

**HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

**Friday, 26th November, 2010**

**10.00 am**

**Council Chamber, Sessions House, County Hall,  
Maidstone**







## AGENDA

### HEALTH OVERVIEW AND SCRUTINY COMMITTEE

**Friday, 26th November, 2010, at 10.00 am**      Ask for:      **Paul Wickenden**  
**Council Chamber, Sessions House, County**      Telephone:      **01622 694486**  
**Hall, Maidstone**

*Tea/Coffee will be available from 9:45 am*

#### **Membership**

Conservative (10):      Mr B R Cope (Vice-Chairman, in the Chair), Mr A D Crowther,  
Mr G Cooke, Mr K A Ferrin, MBE, Mrs J A Rook, Mr C P Smith,  
Mr R Tolputt, Mrs J Whittle and Mr A T Willicombe

Labour (1):      Mrs E Green

Liberal Democrat (1):      Mr D S Daley

District/Borough      Councillor J Cunningham, Councillor C Kirby, Councillor M Lyons  
Representatives (4):      and Councillor Mrs M Peters

LINK Representatives      Mr M J Fittock and Mr R Kendall  
(2)

#### **Webcasting Notice**

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#### **UNRESTRICTED ITEMS**

*(During these items the meeting is likely to be open to the public)*

Item	Timings
1. Introduction/Webcasting	
2. Substitutes	
3. Declarations of Interests by Members in items on the Agenda for this meeting.	

- |  |                  |
|--|------------------|
| 4. Minutes (Pages 1 - 6)   |                  |
| 5. Primary Angioplasty - Update. (Pages 7 - 24)  | 10:00 –<br>10:40 |
| 6. Community Mental Health Services. (Pages 25 - 130)  | 10:40 –<br>12:25 |
| 7. The Future of Community Service Providers - Written Update. (Pages 131 - 142)                         | 12:25 –<br>12:35 |
| 8. Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update. (Pages 143 - 148) | 12:35 –<br>12:45 |
| 9. Committee Topic Discussion. (Pages 149 - 150)   | 12:45 –<br>13:00 |
| 10. Date of next programmed meeting – Friday 7 January 2011 @ 10:00am                                    |                  |

### **EXEMPT ITEMS**

*(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)*

Peter Sass  
 Head of Democratic Services and Local Leadership  
 (01622) 694002

**18 November 2010**

*Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.*

**KENT COUNTY COUNCIL****HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 8 October 2010.

PRESENT: Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr A D Crowther, Mr G Cooke, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mrs J A Rook, Mr R Tolputt, Mrs J Whittle, Mr A T Willicombe, Cllr C Kirby, Cllr M Lyons, Mr R Kendall, Cllr Ms A Blackmore (Substitute for Cllr Mrs M Peters) and Dr M R Eddy (Substitute for Mr M J Fittock)

ALSO PRESENT:

IN ATTENDANCE: Ms D Fitch (Assistant Democratic Services Manager (Policy Overview)) and Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

**UNRESTRICTED ITEMS****3. Introduction/Webcasting**

*(Item 1)*

**4. Minutes**

*(Item 4)*

RESOLVED that the Minutes of the meetings held on 3 September and 20 September 2010 are recorded and that they be signed by the Chairman.

**5. Pain Management Services**

*(Item 5)*

*Dr Jon Norman (Lead Clinician Chronic Pain, Maidstone and Tunbridge Wells NHS Trust), Ashley Scarff (Head of Business and Corporate Planning, Maidstone and Tunbridge Wells NHS Trust), Patricia Davies (Director of Service Improvement, NHS West Kent), Zoe McMahon (Commissioning Pathways Improvement Manager, NHS West Kent), Alison Davis (Assistant Director of Commissioning, NHS Eastern and Coastal Kent), Jo Staddon (Lead Commissioner for Musculoskeletal Services and Adult Therapies, NHS Eastern and Coastal Kent), Val Conway (Clinical Lead-Consultant Nurse Community Chronic Pain Service, NHS Eastern and Coastal Kent), Hilary Birrell (Community Chronic Pain and Orthopaedic Service Manager, NHS Eastern and Coastal Kent), Sheila Pitt (Head of Cancer, Long Term Conditions and Therapies, NHS Eastern and Coastal Kent), Dr Claire Butler (Medical Director, Pilgrims Hospice), Dr Bruce Pollington (Medical Director, Heart of Kent Hospice), and John Ashelford were present for this item.*

(1) Representatives from NHS West Kent presented an overview of the situation for patients in their health economy and explained that large number of patients did require pain management services and these did need to be developed locally.

Specialist services were accessed at Guy's Hospital and elsewhere, but there were concerns that now a service based in Medway had been withdrawn, this would be too far for some patients to travel. Community Hospitals were being utilised, and they were looking at developing a more specialised service at Maidstone Hospital.

(2) An overview from representatives of NHS Eastern and Coastal Kent followed. A review had been carried out in 2005 as it was recognised that pain management services were not delivering and this was followed by a redesign across the eastern half of the county. The system in place involved those with complex pain being referred to the acute sector for interventions and to community services for non-complex interventions.

(3) One Member observed that services in the east of the county appeared to be better than in the west and specifically asked about the pain clinic which had been withdrawn from Maidstone Hospital five years ago. Dr Norman was able to provide the broader context as he had moved to Maidstone and Tunbridge Wells NHS Trust (MTW) after the closure of this service. The previous service had been a single-handed service and was unsustainable, but more staff were hired and the service rebuilt. The 18 week waiting time target was now being reached and in January 2009 the MTW board had agreed to set up a hub and spoke model and Sevenoaks had just opened as the first spoke. A clinic at Maidstone Hospital would not be possible until July 2011 following the move of some services to the new Pembury Hospital to make facilities available at Maidstone. There was no guarantee of funding and there was a possibility of a different provider appearing. Separately, a cancer pain service had been established at Maidstone in 2005 and this was performing well.

(4) A number of Members had personal experience of pain and pain services and this led to a discussion around the patient experience. The view was expressed that the use of painkillers was not always advisable as it masked the pain and that training the patient to manage the pain was the better way. Dr Norman explained that it was important to treat the patient as an individual and that the treatment, be it drugs or rehabilitation, had to suit the kind of patient. In Eastern and Coastal Kent it was explained that self-management was the model. Part of this was to hold Pain Roadshows to reach out to people who had yet to access pain services and overall an unmet need for the service had been found when the redesigned service was set up and there were now 300 referrals a month to the service.

(5) The point was also made by clinical representatives present that education of medical professionals was also required and that clinicians often felt they needed to be seen to do something, such as prescribe drugs, when doing nothing was sometimes the better option.

(6) In West Kent the development of GP services was being looked at and a pilot had been set up by the Invicta cluster concerned with back pain. The skill mix for services in East Kent was different with less focus on consultants and more on nurses. There were referrals between the two parts of the county.

(7) Patients requiring pain services were a very diverse group and there was a need for specialist services where there was enough need for clinicians to gain the appropriate experience. However, with Payment by Results, services were paid for piecemeal and the Market Forces Factor meant that each treatment cost more in London so there was a financial incentive to repatriate services, although patient

choice has and would continue to play a part in patients going outside of Kent. The pain involved in travelling was given as another reason for bringing services closer to home. The repatriation of pain pump work from Basildon to Kent was provided as an example. The establishment of a clinic in Sevenoaks was partly to enable patients who had previously accessed services at Bromley to access them locally. Specialist spinal services were available at Guy's and other services were available at University College London, the Royal National Orthopaedic Hospital and King's. Concerns were raised about communication following discharge from King's.

(8) Representatives of the Hospice sector were present and provided details of the large overlap between their services and regular pain management services. Hospices had built up a good level of expertise in this area over the years, primarily in cancer pain though the number of conditions that the hospices managed was expanding. The work of Dr Norman and the cancer pain services at MTW was highly praised by the clinical directors of the Hospices represented. The amount of funding that hospices receive from Primary Care Trusts varied, with the Pilgrims Hospice receiving 30% from NHS Eastern and Coastal Kent. The hospice at Home programme was being rolled out in East Kent and would cover the whole area from January 2011.

(9) Hospices also played a role in training registrars and sharing knowledge with GPs was also seen as key with the money that could be saved through utilising pain management services rather than drugs given as an example. There was potential for closer integration between the hospices and other sectors dealing with pain management.

(10) The Chairman thanked all those who had participated in a very informative debate.

## **6. South East Coast Ambulance Service - Current Developments**

*(Item 6)*

*Geraint Davies (Director of Business Development, South East Coast Ambulance Service NHS Trust), Geoff Catling (Director of Technical Services and Logistics, South East Coast Ambulance Service NHS Trust), and Darren Reynolds (Head of Business Development South East Coast Ambulance Service NHS Trust) were present for this item.*

(1) Prior to the meeting, Members of the Committee had had the opportunity to visit the Thanet Make Ready Depot and the Coxheath Emergency Dispatch Centre. All Members who were able to attend found the visits highly informative and the Chairman thanked the South East Coast Ambulance Service (SECAmb) on their behalf for arranging these valuable opportunities.

(2) The offer was made to provide further opportunities for Members to spend time at Coxheath at a future date.

(3) Although some reservations had been expressed at the previous meeting on this subject, Members expressed the view that the logic behind the move to Make Ready Depots was inescapable and that it was a better use of resources and staff if paramedics were not expected to clean and stock their ambulances. Community response posts to enable ambulances to be located where they are most needed are

usually easy to find, though one was still being sought on the Isle of Sheppey. Locations for Make Ready Depots were not as easy to locate.

(4) The depots were appropriate for the way the modern ambulance service had changed over the years to where it now offered a mobile health service and often avoided the need for taking patients to an Accident and Emergency Department.

(5) Make Ready Depots also allowed for an improvement in infection control measures, although rates had never been too bad in the service, as ambulances would be able to be deep cleaned every six weeks. In between calls, universal precautions such as hand washing and wiping down the ambulance were used unless they were notified of a reportable disease that required further measures.

(6) The nature of paramedic training was also developing with paramedic practitioners able to deal with a wider range of situations at the scene and critical care paramedics who were able to stabilise patients for transfer to a specialist centre, such as the primary angioplasty service at William Harvey Hospital. In coming years there will also be an increasing range of technology available for use on ambulances such as portable x-ray machines, but improvements need to be made such as in this instance becoming smaller and chargeable.

(7) The Emergency Dispatch Centre in Coxheath had a new Computer Aided Dispatch System installed earlier this year. Sussex already had the same system and it had been installed in Surrey three days prior to the meeting. This meant that the whole region was covered by the same system and the different dispatch centres could communicate efficiently to each other. The system meant that 80% of the time, it could be predicted where ambulances needed to be deployed.

(8) The gaps and inefficiencies in the organisation were often in rural areas, and it was here that Community First Responders had a key role to play. These trained lay responders were trained to use defibrillators. In the case of a Category A incident such as cardiac arrest, for each minute that passed the chance of recovery decreased by 11%, and if treatment is received within 4 minutes, there is an 80% chance the heart attack can be reversed so the Community First Responders could often buy time and save lives.

(9) SECamb explained that they felt that the next stage in streamlining the service was through a Single Point of Access. It has been recognised that accessing the NHS for non-emergency services can be seen as chaotic with a range of different avenues such as NHS Direct, Minor Injuries Units, GP Out of Hours services. It is estimated that 40% of attendances at Accident and Emergency Departments are unnecessary. However, there is currently no live directory of what services are available where and when and, as importantly, what services were not available as an alternative to Accident and Emergency. This is being worked on and when it is available, it will enable people to be directed to the right place at the right time.

(10) A number of Members expressed reservations about the wider issue of bringing in a single non-emergency, 111, number to complement 999 on the grounds that it would confuse members of the public and that if the same system and same call centre was going to receive and triage all the calls, it was felt that just one number would make access even easier.

(11) Representatives from SECamb replied by saying that the issue of phone numbers was important but shouldn't distract from the broader benefits. The North East Ambulance Service was already operating a Single Point of Access. More than 2 million calls had been through the system and the initial response from the public had been positive. The system in use there mean the ambulance service could book a caller an appointment with a GP out of hours service. SECamb are dealing with a 5% compound increase in activity each year and are looking to the Single Point of Access to help them manage this at a time of increasing financial pressures. Geraint Davies, Director of Business Development for SECamb, offered to bring data on the performance of the system in other areas back to the HOSC for a fuller discussion on the pros and cons of the concept.

(12) Another area that was being developed within SECamb was that of Passenger Transport Services. There was a sense that this was often misunderstood by the public and part of the reason for this was that it did differ across the South East Coast region. SECamb provided the service in Sussex, private providers covered Surrey and in Kent in differed by Acute Trust. SECamb were hoping to be in a position where the services could be integrated.

(13) Several Members raised points about the interaction of the Ambulance Service with Acute Trusts. Representatives from SECamb explained that the target was for a thirty minute turnaround at hospitals, fifteen minutes for the handover and fifteen minutes to prepare the vehicle for further use. This could vary according to the nature of the incident. Concerning a specific incident involving an older person being left outside their home at night with no keys following discharge from a hospital and conveyance by an ambulance mentioned by a Member of the Committee, the Trust explained that this should not have happened and offered to speak to the Member about this outside the meeting.

(14) The Ambulance Trust explained that they had a zero tolerance approach to attacks on staff, which were often carried out by onlookers and members of the patient's family. If a prosecution was successful this would enable someone to be flagged on the system so an appropriate response could be made.

## **7. Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update**

*(Item 7)*

(1) Members thanked the Chairman for the letter which had been sent to the Secretary of State for Health on behalf of the Committee and which was included in the Agenda pack.

(2) However, Members were not content with the refusal of the South East Coast Strategic Health Authority to promise to send a copy of their report to the Secretary of State for Health on the grounds that it would be for the Secretary of State to decide who should see the report.

(3) The Committee requested that the Chairman write to the Strategic Health Authority and request once more a copy of the report.

## **8. Forward Work Programme**

*(Item 8)*

Members agreed the Forward Work Programme.

## **9. Committee Topic Discussion**

*(Item 9)*

(1) On the issue of Pain Management Services, several Members felt that the issue of what happens after patients from Kent had been discharged from tertiary centres in London in terms of communicating with parts of the local NHS. Another Member requested the opportunity to visit the chronic pain services in East Kent and Officers undertook to explore this possibility.

(2) Following the discussion with SECAMB, the place of Patient Transport Services in the future with GP Commissioning was raised as one area of note to investigate.

(3) This led to a range of concerns being raised about service provision in the medium term with the demise of Primary Care Trusts (PCTs) and that there was a need for a mapping of the services being provided as PCTs were abolished. One Member felt that the Cabinet Member for Public Health would be able to provide a useful overview of the changes that are occurring.

(4) More broadly, the Chairman made the observation that the Committee had a range of statutory powers and would continue to do so for a number of years. These powers came with commensurate responsibilities and the Committee was well positioned to help the transition process and maintain an oversight of service standards in the NHS.

## **10. Date of next programmed meeting – Friday 26 November 2010 @ 10:00am**

*(Item 10)*

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 26 November 2010

Subject: Primary Angioplasty Update.

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## **1. Background**

- (1) The Health Overview and Scrutiny Committee heard about the plans to develop a 24/7 primary angioplasty service in Kent at its meeting of 5 February 2010. The decision was that the Kent and Medway service should be provided at William Harvey Hospital in Ashford.
- (2) The purpose of this item is for the Committee to gain an understanding of how this project has been progressing.

## **2. Recommendations**

- (a) The Committee is asked to assess whether the outcomes in (2) above have been achieved or if further information on this topic is required by the Committee.

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By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee – 26 November 2010

Subject: Primary Angioplasty – Update.

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1. Background

- (a) As part of the Next Stage Review, Lord Darzi asked the Strategic Health Authorities (SHAs) to produce a regional vision.<sup>1</sup> *Health People Excellent Care, A Vision for the South East Coast* was the report from NHS South East Coast. This was published on 2 June 2008, and made the following pledge:

“By 2010, strokes, heart attacks and major injuries will always be treated in specialist centres.”<sup>2</sup>

2. Cardiac Care

- (a) Coronary Heart Disease (CHD) is the biggest cause of death in the country, killing more than 70,000 people in England each year, with 110,000 having a heart attack.<sup>3</sup>
- (b) The National Service Framework (NSF) for Coronary Heart Disease (CHD) was published by the Department of Health in March 2000<sup>4</sup> and set out a strategy to modernise CHD services over a ten year period. Chapter Three dealt specifically with “Heart attacks and other acute coronary syndromes.” At the time this document was produced, around 300,000 people suffered a heart attack (or acute myocardial infarction) each year in the United Kingdom, of whom 140,000 died. Between a third and two-thirds of these deaths occurred outside a hospital, often within the first few minutes of the onset of symptoms.
- (c) The NSF set out a number of standards to ensure access to the most appropriate care as soon as possible, including use of a defibrillator by an appropriately trained person within 8 minutes, and thrombolysis within 60 minutes of calling for professional help (‘call-to-needle time’;

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<sup>1</sup> London had a slightly different process to the other nine SHAs.

<sup>2</sup> NHS South East Coast, *Healthier People, Excellent Care. A Vision for the South East Coast*, June 2008, p.6, <http://www.southeastcoast.nhs.uk/Downloads/HPEC/Full%20report%20-%20Healthier%20people%20excellent%20care.pdf>

<sup>3</sup> Department of Health website, *Coronary Heart Disease*, <http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Healthcare/Longtermconditions/Vascular/Coronaryheartdisease/index.htm>

<sup>4</sup> Department of Health, National Service Framework for Coronary Heart Disease, March 2000, [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4094275](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094275)

see next page for further key terms)<sup>5</sup>. Thrombolysis is a clot dissolving drug, and at the time the NSF was produced, only a third of A+E departments were able to offer it<sup>6</sup>.

- (d) The treatment of heart attack patients was monitored and in the Seventh Public Report of the Myocardial Ischaemia National Audit Project (MINAP), published in June 2008, it was reported that 71% of patients were receiving thrombolytic treatment (the national target was 68%)<sup>7</sup>. The report also reported on the increasing use of pre-hospital thrombolytics and primary angioplasty (also referred to as primary percutaneous coronary intervention or PPCI).
- (e) “Coronary angioplasty is a technique for unblocking arteries carrying blood to the heart muscle. A small balloon at the tip of a catheter tube is inserted via an artery in the groin or arm and guided to the blocked heart artery. It is then inflated and removed, leaving in place a 'stent' - a rigid support which squashes the fatty deposit blocking the artery, allowing blood to flow more easily. Primary angioplasty uses this technique as the main or first treatment for patients suffering a heart attack.”<sup>8</sup>
- (f) The Department of Health, in collaboration with the British Cardiovascular Society and British Cardiovascular Intervention Society set up the National Infarct Angioplasty Project (NIAP) to examine the feasibility of setting up a primary angioplasty service across the country.
- (g) This began work in 2005 and the final report was published by the Department of Health in October 2008 as *Treatment of Heart Attack Overall Guidance*. The following are the overall conclusions of this report:
- “National roll-out of PPCI is feasible over the next three years but may be logistically challenging in some parts of the country.
  - Times to treatment within 120 minutes are achievable but a PPCI service needs to achieve these reliably regardless of the time of day or day of the week.
  - Hybrid services offering daytime PPCI and out-of-hours thrombolysis are not satisfactory.

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<sup>5</sup> Ibid., Chapter Three, p.2.

<sup>6</sup> Ibid., Chapter Three, p.4.

<sup>7</sup> MINAP Steering Group, *MINAP Seventh Public Annual Report*, June 2008, p.ix, <http://www.rcplondon.ac.uk/clinical-standards/organisation/partnership/Documents/Minap-2008.pdf>

<sup>8</sup> Department of Health website, *Thrombolysis and primary angioplasty*, <http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Healthcare/Longtermconditions/Vascular/Coronaryheartdisease/Thrombolysisandprimaryangioplasty/index.htm>

- A PPCI service needs to be 24/7 and carried out in centres with a sufficiently high overall volume of cases to maintain and develop skills.
  - If an acceptable PPCI service cannot be established, pre-hospital thrombolysis is preferable to in-hospital thrombolysis. Forthcoming European guidelines are likely to recommend subsequent referral for coronary angiography for anyone having thrombolysis.”<sup>9</sup>
- (h) This report also provides the following definitions of some key terms used:

“Call-to-balloon (CTB) time: the time from the patient calling for medical help to the time when an angioplasty balloon is first inflated, or coronary reperfusion is confirmed on angiography.”

“Call-to-needle (CTN) time: the time from the patient calling for medical help to the time when intravenous thrombolysis is given.”

“Door-to-balloon (DTB) time: the time from the patient arriving in hospital (whether this be a PPCI centre or a non-PPCI centre) to the time when an angioplasty balloon is first inflated or coronary reperfusion is confirmed on angiography.”

“Door-to-needle (DTN) time: the time from the patient arriving in hospital to the time when intravenous thrombolysis is given.”

“Reperfusion: the restoration of blood flow to an organ or tissue, for example after a heart attack. An immediate goal is quickly to open a blocked artery and reperfuse the affected heart muscle. Early reperfusion minimises the extent of heart muscle damage and preserves the pumping function of the heart.”<sup>10</sup>

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<sup>9</sup> Department of Health, *Treatment of Heart Attack Overall Guidance Final Report of the NIAP*, October 2008, p.5, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_089454.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_089454.pdf)

<sup>10</sup> *Ibid.*, pp.31-33.

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## **Kent Cardiovascular Network**

### **Update on Primary Angioplasty Across Kent**

**To**

### **Kent Health Overview And Scrutiny Committee Meeting**

**26 November 2010**

#### **Attendees:**

Geoffrey Wheat, Director Kent Cardiovascular Network  
Dr. Bet Mishra, Consultant Cardiologist and Clinical Lead for the Kent Cardiovascular  
Network  
Clare Boggia, Cardiology Matron, East Kent Hospitals University NHS Foundation  
Trust  
Corrine Stewart, Senior Service Improvement Project Manager, Kent Cardiovascular  
Network (Presenting)

## Introduction

Approximately 275,000 people in the United Kingdom suffer a heart attack each year of which around 2,500 occur in Kent. A person has a heart attack (or acute myocardial infarction) when the flow of blood through the arteries, which supply blood to their heart muscle, is reduced to such an extent that part of the heart muscle dies. Between a third and two thirds of heart attack deaths take place outside hospital, many within the first few minutes of the onset of symptoms. Helping people avoid a heart attack altogether is the prime aim. But for those who do have a heart attack, prompt access to the right treatment can mean the difference between living and dying.

The Department of Health and the British Cardiovascular Society<sup>1</sup> undertook a 2 year study looking into the feasibility of providing a 24/7 Primary Angioplasty service as a first line of treatment for patients suffering a heart attack across England. It published its final report in October 2008, and concluded that primary angioplasty should be implemented.

Since 2007, the Kent Cardiovascular Network has worked with the three Primary Care Trusts, four Acute Trusts and the South East Coast Ambulance service, across Kent, to work up plans for the implementation of a 24/7 primary angioplasty service.

The Network presented to the Kent Health Overview and Scrutiny Committee on 5 February 2010, and highlighted the reasons why we were implementing this service and outlined all of the work that had been undertaken to get to the decision that a one centre site at the William Harvey Hospital was the best option. The Kent HOSC gave its overwhelming support to the project.

Since then, work has continued to ensure that the pathways that have been developed are robust and embedded into each of the organisations. It has also ensured that the additional trained staff required to run the service have been put in place. The new telemetry system which has been procured by the ambulance trust has been installed on all ambulances. This system allows the ambulance crews to send the patient's ECG to the Coronary Care Unit (CCU) at the William Harvey Hospital for immediate interpretation. All ambulance crews have been issued with mobile phones, and they now have direct access to nurses within the CCU to discuss the patient, prior to and during transfer.

This has been a significant and challenging piece of work to ensure that the whole population of Kent and Medway has equitable access to a timely, high quality service, reliant on several organisations working collaboratively together.

### **On 12 April 2010, the service was successfully implemented.**

We have 100% coverage of primary angioplasty across Kent and Medway. Whilst the service has been working well, there are several areas that we are working on to improve:

## Contingency plans and resilience lab

We have had to invoke our contingency plan on several occasions, which has meant that patients were diverted to Medway Maritime Hospital for treatment. As a consequence of this, East Kent Hospitals University Foundation Trust is in the process of considering a 2<sup>nd</sup> resilience laboratory to reduce the need to invoke the contingency plan and to reduce the impact on patients.

A business case has been submitted through the Trust's internal processes and is supported by the Chief Executive of the Trust. If the plans go ahead, it is anticipated that the 2<sup>nd</sup> laboratory should be up and running towards the end of 2011

## Pathway work

The Department of Health issued some performance data in relation to primary angioplasty. It stated that 75% of patients should receive treatment within 150 minutes from the time they call for help to the time the first balloon is inflated in the artery [call to balloon]. Quarter 1 figures shows compliance against the target of 58%, and for Quarter 2 it improved to 69%

We are continually analysing the data that is collected for this service and in particular for those patients that have breached the target. In some instances, the breach is entirely appropriate due to the patient being too poorly or unstable, or for those who have had a full cardiac arrest, but we recognise that there are some instances where elements of the pathway could have been delivered more promptly.

As a consequence of this we are working with the East Kent Hospitals University NHS Foundation Trust and South Coast Ambulance Service to try look at each of the individual breaches and undertake a root cause analysis. When this has been completed we will be looking for key themes where improvements can be made and develop action plans to be implemented.

We have already identified two areas where improvements need to be made:

1. Self presenters who need to be transferred to the WHH
2. Prisoners

For those patients who chose to attend their local A&E rather than 999 we need to make the process more refined. The main delays are occurring when the ECG needs to be sent to the WHH. This needs to be faxed, and then scanned at the WHH for onward sending to the consultant for a decision. In light of this, we are now exploring the option of installing the telemetry equipment into the A&E departments.

In terms of the prisons, due to the security measures that are in place, it is sometimes taking considerable time to get the patient diagnosed and out of the hospital. Again, we are exploring whether telemetry can be installed and arrangements to transfer prisons out of the prison.

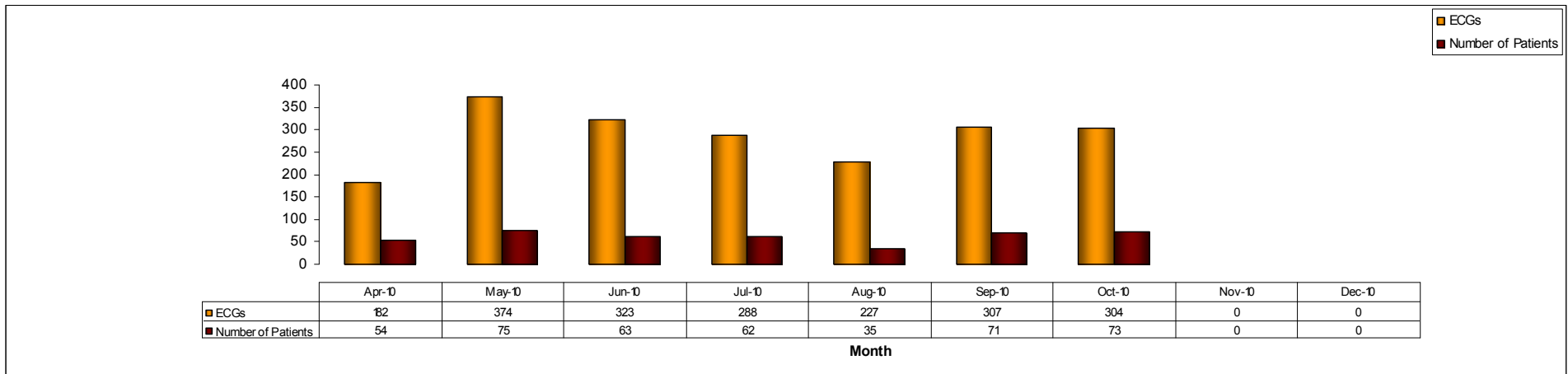
It is clear that if we can't reduce some of this time, then we will need to review how the service is delivered in the future.

## **Performance data**

Below is a set of data showing a high level snapshot of how the service has been performing over the last 6 months. Please note that the April and October data is not showing a full month's data.

Number of ECGs & Patients

**Graph 1**



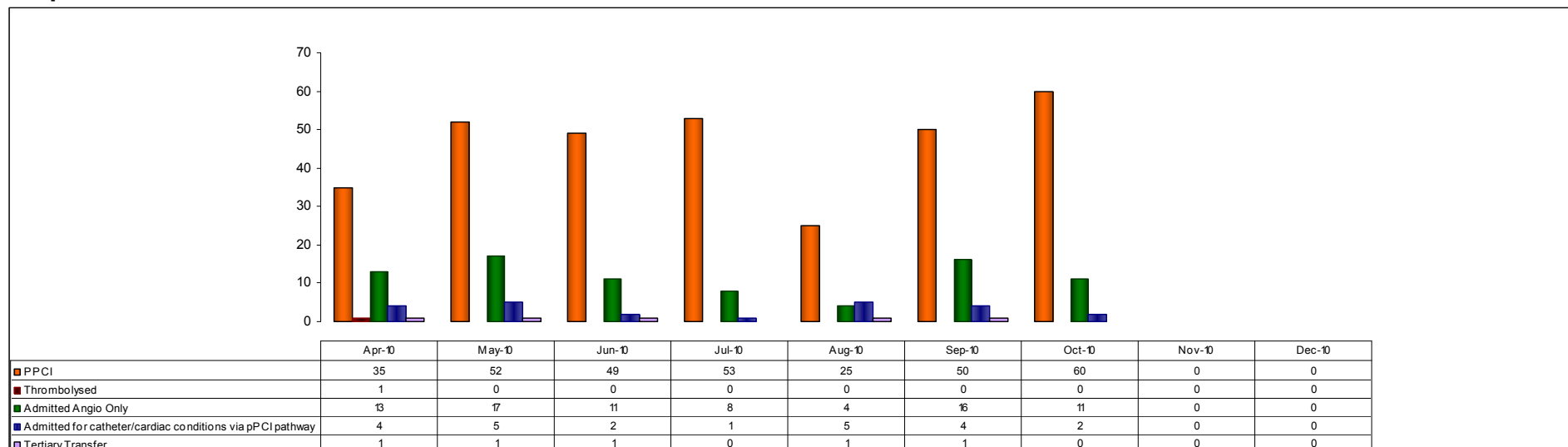
From 12 April 2010 to the end of October a total of 2,005 ECGs have been received by the William Harvey Hospital for interpretation and a decision to transfer, which is an average of 69 ECGs each week.

Of these approximately 15 patients a week are being transferred to the William Harvey Hospital.

The Network is working with the ambulance trust to try and improve the ratio of ECGs sent to patients transferred. It is envisaged that further communications and education will be provided to help the ambulance crews to recognise when an ECG shows no signs of ST-elevation at all.

pPCI, Thrombolysed, Angio and Other patients

Graph 2



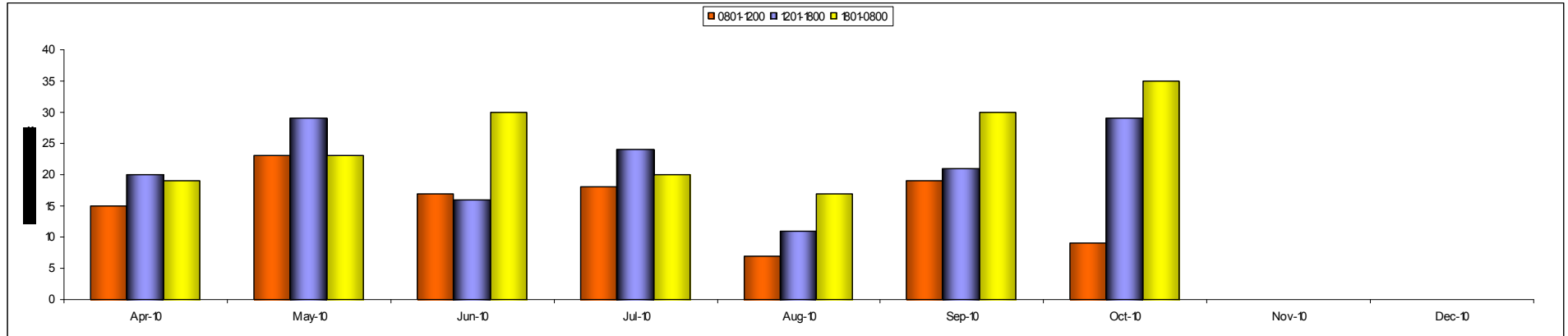
Of the patients who are being transferred to the William Harvey Hospital, approximately 75% have received angioplasty and 25% had an angiogram, but did not proceed to angioplasty.

1 patient has needed to be thrombolysed for clinical reasons and 5 patients have been transferred to a tertiary centre for surgery.

As the service is new, the consultants have taken a cautious view on transferring patients to the WHH for treatment. The figures show that about a quarter of patients do not have the full treatment and therefore, could have been treated at their local hospital. Now that the service is better established and the communication and relationships between the ambulance trust and the WHH is working well, it is hoped that we should start seeing a reduction in the number of patients who only have an angiogram.

Number of patients per week split by time period

Graph 3



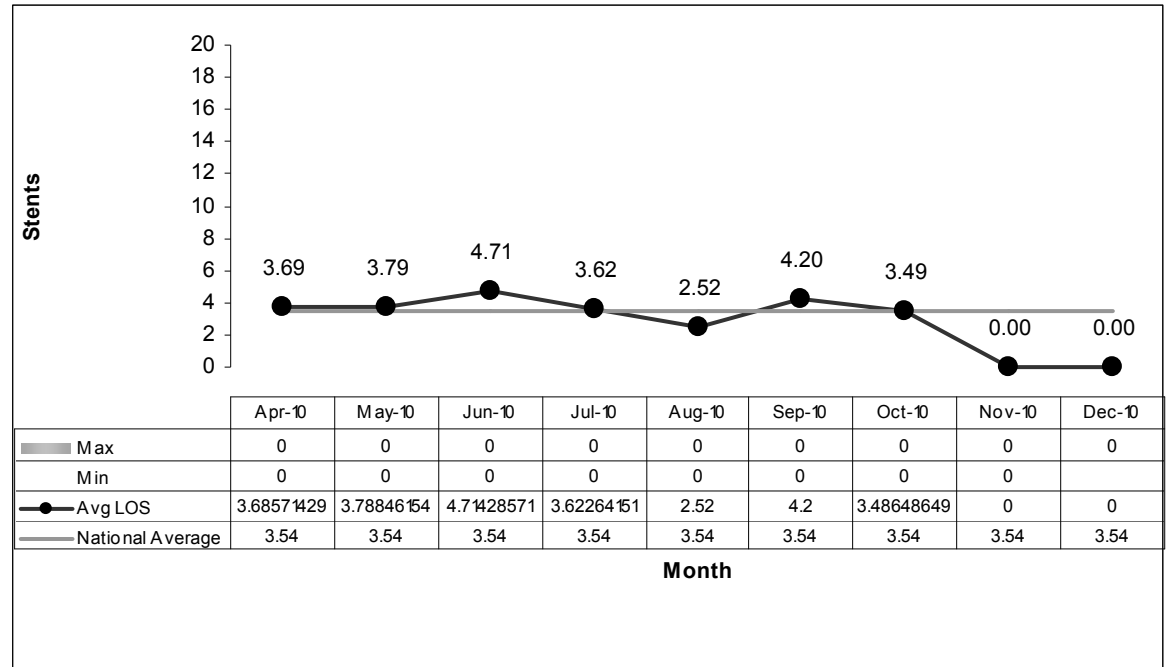
When trying to plan the capacity levels, it was expected that approximately 45% of patients would present during normal working hours, Monday to Friday 9 a.m. to 5 p.m. and 55% of patients would present outside of this time. The graph above has been broken into 3 time brackets:

- 08:01 to 12:00
- 12:01 to 18:00
- 18:01 to 08:00

When looking at the average, the data shows that in real terms, there are approximately 60% of patients presenting during working hours, and 40% out of hours. This hasn't currently had any major impact on the planned elective work that is being undertaken by the lab, due to the fact that they have already extended their working day to take into account that there will be primary angioplasty patients coming in throughout the day, therefore elective patients are not being cancelled as a result of this service.

**Average LoS for pPCI Patients (Days)**

**Graph 4**

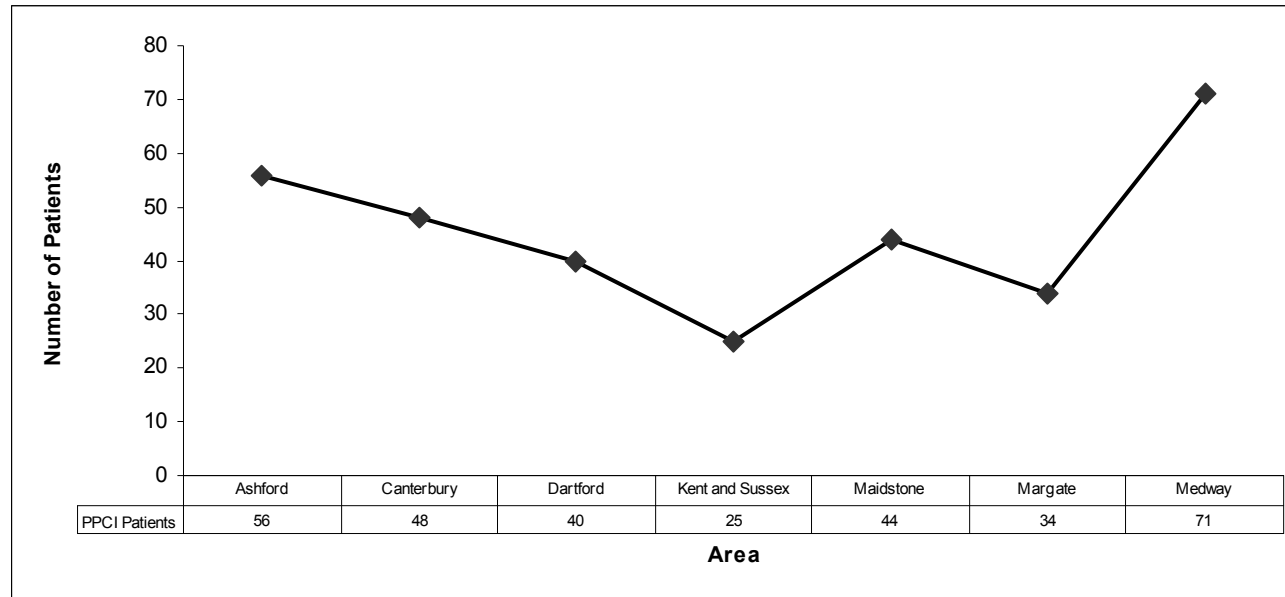


In the original planning, it was estimated that the average length of stay for patients would be 3.54 days. As can be seen above, there has been some variance for patients in terms of their average lengths of stay, which ranges between 2.5 and 4.7 days.

The Trust has been working with each of the other local acute trusts to ensure that when a patient requires ongoing care for other non-cardiac related conditions that they are repatriated back to their local hospital as soon as possible. East Kent Hospitals University NHS Foundation Trust is also continually looking at their discharge policy to ensure that patients are discharge home as soon as is appropriate.

**Patient's Postcode (pPCI patients)**

**Graph 5**



The graph above shows the geographic split of patients that have received primary angioplasty. 44% of the patients treated were from the East Kent area and 34% from the West Kent area. This data is in line with the original expectations.

As can be seen from the graphs, the service is working well. Patient satisfaction surveys are being undertaken, and there is an overwhelming positive message coming back.

Now that the service has settled in, work is underway to review all of the pathways to ensure that they are as effective as possible. We are continually striving to decrease the total call to balloon times of the patients, and all stakeholders are working closely together to push this work forward to ensure the best possible outcomes for the patients.

The Network is currently undertaking a full and in depth review of the service at 6 months and a further review will be undertaken at 12 months.

All in all, this has been a fantastic piece of work, and all those involved in the implementation and running of this service should be congratulated.

### **Media Campaign**

On 20 May a media campaign took place. Radio and press were invited to the William Harvey Hospital to undertake interviews with some consultant cardiologists and staff, and the first patient who was admitted to the service. Items were reported on the BBC and Meridian news.

A campaign similar to the stroke FAST campaign was developed by NHS Eastern and Coastal Kent called ACT – **A**wareness, **C**all, **T**reat. Posters were created (see last page of report), and have been sent out to all GP surgeries in Kent and Medway as well as all hospitals across the area.

A radio campaign, highlighting the symptoms of a heart attack and the action that should be taken was also developed by NHS Eastern and Coastal Kent and had a 4 week run on Heart FM radio. Various news articles have been written as a result of press releases that have been sent out, and good news articles continue to be published.

### **Awards**

Last month, this new primary angioplasty service won an award for 'Outstanding Contribution to Healthier People, Excellent Care' at the Health and Social Care Regional Awards 2010.

The service has also received a nomination for the Health Service Journal (HSJ) awards taking place at the end of November.

### **NB.**

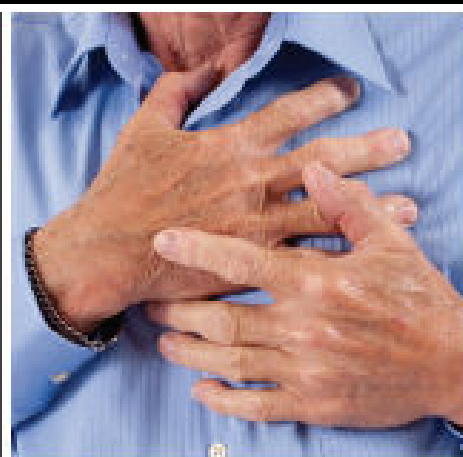
The next page shows the ACT campaign poster that the Network developed to coincide with the launch of the new primary angioplasty service.



# ACT on heart attacks

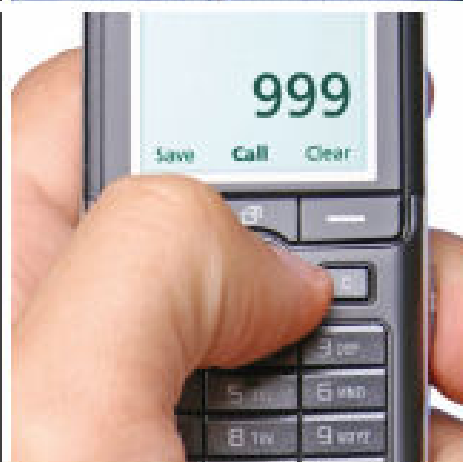
## Awareness

- Crushing central chest pain
- Shortness of breath
- Clammy, sweaty, and grey complexion
- Dizziness, nausea and vomiting



## Call

- Ring 999 if you spot the signs
- Every minute matters
- Fast action can save lives



## Treat

- You will be assessed by paramedics and taken to an appropriate hospital



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<sup>i</sup> Treatment of Heart Attack National Guidance. Final report of the National Infarct Angioplasty Project (NIAP) October 2008, Department of Health and British Cardiovascular Society.

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 26 November 2010

Subject: Intended Outcomes: Community Mental Health Services.

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## **1. Background**

- (1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve. Another has been the need to make the work of the Committee more accessible to members of the public.
- (2) This paper is intended to be a way to progress towards achieving these twin aims. The questions in Section 2 are the ones submitted to invitees in advance of the meeting.

## **2. Questions**

- (1) To NHS Eastern and Coastal Kent, NHS Medway and NHS West Kent
  1. Can you provide an overview of the kind of community mental health services commissioned for the people of Kent?
  2. Who are the main providers of these services?
  3. How many people access these services each year?
  4. How much do you spend on adult mental health services each year, and how much is spent specifically on community mental health services?
  5. What are your expectations for both of these amounts in coming years?
  6. Can you provide an outline of the process by which commissioning decisions relating to community mental health services are made (including joint commissioning with other commissioners)?
  7. Can you please provide any relevant PALs data relating to community mental health services?
  8. How are community mental health services being developed and how is it anticipated that these will complement or replace mental health inpatient services?

Item 6 – Intended Outcomes

9. What is the connection between primary care services such as GPs and community mental health services?

10. How is the performance of providers assessed and monitored?

(2) To Kent and Medway NHS and Social Care Partnership Trust

1. Can you provide an overview of the kind of community mental health services which you provide?

2. How many people access these services each year?

3. What are the main routes by which people access community mental health services?

4. Can you please provide any relevant PALs data relating to community mental health services?

5. How do Crisis Response and Home Treatment Teams co-ordinate with community mental health services?

6. Similarly, how do forensic mental health services co-ordinate with community mental health services?

7. How are community mental health services being developed and how is it anticipated that these will complement or replace mental health inpatient services?

8. What is the Care Programme Approach, and how is this used in your organisation?

9. What is the connection between primary care services such as GPs and community mental health services?

10. Do you have any comments to make of the results of the survey of people who use community mental health services published recently by the Care Quality Commission, in particular the results which relate to your organisation?

(3) To the LINK

1. How has the Kent LINK been involved in any ongoing developments regarding adult community mental health services?

2. Have any particular issues concerning these services been received by the Kent LINK from members of the public, LINK members, and/or partner organisations?

3. Is the Kent LINK currently carrying out any work in these areas?

Item 6 – Intended Outcomes

- (4) In addition, Kent Adult Social Services and the Kent Local Medical Committee were asked for any information they wished to provide on this topic.

**3. Recommendations**

- (a) The Committee is asked to assess whether the outcomes in section 2 above have been achieved or if further information on this topic is required by the Committee.

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Item 6: Background Note.

By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee – 26 November 2010

Subject: Community Mental Health Services

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## **1. An Overview of the Structure of Mental Health Services**

- (a) The following is an overview of the structure of mental health services to provide the broader context within which community mental health services operate.
- (b) Across England, 90% of those receiving care for mental health problems do so within a primary care sector, yet around 80% of mental health NHS spending is spent on inpatient services. The last 30 years have seen a scaling back of psychiatric hospital services<sup>1</sup>.
- (c) GPs treat many patients, and usually refer those they cannot help directly to community mental health teams (CMHTs) or psychiatric outpatient clinics. CMHTs are the main source of specialist help for mental health problems. These teams can include social workers, community psychiatric nurses, doctors, psychologists, occupational therapists and support workers.
- (d) The people for whom CMHTs provide services can be divided into two groups:
  - 1. Patients with time limited disorders who can be referred back to GPs after a certain period (weeks or months);
  - 2. Patients, a substantial minority, who will remain with the team for a number of years for ongoing care and monitoring<sup>2</sup>.
- (e) The details around structure, and indeed name, of local teams are down to local discretion.
- (f) CMHTs assess and monitor mental health needs using two specialist systems – care programme approach (CPA) or care management. The CPA has been part of mental health services since 1991 and describes

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<sup>1</sup> The NHS Confederation, *The NHS Handbook 2009/10*, pp.101-103.

<sup>2</sup> The Department of Health, June 2002, *Mental Health Policy Implementation Guide Community Mental Health Teams*, p.7,  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_085652.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_085652.pdf)

Item 6: Background Note.

the process by which mental health needs were assessed, care plans developed and reviewed<sup>3</sup>.

- (g) Some of the ways in which mental health services have been developed in the community include<sup>4</sup>:
1. Early intervention teams which aim to treat psychotic illness during its early onset.
  2. Assertive outreach teams to provide intensive support for those difficult to engage in traditional services.
  3. Crisis resolution home treatment teams (CRHTs) providing acute care in patients' homes in crises (a 24-hour service).
- (h) The introduction of CRHT teams formed part of the 1999 National Service Framework for Mental Health<sup>5</sup>. The intention was to ensure inpatient care was used appropriately. CRHT teams were to carry out a 'gatekeeping' role for inpatient mental health services. Where appropriate, CRHT teams were to provide intensive support/acute care for people with mental health crises in their own homes. The provision of this service was also intended to enable earlier discharge from acute settings.
1. CRHT teams are usually made up mainly of mental health nurses, with input from consultant psychiatrists, social workers, occupational therapists and psychologists.
  2. Many teams around the country evolved from previously existing services, such as primary care crisis intervention teams, day services and A&E Mental Health Teams.
- (i) Recent years have also seen the development of the Improving Access to Psychological Therapies (IAPT) programme aimed at extending 'talking therapies' and encouraging provision outside hospitals.
- (j) In the acute sector, acute admission wards provide inpatient care with intensive support for patients in periods of acute psychiatric illness. Inpatient Assessment Units assess functional and organic type illness in older adults, and take referrals from Community Mental Health Teams for Older People, GPs and Consultant Psychiatrists. Patients who are in an acutely disturbed phase of a serious mental health

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<sup>3</sup> The Department of Health, March 2008, *Making the CPA Work for You*, p.5, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_083652.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_083652.pdf)

<sup>4</sup> The names given to services can vary between areas of the country.

<sup>5</sup> Available at: [http://collections.europarchive.org/tna/20100509080731/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4077209.pdf](http://collections.europarchive.org/tna/20100509080731/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4077209.pdf)

disorder, are detained in designed Psychiatric Intensive Care Unit (PICU) facilities.

- (k) Other mental health inpatient services aim to provide rehabilitation services and provide care to people with an enduring mental illness and for whom a residential placement in the community has been judged to be unsuitable.
- (l) Forensic mental health services are there to deal with patients whose behaviour is beyond the scope of general psychiatric services and who may require a degree of physical security. Some will be mentally disordered offenders. These services fall into three categories:
  - 1. Low-security services, often near general psychiatric wards in NHS hospitals.
  - 2. Medium secure services operating regionally with locked wards.
  - 3. High-security services provided by the three specialist hospitals of Ashworth, Broadmoor and Rampton.
- (m) Child and Adolescent Mental Health Services (CAMHS) services are arranged in four linked tiers. These range from tier 1 services which contribute to mental healthcare, but where it is not the primary function, such as schools, to tier 4 dealing with the most severe and complex cases and includes inpatient and specialist services such as eating disorders.
- (n) According to the Department of Health Business Plan 2011-2015, a cross-government strategy for mental health services and public mental health will be published in December<sup>6</sup>.

## **2. Mental Health within the NHS Financial Framework**

- (a) Under the current system, Primary Care Trusts control around 80% of the NHS budget. In 2010/11 this amounted to £84 billion (out of a £103 billion NHS budget). This is allocated to PCTs using a weighted capitation formula. £26 billion will be spent using Payment by Results (PbR). The other £58 billion includes prescribing, primary care and those health services not currently included in PbR, such as mental health.<sup>7</sup>

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<sup>6</sup> Department of Health Business Plan 2011-2015, p.13,  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_121413.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_121413.pdf)

<sup>7</sup> The Department of Health, September 2010, *A Simple Guide to PbR*, pp.62-63,  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_120254.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_120254.pdf)

Item 6: Background Note.

- (b) Mental health has been identified as the main priority for the expansion of PbR<sup>8</sup>. *High Quality Care for All* contained a promise to have a mental health currency available for 2010/11 and this was met.<sup>9</sup> The NHS White Paper contained the promise to “implement a set of currencies for adult mental health services for use from 2012/13”<sup>10</sup>. The financial framework being developed for mental health services will operate differently to PbR for acute services.
- (c) The distinction between a currency and a tariff is as follows:
1. “Currencies are the unit of healthcare for which a payment is made. They can take a number of forms, covering different time periods – for instance, in acute physical PbR, outpatient attendances are paid on a contact basis, whilst for long term conditions we are looking to develop annual payments adjusted for complexity, which would be more like the care cluster approach. Our initial commitment in mental health is to develop currencies that are being used nationally.
  2. “Tariffs are set prices for a given currency unit. The collected nationally determined prices for HRGs are sometimes referred to as the tariff. We have committed to examining the case for a national mental health tariff following the establishment of national currencies. Without a national tariff, prices for a given currency can be set locally or regionally (i.e. at SHA level).”<sup>11</sup>
  3. HRGs, Healthcare Resource Groups, are the chosen currency for acute healthcare in England. They are “standard groupings of similar treatments which use similar levels of healthcare resources.”<sup>12</sup>
- (d) The national mental health currency published in 2010/11 is the ‘care cluster’. It was developed by the NHS in the North East and in Yorkshire and Humber.
1. “(T)he clusters identify patient need over a given period of time, and apply to both admitted patient and community care. They therefore balance the risk between commissioners and providers. Commissioners do not have to pay extra for each

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<sup>8</sup> Ibid., p44.

<sup>9</sup> Ibid., p.44.

<sup>10</sup> The Department of Health, July 2010, *Equity and Excellence: Liberating the NHS*, p.25, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_117794.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf)

<sup>11</sup> The Department of Health, February 2010, *Payment by Results Guidance for 2010/11*, p.95, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_112970.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112970.pdf)

<sup>12</sup> The Department of Health, September 2010, *A Simple Guide to PbR*, p.20, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_120254.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_120254.pdf)

contact and intervention. Providers know they will be get paid for each patient they care for and they also have an incentive to innovate and support the patient in the most cost effective setting. <sup>13</sup>

2. "Mental health providers will allocate their patients to the care clusters by the end of 2011. In 2012-13 the clusters will be used as the contract currency, with local prices agreed." <sup>14</sup>
  3. There will be exceptions to the services covered by the care clusters, such as CAMHS, secure services, learning disability services and specialised services. <sup>15</sup>
- (e) A number of specialised services where the number of affected patients is relatively small are commissioned either regionally by one of the ten Specialised Commissioning Groups, or nationally by the National Commissioning Group. In mental health this includes secure services and some personality disorder services.

### **3. The Care Quality Commission survey of community mental health services.**

- (a) On 14 September 2010, the Care Quality Commission published a national survey of community mental health services. The survey involved 17,000 services users at 66 NHS Trusts between July and September 2009. The briefing note by the CQC outlining the national results can be found at Appendix 1 <sup>16</sup> and the report on Kent and Medway NHS and Social Care Partnership Trust can be found in Appendix 2. <sup>17</sup>

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<sup>13</sup> Ibid., p.44.

<sup>14</sup> Ibid, p.44.

<sup>15</sup> The Department of Health, February 2010, *Payment by Results Guidance for 2010/11*, p.102, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_112970.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112970.pdf)

<sup>16</sup> The Care Quality Commission, September 2010, *Supporting Briefing Note: Community Mental Health Survey 2010*, [http://www.cqc.org.uk/db/documents/MH10\\_Briefing\\_note\\_v7\\_FINAL\\_201010262348.doc](http://www.cqc.org.uk/db/documents/MH10_Briefing_note_v7_FINAL_201010262348.doc)

<sup>17</sup> The Care Quality Commission, September 2010, *Survey of people who use community mental health services 2010 Kent And Medway NHS And Social Care Partnership Trust* [http://www.cqc.org.uk/db/documents/KentAndMedwayNHSAndSocialCarePartnershipTrust\\_RXY\\_MH10.pdf](http://www.cqc.org.uk/db/documents/KentAndMedwayNHSAndSocialCarePartnershipTrust_RXY_MH10.pdf)

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## **SUPPORTING BRIEFING NOTE:** **COMMUNITY MENTAL HEALTH SURVEY 2010**

This briefing note provides key findings from the 2010 survey of people who use community mental health services.

The 2010 survey comprises a sample of service users aged 16 and over who had been in contact with NHS mental health services in the three month period 1 July 2009 to 30 September 2009 and who were receiving specialist help for a mental health condition. A total of 17,199 questionnaires were returned, a response rate of 32%.

The survey aimed to find out about the experiences of people using mental health services in the community. These services provide care and treatment to people who have been referred to a psychiatric outpatient clinic, local community mental health team, or other community-based mental health services.

The results from the survey are primarily intended for use by NHS mental health provider trusts to help them improve their performance. They also have relevance to those local authorities that employ social workers and social care staff that work as part of multidisciplinary community-based mental health teams. The Care Quality Commission will also use the results in a number of ways, including setting out national and trust findings; informing patients and the public of trusts' results; and using the results in regulatory activities such as registration, the monitoring of ongoing compliance, and reviews. The Department of Health will also use the results in measuring performance against a range of indicators.

### **The Care Programme Approach**

The term 'Care Programme Approach' (CPA) describes the framework for supporting and coordinating effective mental health care for people with severe mental health problems in secondary mental health services.

Until 2008 CPA applied to all people who were in contact with secondary mental health services and was delivered on two levels: 'enhanced' support for those with more complex needs, who may need help from a range of agencies, and who were more likely to disengage with services; and 'standard' support for those who receive care from a single agency, who are able to self-manage and maintain contact with services.

In March 2008 the Department of Health published "*Refocusing the Care Programme Approach*"<sup>1</sup> which gave revised guidance on the "new CPA". One

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<sup>1</sup> *Refocusing the Care Programme Approach: policy and positive practice guidance* available at:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_083647](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647)

of the key changes made was to only apply one level of CPA for those with more complex characteristics. The policy document notes that for service users with more straightforward needs (formerly standard CPA) it was not the intention that complicated systems of support should surround their care, as they are unnecessary. Service users rights to an assessment of their needs, the development of a care plan and a review of that care by a professional involved, will continue to be a good practice for all. The document describes service users requiring “new CPA” as having “complex needs; multi-agency input; higher risk” and other service users as having “more straightforward needs; requiring support from only one agency; lower risk”.

Surveys of people using community mental health services have previously been carried out annually between 2004 and 2008. In 2008 and in previous years the survey was of service users receiving ‘standard’ or ‘enhanced’ care under the CPA. Following the changes to the CPA set out in *Refocusing the Care Programme Approach*, the sampling methodology for the survey was revised to include both service users who have their care co-ordinated under the CPA and other service users in contact with secondary mental health services. The content of the questionnaire was also updated to reflect the changes in the national policy. As a result of these various changes, the results from the 2010 community survey are not comparable with surveys carried out between 2004-2008.

The changes in national policy mean that there are likely to be some differences in the experiences of service users, dependent upon whether they receive services under the CPA or not. Some of these differences will reflect the different service requirements for people on CPA who have been assessed as having more complex needs and may therefore need more intensive services and on-going support. As such, service users on CPA may have different patterns of care, for example, they may see different health and social care staff for their mental health condition. The revised policy also sets out some specific differences in practice expectations for those who are on ‘new’ CPA - this briefing note presents these findings separately where differences in practice expectations apply. Forty-three percent of the service users who responded to the 2010 survey had their care co-ordinated under the new CPA.

A document containing the full percentage results for the survey is available on the CQC website at: <http://www.cqc.org.uk/PatientSurveyMentalHealth2010>. This document provides results separately for those on CPA and those not on CPA as well as overall percentages based on all respondents. This briefing note summarises the key points from these detailed tables.

## Health and Social Care Workers

The health or social care worker seen most recently by service users for their mental health condition was: Community Psychiatric Nurse (31%), Psychiatrist (28%), Mental Health Support Worker (13%) Psychologist (9%), Social worker (8%), Occupational therapist (3%) and other workers (7%). There are differences between respondents on CPA and those not on CPA in the health or social care worker seen most recently which may be seen in the detailed tables available on the CQC website.

The majority of service users were positive about the last time they saw this health or social care worker for their mental health condition:

- Eighty percent reported that this worker “definitely” listened carefully to them. Just under a fifth (17%) said that this person listened carefully “to some extent” and 3% said they were not listened to carefully.
- Seventy five percent felt that the health or social care worker “definitely” took their views into account. Just over a fifth (21%) said that he/she took their views into account “to some extent” with 4% saying their views were not taken into account.
- Seventy two percent “definitely” had trust and confidence in the last health or social care worker they saw for their mental health condition. Just over a fifth (21%) said they had trust and confidence in this person “to some extent” with 7% saying they did not have trust and confidence in this person.
- Eighty eight percent said that they were “definitely” treated with respect and dignity by the health or social care worker. Ten percent said that they were treated with respect and dignity “to some extent” with 2% saying they were not treated with respect and dignity.
- Seventy three percent said they were “definitely” given enough time to discuss their condition or treatment. Just under a fifth (19%) were given enough time “to some extent” with 7% saying that they were not given enough time to discuss their condition or treatment.

## Medications

In the last 12 months, the majority (89%) of service users had taken prescribed medications for their mental health condition. Of these, over half (57%) said that their views were “definitely” taken into account in deciding which medications to take, with 31% saying their views were taken into account “to some extent” and 12% that their views were not taken into account. Just over two fifths (42%) had new medications prescribed for them by a mental health worker (not including their GP) In the last 12 months. Of these:

- just over two thirds (69%) said that the purpose of the new medication had “definitely” been explained to them, almost a quarter (24%) said that the

purpose had been explained “to some extent” and 7% said that the purpose was not explained to them.

- Less than half (43%) of these respondents said that they were “definitely” told about possible side effects of the new medication, with 28% saying they were told “to some extent” and 29% that they were not told about possible side effects.
- Just over half (52%) said that they were “definitely” given information about the new medication in a way they could understand, with 32% saying that this was done “to some extent” and 15% not receiving information about their new medication in a way they could understand.

The majority (87%) of service users who had taken prescribed medications for their mental health condition in the last 12 months had been taking medication for 12 months or longer. While 81% of these said that they had been asked in the last 12 months how they were getting on with the medicines (i.e. having their medicines reviewed) this leaves almost a fifth (19%) who had not been asked.

## Talking Therapies

There are a number of different types of talking therapy which include psychological therapies such as counselling, cognitive behavioural therapy (CBT), faith and spirituality based counselling, art, music or drama therapy and anxiety management.

Forty-four percent of service users had received some kind of talking therapy from NHS mental health services in the last 12 months and 56% had not. Of those that had not received any talking therapy, 27% said that they wanted it.

Just under half (47%) of those who had received talking therapy said that they “definitely” found it helpful, with just over a third (37%) finding it helpful “to some extent” and 15% stating that they did not find talking therapy helpful.

## Care Coordinators or Lead Professionals

A care coordinator or lead professional is someone who is the main point of contact for the service user. *Refocusing the Care Programme Approach* sets out some differences in approach for service users under CPA and those not on CPA.

Those receiving mental health services under CPA should have a named ‘care coordinator,’ that is someone from community mental health services who is involved in their care and who keeps in regular contact with them by acting as a link between them and the services they receive. The guidance states that service users should receive support from a care coordinator who has received training for this role as part of their job description. The role of the care coordinator should usually be taken by the person who is best placed

to oversee care management and resource allocation and can be of any discipline depending on capability and capacity.

The majority of the respondents to the survey receiving care under CPA said that they knew who their care coordinator was (84%), with 16% saying they did not know or were not sure.

Service users not on CPA should only require the support of one agency and a professional in this agency should be the person responsible for facilitating their care. The guidance states that service user care is self directed with support from a 'lead professional' who undertakes this role in addition to their other clinical or practitioner roles. The person undertaking this role should be identified to the service user.

For those service users not receiving care under CPA, 64% said that they knew who their lead professional was, with 36% saying they did not know or were not sure.

On the whole, those service users who knew who their care coordinator or lead professional was were positive about that person:

- Overall, 74% said that they could "always" contact their care coordinator or lead professional if they had a problem, with 22% "sometimes" able to contact them and 4% saying they were not able to contact their care coordinator or lead professional if they had a problem.
- Overall, 62% of service users said that their care coordinator or lead professional organised the care and services they need "very well", with the remainder responding "quite well" (31%), "not very well" (5%) and "not at all well" (3%).

There were only small differences between CPA service users and others in their responses to the questions about contacting their care coordinator and how well their care is organised by their care coordinator. These differences can be viewed in the detailed tables available on the CQC website.

## Care Plans

A care plan sets out service users' assessed needs and how these will be met. *Refocusing the Care Programme Approach* sets out some differences in approach for service users under CPA and those not on CPA. Service users on CPA should have a comprehensive formal written care plan detailing their care and treatment.

Overall, 71% of respondents receiving care under CPA said that they had been given or offered a written or printed copy of their care plan, 55% "in the last year" and 16% "more than a year ago". Over a quarter (30%) said that they had not been given or offered a written or printed copy of their care plan.

For those service users not under CPA, there is no formal requirement to have designated paperwork for care planning and review, but policy guidance

sets out that they should have a recorded statement of care agreed with the service user which gives a clear understanding of how their treatment will be carried out and by whom. This may be set out in a clinician's letter or in practice notes. According to the survey, less than half of respondents who were not on CPA (46%) said they had been given or offered a written or printed copy of their care plan either "in the last year" (33%) or "more than a year ago" (13%).

Overall, of all respondents (including those on CPA and those not on CPA) who said that they had a care plan:

- Just under half (48%) said that they "definitely" understood what was in their care plan and 29% said that they understood it "to some extent". Nine per cent said that they did not understand what was in their care plan, and 15% were "not sure". There were differences by CPA with a greater proportion of those receiving care under CPA 'definitely' understanding what is in their care plan (53%) compared with respondents not on CPA (45%).
- Just over half (53%) "definitely" thought their views were taken into account when deciding what was in their care plan, with 34% thinking this was true "to some extent" and 13% saying their views were not taken into account.
- Four fifths of respondents (80%) said that their care plan set out their goals, either "definitely" (42%) or "to some extent" (38%). The remaining 20% said that their care plan did not set out their goals. There were differences by CPA with a greater proportion of those receiving care under CPA saying that their care plan 'definitely' set out their goals (44%) compared with respondents not on CPA (40%).
- Of those whose care plan set out their goals, just under half (47%) said that the mental health services they received "definitely" helped them to achieve these goals, 46% thought their care plan did so "to some extent" with 7% saying that the mental health services they received did not help them to achieve these goals.

*Refocusing the Care Programme Approach* expects that all service users on CPA should have explicit crisis and contingency plans set out in their care plan which explains what they should do in a crisis. Just over half (52%) of survey respondents on CPA and who had a care plan said that their care plan "definitely" covered what they should do if they have a crisis and 26% said their plan covered what they should do "to some extent". However, over a fifth (23%) said that their care plan did not cover what they should do if they have a crisis.

Although there is not the same policy requirement for service users not on CPA, they should be aware of who to contact in the event of a crisis. Thirty nine percent of those who said that they had a care plan said that it "definitely" covered what they should do if they have a crisis, with 24% saying that their care plan covered what they should do "to some extent" and 37% saying their care plan did not cover what they should do if they have a crisis.

## Care Reviews

A care review is a meeting between the service user and those involved with their care to discuss how their care plan is working.

Again, there are some differences in expectations in *Refocusing the Care Programme Approach* for service users receiving care under CPA in that they should receive a “formal, multi-agency review at least once a year but likely to be needed more regularly.” Just over two thirds (70%) of respondents on CPA said that they had had a care review in the last twelve months to discuss their care plan, having had either one (35%) or more than one (35%). Over a quarter (30%) said that they had not had a care review meeting in the last 12 months to discuss their care plan<sup>2</sup>.

For service users not on CPA, *Refocusing the Care Programme Approach* states that they should receive “on-going review as required.” Less than half of respondents not on CPA (47%) said that they had had a care review in the last twelve months to discuss their care plan, having had either one (25%) or more than one (22%). Over half (53%) said that they had not had a care review meeting in the last 12 months to discuss their care plan.

Overall, of all respondents (including those on CPA and those not on CPA) who had had a care review meeting in the last twelve months to discuss their care plan:

- The majority said that they were told they could bring a friend or relative to the meeting (80%).
- Almost three quarters (74%) were given a chance to talk to their care coordinator about what would happen before the meeting. A greater proportion of service users on CPA said they had this opportunity (78%) compared with those not on CPA (70%).
- The majority felt they were given opportunity to express their views at the meeting, either “definitely” (70%) or “to some extent” (25%).
- Over half (52%) said that they “definitely” found the care review helpful with 39% finding it helpful “to some extent” and 9% not finding the care review helpful.
- Over half (61%) said that they had “definitely” discussed whether they needed to continue using mental health services with 21% saying this was discussed “to some extent” and 18% saying this was not discussed.

With the exception of being given an opportunity to talk to their care coordinator or lead professional before the meeting there were only very small differences between the responses of respondents receiving care under CPA and those not on CPA which can be viewed in the detailed tables available on the CQC website.

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<sup>2</sup> Respondents who said that they had been in contact with NHS mental health services for less than a year were excluded from the analysis for this question

## Day to Day Living

In the last 12 months, the majority of respondents had been asked by someone in mental health services about any physical health needs they might have, either “definitely” (38%) or “to some extent” (25%). Over a third (37%) said that they had not been asked.

For those service users with physical health needs, just over a third (39%) felt that mental health services had “definitely” given them enough support in getting help for these needs and 27% “to some extent”. Thirty-three percent said that they had not received enough support in getting help for their physical needs.

In the last 12 months, 39% of service users had been asked by someone in mental health services about both their alcohol intake and use of non-prescription drugs. A further 13% had been asked only about their alcohol intake and 2% only about their use of non-prescription drugs. Forty-five percent of service users said they had not been asked about either their alcohol intake or use of non-prescription drugs.

Just over a fifth of service users (21%) had care responsibilities (including looking after children). Of these, 36% reported that mental health services had “definitely” given them enough support with their care responsibilities and a further 26% received support “to some extent”. Thirty-eight percent said that they had not received enough support.

Service users receiving care under CPA should receive support from mental health services with employment, housing and finance if they need this. *Refocusing the Care Programme Approach* states that this should be identified in an initial assessment with mental health services which should cover “the full range of needs and risks”. Survey results showed that for those respondents receiving services under CPA, in the last twelve months:

- Just under two thirds (61%) of respondents who wanted help said that they had received help from someone in mental health services with finding or keeping work. Over a third (39%) said that they would have liked help but did not receive any.
- Just over two thirds (68%) of respondents who wanted help said that they had received help from someone in mental health services in finding or keeping accommodation. Almost a third (33%) said that they would have liked help but did not receive any.
- Almost three quarters (71%) of respondents who wanted help said that they had received help from someone in mental health services in getting financial advice or benefits (such as Housing Benefit, Income Support or Disability Living Allowance). Over a quarter (29%) said that they had not received any help but would have liked some.

For those respondents not receiving services under CPA, the mental health services they receive focus on clinical needs and there is not the same requirement to provide support for a wider range of needs. However,

*Refocusing the Care programme Approach* states that they should receive “a full assessment of need for clinical care and treatment, including risk assessment”. Survey results showed that for those respondents not receiving services under CPA, in the last 12 months:

- Less than half (46%) of respondents who wanted help said that they had received help from someone in mental health services with finding or keeping work. Fifty five percent said that they would have liked help but did not receive any.
- Less than half (47%) of respondents who wanted help said that they had received help from someone in mental health services in finding or keeping accommodation. Fifty three percent said that they would have liked help but did not receive any.
- Just over half (51%) of respondents who wanted help said that they had received help from someone in mental health services in getting financial advice or benefits (such as Housing Benefit, Income Support or Disability Living Allowance). Forty nine percent said that they had not received any help but would have liked some.

## **Crisis Care**

Fifty-six percent of service users said that they had the number of someone from their local NHS mental health service that they could phone out of hours, and 44% did not have a number. Of those that had a number from their local NHS mental health service, 36% had called the number in the last 12 months.

The last time that these service users had called the number of their local NHS mental health service, 66% had got through to someone immediately, 22% in one hour or less, 5% in a few hours and 3% in a day or more. Four percent said they could not get through to anyone.

The last time that service users had called the number of their local NHS mental health service, 50% had “definitely” received the help they wanted and 32% had “to some extent”. Eighteen percent of service users said that they had not received the help they wanted.

## **Overall**

Overall, service users rated the care they received from mental health services in the last 12 months as: excellent 29%, very good 30%, good 20%, fair 12%, poor 5% and very poor 4%.

Of those service users who wanted their family or someone else close to them to be involved in their care, just over half (52%) said that mental health services had involved a member of their family or someone else close to them as much as they would like, with 28% saying they were involved “to some extent” and the remaining 20% saying their family or someone else close to them had not been involved as much as they would like.

## **About the respondents**

Forty two percent of respondents were male and 58% female.

Eighteen percent of respondents were aged 16-35 years, 30% were aged 36-50 years, 26% were aged 51-65 years and 26% were aged 66 years or more.

The majority of respondents were white (93%) with 3% Asian or Asian British, 3% Black or Black British and 2% Chinese, Mixed or other ethnic group.

Four percent of service users said that they were in paid work for between 1-15 hours a week, with 12% working 16 or more hours a week. Over half (52%) were not working, 29% were retired, 1% were working on a casual basis, 2% were full-time students and 7% were doing voluntary work. Respondents were able to tick all the response options that applied to them for this question so percentages will not equal 100.

Just under a fifth (17%) of service users said that they had been in contact with mental health services for less than a year. Over a third (36%) had been in contact for 1-5 years, 14% for 6-10 years, with 33% having been in contact with mental health services for more than 10 years.

Over half of all service users (54%) said that they had last seen someone from NHS mental health services (excluding their GP) in the last month, with 26% seeing someone 1-3 months ago, 13% 4-6 months ago, 5% 7-12 months ago and 2% more than 12 months ago.

In the last 12 months, 13% of service users had been admitted to hospital as a mental health patient with 10% having been admitted once and 3% having been admitted 2 or 3 times. The majority (86%) had not been admitted to hospital as a mental health inpatient in the last 12 months.

Service users described their mental health at the time of completing the questionnaire as being excellent (7%), very good (12%), good (22%), fair (35%), poor (18%) or very poor (6%).

Almost three quarters (72%) of service users filled in the questionnaire themselves, with 16% being completed by a friend or relative, 8% by both the service user and a friend or relative together and 4% by the service user with the help of a health professional.

## **Notes on the survey**

The 2010 survey of people who used community mental health services included 66 NHS trusts in England providing community mental health services (including combined mental health and social care trusts, primary care trusts that provide mental health services and Foundation Trusts). The sample was taken from all service users who were seen by the Trust between 1 July 2009 and 30 September 2009.

The survey fieldwork was carried out between January and April 2010.

Service users were eligible for the survey if they were aged 16 years or older. Excluded from the survey were:

- anyone seen only once for an assessment (for example, those who were seen by a psychiatrist for a single assessment);
- anyone primarily receiving drug & alcohol services;
- anyone primarily receiving Learning Disability services;
- anyone attending specialist forensic services;
- any children who were under 16 on the date the sample was drawn;
- any service users who were known to be current inpatients;
- any service users who only see their GP for their mental health condition.

We received responses from 17,199 service users, a response rate of 32%.

Note that not all percentage totals in this briefing note will add up to 100, due to rounding.

A report for each participating trust is available on the Care Quality Commission website. These reports show how each trust performed for every question that measures the quality of service user experience. Response options that do not directly measure this (such as can't remember) are excluded from results. The results for each trust are compared against all other trusts which took part. Since the types of service user at each trust can differ, these reports are standardised by age and gender. This allows trusts, and others, to compare performance, identify areas where they are currently performing well and to show where improvement is needed. Results are available on the Care Quality Commission website:

**<http://www.healthcarecommission.org.uk/PatientSurveysMentalHealth2010>**

The results for each trust will also be available under the organisation search tool of the CQC website:

**<http://healthdirectory.cqc.org.uk>**

(Select "summary information", enter a postcode or organisation name, then scroll down to 'What patients said about this trust').

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# Patient survey report 2010



Survey of people who use community mental health services  
2010  
Kent And Medway NHS And Social Care Partnership Trust

The community mental health survey was coordinated by the mental health survey coordination centre at the National Centre for Social Research



# National NHS patient survey programme

## Survey of people who use community mental health services 2010

### The Care Quality Commission

#### About the Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act.

Whether services are provided by the NHS, local authorities, private companies or voluntary organisations, we make sure that people get better care. We do this by:

- Driving improvement across health and adult social care.
- Putting people first and championing their rights.
- Acting swiftly to remedy bad practice.
- Gathering and using knowledge and expertise, and working with others.

#### Survey of people who use community mental health services 2010

To improve the quality of services that the NHS delivers, it is important to understand what people think about their care and treatment. One way of doing this is by asking people who have recently used their local mental health services to tell us about their experiences.

This report shows how each trust scored for each question in the survey, compared with national average results. The report should be used to understand the trust's performance, and to identify areas where it needs to improve.

There is also a set of tables on our website showing the national results for the 2010 survey, and a briefing note that highlights key national findings<sup>1</sup> These documents were produced by the mental health survey Co-ordination Centre at the National Centre for Social Research.

The survey of people who use community mental health services 2010 is part of a wider programme of NHS patient surveys, which covers a range of topics including people's experience of acute inpatient services, outpatient services and ambulance services. To find out more about our programme, please visit our website (see further information section).

#### About the survey

The 2010 survey of people who use community mental health services involved 66 NHS trusts in England (including combined mental health and social care trusts, Foundation Trusts and primary care trusts that provide mental health services). We received responses from more than 17,000 service users, a response rate of 32%. Service users aged 16 and over were eligible for the survey if they were receiving specialist care or treatment for a mental health condition and had been seen by the trust between 1 July 2009 and 30 September 2009. The survey included all service users in contact with local NHS mental health services, including those who receive care under the Care Programme Approach (CPA).<sup>2</sup>

<sup>1</sup>These tables show the percentage national results

<sup>2</sup>Since 1990, the Care Programme Approach (CPA) has been the framework for supporting and coordinating effective mental health care for people with mental health problems in contact with secondary mental health services. Until October 2008, CPA was delivered on two levels: 'enhanced' support for those with more complex needs, who may need help from a range of agencies and who were more likely to disengage with services and 'standard' support for those who receiving care from one agency, who are able to self-manage and maintain contact with services. In March 2008 the Department of Health published "Refocusing the Care Programme Approach" which gave revised guidance on CPA. One of the key changes made was to only apply one level of CPA for those with more complex characteristics, with service users with more straightforward needs (formerly standard) no longer falling under CPA.

## Interpreting the report

For each question in the survey, the individual responses were converted into scores on a scale of 0 to 100. A score of 100 represents the best possible response. Therefore, the higher the score for each question, the better the trust is performing.<sup>3</sup>

Please note: the scores are **not percentages**, so a score of 80 does not mean that 80% of people who have used services in the trust have had a particular experience (e.g. ticked 'Yes' to a particular question), it means that the trust has scored 80 out of a maximum of 100. A 'scored' questionnaire showing the scores assigned to each question is available on our website (see further information section).

Please also note that it is not appropriate to score all questions within the questionnaire for benchmarking purposes. This is because not all of the questions assess the trusts in any way, or they may be 'filter questions' designed to filter out respondents to whom following questions do not apply. An example of such a question would be Q9 "In the last 12 months have you taken any prescribed medications for your mental health condition?"

The graphs included in this report display the scores for this trust, compared with national benchmarks. Each bar represents the range of results for each question across all trusts that took part in the survey. In the graphs, the bar is divided into three sections:

- the red section (left hand end) shows the scores for the 20% of trusts with the lowest scores
- the green section (right hand end) shows the scores for the 20% of trusts with the highest scores
- the orange section (middle section) represents the range of scores for the remaining 60% of trusts.

A white diamond represents the score for this trust. If the diamond is in the green section of the bar, for example, it means that the trust is among the top 20% of trusts in England for that question. The line on either side of the diamond shows the amount of uncertainty surrounding the trust's score, as a result of random fluctuation.<sup>4</sup>

Since the score is based on a sample of service users in a trust rather than all service users, the score may not be exactly the same as if everyone had been surveyed and had responded. Therefore a confidence interval<sup>5</sup> is calculated as a measure of how accurate the score is. We can be 95% certain that if everyone in the trust had been surveyed, the 'true' score would fall within this interval.

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<sup>3</sup>Trusts have differing profiles of service users. For example, one trust may have more male service users than another. This can potentially affect the results because people tend to answer questions in different ways, depending on certain characteristics. For example, older respondents tend to report more positive experiences than younger respondents, and women tend to report less positive experiences than men. This could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of service users. To account for this, we 'standardise' the data. Results have been standardised by the age and sex of respondents to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age-sex profile reflects the national age-sex distribution (based on all of the respondents to the survey). It therefore enables a more accurate comparison of results from trusts with different profiles of service users.

<sup>4</sup>If a score is on the 'threshold' for the highest scoring 20% of trusts (that is, for example, the white diamond is on the line separating green and orange), this means that the score is one of the highest 20% of scores for that question. Similarly, trusts with scores on the threshold for the lowest scoring 20% of trusts are included in this lowest 20% of scores.

<sup>5</sup>A confidence interval is an upper and lower limit within which you have a stated level of confidence that the true mean (average) lies somewhere in that range. These are commonly quoted as 95% confidence intervals, which are constructed so that you can be 95% certain that the true mean lies between these limits. The width of the confidence interval gives some indication of how cautious we should be; a very wide interval may indicate that more data should be collected before making any conclusions.

When considering how a trust performs, it is very important to consider the confidence interval surrounding the score. If a trust's average score is in one colour, but either of its confidence limits are shown as falling into another colour, this means that you should be more cautious about the trust's result because, if the survey was repeated with a different random sample of service users, it is possible their average score would be in a different place and would therefore show as a different colour.

The white diamond (score) is not shown for questions answered by fewer than 30 people because the uncertainty around the result would be too great. When identifying trusts with the highest and lowest scores and thresholds, trusts with fewer than 30 respondents have not been included.

At the end of the report you will find the data used for the charts and background information about the service users that responded.

## Notes on specific questions

Seven of the questions in the questionnaire have different scoring for respondents who receive their care under the Care Programme Approach and other respondents who do not. These questions are: **Q20, Q23, Q28, Q29, Q40, Q41 and Q42**. This is to reflect the differences in national policy in relation to those under the Care Programme Approach (CPA) and other service users in contact with secondary mental health services which could result in differences in the service that people receive.

**Q17 and Q18:** The information collected by Q17 ("In the last 12 months have you had any talking therapies from NHS Mental Health Services?"), and Q18 ("In the last 12 months, did you want talking therapy?"), is presented together to show whether the provision of talking therapy met the requirements of the person using the services. The combined question is numbered in this report as Q17 and has been reworded to read: "In the last 12 months, did the provision of talking therapies meet your requirements?" For further details, please see the 'scored' questionnaire on our website, which shows the scores assigned to each question.

**Q29:** (In the last 12 months have you had a care review meeting to discuss your care plan?). Respondents who stated at Q1 that they have been in touch with mental health services for less than a year have been removed from the base for this question.

## Further information

Full details of the methodology of the survey can be found at:  
<http://www.nhspatientsurveys.org.uk>

More information on the programme of NHS patient surveys is available on Care Quality Commission website at:  
<http://www.cqc.org.uk/nationalfindings/surveys.cfm>

The results for the 2010 survey of people who use community mental health services can be found at:  
<http://www.cqc.org.uk/PatientSurveyMentalHealth2010>

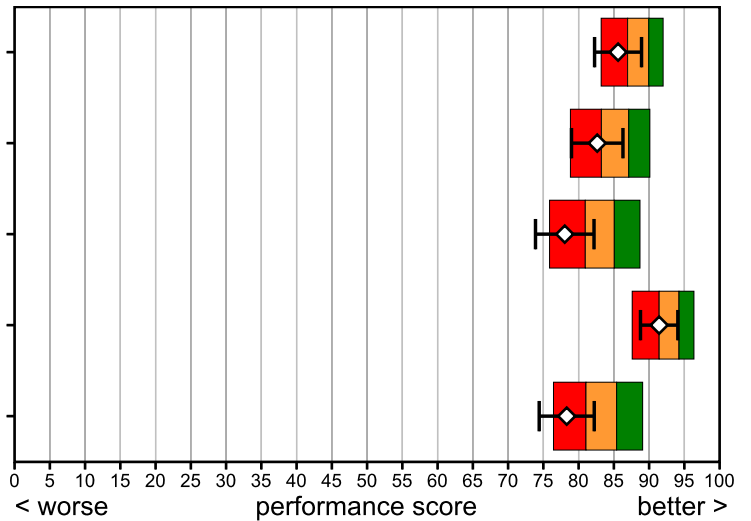
More information on 2009/10 Periodic Review is available on the Care Quality Commission's website at:  
<http://www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/periodicreview2009/10.cfm>

# Survey of people who use community mental health services 2010

## Kent And Medway NHS And Social Care Partnership Trust

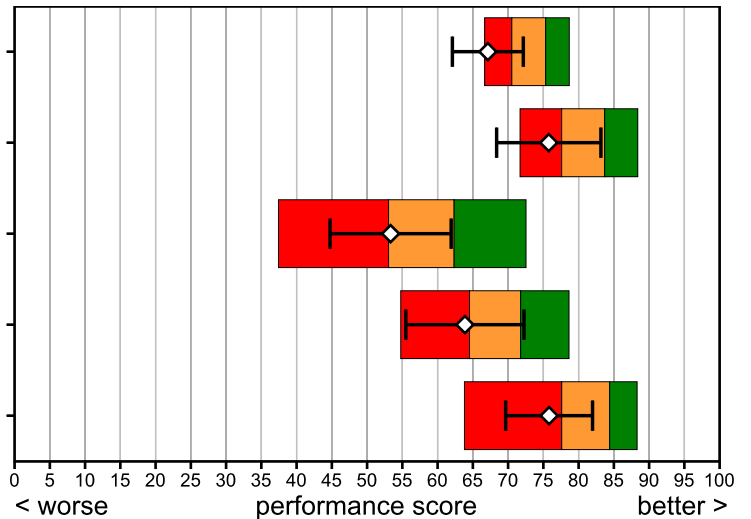
### Health and Social Care workers

- Did this person listen carefully to you?
- Did this person take your views into account?
- Did you have trust and confidence in this person?
- Did this person treat you with respect and dignity?
- Were you given enough time to discuss your condition and treatment?



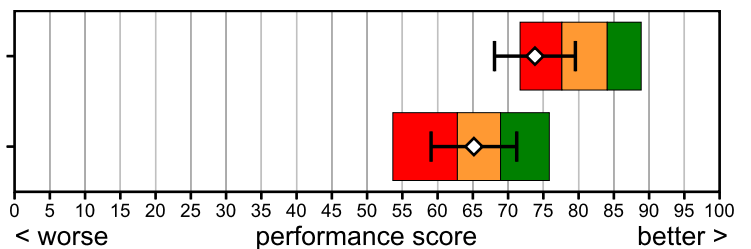
### Medications

- Do you think your views were taken into account in deciding which medicines to take?
- Were the purposes of the medications explained to you?
- Were you told about possible side effects of the medications?
- Were you given information about the medication in a way that was easy to understand?
- Has a mental health or social care worker checked with you how you are getting on with your medication?



### Talking therapies

- In the last 12 months, did the provision of talking therapies meet your requirements?
- If you had any talking therapy from NHS Mental Health Services in the last 12 months, did you find it helpful?



<span style="color: green;">■</span> Best performing 20% of trusts	<span style="color: orange;">◇</span> This trust (vertical lines show amount of uncertainty as a result of random fluctuation)
<span style="color: red;">■</span> Intermediate 60% of trusts	
<span style="color: green;">■</span> Worst performing 20% of trusts	

This trust's results are not shown if there were fewer than 30 respondents.

# Survey of people who use community mental health services 2010

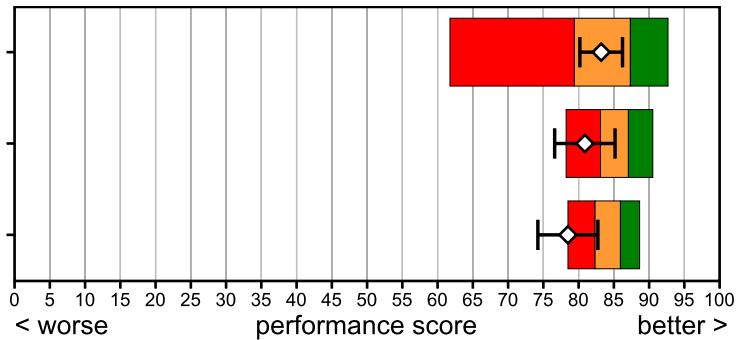
## Kent And Medway NHS And Social Care Partnership Trust

### Care Coordinator

Do you know who your Care Co-ordinator (or lead professional) is?

Can you contact your Care Co-ordinator (or lead professional) if you have a problem?

How well does your Care Co-ordinator (or lead professional) organise the care and services you need?



### Care Plan

Have you been given (or offered) a written or printed copy of your care plan?

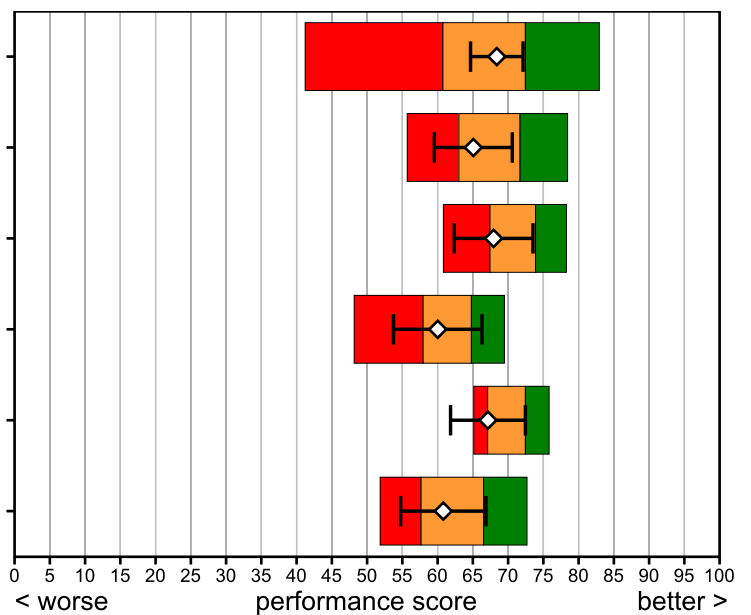
Do you understand what is in your care plan?

Do you think your views were taken into account when deciding what was in your care plan?

Does your care plan set out your goals?

Do the mental health services you receive help you to achieve these goals?

Does your care plan cover what you should do if you have a crisis (e.g. if you may need to be admitted to a mental health ward)?



<span style="color: green;">■</span> Best performing 20% of trusts	<span style="color: orange;">◇</span> This trust (vertical lines show amount of uncertainty as a result of random fluctuation)
<span style="color: red;">■</span> Intermediate 60% of trusts	
<span style="color: green;">■</span> Worst performing 20% of trusts	

This trust's results are not shown if there were fewer than 30 respondents.

# Survey of people who use community mental health services 2010

## Kent And Medway NHS And Social Care Partnership Trust

### Care Review

In the last 12 months have you had a care review meeting to discuss your care plan?

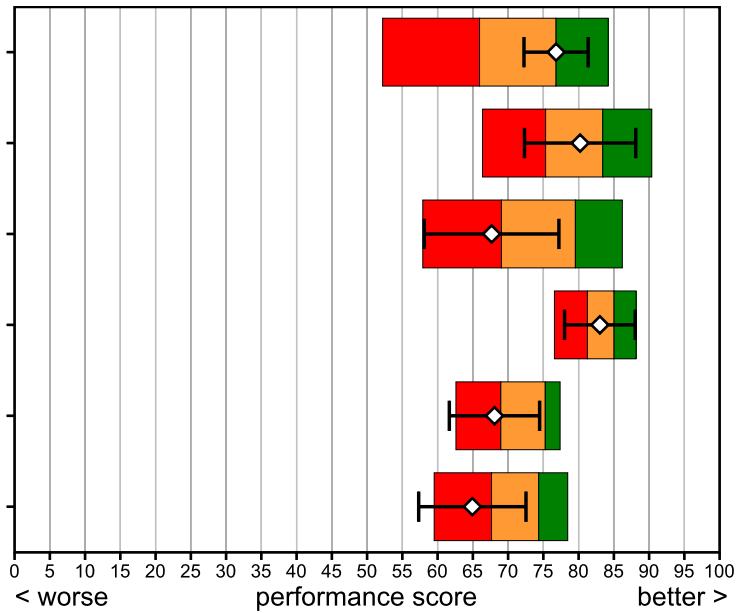
Were you told that you could bring a friend, relative or advocate to your care review meetings?

Before the review meeting, were you given a chance to talk to your care co-ordinator about what would happen?

Were you given a chance to express your views at the meeting?

Did you find the care review helpful?

Did you discuss whether you needed to continue using mental health services?



### Day to Day Living

Did anyone in mental health services ask you about any physical health needs you might have?

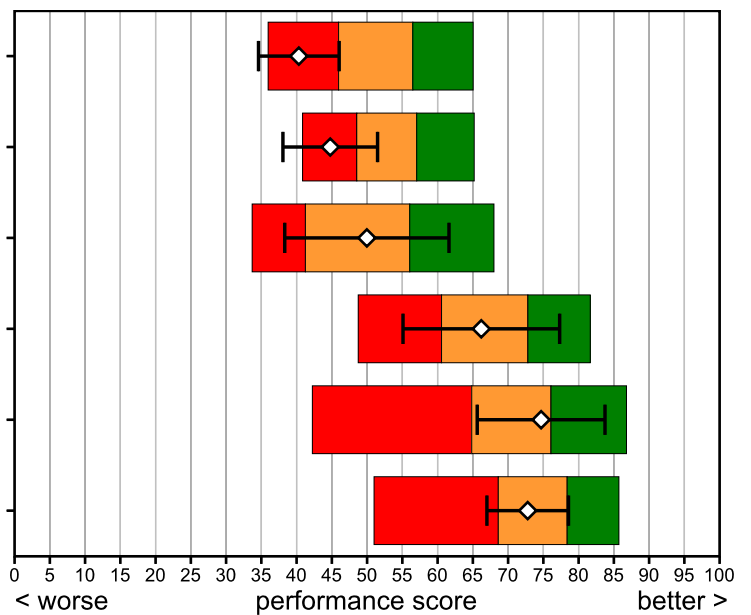
Did mental health services give you enough support getting help for any physical health needs?

Did mental health services give you enough support with your care responsibilities?

Have you received enough help from anyone in mental health services with finding or keeping work?

Have you received enough help from anyone in mental health services in finding or keeping your accommodation?

Have you received enough help from anyone in mental health services in getting financial advice or benefits?



■ Best performing 20% of trusts      ◇ This trust (vertical lines show amount of uncertainty as a result of random fluctuation)  
■ Intermediate 60% of trusts  
■ Worst performing 20% of trusts  
 This trust's results are not shown if there were fewer than 30 respondents.

# Survey of people who use community mental health services 2010

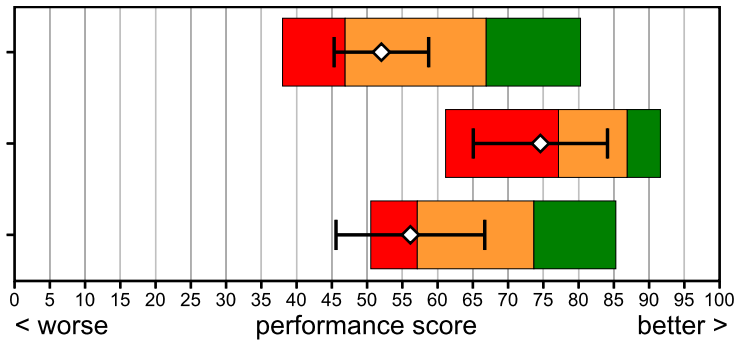
## Kent And Medway NHS And Social Care Partnership Trust

### Crisis Care

Do you have the number of someone from your local NHS Mental Health Service that you can phone out of office hours?

The last time you called the number, how long did it take you to get through to someone?

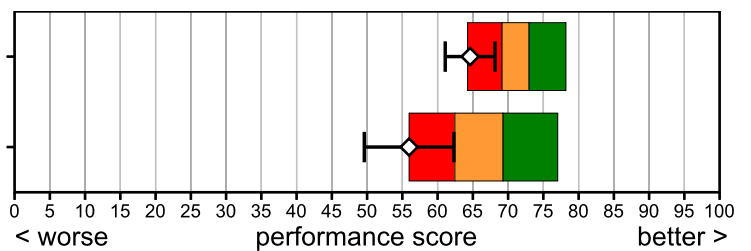
The last time you called the number, did you get the help you wanted?



### Overall

Overall, how would you rate the care you have received from Mental Health Services in the last 12 months?

Have mental health services involved a member of your family or someone else close to you, as much as you would like?



<span style="color: green;">■</span> Best performing 20% of trusts	<span style="color: orange;">■</span> Intermediate 60% of trusts	<span style="color: red;">■</span> Worst performing 20% of trusts	◇ This trust (vertical lines show amount of uncertainty as a result of random fluctuation)
This trust's results are not shown if there were fewer than 30 respondents.			

**Survey of people who use community mental health services 2010**  
**Kent And Medway NHS And Social Care**  
**Partnership Trust**

	Scores for this NHS trust	95% Confidence Interval		Threshold for the lowest scoring 20% of NHS Trusts	Threshold for the highest scoring 20% of NHS Trusts	Highest score achieved (all trusts)	Number of respondents (this trust)
		Lower	Upper				
<b>Health and Social Care workers</b>							
Q4 Did this person listen carefully to you?	86	82	89	87	90	92	262
Q5 Did this person take your views into account?	83	79	86	83	87	90	253
Q6 Did you have trust and confidence in this person?	78	74	82	81	85	89	260
Q7 Did this person treat you with respect and dignity?	91	89	94	91	94	96	261
Q8 Were you given enough time to discuss your condition and treatment?	78	74	82	81	85	89	260
<b>Medications</b>							
Q10 Do you think your views were taken into account in deciding which medicines to take?	67	62	72	71	75	79	217
Q12 Were the purposes of the medications explained to you?	76	68	83	78	84	88	94
Q13 Were you told about possible side effects of the medications?	53	45	62	53	62	73	94
Q14 Were you given information about the medication in a way that was easy to understand?	64	55	72	65	72	79	93
Q16 Has a mental health or social care worker checked with you how you are getting on with your medication?	76	70	82	78	84	88	189
<b>Talking therapies</b>							
Q17 In the last 12 months, did the provision of talking therapies meet your requirements?	74	68	80	78	84	89	238
Q19 If you had any talking therapy from NHS Mental Health Services in the last 12 months, did you find it helpful?	65	59	71	63	69	76	128
<b>Care Coordinator</b>							
Q20 Do you know who your Care Co-ordinator (or lead professional) is?	83	80	86	79	87	93	249
Q21 Can you contact your Care Co-ordinator (or lead professional) if you have a problem?	81	77	85	83	87	91	163
Q22 How well does your Care Co-ordinator (or lead professional) organise the care and services you need?	78	74	83	82	86	89	157

**Survey of people who use community mental health services 2010**  
**Kent And Medway NHS And Social Care**  
**Partnership Trust**

	Scores for this NHS trust	95% Confidence Interval		Threshold for the lowest scoring 20% of NHS Trusts	Threshold for the highest scoring 20% of NHS Trusts	Highest score achieved (all trusts)	Number of respondents (this trust)
		Lower	Upper				
<b>Care Plan</b>							
Q23 Have you been given (or offered) a written or printed copy of your care plan?	68	65	72	61	72	83	219
Q24 Do you understand what is in your care plan?	65	60	71	63	72	78	151
Q25 Do you think your views were taken into account when deciding what was in your care plan?	68	62	74	67	74	78	147
Q26 Does your care plan set out your goals?	60	54	66	58	65	69	139
Q27 Do the mental health services you receive help you to achieve these goals?	67	62	72	67	72	76	117
Q28 Does your care plan cover what you should do if you have a crisis (e.g. if you may need to be admitted to a mental health ward)?	61	55	67	58	67	73	137
<b>Care Review</b>							
Q29 In the last 12 months have you had a care review meeting to discuss your care plan?	77	72	81	66	77	84	166
Q30 Were you told that you could bring a friend, relative or advocate to your care review meetings?	80	72	88	75	83	90	104
Q31 Before the review meeting, were you given a chance to talk to your care co-ordinator about what would happen?	68	58	77	69	80	86	94
Q32 Were you given a chance to express your views at the meeting?	83	78	88	81	85	88	112
Q33 Did you find the care review helpful?	68	62	74	69	75	77	110
Q34 Did you discuss whether you needed to continue using mental health services?	65	57	73	68	74	78	113
<b>Day to Day Living</b>							
Q35 Did anyone in mental health services ask you about any physical health needs you might have?	40	35	46	46	56	65	224
Q36 Did mental health services give you enough support getting help for any physical health needs?	45	38	51	49	57	65	168
Q39 Did mental health services give you enough support with your care responsibilities?	50	38	62	41	56	68	59
Q40 Have you received enough help from anyone in mental health services with finding or keeping work?	66	55	77	61	73	82	43
Q41 Have you received enough help from anyone in mental health services in finding or keeping your accommodation?	75	66	84	65	76	87	47
Q42 Have you received enough help from anyone in mental health services in getting financial advice or benefits?	73	67	79	69	78	86	110

**Survey of people who use community mental health services 2010**  
**Kent And Medway NHS And Social Care**  
**Partnership Trust**

	Scores for this NHS trust	95% Confidence Interval		Threshold for the lowest scoring 20% of NHS Trusts	Threshold for the highest scoring 20% of NHS Trusts	Highest score achieved (all trusts)	Number of respondents (this trust)
		Lower	Upper				
<b>Crisis Care</b>							
Q43 Do you have the number of someone from your local NHS Mental Health Service that you can phone out of office hours?	52	45	59	47	67	80	221
Q45 The last time you called the number, how long did it take you to get through to someone?	75	65	84	77	87	92	52
Q46 The last time you called the number, did you get the help you wanted?	56	46	67	57	74	85	51
<b>Overall</b>							
Q47 Overall, how would you rate the care you have received from Mental Health Services in the last 12 months?	65	61	68	69	73	78	251
Q48 Have mental health services involved a member of your family or someone else close to you, as much as you would like?	56	50	62	62	69	77	173

## Survey of people who use community mental health services 2010 Kent And Medway NHS And Social Care Partnership Trust

### Background information

<b>The sample</b>	<b>This trust</b>	<b>All trusts</b>
Number of respondents	268	17199
Response Rate (percentage)	32	32

<b>Demographic characteristics</b>	<b>This trust</b>	<b>All trusts</b>
Gender (percentage)	(%)	(%)
Male	35	42
Female	65	58
Age group (percentage)	(%)	(%)
Aged 35 and younger	19	18
Aged 36-50	35	30
Aged 51-65	20	26
Aged 66 and older	25	26
Ethnic group (percentage)	(%)	(%)
White	98	93
Mixed	0	1
Asian or Asian British	1	3
Black or Black British	0	3
Chinese or other ethnic group	0	0

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**KENT COUNTY COUNCIL  
HEALTH OVERVIEW AND SCRUTINY COMMITTEE [HOSC]  
26 NOVEMBER 2010**

**COMMUNITY MENTAL HEALTH SERVICES**

This paper gives an overview of the Community Mental Health Services provided by Kent and Medway NHS and Social Care Partnership Trust [KMPT]. The paper also outlines responses to key questions and issues raised by the HOSC in its letter to the KMPT dated 11 October 2010.

**Overview:** This briefing focuses on the Community Mental Health Services provided by KMPT to adults of a working age. These primarily focus on those with severe and enduring mental health problems. However, the KMPT is now running some Primary Care Mental Health Services for people with common mental health problems.

KMPT's integrated services include Community Mental Health Teams [CMHT], Assertive Outreach Teams [AOT], Early Intervention in Psychosis Services [EIPS], Crisis Resolution Home Treatment Teams [CRHT] and a range of psychological interventions across a wide range of need.

The principles of "**Recovery**" underpin the care provided throughout Community Mental Health Services. The broad vision of Recovery involves:

"...a process of changing one's orientation and behaviour from a negative focus on a troubling event, condition or circumstance to the positive restoration, rebuilding, reclaiming or taking control of one's life..."

*National Institute of Mental Health in England [NIMHE] (2004)*

*Guiding Statement on Recovery*

**Principles of Recovery:**

- The primary aim in Recovery is for an individual to take control, make choices, and develop a sense of self-worth and hope.
- Recovery is a unique process because every individual is unique – it is a personal journey.
- Recovery involves a person accepting responsibility for their own wellness.
- Recovery is about engagement and inclusion, participating in one's community, engaging in vocational, educational, leisure interests and enjoying life.
- Recovery requires a holistic approach that addresses an individual's psychological, social, environmental, spiritual and physical needs.

Recovery does not mean discharge from Mental Health Services, although in some cases this may happen. It is important to emphasise that Recovery is not the same as cure – not all are cured but all can be recovered.

Figure 1:

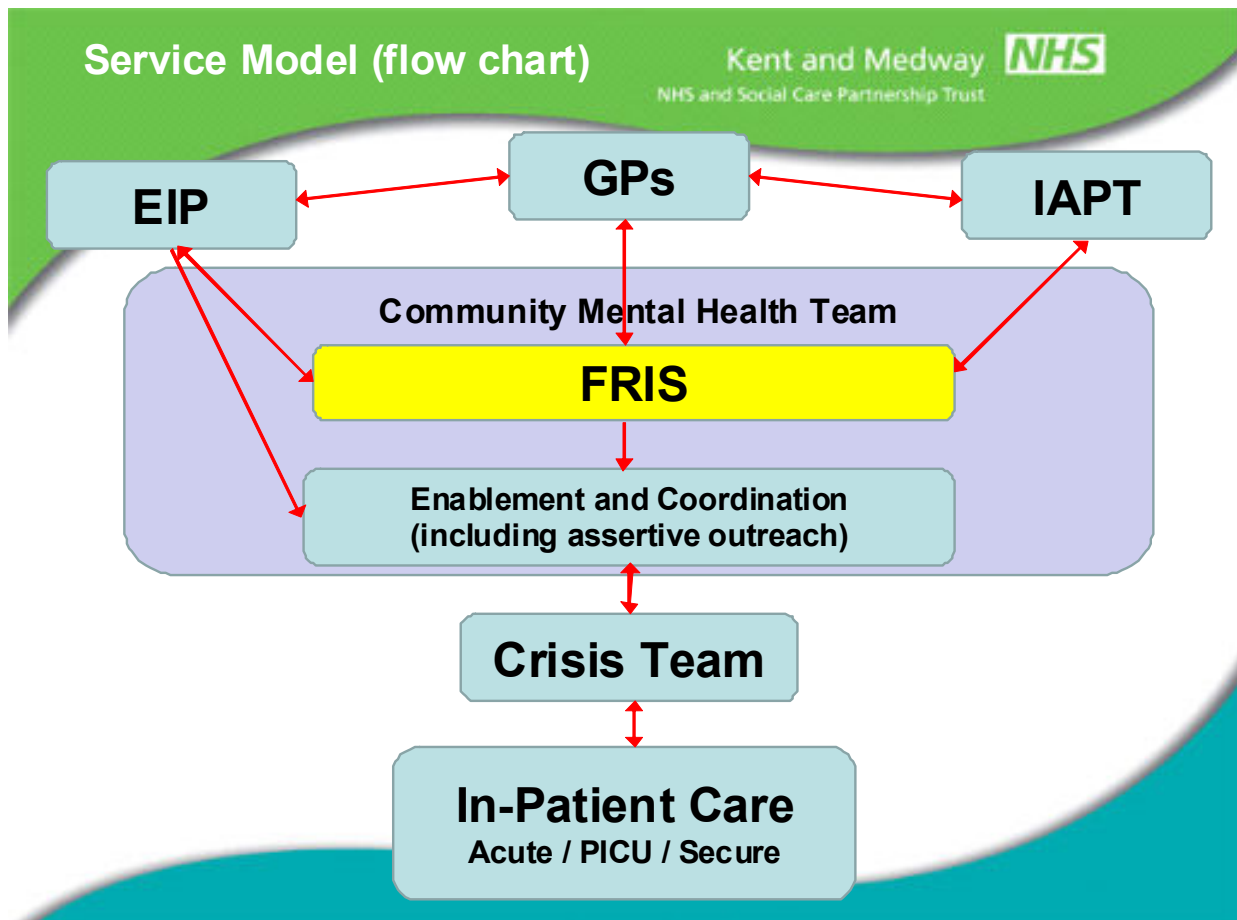


Figure 1: Glossary of Terms:

<i>EIP</i>	:	<i>Early Intervention in Psychosis</i>
<i>GP</i>	:	<i>General Practitioner</i>
<i>IAPT</i>	:	<i>Improving Access to Psychological Therapies</i>
<i>FRIS</i>	:	<i>First Response Intervention Service</i>
<i>PICU</i>	:	<i>Psychiatric Intensive Care Unit</i>

This report does NOT include details of the following Trust services:

- Older Adults Mental Health Services in Community Teams and Hospital Provision
- Children and Younger Peoples' Mental Health Services
- General Hospital / Accident and Emergency – Mental Health Liaison Services
- Drug and Alcohol Community Services and Supporting Hospital Care
- Mental Health Learning Disability [MHL D] and Community Forensic initiatives such as Court Diversion
- Offender Mental Health Services in Prisons

If the Committee would like to receive further information or future presentations on these topics we would be only too happy to oblige.

**HOSC Questions / Issues:**

1. *Can you provide an overview of the kind of Community Mental Health Services which you provide?*
3. *What are the main routes by which people access Community Mental Health Services?*
9. *What is the connection between Primary Care Services such as General Practitioners [GP] and Community Mental Health Services?*

**Community Mental Health Teams [CMHT]:** CMHTs are the main teams providing treatment and care coordination for service users. They are currently being reconfigured into seven locality areas. These areas will be coterminous with Kent County Council [KCC] Kent Adult Social Services [KASS] localities and support a population of approximately 250,000.

- Dartford, Gravesend and Swanley
- Maidstone
- South West Kent
- Swale, Canterbury and Coastal
- Shepway and Ashford
- Thanet, Dover and Deal
- Medway

From early 2011 each locality will have the following services:

- a) **First Response Intervention Service [FRIS]:** The FRIS will be the single point of access for all mental health referrals into secondary care. The purpose of these teams is to create an uncomplicated process for accessing Adult Mental Health Services within the community. Approximately 75% of referrals come from GPs. They work according to **Recovery** oriented values to enable those who are experiencing mental health problems to stabilise, maintain social functioning and live independently in the community.  
They work to promote **personalisation and self-directed support**. This will be achieved through direct payments, personal budgets, individual budgets and self-assessment in order that individuals are promoted as the primary decision-maker.
- b) **Enablement and Coordination Service:** This service provides long term support to those with long term complex mental health needs by offering a community focused service to adults with mental health problems of sufficient severity or complexity to require specialist intervention. There is a multi-disciplinary approach that is flexible and prompt in response to individuals, and includes assessment of mental health problems and provision of effective, evidence-based treatments.

Most people will be referred to the Enablement and Coordination Team by the FRIS.

- c) **Assertive Outreach Service [AOS]:** AO is defined as a systematic care co-ordination and treatment framework which is combined with a comprehensive range of service provision including crisis stabilisation and longer term rehabilitation, where interventions are vigorous, continuous over the long term and typically undertaken in the community for a carefully targeted client group with whom supportive and consistent relationships with mental health workers are a key feature.

The principle aim of AOS is to engage those service users who have demonstrated a reluctance / inability to use mainstream services and who because of their non-engagement with existing support services are deemed at risk of deterioration in their mental health, possibly causing harm to themselves or others.

The primary function of the team is to help service users to achieve the best possible quality of life through a service user centred and recovery approach.

Additional key functions carried out by CMHTs:

**Support to Carers:** Caring can be demanding and should be acknowledged by professionals. Assumptions about their ability and willingness to continue caring never just assumed. Carer's needs should therefore be recognised and supported whilst understanding cultural implications. Critically, Carer's Assessments should be offered and provided and consideration should be given to carer's own support plan when care planning.

A young carer is a child or young person under the age of 18 carrying out significant caring tasks and assuming a level of responsibility for another person, which would normally be taken by an adult. When undertaking assessments, professionals identify if there is a young carer and ensure a Carer's Assessment is undertaken to enable their needs to be met. Young carers should receive adequate support to minimise any adverse effects of their caring responsibilities.

Further community based Mental Health Services outside of the CMHT model:

- a) **Crisis Resolution and Home Treatment Teams [CRHT]:** The CRHT provides help to clients in crisis, by offering short-term, intensive intervention lasting from a few days up to a maximum of four weeks. Staff visiting clients will focus on developing and maintaining a safe environment for them, working in a way that empowers and promotes independence.

The CRHT offer a service 24 hours a day 365 days a year. They provide services in response to crisis with community based assessment and treatment. They act as a gatekeeper to inpatient care and offer an alternative to hospital admission and facilitate early discharge.

- b) **Primary Care Psychological Therapy Services [PCPTS]:** As part of the national Improving Access to Psychological Therapies [IAPT] programme.

In the last twelve months KMPT has expanded its provision of primary mental health care as a result of national IAPT funding. In West Kent, in particular, KMPT is the sole provider of IAPT and works closely with GPs to provide screening, assessments and treatment directly into GP practices while also expediting upward referrals into secondary care where appropriate. This services delivers evidence based talking therapy treatments to people with the common mental health problems of anxiety and depression.

This service now offers a rapid progression to treatment with those being referred to the service being offered an assessment within a maximum of ten working days.

More information about the IAPT programme can be found at: [www.iapt.nhs.uk](http://www.iapt.nhs.uk).

- c) **Early Intervention in Psychosis Service [EIPS]:** This is a specialist service for people aged 14 to 35, staffed by professionals who are experts in assessing, treating and supporting young people in the early stages of a psychotic illness. It can help young people recovering from psychosis to manage everyday activities and maintain links with friends and the wider community.

EIPS assess young people, where possible with their families, and can offer support for up to three years and if appropriate, this may include social, psychological and emotional support, as well as medical input. Research shows this combination works.

The service takes referrals from any source, including directly from parents, friends and relatives.

- d) **Personality Disorder Services [PDS]:** The West Kent and Medway PDS provides for patients with a diagnosis of severe personality disorder. It is a tertiary service, taking referrals through the Care Programme Approach [CPA] process from within Adult Mental Health Services.

At the hub is the Brenchley Unit Therapeutic Community. This is a day therapeutic community situated in Maidstone town centre. It provides twenty-four patients at any one time with an intensive three days a week Group Therapy Programme for one year. Referrals are patients who have severe longstanding problems and who have been in Adult Mental Health Services for one year or more.

- e) **Mother and Infant Mental Health Services [MIMHS]:** MIMHS is for pregnant women, or women with babies up to one year old who are registered with a GP across Kent.

The service caters for women with new onset of mental health problems or history of depression, psychosis or family and personal history of severe and enduring mental illness.

The service provides education, training, specialist advice, consultation, joint assessment, care planning and review. All referrals to the service come from the appropriate Adult Mental Health Services as detailed above.

#### **HOSC Questions / Issues:**

2. *How many people access these (Community Mental Health) Services each year?*

The following table (Figure 2) identifies the number of individuals who had contact with services in the year 1 October 2009 to 30 September 2010, some of these will remain on the caseload whereas others may have only had one contact before discharge.

Due to the delivery of service within a multi-disciplinary approach and the methods of recording on KMPT's electronic record it is not always possible to breakdown such figures to all levels of service. For example both FRIS and Enablement and Coordination are captured jointly under Secondary Care Community Services:

Figure 2:

Service	Number of individuals seen at least once in year 1 October 2009 to 30 September 2010
EIPS	799
Horizons	286
MHLD	780
Psychology	2,629
Secondary Care Community Services	19,563
<b>ALL COMMUNITY RECOVERY SERVICES</b> (excludes duplicates seen in more than one service type)	<b>21,482</b>

These figures do not include the PCPTS. This service expects to see approximately 13,000 people a year once fully fledged, some of these patients may go on to be seen by other Community Mental Health Services.

#### **HOSC Questions / Issues:**

4. *Can you please provide any relevant Patient Advisory Liaison Services [PALS] data relating to Community Mental Health Services?*

PALS aims to help patients and carers with their questions and problems concerning health and related services. The National Health Service [NHS] can then learn from patients' experiences.

PALS representatives can provide advice for service users and their carers and information about KMPT's services.

PALS not only works to help give information to service users about Community Mental Health Services, but to also highlight where problems arise, lessons can be learned and improvements made. PALS plays a key role in service user involvement and works with Service Managers on service development projects.

Typical issues PALS may work with front line services to develop and improve include continuity of care, links between services, transfer procedures and implementation of the Recovery Model.

Only 29% of calls to PALS relate to concerns from service users.

**HOSC Questions / Issues:**

5. *How do CRHTs co-ordinate with Community Mental Health Services?*

Across KMPT there are currently five CRHTs (Dartford, Gravesham and Swanley; Eastern and Coastal; Maidstone; Medway; and South West Kent). All five CRHTs work within the agreed CRHT Policies and Protocols and work collaboratively and in partnership with their community colleagues.

When CRHT receive a referral from the Community Teams a joint assessment or review with the Community Team is undertaken to ensure any service proposed is the most appropriate and the service user is involved at the earliest opportunity. Whilst a known patient is on the CRHT caseload it is accepted that the CMHT Care Coordinator will work in collaboration with the CRHT and continue to visit the patient, as usual, whilst both services remain in contact with each other to update on progress. Discharge planning is a collaborative effort that begins at the time of acceptance for CRHT, there is a formal handover and once a patient is ready for transfer back to the local team in most circumstances a joint visit between CRHT and the CMHT is arranged and transfer occurs.

There are regular bed management meetings with the Community Teams to review all inpatients and those being proposed for CRHT input to streamline and refine the pathway process, along with this when CRHT are assessing inpatients for early discharge, they will also consult with and engage the Care Coordinator in this process and plan.

Where possible weekly joint reviews for clients on caseloads are undertaken. All CRHT staff use the same patient information system as CMHTs, enabling CMHTs to remain up to date with the progress of someone on the CRHT caseload.

Out of Hours: CRHT accept referrals from the Police, Ambulance, Emergency GP Service, Liaison Mental Health Services, Mental Health Matters Helpline, NHS Direct, KCC Out Of Hours Service, service users and carers. These referrals are screened and, where a crisis response is not required, referred to the CMHTs the following working day. This ensures that access to Mental Health Services is 24/7 for all.

**HOSC Questions / Issues:**

6. *How do Forensic Psychiatry Services co-ordinate with Community Mental Health Services?*

KMPT's Forensic Psychiatry Service provides Inpatient Services, Custody Liaison Services, Forensic Case Management to Kent patients placed out of the county, and community follow-up to patients who have been discharged from the Trevor Gibbens Unit. It also provides an assessment service to local Mental Health Services when they have concerns about their service users.

The Kent Forensic Psychiatry Services has a Community Team that is comprised of a number of different elements and the team members involved liaise very closely with local Community Mental Health Teams to ensure a smooth transition for patients returning to the community from High, Medium and Low Secure Services and those who have been detained in Police custody and are in need of psychiatric interventions.

At all stages in a patient's journey of recovery, local Community Mental Health Services are kept fully apprised of progress and are invited to attend CPA reviews and always have an open invitation to attend the weekly Clinical Team Meetings (ward rounds). The Clinical Team liaises closely with CMHTs and Rehabilitation Services across Kent and Medway to identify suitable discharge destinations, which may include individual or group accommodation in the public or voluntary sector, or further step down transfer to another inpatient environment.

The Kent Forensic Psychiatry Service's Community and Social Work Team undertakes most of the liaison with local Community Mental Health Services in Kent. However, there is a team of Community Forensic Psychiatric Nurses who work closely with their Social Work colleagues to ensure that all patients being prepared for discharge into the community leave hospital to an appropriate placement and with a suitable supervisory package of care.

The majority of outpatients are subject to statutory supervision and the Forensic Community Psychiatric Nurses on occasion assume the role of Social Supervisor. The Risk Assessments carried out by the Clinical Team both on the Pre-Discharge Unit and subsequently in the community will identify the level of local CMHT involvement required, and establish when they can assume supervisory responsibility, if that proves to be possible. There will be joint working with local Community Psychiatric Nurses [CPNs] as early as is considered appropriate and the Forensic Community Psychiatric Nurses will only withdraw and handover to local Teams when it is agreed that the risks that might have been evident no longer justify further forensic service involvement.

#### **HOSC Questions / Issues:**

- 7. How are Community Mental Health Services being developed and how is it anticipated that these will complement or replace Mental Health Inpatient Services?*

**Redesign of Community Recovery Services:** KMPT is implementing Service Strategies for Secondary Mental Health Services, including Acute Care, Access, Older People, Community and Specialist Mental Health Services.

The Service Strategy for Community Recovery Services is in place. With the introduction of Service Line Management earlier in 2010, work commenced to develop more detailed local implementation plans with widespread service user and other stakeholder involvement, across Kent and Medway.

Key aspects of the Community Recovery Services Strategy include the full introduction of FRIS and Enablement and Coordination Services, as detailed above.

#### **Rationale:**

- **Improved Access to Services:** The development of a dedicated FRIS will improve access to Mental Health Services for service users and those who refer on their behalf. GPs in a recent listening exercise expressed concern about access to services as they feel services are not readily available when required and do not provide the appropriate advice, support and interventions.
- **The Recovery Approach:** The Recovery Approach will be embedded into the Recovery Team through a dedicated team who are skilled in psycho-social interventions and are not distracted from the care of those with serious mental health problems due to the need to react to the unpredictability of the workload in a generic CMHT.

#### **Objectives:**

- To improve the coordination of care.
- To enable a speedier access to effective treatment.
- To improve choice for service users and provide a greater control of self care through self directed support and personalisation.
- To improve the interface with Primary Care.
- To implement of New Ways of Working through the development of modern capability / competence-based teams.
- To fully implement the actions agreed from the Consultant Case Load Audit by discontinuing the present practice of routine use of outpatient clinics to manage the care of those on standard CPA.
- To develop services along service lines to support the implementation of Service Line Reporting and Management.
- To enable a more effective use of existing resources.
- To make long term savings through rationalising the use of estates.

KMPT's commitment to develop its services in partnership and cooperation with all stakeholders is captured in the following two statements which are part of our Social Inclusion, Personalisation and Recovery Strategy:

*"...To move away from a primary focus on the reduction of symptoms towards one of enabling people to do the things they want to do and lead the lives they wish to lead.*

*The yardstick of success must be the extent to which the treatment and support we provide enables them to rebuild valued and satisfying lives and to gain / maintain the homes, friends, families, relationships, jobs, social and spiritual opportunities, leisure and cultural activities that give their lives meaning...*

*"...We must move away from a culture of 'altruism' towards a 'customer service' culture where the needs, wishes, concerns and convenience of those who use services are paramount. No longer can we operate on the implicit assumption that people should 'take what you are given and be grateful for it' approach in which 'the convenience of the patient comes a poor second to the convenience of the system'. With an increasing emphasis on choice in health and social care, if people do not have a positive experience of using our services they will have the opportunity to go elsewhere..."*

To underpin the strategy, which will take effect over the next two years, we will also be:

- Realigning staff to new services.
- Rationalise estate and gain maximum value from fit for purpose buildings taking advantage of Community Budgeting Initiatives (Total Place) where possible.
- Developing closer links between Primary and Secondary Mental Health, Social Care and third sector providers.

#### **HOSC Questions / Issues:**

8. *What is the CPA and how is it used in your organisation?*

CPA was introduced by the Department of Health [DoH] in 1991 and it continues to occupy a position of prime importance in supporting the delivery of care and treatment in specialist Mental Health Services.

In March 2008 new guidance 'Refocusing the Care Programme Approach-Policy and Positive Practice Guidance' was published by the DoH.

CPA is the approach: *"...in Secondary Mental Health Services to assess, plan, review and coordinate the range of treatment, care and support needs for people in contact with Secondary Mental Health Services who have complex characteristics..."* (DoH, 2008).

KMPT has refocused its use of CPA a new policy was launched in April 2010 following widespread consultation with teams and services regarding the CPA processes.

Responsibility for CPA transferred to the Social Care and Partnerships Director. This enables CPA and Care Pathways to be aligned with the Personalisation and Recovery Agendas. It was agreed that a review of the Care Pathways Policy and Processes would include work to

ensure that these agendas could be successfully delivered by a Care Pathways Process. This work will also improve performance in the National Patient Survey as we continue to seek improvement in this area.

The links between Care Pathways and the successful delivery of Self Directed Support [SDS] are clear. The opportunity to make these links stronger is clear with the responsibility of Care Pathways being moved to the Social Care Directorate. Links have been formed with the Social Inclusion and Recovery Steering Group and the SDS Delivery Project Group.

The Care Pathways redesign work will encompass the delivery of these agendas. A new electronic care records system (RiO) will provide opportunity to ensure that these agendas can be easily and successfully encompassed in the Care Pathways (CPA) Processes.

**HOSC Questions / Issues:**

10. *Do you have comments to make on the National Patient Survey Community Mental Health Service 2010?*

The National Patient Survey 2010 for Community Mental Health Services involved sixty-six NHS Trusts in England, Foundation Trusts and Primary Care Trusts [PCTs] that provide Mental Health Services. Overall there were over 17,000 responses from service users, a response rate of 32% (KMPT also had a response rate of 32%). Service users aged 16 and over were eligible for the survey if they were seen by KMPT services between 1 July 2009 and 30 September 2009 and received specialist care and treatment for a mental health condition.

The DoH and Care Quality Commission [CQC] will use the results in measuring performance against a range of indicators.

The results from the 2010 survey for KMPT were, on the whole, disappointing.

It is clear from the year on year survey that information provision and involvement related key scores have improved. For instance, involvement in decisions about medication and overall care; and on having an out-of-hours number to call. However, scores relating to frequency of treatment have declined: that is, service users being seen in the last month. There are also a number of key issues on which scores have not moved very much at all over the eight years of the survey programme or have flattened out after an initial move upward between the first and second years.

The Trust now has Commissioning Quality and Innovation [CQUIN] targets which incorporate improvement in relation to patient experience based on the findings of the National Patient Survey.

The strategy to address the issues raised in 2010 National Patients Survey has identified key themes which we need to improve and develop. These themes have been developed following extensive discussion with Quality Health, the consultants who provide KMPT with survey results. Discussions with other Trusts have developed strategies to redress their poor performance in relation to patient feedback and analysis by the Patient Experience Group of the results.

Key themes are:

- Target four key performance issues from the results of the patient survey.
- Develop actions against these four areas.
- Develop more innovative and varied mechanisms to receive patient feedback.
- Improve engagement with service users and carers in order to increase the willingness to respond to the survey.
- Embed patient feedback into the performance reporting framework of KMPT.

Each Service Line has identified a Lead Manger to develop their action plan. It will be the responsibility of the identified Lead in each Service Line to develop action plans with support from the Patient Public Community Involvement [PPCI] Team and the Community Engagement Officer.

**Survey Findings:** The four issues that need to be addressed as a result of the survey results were identified as:

- Dignity and respect for service users.
- Engagement of the service users and their wider families.
- Care co-ordination i.e. the care plans and care review.
- Understanding of the affects and side effect of medication and addressing the physical health needs of our service users.

**Actions taken:** Each Service Line has developed action plans to address each of these four key areas; and provide monthly reports showing updates and progress made towards improving patient experience. The Service Lines also incorporate information gathered from a range of patient feedback mechanisms. These include customer care days; engagement with user and carer groups, Local Involvement Networks [LINKs] and KMPT's Patient Consultative Committees. Service Lines also utilise reports already received from voluntary organisations that monitor our services e.g. Heart of the Matter at Little Brook Hospital and the Canterbury and District Mental Health Forum at St Martins.



**Eastern and Coastal Kent**



**West Kent**

**Community Mental Health Services for Adults – Kent HOSC 26 November 2010**

<b>Eastern and Coastal Kent and West Kent</b>	
1. Can you provide an overview of the kind of community mental health services commissioned for the people of Kent?	Eastern and Coastal Kent PCT, West Kent PCT and Kent County Council commission a wide range of community mental health services from NHS, voluntary and independent sector providers.
2. Who are the main providers of these services?	<p>Primary care psychological therapies services are commissioned from three main providers: <b>Kent and Medway NHS and Social Care Partnership Trust (KMPT), KCA (UK) and Counselling Team Limited.</b></p> <p><b>KMPT</b> is the main provider of secondary care mental health services. The Trust provides the following adult mental health services in the community:</p> <ul style="list-style-type: none"><li>• First Response and Intervention Service</li><li>• Early Intervention in Psychosis Service</li><li>• Community Mental Health Teams</li><li>• Assertive Outreach Service</li><li>• Community Rehabilitation Services</li><li>• Crisis Resolution and Home Treatment Services</li></ul>

	<p>Also KMPT provides these specialist community mental health services for adults:</p> <ul style="list-style-type: none"> <li>• Eating Disorders Services</li> <li>• Mother and Infant Mental Health Services</li> <li>• Personality Disorders Service</li> <li>• Neuropsychiatry</li> <li>• Forensic Psychiatric community services</li> <li>• Police Custody Suite and Court Diversion / Liaison Service</li> </ul> <p>(KMPT delivers community mental health services for people with learning disabilities too.)</p> <p>Primary and secondary care adult prison mental health services, serving all of Kent's prisons, are commissioned from <b>Oxleas NHS Foundation Trust</b>.</p>
	<p>A wide range of services are commissioned from Kent's <b>voluntary sector</b>. They are commissioned jointly by KCC and the PCTs and each service is available in every locality in Kent. We contract with 40+ different providers, from those providing one service to those providing a wider range. They include Carers First, Rethink, Invicta Advocacy, MCCH, Mind, Shaw Trust, Tunbridge Wells Mental Health Resource and Voluntary Action Maidstone. The voluntary sector provides the following services:</p> <ul style="list-style-type: none"> <li>• Employment support services for people with mental health problems</li> <li>• Carers support services</li> <li>• Advocacy services, including Independent Advocates under the Mental Health Act</li> <li>• Service user forums</li> <li>• Community day services</li> </ul> <p>The freephone <b>mental health helpline</b> that is available out of hours is commissioned as a county wide service from the voluntary organisation Mental Health Matters.</p>

Mental health residential care is commissioned by KCC and provided by the **independent sector** in Kent and East Sussex. Currently *252 people* are in residential care placements. Some community support services are commissioned from the independent sector to provide support with daily living and independence for people with mental health problems who need support in their own homes.

Finally, a range of supported accommodation is commissioned across Kent, in partnership with Housing Associations who provide the “bricks and mortar” and Supporting People who provide much of the Housing Related Support. We have *321 people* currently in supported accommodation provision across Kent.

3. How many people access these services each year?

Most of the figures given are from KMPT contract performance information for the **half-year to date, April to September 2010 inclusive**

<b>Eastern and Coastal Kent</b>	Patients referred / seen Apr-Sep 2010)	Caseload (at end Sep 2010)	<b>West Kent</b>	Patients referred / seen (Apr-Sep 2010)	Caseload (at end Sep 2010)
<b>Adult Mental Health</b>			<b>Adult Mental Health</b>		
Primary Care Psychological Therapies Services	3846	(% recovery) 47%	Primary Care Psychological Therapies Services	1401	(% recovery) 54%
First Response and Intervention Service (refs)	2678	921	First Response and Intervention Service (refs)	2148	358
Early Intervention in Psychosis		190	Early Intervention in Psychosis		162
Community Mental Health Teams		2671	Community Mental Health Teams		4467
Assertive Outreach		252	Assertive Outreach		203

Crisis Resolution Home Treatment (home treatment episodes)	799	(days held av.) 8	Crisis Resolution Home Treatment (home treatment episodes)	587	(days held av.) 10.7
Eating Disorders Services - Community	(K&M) 74		Eating Disorders Services - Community	(K&M) 74	
Mother and Infant Mental Health Services (refs)	79		Mother and Infant Mental Health Services (refs)	77	
Personality Disorders Service - Intensive Day Treatment (refs)	11		Personality Disorders Service - Intensive Day Treatment (refs)	145	
Neuropsychiatry (first apps)	(K&M) 81		Neuropsychiatry (first apps)	(K&M) 81	
Police Custody Suite and Court Diversion / Liaison Service			Police Custody Suite and Court Diversion / Liaison Service		
Community Mental Health of Learning Disability (refs)	179		Community Mental Health of Learning Disability (refs)	350	

For the **voluntary sector**, the numbers accessing services for 2009 to 2010 are as follows:

Community day services:

- 38,693 attendances in day centres
- 13,252 attendances in community activities outside of the centres.

Mental Health Service User Forums:

- 385 participations by service users in commissioning board and other meetings

Mental Health Advocacy:

- 842 episodes under the Mental Health Act
- 2,231 episodes of other advocacy to mental health service users

Mental Health Carer support services:

- Over 4000 carers are being supported at any one time
- 729 carers received a carer's break
- 169 participations by carers in commissioning boards and other meetings

Mental Health Employment support services:

- Over 300 people are supported in work at any one time
- 109 people with severe mental health problems returned to work for over 13 weeks

Mental Health Helpline:

9,443 calls answered from callers in Kent

<b>Eastern and Coastal Kent and West Kent</b>	
<p>4. How much do you spend on adult mental health services each year, and how much is spent specifically on community mental health services?</p>	<p>HOSC Members are guided to the financial summary at Appendix 1 in the Live It Well strategy at <a href="http://www.liveitwell.org.uk/live-it-well-vision/">http://www.liveitwell.org.uk/live-it-well-vision/</a>.</p>
<p>5. What are your expectations for both these amounts in coming years?</p>	<p>The summary gives the PCTs' expenditure on Mental Health by <b>Programme Budgeting</b>, i.e. PCT spending on <i>all</i> healthcare resource use by people with a primary diagnosis of a mental health condition, and the target reductions by 2014/15 that are set by the PCTs in their Strategic Commissioning Plans 2010.</p> <p>The expressed reductions are: ECK PCT to reduce from spending £130.8m to £126m a year (- 3.8%) a year and WK PCT to reduce from £97.3m to £91m (- 6.5%), which is a sum of £11.1m less expenditure.</p>

In addition, Live It Well Appendix 1 gives overview information on the results of **Mental Health Financial Mapping**, which shows PCT and KCC expenditure on adult mental health services, including pounds spent per weighted head of population. The *service categories* used in the financial mapping reports do not split expenditure between community and inpatient services.

The majority of PCT spend is with **KMPT** for community mental health services. The contract values, or budget lines, are not split between community and inpatient services for all services.

Across Kent and Medway the PCT spend (rounded) on community mental health services is:

- £5m on primary care psychological therapies services
- £15m on secondary care mental health *access* services, including First Response and Intervention, Early Intervention in Psychosis and Liaison Psychiatry
- £32m is spent on secondary care mental health *recovery* services, including Community Mental Health Teams, Assertive Outreach and Community and Inpatient Rehabilitation Services
- £8m on Crisis Resolution and Home Treatment services
- £2m on community mental health of learning disability services

Further, and *not* split between community and in-patient services, it is:

£14m on specialist mental health services and forensic psychiatry services, including the following community services: eating disorders, mother and infant mental health, and personality disorder services; and forensic psychiatric community services and police custody suite diversion services.

KCC provides a further £22m to KMPT, most of which is for First Response and Intervention services and Community Mental Health Teams and related services.

The level of funding of the mental health **voluntary sector** in Kent exceeds £5m a year, of which the PCTs contribute almost £1m.

Recent months, pre- and post- the White Paper (Equity and excellence: Liberating the NHS, 2010), have seen the increasing requirement for the NHS to deliver Quality Innovation Productivity and Prevention (QIPP) plans (nationally and to the Strategic Health Authority, with QIPP being the vehicle where cost savings should be expressed). QIPP plans run over four years from 2010/11 to 2013/14. Kent County QIPP plans are being developed for Adult and Older Persons' Mental Health Services, and separately for Dementia services. The Mental Health QIPP plan recognises the same savings targets as expressed in the Strategic Commissioning Plans identified above - £11.1m – and sets out to achieve 60% or **£6.7m** of these savings in relation to healthcare and mental health services for adults and older person (except dementia).

The Mental Health QIPP envisages three key forthcoming transformations in mental health services:

- Transform care pathways for people with common mental health problems, and people with severe mental illness in recovery, enabling more service users to be supported in / by primary care.
- Develop effective alternative community management and supports to reduce acute in-patient mental health service admissions and lengths of stay.
- Implement a tariff-based system of PBR for mental health services.

Additionally, it provides for mental health services making a positive contribution to reducing both Acute Hospital and Ambulance service costs incurred in providing for some people with a primary diagnosis of a mental health condition.

The post-White Paper environment will expect us to secure agreement on these directions with GP Commissioning Consortia, and we are in the foothills with that process and mental health. We also have to factor in the planned cost-reductions on KCC funding for mental health services.

	<b>Eastern and Coastal Kent and West Kent</b>
6. Can you provide an outline of the process by which commissioning decisions relating to community mental health services are made (including joint commissioning with other commissioners)?	<p>The mental health commissioning infrastructure includes three levels that move from holding a panoramic view of Kent and Medway to a wide-angle lens on a PCT area to a bird's eye view of a locality.</p> <p>Each of the PCTs and KCC is ultimately responsible for the commissioning strategy and decisions it makes, and deploying their resources accordingly. However, there is a Kent and Medway Strategic Commissioning Board for Mental Health, with membership at Executive level from the two Councils and three PCTs, which holds NHS Medway, the PCT Lead commissioner for adult mental health, to account; and co-ordinates and reviews commissioning strategy and delivery. The Strategic Commissioning Board meets three times a year to forward plan service development and evaluate performance. It watches over the whole of the mental health service system and also public mental health.</p> <p>In each of Eastern and Coastal Kent and West Kent PCT areas there is a PCT and KCC Joint Commissioning Board for Mental Health, which comprises commissioners from the PCT and Council, GP / clinical commissioners, and mental health service user and carer representatives. Planning service development and reviewing performance are key functions, and there will also be discussion about differential commissioning for different localities within a PCT area.</p> <p>Each Joint Commissioning Board is informed by feedback from the Local Planning and Monitoring Groups for mental health that bring together representatives of mental health service providers – KMPT and voluntary sector in the main – service users and carers, and commissioners. There are ten Locality Planning and Monitoring Groups in Kent, six in eastern and coastal Kent and three in west Kent. Locality Planning and Monitoring Groups ensure that people in the local mental health services know each other well, and they identify and then solve local issues wherever possible.</p>

	<b>Eastern and Coastal Kent and West Kent</b>
7. Can you please provide any relevant PALS data relating to	KMPT have provided us with a Trust-wide PALS report for Quarter 1 2010/11. The report summarises service user, carer and public contacts with KMPT PALS, together with any

community mental health services?	<p>common themes, follow up actions and implications for service improvement that took place between April and June 2010.</p> <p>During the Quarter, a total of 316 PALS contacts occurred. This compares with 225 contacts (+40%) for the same period during 2009/10, and 276 contacts (+14%) for the period from January to March 2010.</p> <p>This is the first PALS quarterly report that KMPT has produced, and the Trust reports that the Datix system (from which it draws the data) is 'not currently set up to easily report on service lines'. KMPT is working to resolve this. PALS is also responsible for keeping a record of written compliments received throughout the Trust. A total of 75 compliments were received in the quarter, which compares with 66 (+14%) received in the previous quarter.</p> <p>The report is attached for Members' interest.</p>
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8. How are community mental health services being developed and how is it anticipated that these will complement or replace mental health inpatient services?	<p><b>Eastern and Coastal Kent and West Kent</b></p> <p>Following production of the Live It Well strategy we are now progressing three large scale developments which will have significant impact on how mental health services are delivered. These are included in the Mental Health QIPP programme, and therefore imply cost savings.</p> <p>The first of the transformational changes is to create support mechanisms for more patients to be managed in primary care settings, in particular (a) people with common mental health conditions and (b) people with a severe mental illness who are stable or living in recovery. The intention is to see fewer referrals to secondary care community mental health services and a shorter duration of treatment and support in secondary mental health care. This will require the development of more mental health capacity and competence in primary care, including dedicated primary care mental health resources and systems like 'shared care'. We are currently developing with KMPT the roll out of the First Response and Intervention Service (FRIS) model that aims to provide quicker access to secondary care mental health services and an active liaison function with GP Practices. We and KMPT are also developing a recovery model approach in Community Mental Health Teams, which will lead to more people who are stable being returned to primary care for their future care with easy access back into services should they require this.</p>
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The second transformational change will be the development of effective alternative community management and supports for those in need of an emergency response, to reduce acute admissions and also to speed up discharge. More intensive support may be needed by Crisis Resolution Home Treatment services, which can provide treatment *at home* for people in a mental health crisis, in order to keep more people supported out of hospital; and we will aim to reduce the reliance on acute in-patient mental health beds.

The third transformational change will be moving the pricing structure for contracts from a block basis to a Payment by Results basis. Mental Health service users will be grouped by needs clusters, and a tariff will be attached to each cluster. Our particular interest will then be in understanding in much greater detail the cost base of the care we commission, and where we can focus attempts to make savings.

**Eastern and Coastal Kent and West Kent**

9. What is the connection between primary care services such as GPs and community mental health services?

In Mental Health, usually it is the nature and degree of mental illness (not the location of the service) that distinguishes between primary and secondary care.

In general, people with common mental health problems (e.g. mild, moderate and sometimes severe anxiety and / or depression) are managed by GPs who may prescribe medication, refer to primary care psychological therapies services and / or to mental health services provided by the voluntary sector. Few of these patients are referred to the community mental health services provided by KMPT.

Patients with severe mental illness, many of whom enter services at the GP, can be referred to KMPT as either emergency, urgent or routine – depending on need, risk or severity of presentation. There are 4 hour, 24 hour and 4-weeks waiting times targets for KMPT’s response to emergency, urgent and routine referrals, respectively. The First Response and Intervention Service and Crisis Resolution Home Treatment Service are the usual first points of response from KMPT.

	<b>Eastern and Coastal Kent and West Kent</b>
10. How is the performance of providers assessed and monitored?	<p>For KMPT services, the PCTs have a comprehensive system in place. This year we re-organised our arrangements to monitor KMPT performance by its Service Lines, as follows:</p> <ol style="list-style-type: none"> <li>1. Recovery Services and Acute Services</li> <li>2. Forensic Psychiatry Services and Mental Health of Learning Disability Services</li> <li>3. Specialist Mental Health Services and Older Persons' Mental Health Services</li> </ol> <p>Formal performance management of each Service Line is eight times a year for 1 above and quarterly for 2 and 3 above. The management is through meetings of Joint Performance Review Groups that include commissioner, PCT and KCC, KMPT and mental health service user and carer representation.</p> <p>A comprehensive set of data requirements covering activity and ethnicity monitoring and Key Performance Indicators is specified in the PCT-KMPT Contract and reviewed at these meetings, with performance improvement action plans generated and followed through as appropriate. Most of this information can be viewed at PCT level; if performance is different between ECK and WK, it is evident.</p> <p>Over viewing this, there are two other specific meetings: the Quality Assurance Group and the Quarterly Performance Review Group.</p> <p>The Quality Assurance Group focuses on a contractually agreed set of Quality Performance Indicators, including service specific and workforce measures, and also monitors progress on the Commissioning for Quality and Innovation scheme Indicators. (The latter is a financial incentive scheme for improved quality). This Group meets 6 times a year.</p> <p>The Quarterly Performance Review Group takes an overview of KMPT's performance on all services across all areas. It is chaired by the NHS Medway Chief Executive and includes PCT representation at Executive level and the KMPT Chief Executive and some Executive Directors. It meets four times a year.</p> <p>Voluntary organisations are funded through service agreements, via a joint arrangement between the PCTs and KCC. KCC undertakes the administration. Every voluntary</p>

organisation has a service specification and an annually issued schedule with numerical outcomes. They report against these every 6 months and are monitored by the KCC mental health commissioning and contracting team together with the PCT mental health commissioner for the area.

Residential care homes are also performance managed by the KCC mental health commissioning and contracting team. They have regular monitoring visits, some unannounced, using a comprehensive monitoring for quality schedule which complements the Care Quality Commission inspections.

## East Kent

### 1. CONTEXT

This report, prepared by Mental Health Strategies is derived from an analysis of the financial mapping returns received mainly in December 2009 - February 2010 and presents results from the LIT perspective. It includes ONLY information received and if investment is known to be missing for your individual LIT, then this is flagged up on the first report.

The report provides an overall picture of reported investment in adult and older people mental health services for your geographical area, including delivery of services from all providers to, and all commissioners for the LIT, not just NHS organisations.

The financial maps were designed to dovetail with service mapping; to give a detailed and comprehensive picture of the national investment in mental health services; and to enable LITs to use the autumn review results to evaluate their local services. The overall objectives of the initiative are to:

1. provide financial transparency in mental health
2. increase understanding around allocation and spend for mental health
3. improve confidence in, and so validity of mental health financial information, and
4. facilitate the monitoring by DH development of priority mental health services.

The direct service costs (primarily staffing costs) of adult mental health are analysed by sixteen service categories and thirteen categories for older people. Additionally, indirect costs, overheads and capital charges which are not directly allocated to the service categories, are included to identify each LIT's total investment in adult or older people mental health services.

From October 2009 online guidance notes were available for completion of financial maps whilst the DH notified participating organisations. LIT leads were responsible for co-ordinating and delivering the exercise locally, although finance staff in provider and commissioning units actually produced the data. LIT leads distributed blank returns to all providers delivering services to their LIT where they would be broken down by commissioner and returned to LITs for initial validation.

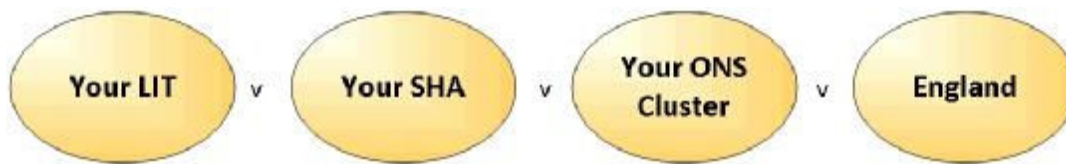
All the spreadsheets were then forwarded to Mental Health Strategies for further validation and production of reports to LITs, provider trusts and PCTs.

### 2. ISSUES

The overall quality of the data nationally supplied from organisations inevitably varies but has been validated by the supplying organisations, LITs and ourselves. However, 2009/10 is only the fourth year that local authorities have collected OPMH finance mapping figures and thus overall, their figures are unlikely yet, to equal the quality or coverage, of the now well established adult finance mapping data. The OPMH analyses should therefore be considered, to a degree, to be provisional, and can be expected to improve in future years. Note that a number of West Midlands LITs did not provide data and this will have affected SHA results for this area.

### 3. THE COMPARATIVE ANALYSIS

Three comparators are used to compare your LIT in 2009/10 as shown below:

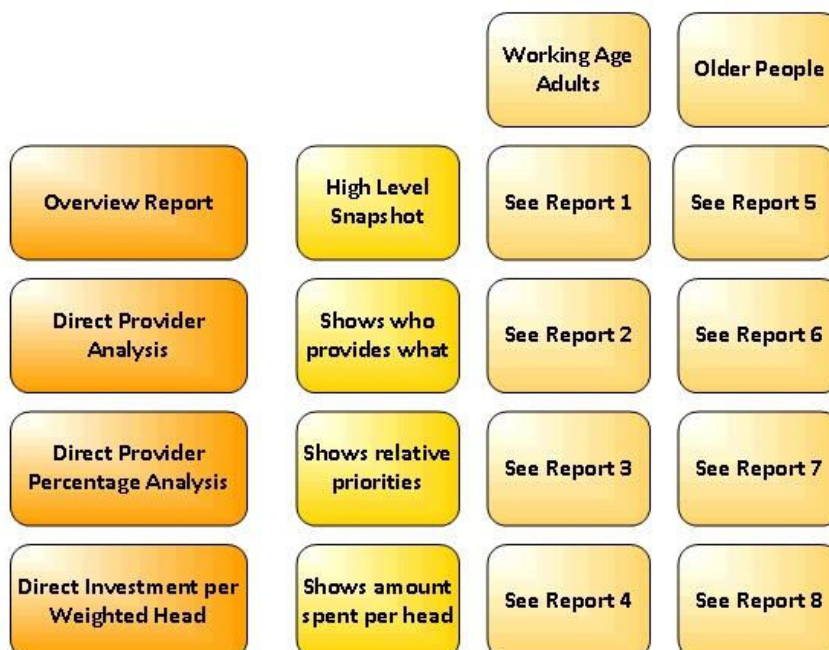


The ONS Cluster refers to the latest classification by the Office of National Statistics (ONS), which allocates all local authorities and health authorities to one of twelve "family groups", or areas with broadly similar characteristics. The ONS Group health area classifications are:

- (a) Centres with industry
- (b) Coastal and Countryside
- (c) Industrial Hinterlands
- (d) London Centre
- (e) London Cosmopolitan
- (f) London Suburbs
- (g) Manufacturing Towns
- (h) New and Growing Towns
- (i) Prospering Smaller Towns
- (j) Prospering Southern England
- (k) Regional Centres and,
- (l) Thriving London Periphery.

The classification is based upon the predominant characteristic of the area's population, not its geography. For those LITs servicing an area not exactly matching a local authority area, the allocation is drawn from the authorities making up the LIT area. Where LITs have merged, we have taken the predominant ONS cluster as "best fit" or classed it as "Mixed ONS Cluster".

The comparative analysis is presented in eight reports providing both a high level and a detailed analysis of investment as follows:-



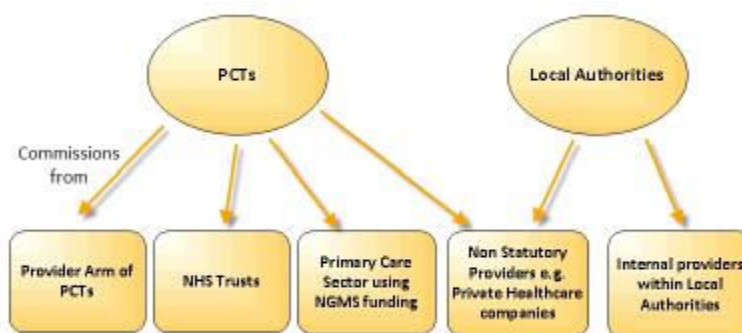
Please note that the figures reflect the way in which submitting organisations have treated indirect costs, capital charges and indirect costs. Consequently the figures in Reports 2, 3 and 4 and Reports 6, 7 and 8, are dependent on the extent to which indirect costs, capital charges and overheads are absorbed into direct service categories. Individual percentage figures in the reports have been rounded up/down for clarity.

This LIT report is based solely on the figures received and the weighted populations for those LITs who have submitted data. The National Report (see below) includes estimates of any missing information.

The direct service categories used in the Older People Reports 6, 7 and 8 are taken from the service development guide document "Everybody's Business - integrating mental health services for older adults" published by CSIP in November 2005.

Note: LIT Report 2 shows the reported direct services investment by the type of organisation which has physically provided it, and NOT by the organisation type commissioning it.

PCTs will typically commission services from NHS Trusts and private healthcare providers. Similarly Local Authorities typically commission services from within their own internal organisation (shown under the "Social Services" Provider heading) and private healthcare providers e.g. residential care homes (shown under the "Non Statutory" Provider heading).



#### 4. ABOUT THE WEIGHTED POPULATIONS FOR THE LIT

This year we have completely recalculated the weighted populations for each LIT, for both need and cost factors using the 2008 mid year population estimates kindly supplied by the Office of National Statistics and updated cost factors from the Department of Health to produce two weighted populations - one for 18-64 year olds and one for those 65 and over.

The weighted populations used within financial mapping are already weighted for both mental health need AND financial factors (e.g. market forces factor), to enable a fair comparison of investment between high and low cost areas. Thus it already takes into account the higher cost of staff in areas such as London thus facilitating direct comparison.

The advantage is that these updated weighted populations are now more representative, the downside is that the investment per weighted head figure will not be directly comparable to those shown in the years 2008/09 and earlier.

#### 5. ABOUT THE NATIONAL REPORT

The National Report which is published after these LIT reports estimates the level of missing, that is "unreported" investment and will inevitably be based on different (greater) totals of both investment and weighted populations. Consequently the more "inclusive" weighted investment figures reported in that National Report may differ from those here.

## LIT Report 1 - Overview of adult investment

Your LIT's total investment in adult mental health services is analysed in four cost groupings - direct costs, indirect costs overheads and capital charges, showing the combined investment from both PCTs and Local Authority commissioners and including all types of provider. The figures identify the extent to which your LIT investment is spent on direct care costs or other costs.

Investment is compared both in overall and percentage terms against Strategic Health Authority, ONS cluster and national figures, rounded up/down for presentation purposes.

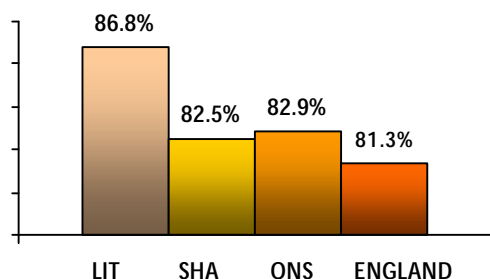
Your LIT's total investment is tabled below followed by two charts showing the percentage of investment reported spent on direct services and the overall investment per weighted head of population for the LIT.

Service category	£'000s	Percentage			
		This LIT	This SHA	This ONS	English LITs
DIRECT COSTS:	£57,520	86.8%	82.5%	82.9%	81.3%
INDIRECT COST:	£5,614	8.5%	8.3%	7.7%	7.0%
OVERHEADS:	£2,232	3.4%	6.0%	6.9%	9.0%
CAPITAL CHARGE:	£936	1.4%	3.2%	2.5%	2.7%
Total adult investment in £'000s	£66,302	100.0%	100.0%	100.0%	100.0%

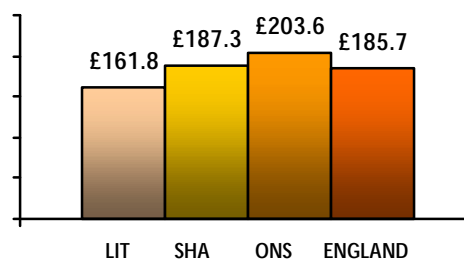
This report compares the total adult investment within your LIT, with the total adult investment of your Strategic Health Authority, the ONS cluster of the LIT and the English national average.

COMPLETENESS OF ADULT DATA: No missing data known

% Investment in Adult Direct Services



Adult Weighted Investment per Head



Working Age Weighted Population for LIT 18 -64 - weighted for both Need and Cost to ensure fair comparison of investment between high and low cost areas. 409,672

## LIT Report 2- Adult direct services provider analysis

Here your LIT's direct services investment is analysed over the four main types of provider - NHS, non GMS, local authorities and the non statutory sector.

It shows who is reported as physically providing the service - NOT who commissions and pays for it. e.g if a PCT or Local Authority commissions a service from a private (that is non statutory) provider, that part of its investment will be shown under the "Non Statutory" provider type column.

The non statutory sector comprises voluntary, independent and private sector providers.

LIT	St HA	ONS			
East Kent	NHS SOUTH EAST COAST	Coastal and Countryside			
Service Category	Provider type				
	NHS	NGMS	Social Services	Non statutory	Total
Access & Crisis Services	£4,481	£0	£0	£0	£4,481
Accommodation	£0	£0	£0	£5,860	£5,860
Carer's Services	£0	£0	£0	£279	£279
Clinical Services	£10,808	£0	£0	£2,272	£13,081
Community Mental Health Teams	£7,643	£0	£0	£3,894	£11,537
Continuing Care	£3,679	£0	£0	£1,687	£5,366
Day Services	£0	£0	£0	£1,355	£1,355
Direct Payment	£0	£0	£0	£139	£139
Home Support Services	£0	£0	£0	£804	£804
Other community and hospital professional teams/specialists	£49	£0	£0	£985	£1,033
Personality Disorder Services	£0	£0	£0	£1,774	£1,774
Psychological Therapy Services (IAPT)	£0	£0	£0	£271	£271
Psychological Therapy Services (Non IAPT)	£2,642	£0	£0	£0	£2,642
Secure and High Dependency Provision	£5,031	£0	£0	£3,569	£8,600
Support Services	£54	£0	£0	£244	£298
<b>Total direct services in £'000s</b>	<b>£34,387</b>	<b>£0</b>	<b>£0</b>	<b>£23,133</b>	<b>£57,520</b>
<b>% provided by each provider type</b>	<b>60%</b>	<b>0%</b>	<b>0%</b>	<b>40%</b>	<b>100%</b>

COMPLETENESS OF LIT DATA: No missing data known

Note: Only those direct services reported as supplied to the LIT are shown above.

## LIT Report 3- Adult direct services percentage analysis

Here your investment in each of the direct service categories is expressed as a rounded up percentage across the three comparator areas.

LIT St HA ONS  
**East Kent** NHS SOUTH EAST COAST Coastal and Countryside

Service category	£'000s	Percentage			
		This LIT	This SHA	This ONS	English LITs
Access & Crisis Services	£4,481	7.8%	11.0%	10.1%	11.1%
Accommodation:	£5,860	10.2%	8.8%	9.7%	9.5%
Carer's Services:	£279	0.5%	0.6%	0.6%	0.5%
Clinical Services:	£13,081	22.7%	20.5%	16.7%	17.2%
Community Mental Health Teams:	£11,537	20.1%	16.5%	15.8%	14.3%
Continuing Care:	£5,366	9.3%	8.3%	12.3%	11.6%
Day Services:	£1,355	2.4%	3.4%	3.4%	3.2%
Direct Payment:	£139	0.2%	0.5%	0.4%	0.4%
Home Support Services:	£804	1.4%	3.0%	1.9%	2.3%
Mental Health Promotion Services:	£0	0.0%	0.0%	0.1%	0.1%
Other community and hospital professional teams/specialists:	£1,033	1.8%	1.9%	1.8%	1.9%
Personality Disorder Services:	£1,774	3.1%	1.7%	0.8%	0.6%
Psychological Therapy Services (IAPT):	£271	0.5%	2.2%	1.8%	2.5%
Psychological Therapy Services (Non IAPT):	£2,642	4.6%	4.1%	3.6%	3.5%
Secure and High Dependency Provision:	£8,600	15.0%	14.7%	19.3%	18.9%
Services for Mentally Disordered Offenders:	£0	0.0%	1.6%	0.9%	1.2%
Support Services:	£298	0.5%	1.1%	0.7%	1.3%
<b>Total direct services in £'000s</b>	<b>£57,520</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>
<b>COMPLETENESS OF LIT DATA:</b>	<b>No missing data known</b>				

## LIT Report 4- Adult direct services investment per weighted head

Here your investment in each of the direct service categories is expressed as an investment per weighted head across the three comparator areas.

LIT St HA ONS  
**East Kent** NHS SOUTH EAST COAST Coastal and Countryside

Service category	£'000s	Weighted Investment per head			
		This LIT	This SHA	This ONS	English LITs
Access & Crisis Services:	£4,481	£10.9	£17.0	£17.1	£16.8
Accommodation:	£5,860	£14.3	£13.7	£16.3	£14.3
Carer's Services:	£279	£0.7	£0.9	£1.0	£0.8
Clinical Services:	£13,081	£31.9	£31.7	£28.2	£25.9
Community Mental Health Teams:	£11,537	£28.2	£25.6	£26.7	£21.5
Continuing Care:	£5,366	£13.1	£12.9	£20.8	£17.5
Day Services:	£1,355	£3.3	£5.2	£5.8	£4.8
Direct Payment:	£139	£0.3	£0.8	£0.7	£0.6
Home Support Services:	£804	£2.0	£4.7	£3.2	£3.4
Mental Health Promotion Services:	£0	£0.0	£0.1	£0.1	£0.1
Other community and hospital professional teams/specialists:	£1,033	£2.5	£2.9	£3.1	£2.9
Personality Disorder Services:	£1,774	£4.3	£2.6	£1.3	£0.9
Psychological Therapy Services (IAPT):	£271	£0.7	£3.5	£3.0	£3.7
Psychological Therapy Services (Non IAPT):	£2,642	£6.4	£6.3	£6.1	£5.3
Secure and High Dependency Provision:	£8,600	£21.0	£22.6	£32.6	£28.6
Services for Mentally Disordered Offenders:	£0	£0.0	£2.4	£1.4	£1.8
Support Services:	£298	£0.7	£1.6	£1.2	£1.9
<b>Total direct services in £'000s</b>	<b>£57,520</b>	<b>£140.4</b>	<b>£154.5</b>	<b>£168.7</b>	<b>£151.1</b>
<b>Working Age Weighted Population for LIT 18-64 - weighted for both Need and Cost:</b>					<b>409,672</b>
<b>COMPLETENESS OF LIT DATA:</b>		<b>No missing data known</b>			

## LIT Report 5 - Overview of OPMHS investment

Your LIT's total investment in Older People's mental health services is analysed in four cost groupings - direct costs, indirect costs overheads and capital charges, showing the combined investment from both PCTs and Local Authority commissioners and including all types of provider. The figures identify the extent to which LIT investment is spent on direct care costs or other costs.

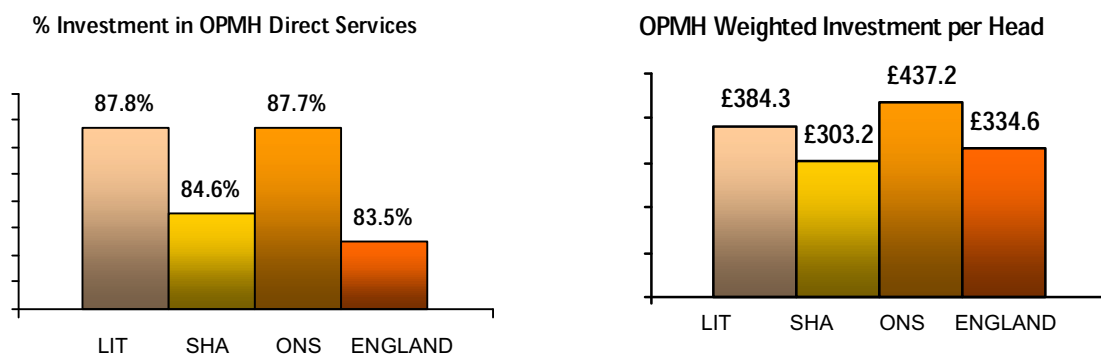
Investment is compared both in overall and percentage terms against Strategic Health Authority, ONS cluster and national figures.

Your LIT's total investment is tabled below followed by two charts showing the percentage of investment reported spent on direct services and the overall investment per weighted head of population for the LIT.

Service category	£'000s	Percentage			
		This LIT	This SHA	This ONS	English LITs
DIRECT COSTS:	£43,005	87.8%	84.6%	87.7%	83.5%
INDIRECT COST:	£3,591	7.3%	7.3%	6.1%	6.6%
OVERHEADS:	£1,716	3.5%	4.9%	4.5%	7.5%
CAPITAL CHARGE:	£683	1.4%	3.3%	1.7%	2.4%
<b>Total OPMHS investment in £'000s</b>	<b>£48,995</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

This report compares the total OPMHS investment within the LIT, with the total OPMHS investment of the LIT's Strategic Health Authority, the ONS cluster of the LIT and the english national average.

COMPLETENESS OF LIT DATA: No missing OPMH data known



OPMH Weighted Population - weighted for both Need and Cost to ensure fair comparison of investment between high and low cost areas.

127,492

## LIT Report 6- OPMH direct services provider analysis

Here your LIT's OPMH direct services investment is analysed over the four main types of provider - NHS, non GMS, local authorities and the non statutory sector.

The non statutory sector comprises voluntary, independent and private sector providers.

It shows who is reported as physically providing the service - NOT who commissions and pays for it. e.g if a PCT or Local Authority commissions a service from a private (that is non statutory) provider, that part of its investment will be shown under the "Non Statutory" provider type column.

<u>LIT</u>	<u>St HA</u>		<u>ONS</u>		
<b>East Kent</b>	NHS SOUTH EAST COAST		Coastal and Countryside		
Service Category	Provider type				
	NHS	NGMS	Social Services	Non statutory	Total
Carer's Services - OPMH	£0	£0	£0	£24	£24
Emergency Services - OPMH	£459	£0	£0	£0	£459
Other Specialist Mental Health Services - OPMH	£16,048	£0	£0	£0	£16,048
Primary and Community Care - Day Services	£1,150	£0	£0	£230	£1,380
Primary and Community Care - Homecare	£737	£0	£0	£891	£1,628
Primary and Community Care - Residential	£0	£0	£3,383	£20,043	£23,427
Support Services - OPMH	£0	£0	£0	£40	£40
<b>Total direct services in £'000s</b>	<b>£18,394</b>	<b>£0</b>	<b>£3,383</b>	<b>£21,228</b>	<b>£43,005</b>
<b>% provided by each provider type</b>	<b>43%</b>	<b>0%</b>	<b>8%</b>	<b>49%</b>	<b>100%</b>

COMPLETENESS OF LIT DATA: No missing OPMH data known

Note: Only those direct services supplied to the LIT are shown above.

## LIT Report 7- OPMH direct services percentage analysis

Here your investment in each of the direct service categories is expressed as a rounded up/down percentage across the three comparator areas.

Service category	£'000s	Percentage			
		This LIT	This SHA	This ONS	English LITs
Care and Repair	£0	0.0%	0.0%	0.0%	0.0%
Care for People in General Hospital	£0	0.0%	0.3%	0.0%	0.3%
Carer's Services	£24	0.1%	0.3%	0.3%	0.5%
Emergency Services	£459	1.1%	0.7%	0.3%	0.5%
Intermediate Care	£0	0.0%	0.0%	0.1%	0.9%
Other Specialist Mental Health Services	£16,048	37.3%	44.5%	30.0%	42.9%
<b>Primary and Community Care:</b>					
- Day Services:	£1,380	3.2%	3.6%	2.4%	5.3%
- Homecare:	£1,628	3.8%	2.7%	6.7%	4.9%
- PCS:	£0	0.0%	0.2%	0.2%	0.9%
- Residential:	£23,427	54.5%	47.4%	59.5%	41.4%
- Specialist Housing:	£0	0.0%	0.0%	0.2%	0.9%
Special Groups	£0	0.0%	0.0%	0.0%	1.2%
Support Services	£40	0.1%	0.1%	0.2%	0.3%
<b>Total OPMH direct services in £'000s</b>	<b>£43,005</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

COMPLETENESS OF LIT DATA: No missing OPMH data known

## LIT Report 8- OPMH direct services investment per weighted head

Here your investment in each of the direct service categories is expressed as a investment per weighted head across the three comparator areas.

Service category	£'000s	Direct Services Weighted Investment per Head			
		This LIT	This SHA	This ONS	English LITs
Care and Repair	£0	£0.0	£0.0	£0.0	£0.0
Care for People in General Hospital	£0.00	£0.0	£0.8	£0.1	£1.0
Carer's Services	£24	£0.2	£0.7	£1.2	£1.5
Emergency Services	£459	£3.6	£1.8	£1.0	£1.4
Intermediate Care	£0	£0.0	£0.1	£0.6	£2.5
Other Specialist Mental Health Services	£16,048	£125.9	£114.1	£115.2	£119.8
<b>Primary and Community Care:</b>					
- Day Services:	£1,380	£10.8	£9.2	£9.1	£14.9
- Homecare:	£1,628	£12.8	£7.0	£25.7	£13.6
- PCS:	£0	£0.0	£0.6	£0.8	£2.5
- Residential:	£23,427	£183.7	£121.6	£228.2	£115.7
- Specialist Housing:	£0	£0.0	£0.0	£0.8	£2.6
Special Groups	£0	£0.0	£0.0	£0.0	£3.3
Support Services	£40	£0.3	£0.4	£0.7	£0.8
<b>Total OPMH direct services</b>	<b>£43,005</b>	<b>£337.3</b>	<b>£256.4</b>	<b>£383.5</b>	<b>£279.4</b>

COMPLETENESS OF LIT DATA: No missing OPMH data known

OPMH Weighted population - weighted for both Need and Cost 127,492

Note that the above weighted investment figures for direct services are based upon the reported figures submitted and that any missing OPMH investment may alter the comparison.

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## West Kent

### 1. CONTEXT

This report, prepared by Mental Health Strategies is derived from an analysis of the financial mapping returns received mainly in December 2009 - February 2010 and presents results from the LIT perspective. It includes ONLY information received and if investment is known to be missing for your individual LIT, then this is flagged up on the first report.

The report provides an overall picture of reported investment in adult and older people mental health services for your geographical area, including delivery of services from all providers to, and all commissioners for the LIT, not just NHS organisations.

The financial maps were designed to dovetail with service mapping; to give a detailed and comprehensive picture of the national investment in mental health services; and to enable LITs to use the autumn review results to evaluate their local services. The overall objectives of the initiative are to:

1. provide financial transparency in mental health
2. increase understanding around allocation and spend for mental health
3. improve confidence in, and so validity of mental health financial information, and
4. facilitate the monitoring by DH development of priority mental health services.

The direct service costs (primarily staffing costs) of adult mental health are analysed by sixteen service categories and thirteen categories for older people. Additionally, indirect costs, overheads and capital charges which are not directly allocated to the service categories, are included to identify each LIT's total investment in adult or older people mental health services.

From October 2009 online guidance notes were available for completion of financial maps whilst the DH notified participating organisations. LIT leads were responsible for co-ordinating and delivering the exercise locally, although finance staff in provider and commissioning units actually produced the data. LIT leads distributed blank returns to all providers delivering services to their LIT where they would be broken down by commissioner and returned to LITs for initial validation.

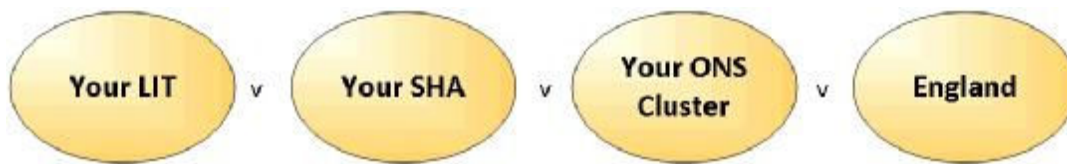
All the spreadsheets were then forwarded to Mental Health Strategies for further validation and production of reports to LITs, provider trusts and PCTs.

### 2. ISSUES

The overall quality of the data nationally supplied from organisations inevitably varies but has been validated by the supplying organisations, LITs and ourselves. However, 2009/10 is only the fourth year that local authorities have collected OPMH finance mapping figures and thus overall, their figures are unlikely yet, to equal the quality or coverage, of the now well established adult finance mapping data. The OPMH analyses should therefore be considered, to a degree, to be provisional, and can be expected to improve in future years. Note that a number of West Midlands LITs did not provide data and this will have affected SHA results for this area.

### 3. THE COMPARATIVE ANALYSIS

Three comparators are used to compare your LIT in 2009/10 as shown below:

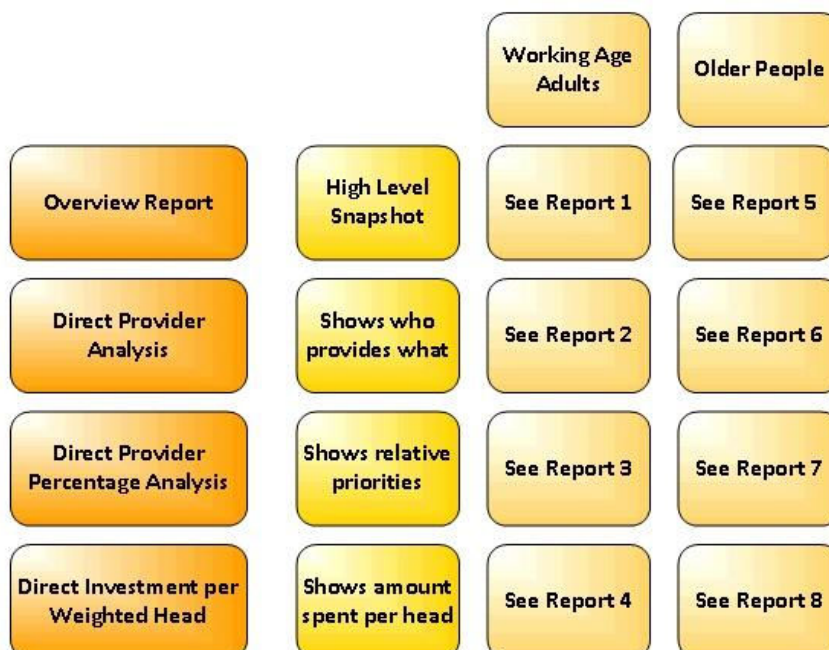


The ONS Cluster refers to the latest classification by the Office of National Statistics (ONS), which allocates all local authorities and health authorities to one of twelve "family groups", or areas with broadly similar characteristics. The ONS Group health area classifications are:

- (a) Centres with industry
- (b) Coastal and Countryside
- (c) Industrial Hinterlands
- (d) London Centre
- (e) London Cosmopolitan
- (f) London Suburbs
- (g) Manufacturing Towns
- (h) New and Growing Towns
- (i) Prospering Smaller Towns
- (j) Prospering Southern England
- (k) Regional Centres and,
- (l) Thriving London Periphery.

The classification is based upon the predominant characteristic of the area's population, not its geography. For those LITs servicing an area not exactly matching a local authority area, the allocation is drawn from the authorities making up the LIT area. Where LITs have merged, we have taken the predominant ONS cluster as "best fit" or classed it as "Mixed ONS Cluster".

The comparative analysis is presented in eight reports providing both a high level and a detailed analysis of investment as follows:-



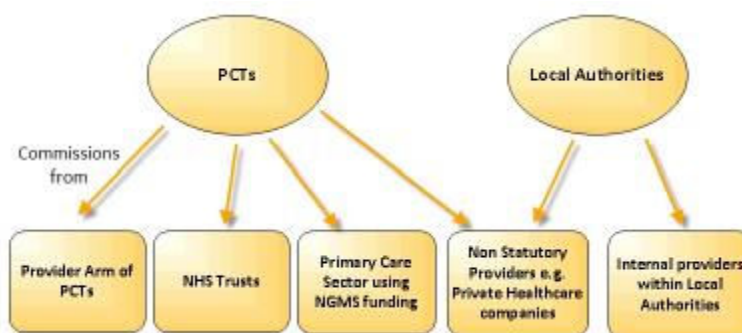
Please note that the figures reflect the way in which submitting organisations have treated indirect costs, capital charges and indirect costs. Consequently the figures in Reports 2, 3 and 4 and Reports 6, 7 and 8, are dependent on the extent to which indirect costs, capital charges and overheads are absorbed into direct service categories. Individual percentage figures in the reports have been rounded up/down for clarity.

This LIT report is based solely on the figures received and the weighted populations for those LITs who have submitted data. The National Report (see below) includes estimates of any missing information.

The direct service categories used in the Older People Reports 6, 7 and 8 are taken from the service development guide document "Everybody's Business - integrating mental health services for older adults" published by CSIP in November 2005.

Note: LIT Report 2 shows the reported direct services investment by the type of organisation which has physically provided it, and NOT by the organisation type commissioning it.

PCTs will typically commission services from NHS Trusts and private healthcare providers. Similarly Local Authorities typically commission services from within their own internal organisation (shown under the "Social Services" Provider heading) and private healthcare providers e.g. residential care homes (shown under the "Non Statutory" Provider heading).



#### 4. ABOUT THE WEIGHTED POPULATIONS FOR THE LIT

This year we have completely recalculated the weighted populations for each LIT, for both need and cost factors using the 2008 mid year population estimates kindly supplied by the Office of National Statistics and updated cost factors from the Department of Health to produce two weighted populations - one for 18-64 year olds and one for those 65 and over.

The weighted populations used within financial mapping are already weighted for both mental health need AND financial factors (e.g. market forces factor), to enable a fair comparison of investment between high and low cost areas. Thus it already takes into account the higher cost of staff in areas such as London thus facilitating direct comparison.

The advantage is that these updated weighted populations are now more representative, the downside is that the investment per weighted head figure will not be directly comparable to those shown in the years 2008/09 and earlier.

#### 5. ABOUT THE NATIONAL REPORT

The National Report which is published after these LIT reports estimates the level of missing, that is "unreported" investment and will inevitably be based on different (greater) totals of both investment and weighted populations. Consequently the more "inclusive" weighted investment figures reported in that National Report may differ from those here.

## LIT Report 1 - Overview of adult investment

Your LIT's total investment in adult mental health services is analysed in four cost groupings - direct costs, indirect costs overheads and capital charges, showing the combined investment from both PCTs and Local Authority commissioners and including all types of provider. The figures identify the extent to which your LIT investment is spent on direct care costs or other costs.

Investment is compared both in overall and percentage terms against Strategic Health Authority, ONS cluster and national figures, rounded up/down for presentation purposes.

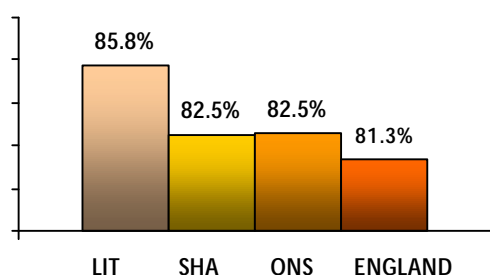
Your LIT's total investment is tabled below followed by two charts showing the percentage of investment reported spent on direct services and the overall investment per weighted head of population for the LIT.

Service category	£'000s	Percentage			
		This LIT	This SHA	This ONS	English LITs
DIRECT COSTS:	£51,290	85.8%	82.5%	82.5%	81.3%
INDIRECT COST:	£5,156	8.6%	8.3%	8.2%	7.0%
OVERHEADS:	£2,309	3.9%	6.0%	6.7%	9.0%
CAPITAL CHARGE:	£1,033	1.7%	3.2%	2.6%	2.7%
<b>Total adult investment in £'000s</b>	<b>£59,788</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

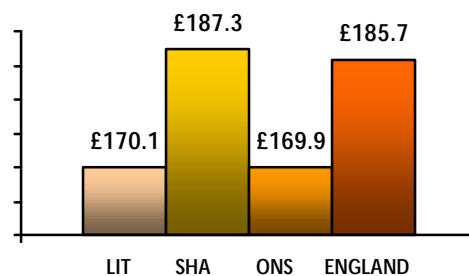
This report compares the total adult investment within your LIT, with the total adult investment of your Strategic Health Authority, the ONS cluster of the LIT and the English national average.

COMPLETENESS OF ADULT DATA: No missing data known

% Investment in Adult Direct Services



Adult Weighted Investment per Head



Working Age Weighted Population for LIT 18 -64 - weighted for both Need and Cost to ensure fair comparison of investment between high and low cost areas. 351,529

## LIT Report 2- Adult direct services provider analysis

Here your LIT's direct services investment is analysed over the four main types of provider - NHS, non GMS, local authorities and the non statutory sector.

It shows who is reported as physically providing the service - NOT who commissions and pays for it. e.g if a PCT or Local Authority commissions a service from a private (that is non statutory) provider, that part of its investment will be shown under the "Non Statutory" provider type column.

The non statutory sector comprises voluntary, independent and private sector providers.

LIT	St HA	ONS			
West Kent	NHS SOUTH EAST COAST	New and Growing Towns			
Service Category	Provider type				Total
	NHS	NGMS	Social Services	Non statutory	
Access & Crisis Services	£2,707	£0	£0	£0	£2,707
Accommodation	£0	£0	£0	£3,054	£3,054
Carer's Services	£0	£0	£0	£157	£157
Clinical Services	£10,500	£0	£0	£2,323	£12,823
Community Mental Health Teams	£4,421	£0	£0	£3,382	£7,803
Continuing Care	£2,211	£0	£0	£4,082	£6,293
Day Services	£0	£0	£0	£1,415	£1,415
Direct Payment	£0	£0	£0	£126	£126
Home Support Services	£0	£0	£0	£245	£245
Other community and hospital professional teams/specialists	£49	£0	£0	£196	£245
Personality Disorder Services	£210	£0	£0	£1,538	£1,748
Psychological Therapy Services (IAPT)	£855	£432	£0	£0	£1,287
Psychological Therapy Services (Non IAPT)	£1,817	£0	£0	£0	£1,817
Secure and High Dependency Provision	£5,337	£0	£0	£4,573	£9,910
Services for Mentally Disordered Offenders	£809	£0	£0	£312	£1,121
Support Services	£48	£0	£0	£491	£539
<b>Total direct services in £'000s</b>	<b>£28,963</b>	<b>£432</b>	<b>£0</b>	<b>£21,895</b>	<b>£51,290</b>
<b>% provided by each provider type</b>	<b>56%</b>	<b>1%</b>	<b>0%</b>	<b>43%</b>	<b>100%</b>

COMPLETENESS OF LIT DATA: No missing data known

Note: Only those direct services reported as supplied to the LIT are shown above.

## LIT Report 3- Adult direct services percentage analysis

Here your investment in each of the direct service categories is expressed as a rounded up percentage across the three comparator areas.

LIT St HA ONS  
**West Kent** NHS SOUTH EAST COAST New and Growing Towns

Service category	£'000s	Percentage			
		This LIT	This SHA	This ONS	English LITs
Access & Crisis Services	£2,707	5.3%	11.0%	11.5%	11.1%
Accommodation:	£3,054	6.0%	8.8%	7.9%	9.5%
Carer's Services:	£157	0.3%	0.6%	0.7%	0.5%
Clinical Services:	£12,823	25.0%	20.5%	21.9%	17.2%
Community Mental Health Teams:	£7,803	15.2%	16.5%	14.6%	14.3%
Continuing Care:	£6,293	12.3%	8.3%	12.1%	11.6%
Day Services:	£1,415	2.8%	3.4%	2.5%	3.2%
Direct Payment:	£126	0.2%	0.5%	0.1%	0.4%
Home Support Services:	£245	0.5%	3.0%	0.7%	2.3%
Mental Health Promotion Services:	£0	0.0%	0.0%		0.1%
Other community and hospital professional teams/specialists:	£245	0.5%	1.9%	0.9%	1.9%
Personality Disorder Services:	£1,748	3.4%	1.7%	2.4%	0.6%
Psychological Therapy Services (IAPT):	£1,287	2.5%	2.2%	1.9%	2.5%
Psychological Therapy Services (Non IAPT):	£1,817	3.5%	4.1%	4.3%	3.5%
Secure and High Dependency Provision:	£9,910	19.3%	14.7%	16.4%	18.9%
Services for Mentally Disordered Offenders:	£1,121	2.2%	1.6%	1.1%	1.2%
Support Services:	£539	1.1%	1.1%	1.2%	1.3%
<b>Total direct services in £'000s</b>	<b>£51,290</b>	<b>100.0%</b>	<b>100.0%</b>		<b>100.0%</b>
<b>COMPLETENESS OF LIT DATA:</b>		<b>No missing data known</b>			

## LIT Report 4- Adult direct services investment per weighted head

Here your investment in each of the direct service categories is expressed as an investment per weighted head across the three comparator areas.

LIT St HA ONS  
**West Kent** NHS SOUTH EAST COAST New and Growing Towns

Service category	£'000s	Weighted Investment per head			
		This LIT	This SHA	This ONS	English LITs
Access & Crisis Services:	£2,707	£7.7	£17.0	£16.1	£16.8
Accommodation:	£3,054	£8.7	£13.7	£11.0	£14.3
Carer's Services:	£157	£0.4	£0.9	£0.9	£0.8
Clinical Services:	£12,823	£36.5	£31.7	£30.7	£25.9
Community Mental Health Teams:	£7,803	£22.2	£25.6	£20.4	£21.5
Continuing Care:	£6,293	£17.9	£12.9	£17.0	£17.5
Day Services:	£1,415	£4.0	£5.2	£3.5	£4.8
Direct Payment:	£126	£0.4	£0.8	£0.2	£0.6
Home Support Services:	£245	£0.7	£4.7	£1.0	£3.4
Mental Health Promotion Services:	£0	£0.0	£0.1	£0.0	£0.1
Other community and hospital professional teams/specialists:	£245	£0.7	£2.9	£1.2	£2.9
Personality Disorder Services:	£1,748	£5.0	£2.6	£3.3	£0.9
Psychological Therapy Services (IAPT):	£1,287	£3.7	£3.5	£2.6	£3.7
Psychological Therapy Services (Non IAPT):	£1,817	£5.2	£6.3	£6.1	£5.3
Secure and High Dependency Provision:	£9,910	£28.2	£22.6	£23.0	£28.6
Services for Mentally Disordered Offenders:	£1,121	£3.2	£2.4	£1.5	£1.8
Support Services:	£539	£1.5	£1.6	£1.7	£1.9
<b>Total direct services in £'000s</b>	<b>£51,290</b>	<b>£145.9</b>	<b>£154.5</b>	<b>£140.3</b>	<b>£151.1</b>
<b>Working Age Weighted Population for LIT 18-64 - weighted for both Need and Cost:</b>					<b>351,529</b>
<b>COMPLETENESS OF LIT DATA:</b>		<b>No missing data known</b>			

## LIT Report 5 - Overview of OPMHS investment

Your LIT's total investment in Older People's mental health services is analysed in four cost groupings - direct costs, indirect costs overheads and capital charges, showing the combined investment from both PCTs and Local Authority commissioners and including all types of provider. The figures identify the extent to which LIT investment is spent on direct care costs or other costs.

Investment is compared both in overall and percentage terms against Strategic Health Authority, ONS cluster and national figures.

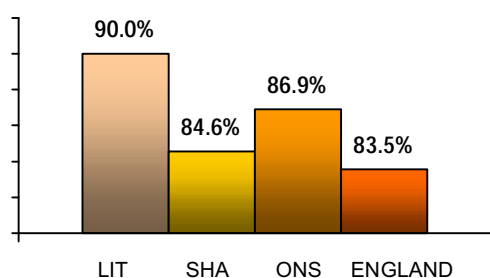
Your LIT's total investment is tabled below followed by two charts showing the percentage of investment reported spent on direct services and the overall investment per weighted head of population for the LIT.

Service category	£'000s	Percentage			
		This LIT	This SHA	This ONS	English LITs
DIRECT COSTS:	£34,405	90.0%	84.6%	86.9%	83.5%
INDIRECT COST:	£1,929	5.0%	7.3%	4.9%	6.6%
OVERHEADS:	£1,242	3.2%	4.9%	5.7%	7.5%
CAPITAL CHARGE:	£664	1.7%	3.3%	2.6%	2.4%
<b>Total OPMHS investment in £'000s</b>	<b>£38,240</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

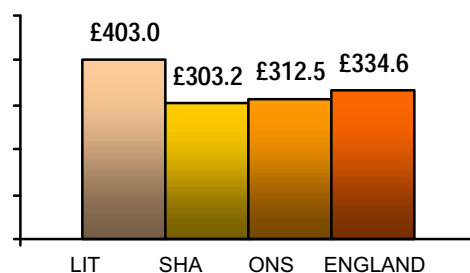
This report compares the total OPMHS investment within the LIT, with the total OPMHS investment of the LIT's Strategic Health Authority, the ONS cluster of the LIT and the english national average.

COMPLETENESS OF LIT DATA: No missing OPMH data known

% Investment in OPMH Direct Services



OPMH Weighted Investment per Head



OPMH Weighted Population - weighted for both Need and Cost to ensure fair comparison of investment between high and low cost areas.

94,876

## LIT Report 6- OPMH direct services provider analysis

Here your LIT's OPMH direct services investment is analysed over the four main types of provider - NHS, non GMS, local authorities and the non statutory sector.

The non statutory sector comprises voluntary, independent and private sector providers.

It shows who is reported as physically providing the service - NOT who commissions and pays for it. e.g if a PCT or Local Authority commissions a service from a private (that is non statutory) provider, that part of its investment will be shown under the "Non Statutory" provider type column.

<u>LIT</u>	<u>St HA</u>		<u>ONS</u>		
<b>West Kent</b>	NHS SOUTH EAST COAST		New and Growing Towns		
Service Category	Provider type				
	NHS	NGMS	Social Services	Non statutory	Total
Other Specialist Mental Health Services - OPMH	£11,701	£0	£0	£0	£11,701
Primary and Community Care - Day Services	£0	£0	£0	£149	£149
Primary and Community Care - Homecare	£0	£0	£0	£966	£966
Primary and Community Care - Residential	£0	£0	£2,163	£19,426	£21,589
<b>Total direct services in £'000s</b>	<b>£11,701</b>	<b>£0</b>	<b>£2,163</b>	<b>£20,541</b>	<b>£34,405</b>
<b>% provided by each provider type</b>	<b>34%</b>	<b>0%</b>	<b>6%</b>	<b>60%</b>	<b>100%</b>

COMPLETENESS OF LIT DATA: No missing OPMH data known

Note: Only those direct services supplied to the LIT are shown above.

## LIT Report 7- OPMH direct services percentage analysis

Here your investment in each of the direct service categories is expressed as a rounded up/down percentage across the three comparator areas.

LIT West Kent	St HA NHS SOUTH EAST COAST	ONS New and Growing Towns			
		Percentage			
Service category	£'000s	This LIT	This SHA	This ONS	English LITs
Care and Repair	£0	0.0%	0.0%	0.0%	0.0%
Care for People in General Hospital	£0	0.0%	0.3%	0.0%	0.3%
Carer's Services	£0	0.0%	0.3%	0.4%	0.5%
Emergency Services	£0	0.0%	0.7%	0.0%	0.5%
Intermediate Care	£0	0.0%	0.0%	0.4%	0.9%
Other Specialist Mental Health Services	£11,701	34.0%	44.5%	44.5%	42.9%
Primary and Community Care:					
- Day Services:	£149	0.4%	3.6%	2.4%	5.3%
- Homecare:	£966	2.8%	2.7%	2.2%	4.9%
- PCS:	£0	0.0%	0.2%	0.0%	0.9%
- Residential:	£21,589	62.7%	47.4%	49.6%	41.4%
- Specialist Housing:	£0	0.0%	0.0%	0.0%	0.9%
Special Groups	£0	0.0%	0.0%	0.4%	1.2%
Support Services	£0	0.0%	0.1%	0.0%	0.3%
<b>Total OPMH direct services in £'000s</b>	<b>£34,405</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

COMPLETENESS OF LIT DATA: No missing OPMH data known

## LIT Report 8- OPMH direct services investment per weighted head

Here your investment in each of the direct service categories is expressed as a investment per weighted head across the three comparator areas.

<u>LIT</u>	<u>St HA</u>	<u>ONS</u>			
<b>West Kent</b>	NHS SOUTH EAST COAST	New and Growing Towns			
Service category	£'000s	Direct Services Weighted Investment per Head			
		This LIT	This SHA	This ONS	English LITs
Care and Repair	£0	£0.0	£0.0	£0.0	£0.0
Care for People in General Hospital	£0.00	£0.0	£0.8	£0.0	£1.0
Carer's Services	£0	£0.0	£0.7	£1.2	£1.5
Emergency Services	£0	£0.0	£1.8	£0.0	£1.4
Intermediate Care	£0	£0.0	£0.1	£1.2	£2.5
Other Specialist Mental Health Services	£11,701	£123.3	£114.1	£120.9	£119.8
<b>Primary and Community Care:</b>					
- Day Services:	£149	£1.6	£9.2	£6.5	£14.9
- Homecare:	£966	£10.2	£7.0	£5.9	£13.6
- PCS:	£0	£0.0	£0.6	£0.1	£2.5
- Residential:	£21,589	£227.5	£121.6	£134.7	£115.7
- Specialist Housing:	£0	£0.0	£0.0	£0.0	£2.6
Special Groups	£0	£0.0	£0.0	£1.0	£3.3
Support Services	£0	£0.0	£0.4	£0.1	£0.8
<b>Total OPMH direct services</b>	<b>£34,405</b>	<b>£362.6</b>	<b>£256.4</b>	<b>£271.4</b>	<b>£279.4</b>

COMPLETENESS OF LIT DATA: No missing OPMH data known

OPMH Weighted population - weighted for both Need and Cost 94,876

Note that the above weighted investment figures for direct services are based upon the reported figures submitted and that any missing OPMH investment may alter the comparison.

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Quarterly PALS Report  
April – June 2010

<b>Meeting:</b>	Complaints, Claims, PALS, SUI Scrutiny Group
<b>Date:</b>	July 27 <sup>th</sup> 2010
<b>Subject:</b>	Patient & Advice & Liaison Service (PALS) Report, April – June 2010
<b>Reporting Officers:</b>	Tony Peploe & Nick Dent
<b>Purpose:</b>	Quarterly Report

<b><i>Please indicate as appropriate</i></b>	
Standards for Better Health:	
<b>Core Standard:</b>	
14A	Healthcare organisations have systems in place to ensure that patients, their relatives and carers have suitable and accessible information about, and clear access to procedures to register formal complaints and feedback on the quality of services.
Element 2	The healthcare organisation should provide opportunities for patients, relatives and carers to comment on their experiences and the quality of any of the services provided, through for example PALS, comment cards, patient surveys or patient forums.
<b>Core Standard:</b>	
17	The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.
<b>Risks identified:</b> None	
<b>Impact on race equality:</b> None	
<b>Legal implications:</b> None	
<b>Summary:</b>	
This report summarises service user, carer & public contacts with PALS, together with any common themes, follow up actions and implications re service improvement.	
<b>Recommendation:</b>	
To receive this report, note its content and offer any comments and feedback.	

**Quarterly PALS Report**  
**April – June 2010**

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**Quarterly PALS Report**  
**April – June 2010**

***Introduction:***

This report summarises service user, carer & public contacts with PALS, together with any common themes, follow up actions and implications re service improvement that took place between April and June 2010.

During the quarter period, a total of 316 PALS contacts occurred. This compares with 225 contacts (+40%) for the same period during 2009-10, and 276 contacts (+14%) for the period January - March 2010.

This is the first PALS quarterly report which uses the reporting mechanisms available in Datix. It is evident that Datix reporting is not currently set up to easily report on service lines. Liaison with the Datix administrator is ongoing to resolve such issues. Any feedback on the tabulations that follow in this report and their usefulness would be welcome.

PALS is also responsible for keeping a record of written compliments received through out the trust. A total of 75 compliments were received in the quarter, which compares with 66 (+14%) received in the previous quarter.

PALS is also involved in other service user involvement activity. In the West, a new Patient Consultative Committee ( PCC) was formed during the quarter, whilst the Medway PCC continues to develop following its introduction in late 2009. It is envisaged that service user involvement initiatives such as these will continue to exist on a locality basis, given the preference that service users have to be involved with local activities.

Tony Peploe

PALS Coordinator West

August 4<sup>th</sup> 2010

**Quarterly PALS Report**  
**April – June 2010**

<b>Table One: Number of enquiries received during April – June 2010 (excl compliments)</b>				
	<b>April</b>	<b>May</b>	<b>June</b>	<b>Total</b>
<b>Request for assistance</b>	9	12	31	52
<b>Expression of concern</b>	22	16	32	70
<b>Request for directions</b>	0	51	30	81
<b>Request for information</b>	41	23	45	109
<b>Unhappy With Service</b>	3	0	1	4
<b>Totals:</b>	75	102	139	316

The above quarterly total 316 compares with 225 enquiries received during the same quarter in 2009/10. *The “Request for Directions”* (total 81) refers to the PALS Team at St Martins giving directions to visitors to the site.

<b>Quarterly contact totals for the year 2009 -10 (excl compliments) were are as follows:</b>				
<b>April – June 2009</b>	<b>July – September</b>	<b>October – December</b>	<b>January – March 2010</b>	<b>Year end total</b>
225	268	254	276	1023

**Quarterly PALS Report**  
**April – June 2010**

<b>Table Two: Number of enquiries received by Region during April – June 2010 (excl compliments)</b>				
	<b>April</b>	<b>May</b>	<b>June</b>	<b>Total</b>
<b>East Region</b>	<b>17</b>	<b>70</b>	<b>63</b>	<b>150</b>
Request for assistance	7	6	13	26
Expression of concern	3	6	6	15
Request for directions	0	51	30	81
Request for information	6	7	13	26
Unhappy With Service	1	0	1	2
<b>Medway</b>	<b>10</b>	<b>4</b>	<b>23</b>	<b>37</b>
Request for assistance	1	0	3	4
Expression of concern	4	2	8	14
Request for information	4	2	12	18
Unhappy With Service	1	0	0	1
<b>Not Applicable</b>	<b>3</b>	<b>3</b>	<b>5</b>	<b>11</b>
Request for assistance	0	0	3	3
Expression of concern	1	0	1	2
Request for information	2	3	1	6
<b>West Region</b>	<b>45</b>	<b>25</b>	<b>48</b>	<b>118</b>
Request for assistance	1	6	12	19
Expression of concern	14	8	17	39
Request for information	29	11	19	59
Unhappy With Service	1	0	0	1
<b>Totals:</b>	<b>75</b>	<b>102</b>	<b>139</b>	<b>316</b>

**Quarterly PALS Report**  
**April – June 2010**

<b>Table Three: Number of enquiries received by Directorate during April – June 2010 (excl compliments)</b>				
	<b>April</b>	<b>May</b>	<b>June</b>	<b>Total</b>
<b>Not applicable</b>	<b>26</b>	<b>13</b>	<b>42</b>	<b>81</b>
Request for assistance	3	3	8	14
Expression of concern	1	0	3	4
Request for directions	0	0	6	6
Request for information	22	10	24	56
Unhappy With Service	0	0	1	1
<b>Adult Mental Health</b>	<b>39</b>	<b>77</b>	<b>81</b>	<b>197</b>
Request for assistance	5	7	17	29
Expression of concern	19	12	23	54
Request for directions	0	51	24	75
Request for information	12	7	17	36
Unhappy With Service	3	0	0	3
<b>Corporate Services</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>
Request for information	0	0	1	1
<b>Forensic Services</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>3</b>
Request for assistance	0	0	1	1
Request for information	1	1	0	2
<b>Learning Disabilities</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>
Request for information	0	1	0	1
<b>Mental Health for Older People</b>	<b>6</b>	<b>9</b>	<b>11</b>	<b>26</b>
Request for assistance	1	2	3	6
Expression of concern	1	4	5	10
Request for information	4	3	3	10
<b>Specialist Services</b>	<b>3</b>	<b>1</b>	<b>3</b>	<b>7</b>
Request for assistance	0	0	2	2
Expression of concern	1	0	1	2
Request for information	2	1	0	3
<b>Totals:</b>	<b>75</b>	<b>102</b>	<b>139</b>	<b>316</b>

**Quarterly PALS Report**  
**April – June 2010**

<b>Table Four: Outcomes to Expressions of Concern and Unhappiness with service received during April – June 2010</b>				
	<b>April</b>	<b>May</b>	<b>June</b>	<b>Total</b>
<b>Expression of concern</b>	<b>22</b>	<b>18</b>	<b>30</b>	<b>70</b>
Outcome unspecified		2		2
Referral to complaints	3	1	3	7
Service improvement recommended	0	1	0	1
Given information	9	2	5	16
Referral to PCT	0	1	2	3
Concern resolved	8	10	13	31
Concern not resolved	2	1	7	10
<b>Unhappy With Service</b>	<b>3</b>	<b>0</b>	<b>1</b>	<b>4</b>
Given information	1	0	0	1
Concern not resolved	2	0	1	3
<b>Totals:</b>	<b>25</b>	<b>18</b>	<b>31</b>	<b>74</b>

**Quarterly PALS Report**  
April – June 2010

**Table Five: Sub Subject grouped by Primary Subject and Directorate during April – June 2010**

	Adult Mental Health	Corporate Services	Forensic Services	Learning Disabilities	Mental Health for Older People	Specialist Services	Total
<b>Admissions, Discharge &amp; Transfer arrangements</b>	<b>14</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>1</b>	<b>17</b>
Admission arrangements	1	0	0	0	0	0	1
Discharge arrangements	2	0	0	0	2	0	4
Discharge Premature	4	0	0	0	0	0	4
Discharge Delay	1	0	0	0	0	0	1
Transfer arrangements	3	0	0	0	0	1	4
Transfer – request to move ward	2	0	0	0	0	0	2
Transfer – communication	1	0	0	0	0	0	1
<b>Aids &amp; Appliances, equipment, premises (including access)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>2</b>
Equipment Lack of	0	0	0	0	0	1	1
Equipment Waiting Time	0	0	0	0	0	1	1
<b>Appointments, delay/cancellation (outpatient)</b>	<b>8</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>3</b>	<b>12</b>
Lack of appointment	2	0	0	0	0	2	4
Waiting time for appointment	4	0	0	0	0	1	5
Appointment Communication	2	0	0	0	1	0	3
<b>Appointments, delay/cancellation (inpatient)</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>
Lack of appointment	1	0	0	0	0	0	1
Waiting time for appointment	1	0	0	0	0	0	1
<b>Attitude of Staff</b>	<b>6</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>6</b>
Disinterested/Uncaring Behaviour	6	0	0	0	0	0	6
<b>All aspects of clinical treatment</b>	<b>31</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>6</b>	<b>0</b>	<b>37</b>
Diagnosis Questioned	3	0	0	0	0	0	3
Treatment Questioned	6	0	0	0	1	0	7
Treatment/Care/Support Lack of	11	0	0	0	2	0	13
Treatment/Care/Support Disagreements	5	0	0	0	0	0	5

**Quarterly PALS Report**  
April – June 2010

**Table Five continued: Sub Subject grouped by Primary Subject and Directorate during April – June 2010**

	Adult Mental Health	Corporate Services	Forensic Services	Learning Disabilities	Mental Health for Older People	Specialist Services	Total
Treatment/Care/Support Observation	0	0	0	0	1	0	1
Treatment/Care/Support Care Planning/CPA	2	0	0	0	0	0	2
Treatment/Care/Support Carers Assessment	0	0	0	0	1	0	1
Medication Prescribing Lack of	0	0	0	0	1	0	1
Medication Side Affects	1	0	0	0	0	0	1
Medication Communication	2	0	0	0	0	0	2
Change of Clinician/Worker	1	0	0	0	0	0	1
<b>Communication/information to patients (written and oral)</b>	<b>36</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>8</b>	<b>1</b>	<b>48</b>
Lack/Poor of information (patients)	3	0	0	0	0	0	3
Lack/Poor of information (relatives)	1	0	0	0	1	0	2
Inadequate involvement in care plan	1	0	0	0	0	0	1
Communication/Information/telephone system	1	0	0	0	1	0	2
Information provided (Trust Services)	18	0	0	0	3	0	21
Information Provided – Trust literature	1	0	0	0	1	0	2
Information provided to inter professional teams	1	0	0	0	0	0	1
Information provided – complaint (external)	0	0	1	0	0	0	1
Information provided – directions	1	0	0	0	0	0	1
Information provided – other organisations/PALS	7	1	0	1	1	1	11
Signposting to other services/organisations	2	0	0	0	1	0	3
<b>Consent to treatment</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>0</b>	<b>2</b>
Capacity to provide informed consent	0	0	0	0	2	0	2
<b>Complaints handling</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>
Complaint handling	1	0	0	0	0	0	1
Complaints Procedure	1	0	0	0	0	0	1

**Quarterly PALS Report**  
April – June 2010

**Table Five continued: Sub Subject grouped by Primary Subject and Directorate during April – June 2010**

	Adult Mental Health	Corporate Services	Forensic Services	Learning Disabilities	Mental Health for Older People	Specialist Services	Total
<b>Patients privacy and dignity</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>2</b>
Confidentiality Consent	1	0	0	0	0	0	1
Privacy & Dignity	0	0	0	0	1	0	1
<b>Patients property and expenses</b>	<b>3</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>4</b>	<b>0</b>	<b>7</b>
Property Missing/Lost/Stolen/Damaged	1	0	0	0	2	0	3
Benefits	2	0	0	0	2	0	4
<b>PCT commissioning (including waiting lists)</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>
Funding	1	0	0	0	0	0	1
<b>Personal records (including medical and/or complaints)</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>4</b>
Access to records	1	0	1	0	1	0	3
Incorrect Records	1	0	0	0	0	0	1
<b>Transport (ambulances and other)</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>
Transport Availability	2	0	0	0	0	0	2
<b>Policy and commercial decisions of Trusts</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>
Trust Policy/Decision – Service Change	1	0	0	0	0	0	1
<b>Hotel Services (including food)</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>
Food – Choice	1	0	0	0	0	0	1
<b>Totals:</b>	<b>110</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>25</b>	<b>7</b>	<b>146</b>

**Quarterly PALS Report**  
**April – June 2010**

<b>Table 6.1 Adult Services – concerns raised by secondary location (sub subjects)</b>		
	<b>April - June 2010</b>	<b>Total</b>
<b>Unspecified location</b>	<b>10</b>	<b>10</b>
Transfer - request to move ward	1	1
Diagnosis Questioned	1	1
Treatment Questioned	1	1
Treatment/Care/Support Lack of	1	1
Treatment/Care/Support Disagreements	1	1
Lack/Poor of information (patients)	1	1
Information provided (Trust Services)	1	1
Signposting to other services/organisations	1	1
Confidentiality Consent	1	1
Incorrect Records	1	1
<b>Crisis Resolution Home Treatment Team</b>	<b>2</b>	<b>2</b>
Appointment Communication	1	1
Treatment Questioned	1	1
<b>Emerald Ward</b>	<b>3</b>	<b>3</b>
Discharge Premature	1	1
Treatment Questioned	1	1
Treatment/Care/Support Disagreements	1	1
<b>MASTT Team</b>	<b>2</b>	<b>2</b>
Disinterested/Uncaring Behaviour	1	1
Treatment/Care/Support Lack of	1	1
<b>Ruby Ward</b>	<b>1</b>	<b>1</b>
Treatment/Care/Support Lack of	1	1
<b>Dartford and Gravesend Mental Health Recovery Team</b>	<b>1</b>	<b>1</b>
Discharge Premature	1	1
<b>Dartford Psychological Service</b>	<b>1</b>	<b>1</b>
Waiting time for appointment	1	1
<b>Thanet CMHT</b>	<b>1</b>	<b>1</b>
Treatment/Care/Support Lack of	1	1
<b>Psychological, Psychotherapy, Cognitive Behavioural Therapy Service</b>	<b>1</b>	<b>1</b>
Waiting time for appointment	1	1
<b>Deal CMHT</b>	<b>1</b>	<b>1</b>
Discharge Premature	1	1

**Quarterly PALS Report**  
**April – June 2010**

<b>Table 6.1 Adult Services – concerns raised by secondary location continued (sub subject)</b>		
	<b>April - June 2010</b>	<b>Total</b>
<b>Tonbridge CMHT</b>	<b>1</b>	<b>1</b>
Lack/Poor of information (relatives)	1	1
<b>Dartford Gravesend and Swanley Access Team</b>	<b>1</b>	<b>1</b>
Waiting time for appointment	1	1
<b>Primary Care Psychological Service</b>	<b>1</b>	<b>1</b>
Waiting time for appointment	1	1
<b>Psychological, Psychotherapy, Cognitive Behavioural Therapy Service</b>	<b>1</b>	<b>1</b>
Treatment/Care/Support Lack of	1	1
<b>Tunbridge Wells CMHT</b>	<b>6</b>	<b>6</b>
Disinterested/Uncaring Behaviour	2	2
Treatment/Care/Support Lack of	2	2
Information provided (Trust Services)	1	1
Funding	1	1
<b>Amberwood Ward</b>	<b>1</b>	<b>1</b>
Transfer - request to move ward	1	1
<b>Woodlands Ward</b>	<b>2</b>	<b>2</b>
Discharge arrangements	1	1
Treatment Questioned	1	1
<b>Willow Suite</b>	<b>3</b>	<b>3</b>
Disinterested/Uncaring Behaviour	1	1
Medication Side Affects	1	1
Food - Choice	1	1
<b>Off Site</b>	<b>1</b>	<b>1</b>
Treatment Questioned	1	1
<b>Patients Home</b>	<b>4</b>	<b>4</b>
Admission arrangements	1	1
Treatment/Care/Support Lack of	1	1
Treatment/Care/Support Care Planning/CPA	1	1
Lack/Poor of information (patients)	1	1
<b>Brocklehurst Ward</b>	<b>1</b>	<b>1</b>
Disinterested/Uncaring Behaviour	1	1
<b>Outpatient Rehabilitation</b>	<b>1</b>	<b>1</b>
Lack of appointment	1	1

**Quarterly PALS Report**  
**April – June 2010**

<b>Table 6.1 Adult Services – concerns raised by secondary location continued (sub subject)</b>		
	<b>April - June 2010</b>	<b>Total</b>
<b>Rochester CMHT</b>	<b>3</b>	<b>3</b>
Lack of appointment	1	1
Treatment/Care/Support Disagreements	1	1
Lack/Poor of information (patients)	1	1
<b>Anselm Ward</b>	<b>4</b>	<b>4</b>
Discharge arrangements	1	1
Discharge Premature	1	1
Discharge Delay	1	1
Treatment/Care/Support Disagreements	1	1
<b>Dudley Venables House</b>	<b>1</b>	<b>1</b>
Property Missing/Lost/Stolen/Damaged	1	1
<b>Crisis Resolution Home Treatment Team</b>	<b>1</b>	<b>1</b>
Treatment/Care/Support Lack of	1	1
<b>111 Tonbridge Road</b>	<b>1</b>	<b>1</b>
Complaints Procedure	1	1
<b>Totals:</b>	<b>56</b>	<b>56</b>

Note 1: it is proposed to cumulate the above totals during the year to identify any trends.

Note 2: it is evident that Datix does not allow precise identification of certain service locations using the above criteria.

**Quarterly PALS Report**  
**April – June 2010**

<b>Table 6.2 Specialist inc Older Adult Services – concerns raised by secondary location (Sub subject)</b>		
	<b>April - June 2010</b>	<b>Total</b>
<b>Unspecified location</b>	<b>3</b>	<b>3</b>
Treatment/Care/Support Carers Assessment	1	1
Capacity to provide informed consent	1	1
Privacy & Dignity	1	1
<b>Ruby Ward</b>	<b>1</b>	<b>1</b>
Treatment Questioned	1	1
<b>Winslow Ward</b>	<b>1</b>	<b>1</b>
Treatment/Care/Support Observation	1	1
<b>CAMHS Team</b>	<b>1</b>	<b>1</b>
Waiting time for appointment	1	1
<b>Wheelchair Service</b>	<b>1</b>	<b>1</b>
Equipment Waiting Time	1	1
<b>Gravesend CMHT for Older People</b>	<b>1</b>	<b>1</b>
Capacity to provide informed consent	1	1
<b>Jasmine Ward</b>	<b>1</b>	<b>1</b>
Treatment/Care/Support Lack of	1	1
<b>Maidstone North CMHT for Older People</b>	<b>1</b>	<b>1</b>
Treatment/Care/Support Lack of	1	1
<b>The Orchards</b>	<b>1</b>	<b>1</b>
Discharge arrangements	1	1
<b>Edmund Ward</b>	<b>1</b>	<b>1</b>
Lack/Poor of information (relatives)	1	1
<b>Totals:</b>	<b>12</b>	<b>12</b>

Note1: It is proposed to cumulate the above totals during the year to identify any trends.

Note 2: There were no concerns raised in Forensic Services that matched the above criteria

**Quarterly PALS Report**  
**April – June 2010**

**Table Seven: Details of shortcomings, follow up actions and outcomes April – June 2010**

Locality	Site	Shortcomings	Follow up actions	Outcomes
West	Highlands House	Various concerns over lack of permanent clinicians	Recruitment in progress	
“	Colin Sams	Affect of closure on patients and their referrals	Referred to Karen Dorey-Rees / service managers	Patient(s) to be referred to alternative services
“	Littlestone Lodge	Family concerns over proposed closure	Liased with continuing care coordinator	Concerns resolved
“	Jasmine Ward	Staff calling patient by incorrect name: patient wearing someone else’s blouse, open at front, laundry mixed up with others: communication with staff difficult.	Follow up through Service Manger	Concerns resolved
West & Medway	Various	delays in IAPT treatment, and access for under 18 year olds.	Follow up through Service Mangers	Delays resolved where possible
West & Medway	Various	Inpatient in out of locality ward: with perception that treatment is not forthcoming from staff.	Liased with modern matron	Meetings with ward manager set up where practical
Medway	CRHT	Issue: wide range of staff visitors from CRHT Medway, and wide time frames for appointments caused anxiety for the patient.	Passed on concerns for information only to manager.	
“	MASTT	Issue: caller concerned about telephone assessment process.	Liased with manager -	New appointment arranged
“	Emerald Ward	Issues inc availability of non mental health medication on the ward.		Care Coordinator to take forward
“	Kingsley House	Issue: delay in transfer of care from Kingsley House to St Barts.	Liased with team managers and clinicians	Transfer arranged

**Quarterly PALS Report**  
**April – June 2010**

<b>Table Eight: Compliments received during April – June 2010</b>					
	Adult Mental Health	Forensic Services	Mental Health for Older People	Specialist Services	<b>Total</b>
	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>
Gillingham CMHT	1	0	0	0	1
<b>A Block, Medway Maritime</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>
Emerald Ward	1	0	0	0	1
Medway Psychology (Secondary Care)	1	0	0	0	1
<b>Alexander Lodge Day Therapy Unit</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>
Sevenoaks CMHT for Older People	0	0	1	0	1
<b>Arndale House</b>	<b>5</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>6</b>
Dartford and Gravesend Mental Health Recovery Team	3	0	1	0	4
Dartford Psychological Service	2	0	0	0	2
<b>Canada House</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>2</b>
CAMHS Team	0	0	0	2	2
<b>Eagle Court Rochester</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>
Rochester Resource Centre	1	0	0	0	1
<b>Eastern &amp; Coastal Area Office</b>	<b>3</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3</b>
PALS Department	3	0	0	0	3

**Quarterly PALS Report**  
**April – June 2010**

**Table Eight continued : Compliments received during April – June 2010**

	Adult Mental Health	Forensic Services	Mental Health for Older People	Specialist Services	Total
<b>Elmsleigh</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>
Medway CMHT for Older People	0	0	1	0	1
<b>Elwick Road Centre</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>
Psychological Service	1	0	0	0	1
<b>Elizabeth Raybould Centre</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>2</b>
Crisis Resolution Home Treatment Team - Dartford	1	0	0	0	1
Off Site	0	0	1	0	1
<b>Frank Lloyd Unit</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>0</b>	<b>2</b>
Woodstock Ward	0	0	2	0	2
<b>Greenacres Site</b>	<b>0</b>	<b>20</b>	<b>0</b>	<b>0</b>	<b>20</b>
Bridge House	0	20	0	0	20
<b>Highlands House</b>	<b>0</b>	<b>0</b>	<b>4</b>	<b>0</b>	<b>4</b>
Tunbridge Wells CMHT for Older People	0	0	4	0	4
<b>Laurel House</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>
Canterbury CMHT	1	0	0	0	1
<b>Little Brook Hospital</b>	<b>5</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5</b>
Amberwood Ward	3	0	0	0	3
Woodlands Ward	1	0	0	0	1

**Quarterly PALS Report**  
**April – June 2010**

**Table Eight continued: Compliments received during April – June 2010**

	Adult Mental Health	Forensic Services	Mental Health for Older People	Specialist Services	Total
Patients Home	1	0	0	0	1
<b>Priority House</b>	<b>6</b>	<b>0</b>	<b>2</b>	<b>0</b>	<b>8</b>
Amherst Ward	5	0	0	0	5
Crisis Resolution Home Treatment Team - Maidstone	1	0	0	0	1
Maidstone North CMHT for Older People	0	0	2	0	2
<b>The Red House</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>
In-patient Service	0	0	0	1	1
<b>Sittingbourne Memorial Hospital</b>	<b>6</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>6</b>
Patients Home	2	0	0	0	2
Swale CHMT - Intake and Enhanced	4	0	0	0	4
<b>St John's Community Mental Health Centre</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>
Sevenoaks CMHT	1	0	0	0	1
<b>Thanet Mental Health Unit</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>
Sevenscore Ward	0	0	1	0	1
<b>Tarentfort Centre</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>
Off Site	0	1	0	0	1
<b>Trevor Gibbens Unit</b>	<b>0</b>	<b>5</b>	<b>0</b>	<b>0</b>	<b>5</b>
Forensic Management Centre	0	3	0	0	3
Walmer Ward	0	2	0	0	2
<b>Totals:</b>	<b>33</b>	<b>26</b>	<b>13</b>	<b>3</b>	<b>75</b>

**Quarterly PALS Report**  
**April – June 2010**

Compliments received during the year 2009-10 can be broken down as follows:

	April 09 - May	June - Sept	Oct – Dec	Jan '10 - March	Total
Medway	11	49	6	3	69
Forensic	64	36	26	23	149
Specialist	3	18	8	3	32
West	71	82	41	31	225
East	25	25	54	6	110
Total	174	210	135	66	585

Note: variations between quarters can be attributed to the reporting habits of certain services, an issue which is taken up in regular reminders to staff via global emails.

**Quarterly PALS Report**  
**April – June 2010**

**Table Nine: a sample of compliment comments received during April – June 2010**

Secondary Loc.	Description
Amberwood Ward	A big thank you for all your help
Amberwood Ward	Thank you very much for allowing me to go back home
Bridge House	Thank you for all your help and kindness. Never forget what you done for me.
Bridge House	A great big thank you for what you have done, once again a big thank you.
CAMHS Team	Thank you so much for helping me, I really appreciate it. You have really helped, thank you so much.
CAMHS Team	Thank you for helping me and listening. I will never forget what you've taught me as it's helped me immensely
Canterbury CMHT	I would like to take this opportunity to highly praise a member of your staff. I can honestly say that her constant and positive input has greatly helped me to cope in such a difficult period. She has always had an extremely positive outlook for me and has taken the time to listen to me. She is exceptional in both the course and the group. Also her aftercare is excellent.
Crisis Resolution Home Treatment Team - Dartford	Thank you from the bottom of our hearts and support you have given us . We could not have done this on our own.
Crisis Resolution Home Treatment Team - Maidstone	I would like to say how much I appreciated your friendly and helpful attitude. You listened to, and answered, my queries and I felt comfortable talking to you.
Dartford and Gravesend Mental Health Recovery Team	for your help and support enabling client move into her flat
Dartford and Gravesend Mental Health Recovery Team	I am just writing to say thank you for attending my appointment at Occupational Health. I was glad of your support.
Dartford Psychological Service	Thank you so much for your hard work and kindness you have given to us over the past few months.
Dartford Psychological Service	Thank you so much for the kindness and understanding that you have both shown throughout your sessions.

**Quarterly PALS Report  
April – June 2010**

<b>Table Nine continued: a sample of compliment comments received during April – June 2010</b>	
<b>Secondary Loc.</b>	<b>Description</b>
Emerald Ward	Thank you all for your care and professional attitude
Forensic Management Centre	Thank you for all the guidance and support you have given me over the past months. You've been a fantastic supervisor and taught me more than just how to achieve what I need for a successful career.
Forensic Management Centre	Thank you so much for arranging some clinical observations. You were really helpful and fascinating to talk to.
Gillingham CMHT	We would like to thank you for all the help you gave to our daughter . Thank you for all your help.
Maidstone North CMHT for Older People	Belated but very sincere thanks for all your help and support over the past few years. Many thanks with love and best wishes.
Maidstone North CMHT for Older People	From grateful clients/we are doing well/wife with dementia all the help given
Medway CMHT for Older People	Thank you for doing what you do. Your kindness has helped ease my anxiety and grief. Thank you for all your time and patience.
Medway Psychology (Secondary Care)	I have to say CBT is an excellent service; every session was carefully planned and delivered with enthusiasm.
PALS Department	I appreciate your commitment towards the Inclusion Agenda, and I'm proud of the professional way you represented Breaking Through and the Transformational Leadership Programme during the week.
PALS Department	Just a short note to thank you for coming along as guest speaker at our meeting. It was useful for our members to hear about the work that PALS carry out.
Rochester Resource Centre	We feel moved to write to you in order to let you know just how well the Eagle Court Drop-In Centre is being run.
Sevenoaks CMHT	I would like to convey that a member of staff has done an outstanding job looking after clients interest.
Sevenoaks CMHT for Older People	I'd like to thank you and your staff for the kindness and care given to my mother over the past years.
Sevenscore Ward	We would like to say a big thank you to everybody for helping to look after my husband during his stay at Sevenscore. You all do a remarkable job, in, at times extremely challenging circumstances. Thank you and best wishes to you all.

**Quarterly PALS Report**  
**April – June 2010**

**Table Nine continued: a sample of compliment comments received during April – June 2010**

Secondary Loc.	Description
Swale CHMT – Intake and Enhanced	I would like to thank your staff member from me. Today, she came out in the rain to meet me; then introduced me to Filmer House. Without her help and support I would not have gone there. She has been so very kind, caring, thoughtful and helpful. I can't thank her and your department enough.
Swale CHMT - Intake and Enhanced	I just wanted to say thank you for all you have done for me over the past year. Your support and encouragement has meant so much.
Tunbridge Wells CMHT for Older People	Thanks for all the help you have given my aunt - who really looks forward to your visits and for the company.
Tunbridge Wells CMHT for Older People	I would like to say how very much the 'Tuesday Club' in Paddock Wood is appreciated. It is helpful for everyone to meet and enjoy a coffee and a few games for a couple of hours.
Walmer Ward	Thanks for all the help
Walmer Ward	Thank member of staff for assistance
Woodlands Ward	Not fully recovered, but on my way, with the help I had from you all. Thank you for your care, thank you for your patience.
Woodstock Ward	big thank you for all the care and help afforded to my mother
Woodstock Ward	Thank you all very much for the care, consideration and companionship shown to him during his stay

By: Paul Wickenden, Overview, Scrutiny and Localism Manager  
To: Health Overview and Scrutiny Committee – 26 November 2010  
Subject: The Future of Community Service Providers: Written Update.

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## 1. Background

- (1) The Health Overview and Scrutiny Committee last considered this subject at its meeting of 3 September 2010. It will consider the subject again in depth at its meeting of 4 February 2011.
- (2) As this is a subject about which Members have expressed a high level of interest in the past, a written update was asked for based on the following requests:
  1. An update on any developments that have occurred since the September meeting;
  2. An updated timeline for the proposals around the future of community service provision; and
  3. A summary of the *Proposal for the Establishment of a Pan-Kent Community Services NHS Trust* that went before the Boards of NHS Eastern and Coastal Kent and NHS West Kent in September.

## 2. Recommendations

- (a) The Committee is asked to note the information provided.

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## The Future of PCT Provider Services

### Progress Report

### Health Overview and Scrutiny Committee – 26<sup>th</sup> November 2010

#### 1. Introduction

This is a joint paper between NHS Eastern and Coastal Kent (NHS ECK), NHS West Kent (NHS WK) and Eastern and Coastal Kent Community Health NHS Trust (ECKCH) relating to the proposed establishment of a Kent wide provider of community services from 1<sup>st</sup> April 2011. It aims to provide a progress report to Health Overview and Scrutiny Committee (HOSC) following the more detailed overview report submitted to HOSC at the meeting on 3<sup>rd</sup> September 2010.

Specifically, the report provides the following:

- An update on developments that have occurred since the September meeting.
- An updated timeline for the proposals around the future of community service provision.
- A summary of the 'Proposal for the Establishment of a Pan-Kent Community Services NHS Trust' submitted to the NHS ECK and NHS WK Boards in September.

#### 2. Stakeholder Engagement

At the September HOSC meeting, a concern was raised regarding stakeholder engagement and in particular the potential loss of local input and ownership into community hospital services if the proposed merger and creation of a larger organisation were to proceed.

One of the key actions within the stakeholder engagement plan is to produce bespoke leaflets for staff, public groups, NHS partners, KCC and voluntary sector explaining what the Kent wide proposal means for them and how an integrated community services model would potentially operate. Each leaflet requested views on the proposal and the results will be presented back to the HOSC meeting in February 2011. Current consensus so far is that in principle a Kent wide model is supported but more information is sought on how the locality arrangements will work in practice.

With regard to the issue raised by the West Kent League of Friends representative for Edenbridge on behalf of other community hospitals a subsequent meeting was held with the League of Friends and a summary of the outcome is extracted below:

*“After listening to Philip Greenhill, and particularly Mark Shepperd, our views have changed. Though we are concerned at the lack of competition in health services for patients in Edenbridge, we feel the proposal for one big provider arm in Kent has merit. **We are persuaded:***

- ***that a Kent wide provider arm could better deliver the policies proposed in the Health White Paper;***
- ***Our local GPs will be able to influence the commissioning of local healthcare***
- ***Edenbridge Hospital could be more vital, and better organised to provide more of the services locality needs.***

*There is a danger that the bigger organisation, the more layers of bureaucracy it needs. We have been persuaded that there will be more local administrative autonomy as well as provision of more local health services with this larger provider.*

*We hope that the Committee will agree with our changed views.”*

Stakeholder engagement will continue in line with the engagement plan.

### **3. Update on other developments**

#### **3.1 Eastern and Coastal Kent Community Health NHS Trust**

The new Trust came into being on the 1<sup>st</sup> November 2010 with the first formal meeting taking place that day.

#### **3.2 NHS ECK and NHS WK Board Meeting**

Both Boards at the September meetings agreed the business case proposing the establishment of a Kent wide provider of community services from 1<sup>st</sup> April 2011. The executive summary from the proposal document is attached as Appendix A.

#### **3.3 Integration Board**

An Integration Board has been established to ensure the effective delivery of the overall integration project. Chairs and Chief Executives from the 4 stakeholder organisations are members along with SHA and Staff side representatives. An implementation plan has been produced containing the key work streams and tasks that need to be undertaken before 1<sup>st</sup> April.

The Board are also responsible for ensuring effective communication is undertaken with staff and stakeholders during the transition phase plus the assessment and mitigation of major risk factors.

### 3.4 Department of Health agreement

On the basis that the proposals meet the National Guidance and tests set out in the NHS Operating Framework, the Department of Health have agreed in principle to the transfer of NHS WK community provider services to ECKCH.

The final decision to agree the proposals resides with the Strategic Health Authority who will need to take account of the judgement of the Cooperation and Competition Panel (See Below).

The SHA have considered the business case, whilst being assured that the proposal met the minimum 'test' requirements, they have flagged that there is additional work required relating to finance and clinical and quality outcome benefits. Both these items are being progressed and a response will be submitted to the SHA early November 2010.

### 3.5 Cooperation and Competition Panel (CCP)

One of the key stages in the assessment process is the consideration by the Co-operation and Competition Panel. The Co-operation and Competition Panel advises on the application of the Department of Health's Principles and Rules of Co-operation and Competition, and makes independent recommendations to the Department of Health, Strategic Health Authorities and Monitor, the independent regulator of NHS Foundation Trusts, on how cases should be resolved.

The Principles and Rules of Co-operation and Competition form the basis of the Department of Health's policy of managing co-operation and competition in the NHS in a fair, consistent and transparent manner. The principles and rules aim to ensure the NHS comprises providers who are best placed to deliver the needs of their patients and population, and that both providers and commissioners co-operate to foster patient choice and offer patients an experience of a seamless health service, regardless of organisational boundaries, whilst maintaining service continuity and sustainability.

A submission has been made to the CCP. Initial advice from the CCP is that the submission will require an in depth analysis as concerns have been raised regarding the potential lack of competition due to the reduction in NHS community providers in the South East region as they too go through merger processes. The CCP will assess whether the benefits of the Kent wide merger outweigh the potential loss of choice and competition. A formal response is unlikely to be available before end of February 2011 partly due to a backlog of cases submitted to CCP from around the country.

#### 4.0 Next Stages

Significant progress has been made since the last HOSC with both PCT Boards and the DH agreeing in principle to the proposals. The next critical stages are:

- Initial consideration of business case by South East Coast SHA – November 2010
- Outcome of due diligence review of West Kent Provider Services – December 2010
- Outcome of CCP – February 2011
- SHA endorsement – March 2011
- Launch of Kent wide organisation – April 2011
- Progress towards Community Foundation Trust – April 2011 – December 2012(indicative)

#### 5.0 Recommendation

HOSC are requested to note progress on the establishment of a Kent wide provider of community services. A further report will be submitted to the February 2011 meeting.

**Paul Duncan**  
**Interim Director, Business Development**  
**Eastern & Coastal Kent Community Health NHS Trust**

## APPENDIX A

### 1. Executive Summary

- 1.1. The purpose of this document is to provide NHS West Kent (NHS WK), NHS Eastern and Coastal Kent (NHS ECK), NHS South East Coast (NHS SEC), the Department of Health (DH) and other key stakeholders with assurance and evidence to support the establishment of a Pan-Kent Community Services NHS Trust from 1 April 2011. The proposed name for the new trust will be Kent Community Health NHS Trust (KCHT).
- 1.2. KCHT will integrate community services already provided by West Kent Community Health (WKCH) and Eastern and Coastal Kent Community Services (ECKCS) to form an NHS provider of community services with approximately 5,600 staff and an income of nearly £200 million per annum on the date of establishment.
- 1.3. This proposal follows the assurance and approvals process outlined within the DH guidance on developing Primary Care Trust (PCT) provided community services. It will also adhere to the NHS Transactions Manual published in February 2009 which governs transactions such as acquisitions and disinvestments and is covered further in section 19. Whilst the main body of this document demonstrates the case for establishing KCHT, we have also completed the *Organisational Form Assurance Template* also summarises our response to the DH tests. This document along with a range of supporting documentation detailed in *appendix A5* is available on request. Each sub heading within this document contains a signpost relating to the specific DH test.
- 1.4. Prior to the establishment of KCHT and in line with national policy expectations, the DH has confirmed the establishment of ECKCS as a new NHS Trust on 1 October 2010, and then subsequently to seek approval to become a Community Foundation Trust (CFT) post April 2011. From October 2010, this new Trust will provide the platform for a solid business and governance model within which to further develop and integrate community services on a Kent-wide basis.
- 1.5. Catalyst for Transformation  
We strongly believe there will be significant benefits in integrating community provider services to form a new entity from April 2011. These benefits will include:

#### **Stronger Community Focus**

A stronger community focus with locality working across the emerging GP commissioning clusters of Kent based on a community ownership model which we will progress in discussion with emerging GP consortia (see Fig 6).

**Better services through sharing best practice**

Better services for each local community by sharing best clinical practice across the region and recognising that each community provider has excellent models of clinical practice and innovation that we can potentially develop and share within the partnership arrangement. These include integration of children services, community nursing in primary care, intermediate care and research and audit work which will benefit patients in both West and East Kent.

**More opportunities for staff learning and career development**

A larger organisation will result in greater opportunities for all staff in both organisations. The new organisation will cover a community of nearly 1.4 million people and have over 5700 staff. Having such a large staff base will create savings in training costs, better opportunities for shared learning and future career opportunities.

**A strong financial base**

A strong partnership and integration of services will be better placed to withstand future economic pressures. The contract income for the partnership will be nearly £200m per annum which will allow us greater flexibility to make maximum use of our assets and minimise the joint impact of any possible loss of income from commissioners.

**Integrated support services to deliver better value for money**

An opportunity to improve value for money for tax payers and commissioners by sharing common support areas and back office functions. Both community providers need effective support services in order to deliver the best quality patient care at the front line. These include areas such as IT, Estates and Governance. We believe by sharing these services we can raise their profile and improve how these services are best delivered.

**A strong base from which to take up future business and development opportunities**

Integration will add weight and momentum to transformational change. A provider of this size and scope will be more able to be an active player in the local health economy and be able to respond more effectively to commissioner requirements. This will include not only being able to play a key role in collaborative working with neighbouring acute Foundation Trusts (FTs) and other providers, but also be a viable competitor for any new business that may arise in these markets. The new trust will also have the critical mass to become a robust CFT.

**More choice for patients**

Integration will provide wider access to services and wider choice to patients especially for those living on the current borders.

### **Streamlining of access to health and social care services**

Integration opportunities across health, Kent County Council (KCC) and social care which could include the potential to realise the benefits of single assessment processes, personal health budgets across health and social care and providing a single point of access for referrals, carers and clients/patients to health and social care services.

### **Opportunity to grow new providers through business support**

KCHT will be well placed to act as a 'service integrator', taking responsibility for provision across a whole pathway and to encourage new providers particularly those in the voluntary and third sector to provide services by offering business support and opportunities for integration.

### **Increase effectiveness in responding to emergencies**

A new Trust with the critical mass of KCHT will be better placed to provide a more effective response to emergency planning needs, business continuity and risk management.

In order to ensure delivery of these benefits, we will produce a Benefits Realisation Plan (BRP) which will focus on delivery of measurable outcomes. An initial draft of BRP is provided in *appendix A4*.

#### 1.6. Readiness to Accelerate Progress

KCHT will be in the best position to act as a catalyst for transformation based on what has already been achieved within the existing community provider organisations. Examples of what the organisations have already achieved include:

##### Quality Improvement

- Clinical service visions developed across all operational services which focus on delivery of improved patient outcomes with measurable performance indicators.
- Implementation of a five year Quality and Performance Strategy and, for West Kent, an agreed Quality Priorities Programme. Registration with the Care Quality Commission.
- Increasing capability and skill base of the workforce through a competency based framework for all grades of staff within adult nursing services.
- Organising services around care pathways and patients' needs, maximising the skills and knowledge of staff for the benefit of the patient and carers.
- Developed a Quality Improvement Support Service made up of clinicians who focus on patient safety improvement projects delivering quality improvements in the front-line services.
- Level 1 accreditation with the NHS Litigation Authority.

### Service Integration

- Implementation of a Primary and Community Nursing Care Service, driven by an agreed commissioning strategy which embeds Primary Care Nursing Teams (District Nursing) (PCNT) and the new Long Term Conditions (LTC) Service (including Community Matrons and Specialist Nursing) in primary care enabling the coordination of community services around individual patient needs.
- 'Team Around the Child' services formed with integrated teams from Health, Social Care and Education providing a single point of access and single records.
- Community Nursing Services, on a locality basis, are working within a Primary Care-led Integrated Care Programme delivering ambulatory care.
- Delivery of Learning Disabilities, Community Children's Respite Nursing and Integrated Equipment Services under section 75 agreements with KCC.
- Development work with Dartford and Gravesham NHS Trust in creating an integrated community and acute paediatrics care pathway for young persons which improves clinical adjacencies and seamless access and throughput to the Children's Community Nursing and therapies teams.

### Finance and Efficiency Improvements

- Both providers have had separate financial ledger since mid 2009, including separate hierarchies of accounts, separate bank accounts and cash management.
- ECKCS has undertaken the largest community staff activity study in England with 1,000 staff and 29,000 hours of activity analysed and made a number of changes in working practice as a result. The Community Nursing teams in ECKCS now spend 48% of their working hours face to face with patients; this compares favourably with the change delivered in those areas that piloted the Productive Community Services programme which achieved an increase from 21% to 35%.
- ECKCS launched a response to the quality, innovation and productivity and prevention challenge; Brainwave vs. Tidalwave. This has led to a strategy to drive down costs, push up productivity and release financial savings which is owned by all members of staff. As a result of suggestions made by staff and the introduction of e-rostering ECKCS has halved the spend on agency staff since August 2009.
- WKCH have developed a programme management office to lead on, currently, 15 QIPP programmes to transform care delivery, improve efficiency and quality and reduce costs. Agency spend has been reduced by 40% since September 2009

- Both provider organisations start from a sound financial base and are able to demonstrate an ability to meet the financial challenges that will materialise over the next five years through efficiency and productivity gains.

#### 1.7. Managing the Transition

An Integration Board has been established with representation from key stakeholders whose main responsibility will be to provide leadership and strategic direction to the integration work and ensure services remain stable during the transition period.

This will include monitoring the delivery of the overall project plan and specific plans to fully separate provider community services from NHS WK, taking forward the outcome of the ongoing due diligence work and ensuring compliance with the processes required in the Transactions Manual.

The Integration Board will also ensure effective communication is undertaken with staff and key stakeholders during the transition phase.

#### 1.8. Next Steps

The key milestones and indicative dates leading up to 1 April 2011 and beyond include:

- Engagement with key stakeholders including Health Overview and Scrutiny Committee, GPs, voluntary sector, LINKs and staff on the proposed arrangement. *August - September 2010*
- PCT Boards agree proposed business case for Pan-Kent organisation. *September 2010*
- NHS ECK Community Services become Eastern and Coastal Kent Community Health NHS Trust. *1 October 2010*
- Cooperation and Competition Panel assess business case for impact on competition and choice. *October - December 2010*
- NHS SEC consider proposed business case for Pan Kent Organisation – *November 2010*
- Cooperation and Competition Panel publish their recommendation. *January 2011*
- Endorsement from Department of Health. *January 2011*
- Undertake formal staff notification. *February – March 2011*
- Integration of WKCH into the new Trust to form Kent Community Health NHS Trust. *1st April 2011*
- Journey to Foundation Trust status including full public consultation. *April 2011 - December 2012 (indicative)*

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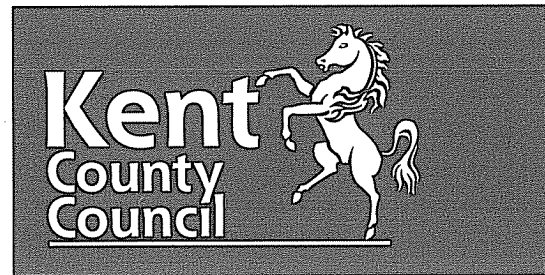
By: Paul Wickenden, Overview, Scrutiny and Localism Manager  
To: Health Overview and Scrutiny Committee – 26 November 2010  
Subject: Women’s and Children’s Services at Maidstone and Tunbridge  
Wells NHS Trust: Update.

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**1. Recommendations**

- (a) The Committee is asked to note the attached correspondence.

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Candy Morris  
Chief Executive  
NHS South East Coast  
York House  
18-20 Massetts Road  
Horley  
Surrey, RH6 7DE

**Legal and Democratic Services**  
Sessions House  
County Hall  
Maidstone  
Kent ME14 1XQ  
DX: 123693 Maidstone 6  
[www.kent.gov.uk/legal](http://www.kent.gov.uk/legal)

Direct Dial/Ext: (01622) 694486  
Fax: (01622) 694383  
Email: [paul.wickenden@kent.gov.uk](mailto:paul.wickenden@kent.gov.uk)  
Date: 21 October 2010

Dear Candy

**Women's and Children's Services – Maidstone and Tunbridge Wells NHS Trust**

As you will be aware, the Health Overview and Scrutiny Committee at Kent County Council held a special meeting on 20 September dedicated to considering the issues surrounding Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust.

The Committee resolved that the report and minute of that meeting be included unaltered as an addendum to the report that NHS South East Coast were preparing for the Secretary of State on this subject. As Chairman and on behalf of the Health Overview and Scrutiny Committee I would like to request a copy of the full report which was presented to the Secretary of State for Health.

If there are any difficulties in either fulfilling this request, would you please be able to explain what these are as this is a matter of keen interest amongst Members of the Committee?

I look forward to receiving a favourable response.

Kind regards

Godfrey Horne MBE  
**Chairman, Health Overview and Scrutiny Committee**

Geoff Wild LL.B, Dip.LG, Solicitor  
Director of Law & Governance

**CHIEF EXECUTIVE'S DEPARTMENT**



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Godfrey Horne MBE  
Chairman  
Health Overview and Scrutiny Committee  
Kent County Council  
Sessions House  
County Hall  
Maidstone  
ME14 1XQ

York House  
18-20 Massetts Road  
Horley  
Surrey  
RH6 7DE

Tel: 01293 778899  
Fax: 01293 778888

[candy.morris@southeastcoast.nhs.uk](mailto:candy.morris@southeastcoast.nhs.uk)  
[www.southeastcoast.nhs.uk](http://www.southeastcoast.nhs.uk)

Ref: CM2693/DG/JRG  
27<sup>th</sup> October 2010

Dear Godfrey

Thank you for your letter of 21<sup>st</sup> October.

As you are aware, the SHA submitted its report to the Department of Health on 30<sup>th</sup> September. Since the report was prepared at the request of the Secretary of State, I am afraid that I am not at liberty to send you a copy – publication remains at his discretion.

I am sorry that I am not able to be more helpful at this stage.

Yours sincerely



**Candy Morris**  
Chief Executive  
NHS South East Coast

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager  
To: Health Overview and Scrutiny Committee – 26 November 2010  
Subject: Committee Topic Discussion.

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## **1. Background**

- (1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve.
- (2) At the meeting on 26 March 2010, Members of the Committee requested an opportunity at each meeting to discuss what they had heard and decide whether the outcomes for each main agenda item had been achieved, or whether there was a need for further information to be requested, and from whom.

## **2. Recommendations**

- (a) The Committee is asked to assess whether the outcomes for this meeting have been achieved or if further information on any topic is required by the Committee.

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