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Dear Member

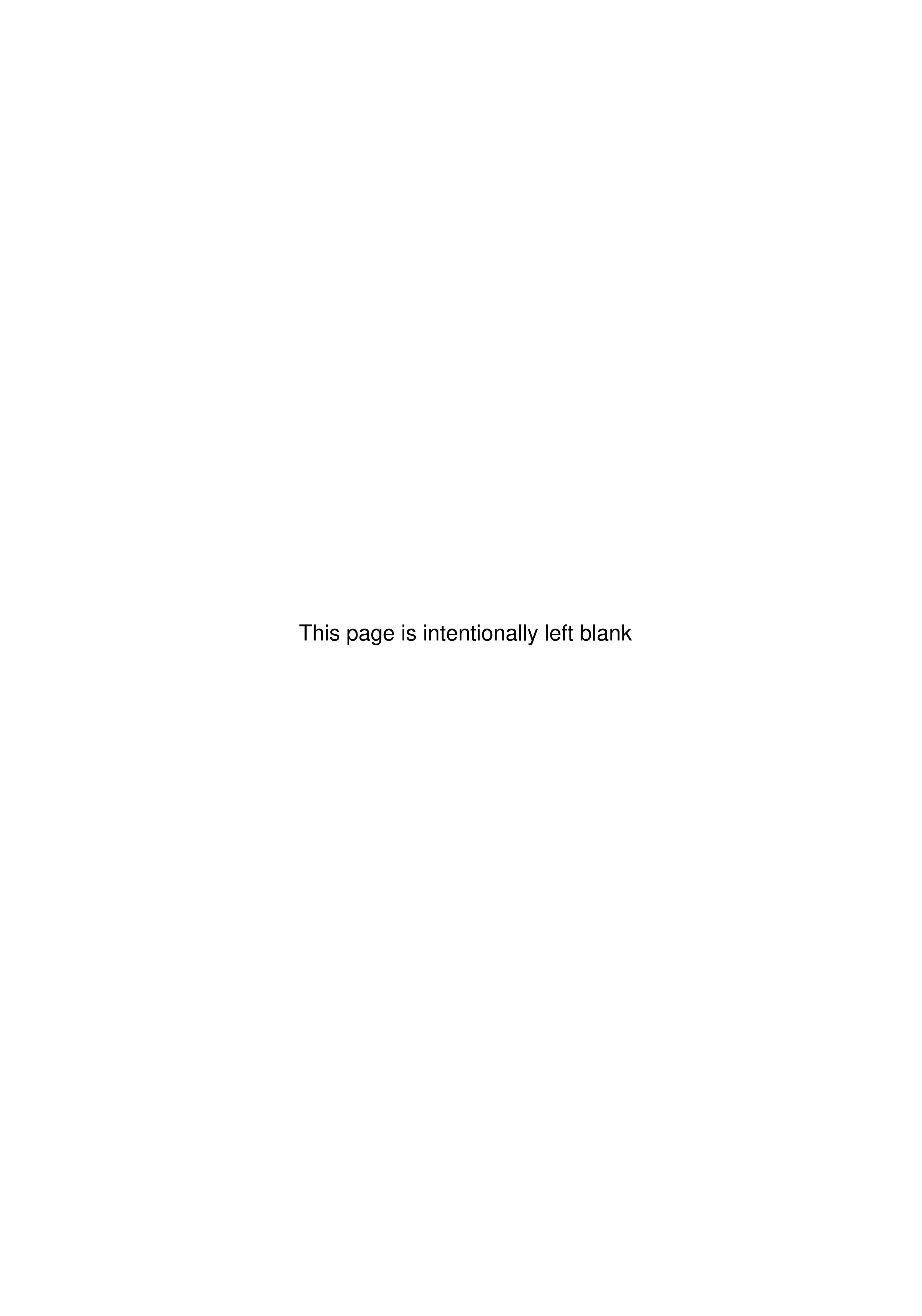
KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE - TUESDAY, 30 JULY 2013

I am now able to enclose, for consideration at next Tuesday, 30 July 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**
6	**Adult Mental Health Inpatient Services Review** **(Pages 1 - 42)**

Yours sincerely

Peter Sass
Head of Democratic Services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Kent County Council/ Medway Council

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

Final version: 24th July 2013

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SUMMARY

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

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

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

Comparisons of Kent and Medway with other places

Kent and Medway have:

- Few acute inpatient beds.
- About average levels of crisis resolution home treatment services.
- An about average number of mental health inpatient beds for older people
- More rehabilitation beds for adults of working age than average

Other comparable places have their acute mental health facilities closer to their most deprived communities than is being proposed for Kent and Medway.

Local data analysis

Local data analysis shows that:

- Existing acute inpatient services, and community alternatives, have been operating at or close to full capacity
- Pressure on these services is higher in East than in West Kent
- The level of crisis resolution home treatment services is different across Kent and Medway
- Only a small number of people are staying in acute inpatient beds after the time they are medically well enough to be discharged

Local stakeholder opinion

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

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

Site visits

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

Our conclusions

This review supports the proposal to concentrate acute inpatient beds at Dartford, Maidstone, and Canterbury. This seems the most realistic way of quickly closing the Medway Maritime wards. It also creates an opportunity to improve the quality of inpatient care, with improvements to staffing levels, therapies, staff cover arrangements, research opportunities, specialist services, and the management of risk.

We think more planning should be done, and better explained, about how the three remaining sites can become genuine "centres of excellence." We have not seen convincing evidence that this idea is understood across staff involved in these services. The opportunity is there, but there needs to be a clearer plan to make it happen.

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

We would encourage all this to be resolved as quickly as possible, given the poor facilities at Medway Maritime, and the long time this has already been discussed. We hope that it is possible for the work required to develop clearer plans for the "centres of excellence" and for additional reinvestment to be taken forward rapidly, and in parallel with the practical plans for the closure of the A block acute service.

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

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

1. INTRODUCTION

1.1. Purpose of report

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

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

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

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

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

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

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

This report sets out the results of that review.

1.2 Structure of report

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

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

2. METHOD

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

2.1 Documents received

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

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

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

2.2 Meetings and interviews

We have met directly and/or interviewed the following:

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

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

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

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

2.3 Site visits

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

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

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

2.4 External data

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

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

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

2.5 Internal data

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

3. FINDINGS

3.1 Benchmarking perspectives

3.1.1 Reference cost analyses

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

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

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

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

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

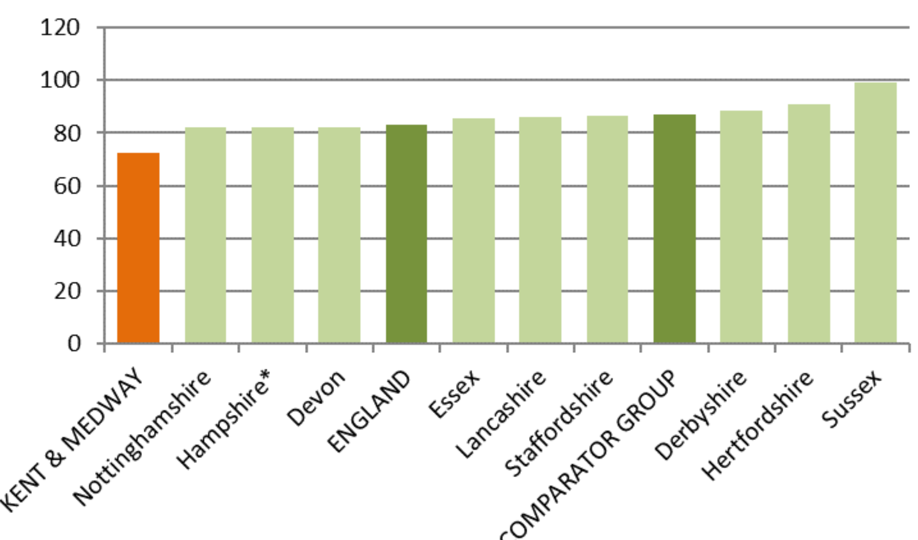
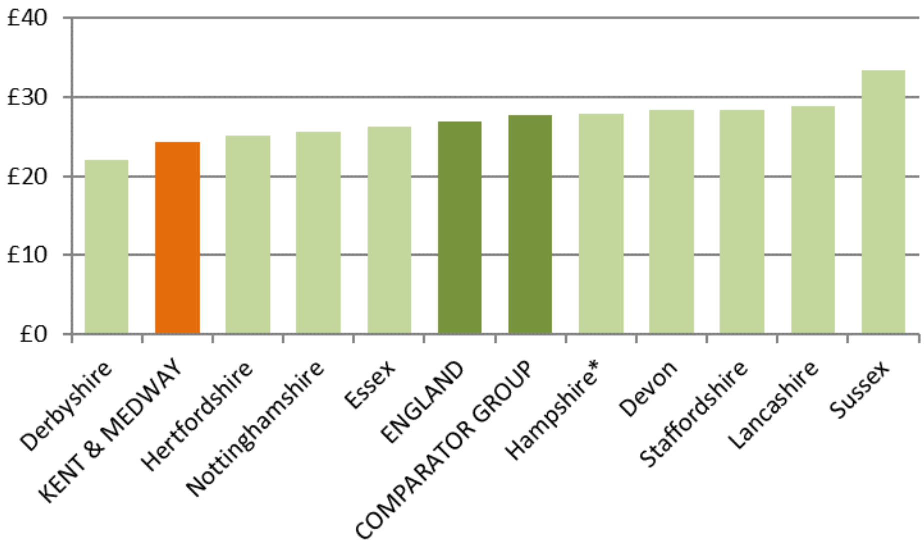


Figure 3.2. Own only - Adult Acute Inpatients - spend per weighted head (£)



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

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

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

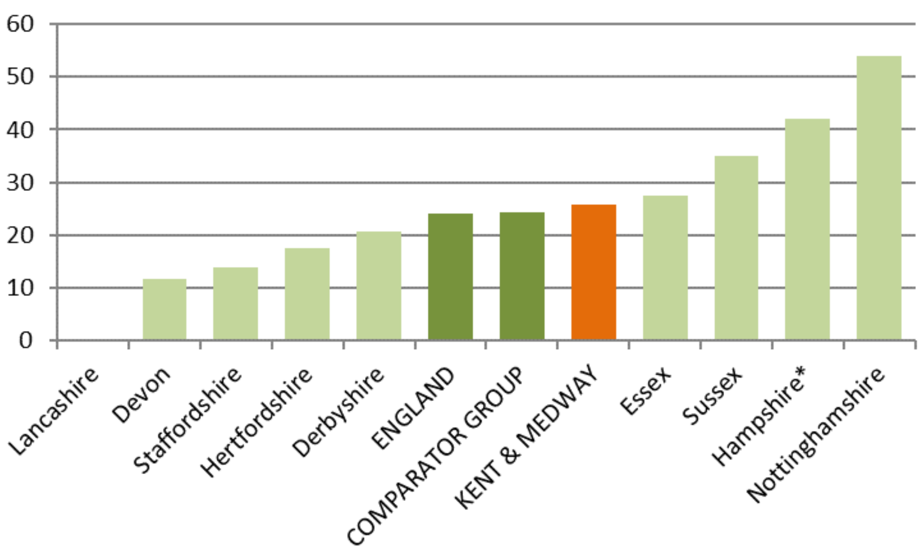
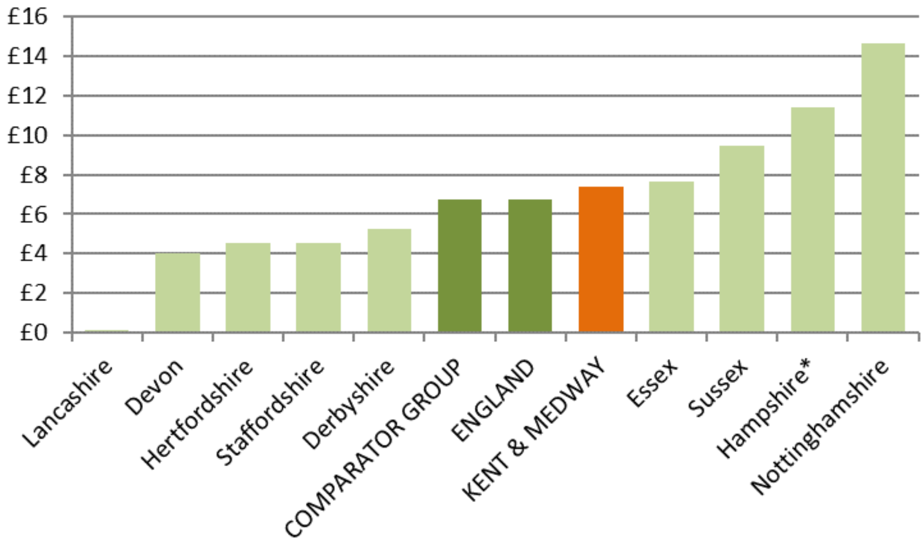


Figure 3.4. Own only - Adult Inpatients - Rehabilitation - spend per weighted head (£)



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

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

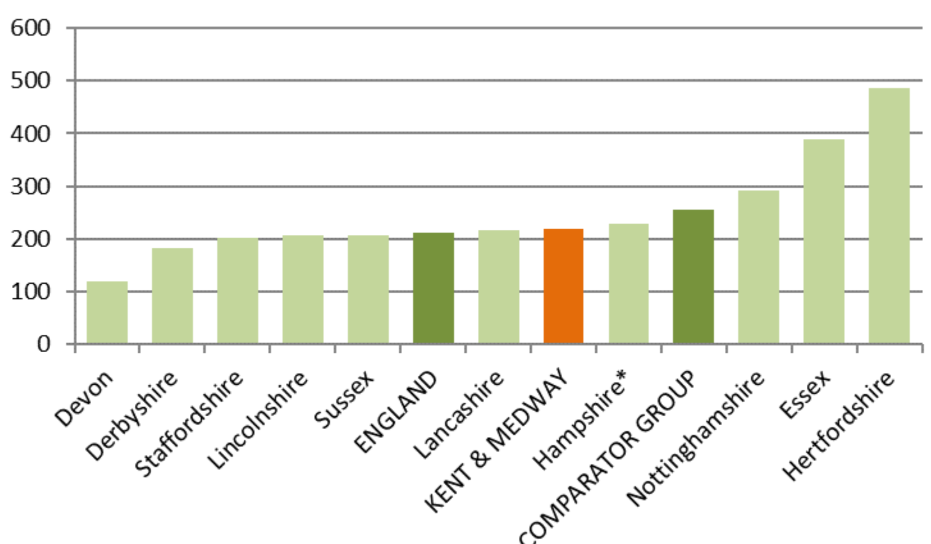
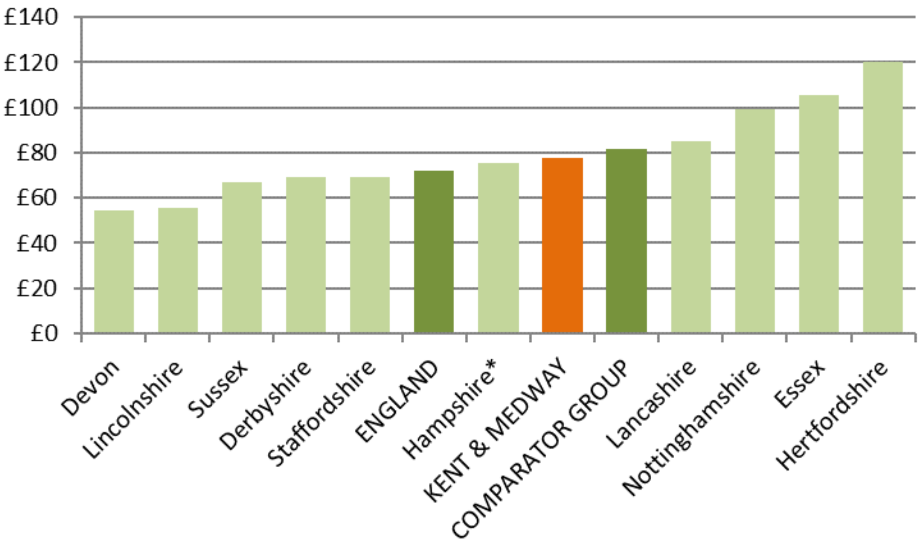


Figure 3.6. Own only - Elderly Inpatients - spend per weighted head (£)



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

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

Figure 3.7. Own only - Contacts per 1,0000 weighted adults for 'Mental Health Specialist Teams Adult: 'MHST: Crisis Resolution Home Treatment Teams'

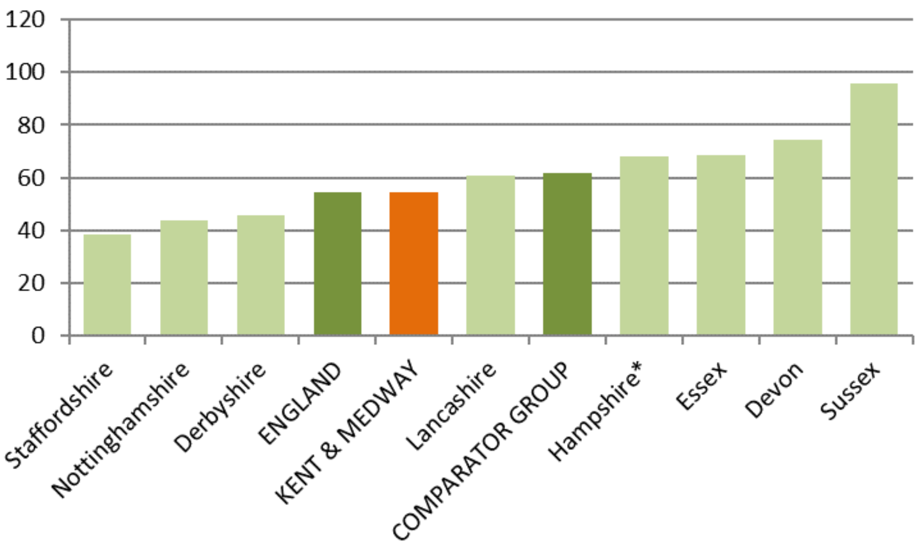
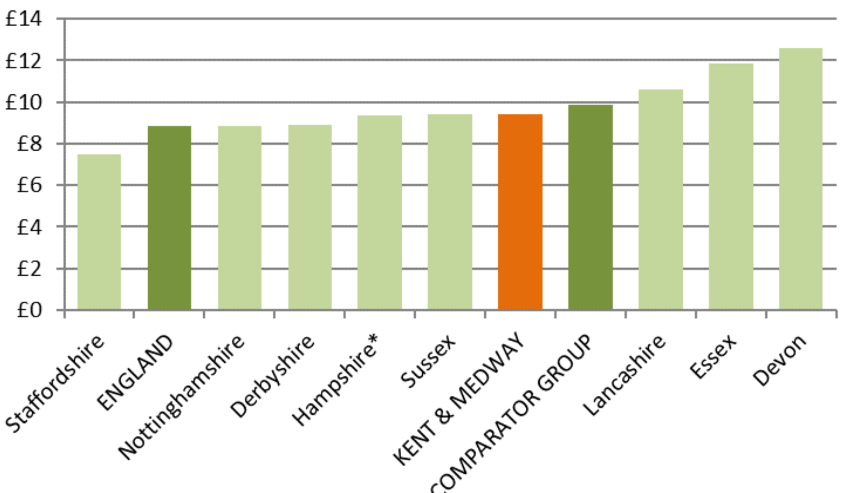


Figure 3.8. Own only - Adult CRHTs - spend per weighted head (£)



3.1.2 Social care indicators

To give additional context to the NHS data above, we have also drawn out a set of data about social care investment and activity in mental health services. The data is taken from the most recently available national returns for Personal Social Services: Expenditure and Unit Costs and is for the year ended March 2012. Comparators and the population base are as in section 3.1.1 above. Figures 3.9-3.12 reveal very different service models have operated in Kent and Medway. Kent invested in a high level of home care for people with mental health problems; Medway much lower. But, in reverse, Medway invested in a high level of day care for people with mental health problems; Kent much lower. We are aware that, since these data were published, there has been significant change in the organisation and delivery of mental health social care in Medway, including reduction in day care investment in Medway, with a proportion of reinvestment into other social care services. This is however the most recent comparable dataset.

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

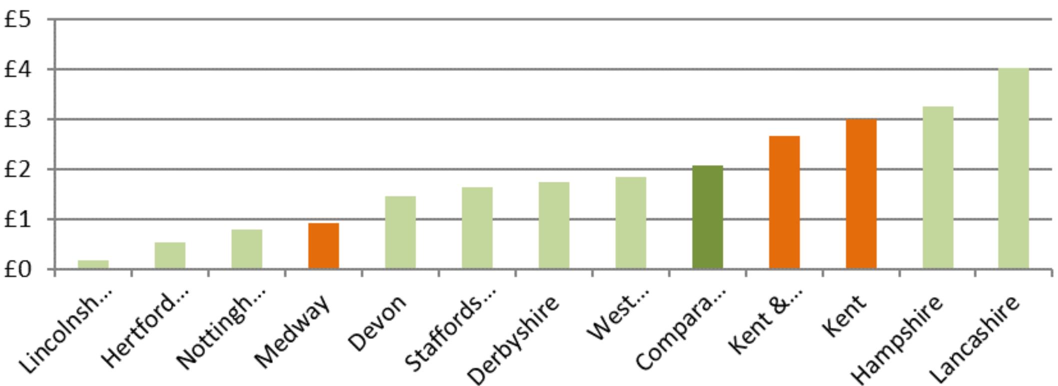


Figure 3.10 Number of adults aged under 65 with mental health needs receiving home care at 31 March 2012 per 100k weighted population

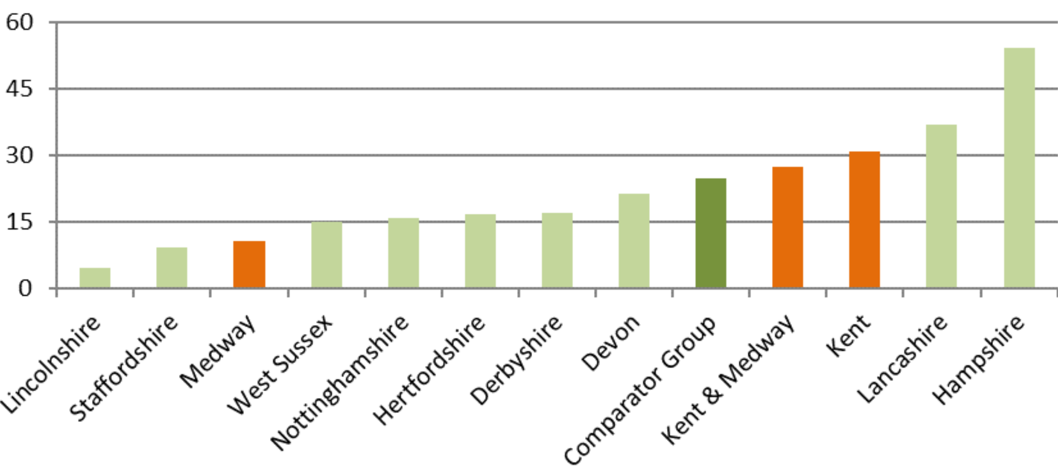


Figure 3.11 Gross total cost for day care or day services for adults aged 18-64 with mental health needs per weighted head

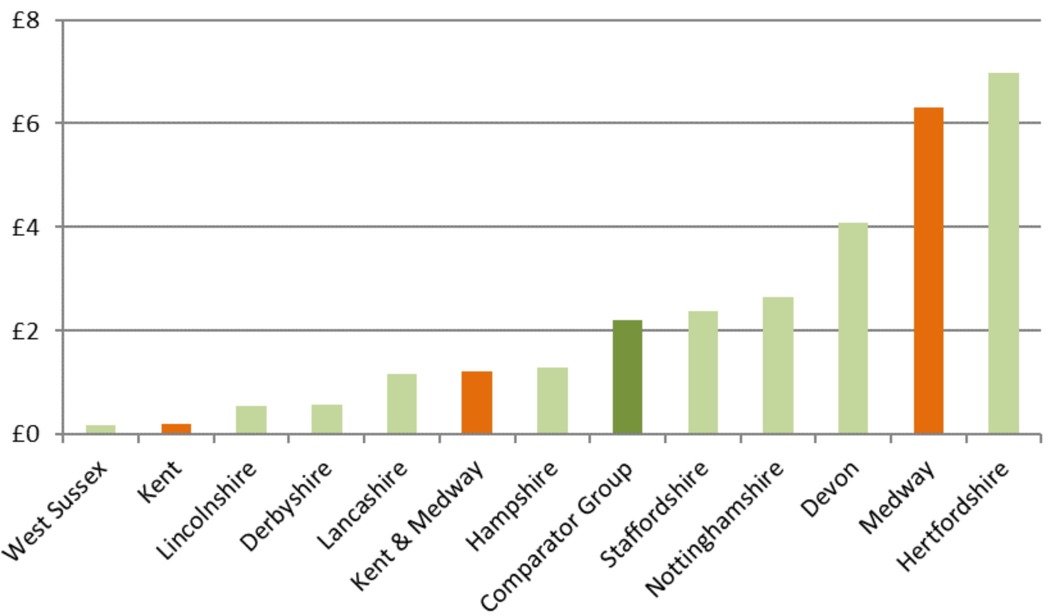
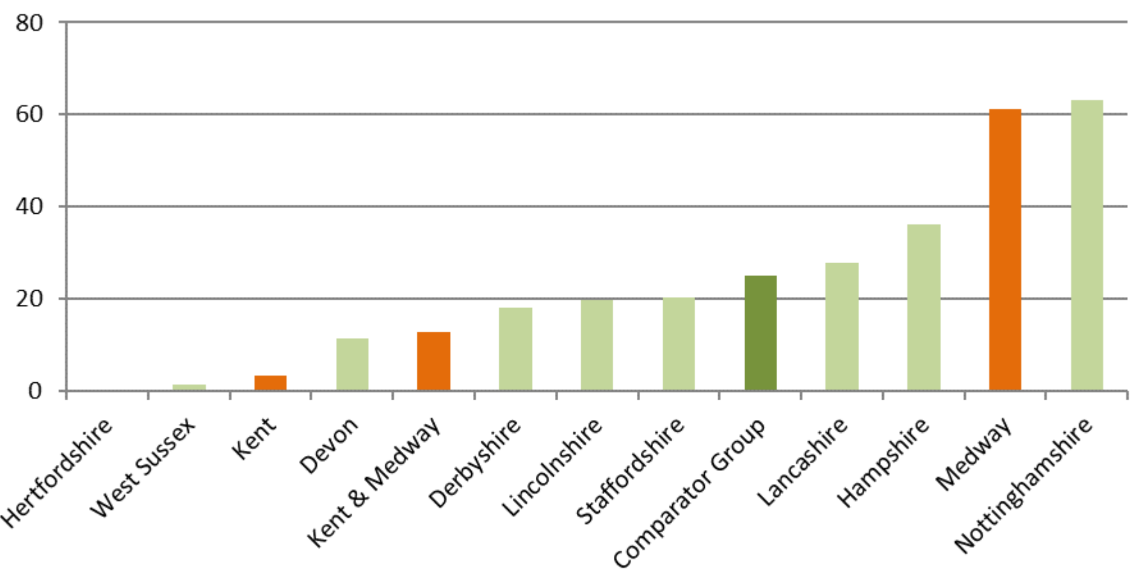


Figure 3.12 Average number of clients of day care or day services for adults aged 18-64 with mental health needs per weighted head



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

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

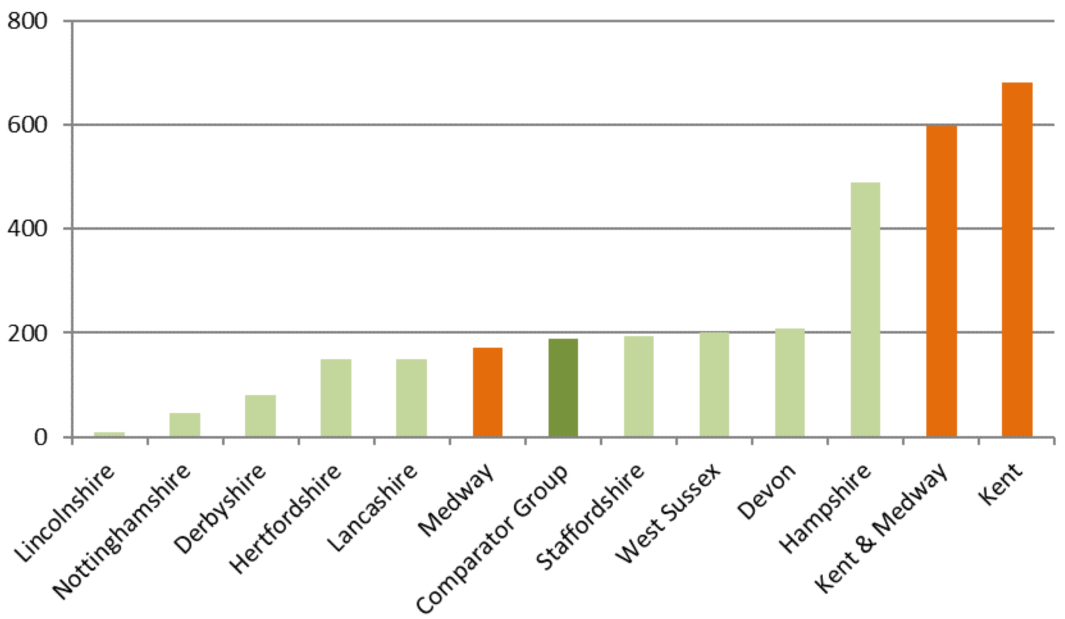
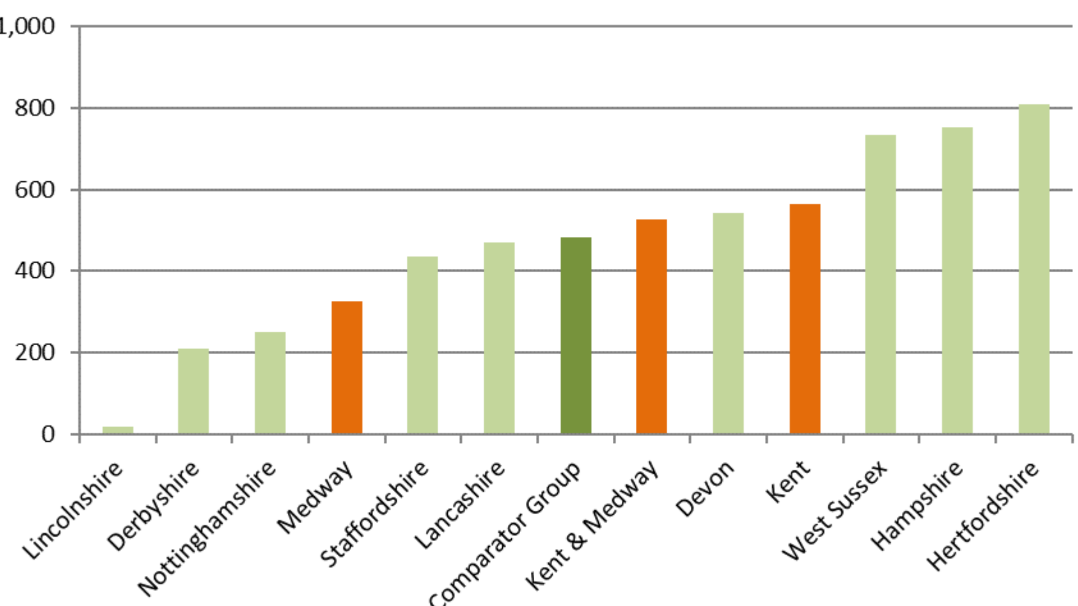


Figure 3.14 Mental health reviews per 100,000 weighted population



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

3.1.3 Geographic analysis

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

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

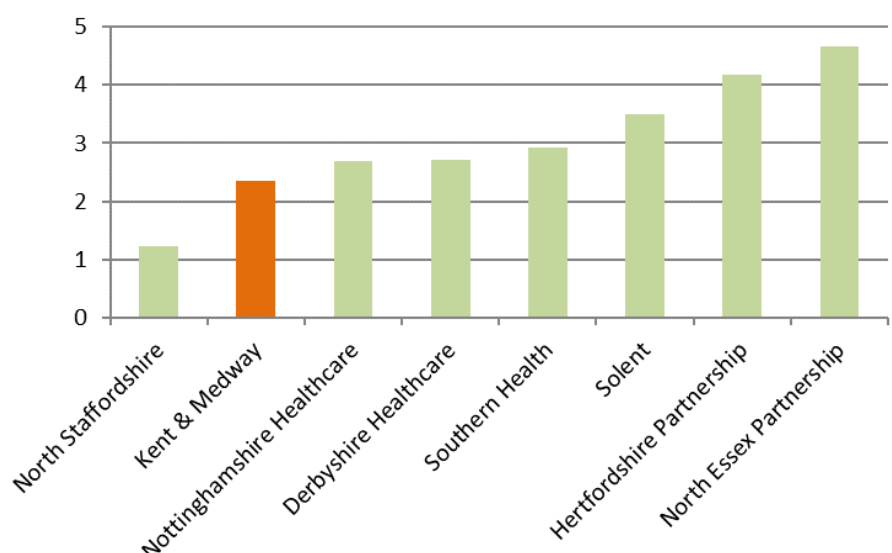
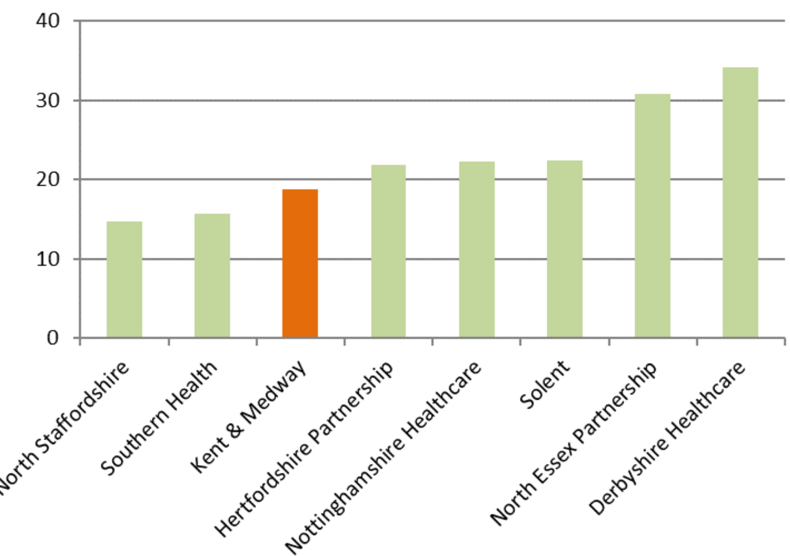


Figure 3.16 Adult acute beds per 100,000 needs weighted population



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

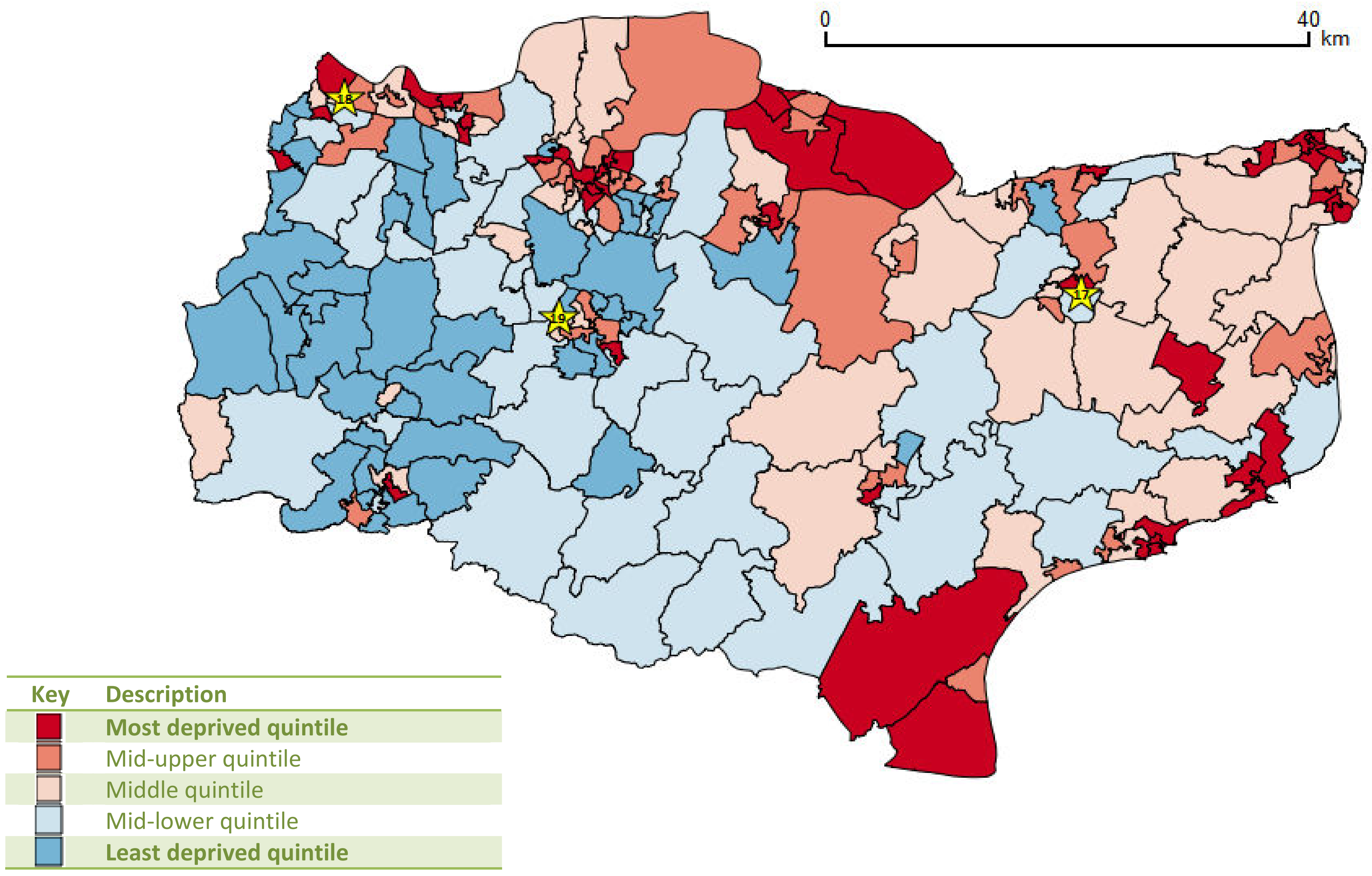
County / Area	Mean distance (miles)
Nottinghamshire	1.91
Hampshire	3.37
North Essex	3.66
Hertfordshire	3.94
Staffordshire	4.87
Derbyshire	5.41
Kent and Medway	**10.64**

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

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

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

Figure 3.17 Kent and Medway – proposed three site model



3.2. Local data analysis

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

3.2.1 Acute inpatient activity

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

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

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

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

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

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

Figure 3.19 Inpatient admissions profile – Q1 2011/12

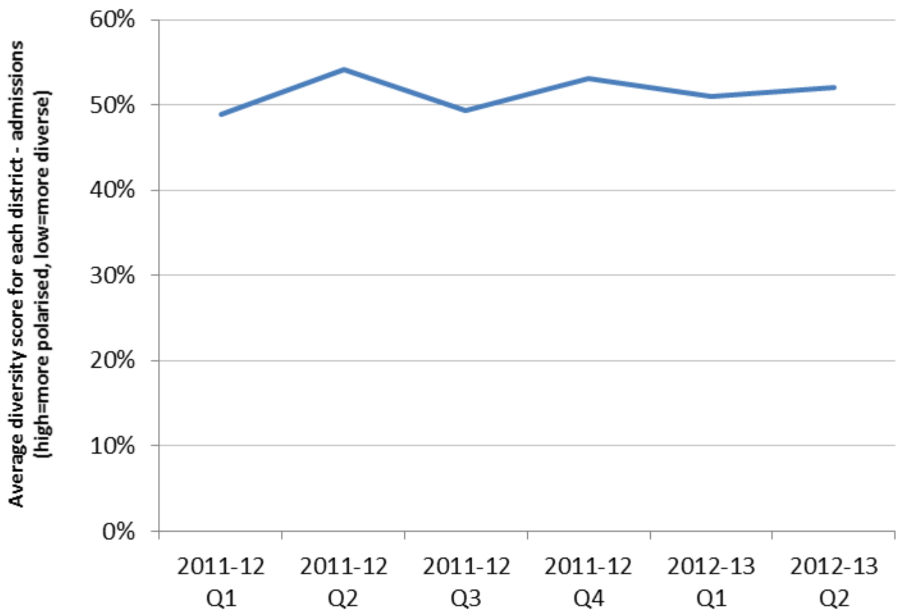
Unit admitted to:	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Medway	Sevenoaks	Shepway	Swale	Thanet	Tonbridge and Malling	Tunbridge Wells
Little Brook	9%	11%	88%	20%	69%	4%	18%	20%	17%	13%	9%	18%	0%
Medway Maritime	9%	4%	1%	2%	4%	8%	72%	10%	10%	65%	11%	5%	17%
Priority House	19%	1%	9%	5%	27%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

Figure 3.20 Inpatient admissions profile – Q1 2012/13

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

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

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



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

Figure 3.22 Inpatient OBDs profile – Q1 2011/12

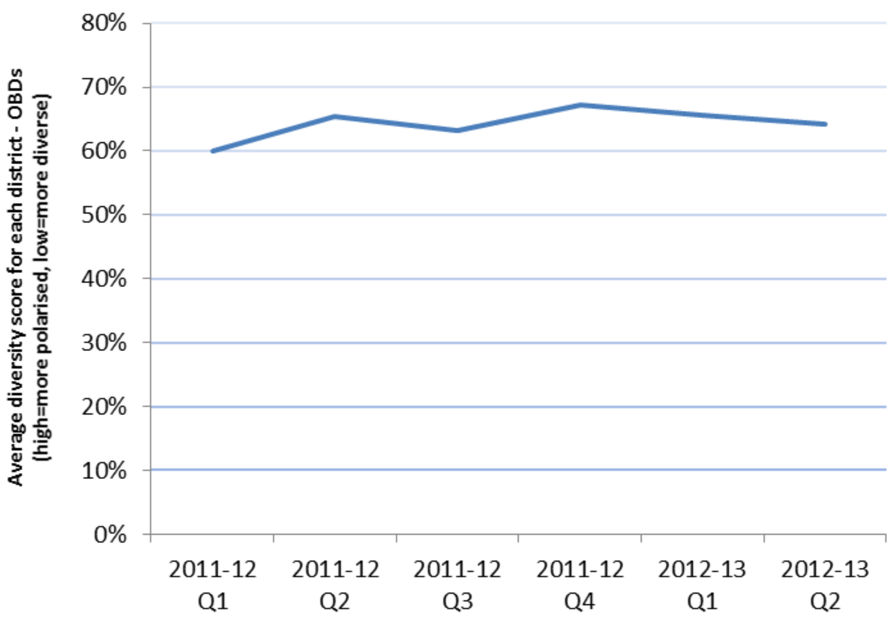
Unit admitted to:	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Medway	Sevenoaks	Shepway	Swale	Thanet	Tonbridge and Malling	Tunbridge Wells
Little Brook	9%	11%	88%	20%	69%	4%	18%	20%	17%	13%	9%	18%	0%
Medway Maritime	9%	4%	1%	2%	4%	8%	72%	10%	10%	65%	11%	5%	17%
Priority House	19%	1%	9%	5%	27%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

Figure 3.23 Inpatient OBDs profile – Q1 2012/13

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

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

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



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

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

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

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

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

3.2.2. Crisis resolution home treatment

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

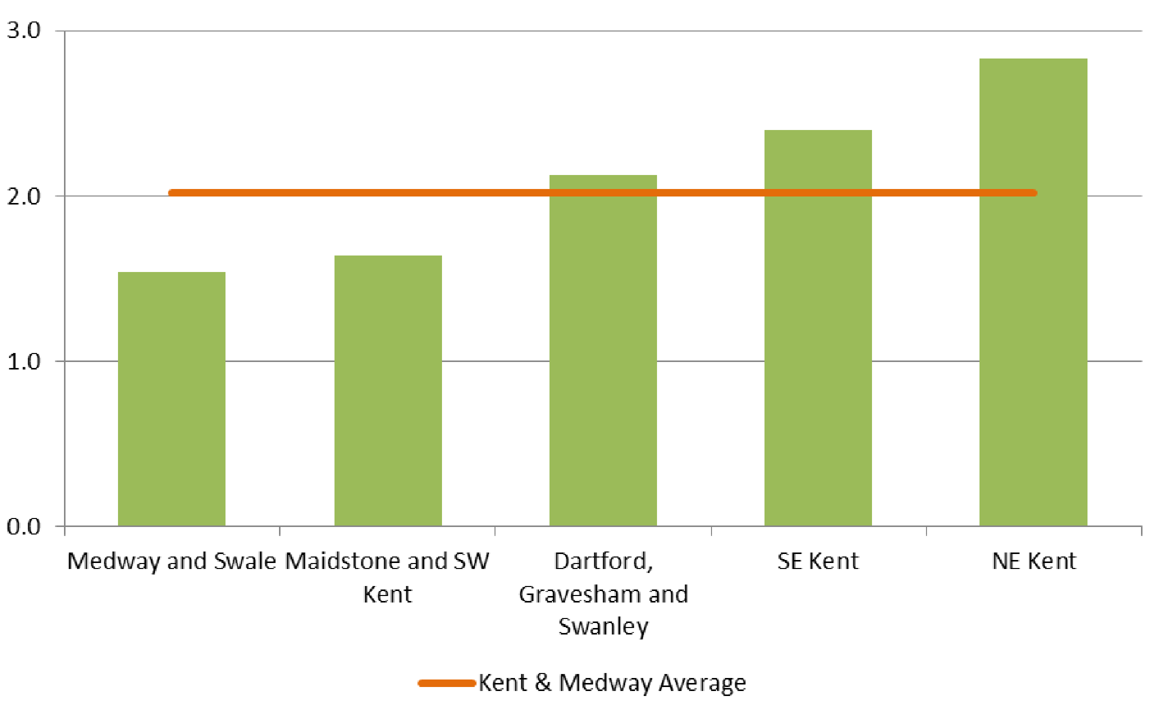
Medway/Swale	25
North East Kent	25 increasing to 30 with new STR recruitment
South East Kent	16 increasing to 21 with new STR recruitment
Dartford, Gravesham and Swanley	16
Maidstone/South West Kent	25

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

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

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

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



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

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

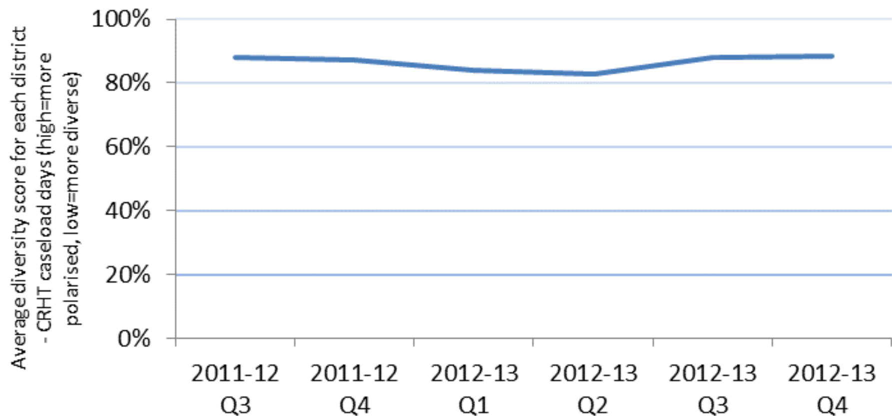
Figure 3.28 CRHT caseload days profile – Q3 2011/12

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

Figure 3.29 CRHT caseload days profile – Q3 2012/13

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

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



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

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

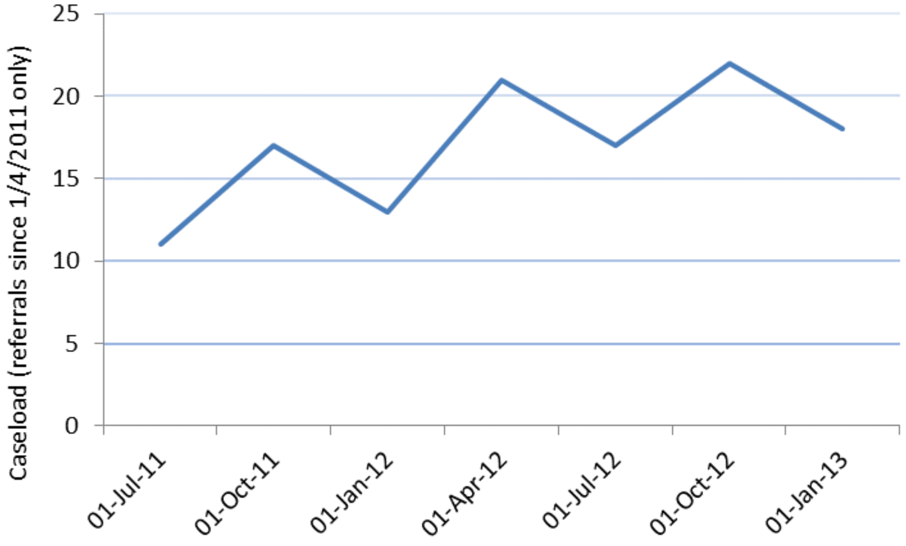


Figure 3.32 CRHT caseload July 2011 to January 2013 – Medway and Swale

Caseload (referrals since 1/4/2011 only)
35
30
25
20
15
10
5
0
01-Jul-11
01-Oct-11
01-Jan-12
01-Apr-12
01-Jul-12
01-Oct-12
01-Jan-13

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

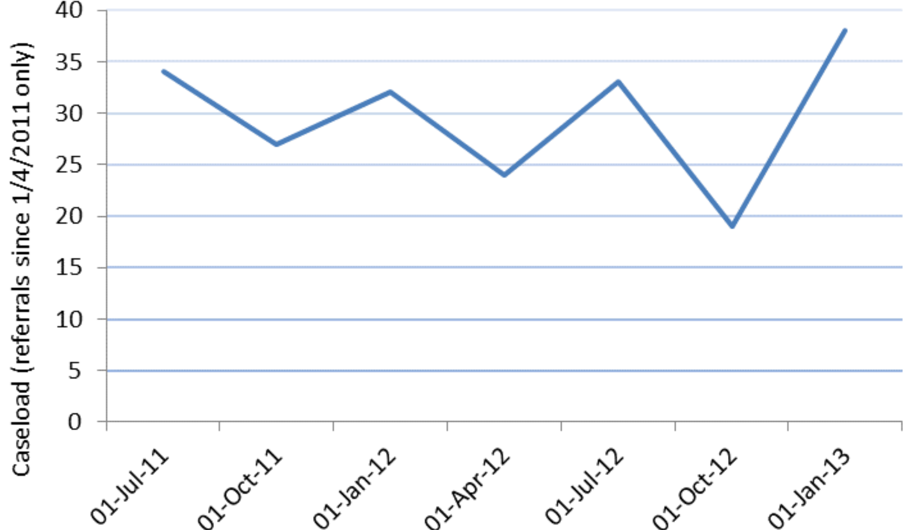


Figure 3.34 CRHT caseload July 2011 to January 2013 – South East Kent

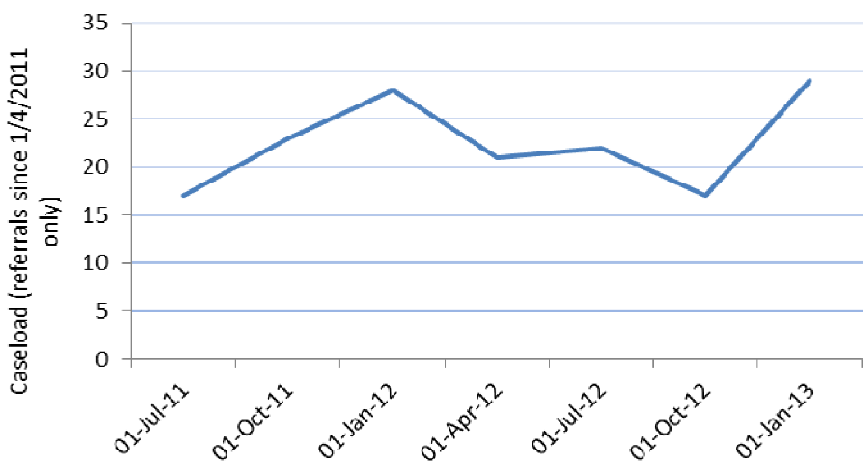
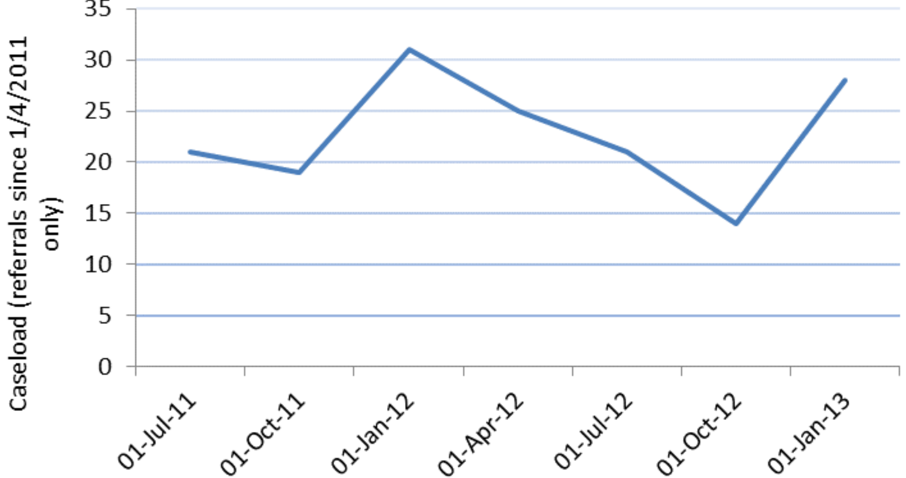


Figure 3.35 CRHT caseload July 2011 to January 2013 – Maidstone and South West Kent



3.3 Perspectives from local visits and interviews

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

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

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

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

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

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

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

The number of sites from which those beds should be provided

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

The location of the sites

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

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

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

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

4. CONCLUSIONS

4.1 Introduction to conclusions

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

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

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

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

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

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

4.2 What does good look like?

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

"The purpose of an adult acute psychiatric inpatient service is to provide a high standard of humane treatment and care in a safe and therapeutic setting for service users in the most acute and vulnerable stage of their illness. It should be for the benefit of those service users whose circumstances or acute care needs are such that they cannot at that time be treated and supported appropriately at home or in an alternative, less restrictive residential setting." (Department of Health, policy implementation guide)

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

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

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

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

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

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

4.3 What does the evidence suggest?

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

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

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

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

Local data analysis
The clear and reliable messages from local data analysis are:

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

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

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

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

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

Site visits

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

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

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

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

4.4 Recommendations

This is not a straightforward decision. We entirely understand the wish to retain services as locally as possible, the importance of good community links between inpatient services and their local community, and concerns about issues of travel and access. We are also conscious of concerns about the various ways in which local debates about this issue have been framed, and regrets that we are starting from the pattern of services as they currently are. There are strong views that past decisions about the NHS estate may have been poor ones, and that current mental health services should not have to be constrained by them. However, solutions which presume that different past decisions had been taken, that we can start from a "blank sheet of paper", or from a different starting point than current reality,

are of only theoretical value, and both our and the JHSOC's task is to consider options which are actually available, either now or in a plausible future.

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

The consolidation option appears to us therefore to offer:

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

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

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

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

In making this recommendation, we are not however convinced that the concept of "centres of excellence" has been sufficiently well articulated locally. The consolidation of services on to a smaller number of sites clearly does offer the opportunity to improve staffing levels, therapies, cover arrangements, research opportunities, specialist service offerings, management of risk, cultural sensitivity and so on – to demonstrate that the characteristics

of a good inpatient service are not just more likely to be met, but will tangibly improve. We gained however insufficient sense of a clear plan to deliver these improvements, or that such a plan was understood and "owned" across current acute care staff; we would encourage both more planning to be done, and better communication of the results of that planning, so that the benefits of this change can be understood as actual, rather than theoretical, and so that their delivery can be implemented and monitored in practice.

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

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

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

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

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

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

and the level of reinvestment which could perhaps create the real momentum for a changed service model which is being sought, and offer reassurance that safe levels of service will continue to be available. A financially neutral plan, in which all of the money saved is reinvested, would not appear to us to represent an excessive spend on acute mental health care.

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

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

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

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

APPENDIX ONE – DOCUMENTS RECEIVED

FOLDER ONE

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

FOLDER TWO

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

27. 20 March 2013. Board Meeting.
28. 20 March 2013. Kent and Medway Cluster Board Minutes.
29. March 2013. Progress Update on Achieving Excellence in Mental Health Crisis Care.
30. 20 March 2013. Email from Rosie Gunstone to Julie Keith re Draft decision from JHOSC for urgent comments. Email returned from Julie Keith to Rosie Gunstone with comments.
31. 28 March 2013. Kent and Medway Trust Board Meeting.
32. March 2013: A critical analysis of the data presented in the KMPT acute service review and redesign 2012. Stephen Allan, University of Kent.
33. 9 April 2013. Email from Angela McNab, Chief Executive, Kent and Medway Trust, to Cllr David Brake re Acute Care Review.
34. 16 April 2013. Email from Cllr David Brake to Angela McNab re Kent and Medway NHS Cluster Board Meeting – Adult Mental Health Inpatient Services Review.

35 19 April 2013. Emails between Rosie Gunstone and Tristan Godfrey.

36. 23 April 2013. Community Care articles website.
37. 1 May 2013. Email from Cllr Wendy Purdy to Angela McNab re Kent and Medway NHS joint overview and scrutiny committee (JHOSC) Adult Mental Health Inpatient Services Review.

38 1 May 2013. Email from Rosie Gunstone to Angela McNab re acute beds mental health redesign.

39. 24 May 2013. Letter from Marie Dodd, Deputy Chief Executive, Kent and Medway NHS to Councillor Wendy Purdy, Democratic Service re demand for acute care and bed pressures.
40. 12 June 2013. Email from Rosie Gunstone, Democratic Services Officer, Medway Council to Tristan Godfrey, Kent, re Independent experts – Medway's view.

ADDITIONAL MATERIALS GATHERED DURING REVIEW

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