KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 3rd July, 2012

10.00 am

Darent Room, Sessions House, County Hall, Maidstone

Medway Council
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Kent County Council

AGENDA

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 3rd July, 2012, at 10.00 am
Darent Room, Sessions House, County Hall, Maidstone

Ask for: **Tristan Godfrey**
Telephone: **01622 694196**

Tea/Coffee will be available from 9:45 am

Membership

Kent County Council	Mr K A Ferrin MBE, Mrs E Green, Mr L B Ridings MBE, Mr C P Smith, Mr K Smith, Mr M V Snelling and Mr A T Willicombe
Medway Council	Cllr Sylvia Griffin, Cllr Teresa Murray, Cllr Wendy Purdy and Cllr David Royle

UNRESTRICTED ITEMS

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

Item — Timings

1. Introduction/Webcasting

2. Substitutes

3. Election of Chairman

4. Election of Vice-Chairman

5. Declarations of Interest by Members in items on the Agenda for this meeting

6. Adult Mental Health Inpatient Services Review (Pages 1 - 32)

7. Date of next programmed meeting

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
(01622) 694002

25 June 2012

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.

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

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 3 July 2012

Subject: Adult Mental Health Inpatient Services Review.

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1. Summary

(a) Under *The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (S.I. 2002/3048)*[1] local NHS bodies must consult the HOSC over any proposals "for a substantial development of the health service in the area of a local authority, or for a substantial variation in the provision of such services."

(b) The subsequent *Directions to Local Authorities (Overview and Scrutiny Committees, Health Scrutiny Functions) 2003*[2] from the Department of Health stated that when an NHS body consulted two or more local authority health scrutiny committees a joint committee "shall" be established.

(c) In effect this means that where a service change is proposed that affects an area covered by more than one statutory local authority health scrutiny committee, and where both consider the change to be a "substantial variation," then a Joint HOSC will need to be established.

(d) On 9 March 2012 the Health Overview and Scrutiny Committee at Kent County Council determined that the proposals for a review into adult mental health inpatient services in Kent and Medway constituted a substantial variation of service. On 27 March 2012 the Health and Adult Social Care Overview and Scrutiny Committee at Medway Council made the same decision.

(e) The Health and Adult Social Care Overview and Scrutiny Committee at Medway Council has an agreed protocol concerning the assessment of a substantial variation of service. The completed protocol on this topic is included in the Agenda paper.

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[1] *The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (S.I. 2002/3048)*, http://www.legislation.gov.uk/uksi/2002/3048/contents/made

[2] *Directions to Local Authorities (Overview and Scrutiny Committees, Health Scrutiny Functions) 2003*, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4066609.pdf

2. Joint Health Scrutiny Committee with Medway Council

(a) In order to prepare in advance for a Joint HOSC being required, a Joint Committee with Medway Council was established at the meeting of the County Council of 25 March 2004. The arrangements were updated at County Council on 14 September 2006.[3]

(b) The agreed Terms of Reference for the Kent and Medway NHS Joint Overview and Scrutiny Committee are attached to this report as an Appendix.

(c) The Joint Committee consists of 12 Members: 8 from Kent County Council and 4 from Medway Council.

3. Recommendation

That the Committee consider and comment on the report.

[3] http://democracy.kent.gov.uk/Data/County%20Council/20060914/Agenda/sep06-item7.pdf

APPENDIX

Kent and Medway NHS Joint Overview and Scrutiny Committee

Terms of Reference

(i) To receive evidence in relation to consultations initiated by local NHS bodies regarding proposals for substantial development or variation of the health service which effect both Medway and a substantial part of Kent.

(ii) To make comments on behalf of the relevant Overview and Scrutiny Committees of Medway and Kent on any such proposals to the NHS body undertaking the consultation.

(iii) To undertake other scrutiny reviews of health services if requested to do so by the relevant Overview and Scrutiny Committees of both Medway and Kent

(iv) To report on such other scrutiny reviews to the relevant Overview and Scrutiny Committees of Medway and Kent.

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

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 3 July 2012

Subject: Mental Health Services: Overview

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1. Introduction

(a) Mental health and mental health services are both terms with a very wide scope:

1. Nearly 11% of England's annual secondary care health budget is spent on mental health.

2. More than £2 billion is spent annually on social care for people with mental health problems.

3. At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time.[1]

2. Definitions and Terminology.[2]

(a) Mental health is a core component of psychological wellbeing, and hence everyday life, and is as important as physical health. The two issues are interlinked; poor physical health may increase the likelihood of developing poor mental health, and poor mental health may increase risks of developing or not recovering from serious physical health problems.

(b) 'Mental health problem' is a loose term which can be used to describe the full range of mental health issues, from common experiences such as 'feeling depressed' to more severe clinical symptoms such as 'clinical depression' and enduring problems such as schizophrenia.

(c) Mental health problems have traditionally been divided in several ways, but are not necessarily mutually exclusive where an individual person is concerned:

1. Organic (identifiable brain malfunction) or functional (not due to structural abnormalities of the brain) illness.

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[1] HM Government, *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages, pp.8, 10,* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

[2] Section 2 has been adapted from definitions supplied by the London Health Observatory (LHO), http://www.lho.org.uk/LHO_Topics/Health_Topics/Diseases/MentalHealth.aspx

2. Neurosis (severe forms of normal experiences such a low mood, anxiety) or psychosis (severe distortion of a person's perception of reality).

(d) Terminology for mental health problems varies considerably across professions and cultures, according to prevailing attitudes towards mental health and current understanding.

1. Common mental health problems include problems such as anxiety, depression, phobias, obsessive compulsive and panic disorders.

2. Severe and enduring mental health problems include those mental health problems such as psychotic disorders (including schizophrenia) and bipolar affective disorder (manic depression).

3. Personality disorder is defined as 'an enduring pattern of inner experience and behaviours that deviates markedly from the expectation of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment'.

(e) Dementia is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. Consciousness is not clouded. The impairments of cognitive function are commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation. This syndrome occurs in Alzheimer's disease, in cerebrovascular disease, and in other conditions primarily or secondarily affecting the brain.[3]

3. Overview 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 of inpatient services. The last 30 years have seen a scaling back of psychiatric hospital services. In England there are 23 mental health beds per 100,000 population.[4]

[3] Definition of dementia taken from International Statistical Classification of Diseases and Related Health Problems, 10th Revision, World Health Organisation, http://www.who.int/classifications/icd/en/

[4] The NHS Handbook 2009/10.

(c) GPs treat many patients, and usually refer where appropriate directly to community mental health teams (CMHTs) or psychiatric outpatient clinic. 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) Some of the ways in which mental health services have been developed in the community include:[5]

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.

(e) There is a range of health services involved in urgent and emergency care for people with mental health problems – including crisis resolution home treatment teams (CRHT) and liaison psychiatry services.

(f) CRHT provide treatment at home for those who are acutely unwell but do not require A&E admission.[6]

(f) Liaison psychiatry provides psychiatric treatment to patients attending general hospitals, whether they attend out-patient clinics, accident & emergency departments or are admitted to in-patient wards.[7]

(g) 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.

(h) 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.

(i) 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.

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[5] NB: The names given to services can vary between areas of the country.

[6] Royal College of Psychiatrists, Acute mental health care: briefing note, November 2009, p.5, http://www.rcpsych.ac.uk/Docs/Acute%20mental%20health%20care%20briefing%20final%2097-03%20version.doc

[7] Royal College of Psychiatrists, Faculty of Liaison Psychiatry, http://www.rcpsych.ac.uk/specialties/faculties/liaison.aspx

(k) Patients who are in an acutely disturbed phase of a serious mental health disorder are detained in Psychiatric Intensive Care Unit (PICU) facilities.

(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. Patients in secure care will be detained under the Mental Health Act; some may have committed an offence.[8] 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) 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.

4. Mental Health Finances

(a) The year 2012/13 will see the beginnings of a major shift in the way mental health services are funded, from block contracts towards Payment by Results (PbR) currencies relating directly to individual service users accessing services. It is the introductory year for mental health care clusters to be introduced with local prices.[9]

(b) The clusters cover post-GP (or other referral) care for mental health services that have traditionally been labelled working age (including early intervention services) and older people's services.[10]

(c) The care clusters as a unit of currency are based primarily on the characteristics of a service user, rather than on their diagnosis alone.[11]

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[8] NHS Confederation, *Defining mental health services. Promoting effective commissioning and supporting QIPP*, January 2012, p. 11, http://www.nhsconfed.org/Publications/reports/Pages/Defining-mental-health-services-QIPP.aspx

[9] Department of Health, *Payment by Results Guidance for 2012-13,* February 2012, p.113, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133072.pdf

[10] Ibid., p.127 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133072.pdf. A list of exclusions can be found here also.

[11] Ibid., p. 117.

(d) A distinction is made between currencies and tariffs in NHS finances. A currency is the unit of healthcare for which a payment is made and the tariff is the price paid for that unit of healthcare.

5. Mental Health and QIPP

(a) QIPP (Quality, Innovation, Productivity and Prevention) is a series of 12 workstreams aimed at making efficiency savings to be reinvested in services. Across the NHS in England as a whole, the QIPP target is to find £20 billion in efficiency saving by the end of 2014/15.[12]

(b) Building on the 2011 Government strategy, *No Health Without Mental Health*[13], in relation to QIPP and mental health, the following indicators are monitored nationally:

- the number of new cases of psychosis served by early intervention teams;
- the percentage of inpatient admissions that have been gatekept by Crisis Resolution/Home Treatment Teams; and
- the proportion of people under adult mental illness specialties on the Care Programme Approach (CPA) who were followed up within seven days of discharge from psychiatric inpatient care.[14]

[12] 12 The Department of Health, Quality Innovation, Productivity and Prevention, http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPP/index.htm
[13] HM Government, *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages,* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf
[14] Department of Health, The Operating Framework for the NHS in England 2012/13, 24 November 2011, p.17, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf

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Appendix 2

MEDWAY COUNCIL
Gun Wharf
Dock Road
Chatham ME4 4TR

Medway Council
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Health Overview and Scrutiny

Health Service development or variation - assessment form

In order that the relevant Health Overview and Scrutiny Committee can assess whether it agrees that a proposed service change or development is "substantial" please provide the following details.

A brief outline of the proposal with reasons for the change and timescales

Over the last eight years, there has been a transformation of mental health services for people in Medway and Kent who are acutely unwell.

Home treatment has become the norm for most people in a mental health crisis, which is in line with national policy and is what most people who use services say they want.

When people are admitted to an inpatient unit now, it is because treatment at home is not an option for them, perhaps because there is a real risk they would hurt themselves, or because their family or those around them can no longer cope.

What this means is that

- **people being admitted are more ill than in the past. They have more complex needs and are higher risk than would have been the case a few years ago**
- **fewer beds are needed for acutely unwell people from Medway and Kent**

Research shows that two elements are essential in offering the best possible care to the smaller number of people who do need admission to an inpatient unit:

– enough highly trained, expert, staff to provide a safe, flexible, resilient service offering continuity of care, purposeful admission, intervention and review, safe provision of 'Section 136'[1] rooms, and a full range of therapeutic interventions, including in the evenings and at weekends
– modern, fit-for-purpose accommodation that is comfortable, relaxed, safe and secure and preserves people's dignity and respect

[1] For people brought to hospital by police under the Mental Health Act

KMPT and the PCT cluster have reviewed the acute inpatient pathway on a Kent and Medway wide basis for the first time, and propose moving to 'centres of excellence' with each providing:

- An excellent acute inpatient mental health service in itself, with a critical mass of staff and opportunities for therapeutic interventions at weekends and into the evening; working in fit for purpose accommodation for safe care and the promotion of recovery.
- A hub of good practice with a research programme and the commensurate ability to attract and retain highly qualified, expert and motivated staff.

People from Medway and Swale are currently looked after in A Block, a KMPT unit in former orthopaedic wards at Medway Maritime Hospital. There are poor sightlines for observation and people who may be very distressed or very delusional have only curtains around their beds to provide privacy.

There is restricted access to the outside, because wards are on the first floor. if someone needs fresh air, he or she has to wait to be accompanied downstairs, rather than being able to move in and out of doors at will. This inevitably builds up anger and frustration, which can have a major impact on people's needs and experience of care, as well as on staff time and resources.

Although the staff at A Block do the best possible job of providing care within the restrictions they face, and despite measures to improve the fabric of the building, this is not an environment that promotes either safety or recovery. It is not as good an environment as that available to people in KMPT's inpatient units in Dartford, Maidstone or Canterbury.

In order to ensure that people from Medway and Swale can access care that promotes their safety and recovery as effectively as that provided to people in the rest of Kent, it is therefore proposed to close A Block and provide services for people from Medway in the centre of excellence in Dartford.

It is also proposed to have one base for Psychiatric Intensive Care services, in Dartford, with an outreach service providing support to the mental health inpatient units in Canterbury and Maidstone, rather than two bases, one in Dartford and one in Canterbury, as now.

The proposed implementation timeframe is between October 2012 and March 2013, but this itself will be subject to further discussion with NHS (staff), service users, and wider stakeholders.

Extent of consultation

(a) Have patients and the public been involved in planning and developing the proposal?
(b) List the groups and stakeholders that have been consulted
(c) Has there been engagement with the Medway LINK?
(d) What has been the outcome of the consultation?
(e) Weight given to patient, public and stakeholder views

The issue of the quality of the acute inpatient mental health estate in Medway and its suitability has been a subject for much discussion and work over the last ten years. Many stakeholders have taken part and various plans have been explored at length.

Two conferences and a number of workshops were held in 2008 and 2009 to look at the acute care pathway within Medway and attempt to find a better inpatient solution for people from Medway and Swale. Medway LINk, mental health voluntary organisations, individual service users and carers took part in this work.

As a result, improvements have been made to a number of services for people who are acutely unwell, including Crisis Resolution and Home Treatment teams and acute liaison psychiatry. However, continuing attempts to find a solution to the location of inpatient beds in an environment which is safe and promotes recovery, have proved unsuccessful.

This review is determined to find a solution which improves the quality of care for adult mental health service users in Medway and Swale, in line with the service delivery in Kent.

A stakeholder options appraisal workshop for the acute inpatient mental health services review was held by KMPT on 24 February to help identify options for change that are acceptable and viable. It was attended by 51 people, including KMPT consultant psychiatrists and other mental health professionals, six GP mental health leads from different parts of Kent and Medway, five members of Medway HOSC including the chairman, one member of Kent HOSC (a KCC member from Swale), and nine service user and carer representatives, including a member of Medway LINk. The workshop's top three (of eight) ranked options for change will be developed and subject to further assessment and consideration.

Effect on access to services

(a) The number of patients likely to be affected
(b) Will a service be withdrawn from any patients?
(c) Will new services be available to patients?
(d) Will patients and carers experience a change in the way they access services (ie changes to travel or times of the day)?

Issues that were raised at the workshop included: Concerns about no longer having adult mental health acute inpatient beds physically situated in Medway after many years of the NHS trying to find more suitable and affordable local alternatives to A Block; how best to meet the demand for acute beds; how to

manage with one specialist psychiatric intensive care service in Dartford; the transport options to proposed new locations for both service users and carers; and how well services will work together in future. These will all be addressed in the redesign proposals. The ranked options will now be taken forward to the next stages, and financial, risk and equalities impact assessments are being undertaken.

No services will be withdrawn. One outcome will be to match acute inpatient and CRHT services with actual demand from Medway; another will be to improve the quality of the inpatient resources available to Medway residents.

Demographic assumptions

(a) What demographic projections have been taken into account in formulating the proposals?
(b) What are the implications for future patient flows and catchment areas for the service?

Demographic changes, relating to working-age adults in the main, will be identified and evaluated as part of the wider assessment process. The catchment area for the new acute inpatient mental health wards for Medway and the flows to it from Medway residents will be similar to the present, except there should be fewer overspills from East Kent into Medway wards and there will be an improvement in the integrated working for service users.

Can you estimate the impact this will have on specific groups?

(a) What will be the impact on children?
(b) What will be the impact on people with disabilities?
(c) What will be the impact on older people?
(d) Has an equalities impact assessment been carried out of this proposal?

This form would benefit from having a separate category: 'what will be the impact on people with mental health problems'. This group can be just as disproportionately affected by policy and practice changes as other groups with less power in society, and people with lived experience of mental illness often do not see themselves as a sub-category of 'disabilities'. The wards affected are not children's or older people's wards, although there will be some inpatients with a physical or learning disability too as in the population, and they are not well served by the current service at A Block.

However, assuming there were such a 'impact on people with mental health problems' question on this form:

The positive impact for this group will be the continuing trend towards more effective care and treatment at home, as NHS resources are invested in robust alternatives to hospital care. For the decreasing minority of service users who still need to be admitted due to higher risk to themselves or others, the result will be a more expert and recovery focused service, and reduced lengths of stay away from their community. The negative impact will be that those in Medway with mental health problems who need inpatient treatment would usually have to travel further to receive it, than those with some physical illnesses would have to; these effects will be mitigated by transport

solutions, earlier discharges and locally-managed Medway care co-ordination. When asked, most service users and carers say that the top priority is effective care and treatment when it is needed, followed by having integrated services, and then service location.

An initial equalities impact assessment is being carried out on different options. A full equalities impact assessment will be undertaken on any final solution selected following further engagement and assessment of the options being considered.

Choice and commissioning

(a) Will the change generate a significant increase or decrease in demand for a service arising from patient choice, payment by results and practice based commissioning?
(b) Have plans been made for "financial cushioning" if additional capacity is not taken up?
(c) Is the proposal consistent with World Class Commissioning and reflected in NHS Medway commissioning plans?

(a) The change will reflect the decreasing demand for the service; patient choice is usually for treatment at home. Both acute inpatient and Crisis Resolution and Home Treatment services for Medway will be in the same 'mental health Payment by Results care clusters' for Medway Commissioning Group, further incentivising effective home care and treatment by provider services.
(b) N/A
(c) Yes

Clinical evidence

(a) Is there evidence to show the change will deliver the same or better clinical outcomes for patients?
(b) Will any groups be less well off?
(c) Will the proposal contribute to achievement of national and local priorities/targets?

There are reservations about keeping the current service in A Block. The Care Quality Commission compliance inspection of Medway wards in November 2010 identified that "people were generally protected from harm although there was risk where the layout of the ward made de-escalation *(of violence)* difficult and there was no seclusion room on the ward". "People would have also been at risk from self harm where there are no ligature free rooms". Similarly, Kent and Medway psychiatric intensive care services are currently provided at two bases, Willow Suite in Dartford and Dudley Venables House in Canterbury. Willow Suite is housed in purpose-built accommodation that offers the best possible environment for intensive care. Dudley Venables House is a converted 1994 ward and is therefore limited in what can be achieved for psychiatric intensive care. A Block and Dudley Venables House do not meet DH standards such as in "Laying the Foundations" while the outcomes from a centre of excellence with a high quality, purpose-built therapeutic environment is the model of care supported by clinicians, including the Royal College of Psychiatrists.

Joint Working

(a) How will the proposed change contribute to joint working and improved pathways of care?

There will still be dedicated CRHT resources for Medway to prevent, manage and support acute mental health care between home and hospital, working with Medway's secondary care community mental health services. The acute mental health care pathway will be integrated and strengthened. One advantage of the proposals for Medway inpatients who need intensive care will be that they will no longer need to move hospitals during their treatment.

Health inequalities

(a) Has this proposal been created with the intention of addressing health inequalities and health improvement goals in this area?
(b) What health inequalities will this proposal address?
(c) What modelling or needs assessment has been done to support this?
(d) How does this proposal reflect priorities in the JSNA?

This is not a preventative or early intervention service, but a specialist support and treatment service for service users and carers facing the more severe and complex mental health problems, such as psychosis. Clearly one of the social outcomes of effective time-limited 'recovery focused' treatment is to reduce the health inequalities faced in the community by people with severe mental illness.

A comprehensive demand modelling exercise has just been completed by NHS commissioners and provider working together, done on a locality/council basis for all parts of Kent and Medway, to assist one of the redesign objectives that is consistent with JSNA objectives: to ensure equal access to high quality acute inpatient mental health care when home treatment and care is not the best option for someone or his or her family.

Wider Infrastructure

(a) What infrastructure will be available to support the redesigned or reconfigured service?
(b) Please comment on transport implications in the context of sustainability and access

Voluntary transport schemes and the increased use of audio-visual web-based technology by community mental health services are ways in which the effects of distance can be reduced. The fast rail service from Medway to Dartford has recently been improved making it a better option for Medway residents than many other Kent towns. Little Brooke Hospital in Dartford is where there is readily available, sufficient and suitable estate for Medway acute inpatient mental health wards. And given that fewer people need inpatient care for longer periods, the overall number of hospital journeys made by service users, carers and staff will be reducing, even though each journey may be longer.

Do you believe the outlined proposal is a substantial variation or development?

We believe the outlined proposal is a further development of a well-established strategy. While it involves removing acute inpatient mental health wards from Medway, in the physical sense, it offers improved access to the most therapeutic environment and best clinical care for people from Medway and Swale. The options being considered will affect the patient flow for service users in Medway and Swale, and West Kent to a degree. We are keen to have a robust and open discussion with everyone affected and to work with both Medway and Kent HOSCs to achieve this.

Is there any other information you feel the Committee should consider in making its decision?

The paper the Committee has is an initial paper written just before the stakeholder workshop, to make the case for change. The most viable and acceptable alternative solutions will be presented in a full discussion with NHS staff, service users and wider stakeholders across Kent and Medway. This will be accompanied by further, targeted stakeholder engagement in Medway itself (the Mental Health Locality Planning and Monitoring Group, Local Involvement Network, HOSC member including visits to the units involved, etc.).

For these reasons, the Committee are asked to support the convening of a Joint HOSC (JHOSC) with Kent to consider the full case for change and alternatives for the future of acute inpatient mental health services.

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Kent and Medway NHS
NHS and Social Care Partnership Trust

NHS
Kent and Medway

Meeting:	Kent and Medway NHS Joint Overview and Scrutiny Committee
Date of Meeting:	3 July 2012

Achieving Excellence in Mental Health Crisis Care

INTRODUCTION

1. NHS Kent and Medway and Kent and Medway NHS and Social Care Partnership Trust recognise the need to improve the quality of care for adult mental health service users who are acutely unwell.

2. The PCT Cluster and the Trust have reviewed current services, with service users and other stakeholders and seek JHOSC support for a three-month public consultation on proposals that will deliver

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

REVIEW FINDINGS

3. The review found:

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

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

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

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

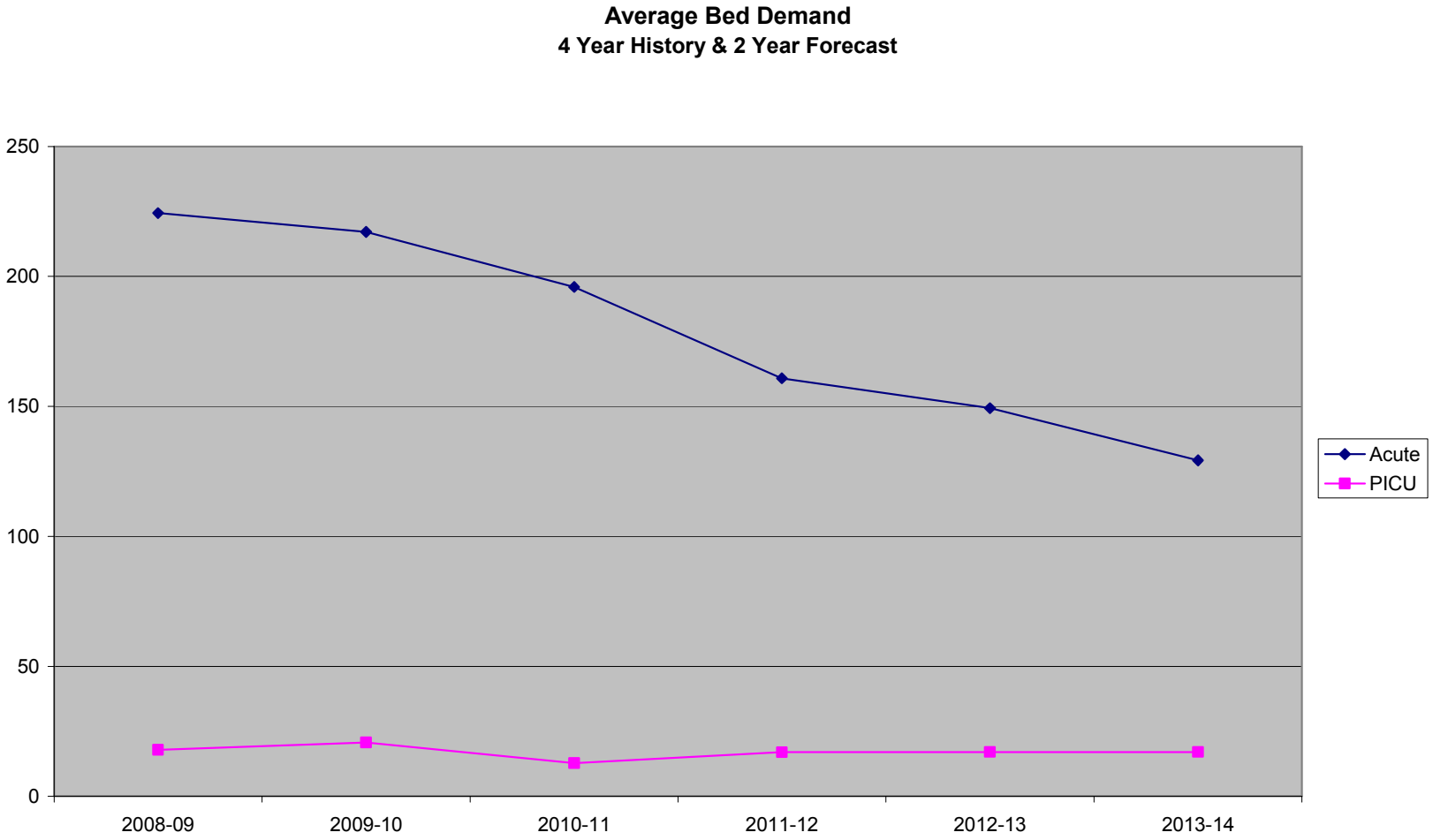

Fig 1: Reducing bed demand over the last four years extrapolated to forecast 2013-14

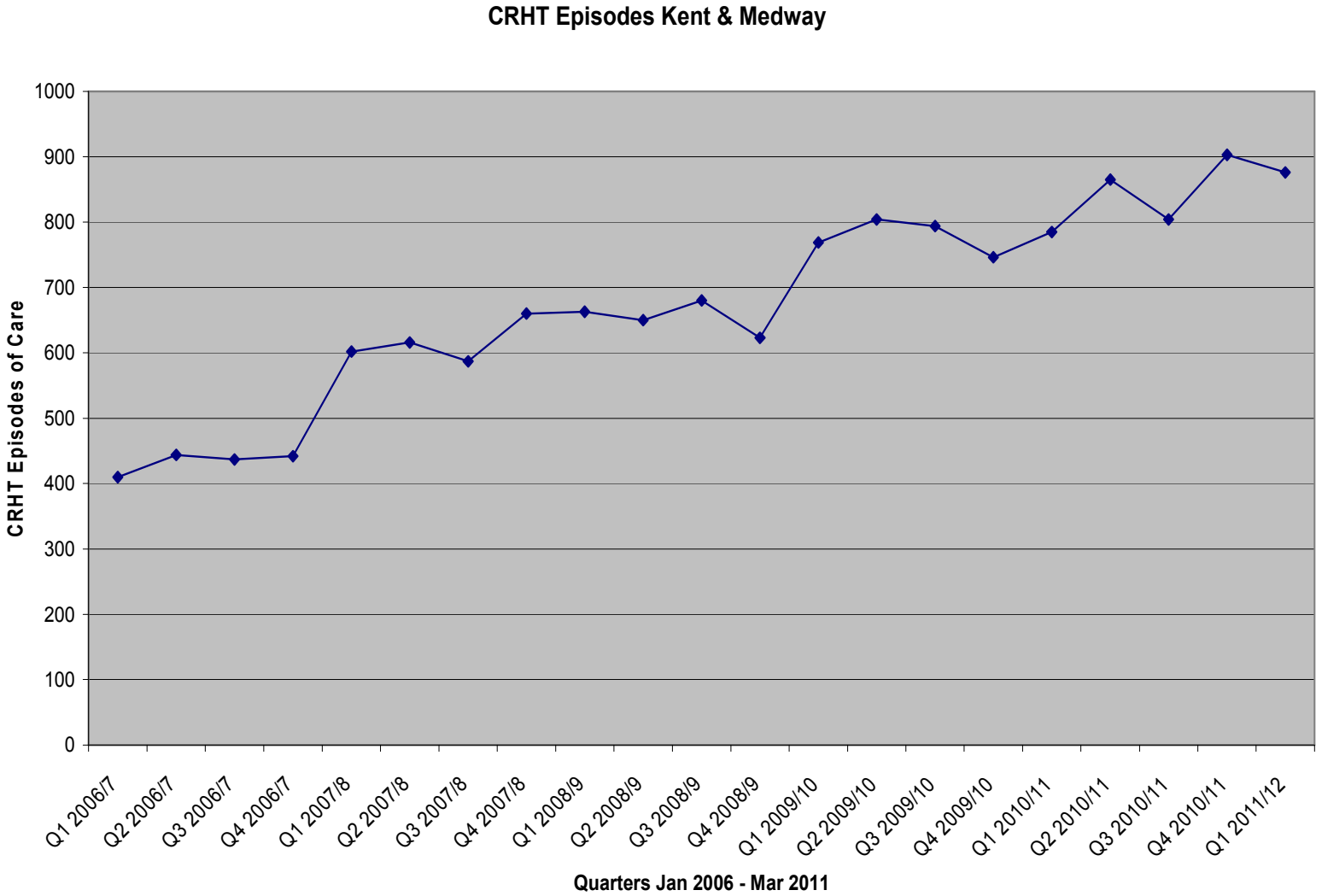

Fig 2: Increasing CRHT episodes of care over the last four years to 2011-12

Acute Ward Stay Days by Financial Year and Local Authority

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

Table 1: Four year reduction in Acute Ward Stay Days and two-year forecast

4. Analysis of four years of data leads us to conclude that, allowing for the usual variations and the seasonal peak between January and March, 150 beds will be required by Kent and Medway plus 12 in one psychiatric intensive care unit (PICU). We propose to allocate the beds proportionately to match actual demand for them over the last four years. Using the postcodes of every service user admitted to an acute or intensive care unit in these years we were able to estimate bed need by service locality and then area. This relative bed usage data shows that

    - East Kent service localities need more beds than at present
    - Medway and Swale localities have about the right number of beds allocated to them
    - North Kent and South West Kent service localities need fewer beds than at present

5. This information has allowed us to propose how each service locality can be allocated to an inpatient ward and aligned CRHT, based at the high quality hospital inpatient units that KMPT has now, plus those they can readily gain use of for acute mental health care (see Annexe A).

DISCUSSIONS WITH STAKEHOLDERS

6. This situation and a range of options to address the issues have been discussed with service users, carers, staff and other stakeholders in recent months. On February 24, a workshop of more than 50 people, including service users, carers, staff, local councillors, GPs, social workers and mental health advocates selected from a 'long list' of eight options the three options proposed for public consultation. These options are all supported by clinicians and agreed by stakeholders to be those which will best deliver a 21st century in-patient mental health service for Kent and Medway.

7. Since then, the issues and the options have been discussed by all 10 Local Planning and Monitoring Groups in Kent and Medway, which consist of representatives from all the service user and carer groups, as well as partner services in the public and third sector.

8. Separate meetings have been held with Medway Service User Engagement Group, Swale Service User Forum, a Buddy scheme focus group of service user experts by experience from Medway and east Kent, Kent and Medway LINKs Mental Health Network, GPs and mental health clinicians from across Kent and Medway, Medway and Swale Clinical Commissioning Groups.

9. Stakeholders have raised a number of key issues of concern, which are outlined and addressed in paragraphs 20-32 below.

PROPOSALS

10. Proposals have been developed to address the review findings. They are to:

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

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

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

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

11. These proposals would mean:

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

CENTRES OF EXCELLENCE

12. KMPT is committed to creating Centres of Excellence (CoEs) for inpatient care. There is no standard model for this nationally, although the direction of travel is clear from policy papers developed over the last 10 years. KMPT proposes taking a rigorous approach to developing a useful model that others

might share and its Acute Service Line Programme board for this redesign describes its 2012 CoE model as:

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

13. CoEs help to drive quality, breadth of services and interventions offered. The opportunity for research and development alongside academic partners enables greater consistency of practice and outcomes to be achieved and shared.

BENEFITS FOR SERVICE USERS AND CARERS

14. As the Centres of Excellence develop and the CRHTs are strengthened, service users and carers will

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

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

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

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

15. NHS Kent and Medway and KMPT aim to develop further a single, clear route for service users and carers to access mental health services. The Trust is determined to ensure it offers its patients a seamless, multidisciplinary, urgent care pathway.

OPTIONS

16. Public consultation is proposed on three options for the three centres of excellence and the dedicated patient pathways to those inpatient wards. In all of them, people from Medway would be treated at Little Brook Hospital, Dartford, when they need a hospital stay. In options A and C it would have its own CRHT and in option B it would share one with Swale. These options were those prioritised by the workshop referenced in paragraph 6 above.

17. For people from Swale (excluding Faversham)

- Option A would mean hospital stays in Priority House, Maidstone
- Option B would mean hospital stays in Little Brook Hospital, Dartford
- Option C would mean hospital stays in St Martin's Hospital, Canterbury

In all the options people from Faversham would be admitted to St Martin's Hospital.

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

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

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

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

ISSUES FOR SERVICE USERS AND CARERS

21. Key issues of concern among stakeholders in our discussions so far are:

    - **Whether there are enough beds in East Kent** as so many overspills to other areas' inpatient units in recent years have demonstrated a shortage
    - **Closing Medway's A Block** mental health wards means having no mental health hospital facility in the Medway Towns and therefore new arrangements for service users and carers from Medway and Swale (excluding Faversham)
    - **Transport** for family and friends visiting people in hospitals further from home
    - **Carers want more support** than the Crisis Resolution Home Treatment teams are giving at present
    - **Choice** of hospital for service users and how this is achievable in a crisis

ENOUGH BEDS IN EAST KENT

22. The analysis of four years of actual bed usage data indicates the proportion of beds that should be in east Kent is 68, eight more than is currently available, and this is the number in our redesign proposals.

CLOSING MEDWAY'S A BLOCK

23. Medway's A Block is unsuitable for 21st Century mental health care. The wards have
    - poor sightlines for staff to observe people who are acutely unwell
    - dormitory bays with only curtains to offer privacy around the beds for people who may be very distressed or very delusional
    - restricted access to the outside so patients have to wait to be accompanied by a member of staff, which builds up anger and frustration, with an experience of care as containment and a major impact on staff time and resources
    - lack of facilities for visitors to meet service users privately, and the general atmosphere there, means few people actually go and visit patients there.

24. It has 34.5% of adult acute mental health beds in west Kent and Medway – but in 2011/12, it had:

    - 43% of the reported violent incidents to staff and other patients
    - 38% of the referrals from acute wards to PICU and
    - 53% of reported serious incidents, all five of which resulted in injury

25. The staff based at A Block do the best possible job of providing care within the restrictions of this environment, but are clear that they could achieve better health outcomes with their patients in a more suitable facility. KMPT's

inpatient units at Dartford, Maidstone or Canterbury are all purpose-built, with single en-suite rooms and are noticeably calmer places.

26. People from Medway and Swale who use A Block deserve to have the same standard of facilities as everyone else in the county. The Trust and Medway PCT (now represented by NHS Kent and Medway) have been trying to find a suitable and affordable solution for a number of years, and further details of the options which have been considered and ruled out are available on request.

TRANSPORT

27. At present, friends and family visit service users infrequently in the current acute inpatient units; we would like this to happen more often and are developing a plan to enable this.

28. Service users from Medway researched the travel issues and produced a report pointing out that road links were good for people able to travel by car and public transport from Medway to Bluewater was also good. The Trust has found there are regular buses from Bluewater to Little Brook Hospital and will make detailed information available through its crisis team and the hospital as well as online on its own website and www.liveitwell.org.uk.

29. A service user from Swale researched the travel issues from Sittingbourne and Sheppey and found the journeys from Sittingbourne to Maidstone and Canterbury took a similar length of time (within five minutes) and cost the same. He found the same was true when travelling from Sheppey. The cheapest way to make the journeys was by bus, using a day saver ticket at £6.70, which is cheaper than the journey to A Block from Sheppey.

30. KMPT proposes a bookable volunteer transport service to assist service users' families and friends with the last part of their journeys to Priority House, Maidstone, and the first part of their return journeys, which would otherwise be a 10-minute walk, as there will not be enough demand to warrant a shuttle bus service.

SUPPORT FOR CARERS

31. These proposals are responding to carers' views that they need more support from Crisis Resolution Home Treatment teams. The new Support Time and Recovery workers will significantly increase the crisis team's capacity to spend longer on cases.

32. They are trained to work with people who are acutely mentally ill and their families and friends, although they are not clinically qualified. They make an important contribution, supporting the service user in a variety of ways, depending on their needs – perhaps accompanying them on errands or shopping, providing respite for carers at the same time.

CHOICE

33. The mental health services these proposals relate to are specialist and only needed in a crisis: they are, in effect, the mental health emergency service. In a crisis in physical health paramedics scoop a person up and whisk them to the Emergency Department without offering them choice because what is needed is effective specialist care and risk management at some speed. This is a good parallel to mental health crisis services.

34. A hospital stay is generally a last resort these days – and one of the most crucial points is the need to go to the unit that works most closely with the individual's Crisis Resolution Home Treatment Team, so that there is seamless care when they are ready to go home. If a patient goes to a different hospital, the linkages to other services are such that people experience delays in discharge and dislocation from other services they need.

FINANCIAL IMPLICATIONS

35. The proposals are affordable and achievable. Initial costings by KMPT indicated that the planned ward improvements would cost £247,000 in the first year of implementation but that net savings would still be generated from 2013/14, after investments in extended CRHT, PIC Outreach and transport services.

ACUTE WORKFORCE IMPLICATIONS

36. The trust has a policy – and a good track record – of keeping clinical redundancies to an absolute minimum. It aims wherever possible to retain the clinical skill and expertise it has within its services.

ACUTE SERVICES RECENT PERFORMANCE

37. Acute Mental Health Services in Kent and Medway have modernised their practice and delivered a strong performance record in the last year or so:
    - Increase in CRHT episodes of care of 26% over the past 8 months
    - Reduction in Admissions of 4.7% between 10/11 and 11/12
    - CRHT bed management is consistently above the Monitor target of 90%, as all alternatives to a hospital stay are examined before admitting a patient to a bed (NOTE: this target rises to 95% in 12/13)
    - CRHT volume of Home Treatment is consistently above the national target, showing that it is working as an alternative to hospital across Kent and Medway

- Emergency re-admissions rate is consistently below the 5% target, showing that patients are not being discharged prematurely

- Delayed transfers of care are consistently below the 7.5% Monitor target, showing that bed blocking is at a minimum

- Consistent length of stay figures, with a median length of stay of between 15-17 days and a mean of around 30 days

TIMESCALE

38. The proposed implementation timeframe is between October 2012 and March 2013, but this itself will be subject to further discussion with service users, NHS colleagues, partner organisations, and wider stakeholders.

39. Kent County Council and Medway Council Health Overview and Scrutiny Committees (HOSCs) have considered the proposals and agreed they amount to a substantial change of service warranting full public consultation and the formation between them of a Joint HOSC (JHOSC) for the process which could take place between July and October 2012.

RECOMMENDATION

The JHOSC is recommended to approve taking the proposals in this report to three months public consultation between late July and late October 2012.

ANNEX A

Area	Ward location	Current Beds	CRHT	PICU/ PICO	Proposed beds	Proposed CRHT	Proposed PICU/ PICO
East Kent	Arundel Unit, William Harvey Hospital, Ashford	36	2	8 at Canterbury No PICO	68 (including those currently used as PICU)	2 (with additional Support Time Recovery Workers)	New PICO service in East Kent 12 at Dartford Continued PICO service in Medway and West Kent
	St Martin's Hospital, Canterbury	18					
	Beds on older people's ward at Queen Elizabeth the Queen Mother Hospital, Thanet	5					
Medway	A Block, Medway Maritime Hospital	35	1	12 at Dartford PICO service prevents 30% admissions	0	1(with additional Support Time Recovery workers)	
West Kent	Little Brook Hospital, Dartford	32	1		48	1(with additional Support Time Recovery workers)	
	Priority House, Maidstone	34	2		34	2(with additional Support Time Recovery workers)	
Total		**160**	**6**	**20**	**150**	**6 (with 20 additional Support Time Recovery workers)**	**12**

Table 2: Current and proposed service arrangements

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