that most visitors used their own transport, including those visiting Medway's A Block.

- **Public Transport:** Service users from Medway and Swale have also tested the various public transport options from Medway and Swale to Dartford and details were included in the consultation. KMPT is completing work over the next month to identify any issues around evenings, weekends and bank holidays and will ensure our transport plan and guidance meets the needs of those visiting the service. We will also look at transport links from main towns around Kent and Medway to the three Centres of Excellence and take account of any flexibility required from inpatient units to facilitate visiting, while ensuring patients have sufficient opportunity to engage in treatment and therapeutic programmes while in hospital. Currently, all inpatient units have flexible visiting times with restrictions only around meal times.

- **Communication:** Availability of bus, train times, walking routes from the nearest bus stop and driving directions will all be available in each inpatient unit, from CRHTs and on the Trust website. A 'plan your journey' section is being developed on the Trust's website and a frequently asked question sheet is also being developed to address some common issues about inpatient services, such as visiting arrangements, attending meetings etc.

- **Voluntary Transport:** Access to the voluntary transport scheme will be available for those unable or who do not wish to use public transport. There is a charge for this service so that the expenses of the driver are covered. We are exploring the possibility of developing a discretionary scheme to support access to the acute service.

- **Hospital leave:** The voluntary transport scheme will also be used to facilitate, as required, leave from hospital as soon as any change resulting from the consultation proposals is in place.

- **Guidance:** Guidance notes will be developed to ensure clinical staff consider travel implications for visitors (carers, family, friends) when arranging meetings, leave etc. so that meetings are arranged at minimal inconvenience for those wanting to attend, including using Skype to support meetings that carers cannot physically attend.

- **Technology:** The Trust will provide patients with access to the internet using dedicated Trust computers so that they can maintain contact with family and friends through email and Skype as well as accessing online systems and services they might ordinarily use at home, including internet banking, shopping, games, social networking and so on.

  The Trust already has three such facilities in place and, once any early lessons have been noted, will roll out 50 internet-connected computers for patients to use across the Trust. The roll-out is

expected to take three months, with each ward having at least one computer.

The Trust is also working on setting up free Wi-Fi access for patients to use the internet on their own computers and smartphones while staying on the wards, just as they can at home. This is likely to be facilitated through the care planning process and to include an advanced agreement about when patients will be able to access the internet and the times when their phones will be taken from them – while they have treatment, for example.

The transport group is also exploring the possibility of CPA meetings being held via the Trust internal video conferencing where the community teams could participate via video link with the inpatient unit. The group will explore this and the possibility for Carers and GPs who wish to attend the meeting but are unable to travel could participate by using the video conference facility at the local CMHT.

4.3 Example public transport journey times from Rochester, Chatham and Gillingham to Little Brook Hospital, researched by a service user and which when supplied to visitors include links to the bus and train company websites and a text code for up-to-date bus service information, are:-

Public Transport from Rochester to Littlebrook Hospital Dartford (Visiting hours 5:30pm – 8pm)

4:19pm Rochester – Medway (From the centre of Rochester (Medway))
Walk for about 11 minutes to

4:30pm Rochester Rail Station
PLUSBUS ticket available with train tickets for this station Visit: www.plusbus.info to check fares etc
Take Southeastern Train towards London Charing Cross Rail Station and get off at:

4:58pm Dartford Rail Station
Walk about 5 minutes to

5:09pm Dartford, Home Gardens, Stop D (on Home Gardens
Take Arriva Kent Thameside Bus 492 towards Bluewater bus station and get off at

5:15pm Dartford, Stone House Hospital (E-Bound) (on London Road)
Walk about 12 mins to

5:27pm Littlebrook Hospital**,** Greenacres, Bow Arrow Lane, Dartford, Kent DA2 6PB.

Return journey

8:19pm Leave Littlebrook Hospital
Walk about 14 minutes to

8:33pm Dartford, adj Brent School (on London Road) [SMS: kntatmwp]
Take Arriva Kent Thameside Bus 490 towards Dartford, Prospect Place
Get off at

8:39pm Dartford, Home Gardens, Stop X (on Home Gardens)
Walk about 5 minutes to

8:55pm Dartford Rail Station
Take SoutheasternTrain towards Gillingham (Kent) Rail Station
Get off at
9:22pm Rochester Rail Station
PLUSBUS ticket available with train tickets for this station. Visit: www.plusbus.info to check fares etc
Then walk for about 11 mins to the centre of Rochester
9: 33pm Rochester

Public Transport Gillingham to Littlebrook Hospital, Dartford (Visiting hours 5:30pm – 8pm)

4:20pm Gillingham Kent
From the centre of Gillingham walk for about 4 minutes
4:24pm PLUSBUS ticket available with train tickets for this station. Visit: www.plusbus.info to check fares etc
Take Southeastern Train towards London Charing Cross Rail Station and get off at:
4:58pm Dartford Rail Station
5:09pm Dartford, Home Gardens, Stop D (on Home Gardens)
Take Arriva Kent Thameside Bus 492 towards Bluewater bus station and get off at
5:15pm Dartford, Stone House Hospital (E-Bound) (on London Road)
Walk about 12 minutes to
5:27pm Littlebrook Hospital

Return journey

8:19pm Littlebrook Hospital
Walk about 14 minutes to
8:33pm Dartford, adj Brent School (on London Road)
Take **Arriva Kent Thameside** Bus **490** towards Dartford, Prospect Place
and get off at
8:39pm Dartford, Home Gardens, Stop X (on Home Gardens)
Walk about 5 minutes to
8:55pm Dartford Rail Station Take **Southeastern** Train
and get off at
9:30pm Gillingham (Kent) Rail Station
PLUSBUS ticket available with train tickets for this station. Visit: www.plusbus.info to check fares etc
Walk for about 4 minutes to the centre of Gillingham
9:34pm Gillingham

Public Transport from Chatham to Littlebrook Hospital Dartford (Visiting hours 5:30pm – 8pm)

4:18pm Chatham (Medway), Waterfront Bus Station
Walk about 10 minutes to:
4:28pm Chatham Rail Station

PLUSBUS ticket available with train tickets for this station. Visit: www.plusbus.info to check fares & etc

Take Southeastern Train towards London Charing Cross Rail Station and get off at:

4:58pm Dartford Rail Station

Walk about 5 minutes to

5:09pm Dartford, Home Gardens, Stop D (on Home Gardens)

Take Arriva Kent Thameside Bus 492 towards Bluewater bus station and get off at

5:15pm Dartford, Stone House Hospital (E-Bound) (on London Road)

Walk about 12 minutes to

5:27pm Littlebrook Hospital

Return journey

8:19pm Littlebrook Hospital

Walk about 14 minutes to

8:33pm Dartford, adj Brent School (on London Road) [SMS: kntatmwp]

Take Arriva Kent Thameside Bus 490 towards Dartford, Prospect Place

Get off at

8:39pm Dartford, Home Gardens, Stop X (on Home Gardens)

Walk about 5 minutes to

8:55pm Dartford Rail Station Take Southeastern Train towards Gillingham (Kent) Rail Station

Get off at

9:55pm Chatham Rail Station

PLUSBUS ticket available with train tickets for this station. Visit: www.plusbus.info to check fares & validity

Then walk for about 11 minutes to the centre of Chatham (Medway)

9:36pm Chatham

Kent and Medway

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
Access and Transport	
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?	The KMPT transport plan will deliver a range of initiatives to support service users, carers and families' access to and from hospital sites. The transport plan is complete and will be signed off at the Acute Service Line Programme Board on the 23rd 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. 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.
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?	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. 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 individuals 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. 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.
3, What help will there actually be for people in meeting the cost of travel to Little Brook Hospital from Medway?	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.
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?	A meeting is already planned between the site manger for Little Brook, senior KMPT staff David Tamsitt and Philippa MacDonald with Dartford council to highlight this situation and to agree a resolution. 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.
5, What arrangements have been put in place for transporting people to A&E from Dartford speedily?	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

	relationships with both organisations and established protocols in place to facilitate smooth support for patients. A&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.
Data quality/accuracy	
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.	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. 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. 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.
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	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

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?	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. 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.
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.
Estates Strategy/acute bed provision in Medway	
11, How were decisions not to invest in acute in-patient	The JHOSC have had two previous briefings on the attempts to pursue an

provision in Medway reached in the context of the overall KMPT Estate Strategy and priorities over the last ten years?	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. 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. • 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. • 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. • The co-dependencies with Medway Trust who were at the time planning a new A and E were also fundamental concerns. 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

	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.
Quality and levels of staffing for the CRHT team in Medway	
13, What is being put in place to ensure there are sufficient numbers of qualified and experienced CRHT staff in Medway over 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?	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. We have listened to users and carers and will be providing an enhanced role for STR workers that links with our commitment to recovery. 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 feed back 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. 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

	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?	If escorted leave is required then staffing to support this is obtained. 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.
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?	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. 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 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. 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. We will be working closely with our Medway Social Care colleagues to

	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 5th 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?	KMPT have increased staffing at night to support access to out of hours support. Previously the Team had 2 staff at night, which meant that when a Section 136 assessment or A&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. 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. We have also agreed a CRHT survey, which will be rolled out imminently to ensure we can act on feedback from service users. 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.

Transport Plan – post consultation; Option A

Introduction

This plan outlines the national and local drivers around transport and the development of the integrated transport strategy which aims to improve transportation across North Kent. This plan has been specifically developed to acknowledge and address some of the issues arising from the proposed relocation of Acute Mental Health Inpatient services for the residents of Medway and Swale from A Block Medway Maritime Hospital to Littlebrook Hospital Dartford and Priority House Maidstone respectively. It will address issues which arise for those accessing Psychiatric intensive care from East Kent as this service will move from Canterbury to Dartford.

The Transport group which has been established to oversee the development and implementation of this plan has sought input from experts by experience and have actively engaged with relatives/ carers and others who visit Medway to seek their views regarding transport issues, their concerns and how they would like to be supported should proposed changes occur.

National Policy

The Government has focused on reducing car dependency and increased travel choices through key guidance in the Transport White Paper, Road Traffic Reduction Act and the Planning Policy Guidance 13 (Transport). Of these, Planning Policy Guidance 13 (PPG 13), this provides the strongest imperative for travel plans and any arising planning obligation. It recommends travel plans for various land uses, including places of work.

PPG13 (Transport) 2001 indicates that travel plans should be submitted alongside major planning applications, developments likely to generate a significant amount of traffic, or to generate traffic in sensitive locations (e.g. Air Quality Management Areas). They should help to deliver:

1. reductions in car usage (particularly single occupancy journeys) and increased use of public transport, walking and cycling;
2. reduced traffic speeds and improved road safety and personal security particularly for pedestrians and cyclists; and
3. more environmentally friendly delivery and freight movements, including home delivery services.

Travel plans, or elements from them, are often secured by a planning condition or agreement. Information on planning obligations secured under Section 106 of the Town and Country Planning Act (1990) can be found in Circular 05/2005 published by the Office of the Deputy Prime Minister (ODPM). The ODPM is now the Department for Communities and Local Government.

Regional Policy

Medway council's Local Transport Plan (LTP3) and Kent County Council's Local Transport Plan (LTP3) were adopted in April 2011. Both documents make numerous references to continued support of schools and businesses in the development of travel plans, as part of their commitment to actively promote the use of alternatives to car based travel. Throughout the lifetime of LTP3 (2011 to 2016),

the intent is to increase the number of travel plans across Kent and Medway. There is a commitment from both Medway Council and Kent County Council to adopt a whole systems approach and have both contributed to the development of North integrated transport strategy which looks at improving transport networks across (and within)Medway and the north of the county.

Local Policy

The Kent and Medway NHS and Social Care Partnership Trust (KMPT), has recently published its Carbon Management Plan. Through this Plan the Trust states a clear commitment to reducing the carbon footprint of its sites. Of particular relevance to this Travel Plan is the Carbon Management Plan's strategic theme of 'Tackling Transport and Travel Emissions'. This theme promotes the use of sustainable transport modes across the Trust's sites, and the use of travel plans to help achieve this.

Patients and Visitors

We wish our patients and visitors to benefit from having a variety of transport options available to them, and from being able to make informed choices about those transport options, when travelling to and from our site. Measures we propose to achieve this include:

- Travel information leaflets detailing options for all modes of transport, and travel contact numbers and websites, will be issued at point of admission to acute care.
- Trust website will include a dedicated website page providing travel information for all modes of transport to visitors, and links to useful resources e.g. journey planning website, etc.
- Main visitor receptions areas will display public transport information e.g. maps and take-away timetables, in.
- Support for patients accessing acute care and home leave; such as use of voluntary transport service, STR workers to facilitate leave.
- Access to secure transport if required to facilitate admission or transfer between units.
- Flexibility with visiting times to support families/carers accessing inpatient facilities via public transport. This will need to be agreed on a case by case basis to ensure needs of the individual are met in regards to receiving visitors and engagement with treatment.
- The Trust will continue to monitor and liaise with partners regarding transport plan developments as per Integrated Transport Strategy, and any future developments between MFT and DVH.
- Improve signage to hospital sites.

We acknowledge that the changes in the delivery of inpatient acute care will have an impact on visitors. We recognise the importance of maintaining links with family and carers and in addition to

the above to aid transition The Trust will, within its absolute discretion provide financial assistance to enable service users to travel to and from in patient units where such units are more than 14.5 miles from the patients home. Eligibility for such assistance will be determined by the criteria set out below. In providing such assistance the Trust is not accepting any ongoing continuing liability to do so. The level of assistance is solely within the discretion of the Trust

Criteria for access in Financial support:

- Immediate Family member (spouse, parent, Child, Sibling) and or main carer.
- In receipt of benefits
- Known disability or infirmity.
- Support would be calculated on distance to new inpatient facility (for Medway this would be Little brook, Dartford, and Swale Priority House Maidstone) less 14.5 miles. This is currently the largest distance from where someone would visit A Block, Medway Maritime Hospital
- Support for East Kent residents visiting PICU in Dartford would be calculated on similar terms – distance to PICU less mileage from larges current distance within East Kent to access intensive care facilities at St Martins Hospital, Canterbury.

Action Plan

When	Activity	By whom
By Dec 2012	Set up Travel Plan Steering Group	Philippa Macdonald & Janet Lloyd
January 2013	Display public transport information in main visitor reception areas then maintain up-to-date	Site managers
February – May 2013	Improve signage within KMPT inpatient sites including signage to bus stops etc.	Site managers
February 2013	Contact local authority regarding provision of signage to inpatient facilities	Site manager
February 2013	Implement flexible visiting times as required to support relatives accessing inpatient facilities via public transport	Service managers/ Ward Managers
March 2013	Complete audit of visitor views at Medway regarding transport and the proposed option.	PALS team/ Expert by experience group
April 2013	Review findings and ensure plan reflects views raised within questionnaire	Steering group/ Acute service line

April 2013	Prepare dedicated travel plan website page then maintain up-to-date	IT and TPC
April 2013	Design and print travel information leaflets	TPC with Kent Highway Services
Point of service change	Extension of voluntary transport scheme to support home leave as required.	Janet Lloyd Service line
Point of service change	Use of STR workers (within CRHT) to support home leave and transition from inpatient care to community care.	Locality CRHT
Point of service change	Budget of £10,000 allocated to support relatives visiting inpatient unit – via voluntary transport or subsidy for public transport as per eligibility criteria.	Service Director
May 2013	Policies underpinning access to voluntary transport, financial support developed and approved	Transport steering group
June 2013	Clear communication to patients, carers, relatives, and other stakeholders regarding transport policy and support available after the service change.	Transport steering group
June 2013	Provision of patient internet access in all inpatient units	IT & transport steering group
June 2013	Access to technology to support case discussion and liaison between acute services and community and primary care	IT & transport steering group
June 2013	Guidance notes to staff re considerations to make when establishing meetings where relatives/carers are required to attend.	Transport steering group / service managers
ongoing	monitor and liaison with partners regarding transport plan developments as per ITS, and any future developments between MFT and DVH.	Transport steering group
Beyond Dec 2013	Annual actions and new actions determined as a result of the annual review of the Travel Plan	Steering Group

Kent and Medway

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Kent County Council and Medway Council

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20 February 2013

Dear Colleagues

The PCT cluster Board met today (20 February) to discuss the options for acute mental health services in Kent and Medway. There was a strong attendance by councillors from Medway Council, carers and the advocacy projects which support service users. At the beginning of the meeting council representatives were able to table some questions previously submitted and other members of the audience were also able to raise several points of concern.

We are aware that there are a number of outstanding issues which the JHOSC has raised which are in the process of being answered, and that the committee will reconvene shortly to consider the mental health crisis care proposal and the answers to members' outstanding questions.

During a wide ranging debate today we touched on the work which has been undertaken over the last 10 years to identify a site in Medway, which has not been possible. We need to be mindful that revisiting this would delay the further improvements in the quality of mental health service and would not consolidate the services into specialist centres of excellence in line with providing the best service for patients.

It was noted that KMPT is already making significant increases in its CRHT and STR resource along with increases in the PICU outreach, but we are of the view that sequencing to further strengthen the acute service at home needs to be in place sufficiently before final changes are made.

The Board noted that all eight Clinical Commissioning Groups who are the future leaders of NHS commissioning have approved implementation of Option A. And the Board was reminded that the Francis report exhorts us to move rapidly to best practice and safest services across the NHS. This plays directly to our responsibility for Kent and Medway residents at a time when we know we have a model of care which is clinically unsustainable in the longer term and gaps in provision which rely on these changes. In the light of this it was appropriate for the Board to take a decision in principle, with some additional assurances, in advance of the final JHOSC outcome.

Cont'd…1/2

The recommendation agreed is that:

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:-

- Extending psychiatric intensive care outreach services to Medway and east Kent where it is currently unavailable.
- Strengthening crisis resolution home treatment services
- Developing centres of excellence for the most unwell in line with national best practice
- Consolidating impatient psychiatric care.

The Board supported the implementation of option A subject to the following requirements being met:-

- That the bed number sensitivity analysis is undertaken and that this is 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.
- That sequencing of implementation is undertaken to introduce CRHT in advance of bed changes. We recommend that CCGs consider this in how they use their transitional non recurrent resources during the period of implementation.
- That a quality impact assessment is undertaken and clear benefits identified as KPIs.
- That the transport plan is completed and any remaining gaps in transport provision closed.

We request that these are completed and considered for approval at the CCG and cluster board meetings on 20 March if the work can be completed to this timetable. If not, these are to 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.

Best wishes.

Yours sincerely

Felicity Cox
Director Kent and Medway
NHS Commissioning Board
Chief Executive NHS Kent and Medway