

Kent and Medway Acute Mental Health Services Review

An independent analysis of the public response to a consultation on 'achieving excellent care in a mental health crisis' by the Centre for Nursing and Healthcare Research at the University of Greenwich



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Executive Summary

Background to Report:

This document presents the results of an analysis of the responses to the formal public consultation on Acute Mental Health Crisis Care services which took place over a 13 week period from 26 July 2012 to 26 October 2012. The consultation was conducted by NHS Kent and Medway working in partnership with Kent and Medway NHS and Social Care Partnership Trust, and the data gathered was analysed independently by the Centre for Nursing and Healthcare Research at the University of Greenwich.

The Consultation Process:

The consultation was widely advertised to service users, carers, members of the public and other interested stakeholders, such as local and national organisations, who were invited to take part. Prior to the consultation the options were discussed in Local Planning and Monitoring Groups across Kent. A consultation document and summary were developed which outlined the need for change, findings from the review, and the proposals for 'achieving excellent care in a mental health crisis' and contained a survey asking people's views on these (see Appendix One). This information was also available on a dedicated website (<http://www.kmpt.nhs.uk/acute-mental-health-review>). Members of the public could attend public meetings. Local mental health organisations were given the choice of attending these public meetings, having focus groups or outreach events where the options could be discussed with service users and carers.

Respondents were asked to consider three main areas of acute mental health service provision - the reasons for change, three main options for service provision and their views on how to improve services. The options proposed for changing services were:

- Option A: Provide beds for people from Medway in Dartford, from Sittingbourne and Sheppey in Maidstone and from Faversham in Canterbury
- Option B: Provide beds for people from Medway, Sittingbourne and Sheppey in Dartford, from Swanley in Maidstone, and from Faversham in Canterbury
- Option C: Provide beds for people from Medway in Dartford, from Sittingbourne, Sheppey and Faversham in Canterbury

Response:

- 207 surveys were returned
- 8 public meetings were held, with 184 attendees
- 13 focus groups were held, with 133 attendees
- 15 public outreach events were held, with approximately 290 attendees

Findings:

There was strong support for the reasons for change amongst respondents.

Of the 207 people who took part in the survey, 141 selected a preferred option and 66 did not select a preferred option. The preferred option with the strongest response rate amongst the survey respondents was Option A which 62% of the respondents chose. Option C was the next strongest response with 27%. Option B was the preferred option for 11% of the respondents. Recommendations for improving acute mental health crisis services were discussed by respondents. They wished to see more resources for services in general; improvements in service provision; and improvement in quality of individual care.

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1. Introduction

This is a report on the review of acute crisis mental health services in Kent and Medway – covering care offered in the community primarily through the Crisis Response Home Treatment service, hospital acute inpatient care and Psychiatric Intensive Care for younger adults, commissioned by NHS Kent and Medway (NHS KM) and provided by Kent and Medway NHS and Social Care Partnership Trust (KMPT). This report is compiled by the Centre for Nursing and Healthcare Research in the School of Health and Social Care of the University of Greenwich.

This report presents the results of an analysis of the responses to the formal public consultation on acute mental health services in Kent and Medway; the report will be submitted to the Boards of NHS Kent and Medway and Kent and Medway NHS and Social Care Partnership Trust.

The aforementioned boards will assess people's views alongside the clinical evidence, and based upon these principles:

- Achievability of best possible health outcomes for service users
- Most therapeutic environment
- Best match to local demand
- Affordability
- Sustainability

(see page 26 of the Full Consultation Document in Appendix Four)

The scope of this report includes all surveys, both paper and electronic, completed by the public and service users, during the period of the public consultation from 26th July 2012 to 26th October 2012, provided by NHS KM and KMPT for analysis. Additionally other types of consultation activities carried out during the period, including records of public meetings and focus groups, information collected during outreach work - as well as letters and emails received, are presented. We also report on pre-engagement activities (local planning meeting groups) and outreach activities during the consultation period.

The approach includes presenting the data from analysis of the surveys; exploring the public view of acute mental health services in Kent and Medway, and identification of the public's preferred option. An overview of the themes discussed at meetings and focus groups is also described.

2. How the consultation was conducted

2.1. Pre-consultation

A review of services had been underway since Oct 2011, with proposals having been developed since Jan 2012. Clinicians and commissioners had evidence which suggested that:

- there was reducing demand over four years for acutely unwell people to use inpatient beds, due to the successful alternatives established in the community since 2004
- there were too few beds in east Kent, meaning people were often placed outside the area covered by the community-based Crisis Resolution and Home Treatment (CRHT) team that supported them, leading to dislocation of services and delays

- there was long-standing concern about the quality of the environment in A Block at Medway Maritime Hospital, the inpatient unit for people from Medway and Swale, which considerable previous efforts had been unable to address within the Medway boundary
- there was concern, that Psychiatric Intensive Care (PIC) was effectively supported in west Kent by an outreach service, which was not available in east Kent and Medway

The proposals discussed with service users, carers, staff and other stakeholders were:

- To move to three 'centres of excellence' for acute inpatients, with each providing:
 - ✓ an excellent acute inpatient mental health service in itself, with a critical mass of staff and opportunities for therapeutic interventions at weekends and into the evening; working in fit for purpose accommodation for safe care and the promotion of recovery.
 - ✓ hubs of good practice with a research programme and the commensurate ability to attract and retain highly qualified, expert and motivated staff.
- To consolidate inpatient psychiatric intensive care in one place and expand its outreach service to cover the whole of Kent and Medway.
- To reduce the overall bed stock slightly and adjust the alignment of patient pathways to ensure patients have more consistent crisis support, whether in the community, provided by the Crisis Resolution Home Treatment teams, or as inpatient care.
- To strengthen community based Crisis Resolution and Home Treatment (CRHT) teams to provide more support to people outside hospital, with an investment of £297,000 in additional CRHT staff from April 2013.

Prior to this consultation, stakeholders, including service users, were consulted in local monitoring and planning meeting groups. The Mental Health Acute Crisis consultation was also discussed at thirteen Locality and Monitoring Groups held in locations in Kent and Medway. The meetings occurred prior to the consultation period (from 1st March 2012 to 22nd May 2012). At the meetings a presentation was given by representatives from KMPT, and attendees were invited to ask questions. Locations and attendance figures are shown below, and the main themes are summarised in Appendix Two.

Date	Location	Catchment Area	Attendees
01 03 2012	Canterbury	East Kent	13
20 03 2012	Thanet	East Kent	19
21 03 2012	Swale	Medway	16
22 03 2012	Ashford	East Kent	12
22 03 2012	Dartford, Gravesham & Swanley	Dartford	17
10 05 2012	Canterbury	East Kent	12
11 05 2012	Maidstone	West Kent	24
17 05 2012	Ashford	East Kent	9
17 05 2012	Thanet	East Kent	19
23 05 2012	Swale	Medway	17
29 05 2012	Dover & Deal	East Kent	15
29 05 2012	Shepway	East Kent	16
31 05 2012	South West Kent	West Kent	14

Table 1. Attendance figures for locality planning and monitoring groups

Summary of Locality Planning and Monitoring Groups

Questions presented during the Locality Planning and Monitoring Groups, largely during meetings held in Ashford, Maidstone, South West and Thanet, centred on the number of beds that will be available in crisis care. Concern was raised in relation to the number of wards that had closed already, and what wards will face closures in the future. The availability of beds and the consequences of when they are not available was raised during other meetings, in addition to whom these beds will cater for. Suggestions and questions were made regarding the relocation of services, the opinion being that old buildings can be refurbished. Travel was highlighted as a potential problem, particularly for residents in Swale and for those living in East Kent having to travel to Dartford. Further questions were focused upon the facilities available to inpatients, gyms, TV's and recreational areas were seen as important features in centres. Safety measures in such facilities were additionally questioned with single rooms perceived to be isolating for service users.

General comments and discussion points were raised across the Locality Planning and Monitoring Groups about the quality of service provision for mental health. In particular GP services were questioned, including their ability to provide mental health referrals and whether experts will be available in surgeries. It was reported that there was a perception that there were gaps in services - especially upon discharge - which service users and carers experienced. Emphasis was made that carers should be supported and provision should be improved to relieve their burden. Their work is vital and should be included in the development of a Code of Practice for staff.

The consultation took place over a 13 week period from 26th July 2012 to 26th October 2012.

2.2. Consulting with members of the public

The consultation was announced on the KMPT website and an online survey could be accessed from that website. The full and summary consultation documents were available on the KMPT website. The consultation was promoted through a series of outreach events (n=15) for members of the public who were invited to complete paper or online surveys. Public meetings (n=8) were held during the consultation period in a range of locations and service users were also specifically consulted through focus groups (n=14). The activity log shows that NHS Kent and Medway invited over 50 organisations from across Kent to take part.

The consultation documents were provided in a variety of formats and languages, including easy read, large print, audio, Braille, Polish, Chinese, Czech, Romanian and Slovak. These documents could be requested via telephone or e-mail and some were available online.

Participants had the option of responding through a paper or an electronic survey. They could also raise their concerns and queries via a telephone line or by letter and email. Members of the public could also attend public meetings to gain clarity and express their views about the acute mental health service changes. NHS Kent and Medway reported that copies of the paper survey were available from all of the outreach events and public meetings as well as GP surgeries, libraries, leisure centres, supermarkets, local mental health charities and other health and social care organisations.

3. The Consultation Proposals

The acute mental health crisis care consultation document stated that the need to consult the public about changes to acute mental health services in Kent and Medway stemmed from a need to provide equal access to good quality care through improving crisis resolution home treatment team provision and developing acute mental health inpatient care.

The survey asked the respondents to consider three main areas regarding acute mental health services. These areas were around reasons for change, improving mental health services and the three main options for where people would receive hospital care. Respondents were also asked to provide some demographical data about themselves.

The options proposed for changing services were:

Option A

Provide beds for:

- People from Medway (as well as Dartford, Gravesham and Swanley) in Dartford
- People from Sittingbourne and Sheppey (as well as Maidstone, Maidstone, Sevenoaks, Tonbridge and Tunbridge Wells) in Maidstone
- People from Faversham (as well as Canterbury, Thanet, Dover, Shepway and Ashford) in Canterbury

Option B

Provide beds for:

- People from Medway and Sittingbourne and Sheppey (as well as Dartford and Gravesham) in Dartford
- People from Swanley (as well as Maidstone, Maidstone, Sevenoaks, Tonbridge and Tunbridge Wells) in Maidstone
- People from Faversham (as well as Canterbury, Thanet, Dover, Shepway and Ashford) in Canterbury

Option C

Provide beds for:

- People from Medway (as well as Dartford, Gravesham and Swanley) in Dartford
- People from Sittingbourne, Sheppey and Faversham (as well as Canterbury, Thanet, Dover, Shepway and Ashford) in Canterbury
- People from Sevenoaks, Tonbridge, Maidstone and Tunbridge Wells in Maidstone

The consultation document outlined the advantages and disadvantages of each option and how they would impact on quality of care, capacity and experience of existing service provision. Respondents were also given the opportunity in the survey to describe what they perceived to be the advantages and disadvantages of each option. There were also questions about what respondents viewed as priorities for acute crisis service and how they felt that services could be improved.

4. Research methods

The survey was a mixture of open and closed questions (see Survey in Appendix One).

Closed questions: These questions were analysed using Statistical Package for Social Sciences (SPSS) – a statistical analysis software package. This allowed us to quantify the number of responses to these questions.

Open-ended responses: The qualitative data gathered in the consultation was analysed using framework analysis. Framework Analysis is a method of analysis developed by the National Centre for Social Researchⁱ, which has become popular in health service-related studies. The advantage of the approach is that it provides systematic and visible stages to the data analysis process. The approach involved five key stages: familiarization; identification of a provisional thematic framework; indexing; charting; and mapping and interpretation. In short, data was read through and common themes in the responses were developed and identified. The codes and the thematic framework were then applied to all responses, including the qualitative data from meetings, outreach and focus groups. The codes were analysed using the statistical software package. The themes identified in the analysis have been compiled in a series of charts.

ⁱ Richie, J & Lewis, J (2006) Qualitative Research Practice: A guide for social science students and researchers. London, Sage.

5. The Public Response

5.1. Survey Findings

The results from the data analysis are presented in this section. The survey consisted of 30 questions - 17 closed questions, 13 open-ended questions and 3 with both open and closed components. There were 207 responses in total to the survey. Over the 13 week period of the consultation 120 respondents chose to complete the paper survey and 87 respondents completed the online survey. The response rate over time is depicted in the graph below.

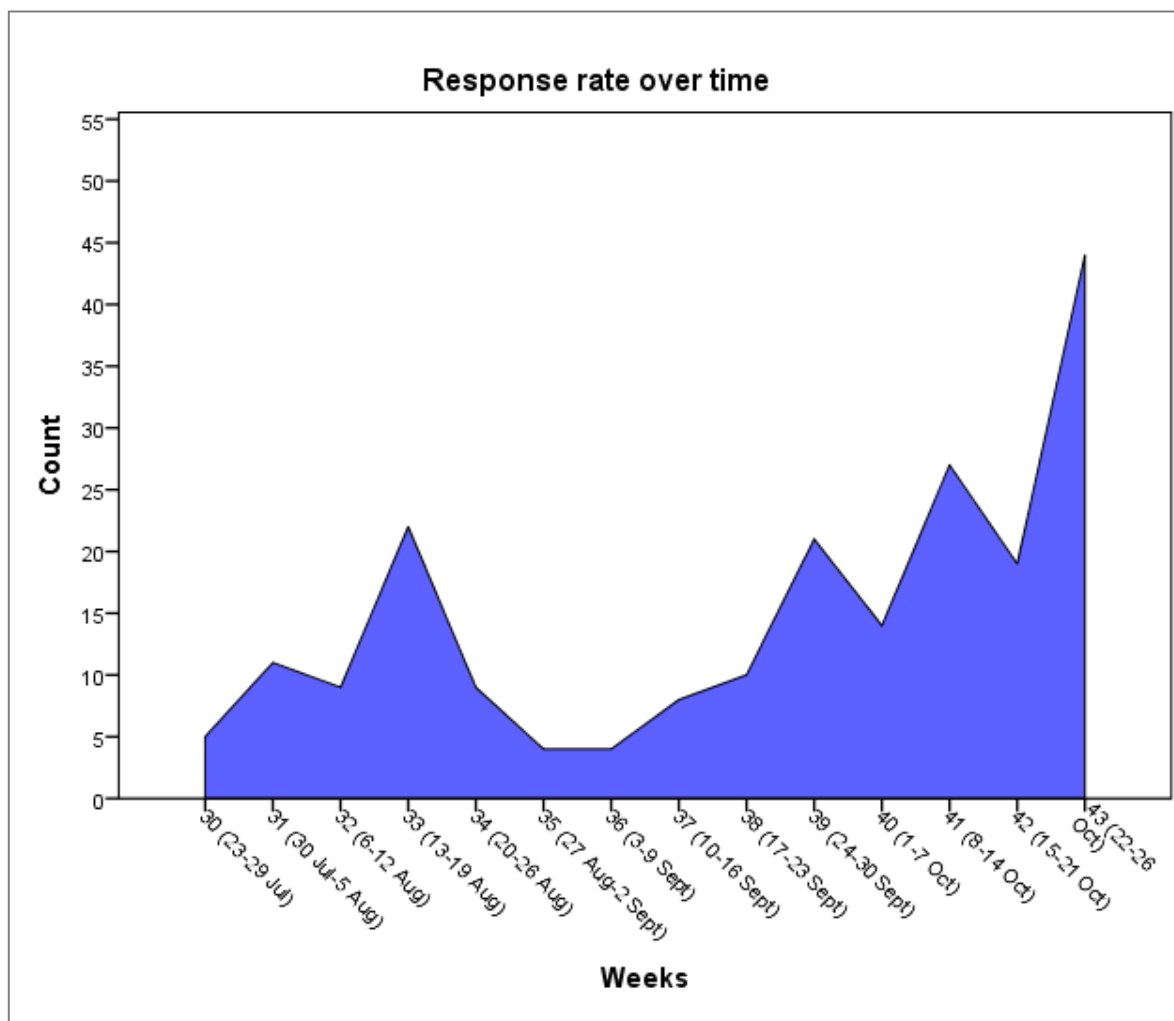


Figure 1. Response rate over time

All respondents were asked to self-report their age, ethnicity etc. using an established set of criteria (Section 'About You' in the survey). The majority of respondents (56%) were current or recent service users, and more than half were aged between 40 and 59. Only 11% of respondents were health or social services staff. 63% of all respondents were female and 88% were either English/Welsh/Scottish/Northern Irish or British. 106 of the respondents reported having a disability of some sort, 42% reported a mental health condition and 37% reported a combination of disabilities. Respondents heard about the consultation in a variety of ways, 21% stated that they heard about the mental health consultation online and 12% at a community meeting, whilst 48% heard about it from an unspecified source.

Distribution of respondents

The survey also asked for the respondents' postcodes. Based on this information the postcodes were then divided by the four current catchment areas for acute mental health inpatients in Kent. The distribution of respondents' postcodes by catchment area is depicted in Figure 2.

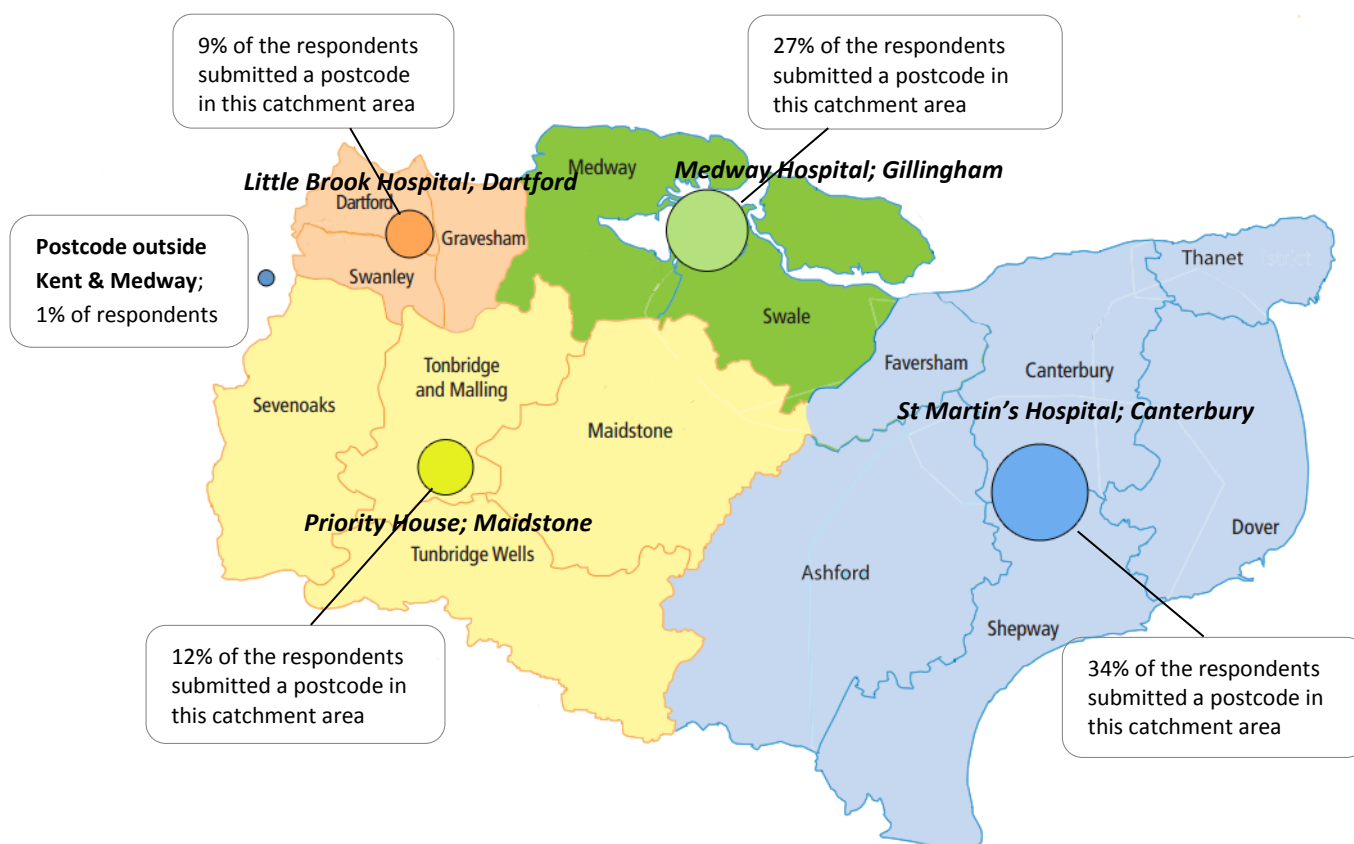


Figure 2. Postcode distribution by catchment area in the survey

When looking at the distribution of the respondents across Kent by catchment area we can see that the majority of respondents (34%) fell within the St Martins Hospital, Canterbury catchment area. Little Brook Hospital Dartford, catchment area had the lowest number of respondents (9%). 17% of the respondents did not provide a postcode.

Section 1: Reasons for change

Respondents in this section were asked their views on why changes to improve acute mental health services were necessary. The results from the closed responses in section 1 (questions 1 to 6) are depicted in graph below. The respondents who chose not to answer these questions are not included in this analysis, which is the reason why the number of responses for each question is different. The responses were represented on a Likert-type scale, where respondents were asked to show their level of agreement or disagreement with the statements presented.

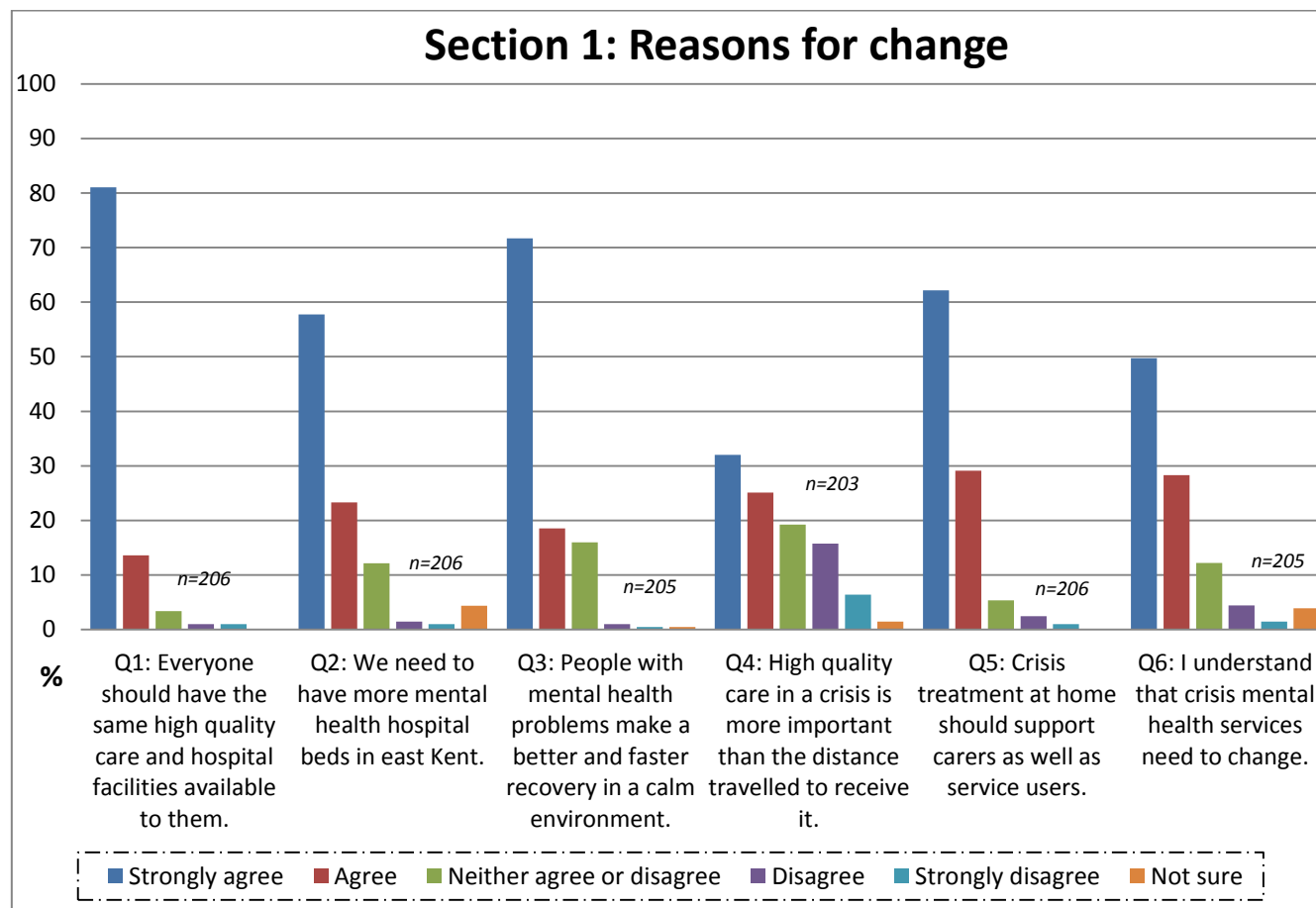


Figure 3. Section 1: Reasons for change

For each question, the majority of respondents strongly agreed or agreed with the statement. However, the strength of agreement was less, when respondents were asked whether “high quality care in a crisis is more important than the distance travelled to receive it”.

The final question in section 1 (question 7) asked “What should be the priorities for crisis mental health services for adults who are severely unwell?” The main priorities identified by respondents were:

22% discussed access (*this included coverage, amount of travel, how local the service was, how quickly the service could be accessed*), e.g. “As a bipolar sufferer and allied health professional working for a mental health service, I strongly believe that accessing help should be quick, whether this is in a hospital or home environment.”

21% discussed appropriate resources (*facilities, financial arrangements, safety, staffing, qualifications, training, numbers of beds*), e.g. “Current staffing levels are not enough to offer quality care”

17% discussed quality of service provision (*organisational improvements, multidisciplinary teams, transition between services, better & more services*), e.g. “Good quality treatment centres with well trained staff”

18% discussed quality of individual care (*this covered support for family and more personalised services*), e.g. “Those working with patients with acute mental health [issues] should seek and take notice of what patients have to say.”

11% discussed community treatment (*mainly care at home*), e.g. “Priority should be to give prompt, effective and satisfactory home treatment to patients and carers of the mentally sick to prevent relapse and minimise recurrent hospitalisation.”

8% discussed hospital treatment (*or inpatient*) e.g. “I would like to see mental health hospitals treating service users, some GPs don’t take mental health patients seriously.”

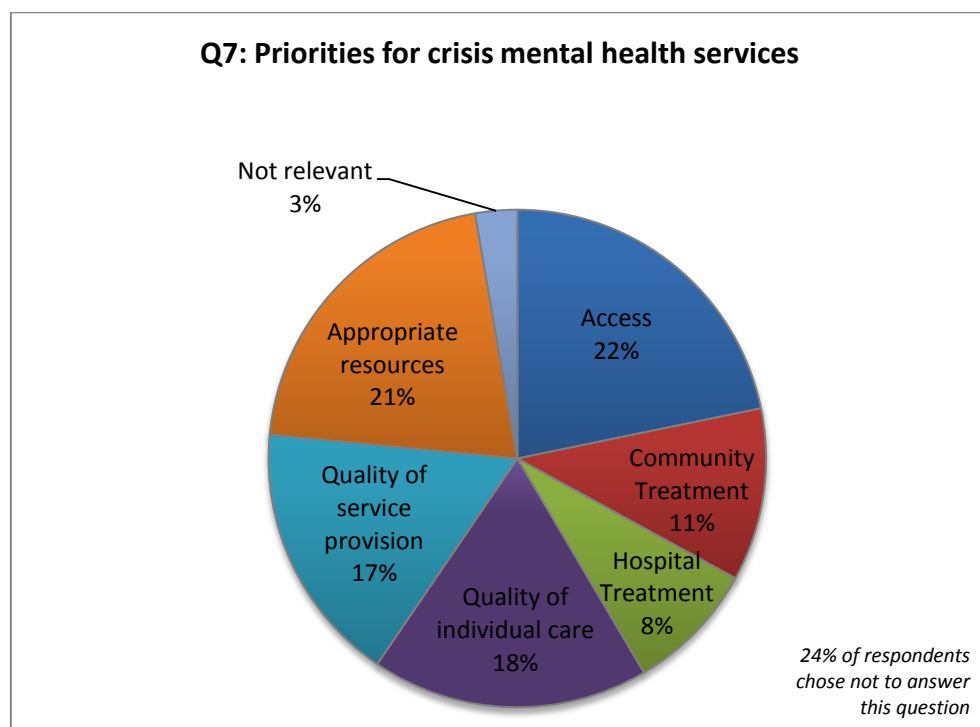


Figure 4. Respondents' opinions on what the priorities for crisis mental health services should be

Section 2: Improving Mental Health Services

This section discussed the improvements in acute Mental Health services respondents would like to see. First, respondents were asked what they would expect from a *Centre of Excellence*.

Centres of Excellence

The majority of respondents strongly agreed that there was a requirement for a better range of staff on call 24/7, better patient experience, a more personal service, modern facilities and single en suite rooms. Most respondents did not associate shorter lengths of stay with Centres of Excellence.

Respondents were also asked to list other ideas about what they expected from Centres of Excellence. The majority of responses (34%) suggested changes to the inpatient environment, e.g.

"I would very much welcome en suites ... walls painted in calm colours ... outside areas with greenery and telephones for service-users to be private."

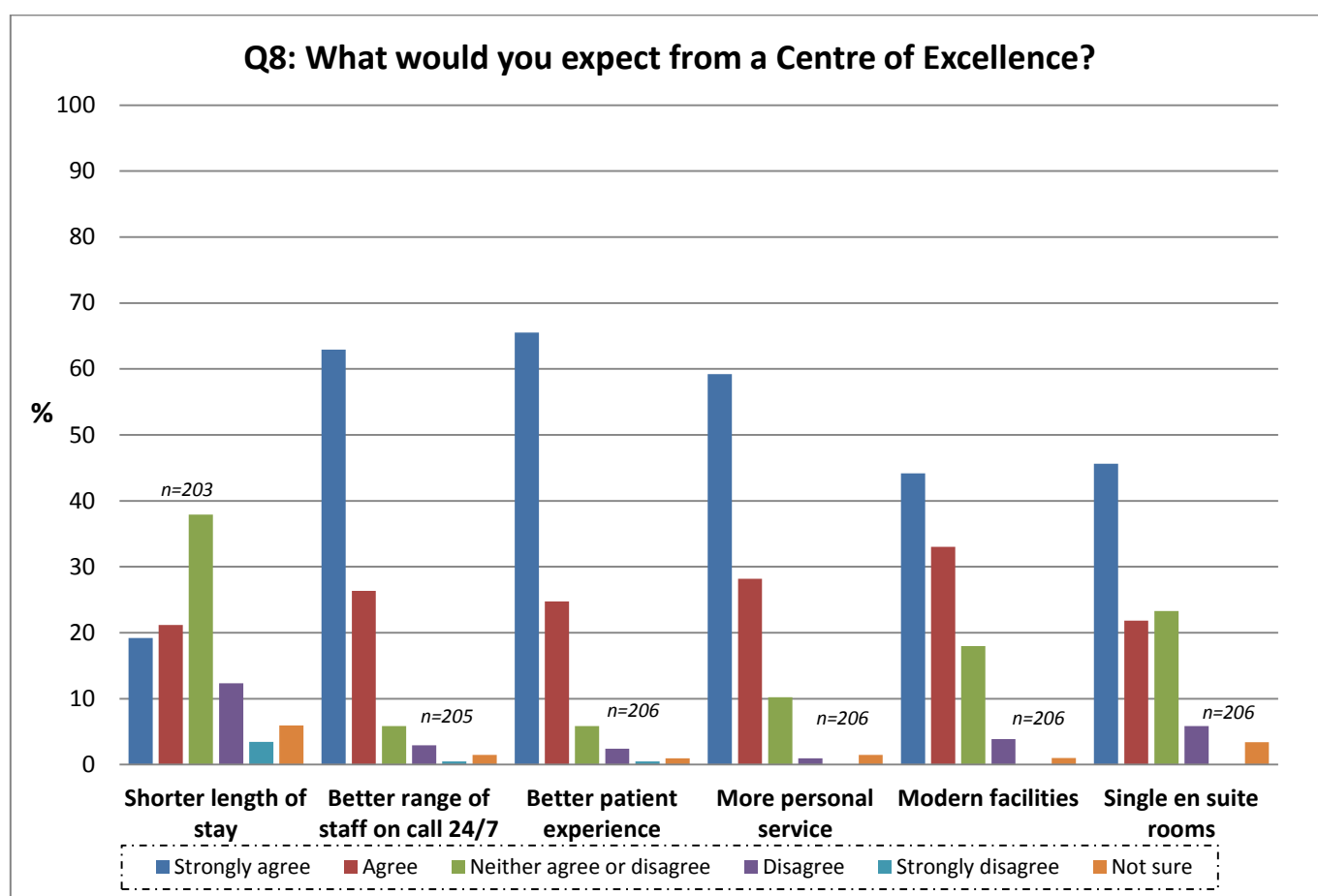


Figure 5. What would you expect from a Centre of Excellence?

Appropriate staffing as well as access to appropriate treatments were also frequently identified (26% respectively) as an expectation from a Centre of Excellence. The importance of information was emphasised by 10% of respondents.

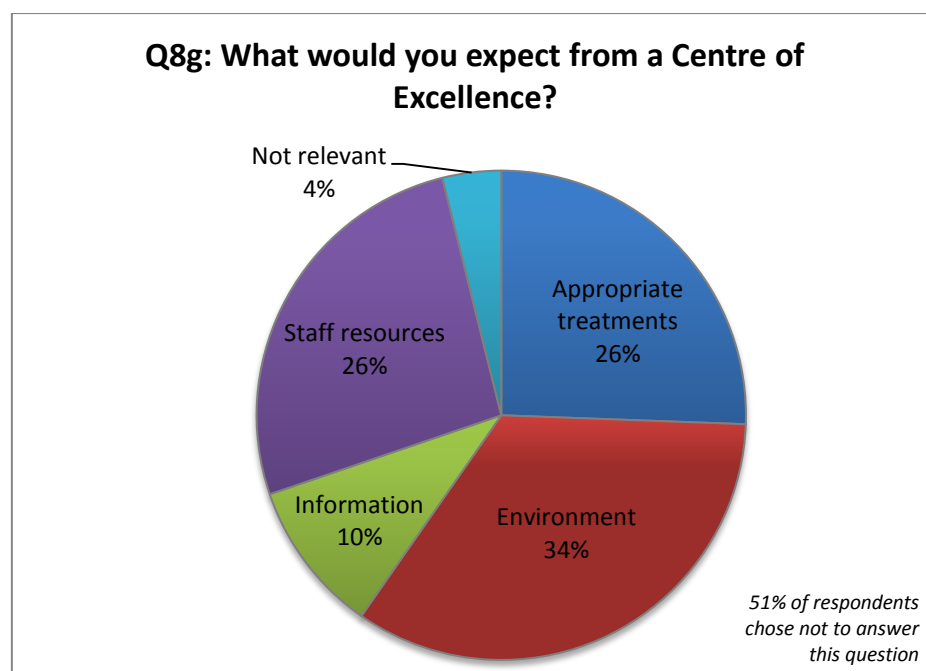


Figure 6. Open-ended question: What would you expect from a Centre of Excellence?

Crisis Teams

Question 9 stated that “extra staff in crisis teams will give more practical support to carers and service users.” And then respondents were asked what else they would expect from a stronger crisis support service.

The majority of respondents (31%) expected an improvement in quality and availability of care as well as more personalised care (20%), e.g:

“When a service user goes into a ward give the main carer a list of things they will need including basics such as pants, night clothes, T-shirts ... It can be such a shock to the carer that they can’t think straight on what the service user might use.”

Staffing, information and communication and continuity of care were also strong themes in the responses.

(chart overleaf)

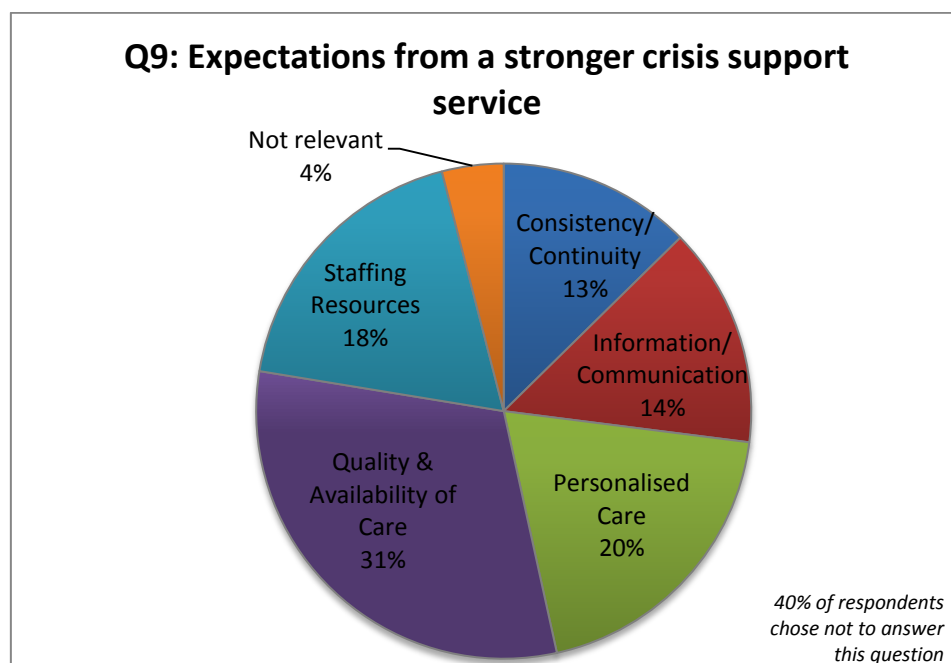


Figure 7. Expectations from a stronger crisis support service

Visitor Travel

Respondents were asked what would be most helpful for people having to travel further to visit people in hospital. Respondents were asked to score which form of help would be least important (scoring 1 point) and most important (scoring 6 points) for them, i.e. how helpful each would be. The categories were well publicised travel information, means to Skype friends and family from each unit, clear signage from bus station to hospital and volunteer transport schemes where there are no buses. The total score given to each category by respondents is shown in the chart below.

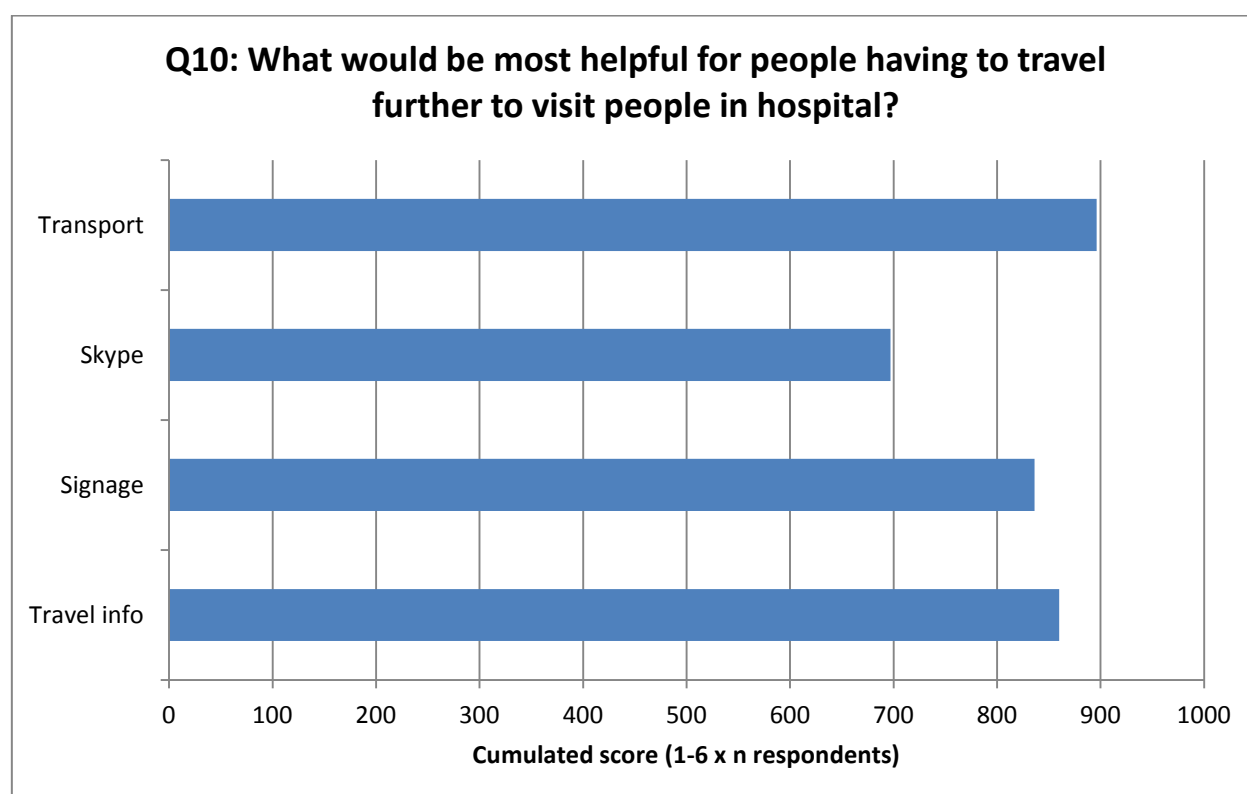


Figure 8. Facilitate visiting

Between 9% and 12% of the respondents chose not to answer one or several of these sub-questions.

Respondents were also asked to provide their own suggestions for help for people having to travel further to visit people in hospital. Responses included flexible visiting and treatment times and the need for adequate information.

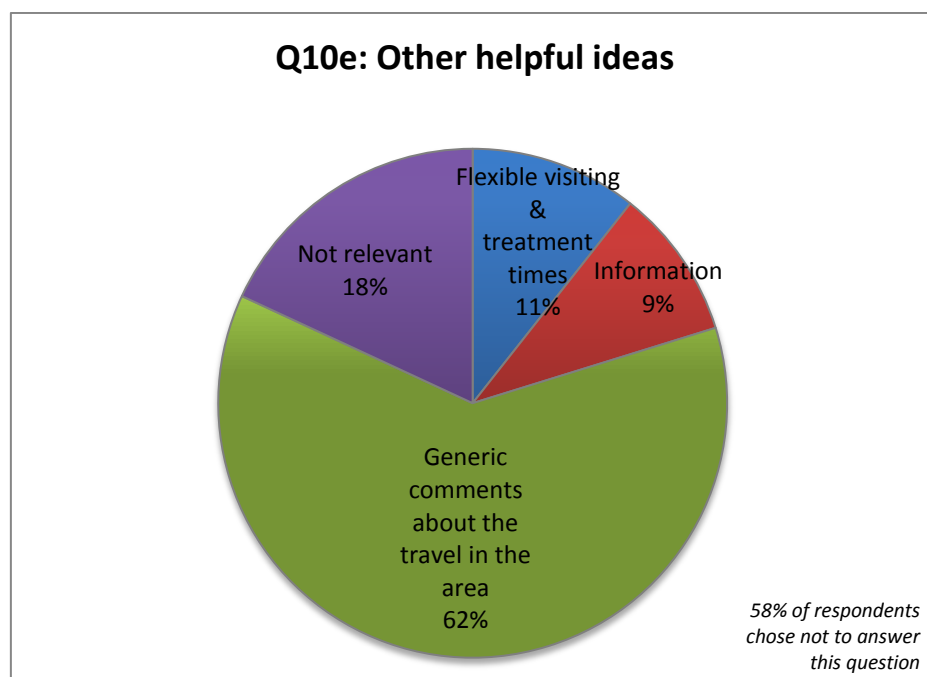


Figure 9. Facilitate visitor travel

Single Care Crisis Pathway

84% of respondents agreed that they would like a single number to call in the event of a crisis. Respondents were also asked to list any other helpful ideas. The chart below summarises their responses.ⁱⁱ

(chart overleaf)

ⁱⁱ This particular question raised some critique in the respondents' answers; some respondents claimed it was impossible to answer since the question itself was two-folded. Hence, the research team cannot draw conclusions as to which of the two questions presented the respondents chose to answer 'Yes' or 'No' to.

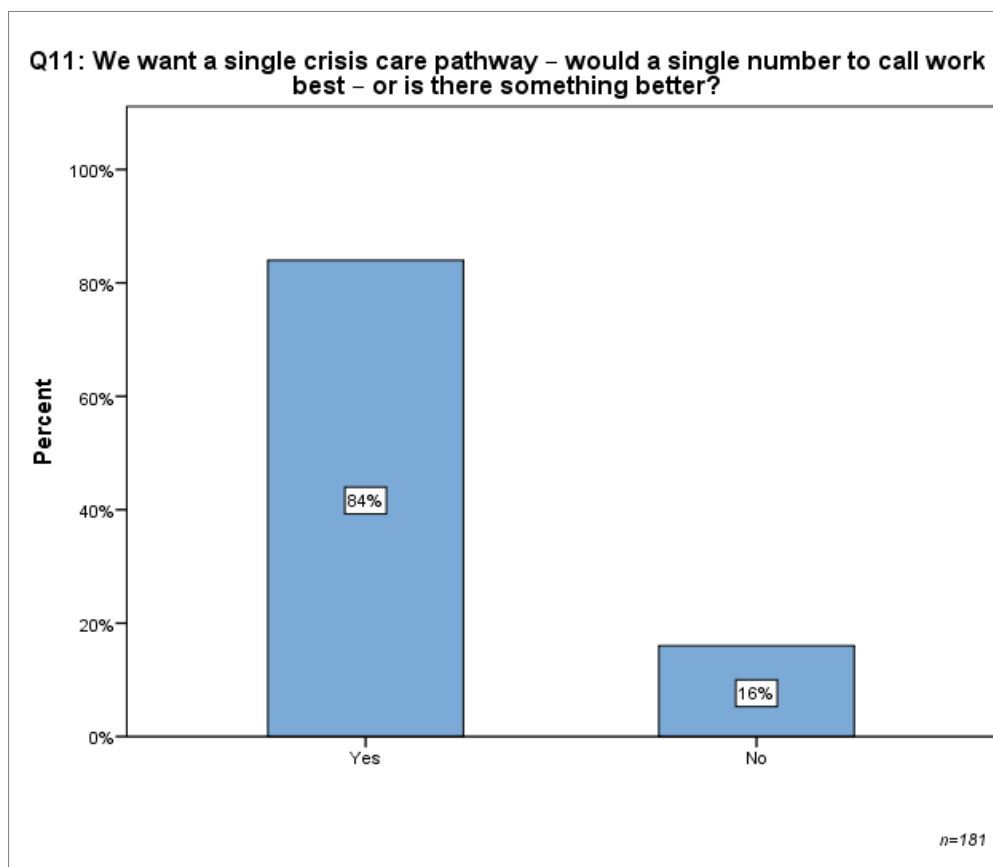


Figure 10. Would a telephone number work best - or is there something better - for a single crisis care pathway?

As we can see the majority of respondents were concerned that the single telephone helpline would not be resourced sufficiently to meet demand - as one respondent commented

“... one number usually means it’s hard to get through.”

22% of respondents also offered alternatives which included:

“Locally-based people on 24 hour call – similar to retained firemen”

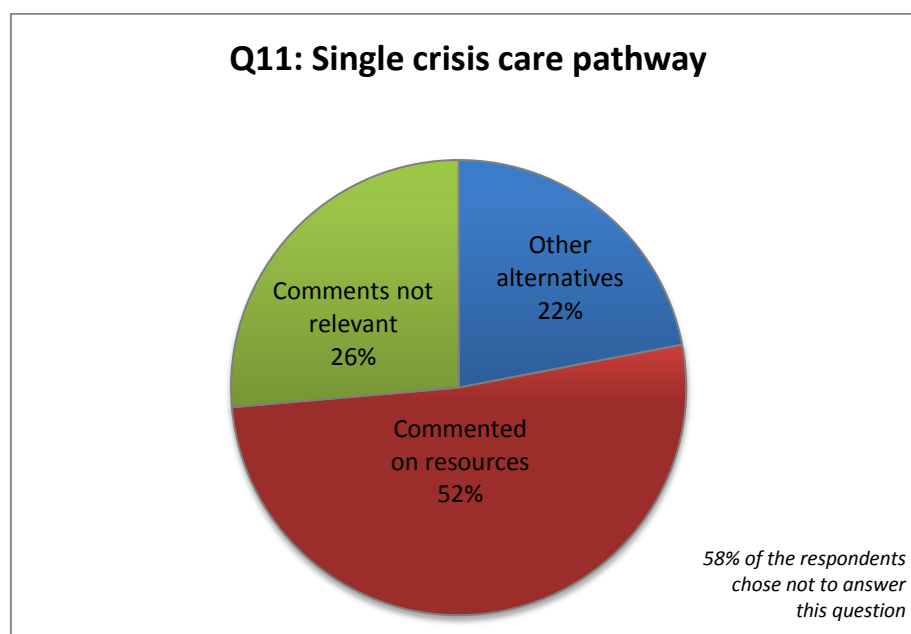


Figure 11. Single crisis care pathway

Excellence in Mental Health Crisis Care

In summing up the section, the survey asked respondents if there was anything else that could be done to achieve excellence in mental health crisis care.

The majority of respondents (35%) commented on quality of care. Information and communication, as well as the need for adequate resources, were mentioned by 23% (respectively) as necessary to achieving excellence. One respondent summed this up:

“Produce a discharge pack with information on where to get on-going support for the service user and carer... Not just from the NHS, but from the voluntary sector as well”

The respondent felt that this should be available for both inpatients and outpatients.

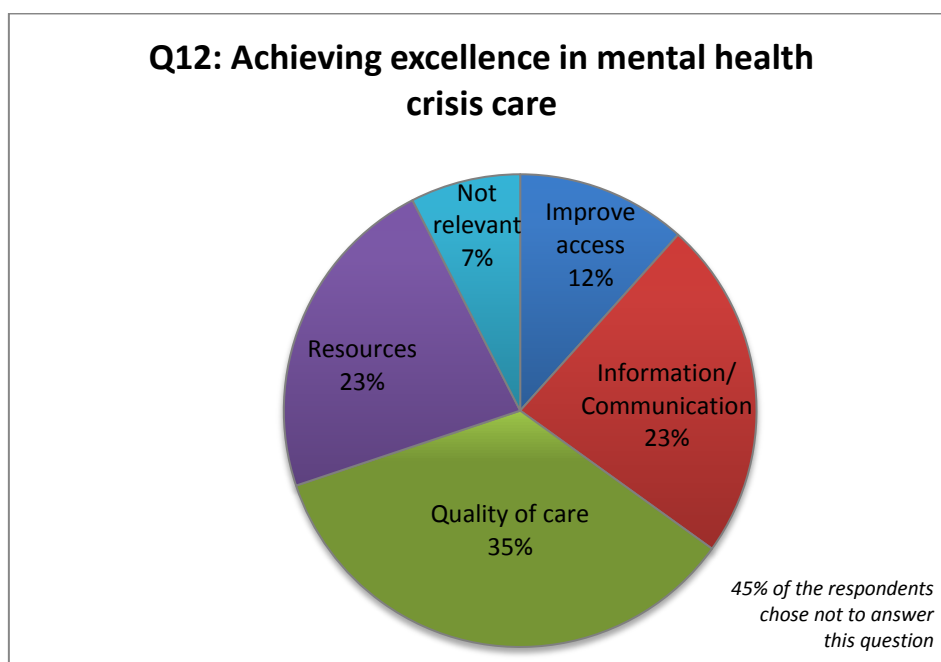


Figure 12. Achieving excellence in mental health crisis care

Section 3: Options for acute mental health services

In section 3 respondents were asked to identify the advantages and disadvantages of each option, having considered those presented in the consultation document. These questions had a low response rate with an average of 66% of respondents choosing not to record any advantages or disadvantages for any of the three options. Additionally, on average 15% of respondents who did respond, responded in a way that was not relevant to the question posed. The overall response rate for these questions was on average 33% of all respondents. Overall, in assessing the options, those who did respond, commented on a relatively small number of issues – travel, resource distribution and quality of care in relation to both advantages and disadvantages.

Option A- Advantages

39% of the responses recorded for the advantages of option A were about travel. These were frequently short answers such as

“Near to my home”

19% of the responses indicated that this option represented a more efficient use of resources.

"More people could be looked after in one place"

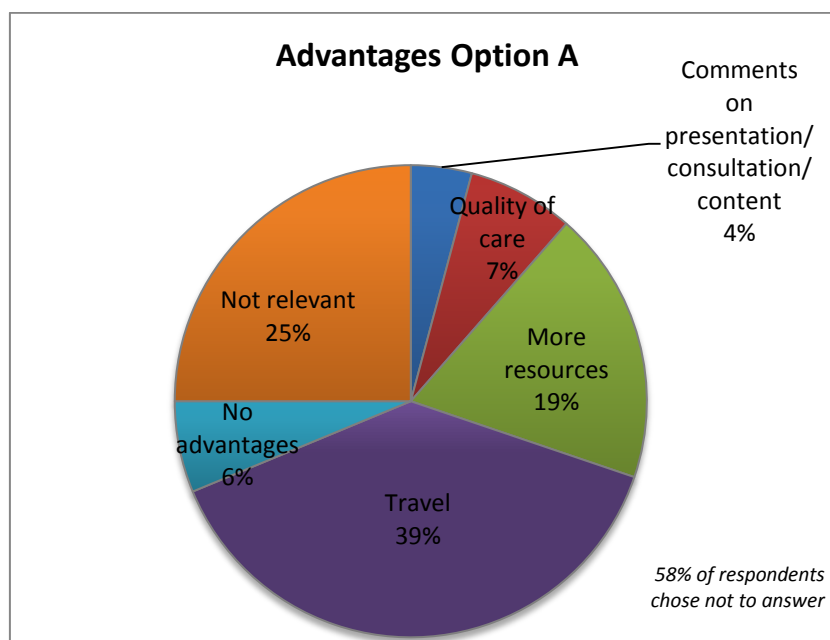


Figure 13. Advantages of Option A

Option A- Disadvantages

58% of respondents viewed the travel associated with this option as a disadvantage

"People from Medway cannot travel to Dartford, thereby increasing their sense of isolation from family and friends at a very low point in their lives"

"No direct trains from Swale to Maidstone"

Additionally, 17% of respondents felt a disadvantage of this option was the distribution and configuration of inpatient resources, which did not represent the most efficient distribution of capacity, with 9% of respondents believing that it could lead to a reduction in the quality of care.

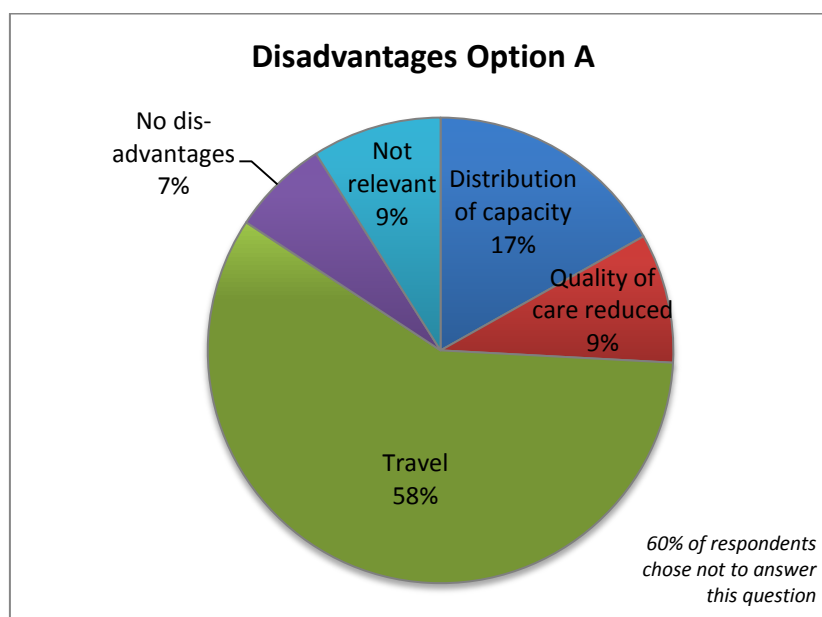


Figure 14. Disadvantages of Option A

Option B – Advantages

22% of respondents felt there were no advantages to this option and another 22% felt it would best meet their travel needs. 21% felt that an advantage of option B was that it was a better use of resources

“Cheaper for KMPT”

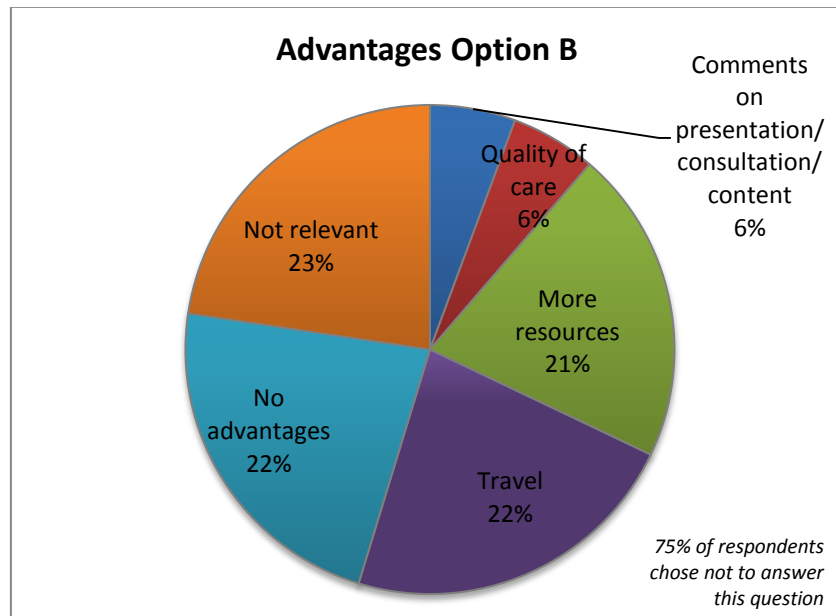


Figure 15. Advantages of Option B

Option B – Disadvantages

67% of respondents saw the impact on travel as a disadvantage of this option, with comments about

“Parents cared for further from home” and

“Further for Sittingbourne/Sheppey patients to travel than in option A”

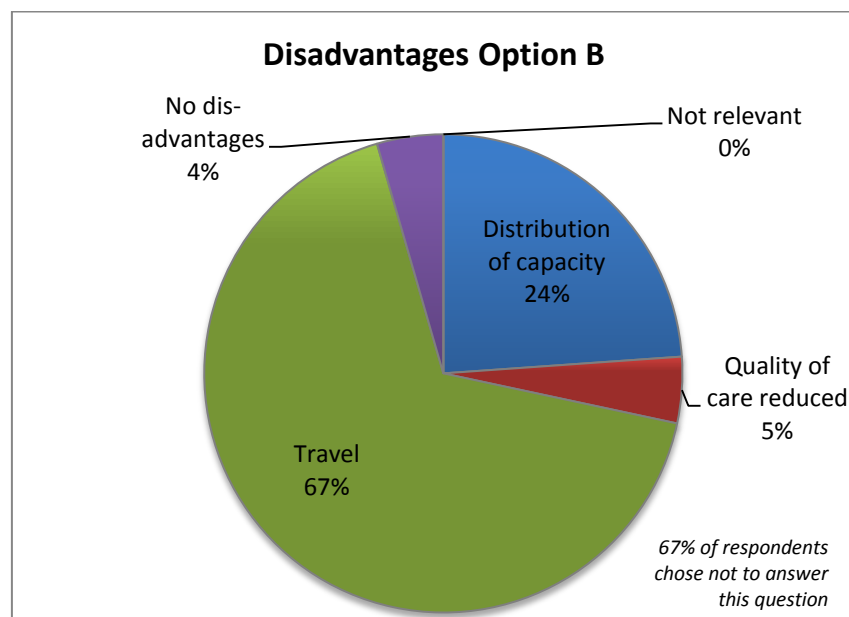


Figure 16. Disadvantages of Option B

Option C – Advantages

31% of respondents felt that Option C would be a good use of resources:

“Less centres, cost less”

29% mentioned that travel could be an advantage

“Less confusion, everyone going to nearest appropriate hospitals rather than unnecessary distance.”

9% of respondents felt that option C would improve quality of care and 14% felt that this option had no advantages.

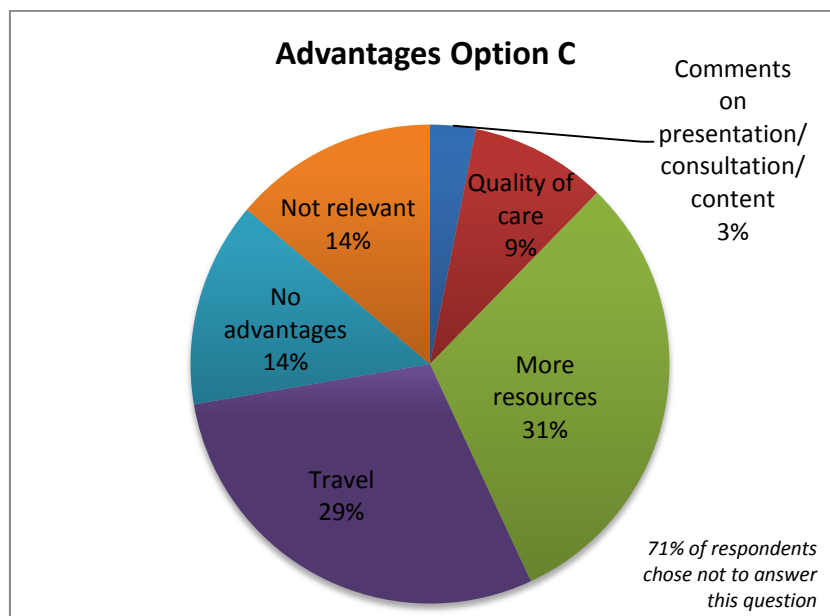


Figure 17. Advantages of Option C

Option C – Disadvantages

36% of respondents saw the main disadvantage of option C as relating to travel

“Once again, a longer distance for some people to have to travel”.

Equally 34% saw this option as a disadvantage in terms of the distribution of mental health service capacity distribution across Kent

“Fewer centres overall”

(chart overleaf)

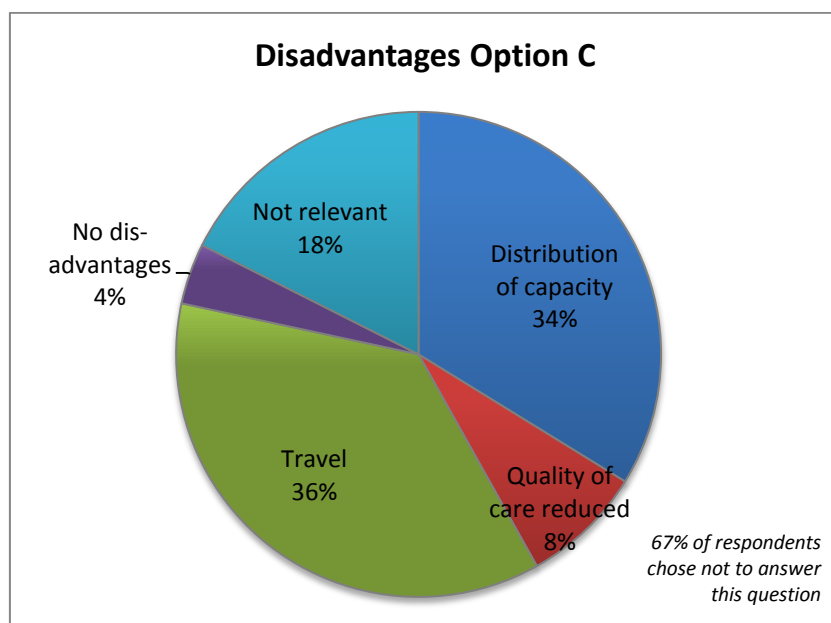


Figure 18. Disadvantages of Option C

The Preferred Option

Respondents were asked to select their preferred option. Of the 207 people who took part in the survey, 141 selected a preferred option and 66 did not select a preferred option. Option A was the preferred option selected by 62% of those who gave a preferred option, option B was preferred by 11% and option C was preferred by 27%.

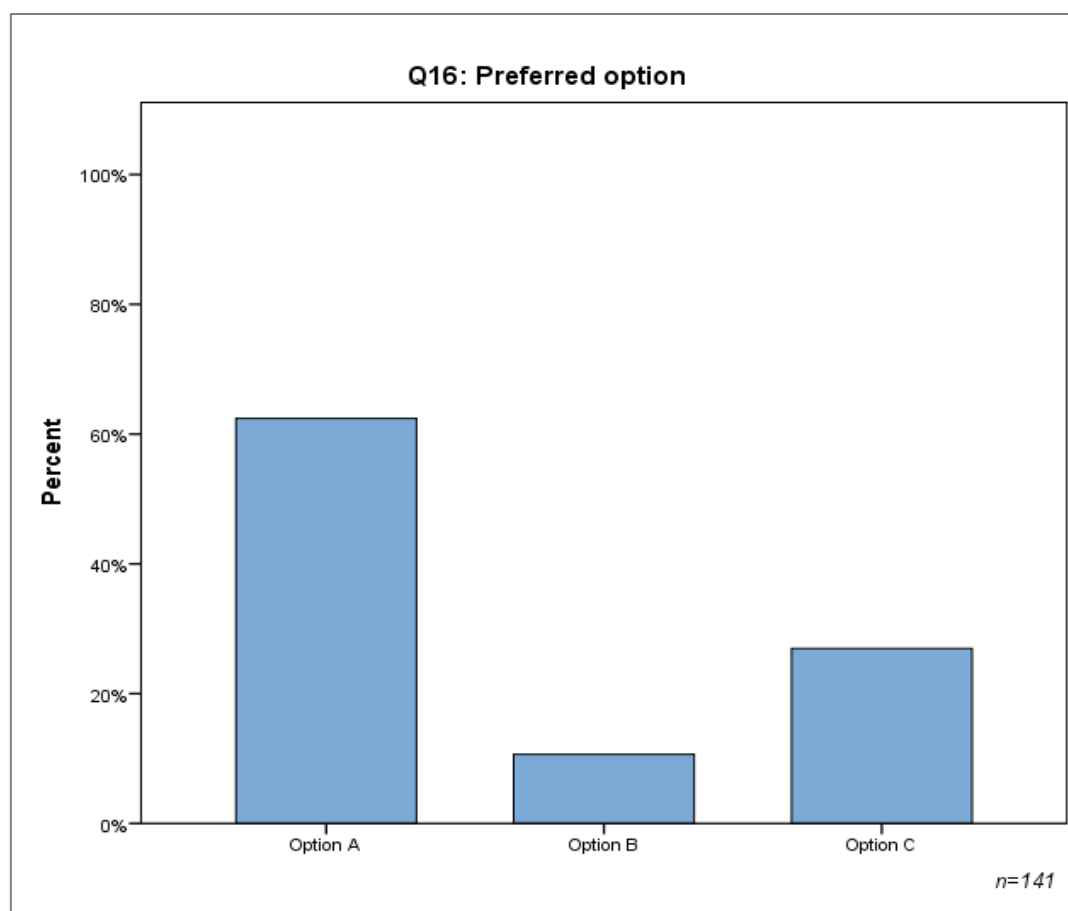


Figure 19. Preferred option

Psychiatric Intensive Care

Respondents were asked to signal their agreement on a Likert scale with the proposal that Dartford's purpose-built Psychiatric Intensive Care unit should serve all of Kent and Medway, with an outreach service to take intensive care to patients in other areas.

Around one third of respondents agreed or strongly agreed with this proposal.

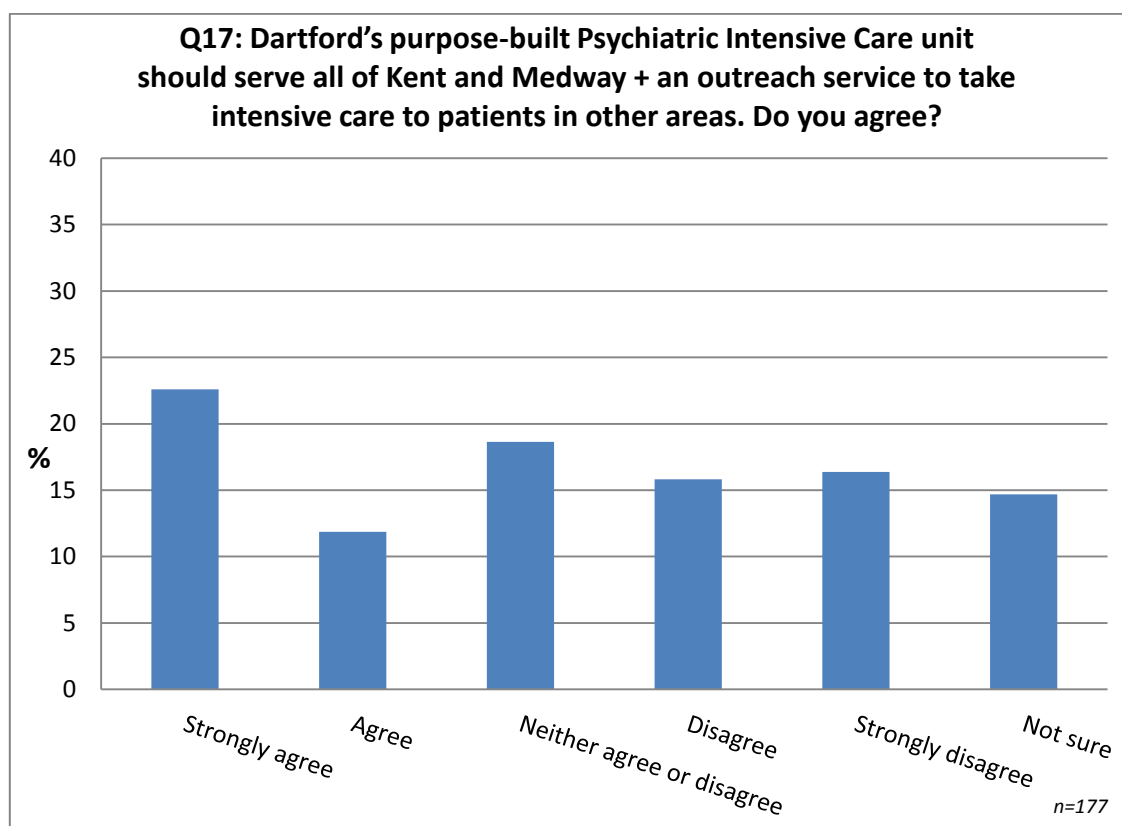


Figure 20. Psychiatric intensive care

Improving Crisis Mental Health Services

At the end of the survey respondents were asked if there was anything else they would like to add about improving crisis mental health services for adults.

The majority of respondents (31%) commented on improving the quality of care.

"CRHT team and the community services which support people need to be stronger, more responsive and give people confidence to cope and be well in the community. Too many stories from carers and service users of no one responding to calls or taking too long or telling people that they are too dependent. Service users are vulnerable by nature of the illness and need more emotional support than this".

"Ensuring that carers are well supported as they will be providing support most of the time--look after them"

Resourcing and access and availability of Mental Health Crisis Services were also discussed.

"We need proper provision in the Medway towns - one of the largest conurbations in Kent"

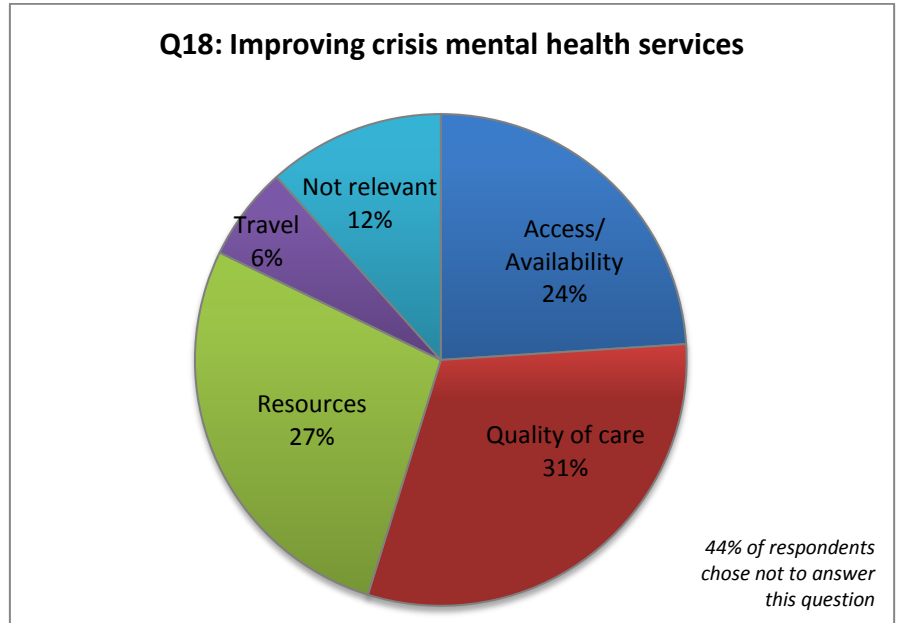


Figure 21. Improving crisis mental health services

Cross-tabulation

In order to explore relationships between the number of respondents in different postcodes and the options they selected, we developed a table showing the options chosen by respondents in different areas.

Postcode * Preferred option Crosstabulation						
			Preferred option			Total
			Option A	Option B	Option C	
Postcode by catchment areas	Little Brook Hospital; Dartford	% within Postcode	64.3%	0.0%	35.7%	100.0%
	Medway Hospital; Gillingham	% within Postcode	70.5%	0.0%	29.5%	100.0%
	St Martin's Hospital; Canterbury	% within Postcode	54.7%	15.1%	30.2%	100.0%
	Priority House; Maidstone	% within Postcode	62.5%	18.8%	18.8%	100.0%
Total		% within Postcode	62.2%	8.7%	29.1%	100.0%

Table 2. Crosstabulation Postcode by catchment area * Preferred option

N.B: Only respondents who provided both their postcode and a preferred option are included in the cross-tabulation.

5.2. Public Meetings

Eight public meetings to discuss the Mental Health Acute Crisis consultation and the options for service provision were held in 7 locations in Kent and Medway, in the period 26th July 2012 to 26th October 2012.

The locations were Sittingbourne and Sheppey for Swale, Swanley, Medway (2 meetings), Ashford and Thanet for East Kent and Maidstone for West Kent. Attendance figures are shown below.

Date	Location	Area	Number of Attendees
10 08 12	Sittingbourne for Swale	Medway	12
04 09 12	Medway 1	Medway	51
18 09 12	Maidstone for West Kent	West Kent	13
28 09 12	Swanley	Dartford	31
02 10 12	Medway 2	Medway	28
04 10 12	Ashford for East Kent	East Kent	13
18 10 12	Thanet for East Kent	East Kent	19
19 10 12	Sheppey for Swale	Medway	17

Table 3. Public Meetings Attendance (absolute numbers)

A tabulated synthesis of the topics discussed can be found in the table in Appendix Two. The data were analysed using the same themes from the analytical framework used to code open ended survey responses. A summary of the main topics discussed at each meeting follows the table. In analysing the public meetings the researchers read and re-read responses. Responses were then read through and a tally was given against themes frequently mentioned. Most responses contained more than one theme - hence, the analysis is a tally of each time a theme was mentioned. The numbers which accompany the themes in Appendix Two, therefore, relate to how frequently a theme was mentioned by respondents as a whole – NOT how many respondents mentioned the theme. For the sake of brevity and clarity, only frequently reported themes are discussed below. The same process was used to analyse the data collected in the focus groups and outreach events in subsequent sections.

Tables tabulating the topics raised at the public meetings can be found in Appendix Two.

A detailed summary of the comments from the public meetings can be found in Appendix Three.

Summary of public meeting findings

This section gives a précis of the issues contained in each of the five most frequently discussed topics in public meetings.

- The main issue raised (n=234 occurrences) in the public meetings related to how resources would be affected by any changes in service provision. Concerns focused on resources, largely the ramifications of service change on current financial arrangements, facilities as well as levels of staffing and patient numbers on wards.
- The impact of any changes on the delivery of mental health service provision was frequently discussed (n=195 occurrences) in the public meetings. Issues arising included how, and what,

improvements would be made to levels of service provision; as well as whether improvements in co-ordination between care sectors would occur under new arrangements for mental health crisis services.

- The availability of care provided – including 24/7 arrangements and more ‘holistic’ approaches looking at the whole of an individual’s needs – was the next most frequently discussed issue (n=155).
- Related to this, attendees at the public meetings frequently discussed issues of individual care (n=131) - issues related mainly to support for carers and families in crisis situations.
- Access, in terms of amount of travel, locality and time taken to travel (for carers and service users) was the next most discussed topic. As we can see, these overlap and reflect the themes raised in the survey data.

5.3. Response from Focus Groups

Thirteen focus groups to discuss the Mental Health Acute Crisis consultation and the options for service provision were held in locations in Kent and Medway, in the consultation period (26th July 2012 to 26th October 2012). The focus groups were conducted by mental health commissioners and the Kent & Medway Engagement Team. Locations and attendance figures are shown below:

Date	Organisation	Location	Area	Number of Attendees
01 10 12	Medway Cyrenians	Gillingham	Medway	7 service users
15 10 12	Monday Hub	Rainham	Medway	6 service users
02 08 12	Herne Bay Umbrella	Herne Bay	East Kent	10 service users
20 08 12	Mental Health Service User Engagement Project	Medway	Medway	13 service users
19 10 12	Ashford Rethink Carers Group	Ashford	East Kent	6 carers
12 10 12	Face of Kent	Sittingbourne	Medway	8 carers
18 09 12	Canterbury Re-think Carers Group	Canterbury	East Kent	15 carers
05 09 12	Thanet Re-think Carers Group	Ramsgate	East Kent	12 carers
07 09 12	Deal Forum	Deal	East Kent	7 service users 2 volunteers
06 09 12	D – A – S – H	Rainham	Medway	8 service users
13 09 12	Rethink Sittingbourne Support Group	Sittingbourne	Medway	10 service users
17 10 12	Speakup CIC Meeting	Dover	East Kent	5 service users 3 workers
25 10 12	Maidstone Voluntary and Community Sector	Maidstone	West Kent	21 members of public

Table 4. Focus group attendance (absolute numbers)

Tables tabulating the topics raised at the focus groups can be found in Appendix Two.

A detailed summary of the comments from the focus groups can be found in Appendix Three.

Summary of focus group findings

The focus groups similarly had several key themes regarding concerns with mental health services, what could be improved and thoughts on the proposed options. Correlating with the public meetings, these areas included: quality of service provision, quality and availability of care, quality of individual care, travel and resources.

While all groups held concerns about travel, for those living in Medway and Swale the proposed changes posed significant challenges, and fears there would be a lack of service provision in the Medway area. Participants in the focus groups agreed that some kind of provision needs to be made to help alleviate issues of cost, distance and time of travelling - especially when travelling via public transport. However, it was stressed that travelling out of the local area causes stress and anxiety for both the patient and carer.

The quality of care and services were felt to be important to the participants in focus groups. While some good experiences of care were cited, including the positive demonstration of a holistic approach, throughout the perception was that improvements can be made. Patients along with carers found it difficult to negotiate the mental health system, often unsure of who to contact and where. As a result service users felt they lacked the required consistent aftercare that they required, with carers feeling put under pressure to provide support as a result of this gap.

Across the focus groups it was felt that mental health services need to be improved throughout with a number of suggestions being given. General organisational improvements to GP services and crisis support were cited; with better signposting to support groups; effective communication between departments and carers; and streamlining of services. It was felt these changes would speed up the assessment of patients and ensure that the correct support for both patient and carer is provided as swiftly as possible - whether this is provided by the NHS or community groups. Additional therapies and support within the hospital setting were welcomed as well as addressing other health needs. It was felt that further out of hours services will ensure that a high standard of care is always available.

Other suggestions included the expansion of staff alongside additional training to equip them with the skills to effectively treat mental health needs. It was argued that with poor levels of staffing, patients do not get the opportunity to develop a relationship with staff that builds a level of trust and consistency, especially vital when patients are living independently. Resources, or the lack of, were reported as being at the centre of many of these problems.

5.4. Response from Outreach Activity

Fifteen outreach events to promote the Mental Health Acute Crisis consultation and the options for service provision were held in 15 locations in Kent and Medway, in the consultation period (26th July 2012 to 26th October 2012). The outreach events were conducted by NHS Kent and Medway engagement staff on behalf of KMPT. Locations and attendance figures are shown overleaf:

Date	Event	Location	Area	Number of Attendees
31 07 12	Mental Health & Wellbeing Community Event	St Paul's Community Centre Thanet	East Kent	10 – 15
22 08 12 03 09 12 03 10 12	Shopping Centre Roadshows	Pentagon (Chatham) and Hempstead Valley (Gillingham) Shopping Centres	Medway	23
06 09 12	Tonbridge & Malling Borough Council Parish Partnership Panel	Gibson Building, West Malling	West Kent	50
31 08 12	Rethink Shepway Support Group	Hythe	East Kent	1
10 09 12	Tonbridge Health Forum	Angel Centre, Tonbridge	West Kent	50
10 09 12	Patient Experience Committee	Maidstone Hospital, Maidstone	West Kent	34
13 09 12	National LGBT Health Summit	University of Kent, Canterbury	East Kent	20
14 09 12	Live it Well Event	Mental Health & Well Being Centre, Tonbridge	West Kent	45
20 09 12	Community Healthy Living Day	TN2 Community Centre, Tunbridge Wells	West Kent	10
02 10 12	Eagle Court Resource Centre	The rear of Eagle Tavern Rochester	Medway	11
22 10 12	Kenward Trust Leadership Team	Kenward Trust Yalding	West Kent	6
25 10 12	The Maidstone Voluntary and Community Sector Focus group	Maidstone Town Hall, Maidstone	West Kent	21
25 10 12	Information stall at opening of new building	St Martins Hospital, Canterbury	East Kent	6

Table 5. Attendance figures at Outreach events

Tables tabulating the topics raised at the outreach events can be found in Appendix Two.

A detailed summary of the comments from the outreach events can be found in Appendix Three.

Summary of Outreach Events

The purpose of the outreach events was to publicise the consultation and distribute consultation documents and surveys. The total number of people engaged was recorded and some comments were noted. Given the informal nature of the events, not all conversation was recorded and comments were not exclusively about the acute crisis mental health services for adults.

The relatively small number of comments recorded were analysed to determine the main areas of concern. Concerns varied by location – in Chatham and Gillingham;

“People asked why a new building could not be built, given that, in time the proposal would probably cost as much money as it would to build a new unit.” and “Support groups from the council are being cut. These are the lifeblood of people with a mental health problem to support them day in, day out”.

Whilst in east Kent access for hospital visiting caused concern;

“if people need to travel by difficult bus route to area they don’t know. Long journeys make it hard for visitors especially if visiting times are fixed and don’t coincide with buses.”

And in west Kent it was questioned;

“Why more Care at Home Nurses would be recruited when charities/voluntary organisations could do this work?”

The distribution of outreach events does not appear to match the distribution of population, with 7 in west Kent (210 attendees), 4 in Medway (34 attendees) and 4 in east Kent (approximately 40 attendees). Pre-consultation and outreach events occurred throughout Kent. Organisations were invited to choose focus groups or outreach events for their area, therefore the pattern reflects requests for outreach events and focus groups, not events planned by NHS Kent & Medway.

5.6. Emails, telephone calls and letters to Kent and Medway Partnership Trust

The researchers were forwarded 28 pieces of correspondence – emails and letters - received by KMPT, relating to the consultation. Seven letters were replies to inquiries by KMPT, these were written by the Head of Service Redesign. One piece of correspondence received by the Trust was a letter from a local MP expressing concern that there was a lack of consultation in east Kent. However, public meetings, outreach events and focus groups had already occurred in the area and an additional public meeting was held in the area to meet demand.

The researchers also received a log of all email enquiries made to KMPT and how these queries were addressed. A few organisations wrote to thank KMPT for inviting them to take part in the consultation. Three letters were received from local charities raising concern that there would be no emergency care for people needing mental health crisis care in Medway. This was reiterated in a letter from a local councillor. Similar to the focus groups and public meetings, these letters also requested that resources for mental health be protected; the need for care to focus on the needs of the patient and concern was expressed about the distances families and carers would have to travel under the new arrangements.

There were multiple pieces of correspondence between one member of the public and KMPT and NHS Kent and Medway commissioners. This member of the public gave a detailed account of flaws which he perceived existed in the clinical case for the consultation. The member of the public was invited to meet with, and met with senior members of the KMPT staff. Commenting on, or assessing the validity of, this member of the public’s assertions is beyond the scope of this report.

6. Summary of findings

Participants in the consultation had a wide range of ways of taking part in the consultation including a paper and online survey, public meetings, focus groups, outreach events and locality meetings, as well as email and phone calls.

There were 207 responses to the survey. Within the survey, there was strong support for the reasons for change amongst respondents. Respondents reported better access as their main priority for acute mental health crisis care. The respondents agreed that they expected the service to have a better range of staff on call 24/7; better patient experience; modernised facilities and better quality of care from centres of excellence. However, they did not necessarily want shorter periods of stay.

Respondents felt that well publicised travel information and the cost of travel were the key issues for those travelling to visit people in hospital. Although respondents reported that they would like a single number to call in the event of a crisis, there were concerns about how the phone line would be staffed. The majority of respondents felt that improving quality of care would help achieve excellence in acute mental health crisis care.

Respondents considered travel issues as the most important issue when weighing up the advantages and disadvantages of each option. Of the 207 people who took part in the survey, 141 selected a preferred option and 66 did not select a preferred option. The preferred option with the strongest response rate amongst the survey respondents was Option A which 62% of the respondents chose. Option C was the next strongest response with 27%. Option B was the preferred option for 11% of the respondents. Recommendations for improving acute mental health crisis services by respondents who wanted to see more resources for services in general; improvements in service provision; and improvement in quality of individual care.

Twenty-one members of the public, 66 mental health service users and 41 carers took part in focus groups. The main themes that emerged from the focus groups related to concerns with mental health services, how they could be improved and thoughts on the proposed options. These areas included: quality of service provision, quality and availability of care, quality of individual care, travel and resources.

166 people attended public meetings – this number was comprised of service users, carers and members of public, as well as representatives from charity, local authority and NHS organisations who had a stake in acute mental health crisis services. The themes emerging correlated with those from the focus groups, with resources - such as the ramifications of service change on current financial arrangements, facilities as well as levels of staffing and patient numbers on wards - being the main themes reported.

Around 290 people attended outreach events, the main concerns raised related to how service changes would affect service provision in local areas. These findings are commensurate with the findings from other methods. The addendum following evaluates the consultation processes and its reach and range.

7. Evaluation of Consultation Process

7.1. Pre-consultation

The consultation processes are governed by legislative requirements under section 242 and 244 of the Public Involvement in Health Act 2007, and guidance from Sir David Nicholson on service reconfiguration and the four tests.”

Requirements under section 242 and 244 of the Public Involvement in Health Act 2007

These requirements relate primarily to:

- **Duty to involve users of health services**

“...section 242(1B) provides that relevant English bodies must involve (whether by consultation or provision of information, or in other ways) users of health services in the planning of the provision of services, the development and consideration of proposals for change in the way services are provided and decisions affecting the operation of services...”

Evaluation: Based on the evidence we have received to date, reported on earlier and below, this requirement is fully met.

- **Reports on consultation**

“This section [242] amends the 2006 Act to impose a duty on Strategic Health Authorities and Primary Care Trusts to report, at times directed by the Secretary of State on consultations they have conducted, or intend to conduct, in relation to commissioning decisions for which they are responsible.”

Evaluation: At this stage (pre-issue of the report) it is not possible to evaluate this requirement fully, as this report provides the main vehicle for informing interested parties of the public view of acute crisis mental health services in Kent.

NHS Reconfiguration guidance and the four tests

There are four tests that any service reconfiguration proposal needs to pass. These are: support from GP commissioners, strengthened public and patient engagement, clarity on the clinical evidence base and consistency with current and prospective patient choice. All four criteria need to be met in order for a public consultation to proceed. This report considers the criteria “strengthening public and patient engagement”.

Evaluation: Evidence is provided of strengthening public and patient engagement in the report. The full consultation document describes the process used to solicit early views and what these were and how they informed the development of options. Based on this evidence the criterion has been met.

7.2. HM Government Code of Practice on Consultation

The codeⁱⁱⁱ sets out the approach the Government will take when it has decided to run a formal, written, public consultation exercise and may be adopted by any public sector organisation. It has seven consultation criteria. These are:

1 When to consult

Formal consultation should take place at a stage when there is scope to influence the policy outcome

Evaluation: The mental health acute crisis care review timetable allows for reporting on the results from the public consultation, before recommendations are made by KMPT to the NHS Cluster board who are the decision making organisations, hence there is sufficient time for the public viewpoint to be fed in to the decision making process.

The survey document stated that;

“No decisions have been taken yet and your views are important in helping us make the right ones”

Based on this evidence the criterion has been met.

2 Duration of the Consultation

Consultations should normally last for at least 12 weeks with consideration given to longer timescales where feasible and sensible.

Evaluation: The public consultation began on 26th July 2012 and ended on 26th October 2012, which is a total of 13 weeks. Based on this evidence the criterion has been met.

3 Clarity of Scope and Impact

Consultation documents should be clear about the consultation process, what is being proposed, the scope to influence and the expected costs and benefits of the proposals

Evaluation: A consultation document was provided, which explained the process and proposals, and gave the respondents the opportunity to comment on the advantages and disadvantages of the options proposed. Affordability is discussed but costs for each option are not included. Based on this evidence the criterion has been largely met. However, the financial consequences of the service redesign will only be apparent when the final decision is made.

4 Accessibility of consultation exercises

Consultation exercises should be designed to be accessible to, and clearly targeted at, those people the exercise is intended to reach

Evaluation: This criterion is evaluated in the reach and range section of this report. See below for further detail. Based on this evidence the criterion has been met.

5 The burden of consultation

Keeping the burden of consultation to a minimum is essential if consultations are to be effective and if consultees' buy-in to the process is to be obtained.

ⁱⁱⁱ HM Government Code of Practice on Consultation can be found on the website:

<http://www.bis.gov.uk/files/file47158.pdf>

Evaluation: The consultation document is 31 pages in length, presented in colour with photographs as well as text. Sections include, the reasons for change, the proposals, what the options are, frequently asked questions and a summary. There is also a 12 page summary document. The survey was 8 pages in length with 17 closed questions, 7 open ended questions and 3 questions with both open and closed components.

The survey was also available online. Other ways of the public providing feedback included emailing comments, attending public meetings, outreach events or focus groups. There were multiple ways of accessing information and responding. Based on this evidence the criterion has been met.

6 Responsiveness of consultation exercises

Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation.

Evaluation: Consultation responses were independently analysed and reported by the University of Greenwich Centre for Nursing and Healthcare Research, to KMPT and NHS Kent and Medway, taking into account the public view. Based on this evidence the criterion has been met. At this stage, we are currently unable to assess the participant feedback mechanisms as this aspect of the consultation process is still pending.

7 Capacity to consult

Officials running consultations should seek guidance in how to run an effective consultation exercise and share what they have learned from the experience.

Evaluation: The consultation exercise was instigated by KMPT and NHS Kent and Medway and conducted by the Citizen Engagement Team, a team which specialises in involving the public in the planning, design and delivery of services for NHS Kent and Medway. The commissioning brief was also informed by the Requirements under section 242 and 244 of the Public Involvement in Health Act 2007 suggesting national guidance had been sought and followed. Based on this evidence the criterion has been met.

7.3. Consultation - Reach and Range

207 people completed and returned the Acute Mental Health Crisis Care Review questionnaire.

Of these 207 people, 87 completed the online survey and 120 returned the paper version of the questionnaire.

Of the 207 respondents:

- 119 (58%) were women
- 63 (30%) were men (5 people preferred not to answer and 20 gave no response at all)
- 106 respondents (51%) identified themselves as having a disability of some kind
- 86 respondents (42%) identified themselves as being Christian, while 51 respondents (25%) preferred not to answer this question or the response was not applicable
- A little less than half of the respondents (47%) were under 50 years of age

Age profile

	Frequency	%
Under 20	1	0.5
20-29	17	9.0
30-39	31	16.4
40-49	39	20.6
50-59	59	31.2
60-69	33	17.5
70-79	8	4.2
80-89	1	0.5
90 years or over	0	0
<i>Total</i>	<i>189</i>	<i>100</i>

18 respondents did not provide an answer

Ethnicity

	Frequency	%
English/ Welsh/ Scottish/ Northern Irish/ British	165	87.8
Gypsy or Irish Traveller	1	0.5
Irish	3	1.6
African	2	1.1
Any other Asian Background	1	0.5
Any other white background	2	1.1
Caribbean	1	0.5
White and Asian	5	2.7
Any other ethnic group	1	0.5
Indian	2	1.1
Prefer not to say	5	2.7
<i>Total</i>	<i>188</i>	<i>100</i>

19 respondents did not provide an answer

Evidence has been provided by NHS Kent and Medway that:

Consultation documents were available in different formats

Paper versions of both the full and summary consultation documents were offered in the following languages - Polish, Czech, Chinese, Romanian and Slovak. Accessibility was provided with Braille, easy read paper or audio versions. All of these could be obtained by telephone or email.

No surveys were received in foreign languages, Braille, audio or easy read formats. The electronic version of the survey on the website was available in the standard format. The survey document invited responses by email.

Consultation documents and paper surveys were widely distributed

Paper copies of the consultation document and surveys were handed out at the outreach events.

Taking Public Views

Public Meetings were held in all catchment areas of Kent & Medway, in all the main towns and city. Each meeting began with an explanation of the consultation and survey made by a representative from KMPT involved in service redesign.

All emails, letters, calls and petitions were recorded and responded to.

7.4. Learning points

Data collection format	Finding	Learning
Electronic Survey	Unlimited space for text in open-ended questions	Paper survey text boxes indicate expected length of response. Capping electronic text at a similar number of words would make the two formats consistent.
Manual and Electronic Survey	Wording of questions ambiguous. Respondents did not know how to answer them (specifically Q10, Q11).	Wording of questions should be neutral. Ranking or a Likert Scale may obviate bias. Two-folded questions avoided. Likert scale response must match question.
Consultation documents in paper and electronic formats	Well-presented and user friendly format	Other consultations would benefit from using a similar format
Manual and Electronic Survey	Analysis of themes provides overview of all responses for each data collection method	Detailed analysis of one specific theme in all questions or one specific aspect of care in all questions provided information to inform service development on that theme/care aspect
Manual and Electronic Survey	12 open ended questions- with each successive question less is written/typed.	Less open ended questions may produce a fuller response in each one
Manual and Electronic Survey	Survey design did not always accommodate research processes that followed e.g. no data coding boxes	Survey design should facilitate processes such as data cleaning, data analysis etc. Positive responses should have a higher nominal value, negative response a low nominal value, e.g. Strongly Agree = 5, Strongly Disagree = 1.
Manual and Electronic Survey	Questionnaires were not numbered prior to distribution.	Numbering questionnaires and logging destination would allow tracking and analysis of locations that produced the highest response
Electronic Data collection tools	File names and content did not match	Consistent pro forma for collecting data from public meetings, focus groups etc.
Mixed method of data collection	Data can be compared across methods to test validity	Collecting data in different formats meant it was possible to compare across data collection methods. Consistency in the findings across methods suggests the findings are robust.

Table 6. Learning points



Pull-out
survey

Achieving excellence in crisis mental health services for adults

We are very interested in hearing your views on the future of crisis mental health services for adults in Kent and Medway.

The way these services are delivered has been transformed in the last few years. Many more people are now treated at home while the number of beds used has been steadily falling for four years. We need to make some changes to our services – both at home and in hospital – to ensure consistent and excellent care for the future.

It is important that we gather opinions from as many people as possible about our proposals to strengthen local crisis resolution and home treatment (CRHT) services and create Centres of Excellence to treat people who have to be admitted to hospital when they are in a mental health crisis.

Please read the consultation document before filling out this survey.

All responses will be analysed by an independent research team and will be considered by NHS Kent and Medway and Kent and Medway NHS and Social Care Partnership Trust.

No decisions have been taken yet and your views are important in helping us make the right ones. Please take a few minutes to answer the questions on the following pages.

Once completed, please return this survey to the freepost address below by **26 October 2012**.

FREEPOST, RRTH-AATU-CYUA
Communications and Citizen Engagement
NHS Kent and Medway
Brook House
Reeves Way
Whitstable
KENT CT5 3DD

You can also complete the survey online at www.kmpt.nhs.uk/acute-mental-health-review, email your comments to consultation@kmpt.nhs.uk or call us on 0800 587 6757 for more information. You can also get updates on the consultation by following us on Twitter @kmptnhs or using the hashtag #acuteMHreview.

NHS Kent and Medway | Kent and Medway NHS and Social Care Partnership Trust

Having read the consultation document and considered why we need to improve mental health services for adults who are acutely unwell, please tell us how strongly you agree or disagree with the statements below:

☐ (1) Strongly agree	☐ (2) Agree	☐ (3) Neither agree nor disagree	☐ (4) Disagree	☐ (5) Strongly disagree	☐ (6) Not sure
---	------------------------------------	---	---------------------------------------	--	---------------------------------------

☐ (1) Strongly agree	☐ (2) Agree	☐ (3) Neither agree nor disagree	☐ (4) Disagree	☐ (5) Strongly disagree	☐ (6) Not sure
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☐ (1) Strongly agree	☐ (2) Agree	☐ (3) Neither agree nor disagree	☐ (4) Disagree	☐ (5) Strongly disagree	☐ (6) Not sure
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☐ (1) Strongly agree	☐ (2) Agree	☐ (3) Neither agree nor disagree	☐ (4) Disagree	☐ (5) Strongly disagree	☐ (6) Not sure
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☐ (1) Strongly agree	☐ (2) Agree	☐ (3) Neither agree nor disagree	☐ (4) Disagree	☐ (5) Strongly disagree	☐ (6) Not sure
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☐ (1) Strongly agree	☐ (2) Agree	☐ (3) Neither agree nor disagree	☐ (4) Disagree	☐ (5) Strongly disagree	☐ (6) Not sure
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Section 2: Please help us to improve mental health services

8. What would you expect from a Centre of Excellence?

Shorter length of stay?

☐ (1) Strongly agree	☐ (2) Agree	☐ (3) Neither agree nor disagree	☐ (4) Disagree	☐ (5) Strongly disagree	☐ (6) Not sure
---	------------------------------------	---	---------------------------------------	--	---------------------------------------

Better range of staff on call 24/7

☐ (1) Strongly agree	☐ (2) Agree	☐ (3) Neither agree nor disagree	☐ (4) Disagree	☐ (5) Strongly disagree	☐ (6) Not sure
---	------------------------------------	---	---------------------------------------	--	---------------------------------------

Better patient experience

☐ (1) Strongly agree	☐ (2) Agree	☐ (3) Neither agree nor disagree	☐ (4) Disagree	☐ (5) Strongly disagree	☐ (6) Not sure
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More personal service?

☐ (1) Strongly agree	☐ (2) Agree	☐ (3) Neither agree nor disagree	☐ (4) Disagree	☐ (5) Strongly disagree	☐ (6) Not sure
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Modern facilities

☐ (1) Strongly agree	☐ (2) Agree	☐ (3) Neither agree nor disagree	☐ (4) Disagree	☐ (5) Strongly disagree	☐ (6) Not sure
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Single en suite rooms

☐ (1) Strongly agree	☐ (2) Agree	☐ (3) Neither agree nor disagree	☐ (4) Disagree	☐ (5) Strongly disagree	☐ (6) Not sure
---	------------------------------------	---	---------------------------------------	--	---------------------------------------

Please list any other helpful ideas:

9. Extra staff in crisis teams will give more practical support to carers and service users. What else would you expect from a stronger crisis support service?

Please list any other helpful ideas:

10. What would be most helpful for people having to travel further to visit people in hospital?

(1 = least important i.e. strongly disagree and 6 = most important i.e. strongly agree)

Well publicised travel information	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Clear signage from bus station to hospital	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
A means to Skype friends and family from each unit	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Volunteer transport scheme where there are no buses	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Please list any other helpful ideas:

11. We want a single crisis care pathway – would a single number to call work best – or is there something better?

☐ Yes	☐ No
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Please list any other helpful ideas:

12. Is there anything else we should be doing to achieve excellence in mental health crisis care?

Please list any other helpful ideas:

Section 3: Options for hospital beds

In our consultation documents we have set out what we think are the advantages and disadvantages of each option, now we want you to tell us what YOU think are the main advantages and disadvantages for each option.

Option A (summary)

Provide beds for:

- People from Medway (as well as Dartford, Gravesham and Swanley) in Dartford
- People from Sittingbourne and Sheppey (as well as Maidstone, Maidstone, Sevenoaks, Tonbridge and Tunbridge Wells) in Maidstone
- People from Faversham (as well as Canterbury, Thanet, Dover, Shepway and Ashford) in Canterbury

13(a) Advantages:

13(b) Disadvantages:

Option B (summary)

Provide beds for:

- People from Medway and Sittingbourne and Sheppey (as well as Dartford and Gravesham) in Dartford
- People from Swanley (as well as Maidstone, Maidstone, Sevenoaks, Tonbridge and Tunbridge Wells) in Maidstone
- People from Faversham (as well as Canterbury, Thanet, Dover, Shepway and Ashford) in Canterbury

14(a) Advantages:

14(b) Disadvantages:

Option C (summary)

Provide beds for:

- People from Medway (as well as Dartford, Gravesham and Swanley) in Dartford
- People from Sittingbourne, Sheppey and Faversham (as well as Canterbury, Thanet, Dover, Shepway and Ashford) in Canterbury

15(a) Advantages:

15(b) Disadvantages:

16. Having considered the three options, please tick your preferred option from the three listed.

(Select only one option)

☐ Option A	☐ Option B	☐ Option C
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17. We propose Dartford's purpose-built psychiatric intensive care unit should serve all of Kent and Medway, with an outreach service to take intensive care to patients in other areas. Do you agree with this approach?

☐ (1) Strongly agree	☐ (2) Agree	☐ (3) Neither agree nor disagree	☐ (4) Disagree	☐ (5) Strongly disagree	☐ (6) Not sure
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18. Is there anything else you would like to add about improving crisis mental health services for adults?

Section 4: Monitoring, about you

Please tell us about you. All information will be kept secure and the results will be anonymous.

19. Where did you hear about the mental health review:

☐ Online	☐ Newspaper or other media
☐ At a community meeting	☐ A local newsletter
☐ From a friend	☐ Social networking websites (e.g. Facebook)
☐ Other. Please state:	

20. Are you:

☐ A current or previous mental health service user	☐ A carer or family member of someone using mental health services
☐ A member of the general public	☐ Health or social services staff member
☐ Representative from an organisation	☐ Other (please state)

If you represent an organisation please state the name:

21. What is your postcode?

22. Please give your age group

☐ Under 20	☐ 20-29	☐ 30-39
☐ 40-49	☐ 50-59	☐ 60-69
☐ 70-79	☐ 80-89	☐ 90 years or over

23. What is your gender?

☐ Male	☐ Female
☐ Transgender	☐ Prefer not to say

24. What is your ethnic group?

☐ English/ Welsh / Scottish / Northern Irish / British	☐ Bangladeshi
☐ Irish	☐ Chinese
☐ Gypsy or Irish Traveller	☐ Any other Asian background Please state:
☐ Any other white background Please state:	☐ African
☐ White and Black Caribbean	☐ Caribbean
☐ White and Black African	☐ Any other Black / African / Caribbean background. Please state:
☐ White and Asian	☐ Arab
☐ Any other mixed / multiple ethnic group background. Please state:	☐ Any other ethnic group. Please state:
☐ Indian	☐ Prefer not to say
☐ Pakistani	

25. Which option best describes your sexual orientation:

☐ Heterosexual (straight)	☐ Bisexual
☐ Gay	☐ Lesbian
☐ Prefer not to say	

26. Do you consider yourself to have any of the following:

☐ Long-term illness	☐ Mental health condition
☐ Physical disability or impairment	☐ Learning disability or difficulty
☐ Other disability or long term condition	

27. What is your religion? (For example Buddhist, Christian, none, prefer not to say)

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Thank you for your comments. The information compiled from all responses will be one of the key pieces of evidence that the NHS considers when making decisions about next steps.

APPENDIX TWO: *Locality planning and monitoring groups, focus groups, public meetings and outreach events*

Locality planning and monitoring groups

Themes	Ashford 22 nd March	Ashford 17 th May	Dartford, Gravesham & Swanley 22 nd March	Dover & Deal Locality 29 th May	Canterbury 1 st March	Canterbury 10 th May	Maidstone 11 th May	Shepway 29 th May	South West Locality, 31 st May	Swale 21 st March	Swale 23 rd May	Thanet 20 th March	Thanet 17 th May	Total
Access (coverage, travel, local, speed)	(0)	(0)	(0)	(0)	/	/	(0)	(0)	(0)	(0)	////	(0)	/	7
Community Treatment (home)	/	(0)	(0)	(0)	(0)	(0)	(0)	/	(0)	/	(0)	(0)	(0)	3
Hospital Treatment (inpatient)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	//	(0)	(0)	(0)	(0)	(0)	2
Quality of Individual Care (support for family, personalised services)	/	//	(0)	(0)	(0)	(0)	//	(0)	/	//	(0)	(0)	/	9
Quality of Service Provision (organisational improvements, multidisciplinary teams, transition between services, better & more services)	(0)	///	/	///	(0)	/	(0)	/	(0)	///	/	/	(0)	14
Resources (facilities, financial, safety, staff, qualifications, training, beds)	///	(0)	/	(0)	(0)	(0)	//	(0)	//	///	/	///	(0)	15

Appropriate Treatments <i>(continuity, length)</i>	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0
Environment	/	//			//	//								7
	(1)	(2)	(0)	(0)	(2)	(2)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	
Consistency/ Continuity	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0
Information/ Communication	(0)	/	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	1
	(1)													
Personalised Care <i>(working with family/carers)</i>	(0)	(0)	(0)	(0)	(0)	(0)	//	(2)	(0)	/	(1)	(0)	(0)	3
Quality and Availability of Care <i>(access, 24/7 care, aftercare, holistic treatment)</i>	(0)	/	(0)	(0)	(0)	/	(0)	(1)	(0)	/	//	(2)	(0)	6
	(1)					(1)				(0)			(0)	
Flexible Visiting and Treatment Times	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0
Travel <i>(costs, distance, practical support)</i>	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	//	(2)	(0)	2
Distribution of Capacity <i>(bed closures, fewer beds in new centres)</i>	/	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	/	///	/	6
	(1)										(0)	(3)	(1)	
Crisis Care <i>(availability, support, quality)</i>	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0

Table 7. Topics raised at locality planning and monitoring groups

Public Meetings

Theme	Swale	Swanley	Medway (2)	Ashford	Thanet	Sheppey	West Kent	Medway (1)	Total
Access <i>(coverage, travel, local, speed)</i>	//////////////// //////////////// (10)	//////////////// /// (13)	//////////////// //// (15)	//////////////// (10)	//////////////// / (11)	//////////////// //////// (19)	//////////////// /// (13)	//////////////// //////// //////// (26)	117
Community Treatment <i>(home)</i>	//////////////// // (12)	//////////////// (9)	//////////////// // (12)	//// (4)	//////////////// (10)	//// (6)	//////////////// //////// / (21)	//////// (8)	82
Hospital Treatment <i>(inpatient)</i>	//////// (8)	//////// (8)	// (2)	/ (1)	/// (3)	// (2)	/// (3)	//////// (8)	35
Quality of Individual Care <i>(support for family, personalised services)</i>	//////////////// //////// (18)	//////////////// // (12)	//////////////// /// (13)	//////////////// /// (13)	//////// (9)	//////////////// //////// / (20)	//////////////// //////// / (21)	//////// //////// //// (25)	131
Quality of Service Provision <i>(organisational improvements, multidisciplinary teams, transition between services, better & more services)</i>	//////////////// //////////////// /// (24)	//////////////// //////// //// (27)	//////////////// //////// / (21)	//////////////// //////// / (21)	//////////////// //////// //// (26)	//////////////// //////// //// (25)	//////////////// //////// /// (23)	//////// //////// //////// (28)	195

Theme	Swale	Swanley	Medway (2)	Ashford	Thanet	Sheppey	West Kent	Medway (1)	Total
Resources <i>(facilities, financial, safety, staff, qualifications, training, beds)</i>	///////// ///////// ///	///////// ///////// ///////// ////	///////// ///////// /////////	///////// ///////// ////	///////// ///////// ////	///////// ///////// 	///////// ///////// ///////// /////////	///////// ///////// ///////// /////////	234
Appropriate Treatments <i>(continuity, length)</i>	// (2)	// (2)	/ (1)	 (0)	/ (1)	/ (1)	/// (3)	//// (5)	15
Environment	/// (4)	///////// ///////// (9)	/ (1)	/// (3)	///////// (10)	///////// (9)	///////// /// (13)	///////// ///////// /// (23)	72
Consistency/Continuity	 (0)	///////// (7)	/ (1)	///////// (7)	//// (4)	//// (4)	///////// (6)	//// (5)	34
Information/ Communication <i>(for service users/carers/family, listening, publicity)</i>	// (2)	///////// ///////// (8)	//// (5)	///////// (8)	///////// (9)	///////// /// (13)	///////// /// (13)	//// (6)	64
Personalised Care <i>(working with family/carers)</i>	//// (6)	///////// (11)	///////// (9)	 (0)	 (0)	 (0)	///////// (10)	/ (1)	37

Theme	Swale	Swanley	Medway(2)	Ashford	Thanet	Sheppey	West Kent	Medway(1)	Total
Quality and Availability of Care <i>(access, 24/7 care, aftercare, holistic treatment)</i>	////////// ////////// /////	////////// ////////// /////	////////// ////	////////// /	////////// //////////	////////// //////////	////////// ///	////////// ////////// ///	155
Flexible Visiting and Treatment Times	(0)	/	/	(0)	(0)	(0)	//	//	6
Travel <i>(costs, distance, practical support)</i>	////////// (8)	////////// ////////// ////	////////// ///	///	////////// //////////	////////// ///	////////// ////	////////// ////////// ////	123
Distribution of Capacity <i>(bed closures, fewer beds in new centres)</i>	////////// (8)	///	////	////////// (9)	////	///	////////// (7)	////////// (7)	47
Crisis Care <i>(availability, support, quality)</i>	////////// (9)	////////// (9)	////////// (8)	////////// (10)	////	////	////////// ///	////////// (9)	69

Table 8. Topics raised at public meetings

Focus groups

Themes	Deal Forum	Margate Forum	D-A-S-H, Millennium Centre Rainham	Speakup CIC Meeting, Dover	Re-Think, Phoenix House, Sitting-bourne	FACES of Kent, Sitting-bourne	MH Service User Engagement Project	Rethink Ashford	Canterbury Umbrella Centre	Herne Bay Umbrella Centre	Parkwood, Rainham	Medway Cyrenians, Gillingham	Thanet Carers, The Beacon Ramsgate	Total
Access (coverage, travel, local, speed)	(0)	(1)	(4)	(0)	(3)	(2)	(0)	(0)	(2)	(3)	(1)	(2)	(2)	20
Community Treatment (home)	(1)	(1)	(0)	(5)	(0)	(0)	(0)	(4)	(0)	(1)	(3)	(1)	(0)	16
Hospital Treatment (inpatient)	(1)	(1)	(0)	(2)	(0)	(1)	(0)	(1)	(1)	(1)	(0)	(1)	(1)	10
Quality of Individual Care (support for family, personalised services)	(4)	(4)	(3)	(3)	(0)	(5)	(2)	(5)	(3)	(4)	(1)	(5)	(8)	47
Quality of Service Provision (organisational improvements, multidisciplinary teams, transition between services, better & more services)	(3)	(9)	(0)	(8)	(2)	(7)	(1)	(8)	(4)	(7)	(3)	(9)	(7)	68
Resources (facilities, financial, safety, staff, qualifications, training, beds)	(1)	(0)	(6)	(5)	(2)	(4)	(3)	(3)	(4)	(6)	(6)	(3)	(4)	44
Appropriate Treatments (continuity, length)	(0)	(1)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(1)	2

<i>Continued..</i> Themes	<i>Deal Forum</i>	<i>Margate Forum</i>	<i>D-A-S-H, Millennium Centre Rainham</i>	<i>Speakup CIC Meeting, Dover</i>	<i>Re-Think, Phoenix House, Sitting-bourne</i>	<i>FACES of Kent, Sitting-bourne</i>	<i>MH Service User Engagement Project</i>	<i>Rethink Ashford</i>	<i>Canterbury Umbrella Centre</i>	<i>Herne Bay Umbrella Centre</i>	<i>Parkwood, Rainham</i>	<i>Medway Cyrenians, Gillingham</i>	<i>Thanet Carers, The Beacon Ramsgate</i>	Total
Environment	/ (1)	// (2)	// (2)	/// (3)	(0)	// (2)	/ (1)	(0)	/ (1)	// (2)	(0)	/// (3)	(0)	17
Consistency/ Continuity	/ (1)	(0)	(0)	/ (1)	(0)	(0)	(0)	/ (1)	/ (1)	/// (3)	(0)	(0)	(0)	7
Information/ Communication <i>(for service users/carers/family, listening, publicity)</i>	/ (1)	// (1)	(0)	//// (5)	/ (1)	//// (4)	(0)	//// (4)	//// (4)	//// (5)	/ (1)	/ (1)	/ (1)	24
Personalised Care <i>(working with family/carers)</i>	(0)	(0)	(0)	/ (1)	(0)	/// (3)	(0)	//// (4)	//// (5)	(0)	(0)	(0)	//// (4)	16
Quality and Availability of Care <i>(access, 24/7 care, aftercare, holistic treatment)</i>	//// (5)	//// (4)	(0)	//// (7)	(0)	//// (6)	//// (4)	//// (12)	//// (7)	//// (6)	/// (3)	/// (3)	/// (3)	60
Flexible Visiting and Treatment Times	/ (1)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	1
Travel <i>(costs, distance, practical support)</i>	/ (1)	/ (1)	//// (5)	/ (1)	//// (6)	//// (4)	// (2)	// (2)	(0)	// (2)	/ (1)	/// (3)	/ (1)	27
Distribution of Capacity <i>(bed closures, fewer beds in new centres)</i>	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	/ (1)	// (2)	(0)	(0)	(0)	3
Crisis Care <i>(availability, support, quality)</i>	(0)	(0)	(0)	//// (6)	/ (1)	/// (3)	(0)	// (2)	//// (4)	// (2)	// (2)	(0)	/// (3)	23

Table 9. Topics raised at focus groups

Outreach events

Themes	St. Martins Hospital, Canterbury	Mental Health & Well Being Centre, Tonbridge	TN2 Community Centre, Tunbridge Wells	Angel Centre, Tonbridge	St Paul's Community Centre	Maidstone Town Hall	Eagle Court, Rochester	Maidstone Hospital Rooms	Uni. of Kent, Canterbury	Tonbridge & Malling B.C. Parish Partnership	Kenward Trust, Yalding	Road-shows, Pentagon, Hempstead Valley	Total*
Access (coverage, travel, local, speed)	(0)	(0)	(0)	(0)	I (1)	(0)	I (1)	(0)	(0)	(0)	(0)	I (1)	3
Community Treatment (home)	(0)	(0)	(0)	(0)	(0)	I (1)	I (1)	(0)	(0)	(0)	(0)	I (1)	3
Hospital Treatment (inpatient)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0
Quality of Individual Care (support for family, personalised services)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	II (2)	2
Quality of Service Provision (organisational improvements, multidisciplinary teams, transition between services, better & more services)	(0)	(0)	(0)	(0)	IIII (4)	(0)	(0)	(0)	(0)	(0)	(0)	II (2)	6
Resources (facilities, financial, safety, staff, qualifications, training, beds)	(0)	(0)	(0)	(0)	(0)	I (1)	IIII (4)	(0)	(0)	(0)	(0)	(0)	5
Appropriate Treatments (continuity, length)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0
Environment	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0

Continued..

Consistency/ Continuity	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0
Information/ Communication (for service users/carers/family, listening, publicity)	(0)	(0)	(0)	(0)	/	(1)	(0)	(0)	(0)	(0)	(0)	(0)	1
Personalised Care (working with family/carers)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	/	1
Quality and Availability of Care (access, 24/7 care, aftercare, holistic treatment)	(0)	(0)	(0)	(0)	/	(1)	(0)	(0)	(0)	(0)	(0)	//	3
Flexible Visiting and Treatment Times	(0)	(0)	(0)	(0)	/	(1)	(0)	(0)	(0)	(0)	(0)	(0)	1
Travel (costs, distance, practical support)	(0)	(0)	(0)	(0)	/	(1)	(0)	(0)	(0)	(0)	(0)	(0)	1
Distribution of Capacity (bed closures, fewer beds in new centres)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0
Crisis Care (availability, support, quality)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0

Table 10. Topics raised at outreach events

* no themes were discussed at the outreach event in Hythe only consultation information was disseminated. Therefore it is not included in the table above.

APPENDIX THREE

Summary of comments from Public Meetings

Summary Comments - Swale

- The public hold negative views towards the trust – feel they are too over optimistic about care at home – not enough thought towards carers
- There were disagreement in views between the panel and the public in regards to crisis care. Panel – introduction of CRHT teams and development of additional services (including acute and community) means better support at home results in less beds being used. Public comment – there are not enough beds with demand keeping open wards due to close
- Disagreement between panel and public regarding patient views. Panel – patients and carers more concerned with quality of care over location. Public disagree. Hospital care should be close to home
- There is further concern about the continuity of care and the need for personalised services, working with carers and families who bare a great burden. This burden is increased with problems of access when visiting loved ones. Too much pressure on carers
- 24/7 care is not sufficient.
- Lack of privacy for patients is an issue and lack of staff makes it difficult for patients to get fresh air.
- Swale is seen to suffer in terms of service provision
- There is concern that there will be fewer beds, when there is already long waiting times. Patients are being transferred else where
- For Sheppey residents transport to Dartford is difficult. Canterbury is easier by public transport. Travel for families costs too much
- Medway facilities are not good enough
- Need for better joint services
- There is not enough staff, impacts upon time spent with patients outside of hospital
- Concern community services are not up to standard

Summary Comments – Swanley

- There was significant dissatisfaction at the level of publicity of the consultation
- Public transport to certain areas is difficult and can cause further problems for those with mental health problems such as anxiety. Also difficult for families
- Volunteer driver schemes/community bus trips are welcome
- When in hospital links with the community must be maintained, along with access to phones
- Hospital environment is important for patients and visitors, access to outside areas for smoking, bag searching policy to be visible, more privacy for patients, an overall pleasant atmosphere, more variety of activities for patients especially at the weekend
- Agreed that there needs to be more beds in East Kent
- High quality care is more important than distance travelled. Consideration is needed for agoraphobic patients, but infrastructure needs to be put in place

Summary Comments – Swanley (continued ...)

- Emphasis on a quick response and appropriate response for suicidal patients
- Shorter length of stay
- Information is important for patients and carers, such as where facilities are, who are staff and contact information
- Important to remember that patients arrive with no personal items i.e. clothes or wash materials
- Option B has no advantages, poor access and travel options, Option A is better for access, Option C results in further travel for Swale and poor distribution of beds – Option A was viewed as the best due to links with the community
- More frequent and direct buses are needed
- Consistency in care is vital with supported aftercare, including consistency in staff
- Money needs to be invested to improve services, so services run on time and are available 24/7
- Training is needed for staff so they can pass on correct information and advice
- Medway facilities are poor, Littlebrook is seen as superior
- Perception that inpatients are simply medicated with little or no other treatment, patients need a range of treatments
- Carers need to be supported and educated, their work is important
- Personalised services are important, with the patient being involved in the creation of their personal recovery plan
- The lack of staff is impacting upon care, especially out of hours
- Increase prevention resources
- More training on mental health needs, especially for GP's

Summary Comments – Medway meeting (2)

- Local services are important
- 9-5 outreach services is not suitable, emphasis on 24/7 care
- Travel is a problem, especially at weekends and Bank Holidays
- Littlebrook is seen to be too far to travel from Medway
- Families need more support
- Carers and family need to be involved more in the treatment process, especially if the patient is in crisis
- There needs to be organisational improvements, it's currently confusing and is not consistent. Requires more joint working
- Community services need to improve, especially if they need to fill in gaps of services
- Alternative contact options should be made available between patients and care coordinators, such as conference calling
- Options A B and C are the same for Medway people
- Option A is preferred. Has the least disadvantages geographically but travel may cause anxiety. Easier access for Swale – Option B too far. However better than Medway facilities but need to signpost where support is available – Option C, too much overspill and people will not want to travel to Dartford
- Response times by CRHT are too slow

Summary Comments – Medway meeting 2 (continued ...)

- Sheppey to Dartford is a long trip and expensive, visitors have to wait around if they arrive at an inconvenient time, patients need support if they have to travel far
- Sustainable volunteer driver scheme would be of benefit
- Local services need to be better signposted with GP surgeries equipped to direct people
- More support is need for mental health patients to find work, as well as financial support
- More additional advice on exercise and diet
- Length of stay should be appropriate for the individual
- More opportunities for research, training and peer support
- Facilities should allow for privacy, however some patients may feel isolated in single rooms
- A block is no longer suitable
- The lack of staff and beds is resulting in a poor service for mental health patients

Summary Comments – East Kent, Ashford

- There was considerable concern show about the number of beds available, the perception is that there is difficulty in finding beds in the area
- There is strain on families travelling to visit patients, expensive from Swale to Dartford
- Ashford is seen to be more central for services
- Continuity of care is vital but is not happening, with shortages in staff patients are seeing several different people during the course of their treatment
- Quality of services need to improve with 24 hour psychiatric liaison support at Medway A&E
- Need for more respite cares both for patients and carers
- Staff are under too much strain, more staff are needed
- Strong emphasis on the need for services to offer a more stream lined service, working together, transition between services, improve on information sharing and awareness of referral pathways
- More help for mental health patients getting into employment
- There is a need for more beds, with the population increasing its going to lead to more strain
- Services are relying too much on carers
- Length of stay is seen to be too long which puts pressure on bed availability
- There was support for crisis houses in the community, providing a quiet retreat as well as giving carers respite

Summary Comments – Thanet

- Mental health patients have multiple needs, holistic care needs to be provided faster
- Information and communication with carers needs to be improved

Summary Comments – Thanet (continued ...)

- Better communication between services, with signposting
- Difficult for patients to access inpatient services without police
- Option A, most reasonable. Option B, not sensible. Option C least favoured, too much pressure on Canterbury. However no one from Swale at the meeting to be able to comment
- Does not want the East of Kent taking Swale patients and continuing current displacement problems
- Lack of provision in Swale, Swale travelling to Dartford unacceptable
- Options do not provide enough details
- Financial support for travel is needed, with volunteer driving schemes
- Transport is difficult, with carers being relied on to transport patients
- Facilities can be improved with single rooms and gym facilities
- Need a range of alternative therapies
- CHRT take too long to respond, need more money for staff and to deliver weekend service
- GP services need to improve, to make it easier to arrange appointments
- Crisis House/lounges were seen as positive, offering 24/7 support
- Need 24/7 support availability
- Community care needs improvement as it is important to treat patients in the community
- Response to patients needs to be quicker
- Perception that the patient is not being put first
- Medway should not close
- Too much pressure is being placed upon carers
- Patients need more fresh air/cigarette breaks when in hospital
- Wards are outdated, A Block is not fit for purpose, wards need to be improved, behaviour of patients in regards to language, texting and habits needs to be controlled
- There are not enough beds
- Crisis teams are not regarded as effective, not enough staff, heavy workload, long response times
- There is concern at the lack of beds in the Thanet area, a very deprived area
- More emphasis needed on preventative measures

Summary of Comments – Sheppey

- Transport is a major issue, especially public transport. Travel times are longer than the documents suggest. Travel takes longer than an hour. It is difficult for older carers. Maidstone is difficult to get to. Train is better as buses stop at 6pm and are only one an hour to Maidstone. Is expensive.
- Carers seen to 'pick up the pieces' of gaps in service, being responsible for transporting patients. Concern for their loved ones after their carers die.

Summary of Comments – Sheppey (continued ...)

- Concern at the lack of services on the Isle of Sheppey, lack of aftercare. New hospital can be utilised.
- Needs to be links between services, improve on communication with each other , more information sharing
- Services are not up to standard, patients do not always get what they need. Too long to wait.
- Emphasis on preventative treatment tailored to individuals
- Medway site is poor, but has access to a variety of services. Needs improvement not closing
- Mental health patients need consistency
- Patients want to go outside more to smoke
- Information about pathways and treatments need to be made clearer, for patients, carers and outside local services
- GP's need more training on mental health needs
- All options have location issues, too far to travel. Option A, some people don't know facility. Option B, unnecessary shifting. Option C, new building. Disagreement between A and C options as to which is better
- Crisis lounges are a good idea
- Not enough beds or staff
- Aftercare needs to be greatly improved
- Community care needs to be improved
- Help needs to arrive quickly
- Crisis teams need to be more responsive, speed is important
- A&E environment needs improving, a quiet area for mental health patients
- Concern about the extent and quality of care in prisons

Summary of Comments - West Kent Meeting

- Questioned the figures regarding the number of beds that were left available. Patients still had to go out of area. Information is not transparent
- There are potential problems with having several large centres of excellence. Could bring back the stigma of Victorian asylums. Patients are also quite isolationist
- There needs to be more support from the community, currently it is not up to standard. Needs appropriately trained staff and more resources
- CRHT teams need to connect people to support services based in the community, fully utilize the full range of support available
- Medway A block needs to be improved and to stay
- Facilities need to be arranged to suit patients; separate rooms are good for getting good sleep but can be isolating, need for communal areas, centres need a shop for patients and carers, a calm environment, suitable family room, TV's, access to hot drink, culturally appropriate
- More staff are needed to; increase trust/relationships, improve quality of care, provide 24/7 care, spend more time with patients to conduct assessments, spread the workload, give opportunity for training, to conduct constant evaluations, to ensure that breaks are covered and staff aren't eating on the go

Summary of Comments - West Kent Meeting (continued ...)

- All services need to work together
- Need for better response times and early intervention
- Staff need better access to patient information
- Dartford is difficult to visit
- Face to face communication is more supporting
- Medway has multiple needs including unemployment and alcohol abuse
- Option A – Central and accessible location. Question the ability of CRHT to take over acute services
- Option B – no advantages. Cost of travel is too high. Will GP's have the knowledge to treat mentally ill patients?
- Option C – no advantages. Overspill is a concern. Worry about continuity of care
- However, some individuals do not like any of the options. Fearing beds will only be given to extreme cases. Want A block to stay
- There was a divide between the opinion that local services are seen as more important than the quality and level of the facilities, being local is vital; and high quality care is more important than distance travelled.
- Some feel that travelling long distances is not appropriate
- Travel is time consuming and costly, scheduling needs to be carefully considered to account for public travel
- Carers should be supported, working together with carers to train them and should be involved with the training of health teams. Carers are worried what will happen when they can't care any longer
- There is a need for more beds, argue that there is a link between beds and the rate of suicide
- More awareness about mental health is needed
- More training for CRHT is needed, their safety is important
- One individual argued how several failings in the system and lack of beds contributed to his daughters suicide
- Discussion how technology can be used to help support workers treat patients in the community, but for patients and carers technology may be difficult to use
- Phone lines need to be manned 24/7
- BME communities need to be considered

Summary of Comments – Medway Meeting (1)

- A block is not suitable for patients or their families, but has the benefit of being local
- Strong emphasis on the need for services in Medway. Medway has a large population
- Resources and facilities are already stretched thin
- GP services need improving; more training
- Access to all people is vital
- Quality of care is important; more support is needed upon discharge. More staff are needed to achieve this

Summary of Comments – Medway Meeting 1 (continued ...)

- Concern that patients will be divided. Unequal provision of care. Potentially leads to prejudice
- Patients have multiple needs; accommodation, therapy, safe environment, understanding , to be kept informed of what's happening
- As inpatients they value good sleep, good food, 'homely' items i.e. soap
- Service users can be dangerous, especially in their own home
- Emphasis on the need to support carers. Staff can be judgemental
- A balance needs to be achieved when watching patients
- Staff need to be friendly and spend more time with patients, more training, monitored to ensure good care
- Response times need to improve. Patients need to be seen as quickly as possible. Lack of care during the night and at weekends
- Transport needs to be considered, especially travelling far at night. Needs to be linked with appointment times. Costs too much, especially for carers. Dartford is too far. Public transport is difficult for the disabled. More signs and information about how to get to centres is needed
- Carers need support
- Community services need to improve, many services are being closed
- Littlebrook: calmer environment but children couldn't visit and there were still fights
- Problem with accessing computers on wards. Facebook is a bad idea
- CRHT need to improve, especially increase presence in the community, need to ensure follow ups are done in a timely manner, more staff are needed to ensure consistency
- Problem of an increasing population in Dartford
- Option A, B, C – aren't suitable for Medway
- Deprivation is hitting services, causing additional strain

Summary of comments from Focus groups

Summary of Comments – Deal Forum

- Transport is a problem. Visiting hours will need to accommodate for this
- Lack of aftercare
- Changes are confusing to service users
- Activities in hospital are important

Summary of Comments – Margate Forum

- Poor inconsistent aftercare, difficult to contact people
- Social care side of mental health needs improvement
- Wards should be single sex
- Support groups should be better promoted with GP's signposting more effectively
- There needs to be a better community support network
- Drop in services are required

Summary of Comments – D-A-S-H meeting

- Could CCTV be installed in A block?
- Would be no service provision for Medway
- Difficult to travel to Dartford, causes anxiety, too far and high costs. Difficult for carers to get back if they arrive via ambulance. Also expensive for staff. Need somewhere closer

Summary of Comments - SpeakupCIC, Dover

- Crisis Team is not effective, poor access
- Agreed that more beds are needed
- A calm environment is needed for recovery
- High quality care is more important than distance
- Carers need to be supported. However must be kept in mind that carers can be interfering and patients need to have more say. Information sharing must be cleared
- More community services and signposting to said services
- Hospital food needs improvement
- Should be more support in hospital and additional therapies
- Experienced consistent staff are needed
- Services need to improve and waiting times for assessment need to be addressed

Summary of Comments - Re-Think, Sittingbourne

- Travelling is too far and costs too much, problematic in winter
- Skype isn't an alternative to visiting
- Would prefer a place with good reputation and better treatment
- Would like to keep Medway

Summary of Comments - FACES of Kent, Sittingbourne

- Proposals don't give much choice to Sittingbourne and Sheppey
- Transport is difficult and expensive
- Littlebrook is depressing. Medway is lighter and friendlier
- MH patients often have physical problems as well
- Crisis teams are slow, difficult to understand over the phone, don't know the user, aren't proactive
- Assessments need to be conducted faster
- Carers need more support, also concerned when they can no longer continue caring
- More out of hours services are needed

Summary of Comments - Rethink, Ashford

- Need for transport provision, it is difficult
- Time to respond to users is too long, don't arrive at appointed times
- GP's need to be more supportive
- Out of hours services need to be improved
- Needs to be a continuity of staff with better qualifications
- Need for good communication
- Carers need support
- More signposting to community and voluntary services
- Good experiences of care, including a holistic approach that included the carer

Summary of Comments - MH Service User Engagement Project

- Littlebrook feels isolating
- Travel needs to be reimbursed and provide volunteer drivers
- Phones need to be answered and users responded to in a timely manner
- More guidance on who to contact

Summary of Comments - Canterbury Umbrella Centre (Re-think Carers Group)

- All areas should be excellent
- Crisis teams take too long to respond
- Lack of out of hours service
- Poor home treatment team. Not enough staff. Don't get the chance to develop a relationship with the patient
- Carers don't feel included and are sometimes seen to make matters worse. Need to be informed of what is happening. Carers want to help with treatment
- Continuity is important
- Lack of coordination and communication between services
- A block is outdated
- Better training for staff

Summary of Comments - Herne Bay Umbrella Meeting

- Patients need to be able to self-refer
- Crisis teams aren't visible
- Lack of clarity on the criteria to get a bed
- Travel is difficult for carers; services need to be closer to home. Travel information needs to be made available
- Lack of awareness between services on who has mental health problems
- MH support from GP services are not perceived as good enough with receptionist staff not being sympathetic. GP's need more training
- Patients have to wait too long to be seen, assessments take too long
- More help is needed out of hours
- There aren't enough beds
- Services need to be more joint up and communicate with each other
- Patients need to be listened to
- There needs to be more consistency in staffing to build a rapport with patients
- Carers need to be supported

Summary of Comments - Parkwood, Rainham

- Lack of support in the community
- Dartford is too far to travel
- Long waiting times
- More funding for crisis teams

Summary of Comments - Parkwood, Rainham (continued..)

- Helplines and services need better signposting
- There is no option for Medway
- Volunteer driving schemes need wheelchair access
- Refurbish A block, don't close it

Summary of Comments - Medway Cyrenians, Gillingham

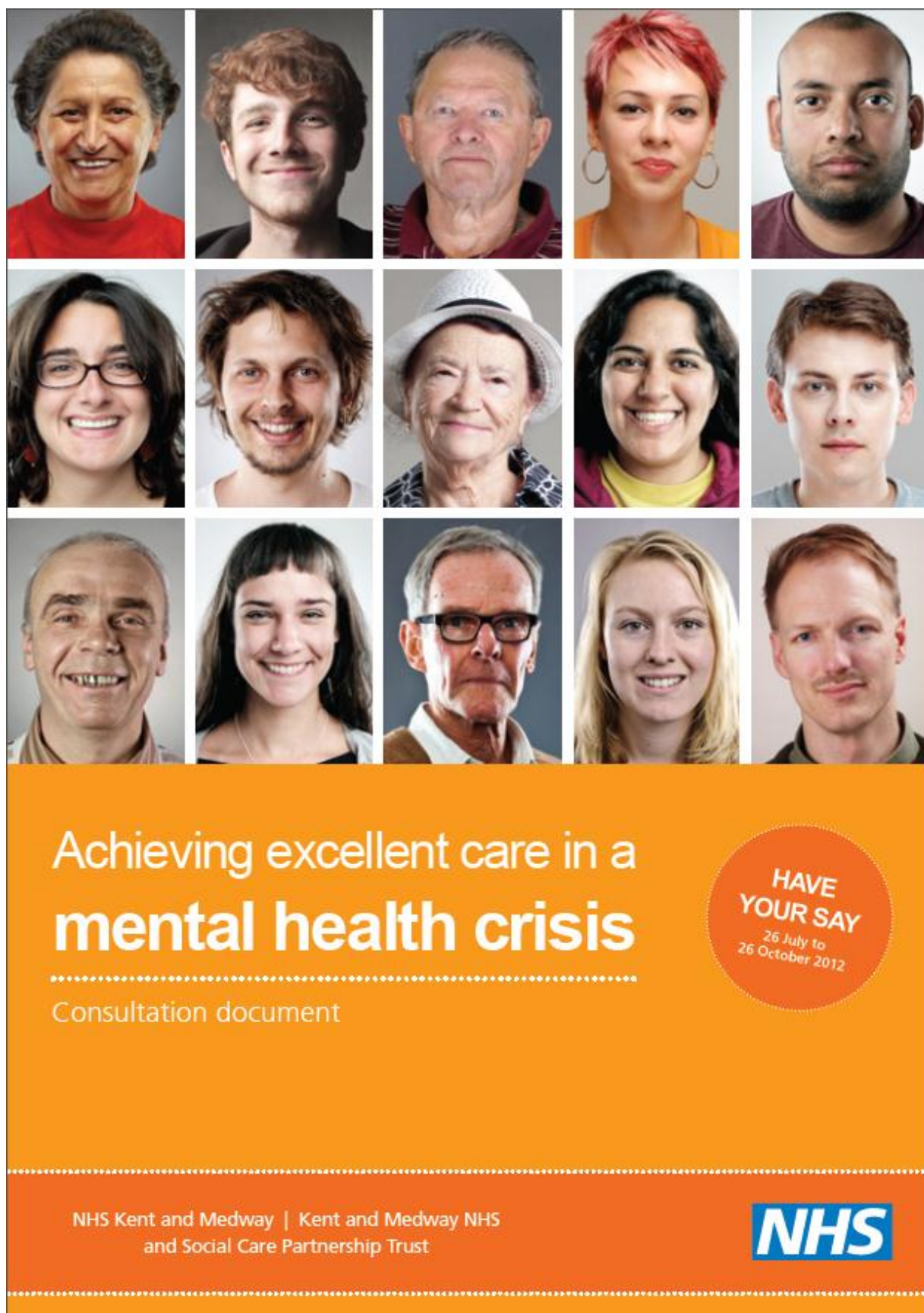
- Travel is expensive
- A block should be refurbished
- Need a welcoming environment
- Follow ups in the community do not happen
- Waiting times are too long
- Communication needs improving
- Staff often discuss problems openly, don't respect privacy
- GP's need to refer to community services

Summary of Comments - Thanet Carers, Ramsgate

- Carers, some with personal health problems, are not getting support. Need to be kept informed of what is happening
- More staff are needed
- Transport is a concern. Carers are also being asked to transport their loved ones during a crisis, very dangerous
- There is a distrust in services
- Need for more support for young people
- Patients are 'falling through gaps' when transitioning between services
- More support is needed during a crisis
- Services need to work together better

Summary of comments from Outreach Events

Summary of Comments - St. Martins Hospital, Canterbury n/a
Summary of Comments - Mental Health & Well Being Centre, Tonbridge n/a
Summary of Comments - TN2 Community Centre, Tunbridge Wells • Concern at changes to the NHS
Summary of Comments - Angel Centre (Tonbridge Health Forum) n/a
Summary of Comments - St Paul's Community Centre • More work should be done alongside social housing organisations • Translation services are needed • Transport is difficult, especially if the route is unknown. • Visiting times need to coincide with buses
Summary of Comments - Maidstone Town Hall • Charities can do the work of care at home nurses
Summary of Comments - Eagle Court, Rochester • Suggested a 'step down' unit in Medway
Summary of Comments - Maidstone Hospital Rooms n/a
Summary of Comments - University of Kent, Canterbury n/a
Summary of Comments - Tonbridge & Malling Borough Council Parish Partnership, West Malling n/a
Summary of Comments - Kenward Trust, Yalding n/a
Summary of Comments - Shopping Centre Roadshows • No mental health services for children • Patients are moved to be closer to family • GP's need to be better equipped • Need more support in the community



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Have your say

We are looking at how to improve services for people in a mental health crisis. In this document we set out some proposals for the future.

Your views on these services are important and we would like to hear from you.

We can make this document available in different formats and languages and will be working with community and voluntary groups to involve people whose views are not always heard.

If you are a local organisation holding an event between 26 July and 26 October 2012 and you would like us to come and talk to you about the proposals in this document, please contact the citizen engagement team on 01227 791281.

We are asking for comments on:

- Our proposals to improve services for people in a mental health crisis
- The options for people who live in Medway, Sittingbourne, Sheppey and Swanley
- Remember to fill out the survey in the middle of this document and send it to the freepost address by 26 October 2012.

For more information:

- Visit www.kmpt.nhs.uk/acute-mental-health-review
- Email consultation@kmpt.nhs.uk
- Call 0800 587 6757
- Or come to discuss our plans at one of our roadshows below

Swale: 10 August, 1pm to 4pm – UK Paper Leisure Centre, Avenue of Remembrance, Sittingbourne, Kent, ME10 4DE

Medway: 4 September, 2pm to 5pm – Corn Exchange, Rochester, Kent, ME1 1LX

West Kent: 18 September, 2pm to 5pm – Maidstone Community Centre, Marsham Street, 39-48 Marsham Street, Maidstone, Kent, ME14 1HH

Swanley: 28 September, 1pm to 4pm – Swanley Banqueting, Alexandra Suite, St Mary's Road, Swanley, Kent, BR8 7 BU

Medway: 2 October, 6pm to 9pm – The King Charles Hotel, Brompton Road, Gillingham, Kent, ME7 5QT

East Kent: 4 October, 10am to 1pm – Norman House, Beaver Business Park, Beaver Road, Ashford, Kent, TN23 7SH

Summary

Every year, around 3,000 of the 1 million men and women of working age in Kent and Medway have a mental health crisis and need treatment urgently.

Typically, someone in a mental health crisis may have delusions, hallucinations, be very distressed or be seriously neglecting themselves, or be at risk of causing severe harm to themselves or others.

They need the right treatment to keep them safe and help them recover. These services, called acute care, are currently provided by psychiatrists, mental health nurses, occupational therapists and other highly trained staff, working for Kent and Medway NHS and Social Care Partnership Trust (KMPT). Working in partnership with clinical commissioning groups, the services are commissioned (planned and paid for) by NHS Kent and Medway.

In the past, people in a mental health crisis would always be admitted to hospital. Over the past eight years, however, services have been quite dramatically transformed.

Most people are now treated in their own homes by specialist staff from Crisis Resolution and Home Treatment (CRHT) teams, who are available 24-hours every day. Staff will visit three times a day if needed.

Treatment at home helps people recover more quickly and stay better for longer because they can keep in touch with their friends and family more easily, stay independent, make choices about their life and avoid becoming institutionalised.

Home treatment is also what people who use services say they want, in both local and national surveys. As a result of the increase in home treatment, patients are not using hospital beds as much as they used to.

This means that people who do get admitted to hospital are those who are the most unwell, with a real risk that they would hurt themselves or others; and those who are so ill that their carers feel unable to support them at home any longer. Many are sectioned (detained for assessment and treatment) under the Mental Health Act.

They need high quality specialist care that keeps them safe and does everything possible to promote their recovery.

Why our acute mental health services need improving

Not everyone in Kent and Medway currently has access to an equally good acute care service. This is not fair and needs to change.

In particular, there are too few hospital beds available in east Kent and more than we need in west Kent, while Medway's beds, based in A Block at Medway Maritime Hospital, are not up to 21st century standards.

Medway's A Block has dormitory bays, with four or five people in each and only curtains between the beds for privacy. Access to outside space is known to improve recovery but people in A Block have restrictions on this and 16 people share two bathrooms in each of the wards there. In contrast, the wards in Dartford, Maidstone and the new unit being built at Canterbury have single, en suite rooms for every patient.

The poor accommodation at A Block has an impact on people's care and on their experience. There is more violence at A Block than at the other units, which makes people feel unsafe. Also, more people deteriorate and need psychiatric intensive care, the specialist support for those people who are most unwell.

We have also reviewed psychiatric intensive care services. There is a very effective psychiatric intensive care outreach service in west Kent and Medway, which prevents patients deteriorating and helps people stay on the ward they were first admitted to – rather than having to move to an intensive care unit and back again. This is not available in east Kent.

Our proposals

We have spoken to people who use services, carers, voluntary organisations, advocacy networks, GPs, mental health specialists, and other clinicians and representatives of the public and have developed plans to:

- Strengthen community based crisis resolution and home treatment teams to provide more support to people outside hospital

Achieving excellent care in a mental health crisis

- Develop three centres of excellence for people in a mental health crisis, each providing:
 - Faster and more complete recovery for service users
 - Patients having a better experience including feeling safe and being able to see the progress they are making in recovering from their crisis
 - An excellent acute inpatient mental health service in itself, delivered by highly effective staff who are well supported and able to deal with any crisis 24/7
 - More opportunities for therapeutic interventions at weekends and into the evening
 - Purpose-built accommodation for safe care, with calm environments that support recovery.
 - Hubs of good practice with a research programme that attracts and retains highly qualified, expert and motivated staff.

These will be based in Dartford, Maidstone and Canterbury, reducing inpatient beds across Kent and Medway by 10 and closing A Block, so that in future people from Medway, Sittingbourne and Sheppey can have their own room without having to move to the psychiatric intensive care unit and back to the ward later. We have also developed plans to:

- Concentrate stays for psychiatric intensive care in one purpose-built hospital unit, the Willow Suite at Dartford, allowing the former Canterbury intensive care unit to be converted to provide more beds in east Kent.
- The proposal is that people who live in Medway would use the centre of excellence at Dartford.
- We are consulting on three options for people who live in Sittingbourne and Sheppey, using the beds at Maidstone, Dartford or Canterbury, and on two for people who live in Swanley, using the beds at Dartford or Maidstone.

We plan to research with academic partners the outcomes and benefits to service users of a new range of alternatives to hospital, such as offering time in a crisis lounge or structured day therapy as part of planned home treatment.



Service users' views

People have told us that what really matters when you are seriously ill is that you get the right care, in a place where you feel safe.

"Quality is more important than distance," a service user from Medway said at a special meeting to discuss these proposals.

However, people are also concerned about transport, particularly for visitors and for people on short-term leave from an inpatient unit.

People who are in a mental health crisis will be transported by the NHS.

Currently, few people admitted to Medway's A Block have visitors because there is nowhere private for them to go and visitors don't feel comfortable there.

Service users have tested out the transport links between Sittingbourne, Sheppey and Medway and the sites in Maidstone, Canterbury and Dartford. People from Sittingbourne and Sheppey found that it was cheaper to get to Canterbury and Maidstone than to travel to A Block.

They have also come up with suggestions for volunteer transport, buddying and keeping in touch through modern technology such as Skype. These suggestions will be part of the discussions during the consultation. (for further details look at page 28)

We have tried over the last few years to find a suitable building or site in Medway which we can afford. However, we feel it is now time to find a way to provide high quality care for all patients rather than fruitlessly pursuing a local solution.

What do you think?

We want to know what you think of these proposals and the options for people from Sittingbourne, Sheppey and Swanley – as well as if there is anything else we should consider.

Your views will help us make the best decisions about future services and care for people in a mental health crisis who need urgent treatment.

Please read this document and fill out our survey on the centre pages. The deadline for us to receive your response is 26 October 2012. For further information please check on our website at: www.kmpt.nhs.uk/acute-mental-health-review

Only after all responses have been received will a final decision be made.

We look forward to hearing your views.

Dr Rosarii Harte

Assistant Medical Director and Consultant Psychiatrist Kent and Medway NHS and Social Care Partnership Trust

Lauretta Kavanagh,

Director of Commissioning for Mental Health and Substance Misuse NHS Kent and Medway

Achieving excellent care in a mental health crisis

What we are consulting you about

Achieving excellent care in a mental health crisis

This consultation is about plans to improve treatment services for people of working age having a mental health crisis, so that they get better faster and stay well longer. It is not concerned with treatment of other mental health problems.

Mental health crisis

Around 3,000 people in Kent and Medway experienced a mental health crisis in 2011-12.

In total, 2,245 people (1,813 from Kent and 432 from Medway) were treated at home and 1,545 were admitted to hospital (1,225 from Kent, including 14 from Sittingbourne and Sheppey and 320 from Medway). Some people had both types of treatment during the year.

A mental health crisis can take different forms in different people.

The mental health charity Mind say a crisis may take the form of suicidal behaviour or intention, panic attacks or extreme anxiety, psychotic episodes that may involve losing any sense of reality, having hallucinations and/or hearing voices, and other behaviour that seems out of control or irrational and likely to endanger the self or others.

It is a real success story that so many people in a mental health crisis can now be treated at home.

Treatment at home is less stressful, for people who are acutely unwell, than being admitted to an inpatient unit, which can be very frightening, particularly for someone who is already very distressed.

Home treatment is in line with national policy and is also what people who use mental health services say they want, in both national and local surveys.

Common mental health problems

In Kent and Medway in 2011-12, around 110,000 of the 1.1million people of working age sought NHS help for a common mental health problem and were treated by their GP or a primary care psychological therapist.

Common mental health problems include anxiety disorders, mild or moderate depression, phobias and obsessive compulsive disorder. The number of people with common mental health problems is increasing and so NHS Kent and Medway is making sure psychological therapy is available. This treatment is approved by the National Institute of Health and Clinical Excellence. NHS Kent and Medway has a good track record on recovery rates, compared to the national average (see page 31).

It is very rare for people with a common mental health problem to have a mental health crisis.

Serious mental health problems

Around 25,000 people with serious, complex and enduring mental illness, such as bipolar disorder, severe depression, schizophrenia, psychosis, personality disorders and alcohol or drug addiction were treated by mental health services in 2011-12.

They were mostly cared for by KMPT's community mental health teams based in 12 areas of Kent and Medway which offer support and treatment in the community for people with an enduring mental health problem. There are Access teams to provide initial assessments of a person's mental health condition and Recovery teams to provide ongoing support.

The rate of serious, complex and enduring mental illness in the population is stable – it is neither increasing nor declining.

Achieving excellent care in a mental health crisis

“ I am hoping the more I feel settled in the flat the less I'll have to contact the Crisis Team. Particularly helpful is that I can get to speak to you any time. ”

CRHT service user

“ The help I received was encouraging and very good. It's good to know there's help at the end of a phone line if needed. I would definitely recommend the service. ”

CRHT service user

Services for people in a mental health crisis

Crisis Resolution and Home Treatment Teams

are available 24 hours a day, 365 days a year. When someone has a mental health crisis, they assess and treat them, supporting them at home intensively, maybe up to three times a day. They help people remain at home rather than go into hospital – and if someone has to go into hospital, they help them get back home as quickly as possible. Six teams cover Kent and Medway, although the Maidstone and Tunbridge Wells ones are merging:

- Dartford, Gravesham and Swanley
- Medway, Sittingbourne and Sheppey
- Faversham, Canterbury and Thanet
- Dover, Deal, Shepway and Ashford
- Maidstone and Malling
- Tunbridge Wells, Tonbridge and Sevenoaks.

Inpatient services are for people in a mental health crisis who cannot be safely treated at home. The team includes psychiatrists, psychiatric nurses, pharmacists, psychologists, occupational therapists, housing and social care. At present, there are inpatient beds in:

- Little Brook Hospital, Dartford (32 single en-suite rooms)
- Priority House, Maidstone (34 single en-suite rooms)
- A Block, Medway Maritime Hospital, six-bedded bays, two bathrooms shared by 16 people (35 beds)
- St Martin's Hospital, Canterbury, Thanet and Ashford (59 beds, in the process of being replaced by £10 million purpose-built wards with single en suite rooms, opening October 2012)

Psychiatric Intensive Care is specialist support for patients who are proving very challenging on inpatient wards. At present there are two units, in Willow Suite at Little Brook Hospital, Dartford, and in Dudley Venables House, at St Martin's Hospital, Canterbury. The Dartford unit is supported by a highly effective Intensive Care Outreach team which works with staff on inpatient wards in west Kent and Medway with strategies to help avoid moving patients to the intensive care unit.



The accommodation at Little Brook Hospital, Dartford

“ Home treatment is more patient-centred. Hospital is quite disturbing and feels like it takes away your rights ”

Medway service user in the buddy scheme

I say...

Dawn's daughter became ill with schizophrenia in 2006 when she was 18. Now, nearly six years on, she has been increasingly well for over 12 months and has been discharged from all mental health services.

“I had a choice: do I let people take her away or do I do this at home?”

“The way I look at it, a child always comes from a family – however disjointed that family might seem from the outside.

“I decided to try to help my daughter recover at home, although I hadn't got a clue what I was doing or what was the matter with her.

“But family was the issue and I knew it was an important part of my daughter's recovery.”

Why we need to change

Achieving excellent care in a mental health crisis

At the moment, not everyone in Kent and Medway is getting access to an equally good service. A review by KMPT and NHS Kent and Medway this year found:

- A four-year reduction in use of hospital beds by people in a mental health crisis, as a result of successful home treatment. There are now 160 Kent and Medway beds for people in a mental health crisis but in 2011-12 an average of 144 were occupied.
- Too few beds in east Kent, so that patients overflow into other areas, where ties with their own area's Crisis Resolution Home Treatment team are more difficult, so care can be disjointed and discharge sometimes delayed. There are also more beds than needed in west Kent.
- Long-standing concerns about A Block at Medway Maritime Hospital, which remain unresolved despite years of effort. A Block continues to offer a lower standard of environment to patients from Medway, Sittingbourne and Sheppey, compared with the rest of Kent
- Lack of psychiatric intensive care outreach service in east Kent, although it offers very effective support in west Kent and Medway.

Ward environments

Since 2000, all new mental health units have been built with single rooms instead of dormitories, and preferably with en suite facilities.

This is true of KMPT's centres at Little Brook Hospital, Dartford; Priority House, Maidstone, and the new £10 million building at St Martin's Hospital, Canterbury, which is due to open in October 2012. When the new building at St Martin's opens, outdated wards in Ashford will close and everyone in those three centres will receive care in the best possible environment.

In contrast, people from Medway, Sittingbourne and Sheppey are still looked after in A Block on the Medway Maritime Hospital site, which is not really suitable for people in a mental health crisis.

The wards were not designed for mental health crisis care but as general hospital wards. There are poor sightlines for staff to observe the patients and only two single rooms.

People who may be very distressed or very delusional have only curtains around their beds to provide privacy.

The only seclusion room is on the women's ward, which means men in a state of great distress have to be brought there to use it.

Medway's A Block has 34.5 per cent of the beds in West Kent and Medway – but in 2011-12 it had

- **43 per cent** of the reported violent incidents to staff and other patients
- **38 per cent** of the referrals from acute wards to the psychiatric intensive care units, and
- **53 per cent** of reported serious incidents, all of which resulted in injury.

There is restricted access to outside space, and if, for instance, someone wants fresh air, they have to wait to be accompanied by a member of staff. This inevitably builds up anger and frustration, which can have a major impact on people's needs and experience of care as well as staff time and resources.

Staff at A Block do the best possible job of providing care within these restrictions but this is an environment that neither promotes safety nor recovery.

The Care Quality Commission (CQC) inspected A Block in November 2010 and pointed out how difficult the layout made it to restore calm after aggressive or violent incidents.

The CQC also noted there were places, which could not be removed, where patients could harm themselves if they were determined to do so. Staff are constantly vigilant and monitor these areas. Nonetheless the risk remains and this is unacceptable.

Since 2004, the local NHS has tried many times to find somewhere in Medway more suitable than A Block. We have also looked at whether A Block

Achieving excellent care in a mental health crisis

could be altered to make it more suitable for mental health crisis care. And we have investigated building somewhere new, designed for the purpose. These solutions would cost between £7 million and £13 million and, every time, the problem has been a lack of capital funding.

A new building is impossible in the current economic climate, especially as KMPT does not own any land that could be used, even if the building funds could be found.

I say...

Robert is 33 and a dad. He lives in Whitstable and has had a number of episodes as an inpatient in various units. *"It's how I deal with stress, I lose the plot a bit,"* he says.

The first time was in 2003 and, for a while, it happened about once every six months. But, after a lengthy spell one summer in St Martin's, Canterbury, he hasn't been in hospital for three years now.

"Everyone dreads going to Ashford. There are dormitories there and one guy had the radio on with pop music all night, quite loud and really irritating."

"I complained, but the nurse said it helped the guy relax. Well, that's all very well but what about me? It certainly didn't help me relax, quite the opposite."

"At Canterbury, you have your own room, which is much better. The downside is, you're not allowed to spend any time in your room during the day."

"But if you're constantly around some very difficult and disturbed people all day, it can be very stressful and you could just do with a bit of a break."

Patients being treated in other areas by other mental health teams

Currently, some patients from east Kent are being admitted to beds in west Kent and Medway because there are not enough in their own area. This can have a knock-on effect, so that patients from Maidstone, Dartford and Medway then find themselves having to be admitted outside their own area too.

This is not ideal for the patients or the clinical staff. Patients get more seamless care and earlier discharge if their Crisis Resolution and Home Treatment team is working closely with a specific inpatient unit. Spreading patients out across different units inevitably causes some dislocation and delays.

We recognise that more beds are needed for people from east Kent. Reductions in bed use there have happened at a slower rate than expected, at least partly due to the impact of the recession.

It would therefore be better if we could alter the balance of hospital facilities across east and west Kent to reflect more closely the needs of local people, with more provision in Canterbury.

“ *I'm really proud of what the staff in A Block do but they are frustrated by the facilities, which simply are not the kind of environment conducive to patients' recovery* **”**

*Louise Clack, Modern Matron,
Medway Acute Service Manager*

Clinical evidence

Published research listed at the back of this document shows that

a) ward environment makes a big difference to people's recovery and wellbeing when they have to stay in hospital. Key factors that reduce violence and aggression, improve the patient/carer experience and raise staff morale are:

- individual en suite rooms
- a range of therapeutic spaces
- single sex facilities
- quiet rooms
- activity areas
- easy access to secure, safe outdoor spaces
- good sightlines for staff.

b) offering a range of interventions and contact with different staff groups in a centre of excellence is effective at:

- enhancing patients' wellbeing
- reducing hospital stays
- achieving consistent treatment practices
- ensuring resilient staffing levels, all day, every day, with the right mix of skills – so therapy is available in the evenings and at weekends, and there are enough staff to provide safe care round-the-clock
- helping the NHS get better value for money.

c) properly joined-up working by CRHTs, inpatient units for people in a mental health crisis and psychiatric intensive care brings:

- better patient and carer satisfaction
- less violence and aggression
- less staff sickness
- shorter stays in hospital
- more prompt discharges back home
- better quality of care.

I say...

Sonia is 34 and has a background in journalism and photography. She was given a diagnosis of bipolar disorder in 2006.

She spent two days in St Martin's Hospital, Canterbury, in 2008 but felt much more comfortable when she moved into the care and support offered by the Crisis Resolution Home Treatment Team.

She said: *"When they came to see me in the hospital, they were really lovely – and they came to support me over the weekend."*

"I really wished I could stay in their care. They seemed much more compassionate and consistent than anyone else."

"Since then, I've found that I can keep myself on an even keel with the help of psychotherapy, acupuncture and reiki and making sure I don't have too many stressful things going on at the same time."

“ *The service provided was excellent in all aspects and the support given to me has enabled me to make decisions in a positive way.* **”**

CRHT service user

Little Brook Hospital

Little Brook Hospital has a total of four wards.

- The Willow Suite is a Psychiatric Intensive Care Unit with 12 single en suite rooms and a special therapeutic activity unit, including group rooms and a gym. It has a higher staff/patient ratio so that more intense nursing can be given.
- Amberwood is a women's ward with 16 en suite single rooms.
- Woodlands is a mixed ward with 16 en suite single rooms.
- Another ward is currently being used for rehabilitation of people with learning disabilities.

The Occupational Therapy team working with patients in Amberwood and Woodlands wards offers sessions on anger management, talking therapies, medication management, arts and crafts and cooking. Patients are assessed to see how well they can manage to look after themselves at home.

I say...

Angela Shorter has been the Acute Service Manager at Little Brook Hospital, Dartford, for six years, after working for some years previously at A Block in Medway Maritime Hospital.

"I couldn't believe how calm everything was at Little Brook, compared with A Block," she says.

"I think the crucial difference for the patients is that, at Little Brook, they have free access to courtyards and fresh air.

"At A Block, people felt locked up all day – especially in the women's ward on the first floor."

Achieving excellent care in a mental health crisis

Day in the life of Little Brook Hospital

The patients' day starts between 7.30am and 8.30am with breakfast of cereal and toast, with tea or coffee. Healthcare assistants help with washing, dressing, changing beds and distributing clean linen as necessary.

The service manager and the ward managers work 9-to-5 but there is, of course, nursing care round the clock every day of the year.

The early shift of five staff comes on at 6.50am and works until 2.40pm. The late shift, also of five staff, starts at 1.30pm and finishes at 9.10pm and the three night shift staff arrive at 8.50pm and stay until 7.10am.

The 20-minute handover between the shifts is a chance to check the diary and to ensure continuity of care and an understanding of any ongoing issues for individual patients.

Each member of staff is allocated three or four patients and will spend at least 15 minutes of quality one-to-one time with each of them during their shift.

The ward staff do routine health checks, such as temperature, blood pressure or glucose monitoring, and four medication rounds every day, at 9am, 1pm, 6pm and 10pm. They take blood samples to check medication levels for some patients and routinely for a full blood count to check on wider health issues.

They keep detailed patient notes on the computer and uploaded onto the Trust's electronic patient information system. These will include details of the patient's core mental health assessment, their care plan, a routine risk assessment and a check that the doctors have completed routine physical health checks.

Occupational therapists run a programme every weekday, working closely with a psychologist. They arrive around 8.30am and leave at 5pm and the sessions for patients include activities like exercise, dance, cooking or art – or a chance to talk with a pharmacist about the medicines they are taking, a group discussion about their condition or a session with a complementary therapist.

The doctors arrive on the wards around 9.30am. The consultant psychiatrists do rounds every day in all the wards. They also chair any meeting held to review a patient's Care Programme Approach. These meetings generally take 20-30 minutes. Sometimes they are quite straightforward but sometimes there are complex issues to address in supporting the individual towards recovery.

The ward clerk will invite the patient's carer or next-of-kin along, as well as the patient's care co-ordinator, who is a social worker. A member of the crisis team will be there, if a timely discharge is to be facilitated and the person is still acutely unwell – but, more usually, it will be a member of the community mental health team, who will be providing on-going support.

Someone from the housing department will attend if accommodation is needed when the patient is discharged from hospital.

The pharmacist looks in on the ward every morning to check the patients' medication charts and the supplies in the stock cupboards and the nurse in charge ensures that any medication needed by patients being discharged or going out on leave is ordered before mid-day.

Patients can make themselves tea, coffee or a soft drink whenever they fancy one during the day. Lunch is a hot meal served around noon with a choice of four dishes, a vegetarian option, a sandwich or salad and occupational therapy sessions resume after lunch until 4pm when the therapists spend an hour writing up their patient notes on the computer system.

Supper is another hot meal, like lunch and with similar choices, served at about 5pm and snacks are available when the night staff come on at around 9pm.

There's a games room and TV in the evenings and at weekends when the therapists are not around.

Some patients go to bed after the 10pm ward round and it's 'lights out' at midnight, with every effort made to help people re-establish a healthy sleep pattern as many will have a disrupted one when they arrive.

Psychiatric Intensive Care

The purpose of psychiatric intensive care (PIC), rather like that of intensive care in a general hospital, is to give the patients more staff time and intensive nursing for a short period.

At present, there are two PIC Units (PICU) in Kent. One is in the Willow Suite at Little Brook Hospital, Dartford, and the other in Dudley Venables House at St Martin's Hospital, Canterbury.

A Psychiatric Intensive Care Outreach (PICO) team provides extra support to staff looking after patients in the mental health wards. They will visit the ward, assess the patient and either suggest different working strategies to the ward staff or admit the person to the PICU.

In 2011/12, the outreach team helped West Kent and Medway ward staff prevent a potential 78 PICU admissions, nearly 40 per cent of those referred to the service. In East Kent, where there is no outreach team, a person who cannot be managed on the ward has to be admitted to the PICU at present. This is not ideal, as patients can find the move to a different unit disruptive.

Some patients only stay in PICU for a few days and more than 80 per cent are discharged from there within six weeks. Once a person's condition is stabilised, they move back to their hospital ward or go home under the care of a CRHT.

Achieving excellent care in a mental health crisis

Our proposals

Achieving excellent care in a mental health crisis

Our ambition is that everyone in Kent and Medway receives high quality inpatient care in safe, purpose-built accommodation that promotes recovery, with good access to the full range of treatments, resilient staffing (24/7) and sharing of best practice.

In addition, wherever possible, people should be in beds used only by their CRHT so that care is consistent and integrated, discharge is faster, and the patient experience is better.

The core proposals aim to develop tighter partnership working between CRHTs and our hospital wards, in line with best practice, while building on the trend for more people to be treated at home with fewer having to stay in hospital. They are as follows:-

CRHTs - As hospital beds are used less, the Crisis Resolution Home Treatment Teams are taking on more work and so they need to be strengthened.

A key feature of the way that CRHT teams work is to ensure that team members all know the patients, so that whoever is on duty is familiar with the case, whatever time of day a service user might need support in a mental health crisis.

We propose to invest £297,000 a year in additional CRHT staff from April 2013. We will keep the balance of work between the hospitals and the CRHTs under review and make further minor staffing adjustments between them as necessary.

“All staff and people very considerate and nice, although it would have been nice to see the same person. I understand this is difficult as you have a large area to cover.”

CRHT service user

Admitting service users to hospital is always a last resort, when their condition cannot be safely managed at home.

Acute mental health wards – We want to develop the hospital facilities at Little Brook Hospital, Dartford, Priority House, Maidstone, and the new adult inpatient facility at Canterbury, into three Centres of Excellence, each with the right number of staff, with the right mix of skills to deliver:

- very high standard, innovative care
- measurable results for service users
- constantly improving practice expertise
- evidence-based research
- close integration of care with the CRHTs that cover the area where their inpatients' homes are.

Each centre will have modern, purpose-built, accommodation, offering:

- single en suite rooms
- spacious communal and therapeutic areas
- safe, secure landscaped outdoor space.

This will provide a total of 150 acute inpatient beds to serve the needs of people in a mental health crisis from across Kent and Medway: 48 at Dartford, 34 at Maidstone and 68, rather than 60 in east Kent, at Canterbury.

The total is 10 fewer than the 160 there are at present, but 6 more than the average used throughout 2011/12, allowing for the seasonal peak often experienced between January and March.

This will enable us to move out of the unsuitable wards at A Block in Medway, so that people from Medway, Sittingbourne and Sheppey are no longer treated differently from everyone else.

We propose that people from Medway who need to be admitted to hospital would go to the Centre of Excellence at Dartford.

We are consulting on three options for where people from Sittingbourne and Sheppey would receive mental health hospital care and two options for people from Swanley (see pages 22 to 25).

Achieving excellent care in a mental health crisis

Psychiatric Intensive Care – We want to expand the PIC Outreach service across the whole of Kent and Medway, so that all three centres of excellence benefit from its support and strategies that help prevent the need for admission to a psychiatric intensive care bed.

We want to consolidate the PICU beds in the Willow Suite at Dartford, so that those in Dudley Venables House at St Martin's Hospital, Canterbury, are always available for acutely unwell people from east Kent, instead of just being unofficially used for them as has happened recently.

This will reduce the number of PICU beds in Kent and Medway by eight.

Bed numbers – These proposals increase the capability of the CRHT teams. They also reduce the total numbers of beds for acutely unwell by 10 and intensive care inpatients by eight, or the equivalent of closing one of the current 11 wards.

We have checked and cross checked our bed use data and are confident this number of beds:

- is correct for the next two to three years
- offers enough leeway for peaks in demand and the expected population increase
- allows acceptable occupancy rates (94 per cent) for efficient and effective bed management
- supports best clinical practice by allowing only same day leave or full discharge on a community treatment order, rather than saving beds for people on longer periods of leave (currently 10 per cent of ward bed days).

Alternatives to hospital – We plan to research with academic partners the outcomes and benefits to service users of a new range of alternatives to hospital, such as offering time in a crisis lounge or structured day therapy as part of planned home treatment.

We have based these proposals on key criteria:

Quality and safety – Delivering the best quality service and experience for service users

Access – Allowing patients, families and carers better access to services from their local CRHT and Psychiatric Intensive Care service and easy access to a Centre of Excellence

Sustainability and flexibility – Services that are able to meet the current and future demand for inpatient beds and are adaptable to meet peak demand

Environment – Offering the kind of therapeutic environment known to deliver better recovery

Staff recruitment, training and development – attractive to staff, with appropriate levels of training for staff and research opportunities

Integration – all associated services can work closely together for the benefit of patients

Value for money – All services must make best use of NHS resources. These proposals and all the options are affordable within current budgets.

“ *Our Crisis Teams need strengthening now to keep up with the volume of cases. People prefer to be treated at home, rather than going into hospital* ”

*Dr Nigel Ashurst,
Crisis Team Consultant Psychiatrist,
South East Kent*

A day in the life of a crisis team nurse

Alex, a qualified psychiatric nurse, works in South East Kent Crisis Resolution Home Treatment Team.

8.30am Arrive at the start of an 'early' shift. Receive handover from night staff and allocated list of visits prepared by yesterday's 'late' shift. Plan today's route.

9.45am Visit a woman in Deal who's feeling very negative and thinking about suicide. Teach anxiety management techniques: breathing exercises, relaxation, going for a walk, helpful website communities, local support group. Agreed to ask our consultant psychiatrist to visit for medication review.

11.30am I'm visiting a patient in Folkestone who's in a depressive phase of his bipolar illness. He's got no motivation to get out of bed, eat, drink or take care of himself. First things first, I encourage him to take some practical steps like preparing some food and taking his medication. We talk the issues through together and I arrange to see him again tomorrow.

1pm Pull into petrol station to fill up and grab a sandwich to eat in the car. Phone goes with an urgent referral in Ashford.

1.45pm Man in Ashford is hallucinating, seeing spiders crawling all over the floor and up his arm. He's scraping his arm with a kitchen knife to get them off. His family are with him and feel unable to cope any longer. Needs a Mental Health Act Assessment so he can be admitted to hospital. Contact the shift co-ordinator at base and ask for a psychiatrist, a Section 12-approved doctor and an approved mental health practitioner to come and make the assessment. Stay till they arrive at 4pm.

4.30pm Get back to the office to write up detailed notes on today's cases and hand over to the shift co-ordinator. Shift ends at 5.30pm.

The late shift works from 1.30pm to 10.30pm and the night shift from 10pm to 9am. The South East Kent team sees 20 to 30 clients a day on average, admitting one or two to hospital each week.



Core proposal – the pros and cons

There are many advantages for service users in making the change to three centres of excellence. We feel these outweigh the difficulties that some visitors will face in having to travel further and the extra effort staff will need to put into working relationships, at least initially, to provide good, joined-up care.

Advantages

Each patient will have

- Equal access to high quality purpose-built accommodation
- Their privacy and dignity better protected
- Their own single, en suite room
- Good access to safe outside space which is proven to help recovery
- Greater access to consultant reviews (which service users want) because the doctors will be concentrated on fewer sites
- Opportunities for activities and therapy in the evenings and at weekends instead of just during the day
- More support for service users and carers at home
- Equal access to psychiatric intensive care from the outreach team visiting their hospital ward
- More joined up care because the CRHT will always be working with their hospital.

Carers will

- Not be expected to transport service users to hospital when they are experiencing a mental health crisis – the NHS will do this.
- Have more support and reassurance as the CRHT capacity increases.

Visitors have

- Free parking at KMPT hospitals.
- A welcoming environment.

Staff will

- Be better aligned to patients throughout their pathway.
- Be more resilient and able to offer a better quality of care in fewer centres, with consolidated staffing levels.

- Have more opportunities for innovation in working practices, research and development.
- CRHT teams will be expanded to include peer support workers and so offer a range of help for service users and carers.

Services will

- Be able to plan more effectively, improve consistency, quality and equity of care.
- Have the opportunity to develop more innovative practice and generate a strong evidence of what 'excellence' means in mental health crisis care, working with one or more university.

Disadvantages

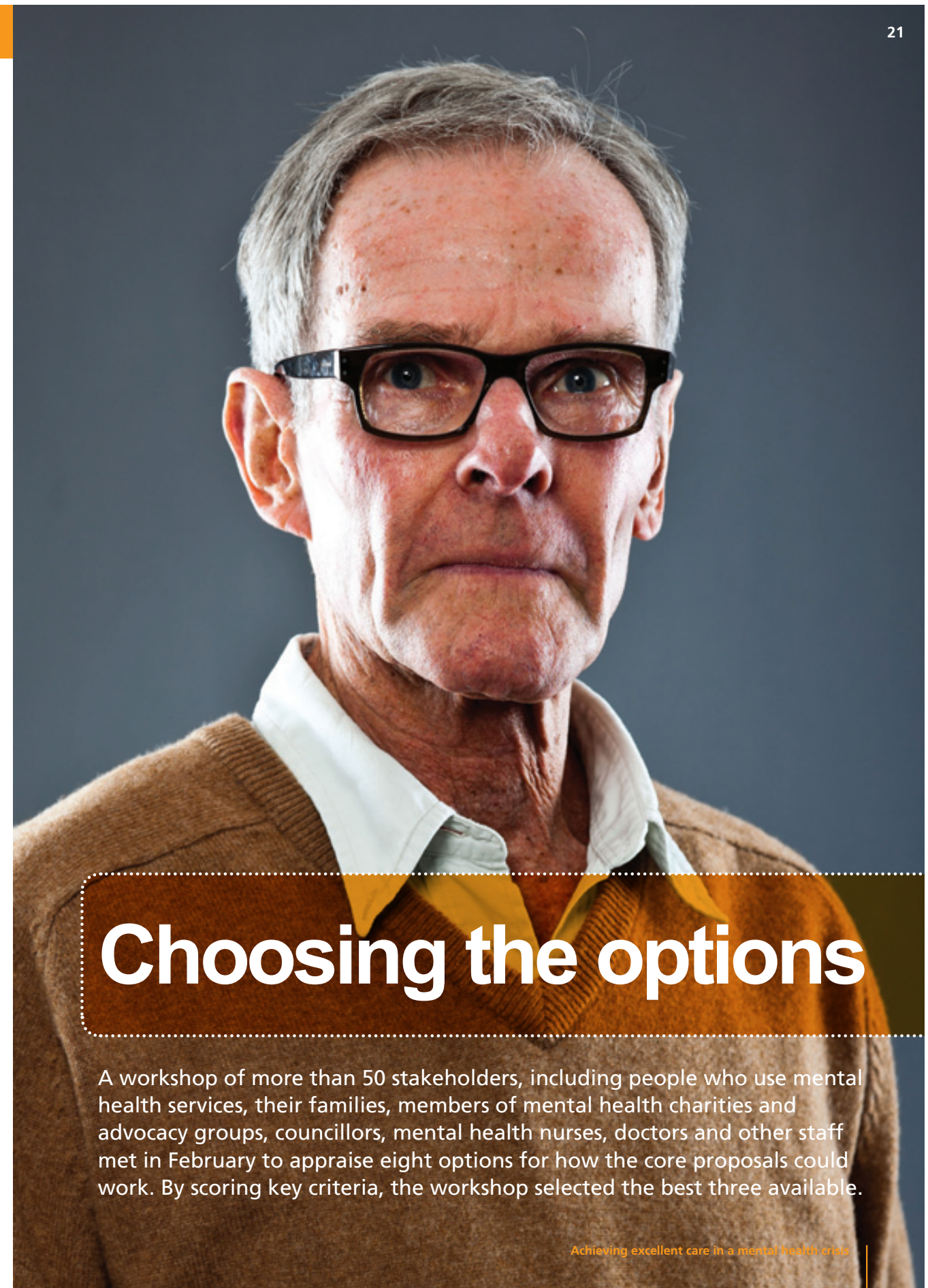
Patients' visitors will have

- Longer and more costly journeys from Medway
- Longer journeys from Sittingbourne and Sheppey

In addition

Staff will need to put more effort into working relationships:

- When some start work in new hospital units or are aligned to different patient journeys
- Between Community Mental Health Teams (Access and Recovery) and CRHTs to ensure their links continue to work smoothly in support of service users and carers.



Choosing the options

A workshop of more than 50 stakeholders, including people who use mental health services, their families, members of mental health charities and advocacy groups, councillors, mental health nurses, doctors and other staff met in February to appraise eight options for how the core proposals could work. By scoring key criteria, the workshop selected the best three available.

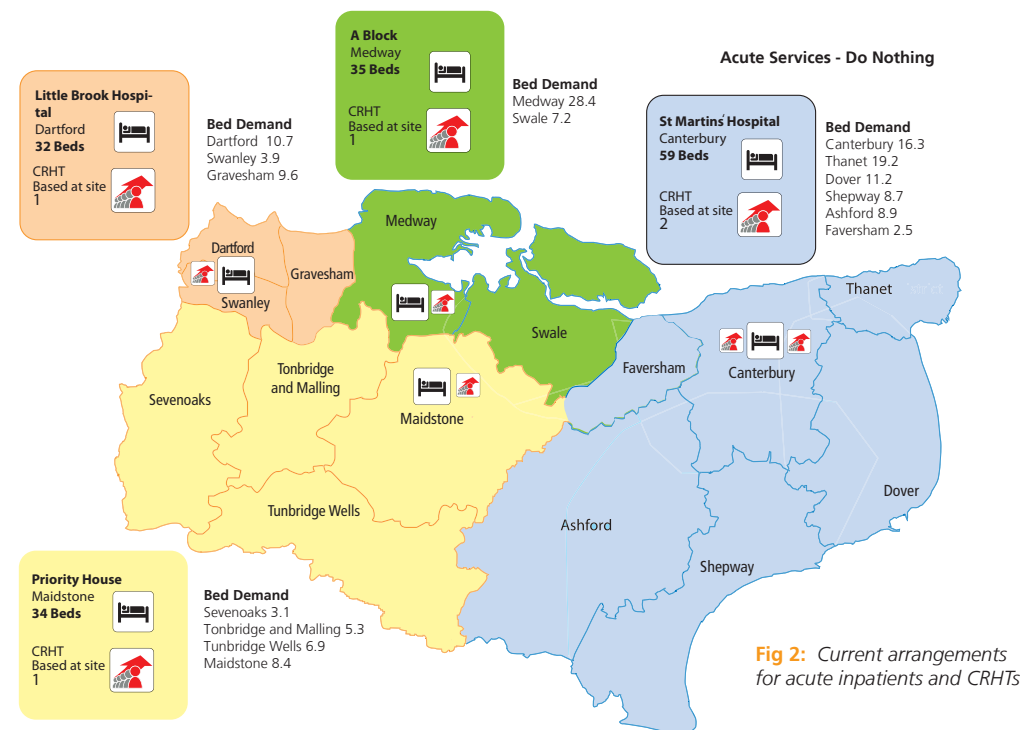


Fig 2: Current arrangements for acute inpatients and CRHTs

Doing nothing would mean:

- Too many acute beds in West Kent and too few in east Kent
- People from Medway, Sittingbourne and Sheppey would continue to be treated in A Block in a far from ideal environment for care
- People from east Kent would still not have access to psychiatric intensive care outreach which is effective in nearly 40 per cent of potential cases in west Kent and Medway
- The proper links between CRHT teams, inpatient units for people in mental health crisis and psychiatric intensive care could not be made, because so many patients would be scattered among the different units
- We would not be able to develop centres of excellence in Kent and Medway – the beds would be in the wrong places, not all the environments would be purpose-built, and the staff would be spread too thinly to provide the highest quality of care
- Sustainable mental health hospital units offering crisis care need to have at least three wards so that robust 24/7 medical support rotas can be maintained, within staff working hours.

- While cost is not a prime driver for the changes we are proposing, maintaining four units is unaffordable in the long term and risky if demand on beds reduces further in the next five years. Focussing three centres of excellence, on sites KMPT owns, gives flexibility to accommodate future demands for more or fewer beds and allows a greater concentration of other supporting professionals, such as occupational therapists, psychologists and senior staff to improve the quality of care.

It could be argued that doing nothing would save:

- service users from east Kent travelling all the way to Dartford to the PICU
- and people from Medway travelling to Dartford and people from Sittingbourne and Sheppey travelling to Dartford, Maidstone or Canterbury to an inpatient unit.

But it is also true that service users and carers in most places already travel such distances to receive specialist hospital care. It is unusual to have specialist care of this nature on your doorstep – the local element is provided by the CRHT team which delivers care in a service user's own home.

The options

The options for consultation will make a difference to service users from Sittingbourne, Sheppey and Swanley, and their families and friends. All the options share all the advantages of the core proposal.

Option A

People from Medway to use beds at Little Brook Hospital, Dartford; people from Swanley to continue to use beds at Little Brook Hospital, Dartford; people from Sittingbourne and Sheppey to use beds at Priority House, Maidstone; people from Faversham to continue to use the beds at St Martin's, Canterbury.

The CRHT working with people in Sittingbourne and Sheppey would work with Priority House, Maidstone, and the Medway CRHT would work with Little Brook Hospital, Dartford.

This is our preferred option because, taking account of where the purpose-built wards are, it:

- Offers slightly easier access to the centres of excellence for more people than options B and C
- Maintains more existing service links between localities than option B and
- Will reduce the likelihood of overspill from east Kent better than option C.

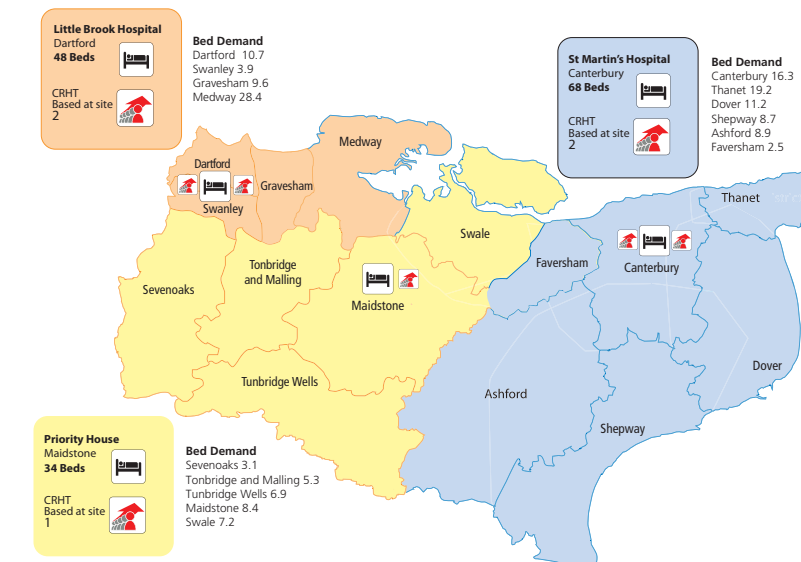


Fig 3: Option A – Catchment areas for acute inpatients and CRHTs

Advantages

- ✓ Patients will have much more chance of staying in the hospital for their area because east Kent overflows are unlikely (A, B)
- ✓ Staff working relationships in support of service users and their families continue current links with Faversham with Canterbury and Swanley with Dartford and Gravesham (A,C)
- ✓ Same cost to Sheppey visitors of bus day saver ticket for visitors from Sheppey to patients in Maidstone or Canterbury as to Medway's A

Block and cheaper than taking the train and bus to Medway's A Block (A, C)

- ✓ Most efficient use of existing NHS buildings (A)

Disadvantages

- ✗ Staff – CRHT teams will be realigned to support patient flow from Sheppey and Sittingbourne
- ✗ Sheppey and Sittingbourne patients and carers journey altered to different route – to Maidstone

Option B

People from Medway and people from Sittingbourne and Sheppey to use beds at Little Brook, Dartford; all people from the Sevenoaks district (including Swanley) to use beds at Priority House, Maidstone; people from Faversham to continue using beds at St Martin's, Canterbury

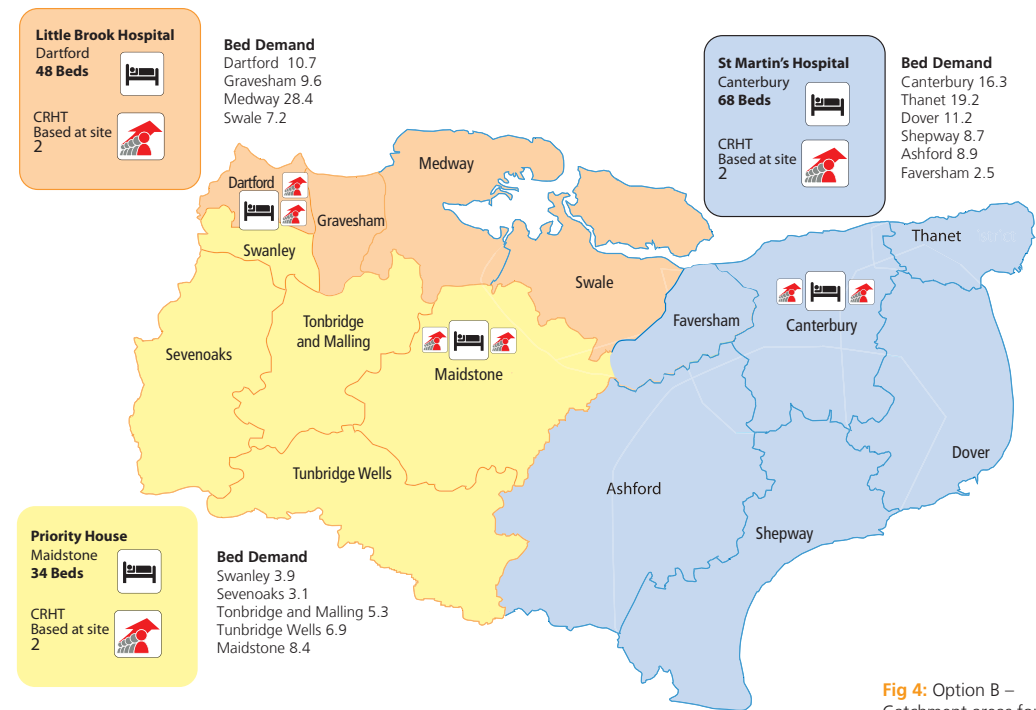


Fig 4: Option B – Catchment areas for acute inpatients

Advantages

- ✓ Patients will have much more chance of staying in the hospital for their area because east Kent overflows are unlikely

Disadvantages

- ✗ Longest and most expensive journeys for visitors from Sittingbourne, Sheppey and Swanley
- ✗ Patients and GPs in Swanley will find this option confusing as they share all other NHS services with Dartford and Gravesham.
- ✗ Dartford Clinical Commissioning Group will be the only one in Kent and Medway dealing with different systems in two inpatient units and two CRHTs.
- ✗ More realignment of staff to reflect changes to patient flows
- ✗ Not the most efficient use of NHS buildings/facilities

Option C

People from Medway to use beds at Little Brook in Dartford; people from Swanley to continue to use beds at Little Brook Dartford; all people from Swale (including Faversham) to use beds at St Martin's, Canterbury

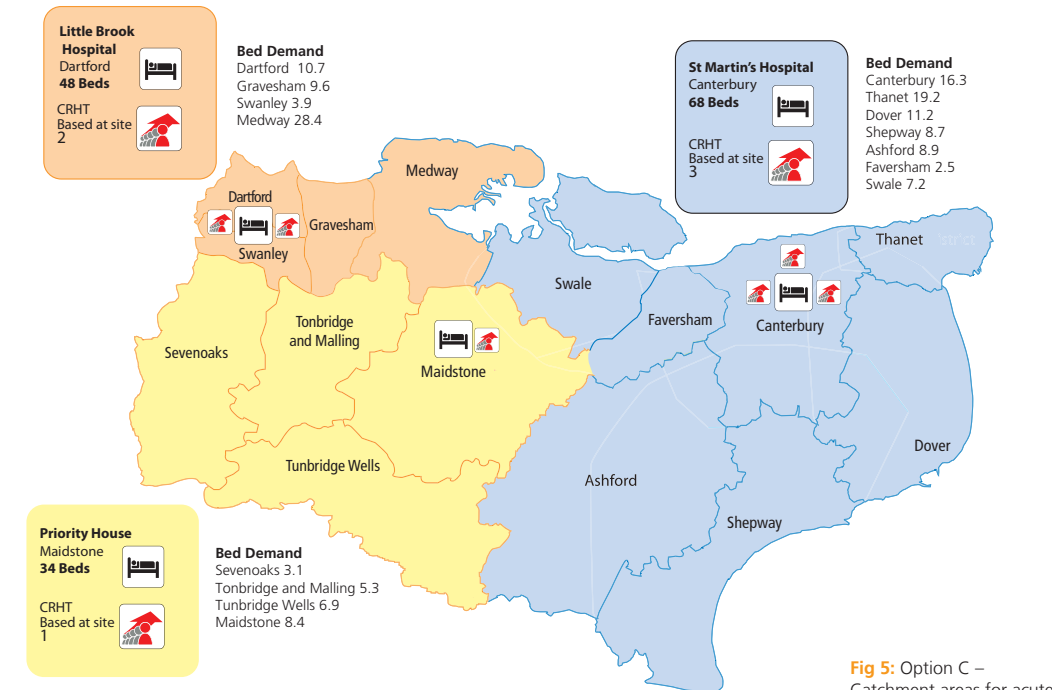


Fig 5: Option C – Catchment areas for acute inpatients and CRHTs

Advantages

- ✓ Staff working relationships in support of service users and their families continue current links with Faversham with Canterbury and Swanley with Dartford and Gravesham (A,C)
- ✓ Same cost to Sheppey visitors of bus day saver ticket for visitors from Sheppey to patients in Maidstone or Canterbury as to Medway's A Block and cheaper than taking the train and bus to Medway's A Block (A, C)

Disadvantages

East Kent patients are

- ✗ More likely to overspill to other hospitals as this option has more patients (including those from Sittingbourne and Sheppey) routinely using Canterbury.
- ✗ Likely to experience some disjointed services and delayed discharges because their CRHT and CMHTs do not have close links with other hospitals.
- ✗ Less likely to receive visitors if they are placed in Maidstone or Dartford
- ✗ Not the most efficient use of NHS buildings/facilities as Priority House is likely to have under-used beds

Discussions held

Early this year, we discussed all the issues with a wide range of stakeholders, including service users, carers, and groups representing them, GPs, psychiatric nurses, consultant psychiatrists, social workers, council members and officials, MPs, trades unions, and Kent and Medway LINKs Mental Health Network. Further discussions have been held throughout April, May and June 2012.

We know that everyone's biggest concern is transport for people who want to visit service users in hospitals further away than they are used to.

Transport links and costs have been researched by service users. Travel times and costs to Maidstone and Canterbury are similar for people from Sittingbourne, and for those from Sheppey, for whom Maidstone and Canterbury are cheaper than travelling to Medway's A Block. Public transport links to Little Brook Hospital, Dartford, are straightforward from Medway. Reports of this research are available at the consultation webpage www.kmpt.nhs.uk/acute-mental-health-review

Comprehensive travel information will be made easily available through mental health services and online.

Improved signage will make hospitals easier to find and the trust is exploring the use of Skype and volunteers to improve contact.

We have tried over the last few years to find a suitable building or site in Medway which we can afford. However, we feel it is now time to find a way to provide high quality care for all patients rather than fruitlessly pursuing a local solution.

Making a final decision

At the end of the consultation, the University of Greenwich will carry out an independent analysis of the views expressed by stakeholders about the proposals and the options. They will look at all the returned questionnaires (in this document and available online) and at any separate communication submitted in writing, by phone or email.

They will then prepare a report for the Boards of NHS Kent and Medway and of Kent and Medway NHS and Social Care Partnership Trust.

The Boards will assess people's views alongside:

- Achievability of best possible health outcomes for service users
- Most therapeutic environment
- Best match to local demand
- Affordability
- Sustainability

to come to a final decision on the way forward.

The Board will be able to decide on one of the options described in this document or it may amend the approach in the light of comments and suggestions received in the consultation.

At the start of consultation, a decision is expected to be made early in 2013, with a view to implementing any changes in late spring/ early summer.



“ I don't blame people not wanting to visit patients in A Block - it's not a very nice place. ”

Member of Medway LINK

FAQs

Some frequently asked questions

Q: People from Medway, Sittingbourne and Sheppey will have to travel further for inpatient treatment or to visit relatives and friends who are in hospital. What plans are in place to support the increased travel for visitors?

A: The NHS plans to:

- extend its voluntary transport scheme, particularly to give lifts to people facing long walks from public transport to the hospital they are visiting
- make comprehensive public transport information easily available at all the hospitals and online
- review visiting times, once the outcome of consultation is known, to make sure they fit with the public transport times
- provide Skype for patient use (family and friends will need to make their own Skype arrangements).

KMPT is looking at the number of visitors to its hospital wards so it can plan more effectively once the outcome of consultation is known.

Medway Service User Forum has already considered how to overcome distance constructively, supplying its own assessment. They recognise that the current low frequency of family and carer visits in A Block could be increased, and suggest how the expense of travel might be overcome with the help of

- a forum-supported voluntary car 'buddying' scheme and/or
- modern information technology arrangements such as Skype.

Swale Service User Forum is concerned about the travel issue and believes public transport links from Sheppey to Maidstone are poor. However, a Swale service user tried out the journeys in May and found that, compared with the journey to Medway's A Block, it took 35 minutes longer to get to Priority House from Sittingbourne and an hour longer from Sheppey – and the cost from both places, on a day saver bus ticket was £6.70, cheaper than the combined train and bus fares to Medway.

All the options will lead to some longer journeys, especially for those families and friends who want to visit people from Medway and Swale, and people from east Kent in a Dartford Psychiatric Intensive Care Unit.

But the NHS believes the improvement in treatment patients receive should outweigh these difficulties.

All the options will also increase journeys for some staff when at work and travelling between wards and PICU, and from the affected Community Mental Health Teams (CMHTs) teams, such as for Care Programme Approach (CPA) assessments, care co-ordination and reviews.

There is no extra burden on patients who are being taken to hospital by the CRHT or in a secure ambulance.

Q: Why can't things stay as they are?

A: If we left things as they are, we would have:

- Too many acute beds in west Kent and too few in east Kent
- People from Medway and Swale would continue to be treated in A Block in a far from ideal environment for care
- People from east Kent would still not have access to psychiatric intensive care outreach which is effective in nearly 40 per cent of potential cases in west Kent
- The proper linkages between CRHT teams, acute inpatient units and psychiatric intensive care could not be made, because so many patients would be placed away from their home team and
- We wouldn't be able to develop centres of excellence in Kent and Medway.

Q: What about patient choice?

A: The services we are describing are the emergency services for mental health service users. The CRHT staff take or arrange transport for people in a mental health crisis to the nearest best-equipped place to deal with the emergency. Sometimes people are so severely unwell that under the Mental Health Act 1983, they can be admitted, detained and treated in hospital against their will.

Under our proposals, this will normally be the centre of excellence working in close partnership with the person's local CRHT. This is because evidence shows these arrangements result in shorter hospital stays and better, more sustainable recoveries for service users.

These proposals maintain the same level of choice that people in a mental health crisis have at present. It is similar to the choice available to people being taken by blue-light ambulance to an A&E department.

Q: How can we have confidence that the bed numbers you are offering now are right?

A: The evidence that we had over-estimated the reduction in bed use in east Kent has been clear from the pressure on beds. We have admitted our mistake and are taking steps to put it right.

GPs, our psychiatrists and other mental health staff believe we have got it right now. Our research and calculations are open to scrutiny and are on the website (www.kmpt.nhs.uk/acute-mental-health-review)

Q: What will happen about day home visits if you are two hours away from home and you only have two hours free?

A: As part of recovery, home leave is arranged in consultation with the patient and their carer(s) so we propose to ensure that day home visits include enough time for travel and that shorter leave periods are structured around some other activity, such as shopping at a venue within reasonable reach of the hospital.

Q: How will people stay in contact with their care co-ordinator or their CRHT if they're further away from home?

A: Tighter relationships between all elements of mental health services supporting a service user are the key to achieving the best and most sustainable health outcomes for service users.

Q: Where will the CRHTs for Medway and Sittingbourne/Sheppey be based?

A: They will have a base in the centre of excellence that treats patients from their area, so that working in close partnership for the benefit of the patients is easier.

But the CRHTs for Medway, Sittingbourne and Sheppey will also have office space in the community they serve, improving their partnership working with the Community Mental Health Teams who support patients when they are feeling better but still need to access mental health services.

Q: What is the evidence that being treated in A Block is having a detrimental effect on people?

A: We know there are more incidents of violence and aggression at Medway than at the units where people

have their own room and easy access to outside space.

It is clear that the kind of environment in Little Brook Hospital, Dartford; Priority House, Maidstone, and the new building at St Martin's Hospital, Canterbury, help people recover better and more quickly and sustainably. This has been demonstrated in units around the country. A number of patients of A Block have also been patients at Little Brook and prefer the facilities in Dartford.

Q: What will happen as the population grows?

A: Our calculations offer room for the amount the population is expected to grow in the next two to three years. We have also considered the seasonal variation in service use. We will continue to keep the situation under review and make adjustments when necessary.

Q: You say mental health services have transformed in the last eight years – what's so different now?

A: In that period, we have introduced a number of services so that:

- People who need urgent care round-the-clock can now access the 24-hour Crisis Resolution Home Treatment service
- People in general wards or who arrive at the emergency department and appear to have mental health needs can now be assessed by the Liaison Psychiatry staff we have placed in the general hospitals
- People brought into custody suites by the police but who appear to have mental health needs can now be assessed by psychiatric nurses based at police stations
- Police and ambulance staff now have guidelines to help them assess people who may be suicidal and to give them guidance on what to do (such as when to involve the CRHT).

All these developments are providing better support to service users and their families and friends and have taken pressure off the acute inpatient mental health beds.

For more information visit

www.kmpt.nhs.uk/acute-mental-health-review

Glossary

Mental health crisis is a sudden phase of more serious psychological symptoms needing urgent treatment and care. Such a crisis can take different forms in different people, such as suicidal behaviour or intention, panic attacks or extreme anxiety, psychotic episodes involving losing any sense of reality, having hallucinations and/or hearing voices, or other behaviour that seems out of control or irrational and likely to endanger the self or others.

Inpatient beds for people in a mental health crisis are beds provided in hospital for people who cannot be safely treated at home and who need to stay overnight and sometimes for several days or weeks.

Alcohol/drug addiction means not having control over taking or using something, to the point where it could be harmful to you.

Anxiety is a feeling of unease, such as worry or fear, that can be mild or severe. Generalised Anxiety Disorder is a long-term condition which causes you to feel anxious about a wide range of situations and issues, rather than one specific event, and which can cause mental and physical symptoms. Anxiety disorders include some phobias and Post Traumatic Stress Disorder.

Bipolar disorder, known in the past as manic depression, is a condition that affects moods, which can swing from one extreme to another.

Crisis Resolution and Home Treatment is available 24 hours a day, 365 days a year to assess and treat people in mental health crisis, supporting them at home intensively, maybe up to three times a day. They help people remain at home rather than go into hospital – and if someone has to go into hospital, they help them get back home as quickly as possible.

Community Mental Health Team offers support and treatment in the community for people with enduring mental health problems and a specialist home treatment service for people with dementia.

Depression is more than simply feeling unhappy or fed up. It can cause a wide variety of symptoms including lasting feelings of sadness and hopelessness, and losing interest in things you enjoy, feeling constantly tired, sleeping badly and feeling very tearful or anxious.

Kent and Medway NHS and Social Care Partnership Trust (KMPT) runs and provides most mental health services in Kent and Medway.

NHS Kent and Medway is the cluster of three primary care trusts – NHS Eastern and Coastal Kent, NHS West Kent and NHS Medway – which plans and buys health services on your behalf.

Psychosis affects a person's mind and causes changes to the way they think, feel and behave. A person may be unable to distinguish between reality and their imagination.

Personality Disorders are mental health conditions that affect how people manage their feelings and how they relate to others.

Schizophrenia is a long-term mental health condition that causes a range of different psychological symptoms, including:

- hallucinations – hearing or seeing things that do not exist
- delusions – unusual beliefs that are not based on reality and often contradict the evidence
- muddled thoughts based on the hallucinations or delusions
- changes in behaviour.

Clinical evidence

This is the list of policies and practice documents which support the proposals:-

- The Pathway to Recovery – A Review of NHS Acute Inpatient Mental Health Services, Healthcare Commission, 2008;
- Laying the Foundations; Department of Health (CSIP), 2008;
- Mental Health Policy Implementation Guide, DOH, 2002, 2006;
- Onwards & Upwards; CSIP; 2007,
- The Virtual Ward: www.virtualward.org.uk ;
- CSIP Integrated Care Network (2006).
- Whole systems working. CSIP: Integrated Care Network, 2006; Healthcare Commission (2007).
- Acute inpatient mental health service review: Final assessment framework 2006/07. Healthcare Commission;
- Model to assess the economic impact of integrating CRHT and inpatient services: National Audit office; 2001;
- Reducing Variation in Clinical Pathways to Reduce Delays, NHS Institute for Innovation and Improvement;
- Productive Wards, NHS Institute for Innovation and Improvement;
- The Acute Care Declaration, National Mental Health Development Unit October 2009;
- Do the right thing: how to judge a good ward, Royal College of Psychiatrists, June 2011;
- Star Wards, www.starwards.org.uk ;
- Enhancing Healing Environments: Kings Fund, 2000;
- Adult acute inpatient care provision, DOH, 2001;
- The Productive Ward: releasing time to care: learning and Impact Review; National Institute for Innovation and Improvement, 2010;
- National Audit of violence, Healthcare Commission, 2005;
- New Ways of Working; NIMHE; 2009;
- PbR 2012/13 Guidance DH Feb 2012;
- Equity and Excellence: Liberating the NHS; 2011;
- Crisis Resolution home treatment teams and psychiatric admission rates in England; British Journal of Psychiatry; 2006;
- Mental health policy implementation guide; DOH; 2001;
- Helping People Through Mental Health Crisis: the role of Crisis Resolution and home treatment service; National Audit Office; 2007; Johnson, S; Nolan, F; Pilling, S; Sandour, A; McKenzie, N; Patel S.N;
- Outcomes of Crisis before and after the introduction of a crisis resolution team; British Journal of Psychiatry; 2005;
- Crisis Resolution and Home Treatment – a practical guide; Sainsburys centre for mental health; 2006;
- Adult Acute inpatient policy implementation guidelines; DOH; 2002
- Inpatient Alternatives to Traditional Mental Health Acute In Patient care; report for the the national institute for health research service delivery and organisational programme; 2010;
- Crisis Resolution and home treatment; National Institute for Mental Health in England;
- Model to assess the economic impact of integrating CRHT and inpatient services; National Audit Office; 2001

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