Appendix 2 – 30.01. 2013

Issues of detail and data raised in the consultation and the review team's response

We welcomed the sometimes lively debate and the frank exchange of views in the *Achieving excellence in mental health crisis care* public consultation between August and October 2012.

A number of challenging questions were asked about the detail of the case for change so we re-visited a number of issues to check our accuracy, which was sound in most cases. In a few instances, mostly raised by one individual who attended all but one of the consultation public meetings, some small amendments have been made to graphs and data that had been published in the detailed pre-consultation Board paper on which the decision to consult was based, which was shared on the consultation web page at http://www.kmpt.nhs.uk/acute-mental-health-review. These do not substantively affect the clinical case.

We believe that, in the interests of transparency, it is important to share this material more widely since many of the questions were raised at public meetings, so we felt people might be interested in the responses made and actions taken. We feel this challenge and response has enhanced the whole process of considering our plans for the future.

The material published here demonstrates that the points have been responded to appropriately and that none of them was large enough (either separately or when added together) to indicate that the consultation should not be held or that the options being consulted upon should be changed.

For the sake of clarity and to aid understanding we are including both the information we originally published and the amended information.

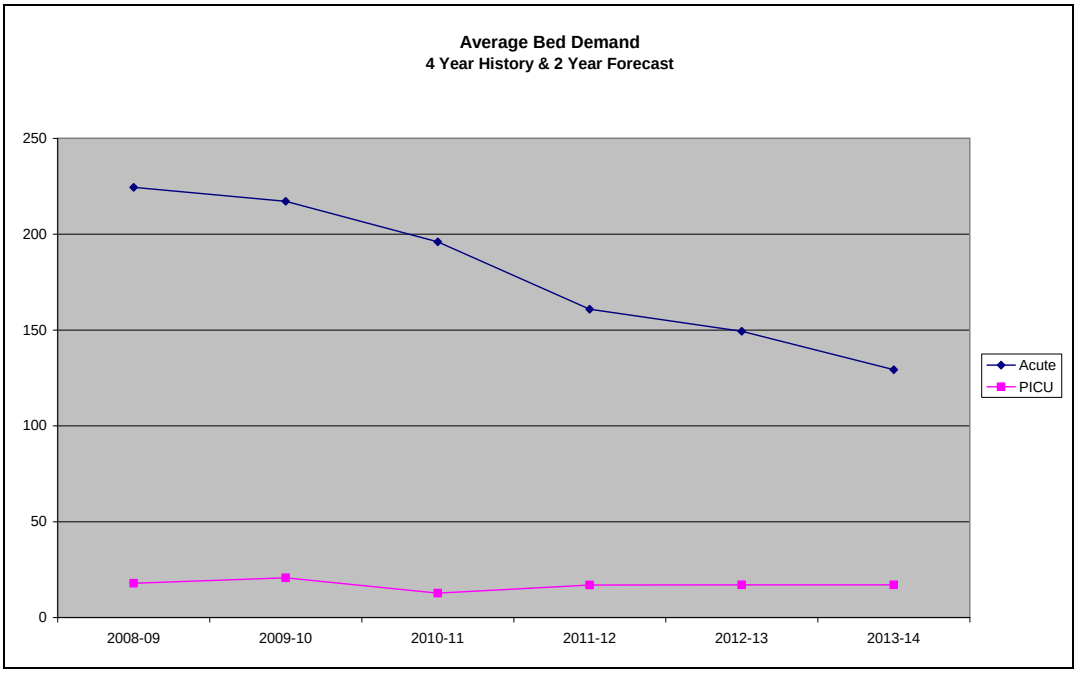
1. Falling demand for beds shown in Figure 2

a. Question: Why are the numbers in Figure 2 graph on page 9 of the July Board report higher than those in Appendix B, when both purport to show the same information?

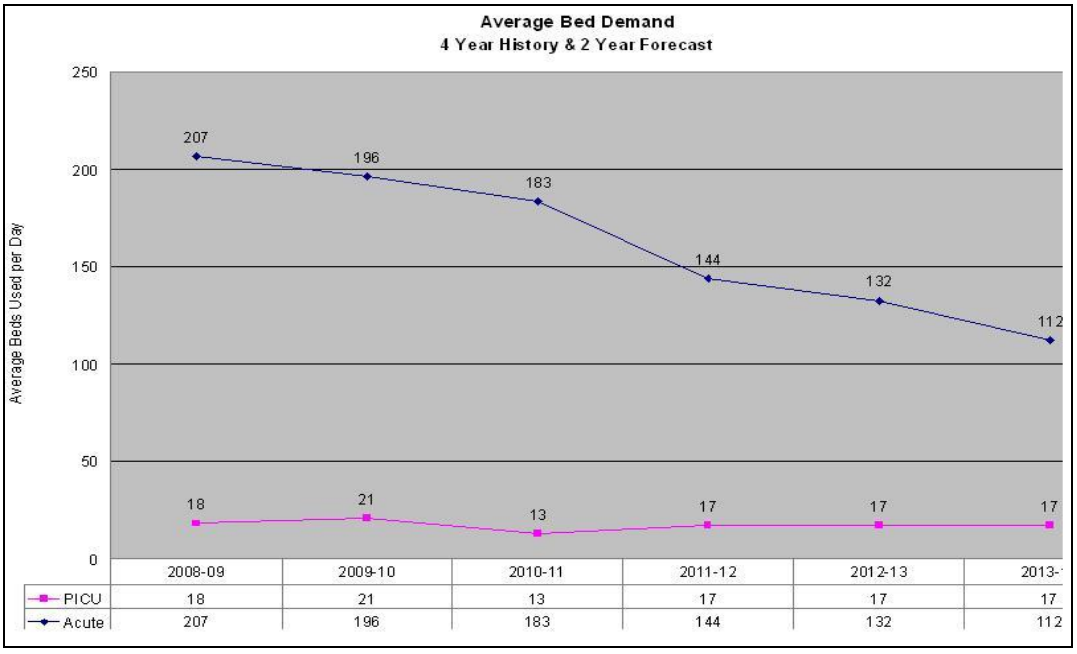
Response: The data in both places accurately reflects the activity recorded in those years. The graph shows one line indicating the PICU bed usage and another indicating the *total* adult acute bed usage (the number of ordinary acute beds *plus* the number of PICU beds). We recognise this is not as clear as it should be and a further line showing the number of ordinary acute beds alone would have been helpful. This would have matched the numbers in Appendix B. We have since drawn this line and the graph displays the same shape and meaning as in the original.

We made two descriptive mistakes: first, the title in the graph should have read *Reducing bed demand over the last four years extrapolated as a forecast to 2013-14*; and secondly, the scale of the graph in the Board report was formatted for a stacked rather than a non-stacked chart in Excel, which resulted in the two figures, for acute beds and for PICU, being added together automatically. Thus, the top line of the graph included not just acute inpatients but also the bed days of people in PICU (between about 17- 20 beds). When we drew this line, it had the same trend as the original.

i) **Graph published in the pre-consultation Board paper where it was entitled *Fig 2:*** *Reducing bed demand over the last four years extrapolated as forecast to 2014-15*



ii) Redrawn Fig 2, with values on the data points and the data table it is taken from. Its correct title is: *Reducing bed demand over the last four years extrapolated as a forecast to 2013-14*



b. Question: Why is the number of adult acute beds indicated in Appendix B as 207 in 2008-9 when there were only 190 beds available?

Response: The 190 is counting the supply – that is, the number of beds we actually had set up in the acute mental health wards. The figure of 207 is counting the demand – that is, the number of adults wanting an acute mental health bed. About 10 per cent of the 207 were patients on home leave, who were not actually using a hospital bed allocated to them. These beds were therefore available for other patients who were in hospital. It also included use of beds by adults who were in hospital for their acute mental health problems but who were on other wards (e.g. older people's wards, and historically, some mixed wards). We have re-checked the underlying ward stays data for 2011-12 and can confirm that bed demand was just as we stated in Appendix B.

2. CRHT treatment data shown in Figure 3

Question: What CRHT activity does the Figure 3 graph on page 10 of the July Board report show? It stops at June 2011 – and doesn't it give a different picture from the data KMPT has from July 2011 to September 2012 when the activity showed a sudden dip? If this is down to computer error, will the hospital bed days data have been similarly affected?

Response:

iii) The title published in the pre-consultation Board paper was *Fig 3: Increasing CRHT episodes of care over the last four years to 2012-12* – It should have read:- *Fig 3: Increasing CRHT episodes of care over the five and a quarter years to 2011-12*

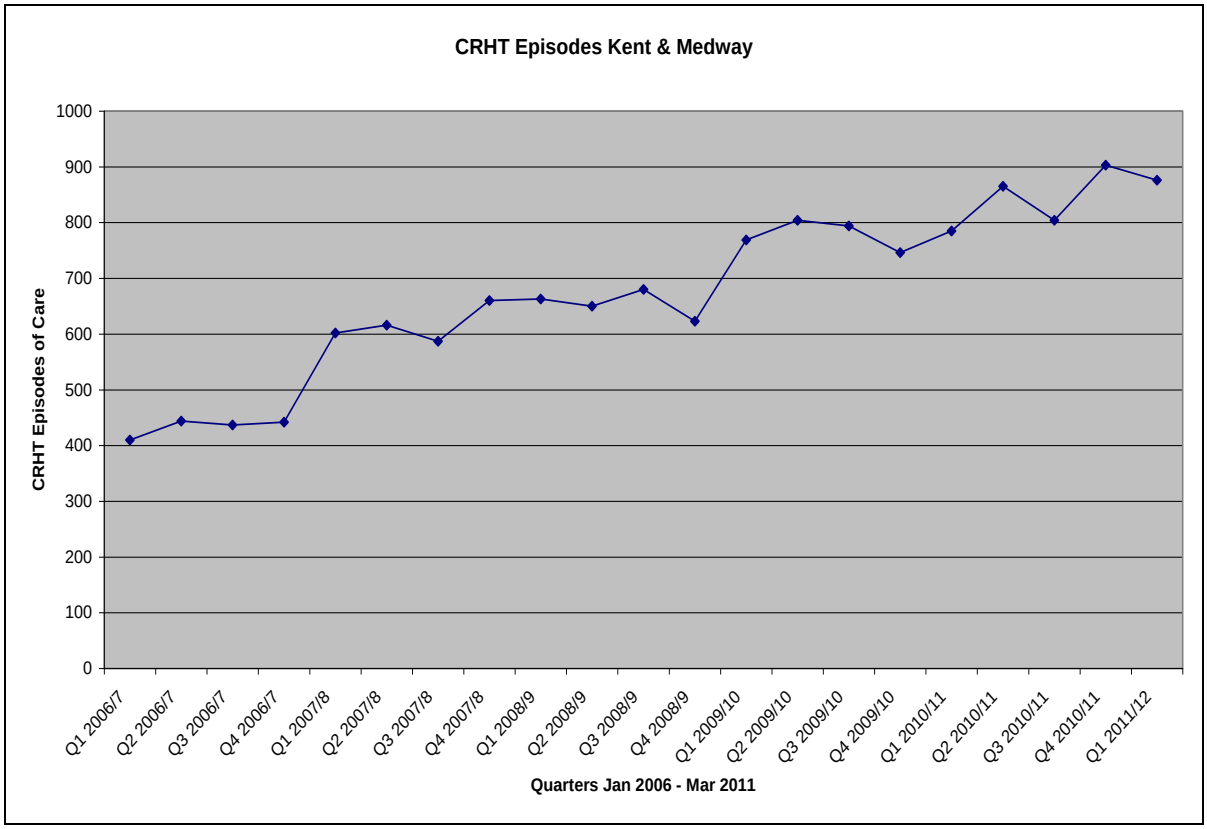


Figure 3 shows episodes of care delivered by KMPT's CRHT teams. An episode of care is the series of visits made by a CRHT team to an individual following a particular referral and covers the care package the CRHT team delivered to that person at this stage of their illness. A service user may have several referrals in a single year, only one, or none at all. Each referral will result in a care package or episode of care that might last for a few days or a few weeks before the service user is transferred back to the care of the Community Mental Health Team. It is these referral-based episodes of care that are counted and reflected in the graph that is Figure 3 in the Board report.

KMPT knows that the CRHTs have been delivering increasing numbers of episodes of care in people's own homes every year while the numbers of hospital admissions and occupied bed days have been falling because that has been a deliberate policy across the country and is supported by organisations like Mind and Rethink who champion service users and their families. This is clearly reflected in the data to June 2011, which was collected on a patient administration system called ePEX. The code for episodes of care on ePEX included single-contact support given by the CRHT team to individual service users as well as full episodes of care lasting days or weeks.

When this review of acute mental health beds began, the Trust was only just changing to a new patient administration system called RiO. Trust staff soon spotted that the CRHT work was being reflected differently by RiO than the previous system, ePEX, but did not then fully understand exactly why. The Acute Service Line knew there had been no dramatic change to CRHT work, so the review based its calculations on the ePEX data, drawing a line at the changeover to RiO, so that the data it was based on was consistent. We did make a tiny mistake in the description of Figure 3 in the Board paper, which mentions four years of data when it quite clearly covers five and a quarter years.

The new patient administration system introduced in April 2011, called RiO, is designed to give the trust more detailed management information. It has two codes where ePEX had only one: episodes of care are counted only when they last for more than a single contact, with single-contact support having a separate code. This takes all the single-contact support away from the episodes of care that ePEX counted and makes it look, when ePEX and RiO data is plotted in a single line, as though CRHT activity has dropped dramatically when it has actually continued to rise as the graph shows, but also beyond June 2011. We stopped at this point because we didn't want to display confusing data and needed to address the coding practice first.

The RiO data still shows a steady increase in CRHT episodes of care, balancing the reduction in occupied bed days in line with national and local policy. This policy is evidence based because it is now known that people experiencing a mental health crisis recover better and faster in their own home, in touch with family and friends and all the key features of their life. Hospital is becoming increasingly a last resort for those who are so unwell that they are a danger to themselves or others.

3. Medway bed stays

Question: Why does Medway's bed stay profile drop so sharply and in an unusually straight line over the four years of data behind the review? Why choose to move all beds out of Medway, the most populous locality in the KMPT area?

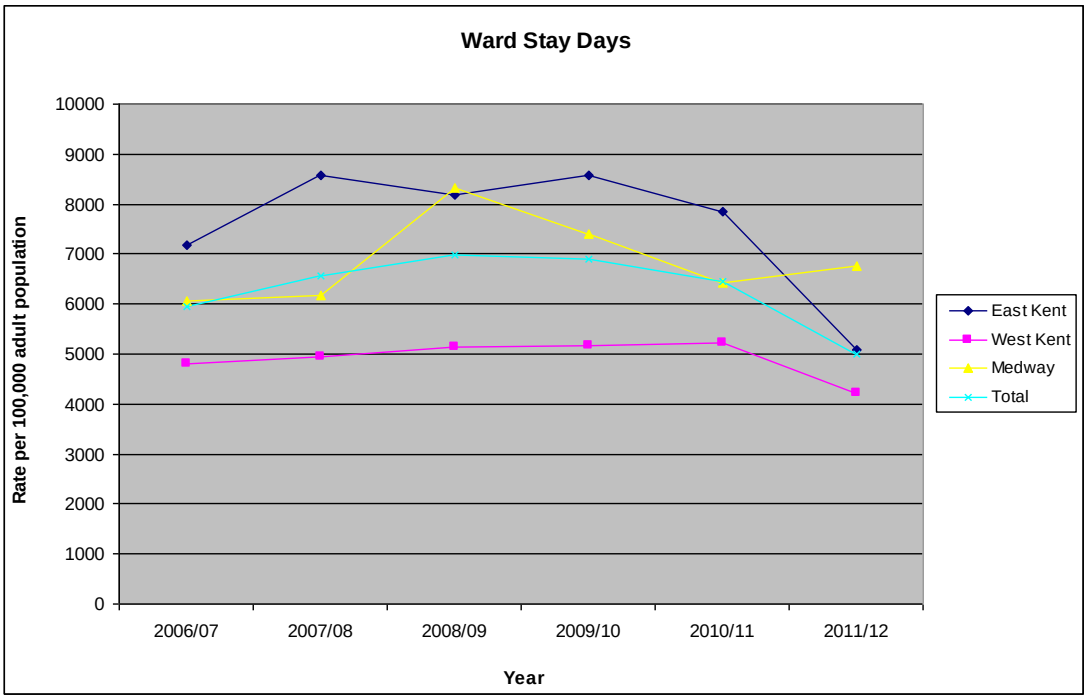
NB: We have placed the relevant graphs at the end of this response as there are so many of them and we think they are easier to understand when seen together and when their relevance has been explained.

Response: The impact of a policy (in this case, admitting fewer people to hospital for less time and providing more crisis resolution home treatment) is bound to show up more dramatically in Medway than in smaller areas. There are a number of local teams working in different areas of Medway and by aggregating their results; any unevenness in the profile will be smoothed out. Using only four (whole year) data points would also have this effect. Other localities should be asked how their particular patterns of reducing bed use could become more consistent.

The reason for closing the beds in Medway Maritime Hospital's A Block is that these wards are not able to provide the calm, therapeutic environment that patients need to help them overcome the mental health crisis that led to their hospital admission. Funding for a purpose-built unit is not available and we already have the right kind of unit available now in Dartford.

The key finding of the review is that we need three centres of excellence for the Kent and Medway population, not more. Inevitably, that means that some people have to travel to reach them. Consolidating the staff in three centres means there will be better Consultant cover available 24/7, unaffected by staff leave or illness in a way that has not been possible until now. Having three centres also means that the service can expand the range of therapeutic staff available and that they can be available at evenings and weekends, which, throughout the consultation, service users have said they want.

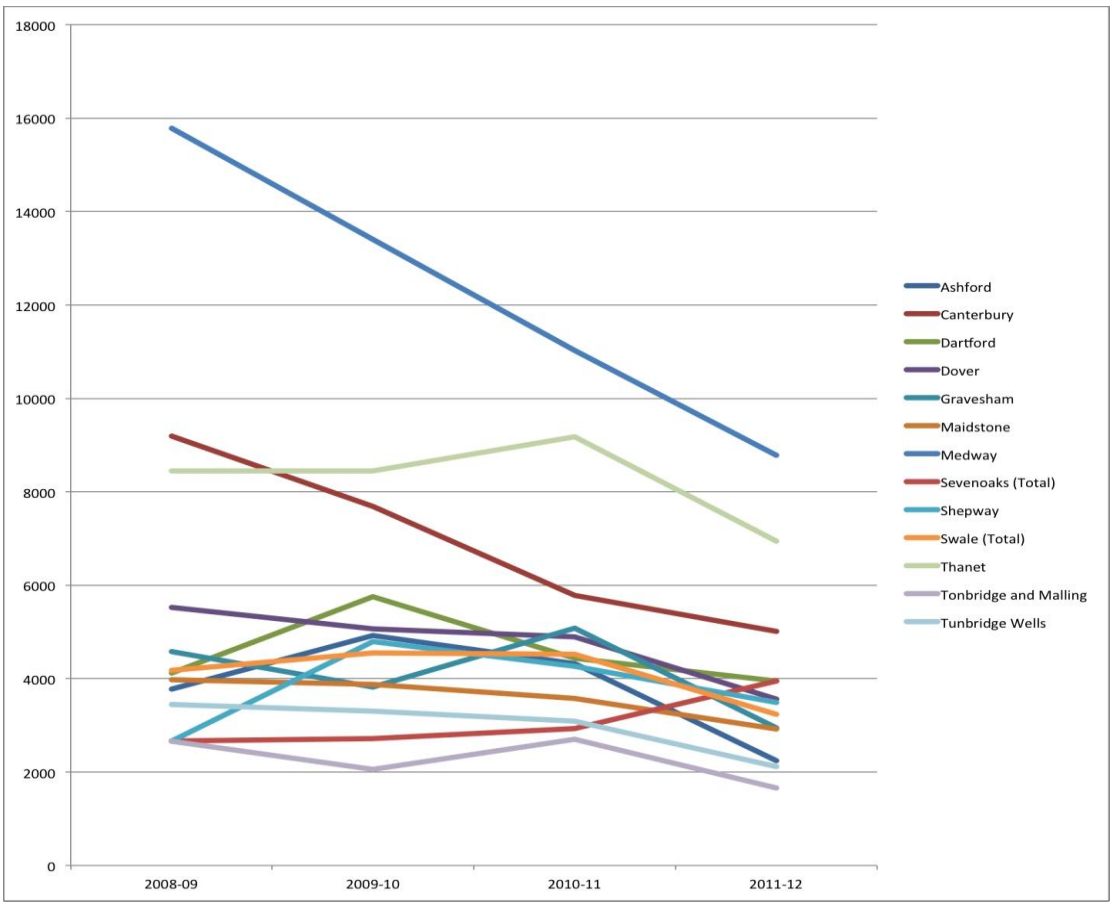
iv) **This graph was published as *Appendix E: Service Area Demand per 100,000 Population* in the pre-consultation Board paper. The purpose was to check that demand relative to population was generally highest in East Kent and higher in Medway, than in West Kent (which was and is still the case) and thus to validate our main method of using relative demand as a proxy for need in allocating hospital beds. Yet there seemed to be a contradiction between the absolute demand data for Medway in Appendix B (see v) below) and this four year graph that is showing a slight rise for Medway in 2011/12, which could not be explained by population alone.**



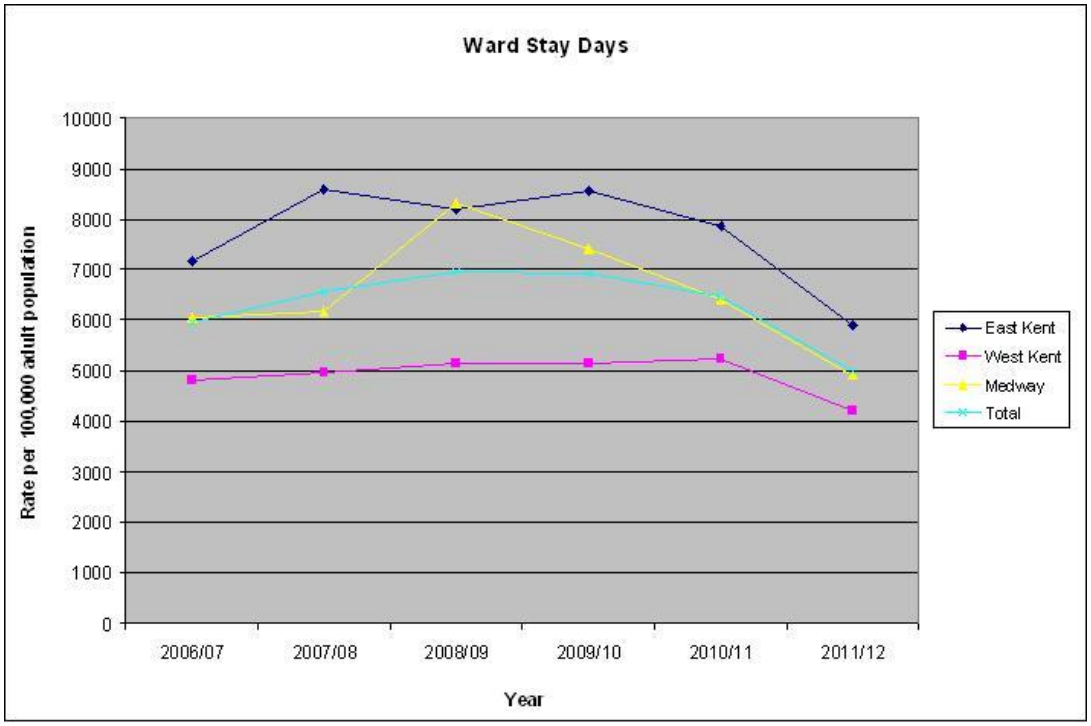
v) Appendix B: Four Year Drop in Inpatient Bed Demand

Acute Ward Stay Days by Financial Year and Local Authority

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



vi) During the consultation this was rechecked and the formula corrected. In the new graph shown here, we can see a decrease for Medway in 2011/12 that complements the absolute demand data illustrated. This mistake had also affected the East Kent figure, which now shows a smaller decrease.



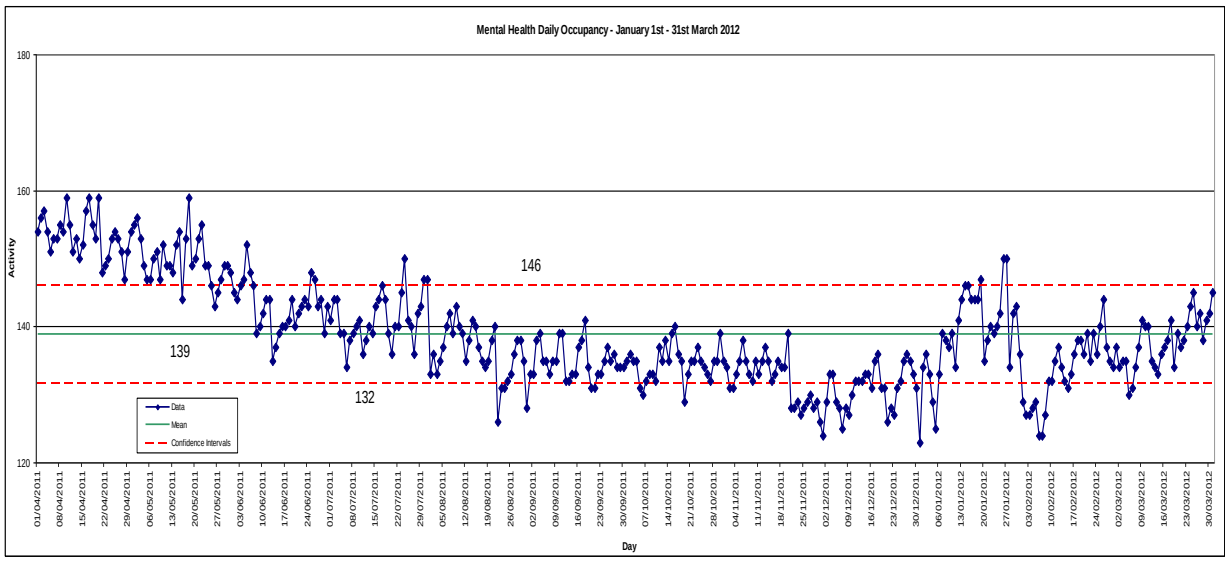
4. Variations in demand

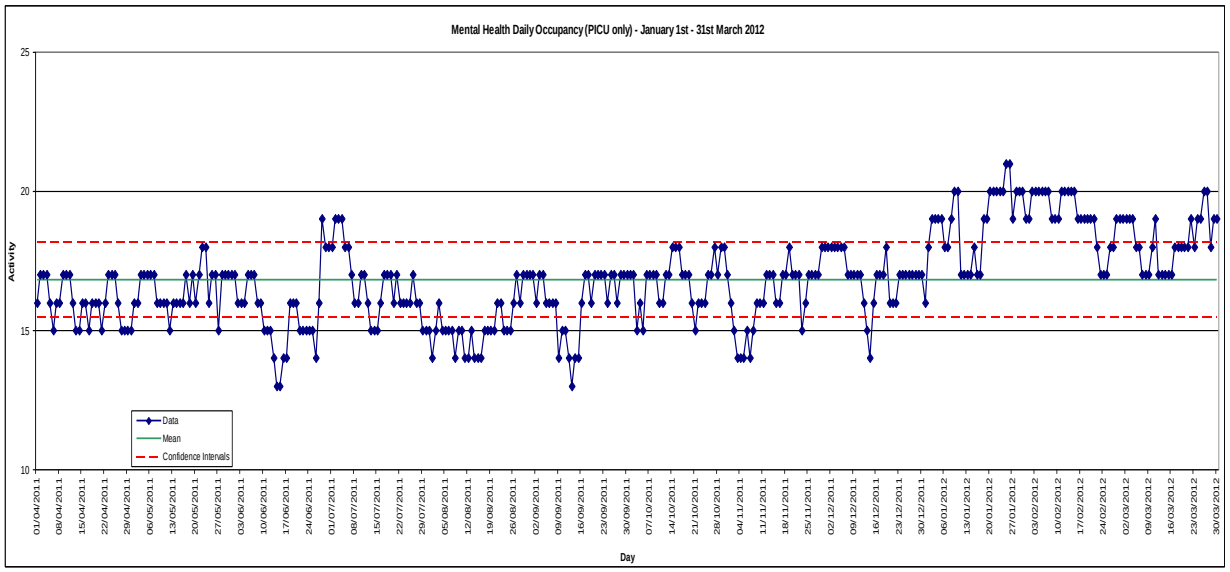
Question: In the first two graphs of Appendix H, why is the 2011/12 acute bed average 139 and not 144 as in Appendix B; why does the line not go over 160 if non-KMPT beds were used; and isn't it weekly rather than daily bed use that is shown? Why is the third seasonal variation bar chart not consistent with acute bed use variation and occupancy data?

Response: The variation analyses were done to estimate confidence intervals in the demand for hospital stays that KMPT is fully responsible for. We did this so that we could add the difference (variation) to the estimated average demand, including the small demand from KMPT patients treated outside the Trust. That total helps us ensure that, in future, beds can be found in KMPT, in the correct hospital ward for a given locality.

Appendix B included data for people "not a KMPT responsibility or unknown" and Appendix H did not. We have revised the graphs to include them.

vii) These two graphs were in the pre-consultation Board paper as *Appendix H: Variations in Demand - Confidence Intervals and Seasonal Effect*



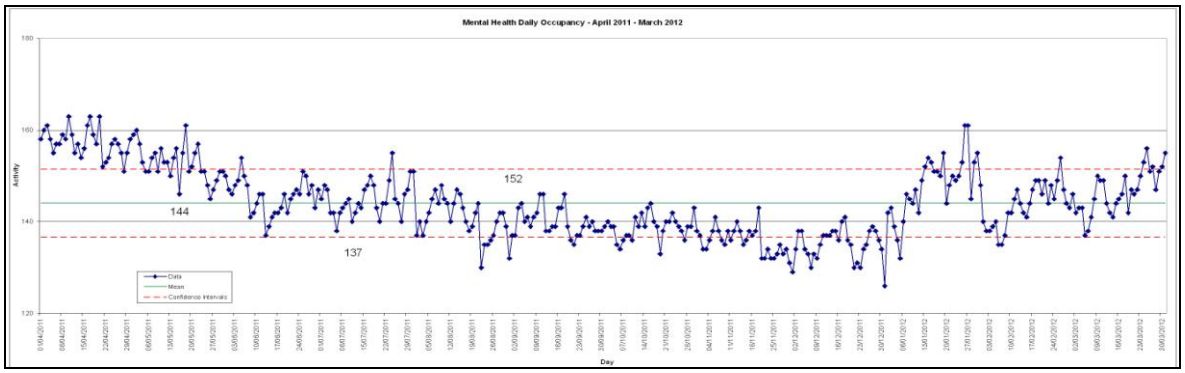


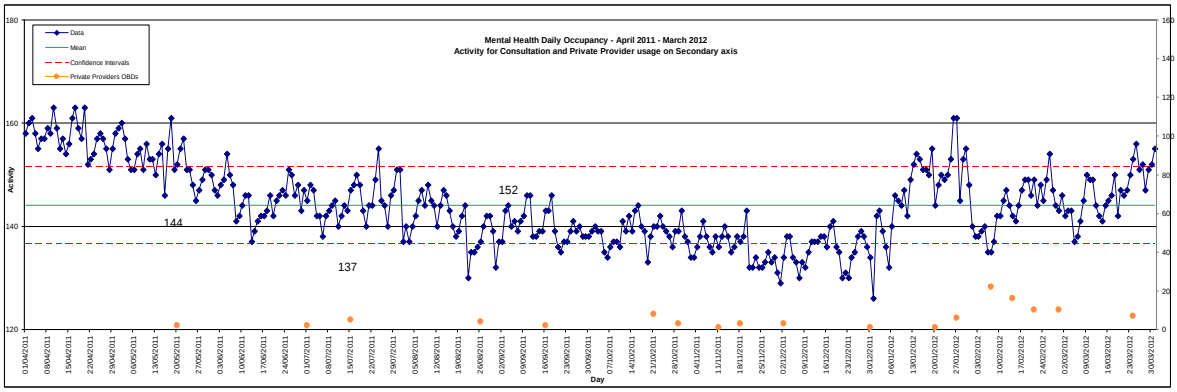
viii) The graphs below show a revision to Appendix H. They include the data about patients who are "not a KMPT responsibility or unknown" – that is, those from outside Kent and Medway. They show a 144 average in 2011-12 and the line going above 160, without counting patients placed outside KMPT. The title on the graph should read April 2011- Mar 2012. The data is correctly described as daily, with 365 data points, although the axis text can only print the weekly dates.

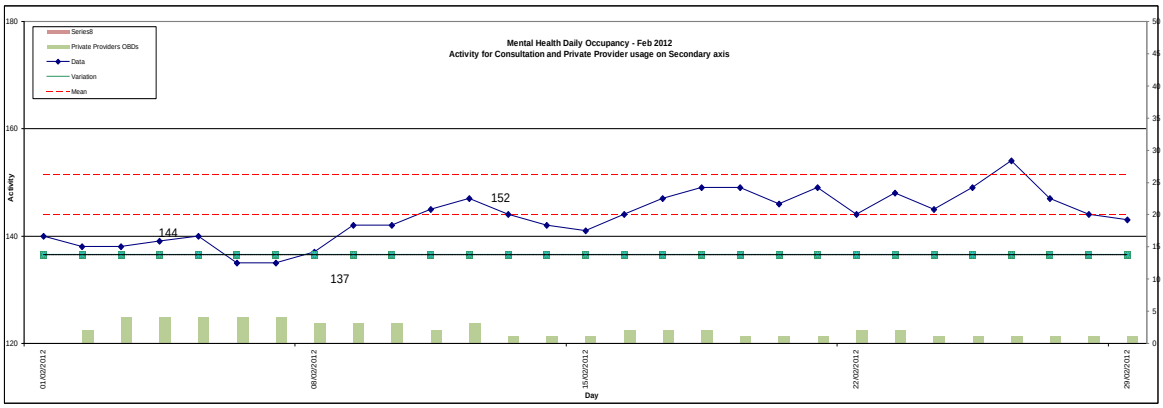
We include an extra version of the chart (the second below) showing where any patient was placed outside KMPT as a dot near the horizontal axis.

The third chart shows the February information (average of 144 beds and higher [58-days] usage of private provider beds) in more detail. This data relates to seven people, mostly at the start of the month. There had been high usage and bed occupancy in KMPT at

the end of January 2011. Patients placed outside KMPT in such circumstances are brought back to KMPT as soon as clinically appropriate







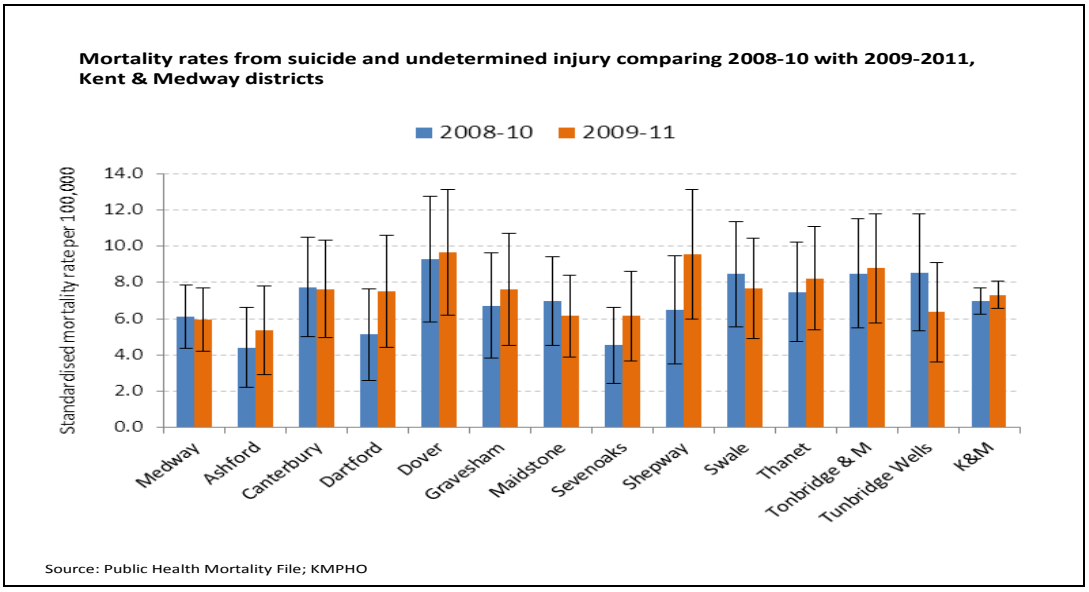
5. Reducing bed supply and suicide rates

Question: There seem to have been more suicides when more service users are placed out of their local area. Doesn't this mean that closing more beds should be avoided? Why was there not more attention in the redesign to any correlation between suicides and inpatient beds?

Response: Colleagues specialising in Public Health have been looking at suicide rates and their data does not indicate that reducing bed supply has any correlation with a higher suicide rate. If there was a link between local mental health activity and suicides, this would be more likely to involve the access and recovery services in the community than the hospital service:

people in hospital are seen to take their medication and they are supported by the staff who are working with them towards recovery, so suicide in hospital is much more infrequent than in people who may, as part of their condition, not take their medication appropriately. Kent and Medway's suicide numbers are so small that, even if "undetermined injury" deaths are included, no statistically valid correlations would be possible. Of course, there are many different variables that contribute to suicide so looking at the numbers of suicides and beds cannot amount to cause and effect, nor can it account for other external factors, such as unemployment, that might underlie both increasing demand for the whole range of mental health services and any rise in suicides.

ix) This graph has been produced by public health colleagues, showing deaths from suicide and undetermined injury, in two consecutive two-year periods.

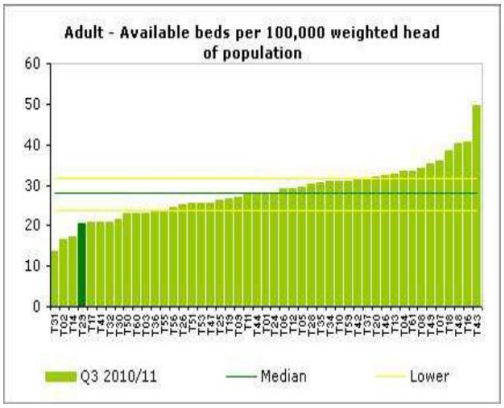


6. Benchmarking of KMPT acute bed supply with other Trusts by weighted population

Question: Why is there a proposal for a further reduction in bed supply when KMPT is already in the bottom quartile of Trusts?

Response: The National Clinical Advisory Team endorsed our proposals after considering, among other things, the Audit Commission benchmarking shown on the next page). Our review took on board the views from many stakeholders, especially service users, that any resources that could be found to expand or strengthen home treatment would be a good outcome. We also know that most mental health Trusts in England are also moving towards using beds for higher risk inpatients, even though they use different supply definitions. Bed need cannot be estimated without taking account of a Trust's acute service practices, access thresholds and the alternative care it makes available.

x) Audit Commission benchmarking of mental health Trusts' bed supply



Benchmarking shows KMPT with a low number of beds per 100,000 weighted head of population. This needs to be taken into account with regard to any consultation around future bed provision.

7. Checking the data

Question: Were figures checked and have there been computer errors? Why are you not looking at all the last six years and at the emerging data in the current year, as well as the four specific years you chose for the review?

Response: There has been extensive checking of data. Two comprehensive fresh analyses were undertaken, in February and April 2012, each compiling the data up to those dates in a different way, and they validated each other. There has been learning and sharing of these findings with stakeholders as the work has progressed. We found only one actual data error, in a graph in the July Board report's Appendix E, which was only used to validate the population's need for acute beds, and not as part of the core analysis of service demand. This error was recognised and corrected. Both the original and new versions show the expected demographic differences between areas and clearly support the clinical case for change and the proposals for the future.

The data analysed was the record of Trust activity made by its staff and this told a consistent story. The only peculiarity showed up when the Trust moved from ePEX to RiO, as described in item 2 above.

The approach of analysing data in April 2012 from a number of whole financial years to 2011/12 was agreed with stakeholders in February 2012. The most recent years were used for the main estimation of locality demand. Six years' data was initially examined but only used in the Board report when necessary to get enough useful data for variations, such as for seasonality. It is always better to use recent data. In this case, we had four whole years' data available during the time when the practice of using CRHTs in place of hospital stays was already taking effect. There is no reason to extend this to other years.

The data published in July 2012 has been subjected to a very thorough scrutiny during the consultation and we have re-examined every discrepancy that has been brought to our attention. This paper makes public any corrections made – and makes it clear that these corrections have been points of detail and are not substantial enough – either separately, or together – to warrant changing the proposals consulted on.

Kent and Medway mental health stakeholders have awaited the redesign outcome for a year. We believe the proposals set out offer the best way forward for everyone and that further delay only perpetuates the disparity between the current services and the imbalance in the capacity.