KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 19th March, 2013

4.00 pm

St Georges Centre, Pembroke Road, Chatham Maritime, Chatham, Kent ME4 4UH

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AGENDA

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 19th March, 2013, at 4.00 pm
St Georges Centre, Pembroke Road, Chatham Maritime, Chatham, Kent ME4 4UH

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

Tea/Coffee will be available from 9:45 am

Membership

Kent County Council	Mr R E Brookbank, Mr D Daley, Mr K A Ferrin ,MBE, Mrs E Green, Mr L B Ridings, Mr C P Smith (Chairman), Mr K Smith, and Mr A T Willicombe
Medway Council	Cllr Sylvia Griffin, Cllr Teresa Murray, Cllr Wendy Purdy (Vice-Chairman) 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.	Declarations of Interest by Members in items on the Agenda for this meeting	
4.	Minutes (Pages 1 - 8)	
5.	Adult Mental Health Inpatient Services Review (further papers to follow) (Pages 9 - 44)	
6.	Date of next programme 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

11 March 2013

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

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Kent and Medway NHS Joint Overview and Scrutiny Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Wednesday, 13 February 2013.

PRESENT: Mr C P Smith (Chairman), Wendy Purdy (Vice-Chairman), Mr R E Brookbank, Mr D S Daley, Mr K A Ferrin, MBE, Sylvia Griffin, Teresa Murray, Mr L B Ridings, MBE, David Royle, Mr K Smith and Mr A T Willicombe

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee) and Ms R Gunstone (Democratic Services Officer)

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

The Vice-Chairman in the Chair opened the meeting and on behalf of Medway Members, expressed their condolences at the sad passing of Mr Michael Snelling, Chairman on the Kent and Medway NHS Joint Overview and Scrutiny Committee.

2. Substitutes
(Item 2)

3. Election of Chairman
(Item 3)

Cllr W Purdy proposed and Mr A Willicombe seconded that Mr C Smith be elected Chairman.

Carried Unanimously.

4. Declarations of Interest by Members in items on the Agenda for this meeting
(Item 4)

5. Minutes
(Item 5)

RESOLVED that the Minutes of the meeting held on 3 July 2012 are correctly recorded and that they be signed by the Chairman.

6. Adult Mental Health Inpatient Services Review
(Item 6)

David Tamsitt (Director Acute Services, Kent and Medway NHS and Social Care Partnership Trust), Lauretta Kavanagh (Kent and Medway Director of Commissioning for Mental Health and Substance Abuse, NHS Kent and Medway), Rosarii Harte

(Assistant Medical Director – Acute Services, Kent and Medway NHS and Social Care Partnership Trust), Dr Peter Green (Chief Clinical Officer, Medway Clinical Commissioning Group), Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway), Patricia Davies (Accountable Officer (designate), Swale CCG), Sara Warner (Assistant Director Citizen Engagement, NHS Kent and Medway), and Dr Pete Sudbury (National Clinical Advisory Team) were in attendance for this item.

(a) The Chairman introduced the item and welcomed the Committee's guests. He then drew attention to an additional paper from Medway Members of the Committee which had been circulated just prior to the meeting. It contained additional information along with concerns and questions to be raised. The question was asked why the paper had only been made available prior to the meeting. It was explained that information required to produce the paper had only been received the week before and it had taken until the morning of the meeting to produce the report. Due to the lack of time available to read the paper and properly evaluate its contents, the Chairman determined that it could not be considered at the meeting.

(b) NHS representatives were invited to introduce the item. It was explained to Members that the NHS representatives present at the meeting would endeavour to explain how the four tests the Secretary of State for Health had laid down for service reconfigurations had been met. This was also evidenced in the information supplied in advance and present in the Agenda. These tests were: ensuring appropriate patient choice; support of GP commissioners; adequate patient and public engagement; and a good clinical evidence base. It was also explained that the proposals for change outlined in the Agenda would be presented to the NHS Kent and Medway board meeting on 20 February and at the board meeting of Kent and Medway NHS and Social Care Partnership Trust (KMPT) shortly after that.

(c) Dr Pete Sudbury was also introduced. He was not part of the team who developed the proposals and was one of the external scrutineers who had commented on them. It was explained that he would be able to provide an independent perspective.

(d) An overview of the case for change was presented. NHS representatives explained that it had been developed over a long period of time with ongoing engagement. The core issue was that the NHS could not guarantee effective treatment and the quality of care at Medway A-block. The excellent work which KMPT staff did was recognised, but it was not sustainable to continue with the service as it was. Medway A-block saw a much higher proportion of serious incidents than comparable facilities and there had recently been a rise in incidents of aggression. It was commented that the ongoing uncertainty about the future shape of services was an additional factor in this. In addition, there was a need to address the imbalance between east and west Kent in terms of the psychiatric intensive care support available. The inequity of service itself caused anxiety amongst service users.

(e) On the question of choice, it was explained that in the context of mental health services this needed to be appropriate choice. For those patients detained

under the Mental Health Act, there was a limitation of choice, but there was still a need to ensure patients were treated with dignity and respect.

(f) There was a lot of discussion about the engagement process. Some Members expressed concerns that the consultation may not have involved many service users. It was explained that the engagement exercise involved a number of public meetings as well as an open invitation to go out to groups. Invitations went out to 700 groups and information was sent to all KMPT Foundation Trust members. It was also featured in the local press. Over 50% of the respondents were services users or their carers. The results showed a high level of support for the ambitions of the strategy but also showed travel and transport were major concerns, particularly for carers. There was a clear mandate given through a 62% preference for Option A, and this is the option that would be taken to the Board meetings. This was a consistent preference across all catchment areas, including Swale. The Agenda papers contained an independent analysis of the consultation produced by the University of Greenwich. One Member commented that this did demonstrate support, but only within the narrow confines of the consultation.

(g) Transport, and the potential cost of it, was a particular issue for carers, friends and relatives, it was explained, as patients would be transported by the NHS. On the issue of transport, one Member mentioned the 'Deal Deal' where he had said he would support the proposals if he could be assured that transport arrangements from Deal, as the furthest point from any centre, would be sufficient. It was explained that these details could not be shared as they involved case studies which would identify individuals. The Member explained that he had been reassured. The same Member also raised the issue of the number of visits received by mental health inpatients was surprisingly low. This was confirmed by NHS representatives and it was also explained that the number of service users who received inpatient treatment in any year was also comparatively low. Visits could aid recovery, but the patient's wishes needed to be respected and this might involve the request not to receive visitors.

(h) The need to have a comprehensive transport plan was emphasised by a number of Members. The Committee was assured that producing a plan formed part of the implementation programme contained in Appendix 3 of the Agenda. Mr Tamsitt explained that he was leading on this work and two committee meetings on it had already been held, the most recent in the previous week. An extension of the volunteer driver scheme was being costed and a business case being worked up. The model operating in Maidstone was given as a good working example. Improving the information available about travel and opening times was another area being looked at. Signage was also being studied and work would be undertaken with Dartford Borough Council on clearer directions to Little Brook Hospital being put in place. Data was given that across the 9 acute wards, there had been 265 visits in the last 2 weeks. This equated to 25 visits for each ward. Of these 81% travelled in their own transport or were conveyed by a friend. 6% used public transport. 13% did not say when surveyed. Other Members felt that although the numbers were small, the issue of transport was exceptionally important to those affected by changes.

(i) A series of points and questions were raised about the adequacy of community mental health services and the availability of crisis resolution home treatment teams (CRHTs). The view was expressed, including the views expressed by a Member who stated his wife was a GP in the Medway area, was that services across the board were not adequate. A variety of examples were given by Members, some revolved around concerns about how to ensure people took the appropriate medication at the right time. This was a barrier to agreeing a change in acute provision.

(j) These concerns were recognised by NHS representatives. In response it was explained that the specialist community health services provided by KMPT received 28-29,000 referrals each year and would be supporting 10,000 at any one time. This compared to the 160 acute mental health inpatient beds available. Since the publication of the National Service Framework for Mental Health, there was more involvement with complementary services provided by local authority social services. Discharges from acute mental health inpatient units were often delayed due to social issues rather than medical. The Kent HOSC had in the past considered the developments in community mental health services across the County.

(k) Proceeding to discuss the CRHTs, it was explained that the workforce for these was being expanded by 24. In addition peer support workers were being recruited and developed. These had proved effective elsewhere, and would be useful to ensure people continued to take their medication. It was explained the developments of this service needed to be seen against the background of wider changes to acute services, namely treating more people at home with home treatment. In response to one particular concern, it was explained that sufferers of mental health illness were more likely to be victims of crime than to commit a crime.

(l) It was also acknowledged by NHS representatives that concerns had been expressed nationally about the quality of inpatient services, both for physical and mental health illness. Recent reports on Medway NHS Foundation Trust were mentioned. It had been recognised nationally that concentration of certain services in specialist centres delivered better outcomes.

(m) The issue of the location of services was raised and in response to a question the reports in the Agenda about other locations in Medway which had been considered were indicated. A Member asked about whether the wards which were being closed at Maidstone Hospital and Sittingbourne Hospital had been considered. In response it was explained that due to the high service standards which needed to be delivered, it was not possible necessarily to simply convert an existing acute ward. These would often not be sustainable environments. In response to a question from a Member, it was explained that the pooling of staff which centralisation allowed also brought benefits. The example of a recent consolidation of services in East Kent was given, centred in Canterbury. This was now the first centre of excellence in effect. There were now 6 consultants on site and this allowed consultant cover at all times. There was also an increase in the number of junior doctors available as well as allied health professionals, such as occupational therapists, who were very important in effecting reintegration with everyday living.

(n) The analogy was used of recent centralisations of angioplasty services at Ashford. This was not because Ashford had more need than other areas, but so that a quality service could be delivered for everyone in Kent and Medway, even if this involved travelling further to the service. Some Members questioned how far the analogy between physical and mental health could be pursued as the nature of mental health illnesses covered such a range of need. Dr Sudbury expressed the view that the two were more similar than not. The average length of inpatient stays for physical health issues was 8 days. The best practice for mental health inpatients was 13 days, but was more often around 21 days. However, the similarities were that the percentage of people with mental or physical ill health who needed to be admitted to hospital was small. The point was to try and avoid admittance to hospital at all. Physical health inpatients could catch infections and mental health inpatients could be influenced by other inpatient behaviour. He expressed the view that focussing on the small percentage admitted at all risked skewing the debate. He also made the observation that when he scrutinised the Kent and Medway proposals, he was concerned that they proposed 3 centres of excellence, when 2 would perhaps be more sustainable.

(o) The question was posed about where the cut off for admittance would be with the reduction in beds overall that the proposals would involve. The response was made that assessments about admittance were more about assessing the risk than the particular condition, although this was a factor. CRHTs carried assessed referrals before admittance. In connection to answering this question it was explained that anorexia was treated separately through a specialist service and did not form part of general mental health inpatient services.

(p) NHS representatives explained that after the public consultation had concluded, two important reports were published. One was from the Schizophrenia Commission and the other from the charity Mind. The findings of these reports were built into local deliberations. One aspect to come from this was the promotion of Recovery Houses as a very valuable addition to treatment at home or hospital. Dr Sudbury had been involved in a pilot of these Recovery Houses when 3 had been set up in Haringey. He explained that these had proven to be extremely popular and were run by Rethink in Haringey. When patients entered a Recovery House, they were reintroduced to regular everyday activities like shopping after a few days with the aim to re-establish normal life as soon as possible. It was explained that home treatment services reached into Recovery Houses. They demonstrated that people who were seriously ill did not need hospital. Dr Sudbury commented that if a mental health service was being developed from scratch, it may not even involve inpatient services. Local NHS representatives explained that conversations had begun with Medway Council over the introduction of one of these Recovery Houses into Medway.

(q) Several Members commented that there was a reassurance for patients in knowing where their local service was. One Member asked a specific question about what was being done to prepare patients for the move. In response, it was explained that reassurance was being built into the recovery programme for patients. The Liaison Psychiatry service would remain at Medway Hospital and there would be a high profile point of contact for patients presenting with mental health needs at Medway, but this did not mean they would be admitted.

(r) On the subject of the support of GP commissioners, it was explained that all 8 of the Clinical Commissioning Groups (CCGs) across Kent and Medway supported the proposals. On behalf of Swale CCG, Patricia Davies explained that the case for change had been made to the CCG board. The two core issues were the need to centralise tertiary specialised care and more broadly ensure continuity of care. GPs are concerned with the whole continuum of care. The proposals for change specifically relate to specialist care and the CCG recognises that Medway A-block was not fit for purpose and a safe unit is needed. The clinical evidence supported centralisation of these specialised services and it was important to deliver the right care in the right place. This was echoed by Dr Green on behalf of Medway CCG. He shared Members' frustration with the quality of care but said that the proposals to move to more community based care was not for economic reasons but because the evidence showed that outcomes were better if this was done. Similarly, better outcomes were achieved where specialist services were centralised. This outweighed any disadvantages involved in travelling further.

(s) Several Members commented that they acknowledged the case for change but remained to be convinced that the change proposed was the correct one. One Member mentioned there were areas of the country which had reopened wards. Reference was made by NHS colleagues and Members to the emphasis the recent Francis Report had put on putting the patient first and ensuring quality of care. Some Members felt it important to be assured that community health services were in place prior to supporting any changes to inpatient services. Another Member commented it would be useful to see the Business Plan for the proposals. NHS representatives explained that there was an opportunity prior to the formal commencement of the following week's Board meeting for questions and issues to be raised and answered. An invitation to this was extended to Members.

(t) The Committee discussed the best way to proceed with this issue as well as whether to include the paper from Medway with the record of the meeting. Cllr Purdy moved that the written submission by Medway should be included in the record of the meeting. The Chairman ruled this out on the basis that he had made clear at the commencement of the meeting that as the paper had been tabled on the day it did not exist.

(u) The Chairman proposed the following motion, seconded by Mr Dan Daley:

- That the Committee convene another meeting in the near future to receive responses to the questions raised by Members.

(v) This was agreed by the Committee, with Mr Kit Smith requesting that his opposition to the motion be noted.

(w) It was also decided it would be appropriate to hold the next meeting at Medway.

(x) RESOLVED that the Committee convene another meeting in the near future to receive responses to the questions raised by Members.

7. Date of next programmed meeting

(Item 7)

It was agreed that the date of the next meeting would be determined as soon as possible.

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Item 5: Adult Mental Health Inpatient Services Review.

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

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 19 March 2013

Subject: Adult Mental Health Inpatient Services Review

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1. Introduction.

(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) 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]

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

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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

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

2. Kent and Medway NHS Joint Overview and Scrutiny Committee.

(a) The first meeting of this Committee took place on 3 July 2012 and was established to consider the review into adult inpatient mental health services. It is a standalone Committee convened to look at this specific issue. Its Terms of Reference are at the end of this report.

(b) A visit to Medway Maritime Hospital's A-Block and Dartford's Little Brook Hospital was arranged for JHOSC Members on 25 June 2012. Individual JHOSC Members have also undertaken fact-finding visits on other occasions to these and other sites.

(c) At the meeting of 3 July 2013, the Committee agreed the following recommendation:

- "That the Committee approves the NHS decision to take the proposals in the report to three months public consultation between late July and late October 2012 and looks forward to a consultation document which will take into account the concerns expressed at this meeting and that these concerns will also be addressed by the further information to be provided and the further site visits to be arranged."

(c) The second meeting was held on 13 February 2013. The draft Minutes of this meeting are included in this Agenda. The Committee agreed the following recommendation:

- "That the Committee convene another meeting in the near future to receive responses to the questions raised by Members."

(d) Along with information submitted by NHS Kent and Medway and Kent and Medway NHS and Social Care Partnership Trust, the following documents are included in this Agenda:

- Proposal from Medway Councillors appointed to the Joint KCC/Medway Health Overview and Scrutiny Committee, 13 February 2013.
- Medway Council – summary of concerns and questions, 13 February 2013.
- Letter from Felicity Cox, 15 February 2013.
- Letter to Felicity Cox, 19 February 2013.
- Public Questions for NHS Kent & Medway Cluster Board, 20 February 2013
- Letter from Felicity Cox, 20 February 2013.
- Letter to Felicity Cox, 28 February 2013.
- A critical analysis of the data presented in the KMPT Acute service review and redesign 2012, Prepared for the Medway Council Health

Oversight and Scrutiny Committee, Stephen Allan, PSSRU, University of Kent, March 2013.

3. 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.

4. Recommendation

That the Committee consider and comment on the report.

Background Documents

Agenda, Kent and Medway NHS Joint Overview and Scrutiny Committee, Tuesday 3 July 2012, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=4918&Ver=4

Agenda, Kent and Medway NHS Joint Overview and Scrutiny Committee, Tuesday 13 February 2013, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=5155&Ver=4

Contact Details

Tristan Godfrey
Research Officer to Health Overview and Scrutiny Committee
Governance and Law
Kent County Council

tristan.godfrey@kent.gov.uk
01622 694196

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Joint Kent and Medway Health Overview and Scrutiny Committee
Wednesday 13 February 2013

Reconfiguration of acute mental health inpatient services

Proposal from Medway Councillors appointed to the Joint KCC/Medway Health Overview and Scrutiny Committee

The Joint HOSC is asked to agree to request the PCT Cluster Board to delay taking a final decision on the reconfiguration of adult mental health acute inpatient services at its meeting on 20 February until such time as:

1. The NHS response to data errors on which the consultation was based as set out in Appendix 2 has been independently validated to the satisfaction of the Committee

2. further discussions have taken place with Medway Council about the scope for acute inpatient provision in Medway including access to the Estates Strategy for KMPT, in light of the concerns relating to access and transport raised by Medway consultees during the consultation. (Note: the information requested by the Committee on 3 July 2012 about sites previously considered was only made available in early January 2013 with cost estimates that are open to challenge and the NHS suggestion for a Recovery House in Medway has been made only in the last few days. A Recovery House is not a substitute for high quality local acute inpatient services).

3. the work underway on a Transport Plan has been completed and the Committee is satisfied that it includes:

i) details of the secure transport to be used for conveying detained patients suffering an acute mental health crisis from Medway to Dartford and that this will be of the required standard
ii) measures to address concerns that have been raised about access to Little Brook Hospital in Dartford for families without a car or on a low income wishing to visit loved ones from Medway and facing a 2.5 - 3 hour round trip by public transport at a cost of £11.60 return by bus per adult
iii) clarity over support for Medway patients on Section 17 leave to return to Medway

4. adequate levels of suitably qualified and experienced staff are in place in the Medway CRHT establishment, in addition to the appointment of STR workers, and concerns raised about the quality of care being provided by the CRHT in Medway during the formal consultation process and previously have been addressed and resolved before any local changes are considered with independent validation by the regulators

5. additional information relating to the implementation of the preferred option (Option A) has been provided to the Joint HOSC including the projected financial costs and savings in the context of the Trust's overall financial position, and there is sight of the equalities impact assessment for the proposed reconfiguration and any risk assessment and risk management plan that has been undertaken.

Joint Kent and Medway Health Overview and Scrutiny Committee
Wednesday 13 February 2013

Reconfiguration of acute mental health inpatient services

Medway Council – summary of concerns and questions

1. Medway's general stance

- We note that clinical arguments for the proposed service change have been validated by the National Clinical Advisory Team and that the consultation process and outcomes have been independently assessed. We also note that continued acute inpatient provision at "A" Block would be inappropriate.

- However none of the consultation options contained a choice for Medway services users other than service provision in Dartford, and no serious attempt has been made by KMPT during the consultation period to re – examine the options for continued acute in-patient provision in Medway. Medway members remain very concerned about the re-location of acute inpatient mental health services to a remote and inaccessible location on the edge of Dartford, given the size and density of our population (254 787) and it's deprivation, including the proportion of people on incapacity benefit with mental health needs.

- Medway is happy to work in partnership with NHS colleagues to address some of our concerns but we are unimpressed by attempts by the NHS to place the onus on Medway Council to come up with transport solutions, alternative sites for inpatient provision in Medway and to progress the idea of a Recovery House. In light of the commitments given by the NHS at the July 2012 meeting, we are surprised there has been no attempt by the NHS to seek a meeting with Medway to properly address the concerns raised by Overview and Scrutiny.

- There remain very serious concerns about data inaccuracies in the information on which the options were drawn up and on which the formal consultation was based, the absence of a completed, comprehensive Transport Plan for detained patients, patients on Section 17 leave, and visiting family members, the quality and capacity of community based support in Medway and the absence of financial information and no sight of an equalities impact assessment and risk assessment for the preferred option

- As set out in the proposal from Medway, the Joint Committee is asked to request the Cluster Board to delay taking a decision on this matter as planned for 20th February, only 4 days after this meeting.

- Members of this Committee have a serious responsibility to ensure that the options presented in the consultation exercise were based on sound statistical information and that a service reconfiguration of this scale is truly in the interests of our communities. In light of the Mid -Staffs Inquiry and the recent call by the CQC for urgent improvements in mental health services we believe the Secretary of State will take a dim view of any Overview and Scrutiny Committee that does not rigorously question and check the merits of a change of this scale and a dim view of any NHS Trust that does not fully and properly address the concerns of Overview and Scrutiny. We would like

this submission to be published as supplementary information with the agenda and minutes of this meeting.

2. Access and Transport

- It is notable that the strength of support for the aims of this review was less when considering whether quality of care was more important than distance travelled to reach it. In question 7 of the survey most people said that quick access was the top priority for crisis mental health services. In the high level feedback presented by the University of Greenwich in the report, there was concern over travel and transport, and as far as priorities were concerned, an important item was **Access** (including coverage, amount of travel, how local the service was and how quickly the service could be accessed). Access for Medway patients will be slower under the preferred option of moving acute inpatient provision for Medway patients to Dartford.

- It is unclear whether the "secure transport" referred to in the agenda is going to be an ambulance equipped to the right standard for the safe transfer of patients between sites, particularly in a crisis situation, for example, individuals detained under a section of the Mental Health Act.

- The concerns of Medway members are accentuated by the comments reported back from the Medway consultation events and the widely acknowledged importance of social care and the wrap around services needed to ensure positive outcomes for mental health inpatient service users and their carers/families. In a recent survey by Rethink, 61% of service users felt that close contact and support from family was vital in their recovery.

- People admitted to inpatient acute services are very often experiencing a crisis and in reality need practical support from their loved ones as well as excellent in-patient clinical care. Accessibility to the home area for periods of section 17 leave is also important to support a phased return home. (Mental health care is very different from the sort of care needed for surgical procedures such as angioplasty, which is cited as a comparable successful service reconfiguration in the paperwork).

- Medway residents who do not have a car are facing a 2 -3 hour journey to visit loved ones at Little Brook Hospital (and our social care staff have tested the journey. From Chatham by bus it took 1 hr 20 minutes to get there and almost 2 hours on the journey back) at a cost of £11.60 for a return journey for each adult. The report tells us a KMPT survey suggests most visitors arrive by car - but it does not tell us how many people without a car have been unable to visit due to the time involved visiting an isolated distant site, the inaccessibility of the hospital and the exorbitant cost of fares. If a family of three people were wanting to visit a loved one at Little Brook Hospital from Medway one visit could cost as much as £36.

- We can see a range of suggestions and intentions relating to access and transport for visitors in the papers but this work is not due to be completed for a further month and there are no guarantees that adequate provision will be put in place once the Cluster Board takes its decision.

- Medway Members would be very concerned if the Cluster Board agreed to implement Option A ahead of this work being concluded and discussed by the Committee.

- This is not simply a matter of convenience – outcomes for people with acute mental health needs are known to be better with access to family, friends and their home community as they move towards recovery. A number of users will be parents on low incomes whose children need close regular contact. A number of users will also be long-term in- patients. Electronic contact cannot be a serious alternative to human contact.

Questions:

- **When will a final Transport Plan be in place with confirmed and definite arrangements dealing with transport links, costs, new signage, information and out of hours access?**

- **Will the secure transport to be used for patients be an ambulance equipped to the right standards**?

- **What help will there actually be for people in meeting the cost of travel to Little Brook Hospital from Medway?**

- **Bearing in mind the journey on foot is difficult in an unlit environment with no signage to Little Brook Hospital what are the plans to improve this situation?**

- **What arrangements have been put in place for transporting people to A&E from Dartford speedily?**

. **Data quality/accuracy**

- Quite complex and concerning queries have been raised during the consultation by one individual who has an expertise in statistics. This includes important questions on the estimate of demand for acute in-patient beds and the number of beds required.
- KMPT have taken 14 pages to try and address these concerns.
- It would be very difficult for the Committee to know if the answers provided by KMPT are valid.
- Given the importance of these statistics and projections as the basis for the options on which this service reconfiguration is based, Medway has commissioned external independent validation of this information. A request to KCC members for this to be a jointly commissioned piece of work to be undertaken in advance of this meeting was declined.

Questions

- **Is the method used to calculate future number of in-patient beds requirements robust? It seems that only four data points have been used to produce a linear trend in the redrawn figure 2 in Appendix 2. Projecting forward two years is not well supported by such a small number of past observations. Furthermore a linear model is not**

generally appropriate where projections suggest zero or negative number of beds in the near future.

- **It would seem more appropriate to use the full dataset available for the last six years. The NHS Kent and Medway paper refers on page 2 to the fact that successful alternatives to inpatient treatment have been established in the community since 2004 so it is hard to see why data from 2006/7 and 2007/8 cannot be used which would make the picture quite different.**

- **The report recognises that inpatient beds will always be required for some mental health patients but it is important to try and provide an estimate of the size of this sub-group and therefore the required bed count to meet expected demand. How can the report authors be confident that the optimum bed count lower threshold has not already been reached especially as bed provision is already low with respect to the national benchmarking?**

- **The reduction in beds was not entirely based on the trend analysis, but as the original paper says the actual proposed bed reduction was based on other factors also particularly the strengthening of other services to enable the bed reduction and therefore is considerably more conservative than the trend analysis alone would suggest. However if the trend analysis has weaknesses and the size of the possible bed reduction cannot be based on this, the case needs to be very clearly spelt out how the additional resourcing for Centres of Excellence and CRHT provision will provide sufficient resource to support the specific bed number reduction proposed.**

- **We are asking the Joint Committee to agree to seek a delay in any decision –making by the PCT Cluster Board until the outcome of the external independent validation commissioned by Medway is available.**

4. Estates Strategy/acute bed provision in Medway

- It is accepted that inpatient provision at "A" Block at Medway Maritime Hospital is not fit for purpose. This has been the case for the last ten years. It would appear the NHS accept the closure of "A" block will leave a gap in acute service provision and crisis services in Medway, evidenced by the offer to consider possible sites for re-provision of in-patient facilities in Medway and the suggestion of a Recovery House.
- However Medway members only received information about sites previously considered for acute provision locally on 7 January 2013 despite asking for it last July. We also received the criteria against which sites can be considered.
- Although the NHS is open to suggestions of locations for acute inpatient provision in Medway, lack of capital funding is cited as a major constraint and no serious attempt has been made by KMPT during the consultation period to re-examine the options in Medway.
- Medway Council's property experts have considered the information provided in the last month and question the validity of the cost estimates in the paperwork. For example, the NHS estimate for a a new build to replace "A" block is given as £13m. Medway's Property Team put the

figure at closer to £5m plus land costs. This is quite a difference of professional opinion.

- Medway would also query the need for all accommodation to be on one ground floor. It is possible to provide suitable access and security arrangements in a two storey building
- Given the feedback from Medway consultees we would like this Committee to withhold support for an option involving Medway people having to access in-patient acute services in Dartford until there as been a meeting between Medway's property experts and planners to evaluate current and new options for local provision.

Questions

- **How were decisions not to invest in acute in-patient provision in Medway reached in the context of the overall KMPT Estate Strategy and priorities over the last ten years?**
- **What are the plans for patients accommodated in Ruby Ward at "A" Block if the other two wards are to be closed?**

5. Quality and levels of staffing for the CRHT team in Medway

- We note the plans to strengthen the CRHT in Medway. Staffing levels are going up but we need to understand if this will address the history of underfunding of mental health services in Medway.
- There is evidence from patient surveys and feedback that the quality and timeliness of CRHT services in Medway are currently inadequate and we would like to see externally validated evidence that the service is judged to be good or better in advance of any change to acute in-patient services.
- There is a stated intention to increase the number of Support Time Recovery (STR) Workers in Medway if option A is accepted. These are, however, unqualified healthcare assistants.

Questions

- **What is being put in place to ensure there are sufficient numbers of qualified and experienced CRHT staff in Medway over and above Support Time Recovery Workers to deal with the complex nature of decisions and risk assessments needed on behalf of vulnerable clients and their families?**

- **What consideration has been given to staffing levels for escorted leave and the accessibility of the home area for periods of section 17 leave to support a phased return home?**

- **What assurances do we have that the very important social care elements of care and support in mental health will be addressed in the new system?**

- **The Care Quality Commission recommend having access to psychological support at an inpatient unit. What plans are there to fill the vacant Psychologist post for Little Brook Hospital?**

- **What verifiable progress has been made to improve patient experience of CRHT services in Medway since concerns were raised with KMPT by the Medway Health and Adult Social Care Overview and Scrutiny Committee last October?**

NHS
Kent and Medway

Chris Smith
Chairman
Kent and Medway NHS Joint Overview and Scrutiny Committee
Kent County Council and Medway Council

15 February 2013

Dear Chris

Kent and Medway NHS Joint Overview and Scrutiny committee Meeting – 13 February 2013

Further to the discussions on Wednesday and the paper submitted by Medway Council HASC Members for consideration at the Joint Overview and Scrutiny Committee meeting, I thought it would be helpful to set out how we propose to respond to the additional information requested.

The questions in the Medway paper will be extracted and those that can be answered immediately, which we believe to be the majority, will be addressed at the NHS Kent and Medway Board meeting on Wednesday 20 February. There is a slot on the agenda which accommodates questions submitted in advance. This will mean that the questions and answers can be heard in public and Board Members will have heard the responses prior to making their decision.

With regards to the next JOSC meeting which I believe will take place next month before the election purdah starts, colleagues feel that it would be helpful to set out the pertinent issues relating to this complex review in a presentation to be given at the start of the meeting . If you are in agreement with this proposal my office will liaise with Tristan Godfrey and Rosie Gunstone to ensure that we address in the presentation all the key concerns raised by members this week, e.g. mental health community provision.

As you know the review has taken close to a year to arrive at this stage and we are anxious to avoid prolonging the debate to the detriment of the service and the anxiety of those involved. We are also keen to provide you and your colleagues with the assurance you seek about these outstanding questions. We look forward to your confirming the date for the next meeting.

Kind regards

Felicity Cox
Chief Executive
NHS Kent and Medway

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Please contact: Rosie Gunstone (direct line 01634 332715)
Your ref:
Our ref:
Date: 19 February 2013

To:
Felicity Cox
Local Area Team Director & NHS Kent
and Medway Chief Executive
By email

C/o Democratic Services
Gun Wharf
Dock Road
Chatham
Kent ME4 4TR
Telephone: 01634 332715
Email: rosie.gunstone@medway.gov.uk

Dear Ms Cox

Re: KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE (JHOSC) - 13 FEBRUARY 2013 - ADULT MENTAL HEALTH INPATIENT SERVICES REVIEW

Following the JHOSC meeting of 13 February 2013, we are writing to you ahead of your Cluster Board meeting tomorrow to reinforce the request for a delay in your decision concerning this matter. The Cluster Board need to be aware of the strength of concerns across Medway and Kent about the proposals as they stand. The view of Medway Members is that Medway residents are best served through the reprovision of local acute in-patient beds located in Medway.

This review has been ongoing for some years. While we understand the need for urgency in proceeding with plans for acute inpatient services for Kent and Medway, we strongly advise that the decision is delayed until such time as the predicted bed numbers data is validated by an independent source and it is clear that it is based on reliable factual evidence. This work has been commissioned by Medway Members and will be available at the beginning of March. We believe that an independent expert view is needed on the data on which this proposal rests. Two examples emerged last week in Medway of a lack of beds available for patients detained under the Mental Health Act.

There are also concerns about the adequacy of transport arrangements. It is important that, before you take such a critical decision, all concerns around transport for family and carers are resolved within a comprehensive transport plan, bearing in mind the impact lack of family contact will have on patient recovery. A Transport Plan was promised in July 2012, but as yet has not been produced. Significant concerns were raised by consultees across Kent and Medway during the consultation period about access.

A third vital point is that, in order for option A to be successfully implemented, it is heavily reliant on high quality services being delivered in the community by the Crisis Resolution and Home Treatment Team (CRHT) and other community mental health services. You will see from comments made during the consultation process and from the comments made at the JHOSC that there are serious concerns about the quality and safety of community services from service users, families, GPs and Members of both Councils. We

respectfully ask the Cluster Board to review these matters before coming to a decision on Option A.

We recognise that taking these three important issues into account is likely to mean that your proposed decision tomorrow will need to be delayed for a short time until these matters can be fully resolved. We believe we are making a reasonable request for the Cluster Board to defer its decision on this matter until next month. We trust you will appreciate the necessity of ensuring that all the outstanding issues are resolved satisfactorily prior to proceeding with the outcome of this Review.

Rosie Gunstone will be in touch with you shortly to let you know the proposed date for the re-arranged JHOSC meeting.

Yours sincerely

Cllr Wendy Purdy
Vice-Chairman - Kent and Medway NHS Joint Overview and Scrutiny Committee

Cllr John Avey
Chairman - Health and Adult Social Care O&S Committee

cc Helen Buckingham
Sara Warner
Lauretta Kavanagh
David Tamsitt

Mr C Smith (Chairman of the JHOSC)
Tristan Godfrey, KCC
Emailed to all JHOSC Members

PUBLIC QUESTIONS FOR NHS KENT & MEDWAY CLUSTER BOARD
20th FEBRUARY 2013

1. Given the strength of local concerns across Kent and Medway about the quality and availability of community services, (cited in the High Level Feedback received during the consultation and recorded by the University of Greenwich in their Independent Report) and especially about the adequacy of the Crisis Resolution and Home Treatment (CRHT) how will the Cluster Board ensure that there is more personalised care, better staffing (over and above the appointment of unqualified STR workers) and improvements in information, patient safety and continuity?

2. How is the Cluster Board assured that the Review contains factual and reliable evidence on the number of predicted acute in-patient psychiatric beds required?

3. Does the Cluster Board believe it is reasonable to expect family members and Medway patients on Section 17 leave to endure a 2½-3 hour round trip on Public Transport to Little Brook Hospital in Dartford at the cost of almost £12.00 per adult? Has this matter been addressed in any Transport Plan?

4. Given the size, density and deprivation of the Medway Population, what is the logic of siting the reprovided beds for Medway in an isolated and inaccessible location on the edge of Dartford?

5. Why is it not possible for the NHS to work with Medway Council to deliver a local acute in-patient solution within Medway?

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Kent and Medway

Chris Smith
Chairman
Kent and Medway NHS Joint Overview and Scrutiny Committee
Kent County Council and Medway Council

Councillor Wendy Purdy
Medway Council

Wharf House
Medway Wharf Road
Tonbridge
Kent
TN9 1RE

Telephone: 01732 375200
Direct Line: 01732 375294

20 February 2013

Dear Colleagues

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

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

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

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

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

Cont'd…1/2

The recommendation agreed is that:

The NHS Kent and Medway PCT Cluster board endorses the model of care which improves service for people who have acute mental health problems by:-

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

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

- That the bed number sensitivity analysis is undertaken and that this is confirmed as being in line with best practice evidence for the size and type of population in Kent and Medway within this model of care.
- That sequencing of implementation is undertaken to introduce CRHT in advance of bed changes. We recommend that CCGs consider this in how they use their transitional non recurrent resources during the period of implementation.
- That a quality impact assessment is undertaken and clear benefits identified as KPIs.
- That the transport plan is completed and any remaining gaps in transport provision closed.

We request that these are completed and considered for approval at the CCG and cluster board meetings on 20 March if the work can be completed to this timetable. If not, these are to be taken to CCG boards and confirmed by the Area team of the NHS Commissioning Board as part of their ensuring that the CCG have clear and credible plans for health services in Kent and Medway for the future.

Best wishes.

Yours sincerely

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

Please contact: Rosie Gunstone (direct line 01634 332715)
Your ref:
Our ref:
Date: 28 February 2013

To:
Felicity Cox
Local Area Team Director & NHS Kent
and Medway Chief Executive
By email

C/o Democratic Services
Gun Wharf
Dock Road
Chatham
Kent ME4 4TR
Telephone: 01634 332715
Email: rosie.gunstone@medway.gov.uk

Dear Ms Cox

Re: KENT AND MEDWAY NHS CLUSTER BOARD MEETING - ADULT MENTAL HEALTH INPATIENT SERVICES REVIEW

Thank you for your letter dated 20 February 2013 summarising the discussion from the Board meeting earlier that day. I would just like to put forward a number of concerns from Medway Members of the Kent and Medway NHS Joint Overview and Scrutiny Committee, which are set out below:

- Paragraph 2 of your letter refers to a number of outstanding issues that the JHOSC raised. Appendix 1 to this letter sets out the five questions raised at the cluster board meeting by Medway Members. As these questions remain unanswered, I would be grateful if you can confirm that a full response will be given to each of these five questions in time for the despatch of the agenda on 11 March 2013?

- The Medway Members in attendance at the cluster board meeting on 20 February were disappointed that the letter which I sent, also signed by Councillor Avey as Chairman of the Health and Adult Social Care Overview and Scrutiny Committee, (attached as Appendix 2 to this letter) was not referred to at the meeting (other than at the point where I referred to its contents), neither was it part of the paperwork laid out on the table in the room for the meeting. The content of the letter was very important to the meeting not least because it was clearly requesting the Board to delay a decision on the review until such time as the predicted bed numbers data was validated by an independent source, as concerns have been raised, and it is clear that the data is based on reliable factual evidence.

- Paragraph 3 of your letter seems to imply that you are proposing that the door is now closed on the possibility of finding an alternative option, which meets the needs of Medway residents and those from surrounding areas of Kent. This point was not made at the cluster board meeting. Medway Councillors appreciate that the NHS has undertaken this work over the last 10 years, which in itself is worrying particularly in view of the number of serious untoward incidents, which have taken place during that period. There has not, however, been any engagement with officers of Medway Council to discuss options

during that period. No-one at Medway Council disagrees with the conclusion of the Board that the existing arrangements at 'A' block at Medway Maritime Hospital are unsatisfactory. The view of Medway Members is that from a social care perspective it is not in the best interests of Medway residents or residents from the surrounding areas of Medway for provision to be at Little Brook in Dartford, which is an isolated and inaccessible site. This will preclude a number of their carers and family from visiting their relative if they do not have access to a car. Public transport is complex and expensive. This social contact with family is vital not only for the patient's recovery but nearness to home is also important for Section 17 leave.

- There was no reference at the meeting either to another important point set out in the letter which was the example given of two recent examples in Medway of a lack of beds available for patients detained under the Mental Health Act. Similar issues were referred to by two of the carers in the audience at the cluster board meeting so this is obviously not an isolated incident.

Medway Councillors understand you wish to conclude this review before the end of March but I am sure you will want to have the reassurance that, bearing in mind the far reaching consequences of a wrong decision, any decision taken is based on reliable factual data and is in the best interests of residents of Kent and Medway.

I look forward to hearing from you to confirm that all the issues raised, not only those from Medway Council but also those articulated very competently by carers at the cluster board meeting will be addressed for the next JHOSC meeting on 19 March 2013.

Yours sincerely

Cllr Wendy Purdy
Vice-Chairman - Kent and Medway
NHS Joint Overview and Scrutiny
Committee

Cc Mr C Smith (Chairman of the JHOSC)
Tristan Godfrey, KCC
Emailed to all JHOSC Members + Cllr Igwe

A critical analysis of the data presented in the KMPT Acute service review and redesign 2012

Prepared for the Medway Council Health Oversight and Scrutiny Committee

Stephen Allan

March 2013

Stephen Allan

PSSRU

University of Kent

Introduction

NHS Kent and Medway and Kent and Medway NHS and Social Care Partnership Trust (KMPT) have undertaken a review of inpatient mental health services across Kent and Medway, recognising the need to improve the quality of care received by acute mental health inpatients, both in terms of the safety and outcomes of the patients, and promote equality of access to high quality mental health wards.

The Acute service review and redesign 2012 (hereafter referred to as 'the review') developed proposals to improve acute mental health care in Kent and Medway. The proposals were to: develop three Centres of Excellence for acute inpatients; strengthen the Crisis Resolution Home Treatment (CRHT) teams; expand the Psychiatric Intensive Care Outreach (PICO) service to cover the whole of Kent and Medway; and consolidate psychiatric intensive care in to one place. The results of these proposals would be a reduction in the number of acute inpatient beds from 160 to 150 and in the number of Psychiatric Intensive Care Unit (PICU) beds from 20 to 12, but that there would be a reallocation of beds around the county to create more equality in availability.

The proposals were based on an analysis of acute inpatient mental health services data which found that: there had been a reduction in demand for acute inpatient beds over the last four years; too few beds in East Kent leading to out-of-area placements; concerns over the quality of the A Block at Medway Maritime Hospital which provides acute inpatient care for Medway and Swale; and there is no current PICO service in East Kent.

Concerns have been raised by members of the public at the consultation stage about the validity of the data used. This paper analyses the data presented in the review asking if it is robust and if it can be used to inform a decision on proposals for acute mental health services in Kent and Medway. Only the quality of the data is assessed in this note; in no way does it make inferences as to the suitability of the proposals outlined in the original review. Where possible, the note discusses many potential issues with the data presentation where possible. Indeed, some of the concerns raised may be seen as inconsequential, but in so doing this critique draws attention to the relevant data (or lack thereof) so that decisions can then be made as to which, if any, issues are to be addressed.

The conclusion of this critique is that, whilst there is a lot of data presented to try and be as open as possible, the review does not make the confidence levels attached to the data clear. In addition, there does seem to be some data missing from the review. Of particular concern are the acute ward stay days trend forecasts which use a simple regression on 4 observations for the overall totals in Kent to estimate a time trend. The low number of observations is worrying, and this is especially so as data would seem to be available for at least 2 further years (which would not solve the small sample size issues). In addition, no account is taken of socio-economic factors, which seems remiss.

This note shows that extending the regression analysis for Kent and Medway as a whole to include all Local Authorities' demand data and including socio-economic factors reduces the

downward trend in acute ward stay days, but even this has a wide range of confidence. The positive aspect of this additional analysis is that projected demand would still seem to fall under the proposed 150 acute inpatient bed supply, even before accounting for the potential fall in demand from the use of PICO in East Kent. Overall, whilst the issues raised do not necessarily indicate a problem with the suggested proposals themselves, they do call into question the voracity with which the data in the original review was presented and therefore reduce the likelihood that the data can be used to inform a decision on proposals for acute mental health services in Kent and Medway.

This note continues with a review of the issues found in the data presented in the review. The third section then takes a more detailed look into the issues surrounding the trend forecasts in acute inpatient demand, and then a conclusion follows.

Issues in the presentation of the data in the review

The review presents a lot of data to present a case for the proposed changes to the acute mental health care service in Kent and Medway. As such, the effort to put this data in to the review is commendable, as it does not shy away from presenting data that is not necessarily ideal to the purpose of the proposals in the review. However, there are a number of issues with the data presented (or not) in the review. This section goes on to outline these issues. Some of the concerns raised would appear to be potentially important issues with the data, but other concerns are (likely) minor issues. Taken individually, these latter issues probably do not leave any cause for concern; however, when taken as a whole, they do bring in to question the level of clarity in the data on which the proposals have been based. As to the former issues, they raise serious doubts about the validity and robustness of the data.

Each of the following is an issue with the data presentation in the review:

1. Forecasts of future acute inpatient bed demand are based on extremely small samples (four observations for each LA and for Kent as a whole).
2. No allowance for projected population change.
3. No use of socio-economic characteristics.
4. Data is not shown for 2006/07 and 2007/08.
5. More clarity in discussing Appendix H.
6. Total number of beds required in Appendix C.
7. No data on external adult acute bed use.
8. Bed occupancy rates and average length of stay.
9. Total number of acute service users.
10. Potential lack of clarity in figure 2.
11. Appendix A does not show any data on CRHT use.
12. Footnote 6 does not show the data for the demand for CRHT in KMPT.

The first issue is at the heart of the whole review, as the future forecasts are used to explain the appropriateness of the proposed reduction in acute inpatient beds. Extremely small samples mean that the confidence which can be assigned to the statistical results is extremely small. This is not to say that the forecasts are incorrect (although it is more likely they are incorrect given they are based on very weak data because of the sample size) but the review should have made clear the weakness of this analysis and presented alternative scenarios (such as using the average of the previous four years like that used in Appendix G when looking at PICU demand). In section III, this note goes into more detail on the weak level of confidence that can be associated with the forecasts presented in the review, and in addition some robustness checks to these forecasts are calculated, which show that a range in the demand forecasts would have been appropriate.

Appendix C of the review describes the process used in estimating future demand for acute inpatient beds. The review does not ignore potential population change completely, as it is used as one of the reasons why the final reduction in supply will be 18 beds as opposed to the projected 32 bed decrease in demand. However, this assumes that the projected bed demand is correct, and, as is discussed in the previous paragraph and section III that follows, that is not likely to be the case.

It would have been useful if the review had actually outlined the effect of population change on bed demand, something this critique now shows with a mathematical example. This is achieved using the figures cited in the review and assuming that the ONS projection of a 3.6% population increase by 2020 is correct. The review (Page 6) assumes around 12,000 people in Kent and Medway have a severe complex and enduring mental health problem, of which there were some 3,790 service users in 2011/12. So 31.7% of those with a severe complex and enduring mental health problem were service users of the acute service in 2011/12. Of the 3,790 service users, 1,555 (41.0%) were treated in acute inpatient wards. Total ward days for 2011/12 (Appendices B and G) were 58716 stay days (52522 acute inpatient and 6194 PICU). So the average length of stay of those treated in acute inpatient wards was 37.8 days.[1] 12,000 people with a severe complex and enduring mental health problem out of a 2010 projected total population of 1,680,500 (Appendix D) is 0.00714% of the population. Assuming that the 3.6% increase in working age population in Kent and Medway is correct, there will be 42,300 additional working age individuals in 2020, of which approximately 302 (0.00714%) will have a severe complex and enduring mental health problem. Of these, approximately 95 (31.7%) people will be service users of the acute service in 2020. Using the 2011/12 figures still, 39 (41.0%) of these will be treated in acute inpatient wards for a total number of stay days of 1474, which equates to 4 additional beds a year.

This, of course, is just one example, and the proposed changes to acute mental health services may well reduce both the percentage of people using acute inpatient wards as well as the average length of stay. So a range of forecasts on increased acute inpatient bed demand may

[1] The difference between this average length of stay and the figures quoted in the review are discussed later in this section. Using the stated average from the review of 29 days for 2011/12 gives an increase in demand from population growth of 3 additional beds a year by 2020.

have been more realistic. For example, assuming only 25% of acute service users go on to stay at acute inpatient wards, and only for an average of 23 days (the PCT target mentioned in the review), 1.5 extra beds would be required by 2020. These same figures with a population increase of only 2% would suggest 0.8 extra beds would be used per year. A range of 1-4 extra beds per year being required by population change seems likely, and we can add this to the projected demand estimates in section III to assess whether the proposed 150 bed supply would be adequate to cover demand in future years.

Appendix C also discusses the use of socio-economic factors in the estimation of acute inpatient demand forecasts. The review refers to Appendix E as evidence of socio-economic factors not playing a role in acute inpatient demand. This shows the rate of ward stay days per 100,000 population, and this does seem to show little relationship between population and acute inpatient demand. However, there is an extensive literature that points to socio-economic factors being very important in determining mental health service demand, much of it using UK data. For example, Barr *et al.* (2012) link increased suicides to the recent economic downturn, Brown *et al.* (2005) find a lack of psychological wellbeing is linked to increased debt levels, and McKee-Ryan *et al*. (2005) found that unemployment of an individual was linked to lower psychological wellbeing using meta-analysis. The Audit Commission (2010) also found that admission rates were linked to several socio-economic characteristics such as race and employment status, and this briefing is included as a footnote in the review itself. In the section that follows, socio-economic factors are included as control factors in robustness checks for the forecasts of future acute inpatient demand. The analysis shows that these factors are significant in affecting demand, so the review's non-use of socio-economic factors in calculating future acute inpatient bed demand seems incorrect.

An additional issue is that data is not shown for 2006/07 and 2007/08. Figure 3 and Appendix F seem to indicate that data on mental health services is available for both of these financial years. Unless there is a clear reason as to why the data could not be used, which should have been made clear in the review if so, then, at best, this seems like an oversight to not use this data and, at worst, this could appear like a deliberate manipulation of the data to fit the outcomes sort after in the review. Additionally, more data would certainly be useful in forecasting the future demand of acute inpatient stay days (Issue 1), although having six observations for each LA instead of four would not solve the small sample size issue by itself.

Appendix H shows the day-by-day demand for acute inpatient beds.[2] While the data shows that Kent and Medway would only have been undersupplied on 5 days over the financial year 2011/12, it also shows that demand would have been above the +7 confidence interval (146 beds) for 74 days out of the year (approximately), about 20% of the year for 2011/12, which was a year of lower demand compared to previous years. The more important number is the proposed 150 acute inpatient beds; how many days of the financial year 2011/12 was demand above 150 beds? The review should have made this clear for clarification purposes if nothing else.

[2] The titles of these graphs would appear to be incorrect given the data presented.

Linked to this last issue is issue 6, which is that Appendix C (Page 35) of the review suggests that, to cover peak demand and seasonality, 160 acute inpatient beds (plus 12 PICU beds) would be required to cover the average level of demand from 2011/12 of 151 beds (plus 10 PICU beds). Yet the proposed changes have only 150 acute inpatient beds plus (12 PICU beds). Again, relying on the forecasts for future bed demand is the only statistical explanation given as to why the 150 bed proposal would be plausible. A more rigorous statistical argument is required as to why this would be sufficient.

Following on from this, the use of external adult acute beds by KMPT is also an issue for which there seems a lack of data. The review does refer to the placement of acute inpatients in other PCTs for 2011/12 in Appendix C (page 35) but does not provide any further data. If this data is available it should be presented and discussed fully since external adult acute bed use could explain falling acute inpatient demand within Kent and Medway. This is potentially concerning as the KMPT Financial Performance Report (April 2012) outlined that spending on acute beds out-of-area amounted to £0.14m in 2011/12 but that for the first month of 2012/13 the spend was £0.11m.

The final issues should be seen as more minor compared to the first 7. Each issue is of itself a small area where the review could have perhaps been a little clearer. The first is that occupancy rates and average length of stay are not presented in the data. The occupancy rate for 2011/12 is discussed in Appendix C, which also provides some discussion of the seasonality issue and what is expected in the future for average occupancy rates. Given occupancy rates are usually an important measure of acute mental health services, it would have proven useful – even given the seasonality issues that means the average is not a very accurate representation of usage at times of peak demand – if the review had included them. The review also states that the average stay reduced from 32 to 29 days from 2009/10 to 2011/12. This seems at odds with the data provided in the review, which gives an average length of stay of 37.8 days.[3] This difference is most likely caused by multiple stays by different individuals, but presentation of this data would prevent any confusion. Overall, inclusion of data for occupancy rates and average length of stay could have been used as an affirmation that improvements had already been started, or that improvements needed to be made, in the acute mental health service provision in Kent and Medway.

The next issue is found on page 6 of the review, where it is stated that there were "*approximately 3000 users of the acute service in 2011-12*". The very next paragraph shows that this figure is for Kent alone, whereas with Medway combined the number of acute service users is almost 3800. An additional issue is found in figure 2 of the review (page 9), which shows that in 2008/09 acute bed demand was (approximately) 225 beds but Appendix B states that acute bed demand was 207 beds in 2008/09. The same overstatement of demand can be said for all the subsequent years in the figure – suggesting perhaps that PICU beds are included in the data for acute beds in figure 2.

[3] See the calculations made earlier in this section.

There are two further issues in the review. Page 8 of the review refers to Appendix A as providing evidence of the increase in CRHT use in the last five years but this is not the case as there is no data provided. This data is however shown graphically in figure 3, but it would be useful to have the actual data as well. Finally, footnote 6 appears to be misplaced, as the briefing referred to does not appear to show information on CRHT demand within KMPT by locality or time of day.

Analysing acute inpatient bed demand

This section outlines the area of the data presentation that potentially raises the largest question in terms of the validity of the data. The review presented (in Appendix B) a four year history of the demand for acute inpatient beds by Local Authority within Kent and Medway, and also presented trend forecasts of acute ward stay days for 2012/13 and 2013/2014. Appendix C discussed the approach used in the analysis of the demand for acute inpatient beds in Kent and Medway. However, as the previous section outlined, there are two key concerns with the trend forecasts for acute inpatient demand for the next two financial years:

1) The trend forecasts are based on extremely small samples (4 observations).
2) The trend forecasts do not take into account socio-economic characteristics.

Given these two key concerns, it is unlikely that the trend forecasts are accurate. It is possible that the forecasts are indeed correct, but in this (unlikely) scenario the review has failed to provide any clarity to the potential pitfalls of the projections presented. This section first analyses the approach to the trend forecast itself before going on to discuss how the confidence that is put in these figures seems misplaced. Additional regressions go on to show that the estimated future acute inpatient demand presented in the review would seem to be a very positive scenario, but even under less positive scenarios future acute inpatient bed demand still seems to fall under the new proposed supply of 150 beds.

Table 1 presents a snapshot of Appendix B from the review. We use Ashford and Canterbury as examples of the LAs (the discussion that follows could apply to any LA). The figures in red are the trend forecast figures and are estimated from a simple regression for each LA:

$$D = a + bY + e \tag{1}$$

Where D is the demand in terms of stay days, a is a constant, Y is the year (2008/09 takes the value 1, 2009/10 equals 2, and so on), and e is a random error term. The coefficient b is the time trend that shows how much demand changes from year to year. The review uses the 4 observations of demand presented in Appendix B to perform regressions of equation (1) for each LA. For Kent as a whole, the same regression is used using the total demand figures for

each year instead, so again using only 4 observations. The output of these regressions for the example LAs and Kent and Medway as a whole is presented in Table 2 below.

Table 1: Inpatient bed demand for selected LAs and Kent and Medway

LA	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Ashford	3771	4918	4325	2241	2518	2000
Canterbury	9195	7692	5778	5012	3304	1857
Kent and Medway	75398	71699	66932	52522	48289	40950

The coefficients from the regressions are used in the review to estimate future acute inpatient demand. So, for example, in Ashford in the year 2012/13 (year 5) the projected demand is equal to 5109.5 + (-518.3*5) = 2518 stay days, and in Kent overall in 2013/14 (year 6) the projected demand is equal to 84986.5 + (-7339.5*6) = 40949.5 stay days.

The major problem with these calculations is that they are based on so few observations, and as such this means that the level of confidence which these figures come with is extremely wide. The 95% confidence intervals for the coefficient b (the time trend) for Ashford is -2717.7 to 1681.1, for Canterbury is -2136.5 to -756.1 and for Kent as a whole is -15079.2 to 400.2. Because of so few observations the statistical certainty that can be placed on the estimated time trends is very limited. Also, positive values for the coefficient b would indicate demand would *increase* over time, and for both Ashford and Kent this cannot be ruled out.

Table 2: Regression results to estimate future inpatient bed demand

Coefficient	Ashford	Canterbury	Kent and Medway
Constant	5109.5*	10535***	84986.5***
Year	-518.3	-1446.3***	-7339.5*
n	4	4	4

Note: *, ** and *** indicates significance at the 10%, 5% and 1% levels respectively.

Note that this does not necessarily suggest that the forecasts presented in Appendix B of the review are incorrect. However, the forecasts presented do lack any precision. For example, the downward trend over time found for Ashford is not significantly different from zero (suggesting that there is no time trend of acute inpatient demand and that it would stay constant from year to year).

For each LA there is little more precision with which a forecast can be estimated other than to increase the number of data observations as suggested in the previous section, but note that this would not solve the small sample issues which this analysis suffers from. What the review neglected to do was to examine all the LA figures combined together to improve the analysis for Kent overall. This would give 52 observations on acute inpatient demand across 13 LAs in Kent and Medway. More specifically, one would estimate the following regression:

(2) $$D_i = a + bY_i + e_i$$

The variables in equation (2) are as described in equation (1), except that now we are looking at all LAs combined, hence the subscript i to represent each LA, where $i = 1,2 \ldots ,13$. This section now goes on to analyse the different outcomes on forecasted acute inpatient demand when all the LA data is combined. Table 3 presents the regression results for Kent under four different scenarios: 1) the original analysis of the review; 2) where all 52 LA data observations of stay days are included in the regression of stay days on year alone; 3) where additional socio-economic variables are included in the regression; and 4) where a binary variable for West Kent is included.

Regression 2 is very much the same as the analysis presented in the review and re-estimated here in regression 1. However, the difference is that the number of observations is greater and so a little more certainty can be assigned to this analysis. As noted in section II, the arguments presented in Appendix C for the non-use of socio-economic characteristics in estimating acute inpatient demand seem weak. This note includes the following socio-economic characteristics as variables under the third regression scenario: population of the LA and the number of people claiming income support in the LA.[4] In addition, the fourth regression includes a binary variable taking the value of 1 for West Kent and 0 for East Kent. The use of this variable was to try and capture the effect of the PICO service on acute inpatient demand in West Kent but could easily capture some other difference between West Kent and East Kent.

The results, presented in Table 3, show the variation that can be found in the analysis because of looking at so few observations. In column 1, the original regression for Kent from the review, the time trend is significant at 10%, but in column 2, where all the data available for LAs in Kent over the last 4 years is included, the time trend is not significantly different to zero. However, when including additional control variables in the combined regression there is evidence that the time trend is negative and significantly different from zero.

The inclusion of socio-economic variables is validated as they have a significant positive effect on acute inpatient demand. The effect of population on bed demand is only significant, and then only at 10%, when the West Kent control variable is included (column 4). However, the number of income support claimants has a highly significant effect on influencing acute inpatient bed demand whether or not the West Kent variable is included. The reviews decision not to include socio-economic variables in the calculation of future acute inpatient bed demand appears to have been incorrect.

[4] For 2008/09, 2009/10 and 2010/11 data on population and income support claimants from 2008, 2009 and 2010 were used, respectively. 2010 is the last year for which data is currently available and so observations in each LA for 2011/12 have the same values for population and income support claimants as the observations for each LA in 2010/11.

Table 3: Various regression results

Model	1 (as the review)	2 (Combined LAs)	3 (4 + socio-economic controls)	4 (3 + West Kent (PICO) control)
Constant	84986.5***	6214.2***	255.8	464.2
Year	-7339.5*	-501.2	-359.4*	-387.2**
Population/1000	-	-	9.4	17.3*
Income Support Claimants	-	-	1.3***	1.1***
West Kent	-	-	-	-838.7*
N	4	52	52	52
95% Confidence	-15079.2	-1203.3	-736.2	-730.6
Interval for b	400.2	200.8	17.4	-43.9
2012/13 stay days	48289	48207	52813	51908
2012/13 beds	**132**	**132**	**145**	**142**
2013/14 stay days	40950	41688	48141	46874
2013/14 beds	**112**	**114**	**132**	**128**

Note: *, ** and *** indicate significance at the 10%, 5% and 1% levels respectively.

Interestingly, the West Kent variable is significant and negatively impacts on acute inpatient bed demand. Assuming that there are no other differences between West Kent and East Kent other than the PICO service, the results in column 4 suggest that PICO services reduce acute inpatient bed demand for a LA with the service by 839 days a year, or 2.3 beds a year. Introducing a PICO service in East Kent could therefore reduce acute inpatient demand by up to 14 beds a year.[5]

The table also presents the estimated forecast for future demand for the next two financial years. For the second column this is calculated in a similar manner to the first shown previously in the section, with the estimated demand for acute inpatient beds for 2012/13 for each LA being equal to 6124.2 + (-501.2*5) = 3708, and therefore the overall demand for Kent and Medway is equal to 3708*13 (the number of LAs in Kent and Medway) = 48206.6. Note the main downside of putting all the observations for every LA together means that it is assumed that every LA will have the same demand, which is obviously not a very realistic situation.

For the final two columns, including additional variables allows acute inpatient demand to be calculated for the 'average' LA. So for example, the fourth column suggests that bed demand is equal to: 464.2 + (-387.2*Year) + (17.3*Population/1000) + (1.1*Income Support Claimants) + (-838.7*West Kent). Using the mean values of the control variables gives acute inpatient demand for 2012/13 equal to 3993 for the 'average' LA in Kent and Medway, and therefore total inpatient demand is equal to 51908 (3993*13).

These additional regressions may themselves not be correct as they too give a wide range of confidence as to the exact value of the downward time trend, as shown by the confidence

[5] Note that this variable may capture some other difference in the delivery of acute mental health services between West Kent and East Kent, and in addition PICO services will affect PICU bed demand (and therefore in turn could increase acute inpatient demand), the demand for which are not included in the regressions. Therefore, the projections of bed demand presented later in the section do not explicitly take into account a potential fall in acute inpatient bed demand from a PICO service being introduced in East Kent as it could be misleading.

intervals for the coefficient b. Also, given the data, time-series analysis could be used to further refine the results, but this is beyond the scope of this current critique. However, the point that this section makes is that, at the very least, a discussion of the weakness of the estimates of future inpatient bed demand should have been presented in the review, and, more likely, additional estimates should have been derived to give some range of confidence of the likely bed demand in future years. The estimates derived above suggest a range of acute inpatient bed demand from 132-145 for 2012/13 and 112-132 for 2013/14. Adding in a range would have increased the openness of the review and not necessarily weakened it, as one of the overarching aims of KMPT is to reduce demand still further. However, it is also noteworthy that 7 extra acute inpatient beds will be required because of the fall in the number of PICU beds. Also, assuming the projected population change occurs proportionally over the 10 years, at the upper end of the demand increase due to population change presented in the previous section, we would expect a maximum of 1 extra bed demanded over each of these two years. These additional projections give a final range of acute inpatient bed demand of:

2012/13: 140 – 153

2013/14: 120 – 140

Only in one specification and for one year (estimates from column 3 for 2012/13) is the projected demand above the proposed 150 bed supply, and the preferred specification (the estimates from column 4) suggest a demand of 150 and 136 beds for 2012/13 and 2013/14 respectively. In addition to this, the introduction of a PICO service in East Kent should potentially lower acute inpatient bed demand. Therefore, this additional analysis presents a generally positive case that the estimated acute inpatient bed demand will be below the proposed 150 bed supply.[6]

Naturally, there will be some lower 'base' level in the demand for acute patient beds; whether or not this level has been reached for Kent and Medway is open to question. Over the short term one could expect that demand could be reduced below the 'base' level, but on average the 'base' would be the lower limit of bed demand that could be achieved. It is not for this critique to suggest what is achievable, but it should be noted that the marginal returns of reducing bed demand towards this 'base' level will be diminishing as the cost of lowering demand for acute inpatient beds by one unit will escalate the closer to the 'base' level you get.

Conclusions

A number of issues have been outlined in this critique, some seemingly of more cause for concern than others. Using regression analysis, this note has shown that, whilst the downward trend for demand for acute inpatient beds is not necessarily incorrect, there is a wide range of possible outcomes for the trend in demand given the lack of data used in the analysis. In

[6] The suitability of what this means for occupancy rates and the potential use of beds external to the county at times of peak demand is not discussed here but may require consideration.

addition, not controlling for socio-economic factors has almost certainly weakened the analysis used in the review. A positive outcome of the additional analysis from this critique is that, even after controlling for socio-economic factors, projected population increases and the extra acute inpatient beds required because of cutting the number of PICU beds, the projected range for future acute inpatient bed demand is usually lower than proposed supply of 150 beds for Kent and Medway.

In addition to the major concern for forecasted acute inpatient bed demand, there are issues with the presentation of the data and of data not presented which would be of use to be fully transparent in the decision making process towards changes in acute inpatient care in Kent and Medway. Some of these issues are potentially not very burdensome. For instance, it would be useful for the review to make clear just how many days of the financial year 2011/12 that acute inpatient demand was above the proposed available 150 beds. These suggestions are made so as to give as much information as possible since KMPT are committed to continuing to reduce inpatient demand with increased use of CRHT and introducing PICO in East Kent. However, some of the remaining issues could also potentially be of critical concern, in particular the potential non-use of available data on acute inpatient bed demand and spending on acute beds out-of-area.

The main conclusion to be drawn from this note is that the review does not seem to have given a fair and accurate representation of the potential weaknesses in the analysis of the data. The data does not appear to be very robust and so calls into question whether it can be used to inform a decision on acute mental health services in Kent and Medway. This critique does not make any judgement as to the effect of the apparent weaknesses in the data; it is left to be decided as to whether or not any of the issues raised are worthy of leading to a re-assessment of the proposals.

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