Kent and Medway NHS
NHS and Social Care Partnership Trust

NHS
Kent and Medway

Achieving Excellence in Mental Health Crisis Care

1. INTRODUCTION

1.1 This paper reports on Kent and Medway residents' responses to the public consultation on Achieving Excellence in Mental Health Crisis Care, held for 13 weeks between 26 July and 26 October 2012.

1.2 The proposals were developed with the help of stakeholders in Spring 2012 as a result of significant concerns about

- Inequitable distribution of hospital beds for Kent and Medway people who are acutely mentally ill
- The long standing concerns about shortfalls in the therapeutic environment at Medway's A Block, including the inadequate privacy and dignity on offer and therefore the sustainability of clinical safety.
- The increasing need to enhance staffing and improve the service delivered by Crisis Resolution and Home Treatment (CRHT) teams following the success of this community-based alternative to hospital admission
- Very different levels of psychiatric intensive care support between the east and the west of the area

1.3 The year-long discussions about how to improve the situation and raise the standards of care to appropriate and equitable levels across the area have naturally caused some anxiety for service users and carers and for staff facing uncertainty about their futures.

1.4 Medway's A Block, which already had significantly more violent and aggressive incidents than any other unit in Kent and Medway and which is listed in the local NHS Risk Register for this reason, has seen a further eight such incidents at Medway, in a period when there have been none at either Dartford or Maidstone. Inevitably, the situation becomes more untenable the longer it remains unresolved.

1.5 This paper reports on the independent analysis of the consultation responses and the independent assessment of the consultation process. It sets out how the points raised by the respondents are being addressed and includes further information requested by, and supplied to, Kent and Medway Joint Health Overview and Scrutiny Committee (JHOSC).

1.6 Seven Clinical Commissioning Groups have considered the response from the consultation, the proposed actions to address points raised within consultation and the implementation plan, and offered their support, the eighth CCG is due to respond shortly.

1.7 All of this, together with views expressed by the Kent and Medway JHOSC, will be reported to the PCT Cluster Board and the Kent and Medway NHS and Social Care Partnership Trust Board (KMPT) towards the end of February when next steps will be decided.

2. BACKGROUND

2.1 The service review

2.1.1 The public consultation, which all the Kent and Medway Clinical Commissioning Groups (CCGs) supported, was approved by the Cluster Board in July 2012, following a review of current services that found:

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

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

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

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

2.1.2 The review analysed four years of bed usage data, leading to the conclusion that, allowing for the usual variations and the seasonal peak between January and March, 150 beds would be required (rather than the current 160), plus 12 in one psychiatric intensive care unit (PICU) supported by an outreach service across the whole of Kent and Medway, rather than 20 in two such units with only some places having the outreach service. The 150 beds will be allocated proportionately to match actual demand, with each service locality allocated to a specific inpatient ward and an aligned Crisis Resolution Home Treatment team.

2.2 Proposals for consultation

2.2.1 With the approval of all CCGs in Kent and Medway, the Cluster Board sought and gained JHOSC support for consultation on the review's proposals for future services that will deliver

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

2.2.2 The proposals are designed to:

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

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

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

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

2.2.3 They would mean:

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

2.2.4 In developing the proposals, KMPT made clear it was committing to creating Centres of Excellence to drive quality, breadth of services and interventions offered. The opportunity for research and development alongside academic partners enables greater consistency of practice and outcomes to be achieved and shared. KMPT described its Centres of Excellence (CoE) model as:

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

2.2.5 The Centres of Excellence, together with strengthened CRHTs, will ensure service users and carers:

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

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

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

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

2.2.6 Three options for the allocation of service localities to inpatient wards were consulted on. In all of them, people from Medway would be treated at Little Brook Hospital, Dartford, when they need a hospital stay. In options A and C, Medway would have its own CRHT and in Option B, it would share one with Swale.

2.2.7 For people from Swale (excluding Faversham)
- Option A would mean hospital stays in Priority House, Maidstone
- Option B would mean hospital stays in Little Brook Hospital, Dartford

- Option C would mean hospital stays in St Martin's Hospital, Canterbury

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

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

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

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

3 ENGAGEMENT AND CONSULTATION

3.1 Pre-consultation

3.1.1 From February to June 2012 there was extensive engagement with stakeholders, staff, service users and carers to ensure their views were able to influence the review. The review met the requirements of the four tests set out by the Department of Health in relation to service configuration as outlined below:

- **Support from GP commissioners**
  All eight of the Clinical Commissioning Groups reviewed the evidence presented by the Acute Mental Health Board, and clinical leads from each locality were involved throughout the development of the options.

- **Strengthened public and patient engagement**
  The Commissioners and the Trust have several ways in which they regularly talk to their service users and carers including: patient consultative committees, nine Locality Planning Meeting Groups twice in March and May/June, Performance meetings and Joint Commissioning Boards. The commissioners and Trust senior staff used all of these meetings to ensure that service users and carers were involved from the outset in developing and commenting on the proposals for achieving excellence in a mental health crisis.

  Service users, carers, council members and clinicians all took part at options appraisal in February, there were several further meetings with service users, staff, clinicians, GPs and carers to finalise the options to be taken forward including a workshop with Kent LINk's mental health network.

- **Clarity on the clinical evidence base**
  A wide range of stakeholders: GPs, clinicians, service users, carers, councillors and partner organisations were invited to a stakeholder option appraisal event in February to consider eight potential options and reduce these to a short list of robust, viable options to take forward.

  Following this, a series of meetings was held with mental health clinical staff and the clinical commissioners (CCGs) to test the short listed options and ensure that all aspects of the proposed clinical pathway were robust and supported by front line staff as well as senior staff.

  The clinical case for change was reviewed and supported by the National Clinical Advisory Team in July 2012, and the SHA service reconfiguration team.

- **Consistency with current and prospective patient choice**
  Each of the options for change retains choice of home treatment from the CRHT or inpatient treatment if appropriate. The core proposal is for relocation of acute services in Medway following clinical opinion that there was a need to resolve the problems with A Block after a 10 year pursuit of local alternatives.

3.1.2 Throughout the review the team has worked closely with the Medway and Swale advocacy project to ensure those service users most affected by the changes would be able to influence the plans. Travel and transport for carers, family and friends was a major concern so staff worked with the Medway and Swale service user group to test the public transport available to reach the centres of excellence from Medway, and Sittingbourne and Sheppey. The information they found was fed into the plans and information provided during the wider consultation.

3.2 Regular communication and information

3.2.1 Key stakeholders such as MPs, local authorities and other partner organisations were also briefed and asked for their input through their regular working meetings, or via meetings with senior staff to ensure they were kept abreast of developments and were aware of the early thoughts and plans.

3.2.2 Both scrutiny committees in Kent and Medway were given an early briefing in which the potential requirement for a Joint Health Overview and Scrutiny Committee (HOSC) was highlighted. Both Kent and Medway HOSCs agreed to form a JHOSC using the existing agreement for how this would be set up.

3.2.3 The Members of the JHOSC and their support staff were invited to visit two of the key sites affected by the proposals being developed.

3.2.4 The PCT featured the review in two issues of the award winning *Your Health* magazine, 50,000 copies of which are distributed through GP practices, hospital waiting areas, supermarkets, libraries and community centers, as well as in hairdressers and other outlets to ensure the wider community was aware of, and able to be involved in the review.

3.2.5 The local media have also been regularly updated with press releases and news statements. Both the broadcasting media and local newspapers have featured the review.

3.2.6 A dedicated page on the KMPT website was set up and two consultation documents written.

3.2.7 In June and July the JHOSC and the two NHS Boards met to agree and approve the proposals and the plans for formal consultation with the wider public, following approval from all the 8 clinical commissioning groups across Kent and Medway.

3.3 Independent assessment of the clinical case for change

3.3.1 The National Clinical Advisory Team examined the clinical case for change before the consultation was launched and said:

> *"The clinical case for change is sound, and this overall is an outstanding piece of work.....The paper has a really impressive and well worked-through set of interventions and service changes which should reduce both admissions and length of stay."*

3.4 Consultation methods

3.4.1 The formal consultation ran from 26 July until 26 October and a range of methods were used to promote the process:

- The public consultation document and summary was written and tested with various stakeholders, including non-executive directors, staff, and service users, to ensure it was clear, easy to understand and provided sufficient information without overwhelming the reader with details. It was successfully launched on 26 July 2012 and over 200 individuals, staff, service users and carers responded.

- The engagement team sent out 966 invitations, with a link to the website and the electronic versions of the document, to organisations and individuals with an offer to attend any meetings or events where people were interested in the review to provide further information and listen to what people thought of the plans. The Commissioning team and KMPT also sent the document out to key stakeholders, organisations, over 3,000 Foundation Trust members, and staff. Also the VCS organisations which support service users and carers and are interested in mental health, cascaded the information to their members – for instance, 575 individuals registered with MIND for the LPMGs

- The engagement team booked six venues to cover each area, holding the Public Consultation meetings at a range of times in accessible and well used venues, and wrote to all known service user and carer organisations with the offer of being involved in focus groups or the engagement team coming to their meetings to provide some information and raise awareness of the consultation. A further two public meetings were added at the request of stakeholders. Over 180 people attended these eight meetings and a few carers attended several meetings.

- KMPT had a specific page on their website, with information available and suitable links on the three PCT websites, the *live it well* website and from partners in social care. The website and Intranet contained supporting documents of the Review including:

  - Online Consultation Response Form
  - Full Public Consultation Document and Consultation Response Form and Summary Consultation Document
  - Easy Read Consultation Document and Easy Read Consultation Response Form
  - Large Print Consultation Document and response form

  Background papers were also available online, including:

  - Full Board papers
  - Summary Board papers

- Non-financial appraisal
- Risk appraisal
- Risk scores for Appendix B of the full Board paper
- Right care, right time, right place document
- Equalities Impact Assessment

The consultation was also accessible through social media such as Facebook and Twitter.

- The communications teams distributed 3,000 Public Consultation Documents and 15,000 summary documents to over 700 organisations in Kent and Medway: GP practices, libraries, voluntary organisations and community centres, KMPT trust community buildings, pharmacies, opticians, hairdressers, job Centres, fitness centres, citizens advice and volunteer bureaus.

- The review and consultation also featured in *Your Health* and *Medway Matters,* the NHS magazines with a circulation in excess of 50,000. The information was also placed with local councils known to publish residents' papers in Medway and Swale, the LINk and Kent Community Action Network.

- Press releases were issued to raise awareness and promote the consultation and specific releases went out before and after each public event.

- The PALS phone number and email address was offered for any individuals wishing to comment or request more information.

3.5 Public meetings

3.5.1 Many of the eight public meetings in the consultation were chaired by an independent person from one of the local VCS support organisations to ensure that service users and carers felt comfortable and confident to contribute their views.

3.5.2 At these three-hour public road shows, a panel of clinicians and commissioners presented information on the review, the reasons why it was necessary, the outcome expected of the review, the steps taken during the review, the options arrived at and what would happen following the consultation. There was also a film of a service user's story so that people could hear how the Crisis Response and Home Treatment service worked to treat people at home. A quick question and answer session was followed by an hour of round table discussions to ensure that everyone present was able to give their views. Then, finally, a further open question and answer session and those present were asked to evaluate the events so we could ensure they worked.

3.5.3 184 people attended the eight meetings: there was a good mix of service users and carers, support organisations, NHS and social care staff and some local councillors. It had been anticipated that the numbers attending wouldn't be high due to the specialized nature of mental health crisis care and also, partly, to consultation fatigue. A number of people commented upon the high level of changes happening across the public sector. The NHS is grateful for the contributions of all those who took part.

4 CONSULTATION RESPONSES

4.1 Public response

4.1.1 An independent University of Greenwich research team analysed all the responses to consultation made through surveys, focus groups, public meetings, road shows and individual letters, emails and telephone calls. The team's detailed report is attached as Appendix 1 to this report.

4.1.2 25 queries or comments were received directly from the public in the form of letters, faxes and emails.

4.1.3 207 surveys (120 paper versions and 87 submitted online) were sent to a research team at the University of Greenwich for analysis.

4.1.4 133 people attended 13 Focus Groups, including 66 service users, 41 carers, 2 volunteers, 3 workers and 21 members of the public.

4.1.5 In addition to this, the engagement team and KMPT staff attended 15 other events with 290 attendees, including holding road shows at three shopping centres in the Medway towns to raise awareness and share the information.

4.1.6 The media took an interest in the consultation. 19 articles were written in local papers and published online with various circulation figures totalling approximately 447,604.

4.1.7 One correspondent attended seven of the eight meetings and approached various senior managers and GP commissioners to discuss his concerns. He raised a number of issues of detail and identified some errors in the review data, which the review team has now corrected. The review team also gave him a detailed response to his concerns, none of which have a substantial impact on the overall clinical case for the proposed changes. A summary of this detailed response from the review team is attached to this paper as Appendix 2.

4.2 High level feedback

4.2.1 The University of Greenwich reports there was strong agreement with the aims of the review:

- Over 80% of respondents strongly agreed everyone should have the same high quality of care and hospital facilities.
- 70% strongly agreed that people with mental health problems make a better and faster recovery in a calm environment
- 62% strongly agree crisis treatment at home should support carers as well as service users.

4.2.2 The strength of support was less when considering whether quality of care was more important than the distance travelled to reach it but, even on this point, over 50% strongly agreed or agreed.

4.2.3 Concern over travel and transport was clearly a major issue for many people and, when asked about the kind of support that would be most helpful, people were strongly in favour of the volunteer driver scheme, clear information and better signage. They also suggested support with payment of fares, a subsidized shuttle service and working with the Medway Foundation Trust or the local council to pursue a cheaper public transport solution.

4.2.4 When asked about their priorities, the themes were:

- **Access** (including, coverage, amount of travel, how local the service was and how quickly the service could be accessed)
- **Greater resources**
- **The quality of individual care** (including the family and more personalized care) and
- **The quality of service provision** (organisational improvements, multidisciplinary teams, transition between services, more and better services)
- **Community provision** summed up by this quote: “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 hospitalization.”
- **Compound impact of changes** – Mental Health service users made the point that they were being affected by several changes to public services including the changes to the benefit system, supported housing and charges being introduced for some social care services.

4.2.5 What people want from centres of excellence are: a better patient experience, a better range of staff 24/7, more personal service. They expect them to provide a high quality environment, better resources, and appropriate treatment. People welcomed the idea of calm environments with better personal facilities. They also asked that staff provide a response to questions raised and work better with carers by giving more practical advice and information so that both service users and carers could understand and receive the support they need from this complex system. This was, they said, particularly necessary when service users were being discharged.

4.2.6 In terms of CRHT they would like an improvement in the quality and availability of support, more personalised care, better staffing, information and continuity.

4.2.7 The support for plans for Psychiatric Intensive Care were less clear cut with just over a third agreeing, a third disagreeing, and just under a third unsure.

4.2.8 In terms of options for Swale service users, 141 respondents chose an option with 66 not indicating a preference.

- 62% chose Option A Priority House
- 11% chose Option B Littlebrook Hospital
- 27% chose Option C St. Martin's Hospital

4.3 Profile of survey respondents

4.3.1 The final section of the survey tells us about the respondents :

- 39% were service users
- 13% carers
- 11% members of the public
- 11% health and social care staff
- 17% felt they represented a combination of the above
- 6% fitted none of these categories
- 3 % were organisational responses.

4.3.2 In geographical terms:

- 34% came from the east Kent catchment area,
- 27% from Medway and Swale,
- 12% from the Priority House (west Kent) catchment area and
- 9% from north Kent the Dartford, Gravesham and Swanley area, with
- 13% of respondents did not provide a postcode.

4.4 Evaluation of the consultation process

4.4.1 The University of Greenwich research team also independently evaluated the consultation process undertaken. Its findings are shown in Table 1 below.

Issue	Evaluation
Public consultation processes are governed by legislative requirements	Based on the evidence received to date... this requirement is fully met
The 'Strengthening public and patient engagement' element of the four tests for NHS Reconfigurations	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.
The seven criteria of HM Government Code of Practice on Consultation 1. When to consult – Formal consultation should take place at a stage when there is scope to influence the policy outcome	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.	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	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. The full financial consequences of the redesign will only be known when the decision is made. Based on this evidence the criterion has been largely met.
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	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.	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 eight pages in length with 17 closed questions, seven open ended questions and three 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

6. Responsiveness of consultation exercises – Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation.	has been met. 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.	The consultation exercise was instigated by KMPT and conducted by the Assistant Director of Citizen Engagement, a role which specialises in communications with the public for the 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.
Consultation documents were available in different formats	Paper versions of the full and summary consultation documents were offered in 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.
Consultation documents and surveys were widely distributed	The survey and consultation document were sent to, for example, the Ethnic Minority Independent Council with 10 copies each of Czech, Nepalese and Chinese documents. 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 and Medway, in all the main towns and cities. Each meeting began with an explanation of the consultation and survey by a representative from KMPT involved in the service redesign. All emails, letters, calls and petitions were recorded and responded to.

Table 1: Independent University of Greenwich evaluation of the consultation process

4.4.2 The University team highlighted a number of learning points, mostly related to ways of improving the survey design, its questions and the data collection tools, which would have facilitated the analysis of responses. They also said the consultation documents in paper and electronic formats were in a "well presented and user friendly format" and that "other consultations would benefit from using a similar format".

4.5 Health Gateway Review

4.5.1 In the last three days of the consultation period, a team of three provided by the Department of Health conducted a Health Gateway Review 0 : Strategic Assessment, centred around the implementation phase of the programme. They interviewed 15 members of the programme team and a small number of key stakeholders and reported to David Tamsitt, KMPT's Director of Acute Services on 26 October.

4.5.2 The purposes were to

- Confirm the programme's outcomes and objectives (and the way they fit together) make the necessary contribution to the overall strategy of the organisation and its senior management
- Ensure the programme is supported by key stakeholders
- Confirm the programme's potential to succeed has been considered in a wider context
- Review arrangements for leading, managing and monitoring the programme and its main risks
- Check that the programme is resourced and that plans for the next stage are realistic and feasible and join up with other programmes (internal and external) and
- After the initial review, check progress against plans and expected achievement of outcomes.

4.5.3 The review team made six timely recommendations, shown in Table 2.

Recommendation	Timing	Action
1. The Programme Team should continue to develop a detailed response to the emerging findings from the consultation to fully support the final submissions to the approving bodies.	Do Now	Done – see sections 5 and 6 of this paper and ongoing discussions with stakeholders
2. The Programme Team should identify the main initiatives required to achieve the anticipated outcomes and put in place a performance framework to assure delivery.	By Jan 2013	Done – marked in Implementation Plan see Appendix 3
3. The Programme Manager should implement a comprehensive risk and issues management process and produce and maintain an updated risk register to reflect the current status of the Programme.	By Nov 2012	Done – reported to KMPT Board in January 2013
4. The Programme Team should produce contingency plans to address the risks associated with challenge and delay in order to maintain momentum in seeking better patient outcomes and increased efficiencies.	By Nov 2012	Done – reported to KMPT Board January 2013
5. The Programme Team should prepare a detailed implementation plan which captures all of the activities, dependencies between all of the workstreams and which identifies the critical path.	By Nov 2012	Done – attached to this paper at Appendix 3
6. The SRO should review and implement new governance arrangements to ensure clear reporting and accountability lines for performance and delivery.	Do Now	Done – KMPT NED, Medway/ Swale CCG GPs and service user on Programme Board

Table 2: Health Gateway Team recommendations to KMPT

4.6 Important additional information

4.6.1 In November 2012, the independent Schizophrenia Commission established by Rethink Mental Illness published its report *The Abandoned Illness* following a year of research by its 14 experts. Their work focused, in particular, on the delivery of adult mental health services. It is especially interesting that this was being undertaken at the time of the Kent and Medway review and redesign programme and its formal public consultation process.

4.6.2 The Commission's work involved six formal evidence-gathering sessions from 80 people who have lived with schizophrenia or psychosis, family members and carers, health and social care practitioners and researchers. 2,500 people responded to the Commission's survey online.

4.6.3 Their report makes a number of crucial points about healthcare offered to adults with severe mental illness and says: "Ensuring good quality acute services are in place must be a top priority for the commissioners and providers of mental health services. "

4.6.4 It calls for "a radical overhaul of poor acute care units" and says: "Recovery houses can offer an alternative to an acute admission or be a half-way house back to the community after time on an acute ward." In the same section it says: "Alternative providers such as voluntary organisations and charitable housing associations should be involved in discussions about expanding this provision. We recommend that Clinical Commissioning Groups and providers explore alternatives to admission as part of their plans for the development of acute care and crisis services."

4.6.5 The report, which makes 42 recommendations, says: "We found broad agreement about the changes that need to be made to transform the lives of those with schizophrenia or psychosis and of their families. Encouragingly, we also had support from a range of organisations and practitioners for our approach."

4.6.6 It adds: "There are things we can build on. In the last 20 years much progress has been made in understanding schizophrenia and psychosis. There have been many positive developments including the growth of the service user movement, initiatives like crisis resolution teams and early intervention in psychosis services, exercise prescriptions, investment in new IT systems and direct payments. There are now more single sex acute care units with individual rooms, flexible day centre provision and multi-disciplinary team working."

4.6.7 It also says: "We...commend the innovative and progressive mental health services that are being delivered in some areas as well as the Government Strategy *No Health without Mental Health* which provides a good foundation for building the attitudes and values that we need. We are hopeful that outcomes can be improved for everyone affected by severe mental illness. But it will require a radical overhaul of the system including

an integrated approach with health and social services working together, a greater emphasis on patient preferences and a widespread application of flexible and innovative solutions. We do know what works – let's apply it."

4.6.8 The charity Mind produced *Mental health crisis care: commissioning excellence,* a briefing for Clinical Commissioning Groups in November 2012, highlighting the uneven provision across the country. Following a Freedom of Information request to mental health trusts around the country, Mind established that referrals to crisis care ranged from 42-430 per 10,000 population. KMPT receives 147, above the average of 107. It visits service users in crisis an average of 14 times. The range across the country is 1-23 visits and the average is 8.

4.6.9 The briefing points out that having a range of alternatives to hospital admission facilitates service user choice, meets a diversity of needs and helps CRHTs work more effectively. Examples include:

- Crisis houses, sanctuaries and recovery houses
- Retreats/respite care
- Peer/survivor-led services
- Host families
- Crisis-focused therapeutic programmes

4.7 Conclusions

4.7.1 Based on all the above consultation and engagement, the following conclusions are drawn:

a. The work on which the consultation was based has been examined independently and found to be clinically sound and of high quality.

b. The independent research team analysing the consultation responses is clear that the consultation has been properly conducted.

c. Stakeholders strongly supported the consultation's aims

d. Two-thirds of respondents supported the proposals in Option A, giving a clear mandate to proceed

e. A number of key issues raised in the consultation need to be addressed to facilitate establishing and embedding the proposed changes

f. None of these issues is of sufficient substance reasonably to prevent the proposed changes going ahead

g. The proposed centres of excellence are the kind of acute units that the Schizophrenia Commission wants to see established.

5 ADDRESSING THE POINTS RAISED IN CONSULTATION

5.1 Travel and transport

5.1.1 KMPT staff are expanding the volunteer driver scheme and preparing clear travel information for CRHTs and Centres of Excellence to hand out, as well as making it available on the Trust website.

5.1.2 Carers from Swale and Medway are involved with staff from KMPT in a group preparing the transport plan to support visitors to patients from these two areas to their new acute units . This group is considering all the issues outlined in the consultation document including:

- Estimating the funding needed to cover higher fare repayments for claimants
- Exploring use of hospital transport economies of scale with acute providers
- Checking that bus times work well with end of ward visiting times: at Little Brook Hospital, Dartford, visiting times are currently 3pm - 5pm and 6pm - 8pm, Monday to Friday and flexible at weekends and Bank Holidays; at Priority House, Maidstone, visiting times are currently 4pm – 8pm except during the 6-6.30pm protected meal time, and at weekends and Bank Holidays 2pm-8pm except during the 6-6.30 protected meal time. There is always flexibility in difficult circumstances, and that judgment is made by the ward manager/nurse in charge. No-one wants people to have a long wait for a bus if they stay to the end of the ward day
- Voluntary transport/'buddying' for service users and carers from localities affected
- Secure transport for the safe transfer of patients between sites and PICU
- Liaising with the Police to ensure best use of Section 136 admission
- Use of web technology (e.g. Skype) to support community team-ward/patient liaison
- Service user forum based web technology to support family/carer communications
- Further integration of CRHTs and acute ward resources for service users' benefit
- A week-long audit of transport used by visitors, which was done in the summer, showing that most used their own transport whichever unit they were visiting.

5.2 Service user priorities expressed in the consultation

5.2.1 Access:

a. Sheppey service users were clear in the consultation that they want access to some crisis care on the island. The CCG and KMPT will

discuss the feasibility of this and whether it could be aligned with the walk-in centre at Sheppey Hospital.

b. Medway service users were clear in the consultation that they want to see another alternative to admission available in Medway. KMPT is looking into whether the local CRHT base in Medway could be with the Liaison Psychiatry Service at Medway Maritime Hospital, so service users have a clear place to go when necessary.

c. Medway councillors also expressed disquiet at the relocation of services. In view of the campaign by Rethink and Mind, possibly Medway Council could discuss with the voluntary sector the feasibility of establishing and running a Recovery House in Medway to provide an alternative to hospital admission and to ease people's return home from a hospital stay.

5.2.2 Greater resources:

a. Three STR workers have already been appointed in Medway to work with the CRHT to ensure more continuity of care for service users, more time, and practical support for carers and service users.

b. 11 STR workers were recruited in East Kent in December

c. 11 STR workers will be recruited in West Kent once the ward changes have taken place and the funding is released.

5.2.3 The quality of individual care and the quality of overall service provision is being improved by

a. **The addition of STR workers** who provide respite for carers and additional support to service users

b. **A more consistent approach to care across the area** - KMPT is working to ensure the CRHTs across Kent and Medway work consistently with clients wherever they live in the area. It is also monitoring the impacts from initiatives to develop alternatives to hospital admission and will report publicly on the emerging picture in March 2013 after its acute care clinicians have examined the situation

c. The role of the **Discharge Co-ordinator** provides service users with practical support removing barriers to discharge such as problems with housing or utilities. It has been piloted in East Kent and reviewed in November 2012, when it was found to have achieved a significant reduction in out of area placements, which were down from 35 in August to just four in October. This resulted in savings as well as improved support for service users so KMPT proposes to appoint Discharge Co-ordinators in Dartford and Maidstone too. At the same time, KMPT is overhauling its protocols and practice

throughout the acute care pathway and this work is expected to be completed by March 2013

d. **Therapy at evenings and weekends too** - In preparing for Payment by Results, KMPT's acute service has developed packages of therapeutic interventions for service users in hospital which are based on NICE standards and best practice and will make those available in the centres of excellence in the evenings and at weekends as well as during the day. This means the overall service is better and individuals will have more support in reaching their care plan goals.

e. **Peer support workers** - Research evidence from Recovery Scotland indicates that peer support workers – people who are themselves in recovery from mental illness – are a valuable addition to the multi-disciplinary team supporting service users. This approach is being introduced by KMPT in December 2012 at Little Brook Hospital, Dartford, and at St Martin's Hospital, Canterbury, and at Priority House, Maidstone, in May 2013. It will be evaluated in June and, if the achievements are sufficient, a plan to expand it to CRHT work will be prepared in July.

f. **Working better with protected groups** – a conference involving service users, carers and agencies representing older people, younger people, those with disabilities, gay, lesbian, bisexual and transgender groups, parents, those of different races, men and women and people of different faiths considered the consultation document and commented on how the proposals could affect them. The Trust is working hard to improve its connections with the communities it serves, and will build upon the local knowledge of the community and voluntary sector to support people.

6 NEXT STEPS

6.1 Implementation Plan

6.1.1 The Implementation Plan has been developed, following the closure of the consultation and submission of the analysis of responses by the University of Greenwich. The planning is being undertaken with input from clinicians, KMPT Acute Service Line leadership and managers and Kent and Medway NHS commissioners. The plan appears at Appendix 3. Key stakeholders will continue to be briefed regularly as the next steps are taken.

6.1.2 The planning includes draft timelines that will apply if the cluster board approves the recommendations at its meeting on 20 February 2013 but no action will be taken until that approval is given.

6.1.3 The plan includes:

- **Staff consultation** about the re-aligned jobs resulting from the changes between 1 and 30 March 2013, with interviews in April/May and staff in their new roles by July

- **Psychiatric Intensive Care**
  - Two Band 6 psychiatric nurses to provide Psychiatric Intensive Care Outreach support to the East Kent centre of excellence from May 2013. They will have a base at St Martin's, Canterbury, but be managed from the PICU at Dartford. They will support staff in the East Kent centre of excellence with strategies to work with patients who are particularly unwell, so that fewer of those patients need to be transferred to PICU than in the past.

  - All Canterbury-based Psychiatric Intensive Care patients to move to the Willow Suite in Dartford by 30 April 2013

- **East Kent centre of excellence** A £400,000 redesign and refurbishment of Dudley Venables House on the St Martin's, Canterbury, site to convert the building from a Psychiatric Intensive Care Unit to a modern, light and airy therapeutic acute unit space is expected to be completed by 1 August 2013. The work will involve establishing a new dedicated de-escalation suite where staff can take patients who need to calm down away from the busy-ness of the whole unit. A total of 14 bedrooms will be created with modern toilet and bathroom facilities for patients to share in segregated male and female areas.

- **West Kent centre of excellence**
  - Sittingbourne and Sheppey patients to routinely use the acute unit at Priority House, Maidstone, from August 2013

  - Around £40,000 to be spent on improving the Section 136 suite at Priority House, used for people with apparent mental health problems who are brought in by the police for assessment The work should be completed by August 2013

  - Plans to upgrade the accommodation in Priority House are being drafted, with a capital bid due to be submitted in January 2013 and the work completed by August.

  - The Crisis Lounge being piloted in Maidstone will be evaluated in July.

- **North Kent centre of excellence**
  - Medway patients to begin routinely using the acute unit at Dartford from August 2013, once Birch Ward in Dartford has been refurbished and prepared for its new role.

  - Medway CRHT is being strengthened by 3 STR workers, currently being recruited to offer crisis day care in the Medway towns. If Option A goes ahead, Medway will recruit a further 4 STR workers.

7 RECOMMENDATIONS

The CCG/KMPT/Cluster Board is recommended to

a. Approve the implementation of Option A in line with the plan at Appendix 3

b. Approve the actions in response to the points raised by respondents to the consultation

c. Endorse the Implementation Plan

d. Encourage the establishment of a Recovery House in Medway