KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 30th July, 2013

2.00 pm

Darent Room, Sessions House, County Hall, Maidstone

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AGENDA

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 30th July, 2013, at 2.00 pm
Darent Room, Sessions House, County Hall, Maidstone

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

Tea/Coffee will be available from 9:45 am

Membership

Kent County Council	Mr M Angell, Mr R E Brookbank, Mr D Daley, Dr Mike Eddy, Mr R Latchford, OBE, Mr G Lymer, Mr C Pearman, and Mrs Z Wiltshire
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. Election of Chairman
4. Declarations of interest by Members in items on the Agenda for this meeting
5. Minutes (Pages 1 - 6)
6. Adult Mental Health Inpatient Services Review (Pages 7 - 52)
7. Date of next programmed meeting

EXEMPT ITEMS

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

Peter Sass
Head of Democratic Services
(01622) 694002

22 July 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 St Georges Centre, Pembroke Road, Chatham Maritime, Chatham, Kent ME4 4UH on Tuesday, 19 March 2013.

PRESENT: Mr C P Smith (Chairman), Cllr Wendy Purdy (Vice-Chairman), Mr R E Brookbank, Mr D S Daley, Mr K A Ferrin, MBE, Cllr Sylvia Griffin, Cllr David Royle, Mr K Smith and Cllr Isaac Igwe (Substitute for Cllr Teresa Murray)

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)

2. Substitutes
(Item 2)

3. Declarations of Interest by Members in items on the Agenda for this meeting
(Item 3)

4. Minutes
(Item 4)

RESOLVED that the Minutes of the meeting held on 13 February 2013 are correctly recorded and that they be signed by the Chairman.

5. Adult Mental Health Inpatient Services Review (further papers to follow)
(Item 5)

Felicity Cox (Chief Executive, NHS Kent and Medway), Dr Rosarii Harte (Assistant Medical Director – Acute Services, Kent and Medway NHS and Social Care Partnership Trust), Dr James Osborne (Consultant, Medway NHS Foundation Trust), Lauretta Kavanagh (Director of Commissioning for Mental Health and Substance Abuse, NHS Kent and Medway), Dr Mick Cantor (Swale CCG), Sarah Holmes Smith (Assistant Director, Community Recovery Services), Sara Warner (Assistant Director Citizen Engagement, NHS Kent and Medway), Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway), Dr Peter Green (Chief Clinical Officer, Medway Clinical Commissioning Groups), Dr Elizabeth Lunt (Dartford, Gravesham and Swanley Clinical Commissioning Group), and David Tamsitt (Director Acute Services, Kent and Medway NHS and Social Care Partnership Trust) were in attendance for this item.

(a) The Chairman welcomed Members of the Committee (Joint HOSC), the Committee's guests and members of the public. Representatives of the NHS were then asked to introduce the item.

(b) Members received a PowerPoint presentation setting out the broad areas covered by mental health services in order to put the proposed changes to acute mental health inpatient services in their wider context (see Appendix A). Part of this presentation included a link to a service user's story available on the Live It Well website (http://www.liveitwell.org.uk/live-it-library/jamess-story/). Members were also provided with an additional information sheet (Appendix B). The services outlined went from preventative care to tertiary and related to the most common mental health disorders. It was stated that concerns had been expressed in the past about the ability to access secondary services following referral from primary care. 90% of these referrals were assessed in 4 weeks. Most of these referrals required short term assistance and could be handed back to be cared for by primary care. It was only those with longer term needs who required inpatient services. Members were informed that the implementation of the proposed changes would be phased to ensure the community based crisis teams were established before any changes to inpatient provision.

(c) Acute services followed the pathway from crisis and home treatment to acute inpatient care to psychiatric intensive care. The proposed changes under discussion focused on this pathway. It was explained that the service model proposed of 3 centres of excellence was evidence based and there was best practise to learn on, both in the United Kingdom and abroad with New Zealand highlighted in particular. In addition, there were also the requirements of the Care Quality Commission for treatment to ensure people's dignity as well as the recent Francis Report putting additional emphasis on putting the patient first.

(d) NHS representatives explained that Medway A-Block was not fit for purpose and the requisite level of care and service could not be delivered there. Members were reminded of the comparatively high level of serious incidents at Medway A-Block compared to Priority House in Maidstone and Littlebrook Hospital in Dartford and were informed that there had been one since the previous meeting, but none at either of the other two sites. Members were in agreement that Medway A-Block was not suitable, but Members had different views about the alternatives.

(e) The Chairman explained that he wished to concentrate on the answers provided by the NHS in response to questions posed specifically by Medway Council (pages 61-8 of the first supplementary agenda) and asked NHS representatives to provide an overview of these.

(f) One set of questions related to the transport plan, and attention was drawn to pages 69-72 of the supplementary agenda where this was set out. In answer to a question about the process, Mr Tamsitt informed the Committee that the service line within the Trust of which he was director would be overseeing this workstream on the Transport Plan and would also ensure its implementation. It was explained that £10,000 had been allocated to support relatives and carers visiting inpatient units and there was a strong focus on the voluntary sector.

The transport of patients to inpatient units formed part of the formal contract with the provider of Patient Transport Services and an ambulance would be used. Each case would be risk assessed and there were occasions when the staff of the crisis team would be able to convey patients to hospital.

(g) One large area of discussion involved the set of answers around the data upon which the consultation on the proposal to reduce bed numbers had been based. Some Members felt there were questions to be asked about the robustness of the data and subsequently concerns about how reliable any conclusions based on this data would be. Medway Council Members drew attention to the evaluation they had commissioned from the University of Kent which formed part of the Agenda. NHS representatives explained that the different critiques of the data, including that provided by Medway Council, was valuable in checking and triangulating the reliability of the data. The report commissioned by Medway Council raised some questions but did agree that the general trend of bed number need was downwards. It was important for the data to be robust as it would not be in anyone's interest if the wrong outcome was arrived at which then needed to be dealt with after 12 or 18 months. At the NHS Kent and Medway PCT Cluster Board on 20 February the Board requested a bed number sensitivity analysis be undertaken along with a Quality Impact Assessment to be reported in turn to the CCG Boards when they made their final decisions on the proposals. It was reported that this should be concluded by the end of May. Due to the imminent changes happening in the NHS, it would be for all 8 CCGs across Kent and Medway to decide how to take the proposals forward whatever the findings of the analysis was. CCGs were required to produce credible commissioning plans and there would be oversight by the Local Area Team on the NHS Commissioning Board. There was funding available to allow double-running of services if this was seen as the best solution. It was confirmed that whilst the decision of the PCT Cluster Board on 20 February was to support the implementation of Option A the CCGs would be able to adjust the detail of the implementation plan in the light of the outcome of the Bed Sensitivity Analysis.

(h) A member of the public, Mr Antoniou, requested the opportunity to speak on the issue of data. He referred to information he had acquired to back up his arguments which was not available to the Joint HOSC. He presented an argument claiming to have identified a number of flaws which made the case for reducing bed numbers unreliable. NHS representatives explained that responses to a number of the points raised by Mr Antoniou had been included in Appendix 2, a paper included in the Agenda of the meeting of 13 February. The Chairman thanked Mr Antoniou for his comments but stated that the JHOSC was not the appropriate channel for dealing with individual complaints.

(i) A Member of the Committee argued that the issue of data was a difficult one and that one challenge was that it was always historical. However, he believed the data needed to be approached in good faith. Other Members contributed the thought that as the sensitivity analysis was underway it would be useful for the JHOSC to be able to see the outcome of this work.

(j) On the topic of bed numbers, NHS representatives explained that the proposal involved reducing the number of inpatient beds from 160 to 150 and the number of psychiatric inpatient beds from 20 to 12. It was further clarified that

these were the overall bed numbers for Kent and Medway; the number of beds commissioned for patients from Medway, Swale and Sheppey remained the same at 28 for Medway and 7 for Swale/Sheppey. The proposals were for a relocation of these beds, not a reduction in the number.

(k) Related to the prediction of future bed need, Members raised the issue of the additional need arising from the numbers of returning servicemen and women. It was explained that medical care for the armed forces was commissioned separately, although there was liaison between the services and that there was no additional demand being placed on mental health inpatient services from returning servicemen and women.

(l) The question was also asked as to whether the Dartford site would reach capacity due to demand from London. In response it was explained that services were commissioned locally and there were strong financial disincentives not to send patients out of area, such as from London to Dartford, so this was highly unlikely.

(m) Questions were also asked about the idea of establishing recovery houses and what impact this may have on bed numbers. In response it was explained that the driver behind recovery houses was a report which was produced by the Schizophrenia Commission and that this came out after the consultation on the proposals had commenced. There were good examples to learn from in London and discussions were underway with Medway Council exploring the possibility of establishing a recovery house in the locality. Medway Members stated that a Recovery House would not be a suitable substitute for local provision in Medway and requested a constructive discussion with the NHS about potential for acute inpatient beds in Medway. Their view was that the proposed option was not in the interests of Medway residents. It was explained that any recovery house service would be additional to and complementary to currently existing services and to the proposed changes. Acute inpatient bed numbers would not be affected therefore.

(n) Another area where NHS representatives were able to provide answers and information was on the staffing of crisis teams. It was explained that additional capacity was being introduced and the new Support Time Recovery Workers were able to provide the continuity of contact with service users which could not be guaranteed with clinicians. Section 17 escorted leave could be carried out by these Support Time Recovery Workers, or hospital staff depending on the individual circumstances. In addition, Medway Council had invested in support workers going into wards and this was an initiative welcomed and supported by the NHS. There was also a pilot being rolled out in North Kent of discharge coordinators which would help bridge the gap between acute and community health care.

(o) One Member referred to what he called the ‘Deal deal’ in relation to transport. The town of Deal was a 150 mile round trip, approximately, to Little Brook Hospital in Dartford but he was personally convinced that the benefit to be gained from accessing services at centralised centres of excellence serving the whole of Kent and Medway strategically outweighed the disadvantage of needing to travel. Other Members put forward a counter view that the location of services was critical as those people more in need of treatment needed to

be able to access them locally and there was a need to ensure centres of excellence were closer to centres of population.

(p) NHS representatives drew attention to the reports which had been received by the Committee previously setting out how alternative sites had been sought in Medway. This had been continuing for around a decade with no suitable site found. It was explained that the case mix had also changed over this time with those requiring inpatient services being fewer in number but more severe cases than previously. One NHS representative expressed the view that the inpatient facility needed to be away from the centre of Medway if NICE guidelines on treating those with personality disorder were to be followed and appropriate care delivered. The offer made at previous meetings from commissioners to meet with Medway and consider any proposed alternative sites was repeated.

(q) Members of the Committee discussed a range of views as to how to proceed with this matter. There was a degree of consensus around the move towards centres of excellence and the unsuitability and unsustainability of continuing the provision of services at Medway A-block but a number of Members were not convinced that there should not be a centre of excellence in Medway. It was made clear that Medway and Maidstone area had the greatest concentration of the population and it made sense to locate the provision in the area of greatest need rather than moving services outside the perimeter. The view was also expressed that a way needed to be found to allow the NHS to move forward as well. It was noted that the upcoming elections for Kent County Council needed to be borne in mind. This would involve a pre-election period limiting the activities of the Committee and there would be a delay following the election until such time as the Kent Members of the Committee were appointed. This may or may not involve some or all of the current Kent membership. It was also noted that there was a possible window of opportunity in that it seemed likely that the bed sensitivity analysis would only be available to CCG boards for May. The possibility of obtaining advice from an independent expert was mooted and it was agreed the practicalities of this would be considered.

(r) NHS representatives explained that from 1 April, the responsibility for commissioning the services under discussion moved from NHS Kent and Medway to 8 CCGs across Kent and Medway and these CCGs would be meeting at different times across Kent. The request was made that the NHS be allowed to continue developing these services and any further discussions take place concurrently with these board meetings rather than necessarily prior to all of them, which would be a challenge.

(s) Councillor Wendy Purdy proposed the following motion, seconded by Mr Keith Ferrin:

- That:

i. the outcome of the Bed Sensitivity Analysis and Quality Impact Assessment should be reported to the Joint HOSC before it takes a final view on the proposed option for reconfiguration of adult mental health inpatient services and before the CCGs meet in May;

ii. the NHS should meet with Medway Council to informally discuss options for local bed provision and;

iii. simultaneously the advice of an independent expert be sought on the review of adult mental health inpatient services and the proposed option for future provision.

(t) This was agreed unanimously by the Committee.

(u) RESOLVED that:

i. the outcome of the Bed Sensitivity Analysis and Quality Impact Assessment should be reported to the Joint HOSC before it takes a final view on the proposed option for reconfiguration of adult mental health inpatient services and before the CCGs meet in May;

ii. the NHS should meet with Medway Council to informally discuss options for local bed provision and;

iii. simultaneously the advice of an independent expert be sought on the review of adult mental health inpatient services and the proposed option for future provision.

6. Date of next programme meeting
(Item 6)

(a) It was agreed that the date of the next meeting would be determined at a later date.

(b) One Member noted that this was to be the last Committee meeting which Helen Buckingham would be attending as she was moving on to a new role. Members of Committee expressed their thanks for her work in the past.

Item 6: 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, 30 July 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. These were the regulations in force when the Kent and Medway NHS Joint Overview and Scrutiny Committee begun its current review.

(c) These regulations mean 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]

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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

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

(g) Coming into force on 1 April 2013, *The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (SI 2013/218)*[4] came into force and revoked the 2002 regulations. Under these new regulations, where more than one local authority is consulted on a substantial variation of service, "those local authorities must appoint a joint overview and scrutiny committee for the purposes of the consultation."[5]

2. Kent and Medway NHS Joint Overview and Scrutiny Committee, Terms of Reference

(a) 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.

(b) 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.

(c) 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

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

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

(a) The first meeting of this Committee took place on 3 July 2012 and it 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 above.

(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

[4] *The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (SI 2013/218)*, http://www.legislation.gov.uk/uksi/2013/218/contents/made
[5] Ibid. Section 30(5).

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 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) The third meeting was held on 19 March 2013. The draft Minutes for this meeting are contained in this Agenda. According to these draft Minutes, the Committee agreed the following recommendation:

- "That:

i. the outcome of the Bed Sensitivity Analysis and Quality Impact Assessment should be reported to the Joint HOSC before it takes a final view on the proposed option for reconfiguration of adult mental health inpatient services and before the CCGs meet in May;

ii. the NHS should meet with Medway Council to informally discuss options for local bed provision and;

iii. simultaneously the advice of an independent expert be sought on the review of adult mental health inpatient services and the proposed option for future provision."

(e) Information relating to parts i and ii above will be available to Members prior to the meeting.

(f) In relation to part iii above, the Committee commissioned an independent report from Mental Health Strategies. This report will be available to Members prior to the meeting.

4. Options for the Committee

(a) At the end of the current meeting, a number of options are available to the Committee. These include:

i. Support the NHS proposals.

ii. Support the NHS proposals with comments.

iii. Support the NHS proposals with a recommendation.

iv. Reject the NHS proposals.

v. Reject the NHS proposals with comments.

vi. Reject the NHS proposals with a recommendation and propose a vote on the option of referral of the proposals to the Secretary of State for Health within a timeframe agreed by this Committee should any negotiations with the NHS as set out in (c) below be unsuccessful.

(b) Options i – v above would bring the deliberations of the Committee on this issue to an end, unless the Committee asked for an update after a specified period of time. Any updates could alternatively be presented separately to the Health and Adult Social Care Overview and Scrutiny Committee at Medway Council and the Health Overview and Scrutiny Committee at Kent County Council as the formal review would have ended

(c) Under *The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (SI 2013/218)*, a referral to the Secretary of State for Health can only be made once the following steps have been taken:

1. A recommendation has been made by the Committee to the relevant NHS organisations, the recommendation has been rejected by the NHS and the Committee notified;

2. The Committee and the NHS (which should include the commissioner of the service) take steps to reach agreement in relation to the subject of the recommendation; and

3. The Committee has informed the NHS of the date by which it proposes to make a final decision on referral.

(d) The text of Section 23 of the SI 2013/218 is appended to this report for reference.

(e) In addition, there may be local protocols which must be adhered to. The protocol for health scrutiny at Kent County Council require that, where practicable, full Council be given the opportunity to comment on the decision to refer.[6]

(f) Medway Council delegated responsibility to the Health and Adult Social Care and Children and Young People Overview and Scrutiny Committees the right to refer contested service reconfigurations to the Secretary of State without a requirement to notify full Council of the decision to make a referral before that referral is made given the scope for delay this would cause.

[6] The Constitution of Kent County Council, Appendix 4, Annex B: Protocol for the Health Overview and Scrutiny Committee, 6(10), https://shareweb.kent.gov.uk/Documents/council-and-democracy/CONSTITUTION.pdf

(g) A referral to the Secretary of State for Health can be made, either by the Joint Committee or by KCC or Medway HOSCs individually on the following grounds:

1. There has not been adequate consultation with the Committee.

2. Where a consultation was not possible because of a risk to the safety of welfare of patients or staff, the reasons given for the lack of consultation were inadequate.

3. The Committee considers that the proposal would not be in the best interests of the health service in its area

(h) Any report to the Secretary of State for Health must include:

1. an explanation of the proposal to which the report relates;

2. in the case of a report under paragraphs f1 or f2 above, the reasons why the authority is not satisfied;

3. in the case of a report under paragraph f3 above, a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area of the Committee;

4. an explanation of any steps the Committee has taken to try to reach agreement with the relevant NHS organisations in relation to the proposal or the matters set out in paragraphs f1 or f2 above;

5. in a case falling within paragraph f3, evidence to demonstrate that the Committee has taken steps to reach an agreement locally within a reasonable period of time;

6. an explanation of the reasons for the making of the report; and

7. any evidence in support of those reasons.

(i) In addition, any health service reconfiguration is subject to the following four tests, set out by the Secretary of State for Health in 2010:

1. Support from GP commissioners;

2. Evidence of public and patient engagement;

3. Clarity about the clinical evidence base; and

4. Proposals must take into account the need to develop and support patient choice.

5. Recommendation

That the Committee consider the report and determine which of the options set out in paragraph 4(a) to agree as a way forward.

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

Agenda, Kent and Medway NHS Joint Overview and Scrutiny Committee, Tuesday 19 March 2013, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=5183&Ver=4

Contact Details

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Appendix – Section 23 of *The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (SI 2013/218)*

Consultation by responsible persons

23.—(1) Subject to paragraphs (2) and (12) and regulation 24, where a responsible person ("R") has under consideration any proposal for a substantial development of the health service in the area of a local authority ("the authority"), or for a substantial variation in the provision of such service, R must—

(a)consult the authority;

(b)when consulting, provide the authority with—

(i)the proposed date by which R intends to make a decision as to whether to proceed with the proposal; and

(ii)the date by which R requires the authority to provide any comments under paragraph (4);

(c)inform the authority of any change to the dates provided under paragraph (b); and

(d)publish those dates, including any change to those dates.

(2) Paragraph (1) does not apply to any proposals on which R is satisfied that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff.

(3) In a case such as is referred to in paragraph (2), R must notify the authority immediately of the decision taken and the reason why no consultation has taken place.

(4) Subject to regulation 30(5) (joint committees) and any directions under regulation 32 (directions as to arrangements for discharge of health scrutiny functions), the authority may make comments on the proposal consulted on by the date or changed date provided by R under paragraph (1)(b)(ii) or (c).

(5) Where the authority's comments under paragraph (4) include a recommendation to R and R disagrees with that recommendation—

(a)R must notify the authority of the disagreement;

(b)R and the authority must take such steps as are reasonably practicable to try to reach agreement in relation to the subject of the recommendation; and

(c)in a case where the duties of R under this regulation are being discharged by the responsible commissioner pursuant to paragraph (12), the authority and the responsible commissioner must involve R in the steps specified in sub-paragraph (b).

(6) This paragraph applies where—

(a)the authority has not exercised the power in paragraph (4); or

(b)the authority's comments under paragraph (4) do not include a recommendation.

(7) Where paragraph (6) applies, the authority must inform R of—

(a)its decision as to whether to exercise its power under paragraph (9) and, if applicable, the date by which it proposes to exercise that power; or

(b)the date by which it proposes to make a decision as to whether to exercise that power.

(8) Where the authority has informed R of a date under paragraph (7)(b), the authority must, by that date, make the decision referred to in that paragraph and inform R of that decision.

(9) Subject to paragraph (10), the authority may report to the Secretary of State in writing where—

(a)the authority is not satisfied that consultation on any proposal referred to in paragraph (1) has been adequate in relation to content or time allowed;

(b)in a case where paragraph (2) applies, the authority is not satisfied that the reasons given by R are adequate; or

(c)the authority considers that the proposal would not be in the interests of the health service in its area.

(10) The authority may not make a report under paragraph (9)—

(a)in a case falling within paragraph (5), unless the authority is satisfied that—

(i)the steps specified in paragraph (5)(a) to (c) have been taken, but agreement has not been reached in relation to the subject of the recommendation within a reasonable period of time;

(ii)R has failed to comply with its duty under paragraph (5)(b) within a reasonable period of time; or

(b)in a case to which paragraph (6) applies, unless the authority has complied with the duty in paragraph (7) and, where applicable, paragraph (8).

(11) A report made under paragraph (9) must include—

(a)an explanation of the proposal to which the report relates;

(b)in the case of a report under paragraph (9)(a) or (b), the reasons why the authority is not satisfied of the matters set out in paragraph (9)(a) or (b);

(c)in the case of a report under paragraph (9)(c), a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area of the authority;

(d)an explanation of any steps the authority has taken to try to reach agreement with R in relation to the proposal or the matters set out in paragraph (9)(a) or (b);

(e)in a case falling within paragraph (10), evidence to demonstrate that the authority has complied with the applicable condition in that paragraph;

(f)an explanation of the reasons for the making of the report; and

(g)any evidence in support of those reasons.

(12) In a case where R is a service provider and the proposal relates to services which a clinical commissioning group or the Board is responsible for arranging the provision of—

(a)the functions of R under this regulation must be discharged by the responsible commissioner on behalf of R; and

(b)references to R in this regulation (other than in paragraph (5)(c)) are to be treated as references to the responsible commissioner.

(13) Where the functions of R under this regulation fall to be discharged by more than one body under paragraph (12)(a), the duties of those bodies under that paragraph may be discharged by those bodies jointly or by one or more of those bodies on behalf of those bodies.

(14) In this regulation—

“service provider” means an NHS trust, an NHS foundation trust or a relevant health service provider;

“the responsible commissioner” means the clinical commissioning group or groups or the Board, as the case may be, responsible for arranging the provision of the services to which the proposal relates.

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Achieving Excellence in Mental Health Crisis Care
Adult Mental Health Acute Inpatient Services Review

Briefing Paper for the Kent and Medway Joint Health and Overview and Scrutiny Committees – 30th July 2013

Introduction

This briefing paper has been prepared for the Kent and Medway Joint Health and Overview and Scrutiny Committee (JHOSC) meeting on 30th July 2013.

It summarises:

- The background to the review
- The proposals, consultation process, and subsequent review by the JHOSC
- Progress on actions agreed at March 2013 NHS Kent and Medway Primary Care Trusts (PCT) Cluster Board
- Impact of the Keogh review into quality of care and treatment provided by 14 hospital Trusts in England
- Next Steps

Background

Since 2011 NHS Kent and Medway PCTs and subsequently the eight Clinical Commissioning Groups (CCGs) have been reviewing acute mental health care in collaboration with Kent and Medway NHS and Social Care Partnership Trust (KMPT).

In Spring 2012 proposals were developed with the help of clinicians, service users, carers and stakeholders which focused on developing a new model to address:–

- The increasing need to enhance staffing and improve the service delivered by Crisis Resolution and Home Treatment teams following the success of this community-based alternative to hospital admission.
- Very different levels of psychiatric intensive care support between the East and the West of the area.
- Inequitable distribution of hospital beds for Kent and Medway people who are acutely mentally ill and the imbalance in capacity across the area.
- Long standing concerns about the poor quality therapeutic environment at Medway's A Block, including inadequate privacy and dignity on offer and therefore the sustainability of clinical safety. – This is brought into sharper focus by the Keogh review into the quality of care and treatment provided by 14 hospital trusts in England which has given an increased focus on delivering

services that are clinically effective, safe, and give a positive patient experience.

Proposals, consultation process, and subsequent review by the JHOSC

The proposal is for:

- An increase in Crisis Resolution and Home Treatment teams' staffing to enhance the primary alternative to admission for appropriate patients and facilitate a timely discharge by offering more intensive support.
- A reconfiguration of acute beds to provide centres of excellence in Dartford, Maidstone, and Canterbury for individuals requiring admissions. These will enable medical cover and expertise to be focused - driving up quality of service, care, and patient experience.
- A consolidation of psychiatric intensive care beds in Dartford and establishment of a psychiatric intensive care outreach service in East Kent.

A reconfiguration of acute beds to provide centres of excellence in Dartford, Maidstone, and Canterbury for individuals requiring admissions. These will enable medical cover and expertise to be focused - driving up quality of service, care, and patient experience. Consideration was given to a range of options for the locations of centres of excellence, including the potential for a centre in Medway. However, it was not possible to identify an affordable or feasible option in Medway.

The National Clinical Advisory Team examined the clinical case for change. Their assessment concluded that proposals and direction of travel were clinically sound and should deliver reduced need for admissions and duration of inpatient stays.

Proposals were submitted to the Kent and Medway PCT Cluster in June 2012.

In July 2012, the PCT Cluster Board and the Joint Health Overview and Scrutiny Committee agreed to conduct a public consultation. The consultation ran between 26 July 2012 and 26 October 2012. The consultation responses and process were assessed by the University of Greenwich and the University's findings were reported to the Joint Health and Overview Committee meeting in February 2013.

Overall responses to the consultation were:

- Support for the need to improve services, including a recognition that Medway A Block is not fit-for-purpose.
- Support for enhancing Crisis Resolution and Home Treatment teams' staffing and psychiatric intensive care outreach.
- Concern that the number of acute beds proposed was not sufficient to meet demand.
- Concern about Medway residents needing a bed having to travel to Dartford.

The Kent and Medway Cluster PCT Cluster Board met in March 2013, reviewed the results of consultation, endorsed the model of care and supported the implementation of Option A subject to undertaking the following work:

- A bed sensitivity analysis to test the proposed bed nembers
- Completion of a travel plan covering gaps in transport provision
- Quality impact assessments to be undertaken
- Enhancement of Crisis Resolution and Home Treatment teams' staffing and psychiatric intensive care outreach in advance of any change to beds.

The JHOSC met in February 2013 and March 2013 to consider the proposals and raised questions, in particular about the effects of the proposals on Medway people.

Progress on actions agreed at March 2013 NHS Kent and Medway Primary Care Trusts (PCT) Cluster Board

Bed Sensitivity Analysis

The Public Health Directorate in Medway Council was commissioned to:

- Review the original calculations of bed numbers
- Develop a more needs based approach to estimating the number of beds needed taking account of the relationship between local and out of area beds, and the impact of the requirement for beds as a result of the proposed improvements to out of hospital services.

The results of the review of the original calculation is that the original figure of 150 acute beds being sufficient for Kent and Medway is no longer supported by the data. The calculation of beds needed, using correct, up to date data is 174.

Development of a more needs based approach is almost complete.

Attachment 1 is the latest draft paper setting out in detail the results of this analysis. A final version will be available by the end of July 2013 and will be circulated to JHOSC members.

KMPT, in partnership with Commissioners, have reviewed the original model and the particular needs of Medway. This review has considered:

- The longstanding need for the development of supported living and recovery house models to support patients requiring short term enhanced support during a crisis.
- The high number of people with a personality disorder within Medway who are recognised to not do well in an acute setting but who in a crisis need immediate intensive support tailored to their need.

In light of this further review in line the clinical strategy and acknowledging the specific needs of the population of Medway, KMPT proposes the following:

- Developing 8-10 intermediate care beds and a day care intensive treatment service for patients with Personality Disorder (through capital investment).
- Establishing a recovery house model in partnership with a third sector provider where 8-12 people would be able to be supported in supervised accommodation with intervention/input from mental health professionals.
- Developing 12 extra acute beds within Maidstone as added capacity in addition to the proposed additional beds at Dartford.
- Changing the function of and extending Dudley Venables House to allow the provision of an additional 8-10 acute beds in Canterbury.

These resources will provide local and immediate support to patients who cannot be safely looked after at home in addition to (and working with) the original proposals of intensive home treatment which would significantly reduce the number of people requiring acute admission, and support more timely discharge.

Travel Plan

A travel plan has been developed and is being implemented. This is included as attachment 2.

Quality Impact assessments

Quality impact assessments have been developed for the proposed changes and for maintaining the existing arrangements. These are included as attachment 3.

Development of Crisis Resolution and Home Treatment teams and psychiatric intensive care outreach

Agreement has been reached with the CCGs and with NHS England for KMPT to commence further investment in Crisis Resolution and Home Treatment teams and psychiatric intensive care outreach ahead of any changes to acute beds configuration and additional funding will be provided to fund any double running costs incurred.

Impact of the Keogh review into the quality of care and treatment provided by 14 hospital trusts in England

Overall the Keogh review has strengthened the pressure for the NHS to take rapid action to improve clinical safety, effectiveness and patient experience in areas where there are concerns.

Medway NHS Foundation Trust was one of the 14 hospitals reviewed by Sir Bruce Keogh and is one of the 11 hospitals put into special measure as a result of the review. The recovery plan agreed by the review team and the trust requires the trust to make significant changes to the layout of its services in order to improve clinical safety, effectiveness and patient experience. To achieve this the trust requires KMPT to vacate the site so that the space currently occupied by them in A Block can be used to improve the quality of acute care.

Whilst this does not change the direction of travel for these services it imposes the need to make rapid progress.

KMPT have undertaken undertaken contingency planning to establish how soon they could vacate the site which indicates that this work could take 45 weeks to achieve. This means that they will continue to be providing services in A Block through next winter which presents a continuing significant risk to the clinical safety, effectiveness and patient experience of acute services provided at Medway hospital.

Next Steps

The work that has been undertaken since March 2013, as described in this paper, will be taken to CCGs for consideration in the next month . It is proposed to make the following recommendations for CCGs to approve.

- KMPT commence enhancement of Crisis Resolution and Home Treatment teams and psychiatric intensive care outreach to provide increased and improved alternatives to admission for appropriate patients and facilitating timely discharge.

- KMPT commences implementation of the changes to acute beds in Kent (Canterbury and Maidstone) to improve the levels of care provided, especially in the East of the area.

- In the light of the requirement to vacate A Block (enabling Medway hospital to improve acute services), KMPT commences rapid development of alternative provision for acute beds at Dartford, Maidstone and Canterbury, based on a total current Kent and Medway-wide possible requirement for 174 beds.

- CCGs working with local authorities and KMPT commence work to develop detailed implementation plans for local, multi agency urgent care mental health pathways.

Adult Mental Health Review – Position Paper for the Kent and Medway Joint Health and Overview and Scrutiny Committees

Analytical review and sensitivity analysis of bed number estimates

This report is set out in 4 parts

1. Introduction and Context
2. Sensitivity analysis: review of bed number estimates and updated numbers
3. Project plan for future work
4. Re-modelling of bed numbers; approach used and initial progress report

1. Introduction

The Adult Mental Health Review was submitted to the June 2012 Kent & Medway Cluster PCT board proposing a reconfiguration of inpatient mental health services. The review argued that a reconfiguration of acute bed capacity was necessary in order to address undersupply in East Kent, close facilities which are not fit for purpose and expand the Psychiatric Intensive Care (PIC) Outreach service to cover the whole of Kent and Medway in order to concentrate services in three centres of excellence.

This has generated a number of questions both internally and externally, some of which were to do with the methodology for estimating bed numbers and the data produced for this. This report deals only with this methodology and the data issues. The quality arguments for change are not the subject of this report.

In order to ensure that we can be confident in our analysis, we have reviewed both the methodology used and tried to make any methodological issues and uncertainties explicit.

We have re-run the analysis completely from raw data to identify any issues in the original implementation of this approach and updated it to reflect more recent data to see if this affects the proposed changes.

The first concern of all involved in this process is patient safety and welfare and we therefore consider it healthy to question ourselves and listen to concerns continually in order to make sure that any actions we take are based on robust evidence.

2. Estimating the number of beds needed

The argument for the number of beds needed is based on three elements:

1) Average bed use over the year 2011/12 with adjustments (see below for details)
2) A decreasing trend in bed use over the previous four years to provide confidence that the proposed reduction in the number of beds is conservative
3) A reduction in the number of beds needed as a result of expansion of Crisis Resolution Home Treatment and improvements in community mental health services.

These three elements are considered in turn below.

Element 1: The number of beds needed

Most of the description of the method used to calculate the number of beds needed is covered in Appendix C of the Review (page 35). The method is described in a narrative form and can be summarised as consisting of the following components:

- The average daily bed use in 2011/12;
- The average number of PICU beds used in 2011/12 by patients who should be in an acute ward;
- An allowance for within-year variation;
- The average net use of out of area beds in 2011/12, i.e. the average of the number of out of area beds used by KMPT patients minus the number of KMPT beds used by patients from other areas.

The values for these four components were calculated in the Review as follows:

144 average daily bed use (shown in Appendix B) plus
7 PICU beds, on average, currently used for acute patients plus
7 for within-year variation plus
2 average net daily use of out of area beds

i.e. 144 + 7 + 7 + 2 = 160

Then on page 20 the Review states that "*addressing […] the continued high use of non-same-day ward leave, alongside many other factors that affect demand, should result in an average of at least 10 more available beds across KMPT.*"

Therefore the complete formula for calculating the number of beds needed is:

144 + 7 + 7 + 2 – 10 = **150 beds needed**

Re-examination of the data used to produce Appendix B in the Review has now shown that there was an error in the analysis that particularly affects the year 2011/12. Correcting that error shows that the average bed use in 2011/12 was actually 168 (not 144). Using the same logic for the calculation of the number of beds with this revised average use in 2011/12, the number of beds needed is:

168 + 7 + 7 + 2 – 10 = **174 beds needed**

Element 2: Linear trend shows that a reduction to 150 beds is conservative

The Review uses the linear trend to demonstrate that the reduction to 150 beds in the redesign is conservative. This happens in several places:

- The review states that over the last four years there has been a reduction in demand (pages 4 and 9). For clarity it should be noted that the data are in fact for bed *use*, not *demand*.
- The Review states that rather than following this decline the reduction to 150 beds is conservative (pages 10, 20 and 34) because the linear trend shows that over two years 32 beds could be removed (pages 10 and 20)

- There are three more references to the trend supporting the reduction in Appendix C (page 34)

The linear trend raises two issues: 1) is it appropriate to use a linear trend and project is further into the future?; and 2) has the trend been calculated correctly?

How valid is the linear trend modelling as a basis for reducing bed numbers?

1) We have looked at this again and feel we have identified significant concerns that the linear trend modelling approach used to estimate the number of beds that will be required in the next two years is not sufficiently robust as a basis for a decision on bed reduction.

   The approach taken in the Review uses a linear trend to project forwards for two years. We do need to make clear that there is considerable uncertainty around the use of such a trend line and that this should be made more explicit. There are four main reasons for this.

   i. It is unlikely in the real world that change of this nature will continue in a straight line for even two years.

   ii. It is also likely that there will be still be a number of people whose mental illness will need inpatient treatment even as community services are increased so at some point the trend may level off. We need to be aware of this and so be constantly checking with real time data what is happening rather than putting much reliance on forecasts which are subject to uncertainty.

   iii. Bed usage and bed closures have a complex relationship but it is clear to a significant extent bed usage figures are influenced by bed closures. Consequently there can be a circular argument in that when you close beds demand appears to go down rather than this being driven by a reduction in underlying need. This is explored more fully in Appendix 2 but again gives a reason why we need to be cautious about bed use as the main basis for predicting future need.

   iv. Even if the linear trend method is used, how accurate are the numbers and estimates and what level of uncertainty do we need to recognise?

On completely re-analysing the raw data, some previous analytical errors have been identified which mean that the rate of decrease in the number of beds assumed in the Review may have been considerably over-estimated. As noted above (Element 1), this has a small effect on 2008/9 to 2010/11, however the figures for 2011/12 show a larger difference (168 as opposed to 144).

This has an impact on any projections made. See Table 1 for the differences in numbers and Figure 1 for the effect this has on predictions.

Table 1: Average daily bed use on adult mental health acute wards in Kent & Medway by financial years

	Average daily bed use	
Financial year	Original (Mental Health Review)	Recalculated (this report)
2006/07	-	207
2007/08	-	192
2008/09	207	210
2009/10	196	200
2010/11	184	188
2011/12	144	168

Source: Excerpt from Appendix B, Adult Mental Health Review and NHS Medway Public Health Intelligence Team

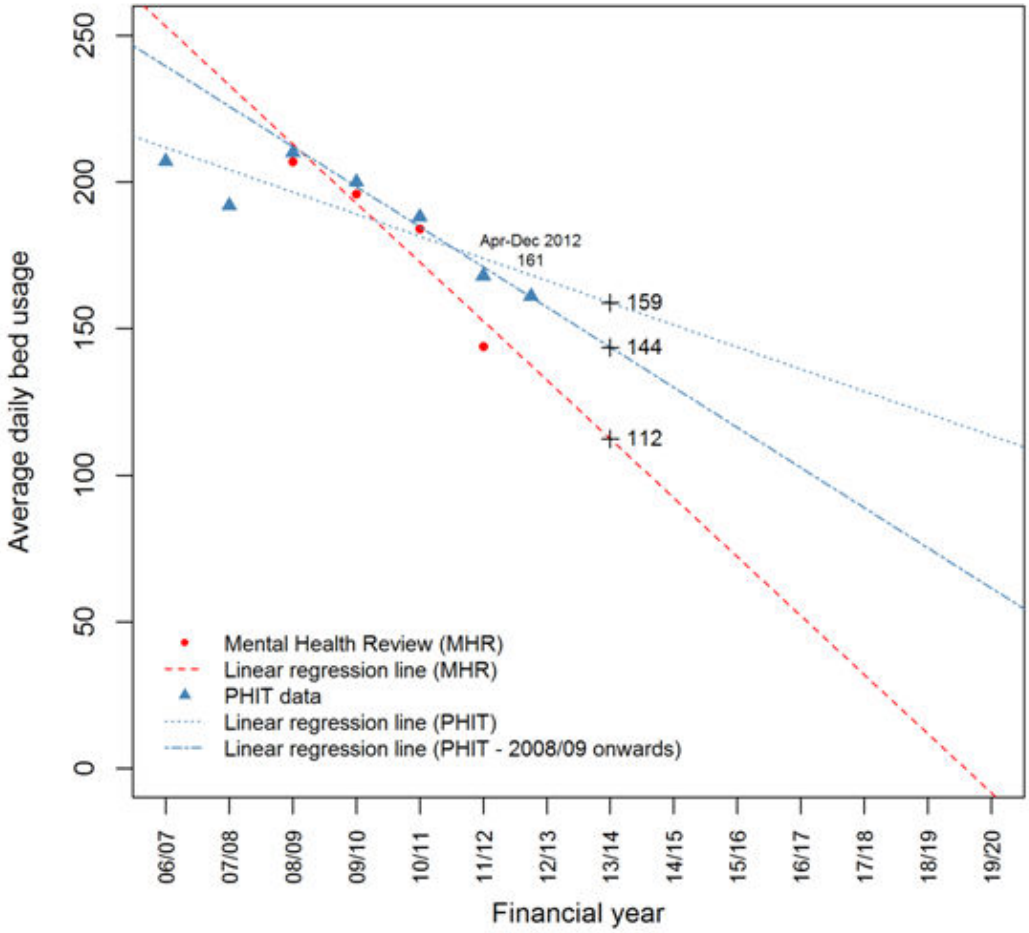
We conducted a sensitivity analysis using the six years data available for Community-based Crisis Resolution and Home Treatment episodes and bed usage in addition to the four years data that was used in the Review. There have been concerns raised that using six years data was more appropriate and we recognised that carrying out a sensitivity analysis using six years would give us greater assurance as to the robustness of our numbers. We have also obtained more data, covering the period April to December 2012.

Using six years of data, ensuring that all the data for 2011/12 are included and adding the new data from April to December 2012 the linear trend shows that rather than falling to 112 beds in 2013/14 as shown in Appendix B in the Review (red line in Figure 1), bed use would fall much more slowly, reaching 159 beds in 2013/14.

Using the complete data for 2011/12 and the new data for April to December 2012 and taking the trend from 2008/09 as per the Review, the projection to 2013/14 is (coincidentally) 144 bed, 32 higher than 112 show in the Review. Note that this is a linear projection and this number may not be reached.

The Review did not use such a projection to estimate the number of beds needed, it used the projection to show that the reduction was conservative.

Figure 1: Average bed use on acute ward in Kent & Medway by financial year with linear regression lines



Source: Excerpt from Appendix B, Adult Mental Health Review and NHS Medway Public Health Intelligence Team

Looking more widely, we are aware that we have no reason and no evidence to lead us to believe that mental health need in the population is decreasing. This again reinforces that the primary rationale for decision making on the reduction of bed numbers needs to be based on clarity that the proposed service changes will sufficiently meet the presenting needs for acute care, rather than on this trend analysis. Further consideration also needs to be given to whether underlying need may be captured more accurately.

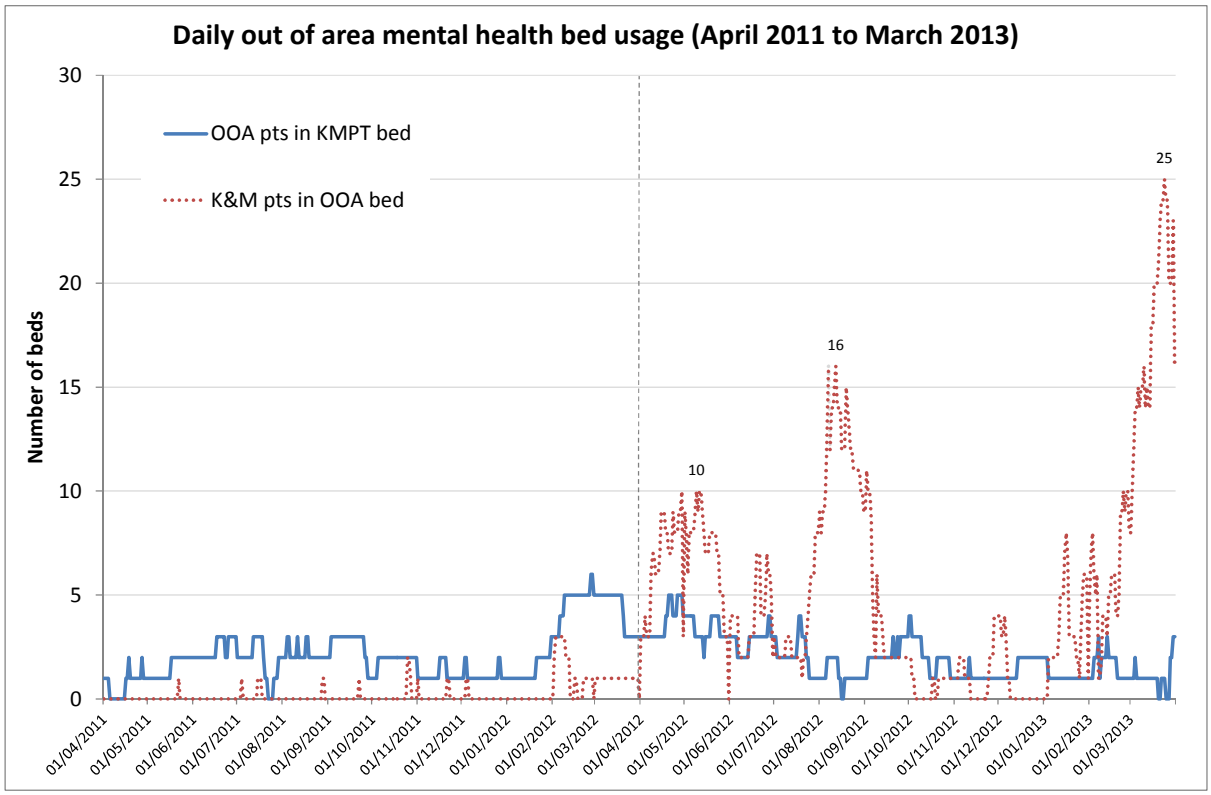
Element 3: Reduction in bed use as a result of reduced demand

Page 20 of the Review states that "*addressing […] the continued high use of non-same-day ward leave, alongside many other factors that affect demand, should result in an average of at least 10 more available beds across KMPT.*"

This reduction bed use is used in Element 1, however, we feel that more work needs to be done to make explicit how these changes will lead to proposed bed reduction.

Element 4: Increase in out of hours area bed usage

In addition we have done some more work looking at out of area bed usage which is shown below. This also indicates the need to review our previous estimates.



Source: Kent & Medway Social Care Partnership Trust (KMPT)
Analysed by: Medway Public Health Intelligence team (PHIT)

The data presented here is total ward stays and does not reflect any periods of ward leave. It has been assumed that ward stays relating to Kent and Medway patients being placed in an out of area bed, does not include any kind of ward leave.

Please note: KMPT provided the following explanation for the three peaks observed in 2012/13:

- *May 2012 - There was a reduction of 3 beds due to the decant of Anselm Ward to enable work of new wards at Canterbury, this remained in place until November.*
- *August 2012 – There was a dramatic increase in demand for Acute care, this was also experienced elsewhere in the country (as there was difficulty in finding beds with Private Providers).*
- *March 2013 – Emerald ward was reduced by 2 beds due to maintaining a safe environment. 1 bed remains temporary out of use at Canterbury due to a fire in January. Net effect of 3 beds removed following changes to Woodchurch ward.*

For the most recent financial year (April 2012 to March 2013) there were 741 more bed days involving a Kent & Medway patient using an out of area bed compared to out of area patients using a KMPT bed. The average daily figures are 4.5 and 2.5 respectively (table 1).

Table 1: Summary of bed use statistics

	OOA pts in KMPT bed	K&M pts in OOA bed
Total bed usage (2012/13)	921	1,266
Mean bed usage (2012/13)	2.0	5.5
Daily max (2012/13)	5	25

Conclusions from sensitivity analysis

Having checked the data and assumptions again, the basis for 150 acute beds being sufficient for Kent and Medway is no longer supported by the data. The calculation of beds needed, using the approach in Appendix C of the Review, now works out at 174, and the linear trend that was used to provide confidence that a reduction to 150 was conservative no longer provides such assurance. The reduction in the number of beds needed through improvements has not been quantified sufficiently and assumptions need to be made more explicit.

The numerical estimates therefore do not now give us sufficient assurance on bed reductions in order to use them confidently to inform decision making therefore further work needs to be undertaken.

3. Project planning for the future

Following the work undertaken above a project plan has now been developed to take this work forward which is attached as Appendix 3.

4. Approach and progress to date on modelling estimated numbers needed

Introduction

The ideal way to estimate the number of beds needed (i.e. demand) is to have a means of estimating the number of people in the population who have acute mental health problems that require admission, and the frequency and duration of those admissions. As far as we are aware there is no recent robust tool for generating such estimates based on current practices of care. We must therefore use proxy estimates of need that are based on previous bed use as indicated above and in the original Review. Bed use is driven to some extent by bed availability and this is therefore hard to interpret when wards are being closed. During the year 2012/13 no wards were closed which means that the 2012/13 year provides a more stable set of data with which to model the estimated number of beds needed.

Approach

The approach taken here is in two parts. The first is to demonstrate how often a given number of beds would provide enough beds on each day of the year, and from this to work out how often, and how many, out of area (usually private provider) beds would be needed. As there is variation in bed use (both seasonal and random) a

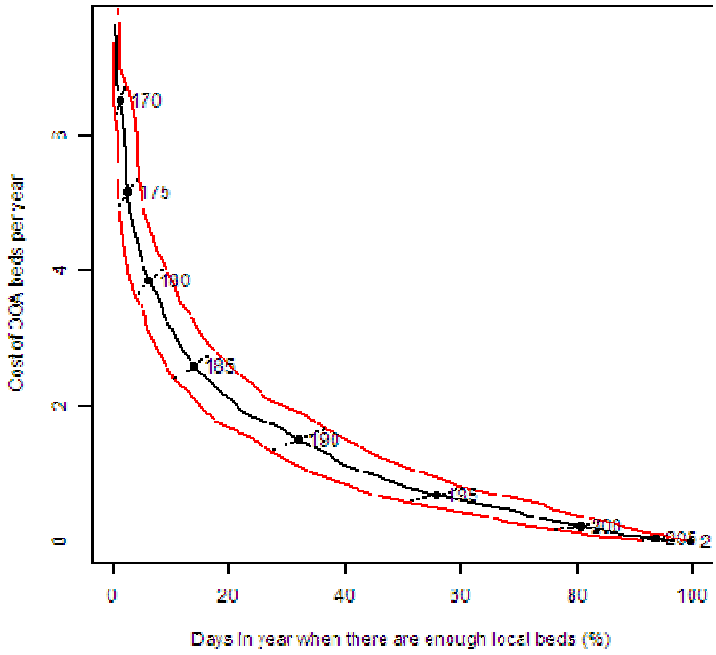
technique known as boot-strapping[1] is used to provide ranges around the most likely values. Using estimates of the average cost of an out of area bed it will be possible to show on one plot for a given number of beds what percentage of days in the year there will be enough beds, and what the expected cost of out of area beds will be.

The second part of the approach is to model the proposed changes to see what effect these are likely to have on the expected bed use. These will be modelled using estimates of the most likely effect of the changes, with ranges around those estimates demonstrating explicitly that we cannot be certain of the exact effect size.

Results so far

The approach involves developing analytical code that is run many times. The code is almost ready and the figures below illustrate the types of output that will be produced. **Please note that these are for illustrative purposes only and that these numbers should not be used.**

Figure 1 Example of the type of curve that will result from the analysis

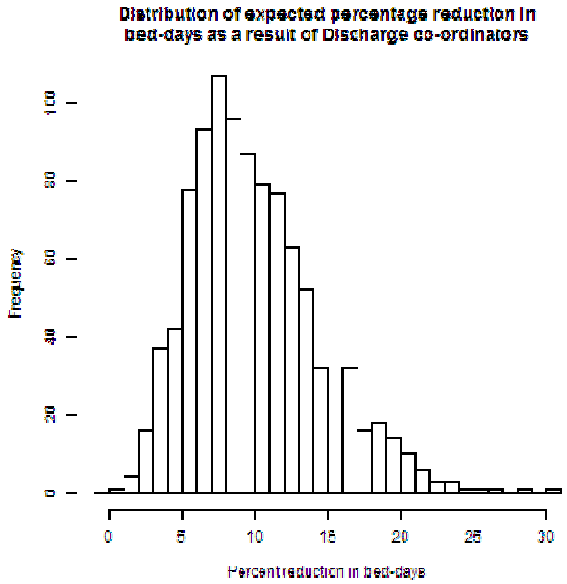


Part 1 of the model: In Figure 1 the number of beds is indicated on the curve line itself, the x-axis shows the percentage of days in the year when there will be enough local beds (assuming no change in need and no change in length of stay as a result of improvements). The y-axis shows the cost of out of area beds (currently this has no units as this is for illustrative purposes only). The red lines show the 95% confidence intervals, and the dashed lines show the confidence intervals for a given number of beds.

[1] Boot-strapping is a statistical technique that involves repeatedly sampling from the data to show which values are very likely to happen and which are much less likely. The approach creates 95% intervals around the estimate. For example, it might say that when there are 165 beds there will be enough beds for 75% of the days in the year, with a confidence interval of 71% to 77%. This means that it will most likely be 75% and we are pretty sure that most of the time it will not be lower than 71% or higher than 77%.

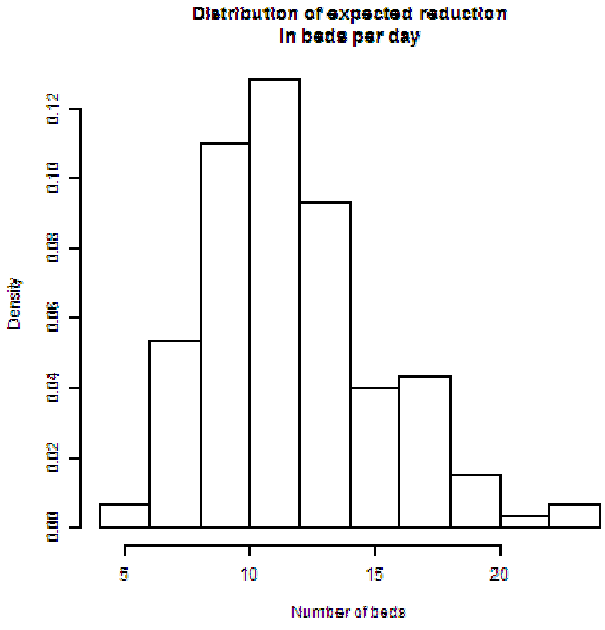
Part 2 of the model: Modelling of the improvements, i.e. reduction in length of stay as a result of STR workers and discharge co-ordinators, is also underway. An example of how the expected effects of the improvements in care will be considered is shown in Figure 2. In this example the discharge co-ordinators are expected to reduce the length of stay by 10%, with a range of 5% to 20%. This information is used to create a distribution of the effect, as shown in Figure 2. This distribution is used in the model so that sometimes the effect may be 10%, other times 5%, others 15%, etc., with 10% being more common than 20%.

Figure 2 Example of the distribution of expected reduction in bed-days assuming a 10% reduction with a range of 5% to 20%



A similar approach is used for the other service improvements and these are combined to calculate a distribution of the overall reduction in length of stay and occupied bed days. This will be shown as a distribution, as shown in Figure 3.

Figure 3 Example of the distribution of expected reduction in beds per day as a result of all of the service changes



How will this information be used?

Once all of the changes have been modelled and the code run several thousand times, the resulting figures will show how often commissioners can expect there to be enough beds for a given number of beds, and the likely cost implications of out of area beds when there are not enough local beds. It will also show the likely effect of the planned improvements. These will be shown as ranges, e.g. with 170 beds there will be enough local beds for 70% of days (range 65% to 75%), it will cost £XX (range £YY to £ZZ) in out of area beds and the changes are likely to reduce the use of beds by 10 beds per day (range 5 to 20).[2]

Combining this information it will be possible to create a table similar to the one shown below. In this table it is assumed that we want to have enough in-area beds for 70% of the days in the year, and that the ranges around bed use and effect of service improvements are as described above. The shaded area shows the number of beds needed minus the reduction as a result of service improvements, with the most likely scenario being 165 beds.

Table 1: Example showing the number of beds needed to cover 70% of days after the effect of service improvements (for illustrative purposes only, please do not use these estimates)

		Service improvements (reduction in bed use per day)		
		Worst case scenario	Most likely scenario	Best case scenario
Enough local beds for 70% of days		5	10	20
Worst case scenario	176	**171**	166	156
Most likely scenario	175	170	**165**	155
Best case scenario	174	169	164	**154**

[2] These ranges will be 95% confidence intervals

Appendix 1: Methods used for re-calculating the bed numbers Methods

Analysis was based on the same raw ward stay data files used to produce the mental health review. Prior to work starting, clarification on the search criteria applied to the patient administration system (PAS) was sought from the analyst at Kent and Medway Social Care and Partnership Trust (KMPT) who supplied the original data. Clarification was also sought regarding the history of modifications to the extracted data from the data analyst in the PCT Cluster, who produced the tables and figures in the review, to enable the outputs in the June 2012 document to be recreated independently.

The raw data contains rows of separate ward stays with multiple variables including a start and end date covering the period from 01/04/2006 to 31/03/2012. Multiple ward stays can make up a 'spell' of treatment if the patient is transferred from one ward to another and each patient can have multiple spells. Other key variables are the Ward name, Ward type (Acute Ward, Acute Older People Mental Health, Psychiatric Intensive Care Unit), Postcode and Age at start of stay.

The data was submitted by KMPT in two batches. The first file contained 19,084 rows and included ward stays during the period 01/04/2006 to 09/02/2012. The second file contained 956 rows and included ward stays during the period 01/01/2012 and 31/03/2012. The datasets were combined and 440 duplicates were removed (retaining the most recent version) which left 19,600 rows of data for further analysis.

First, the data were examined for completeness. Plots of bed occupancy by day, month, quarter and financial year were produced for each ward over the six year period using the R statistical programming language[3]. Re-naming of wards, closures and reclassifications from one type to another were identified. The wards were mapped to the six Mental Health Units (MHUs) in order to take account of possible transfer of patients between wards within the same site and the same analysis was repeated. The plots were annotated with details of changes to the wards in each MHU.

The numbers of younger adults (aged under 65) placed on Older People's Mental Health wards was examined as well as the age profile of patients placed on acute wards. To check data quality, the age distribution of new spells on an acute ward was examined.

Lastly, the number of new spells and average length of stay on acute wards was calculated for each MHU.

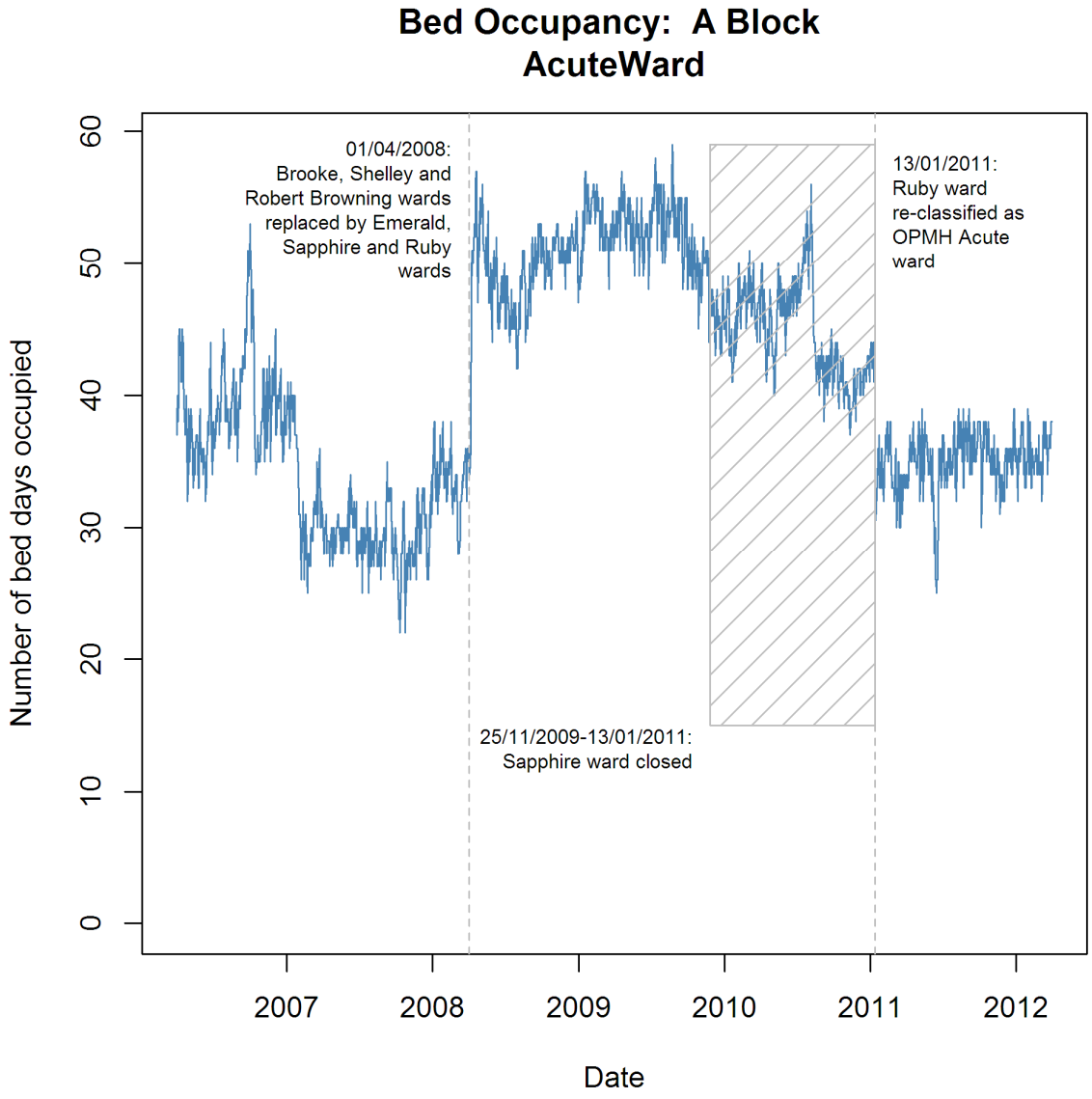
[3] R Core Team (2012). R: A language and environment for statistical computing. R Foundation for statistical Computing, Vienna, Austria. ISBN 3-900051-07-0, URL http://www.R-project.org/.

Appendix 2: Bed usage and bed closures

Figures 2-7 show the daily bed occupancy trends for the six mental health units across Kent and Medway which at some point included wards classified as 'acute' for younger adults. They have been annotated with details of when wards have been opened, closed or re-classified. Figure 8 shows all the known changes annotated on one plot. These show the links between bed closures and bed usage.

In the case of A Block at Medway Hospital, Arundel Unit at William Harvey Hospital, St Martin's Hospital in Canterbury and Thanet Mental Health Unit, it is clear that daily bed occupancy suddenly changes corresponding to changes to the wards.

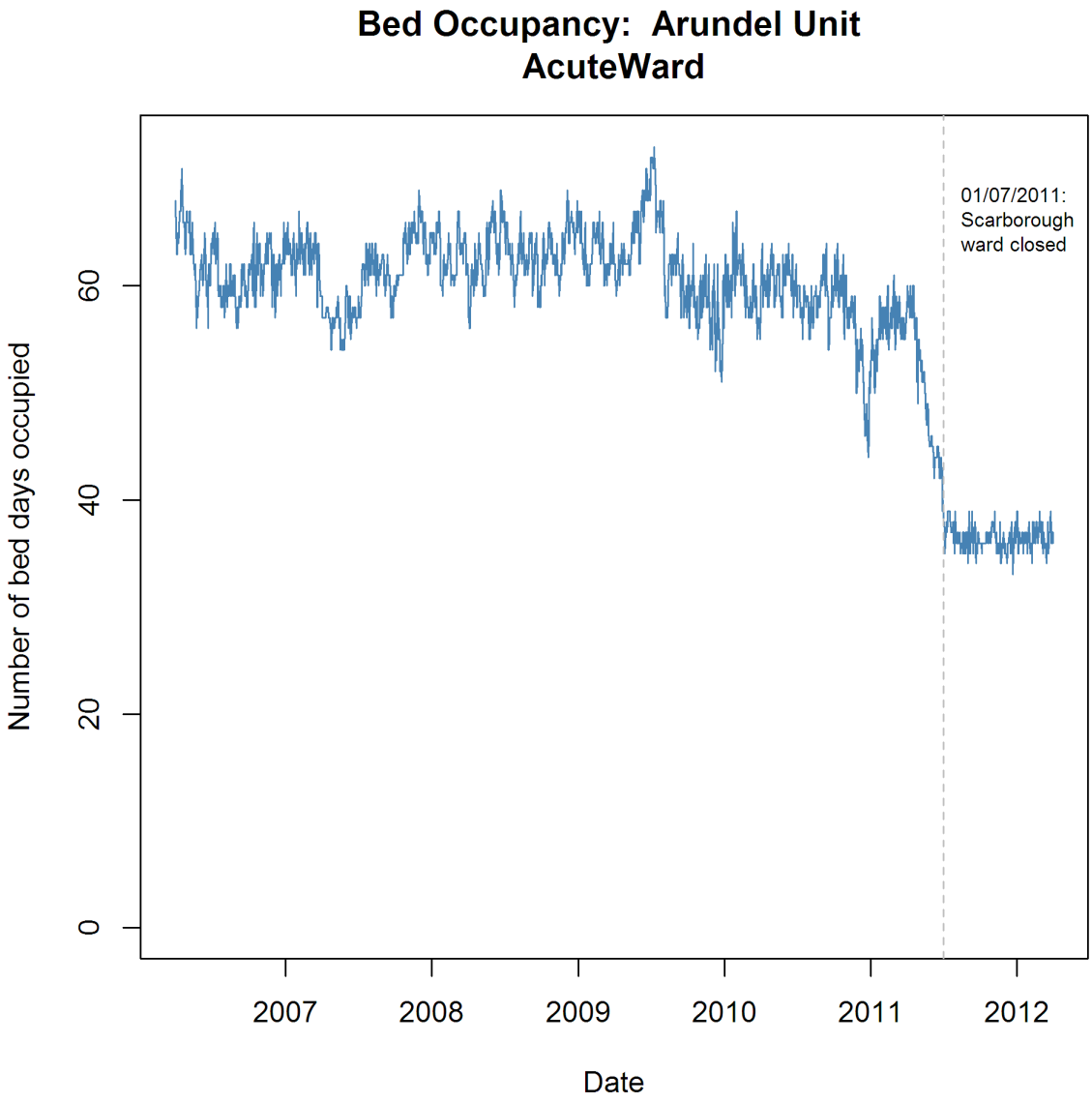
Figure 2: Daily bed occupancy on an acute ward at A Block (Medway Hospital)



Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

At A Block, bed occupancy rose sharply in April 2008 but this could be due to an increase in bed capacity not known at the time of writing this report. Sapphire ward was closed between 25th November 2009 and 13th January 2011 (indicated by the shaded box). It is evident that Bed occupancy was level or increasing when Sapphire ward was in use.

Figure 3: Daily bed occupancy on an acute ward at Arundel Unit (William Harvey Hospital)

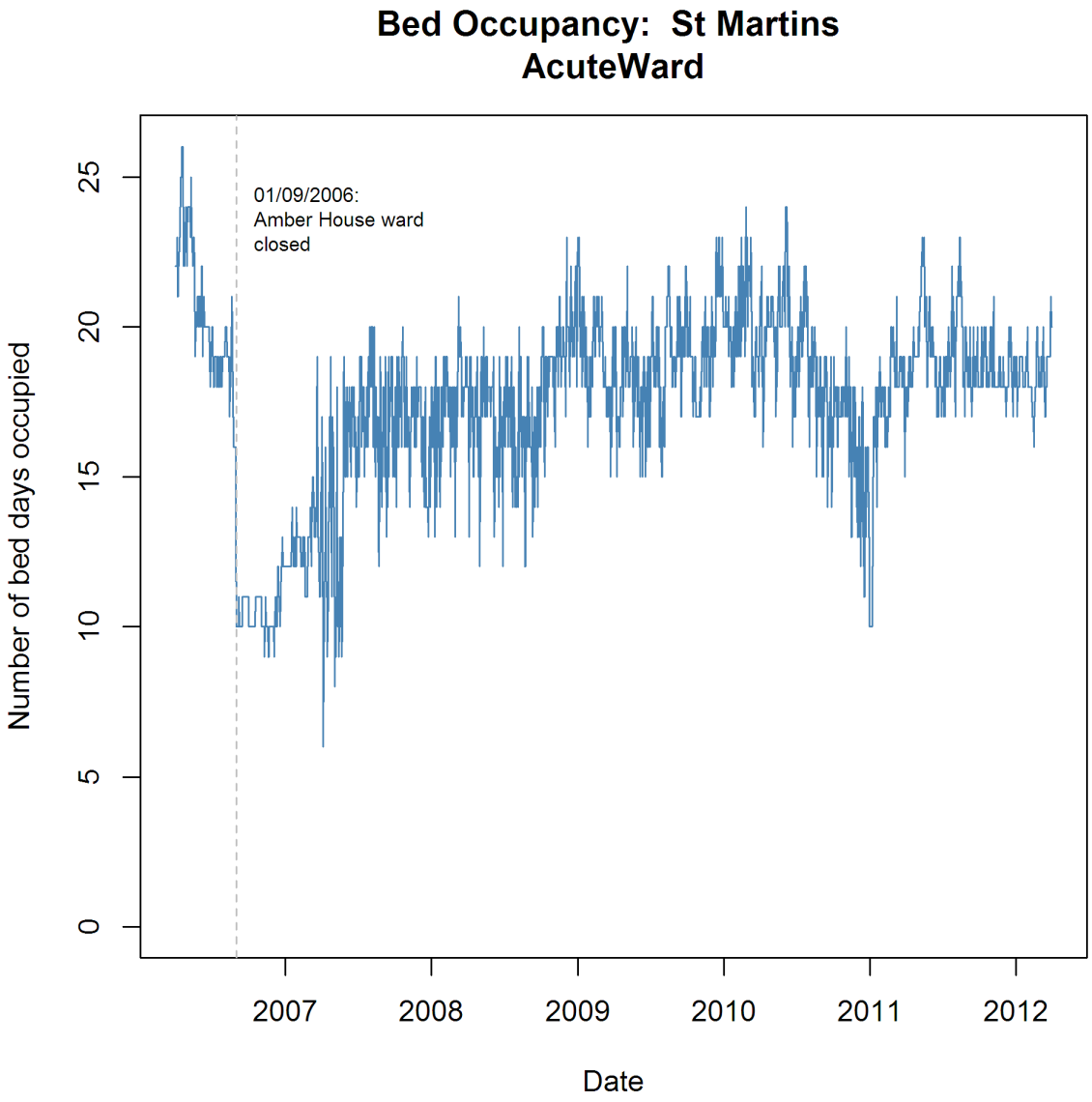


Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

At the Arundel Unit (Figure 3), Edgehill and Newington wards have subsequently been moved to St Martin's with effect from 01 November 2012.

Prior to Scarborough ward being closed there is evidence of a slight reduction in bed occupancy.

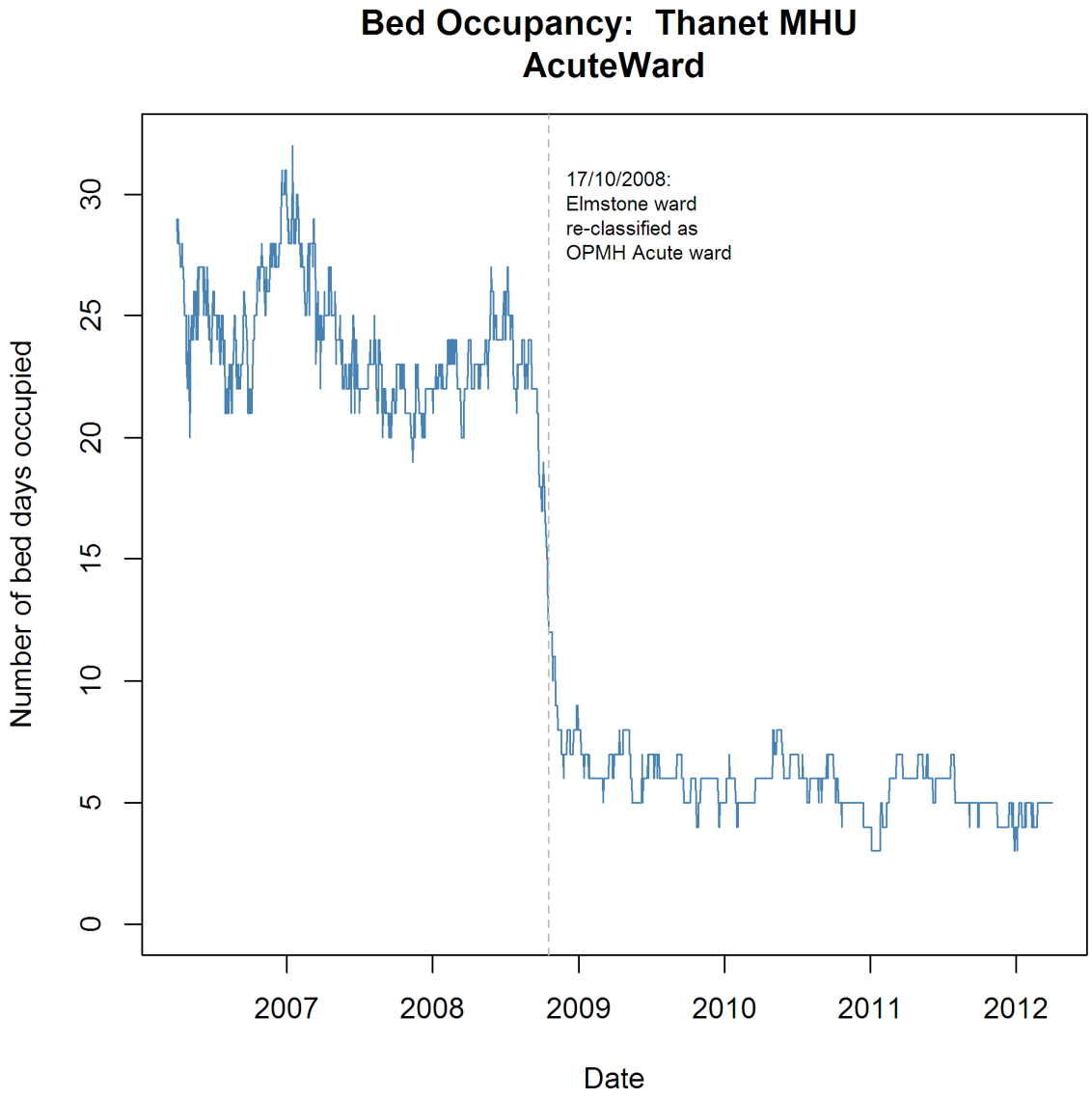
Figure 4: Daily bed occupancy on an acute ward at St Martins Mental Health Unit (Canterbury)



Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

At St Martin's Hospital, bed occupancy has remained level over recent years with the exception of a brief dip in late 2011 (reason unknown).

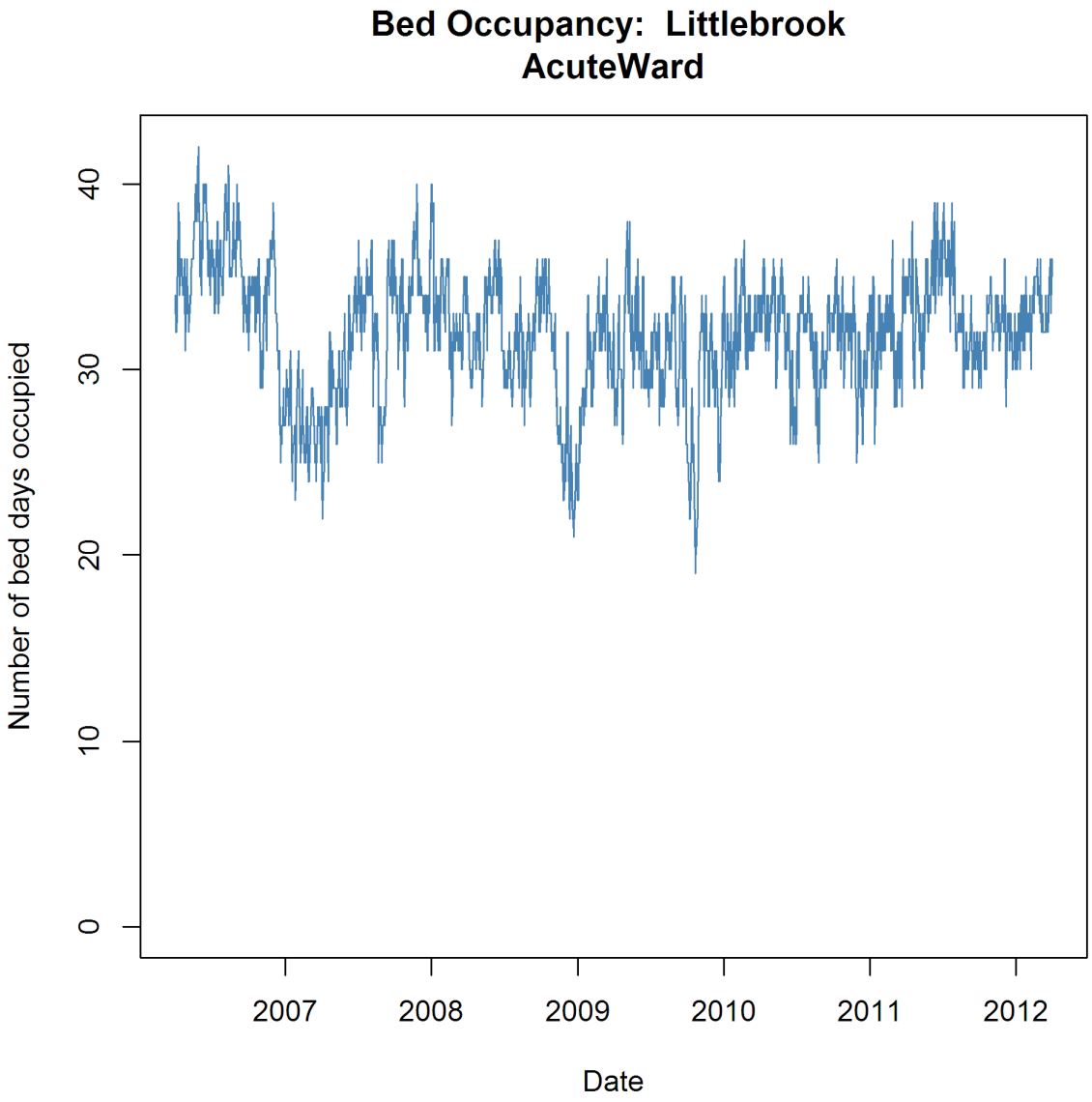
Figure 5: Daily bed occupancy on an acute ward at Thanet Mental Health Unit



Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

The Mental Health Review refers to five beds on an Older People's Mental Health ward at Thanet Mental Health Unit being used for younger adults. This is evident in Figure 5.

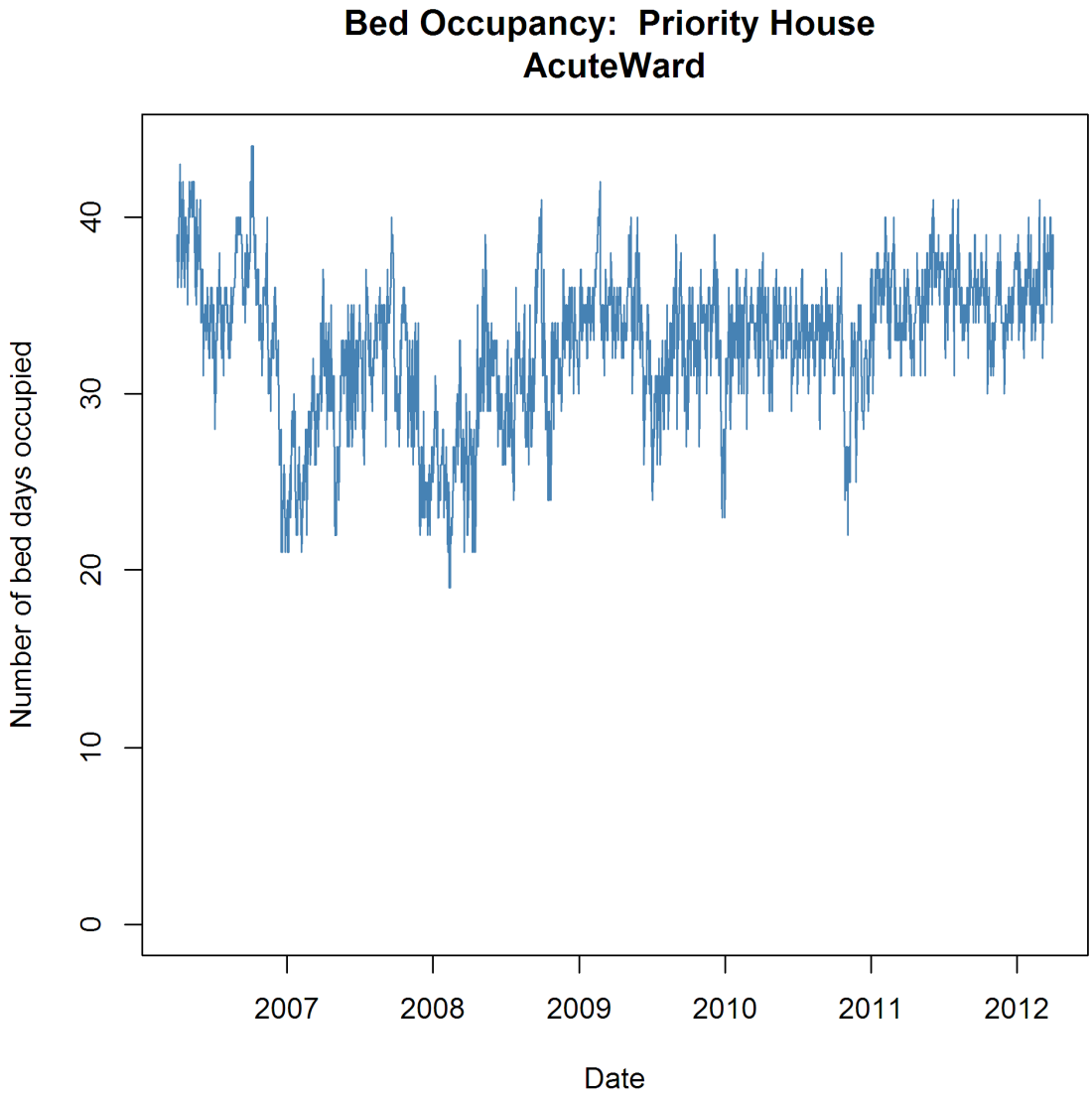
Figure 6: Daily bed occupancy on an acute ward at Littlebrook Hospital (Dartford)



Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

Bed occupancy at Littlebrook Hospital, Dartford has, on average, remained constant over time.

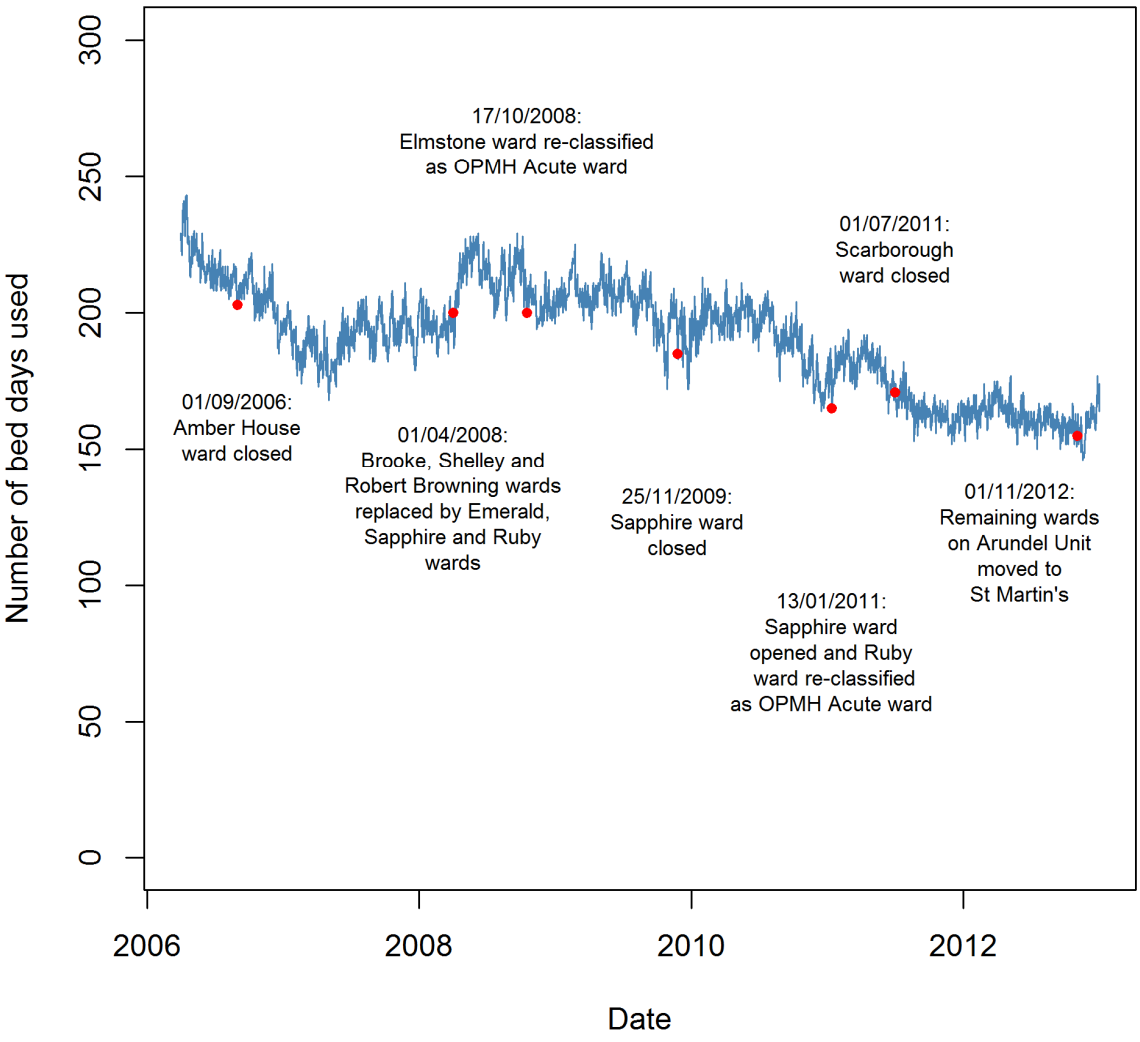
Figure 7: Daily bed occupancy on an acute ward at Priority House Mental Health Unit (Maidstone Hospital)



Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

Bed occupancy at Priority House has increased gradually since 2008.

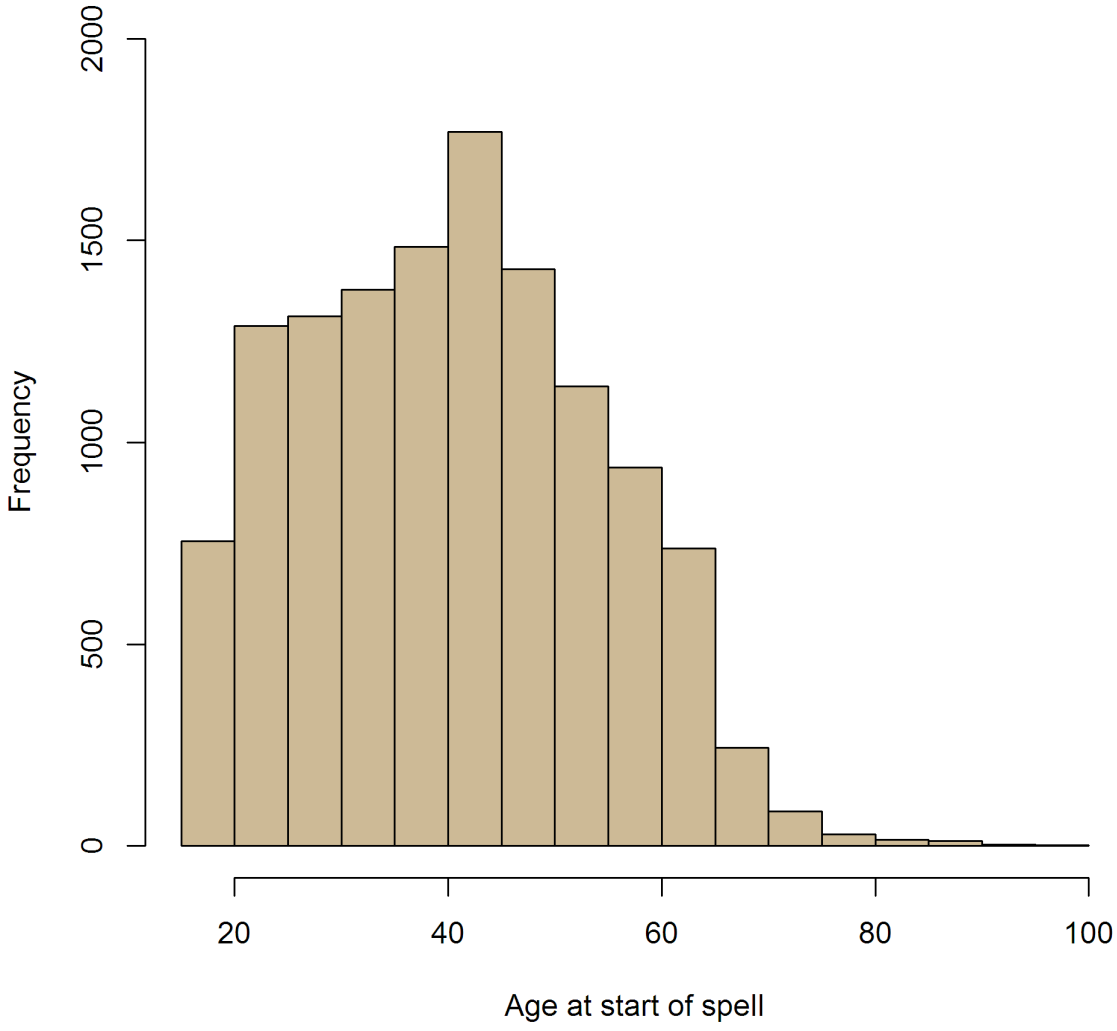
Figure 8: Daily bed occupancy on an acute ward at all sites



Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

In Figure 9 it can be seen quite clearly that the vast majority (97%) of patients on an acute ward are aged 65 years or under.

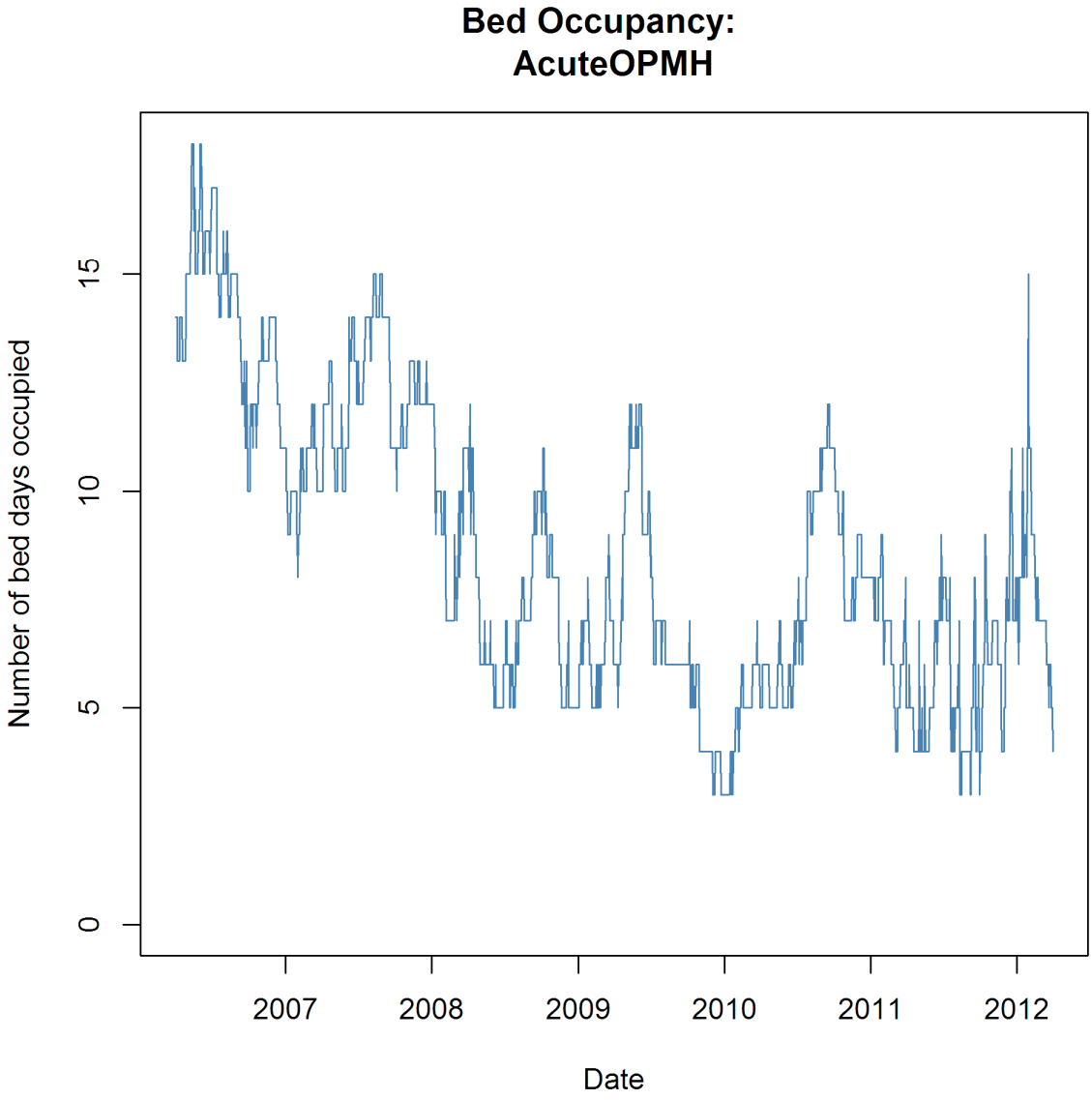
Figure 9: Age distribution of patient spells on an acute mental health ward, April 2006-March 2012



Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

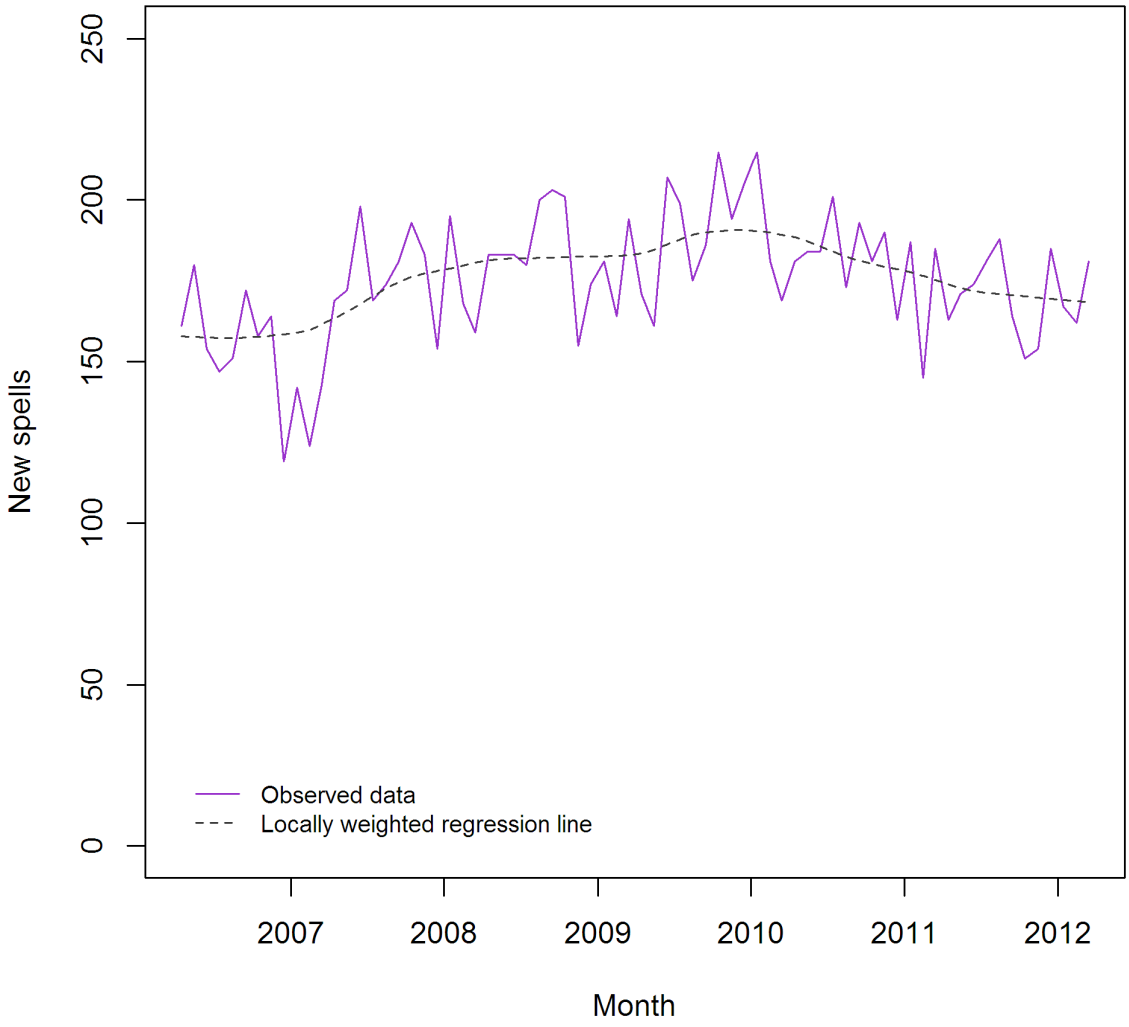
The review states that in some instances it is clinically appropriate to place younger adults (aged under 65) on an older people's mental health ward if they have Dementia. Figure 10 shows the daily bed occupancy of younger adults on older people's mental health wards. This has reduced from around 15 beds per day in April 2006 to around 5 in March 2012 but has spiked over that period in particular between 10 and 15 in late January and early February 2012. A closer analysis of the 190 separate spells over this period reveals that around half (93) have a primary diagnosis of Dementia. Of the 97 spells without a diagnosis of dementia, of which 26 are at Thanet Mental Health Unit which has five beds set aside for younger adults and the rest are in wards not intended for younger people.

Figure 10: Daily bed occupancy on an older people's mental health ward at all sites



Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

Figure 11: New spells starting on an acute mental health ward at all sites by month

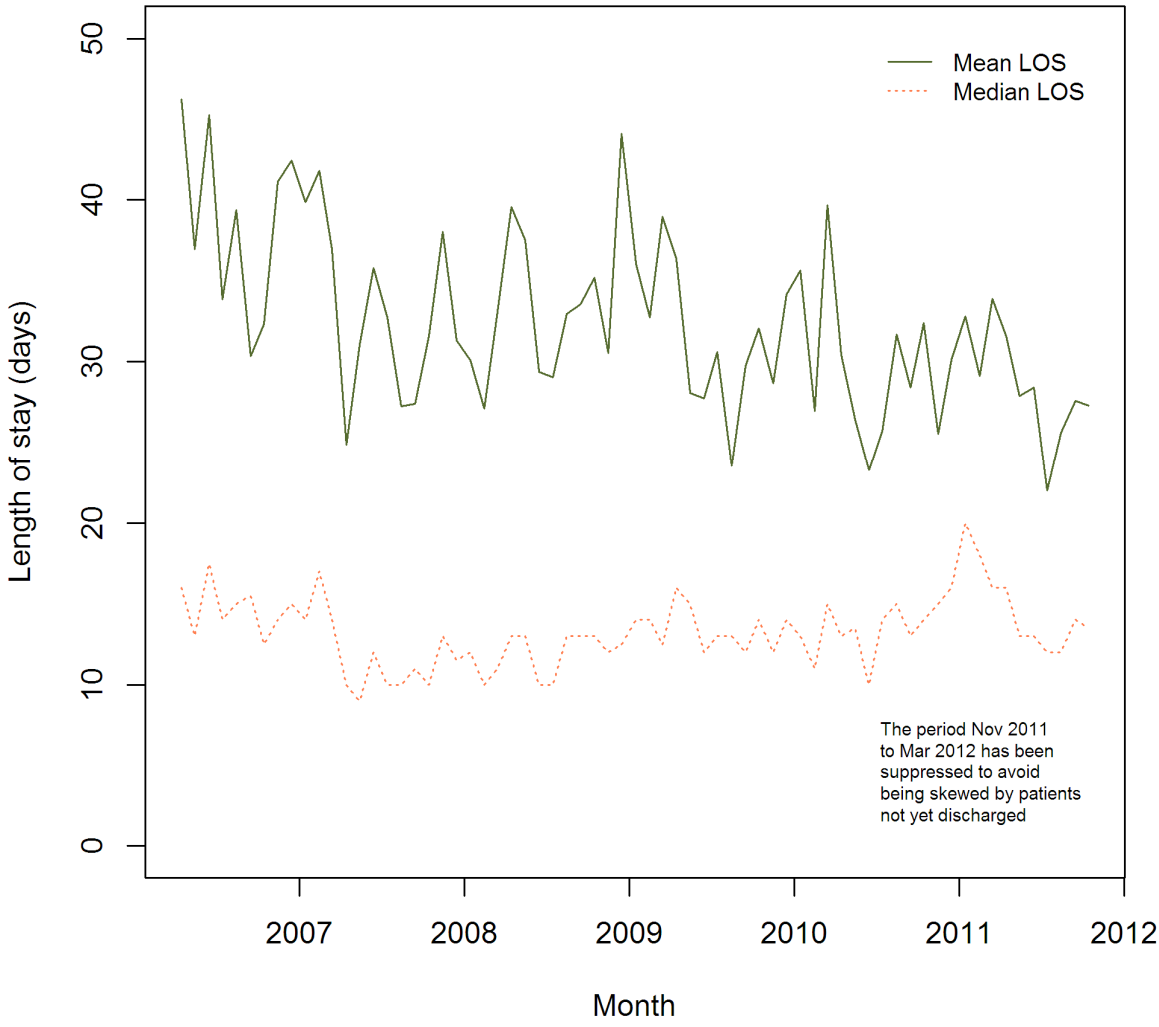


Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

Figure 11 shows that the number of new inpatient spells on an acute mental health ward has reduced since 2010. It is not possible to disaggregate by MHU as patients are often transferred between sites in the course of a single spell so the Kent and Medway total has been presented as one series.

The average length of stay (LOS) has been measured by using the arithmetic mean and median (middle value). In Figure 12 it can be observed that the mean LOS has fluctuated and generally reduced. Some patients stay on a ward for an extremely long time. Over the entire period, 2,145 spells (17%) lasted more than 50 days, 2.5% lasted more than 200 days and 0.6% lasted over 1,000 days. The median LOS has remained fairly constant between 10 and 15 days except for a peak between December 2010 and February 2011.

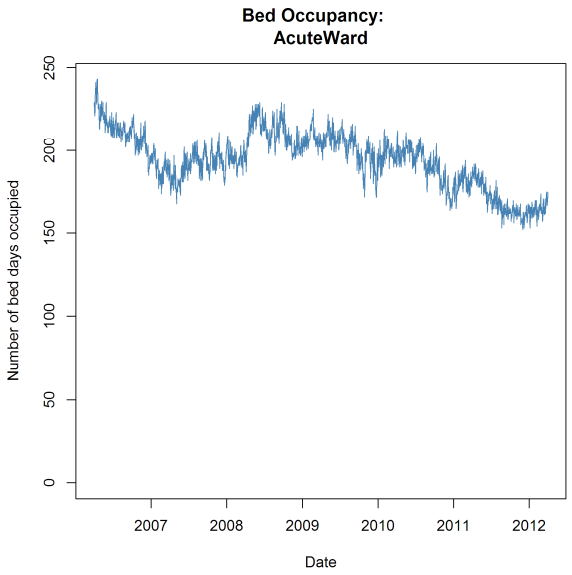
Figure 12: Average length of stay on an acute mental health ward at all sites by month

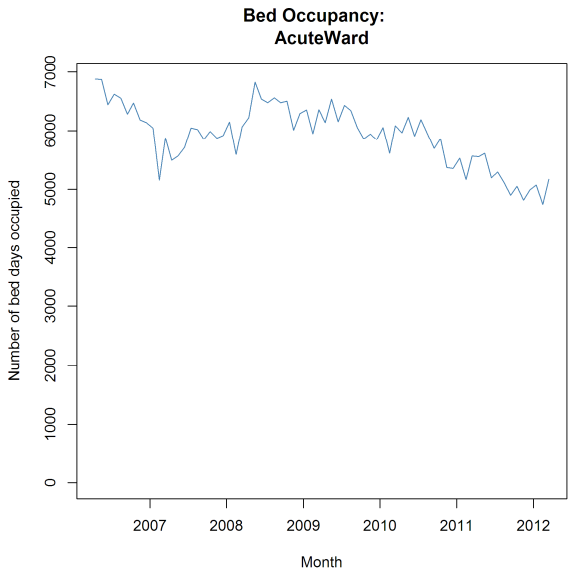


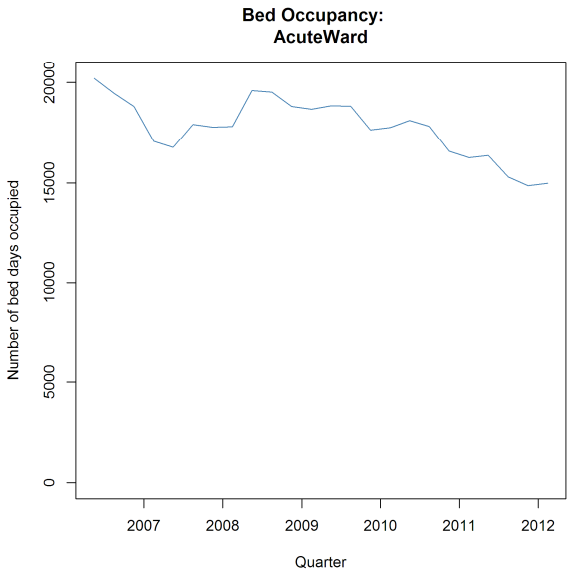
Source: Raw ward stay data (KMPT), analysed by NHS Medway Public Health Intelligence Team

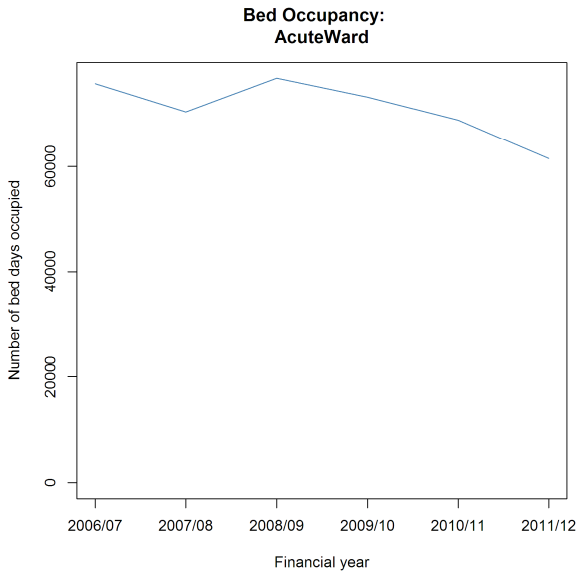
The June 2012 paper does not attempt to model the effect of changes to the service. Creating a model around the proposed service changes would be informative because it would require explicit specification of the parameters and enable the testing of scenarios. This would not on its own determine the actual need for beds, ideally a clinical review is required to do this.

Appendix A


Bed Occupancy:
AcuteWard
Number of bed days occupied
0
50
100
150
200
250
2007
2008
2009
2010
2011
2012
Date


Bed Occupancy:
AcuteWard
Number of bed days occupied
0
1000
2000
3000
4000
5000
6000
7000
2007
2008
2009
2010
2011
2012
Month


Bed Occupancy:
AcuteWard
Number of bed days occupied
0
5000
10000
15000
20000
2007
2008
2009
2010
2011
2012
Quarter


Bed Occupancy:
AcuteWard
Number of bed days occupied
0
20000
40000
60000
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
Financial year

Review and sensitivity analysis of mental health bed redesign: work completed and project plan going forward

1. Work completed as of 01/05/13

(i) Model used to calculate bed numbers reviewed and rerun, accuracy of calculations assessed and update

(ii) Trend analysis reviewed, accuracy of calculation assessed and updated. Sensitivity analysis carried out to see the effects of 4 and 6 years data

(iii) Out of area bed numbers reviewed and updated

2. Project plan going forward

(i) Probability curves for out of area beds

- Create probability curves with number of beds on x-axis and probability of needing out of area beds on y-axis. Use data on historical use of mental health beds in KMPT.

- Include a check of the use of out of area beds when the use of in-area beds was low. At the moment we are not able to explain why out of area beds were used when in-area beds were available.

(ii) Document the effect of proposed changes

- KMPT to list the proposed changes and specify which relate to quality of care and which are expected to have an effect on beds days. For those that are expected to affect beds days, specify the expected effect, and define a range for that effect. E.g. STR workers are expected to lead to a 5% reduction in total bed days, with a range of 1% to 10%.

(iii) Model the probable effect of the proposed changes

- Use the information provided by KMPT to model the probable effect on the number of beds used resulting from the proposed changes in the service reconfiguration. Combine this with the probability curves to determine the probability of needing out of area beds after the reconfiguration.

(iv) Review other methods for determining need for mental health care to assess if applicable

- Review needs assessment work done in other areas to see if other methods used may be more appropriate.
- Review local measures of mental health need.

(v) Review other models of community services

- KMCS to review good practice in areas with high satisfaction ratings with mental health services with respect to bed ratios and community mental health services design.

(vi) Review proposed distribution of beds across Kent and Medway

- With updated demand and need information review proposed distribution of beds across Kent and Medway

Timescales and Responsibilities

Overall project plan: KMCS, Head of Mental Health Commissioning: Kim Solly

Task	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Lead responsibility
Probability curves for out of area beds									Medway Public Health
Document the effect of proposed changes									Kent and Medway NHS and Social Care Partnership Trust
Model the probable effect of the proposed changes									Medway Public Health
Review other methods for determining need for mental health care to assess if applicable.									Medway Public Health
Review other models of community services									KMCS
Review proposed distribution of beds across Kent and Medway									Medway Public Health

Travel Plan Update: July 2013

The following table summarises progress to date with the travel plan in relation to the proposed acute mental health service redesign. The Travel Steering group are due to meet on the 22nd July, 2nd October and 4th December and will provide monitoring and oversight of plan as service redesign is implemented.

RAG Rating:

Red: at risk either of slippage or in delivery; Amber: in progress/on target; Green: completed

White: not started

Area	update	Lead Organisation – Responsible Officer	Further actions required	Milestone/Timeframe	RAG
Signage - internal	All internal signage in place at the Littlebrook site providing directions to the inpatient unit and to local public transport routes.	KMPT	KMPT to consider adding directions from Bluewater Shopping Centre to Littlebrook Hospital on their Internet site.	End August 2013	(A)
Signage - external	Advice has been sought with view to signage on external roads/ motorway; we are currently awaiting feedback and will formulate plan/provide further update when we are in receipt of this information.	KMPT	To explore possibility of Bluewater SC providing signage to Littlebrook Hospital on their site.	End August 2013	(A)

Transport information	Information on public transport is available at main entrances at each acute inpatient site.	KMPT	Review current availability of travel to KMPT sites information on Trust Web site to ensure it is robust and up to date. Review information held at each acute in-patient site to ensure that it is easily found and is 'user friendly'	End August 2013 End August 2013	(A)
Secure Transport	Secure vehicles have now been delivered and are available for the internal transfer of patients.	KMPT		Completed	(G)
Voluntary transport scheme	Plans in place to extend the voluntary transport scheme which is present in Maidstone/SWK. Guidance and policy to be reviewed to reflect extension of the scheme.	KMPT	Plans in place to provide this scheme for three main acute in-patient sites. Voluntary transport scheme to be in place to support all three main acute in-patient sites.	End September 2013 End March 2014	(A)
Visiting times	Wards have protected times to ensure patients	KMPT	This information to be included on Trust web	End August 2013	(A)

	have opportunity to eat uninterrupted, and to engage in therapeutic interventions/ treatment. However flexible visiting can be requested should a carer/close family member be unable to visit within set hours due to distance, public transport restrictions; the wards will accommodate requests in those circumstances.		site in relation to all wards. KMPT to ensure that all acute in-patient wards fully implement this initiative.	End August 2013	
Visitor Audit	Further audit was completed seeking views of those visiting Medway A Block. Findings and implications of this audit are to be reviewed at the July steering group	KMPT	Update on July Steering Group review required. Actions in relation to findings to be developed and action plan with milestones/timeframes to be developed.	End August 2013 End September 2013	(A)
Technology	All wards have access to spider phones to facilitate clinical engagement with community colleagues (secondary and primary	KMPT	Completion of protocols and guidance notes required.	End September 2013	(A)

	care) around an individual's treatment plan. Patient Internet Access has been established and SKYPE is now available. Final protocols and guidance notes are being developed.				
Guidance notes and policies	Existing policies and guidance notes have been collated from current voluntary transport scheme. Steering group will allocate a small working group to review and amend so meets need for an extended service.	KMPT	Working Group to be established. Complete work required.	End September 2013 End December 2013	(A)

KMPT Quality Impact Assessment
Achieving Excellence in Mental Health Crisis – Do Nothing

KMPT
Quality Impact Assessment

Scheme number:	
Date of QIA:	14.03.2013

Scheme Name	Achieving Excellence in Mental Health Crisis - Do Nothing
Benefits for patients	This option is based on the outcome of the consultation not being supported and the status quo re current acute care provision being maintained. Reduced travel as individuals accessing inpatient care from Medway & Swale can continue to access inpatient care from within A Block Medway.
Clinical Lead	David Tamsitt/ Rosarii Harte
Service line	Acute
Quality Indicator(s) - consider Performance Management Framework PAF KPIs	Length of stay; Delayed Transfers of care; Occupancy Patient Satisfaction; Staff Survey; Home treatment episodes per locality; admissions per locality CQC standards; PEAT scores

Risks to Patient Safety

Details (include mitigation)	Consequence	Likelihood	Score
Fixtures & Fittings and poor sight lines inherent within the building design in A Block Medway. The current environment increases risks of incidents occurring which impact on the well being of all patients. Increased incidents, staff sickness, poor retention and recruitment has a direct link to patient safety. The service has sought to mitigate these risks as far as possible however the issues listed above remain.	4	4	16 (R)

Risks to Clinical Effectiveness

Details (include mitigation)	Consequence	Likelihood	Score
Increased sickness rates, poor retention and recruitment impacts on ability to provide continuity and monitoring of best practice with increased dissatisfaction from patients, carers and staff as a result The lack of easy access to outside space hinders the therapeutic environment available to service users on Sapphire Ward and increases frustrations leading to an increase in incidents.	4	4	16 (R)

Risks to Patient Experience

Details (include mitigation)	Consequence	Likelihood	Score
Incidents of violence and aggression are higher than other environments and this and other environmental issues such as lack of outside space ,single rooms have resulted in e poor surveys and complaints. The accommodation within Medway limits choice regarding single rooms, access to en suite facilities and access to external space.	3	5	15 (R)

Overall Risk Score (highest from above quality domains)	16

Date approved by Service Line Director	15/03/2013
Date approved by Medical Director	
Date approved by Executive Nurse	15/03/2013

KMPT Quality Impact Assessment
Achieving Excellence in Mental Health Crisis – Option A

KMPT
Quality Impact Assessment

Scheme number:	
Date of QIA:	14.03.2013

Scheme Name	Achieving Excellence in Mental Health Crisis (development 3 centres of excellence, PIC Outreach, development of CRHT; Option A preferred outcome of consultation - relocation of inpatient services Medway to Dartford; Swale to Maidstone & centralised PICU)
Benefits for patients	Delivering acute care services within Kent and Medway from three centres of excellence will optimise care within purpose built accommodation and provide opportunity for staff to share of experience, knowledge and best practice. This will also optimise productivity. There will be an improved environment for patients, Staff and visitors. The accommodation within the three centres reduces ligature risks that are present within current environment in Medway. This will also provide a critical mass of staff and optimises skill mix. Supports the delivery of the acute care pathway. The scheme addresses inequality of inpatient environment, reduces ligature risks, addresses concerns relating to privacy and dignity, reduces the liklehood of out of area placements. Improved environments have a positive impact on incidents of violence and agression, recruitment and retention of staff, reduced sickness.
Clinical Lead	David Tamsitt/ Rosarii Harte
Service line	Acute
Quality Indicator(s) - consider Perfomance Management Framework PAF KPIs	Length of stay; Delayed Transfers of care; Occupancy Patient Satisfaction; Staff Survey; Home treatment episodes per locality; admissions per locality CQC standards; PEAT scores

	Details (include mitigation)	Consequence	Likelihood	Score
Risks to Patient Safety	This will have a positive impact on patient safety. The development of the three centres of excellence will mitigate against the current and inherent risks present in Ablock, Medway.	1	1	1 (G)
Risks to Clinical Effectiveness	This will have a positive impact on clinical effectiveness. The three centres of excellence will enable shared learning and opportunities for shadowing and coaching which in turn will improve the quality of care delivered. Skill mix and expertise will be optimised across the pathway. the scheme will also support robust clinical leadership and consitency to the leadership prvoded across all aspects of acute care. It supports the delivery of the acute care pathway and supports /encourages the implementation of audit and peer review.	1	1	1 (G)
Risks to Patient Experience	Overall we anticipate improvement to the patient experience. The scheme delivers improved inpatient environment, ability to have own room when an inpatient and access to external space both of which are limited in Medway. The development of the acute care pathway supports and actively promotes individualised care. The consolodation of staff onto 3 centres also inproves level of expertise and skill mix available. However the scoring noted reflects for some this may have a negative impact regarding the proximity to friends family and carers to the inpatient facilities and their ability to visit A transport plan has been developed to aid mitigation of this, and provide support where applicable. Concerns remain regarding sufficient bed capacity due to unprecidentied increased demand for acute inpatient care over the past year. Further sensitivity work is being undertaken to review bed capacity. This will inform final decisions regarding the redesign and bed requirments.	3	3	9 (A)

Overall Risk Score (highest from above quality domains)	9
Date approved by Service Line Director	
Date approved by Medical Director	
Date approved by Executive Nurse	