AGENDA

MAIDSTONE AND TUNBRIDGE WELLS JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING

Date: Friday 14 September 2012
Time: 3.00 pm
Venue: Room 300, Priority House, Maidstone

Membership:

Councillors: Basu, Mrs Blackmore, Crowhurst, Elliott, D Mortimer and Vizzard

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Page No.

1. Apologies

2. Notification of Visiting Members

3. Appointment of Chairman and Vice-Chairman
   a) Election of Chairman
   b) Election of Vice-Chairman

Continued Over/:

Issued on 10 September 2012

The reports included in Part I of this agenda can be made available in **alternative formats**. For further information about this service, or to arrange for special facilities to be provided at the meeting, **please contact Orla Sweeney on 01622 602524**.To find out more about the work of the Overview and Scrutiny Committees, please visit www.maidstone.gov.uk/osc or www.tunbridgewells.gov.uk

Alison Broom

Alison Broom, Chief Executive, Maidstone Borough Council, Maidstone House, King Street, Maidstone, Kent ME15 6JQ

4. Disclosures by Members and Officers:

    a) Disclosures of interest
    b) Disclosures of lobbying
    c) Disclosures of whipping

5. To consider whether any items should be taken in private because of the possible disclosure of exempt information

6. Minutes of the meeting held on 17 November 2011 — 1 - 11

7. Achieving excellence in a mental health crisis — 12 - 32

    The meeting will include a visit to in-patient facilities in Priority House –***Helen Grant MP is due to join the group at this stage.***

8. Future Work Programme — 33 - 34

MAIDSTONE BOROUGH COUNCIL
TUNBRIDGE WELLS BOROUGH COUNCIL

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON THURSDAY 17 NOVEMBER 2011 AT THE TOWN HALL, TUNBRIDGE WELLS

PRESENT: Councillor Elliott (Chairman)
Councillors Basu, Mrs Crowhurst, Mortimer, Mrs Paterson and Yates

Mike McGeary (Overview & Scrutiny Officer, Tunbridge Wells Borough Council)
Orla Sweeney (Overview and Scrutiny Officer, Maidstone Borough Council)
Ryan O'Connell (Corporate Projects and Overview and Scrutiny Manager, Maidstone Borough Council)

Witnesses:
Lauretta Kavanagh, Director of Commissioning for Mental Health and Substance Misuse for the Kent and Medway PCT Cluster
Dr Kuran Coonjobeeharry, GP in West Kent
Phil McSweeney, QIPP Programme Lead for Mental Health, NHS Kent and Medway
Dr Alison Milroy, GP Mental Health Lead in West Kent
Jess Mookherjee, Assistant Director/Consultant in Public Health, NHS Kent and Medway
Helen Wolstenholme, Communities and Health Manager, Tunbridge Wells Borough Council

Other attendees:
Cate Boland, Kent LINk Development Worker (Mid Kent)
Mark Fittock, Kent LINk Governor, with responsibility for improving mental health services

1. Apologies

Apologies were reported from Councillor John Wilson (Portfolio-holder for Community and Leisure Services, Maidstone Borough Council) and from Jim Boot (Community Development Manager, Maidstone Borough Council).

2. Notification of Visiting Members

Councillor Cunningham, (Portfolio-holder for Health, Wellbeing and Rural Communities, Tunbridge Wells Borough Council), had given prior notice of his wish to attend and speak at the meeting. Councillors Backhouse,

McDermott, Mrs March, Smith and Mrs Weatherly, (all from Tunbridge Wells Borough Council), had given prior notice of their wish to attend the meeting, but not to speak.

3. Disclosure by Members and Officers

a) Disclosures of interest

Councillor Yates declared a personal interest in minute 6 below, on the basis that he was a member of the Age Concern (Maidstone) Management Committee.

Councillor Basu declared a personal interest in the same minute as a retired consultant pathologist and former employee of the NHS.

b) Disclosures of lobbying

There were none.

c) Disclosures of whipping

There were none.

4. To consider whether any item should be taken in private because of the possible disclosure of exempt information

Resolved: That all items be taken in public.

5. Minutes of the meeting held on 4 August 2011

Attention was drawn to minute 9 (Maidstone and Tunbridge Wells NHS Trust: Quality Report 2010/11), under which it had been resolved that the Joint Committee should be provided with conclusive information indicating the reduction in C difficile and MRSA cases to date. It was reported that, although no further response had been submitted by the witnesses, information on this aspect was available on the Trust's website.

The Chairman also drew attention to Minute 12 (Future Work Programme), under which it had been agreed that any work by the Joint Committee looking at elderly care provision in the two Boroughs could not be commenced until 2012/13. It was suggested that, as a first step, representatives from the Care Quality Commission could be invited to attend a meeting in the Spring, and report on current issues. This proposal was supported by the Joint Committee.

Resolved:

(1) That the minutes of the meeting of the Maidstone and Tunbridge Wells Joint Health Overview and Scrutiny Committee held on 4 August 2011 be agreed as a true record and duly signed by the Chairman; and

(2) That a meeting of the Joint Committee be convened in the Spring, at which representatives of the Care Quality Commission be invited

to report on the outcome of their reviews into care for elderly people within the two Boroughs.

6. Adult Mental Health Services

The Chairman explained that the Committee had been convened in order to consider the progress made against a wide range of recommendations and commitments in respect of adult mental health services.

There were two principal sources of assessing progress, the Joint Committee heard. First, there was a list of 12 recommendations made through this Joint Committee as a result of its work in 2010, which were directed at NHS services, as well as local authorities, i.e. Kent County Council (working in partnership with the Primary Care Trusts (PCTs)), as well as Maidstone and Tunbridge Wells Borough Councils. These recommendations were set out in Appendix A of the agenda report.

Secondly, an extract had been provided from the 'Live it Well' Strategy – a strategy for improving the mental health and wellbeing of people in Kent and Medway, published in 2010 and covering the period up to 2015. Within this strategy, 10 commitments existed, each with its own statement of what the cluster of Kent PCTs and Kent County Council (Social Care) planned to achieve in 2010/11. (Each commitment, it was noted, had a further set of actions which would be achieved 'over the next five years'.)

The agenda report added that each of the 10 commitments came with 'measures of success'. Progress made with each commitment was to be monitored: (a) against those measures of success; (b) from feedback with people who use mental health services and their carers; and (c) from key quality targets included in contracts.

This list of commitments, including a statement of what had been planned as a priority in 2010/11, was set out as Appendix B in the agenda report.

A number of key representatives from the PCTs had agreed to come and talk to the Joint Committee about the progress made against the recommendations and priority actions. The full list of witnesses is set out above.

The first set of responses related to Appendix A, i.e. the list of recommendations made through this Joint Committee in 2010.

Recommendation 1 related to local authorities: *Local authorities embrace the Time to Change Campaign as a route to tackling the stigma attached to mental health disorders.*

Helen Wolstenholme advised that the previous Portfolio-holder at Tunbridge Wells BC had fully endorsed the 'Time to Change' campaign, which was still being actively promoted via the authority's website. In respect of Maidstone BC, the Joint Committee heard that they had undertaken a 'Wellbeing week' for all staff (which had included a stress

survey of staff) and had supported a similar initiative at Swale Borough Council.

Councillor Cunningham enquired how central Government funding for the 'Time to Change' campaign had been spent. It was noted that although the majority of this funding had been spent at a county level as part of the 'Live it Well' Strategy, some had been invested at a more local level, to help with specific initiatives.

Recommendations 2 to 9 came within the remit of the PCT Cluster for Kent:

Recommendation 2: *The PCT engages with local authorities in the development of its Wellbeing Strategy.*

Mrs Mookherjee reported that the Wellbeing Strategy had been developed at a West Kent level two years ago and was still in place. She advised that 40% of the funds spent on 'wellbeing' were focused on mental health service provision.

Mrs Mookherjee advised that the over-riding operational document was the 'Live it Well' Strategy, although each local team had a mental health wellbeing plan in place. It was from the 'Live it Well' Strategy that the Change for Life and healthy passport initiatives had been developed, members were advised.

Mrs Mookherjee added that the next steps in this work included the establishment of an 'engagement' steering group; local authorities would be invited to be part of this, she advised.

Recommendations 3 and 4: *Information on voluntary, community, public and private mental health services for all sectors of the community be made more easily available*.

A website be developed, along with an accompanying leaflet, outlining all local mental health services in Kent along with details on how to access these.

In response to these two recommendations, Mrs Kavanagh advised that the priority had been on developing a 'Live it Well' website. She advised that the website had been formally relaunched on 10 October this year, on World Mental Health Day.

The website was designed, members noted, for easy access, to allow people to find out about local services, with a strong emphasis on the community, so that details of locally-based meetings – some of which involving carers and family members – could easily be found.

The issue of providing the same information in leaflet format was raised, for those unable or unwilling to use the website. Mrs Kavanagh advised that, while this format was not currently available, it was planned to

produce such a leaflet as the next stage which, she confirmed, would be available in different languages, on demand.

In response to a member-led suggestion, Mrs Kavanagh agreed that the provision of a leaflet in large print, for those with a sight impairment, or the availability of screen-reading software, was a very helpful suggestion, which she would take back to her communications team to try and implement.

Recommendation 5: *The local website referred to in recommendation 4 be advertised in GP surgeries, Gateways and libraries alongside the NHS Choices website and highlighted to GPs new to the area to improve knowledge of services.*

Dr Coonjobeeharry confirmed that details about the website were being distributed to all GP surgeries, including via a memory stick, which would provide a link to the website and its easily-accessed information.

Mrs Kavanagh also reported on the emphasis being placed on how best to treat the more prevalent mental health problems within a primary care setting, through the introduction of the 'knowledge transfer partnership'.

Alongside this, Mrs Mookherjee advised that Kent had been chosen to act as a pathfinder site under which pharmacies provided an improved information access point for mental health services.

Mr Fittock drew attention to an earlier recommendation about having a single point of contact for information on mental health services. Mrs Kavanagh had two points to make in response: (i) she undertook to check the NHS Choices website, to see if that concept had been developed; and (ii) she reminded members that the County now operated a 111 telephone service for all non-emergency services, which could be used if anyone enquiring about mental health services was unsure where to seek help.

Recommendation 6: *Clarity is ensured over developments or cuts in mental health services to reduce uncertainty over services, which can be worrying for vulnerable patients.*

Mrs Kavanagh advised that there was an active network of staff in place, who were constantly aware of changes to mental health services and related issues, who could easily communicate with service users when changes were about to be introduced.

On the general theme of cuts in budgets and services, Mrs Kavanagh advised that the spend of the Kent PCT Cluster on mental health services was lower than the national average. Savings, she added, had been achieved not through any reduction in services but through efficiency measures, like the joint commissioning of services in partnership with the Sussex Partnership Trust.

Mrs Kavanagh also advised that the PCTs were looking to commission mental health services in the acute setting on a 'payment by results' basis in the future.

Dr Milroy added that GP commissioning groups were aiming to protect mental health services through greater efficiency, with the emphasis on providing such services at primary care level.

From a councillor perspective, it was stressed that having access to accurate information about changes in service provision in a timely manner was essential. Mrs Kavanagh acknowledged the importance of this fact and undertook to improve the communication channels with Maidstone and Tunbridge Wells Borough Councils, which exist elsewhere.

Recommendations 7 and 8: *Consultations should be in a variety of formats, with short versions available containing only priority questions, to ensure that carers and service users can participate even where time is limited.*

Consultation results should be clearly publicised along with proposed follow up actions, including for the recent listening exercise.

Mrs Kavanagh advised that there had been no formal consultations since publication of the review into mental health services in 2010. However, the principle of the recommendation had been accepted fully, she added.

Mrs Kavanagh also reported that the PCTs made good use of the existing network of service users and carers to test out ideas on new ideas or practices affecting service provision. This, she said, was invaluable when testing the results of commissioning work and had the added advantage of providing quick feedback.

Recommendation 9: *The following areas of concern are focussed on:*

Access to psychological therapies and availability of funding for services which tackle mild to moderate mental illness;

Tackling long waiting lists for talking therapies in order to prevent deterioration of patients' mental health;

Improving access to secondary care for a broader range of patients;

Ensuring an emphasis is placed on listening to the needs of service users in secondary care; and

Improving access to information on patient healthcare, budgets and statistics, in particular via websites.

Mrs Kavanagh advised that, at the time of the original review in 2010, there were long waiting lists for people trying to access 'talking therapies' via their GPs. Since then, the psychology services had been recommissioned, based upon nationally-agreed and approved therapies.

Mrs Kavanagh added that, as part of the service currently provided, structured assessments took place during the course of treatment, with the focus on a patient's pathway to recovery or 'on the road' to recovery.

The outcome from this approach, members were pleased to hear, was that waiting lists had been cleared and were currently sitting at a maximum period of four weeks. In addition, there was now a self-referral service for 'talking therapies', if people preferred not to follow the GP route.

Mrs Kavanagh added that a survey was being conducted of patients' experiences of the service they were receiving, to monitor progress and ensure that the quality of service was being maintained.

Dr Milroy advised that a telephone-based coaching support service was also in existence, which was viewed as often a more helpful provision for men.

The point was made that it must be very difficult to be able to provide sufficient publicity for the range of support services available, particularly the self-referral element. Mrs Kavanagh advised that she would provide the Joint Committee members with the: (i) 'Mental Health Matters' telephone number; (ii) the 'Live it Well' website link; and (iii) the list of local primary care facilities, all of which were significant in terms of accessing information about services available.

A number of visiting members enquired if they could ask the PCT and GP representatives specific questions at this point, which the Joint Committee approved.

Recommendation 10: *In the light of evidence that physical activity contributes to good mental health, local authorities and the health trusts should work together to provide exercise on prescription.*

(This had been addressed to local authorities and the health trusts.)

Helen Wolstenholme advised that this principle had been very keenly followed up, through the 'Exercise Referral' programme, which formed part of Tunbridge Wells Borough Council's (TWBC) 'Choosing Health' service. Through this, GPs had been able to refer patients to leisure centres in the Tunbridge Wells Borough, run by Fusion Lifestyle. There, physical activity has been provided very successfully in order to help tackle health problems linked to anxiety, stress, depression and other commonly-found mental health conditions. In some cases, Mrs Wolstenholme advised, patients were seeking a second referral for this scheme, via their GPs.

Mrs Wolstenholme added that this referral contract was still running and its capacity had been increased, to take account of both demand and its success. She advised that relevant mental health training had been provided for the Fusion Lifestyle staff at the leisure centres, to raise

awareness of the issue; feedback from this training was tabled for members' information. (A copy of this is attached to these minutes.)

Mrs Wolstenholme advised that TWBC had operated a 'Go!Card' scheme for people on low incomes in the Borough for a number of years, under which people could access the Council's leisure services at a special rate. She added that this scheme was currently under review by TWBC's Communities and Partnerships Select Committee and options for its future development were being explored.

Mrs Wolstenholme was also able to comment on the situation within Maidstone Borough, following the submission of written comments from their Community Development Manager, Jim Boot. The Joint Committee was advised that Maidstone Borough Council (MBC) had initially used health preventative funding to support an exercise referral programme, although this had been re-focused on reducing obesity in people with a BMI of over 28. However, MBC were still seeking funding to reintroduce an exercise referral programme for people with a more general range of health issues, including mental health. Members were also advised that a 'health walks' initiative in that Borough, which operated on an informal referral basis from a range of health practitioners, which had previously been funded, was now continuing on a voluntary basis, with only 'arms' length' support from the authority's Community Development and Parks and Open Spaces teams.

Mrs Mookherjee also reported on the effectiveness of partnership working between the PCTs and local authorities in respect of the 'Change for Life' programme, for the benefit of some mental health patients.

Finally under this heading, Mrs Wolstenholme reported on the success of the waymarking of routes in some of the parks in Tunbridge Wells, which was enabling people to walk or run a specific distance (e.g. one mile, two miles, etc), in support of following a healthier lifestyle.

Recommendations 11 and 12 were directed to local authorities, the health trusts and the third sector.

Recommendation 11: *Joined-up working between service providers should be encouraged to ensure seamless and complementary provision of services for the benefit of all members of the public experiencing mental health problems.*

Mrs Kavanagh advised that the NHS commissioners consistently worked collaboratively and effectively with their partners. She added that a 'social model of recovery' was as important as the clinical care provided, so there was a good emphasis on support for the families of those receiving mental health services.

Mrs Kavanagh acknowledged that there were still further improvements to make, as some patients were still having to 'tell their story more than once', thus highlighting the need to ensure greater joined up working

between agencies. This, Mrs Kavanagh said, required an even greater focus on care pathways.

Recommendation 12: *Patients should be supported in undertaking voluntary work as a precursor to returning to paid employment.*

Mrs Wolstenholme reported on how Tunbridge Wells Borough Council worked with Voluntary Action West Kent (VAWK) and with the Kent Supported Employment scheme, to draw up a project outline for a programme to help people achieve a return to paid employment. She added that funding for this project had not yet been secured.

Mrs Kavanagh stressed the importance of this aspect, i.e. how much it was a national priority, with a key objective of trying to ensure patients with the most common forms of mental health problems were able to progress from benefit support towards securing paid employment. There was also an emphasis, members noted, on assisting people towards retaining their existing employment.

Mrs Kavanagh added that there was an effective focus on the 'individual placement and support' approach, whereby a programme of recovery was based upon each individual's needs, with services working well towards this end. In response to a question raised about college attendance being a desired outcome, Mrs Kavanagh advised that, in certain circumstances, an individual's needs could easily involve specific knowledge training, through college education.

After a short break, the Joint Committee reconvened, in order to consider Appendix B in the agenda report, namely progress made by the PCT Cluster and KCC against the priority actions set out in the 'Live it Well' Strategy.

Mrs Kavanagh advised that a progress report on the implementation of the 'Live it Well' Strategy had been posted on the NHS Kent and Medway website. A copy of that response is appended to these minutes.

The Joint Committee agreed that, rather than hear evidence on each of the 10 commitments made within the Strategy, they would examine the progress report outside the formal Committee process.

Instead, the Joint Committee decided to consider a number of points raised by the mental health service user, covering the aspects of: (i) the impact of charging for some mental health services; and (ii) what support was planned for mental health patients who would be adversely affected by the Government's welfare benefit reforms.

Mrs Kavanagh responded by saying that issue (i) above related to some KCC social care services, which had been the subject of a summer period consultation process. The specific service was residential care, which would be subject to a financial assessment. Two other services would incur charges, namely employment support and community support. Mrs Kavanagh explained that the rationale behind the charging proposal was

to ensure continuity of service, adding that she believed the impact of the charging policy would be small.

Mrs Kavanagh was asked about what monitoring would be taking place, to gauge the impact of the charges. She advised that KCC would be carrying out an evaluation of the impact of the policy.

On the second issue raised by the service user (impact of the Government's welfare benefit reforms), Mrs Kavanagh admitted that she was not an expert on the detail but she reassured members that the issue had been discussed with service user forums, where a robust message was given that active support would be provided for patients, during the implementation period.

Mrs Mookherjee reported that she did have concerns about the impact of welfare benefit reforms, adding that it might mean that the voluntary sector would become significantly more active in supporting service users.

In summary, the Chairman warmly thanked all the expert witnesses for their attendance, expert input and willingness to engage with the Joint Committee members.

Resolved:

(1) That the PCT Kent Cluster consider the provision of alternative formats for disseminating information about mental health services, for the benefit of those who have a hearing impairment, blind people and those who are partially-sighted, including (for the last category) software designed to assist easier pc screen reading (Recommendations 3 and 4 above);

(2) That the PCT Kent Cluster provide an update, within the next six months, on the development of the '111' telephone number as a means of accessing non-emergency mental health services (Recommendation 5 above);

(3) That the PCT Kent Cluster provide Joint Committee members with an up-to-date understanding of the mental health resources available locally within Maidstone and Tunbridge Wells, for the benefit of councillors being able to pass on relevant and current details to organisations such as Age Concern (Recommendation 6 above);

(4) That the PCT Kent Cluster provide the patient satisfaction survey results for Joint Committee members in relation to the psychological secondary care services (Recommendation 9 above);and

(5) That the Kent PCT Cluster provide the Joint Committee members with the alternatives to the 'Live it Well' website contact details, to include: (a) the 'Mental Health Matters' telephone number; (b) the 'Live it Well' website link; and (c) the telephone number for 'primary' mental health care for self-referral (Recommendation 9 above).

7. Duration of the Meeting

2.00 p.m. to 4.30 p.m.

Maidstone Borough Council

Maidstone and Tunbridge Wells Joint Health Overview and Scrutiny Sub Committee

Friday 14 September 2012

Achieving excellent care in a mental health crisis

Report of: Overview and Scrutiny officer

1. Introduction

1.1 The Local Government Act 2000 and the Health and Social Care Act 2001 set out statutory functions for local authorities to review and scrutinise matters that relate to the planning, provision and operation of health services in the area of its local authority.

1.2 In June 2010 The Maidstone and Tunbridge Wells Joint Health Overview and Scrutiny Sub Committee agreed a joint protocol which states: The Committee will perform all National Health Service Overview and Scrutiny functions on behalf of both Boroughs.

2. Recommendation

2.1 The Committee is recommended to:

- Interview witnesses about the proposed changes outlined in the consultation document to establish the likely effect upon local health services;
- Identify specific issues in the consultation papers that will impact upon both patients and the provision of services in the local area; and
- Collate the evidence from the witnesses and discussion of the consultation into clear points to be included in the Committee's response to the consultation. The Committee should seek to make a recommendation in support of one of the three options being proposed.

2.2 Areas of questioning could include but are not limited to:

- The overall effectiveness of the proposals being put forward;
- The public's confidence and understanding of the services available to them;
- Are the proposals part of a long term objective or are they a short term solution (i.e. the lack of capital funds to improve facilities and services at Medway's A Block)?;
- The current success of Crisis Resolution and Home Treatment;

- The effect of Maidstone and Tunbridge Wells Crisis Resolution and Home Treatment (CRHT) Teams merging on current proposals;
- Will there be more in depth consultation with patients, carers and organisations in Medway, Sittingbourne and Sheppey as areas where they impact of the proposals could be perceived most negatively?;
- The impact on current services provided at Maidstone and Tunbridge Wells Crisis resolution based a Priority House;
- What savings, if any, are proposed by the current plans?; and
- What investment, if any, is to be made to ensure that CRHT teams and centres of excellence remain robust and responsive to changing need?

3. Background information

3.1 On 26 July 2012 the Kent and Medway NHS and Social Care Partnership Trust published a consultation document entitled 'Achieving excellence in a mental health crisis' (**Appendix A**). It is a review of adult acute mental health service in Kent and Medway and is seeking to improve the service provided for people in a mental health crisis. The document sets out proposals for the future for consideration.

3.2 The consultation states: 'Every year, around 3000 of the 1 million men and women in Kent and Medway have a mental health crisis and need treatment urgently. '

3.3 In its online booklet, 'The Mind guide to crisis services,' the mental health charity Mind describes the type of mental health crisis that requires urgent help as either an already diagnosed severe mental health problem such as schizophrenia, bipolar disorder or severe depressive disorder or a first episode of a diagnosable mental health problem.

3.4 The booklet includes the following examples of mental health crises:

- Suicidal behaviour or intention;
- Panic attacks/extreme anxiety;
- Psychotic episodes (loss of sense of reality, hallucinations, hearing voices) ; and
- Other behaviour that seems out of control or irrational and that is likely to endanger yourself or others.

3.5 The consultation document explains that crisis services have been drastically transformed over the past eight years. Crisis Resolution and Home Treatment (CRHT) services were one of the key elements in the 1999 National Service Framework for mental health. The NHS Plan (2000) made the provision of CRHT services a national priority.

The Department of Health's 2002 Public Service Agreement included targets both for the number of teams and the number of people treated. Prior to this most patients would have been admitted to hospital as an inpatient.

3.6 It is explained that most people are now treated in their own homes by specialist staff from the CRHT teams. Staff are available 24 hours day and can visit three times a day if needed. This type of treatment is said to offer a better recovery rate, it offers independence and avoids patients becoming institutionalised.

3.7 In support of its proposals for community cased Crisis Resolution and Home Treatment teams and to demonstrate the success of this method of treatment, the consultation highlights the following finding: "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." It should be noted that of the six teams currently covering Kent and Medway, the Maidstone and Tunbridge Wells ones are merging.

3.8 In terms of acute care, the consultation states that 'Not everyone in Kent and Medway has access to this'. There are said to be too few beds in East Kent, more required in East Kent and those currently provided in Medway (A Block) are 'not up to 21st Century Standards'. Since 2000 all new mental health units (Dartford, Maidstone and Canterbury) have been built with single rooms instead of dormitories and preferably with en suite facilities which helps alleviate patient distress and violent incidents.

3.9 The proposals offer equal access to psychiatric intensive care (PIC) with this being delivered by the outreach team visiting the hospital ward. Currently there are two PIC Units (PICU) in Kent. These are in Dartford and Canterbury. "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."

3.10 The Key Proposals for consideration in the consultation document include plans to:

- Strengthen community based crisis resolution and home treatment teams to provide more support to people outside hospital;
- Develop three centres of excellence for people in mental health crisis based in Dartford, Maidstone and Canterbury; and
- The closure of A Block at Medway Maritime Hospital.

4. Reason for Urgency

4.1 This meeting has been arranged to enable the Maidstone and Tunbridge Wells Joint Health Overview and Scrutiny Sub Committee to make a response to the consultation, in line with the consultation timetable and deadline.

Achieving excellent care in a **mental health crisis**

Consultation document

HAVE YOUR SAY
26 July to
26 October 2012

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

NHS

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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.

Achieving excellent care in a mental health crisis

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
- 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.

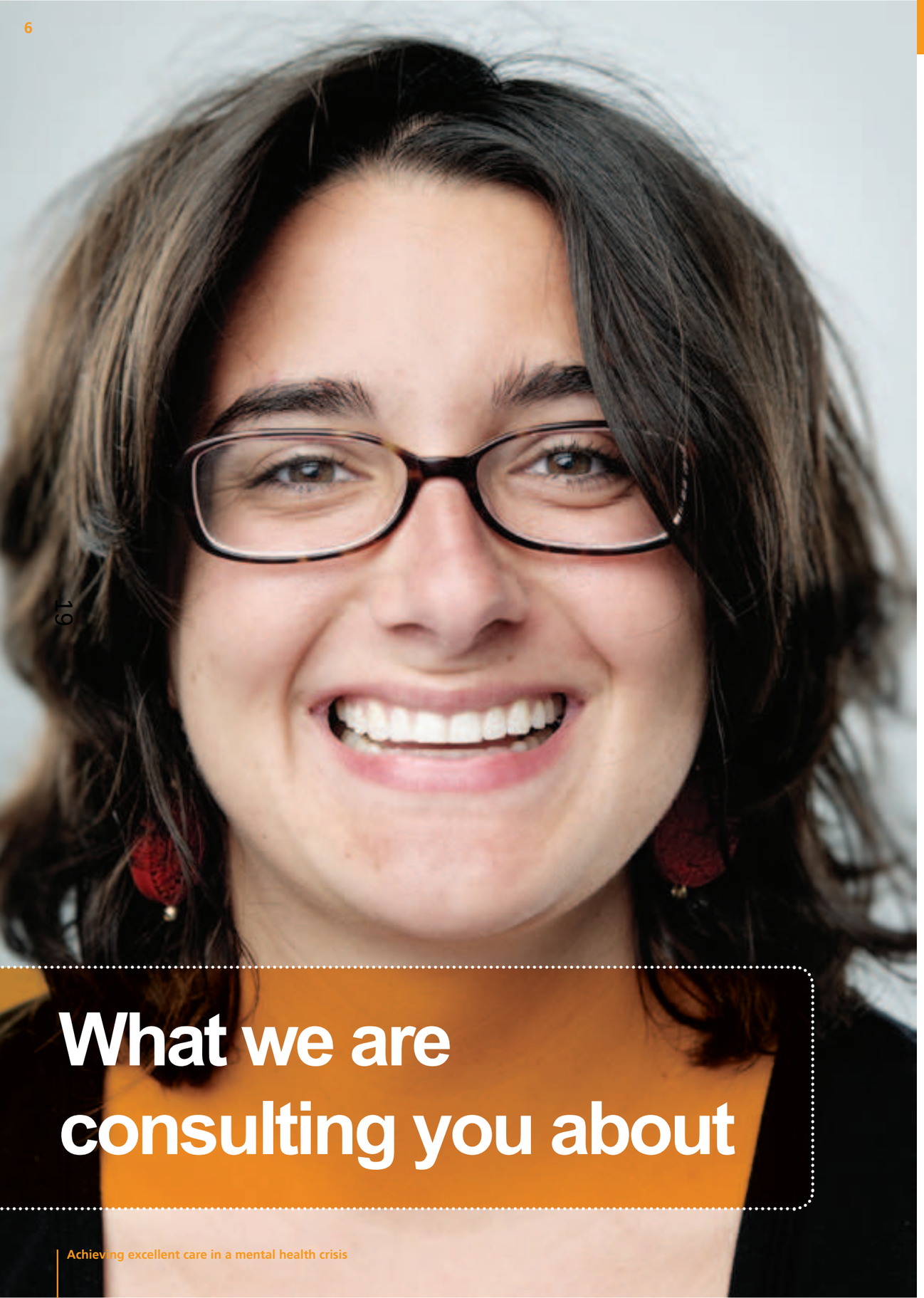
Please read this document and fill out our survey on the centre pages. The deadline for us to receive your response is 26 October 2012. For further information please check on our website at: www.kmpt.nhs.uk/acute-mental-health-review

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



What we are consulting you about

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.

> *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...

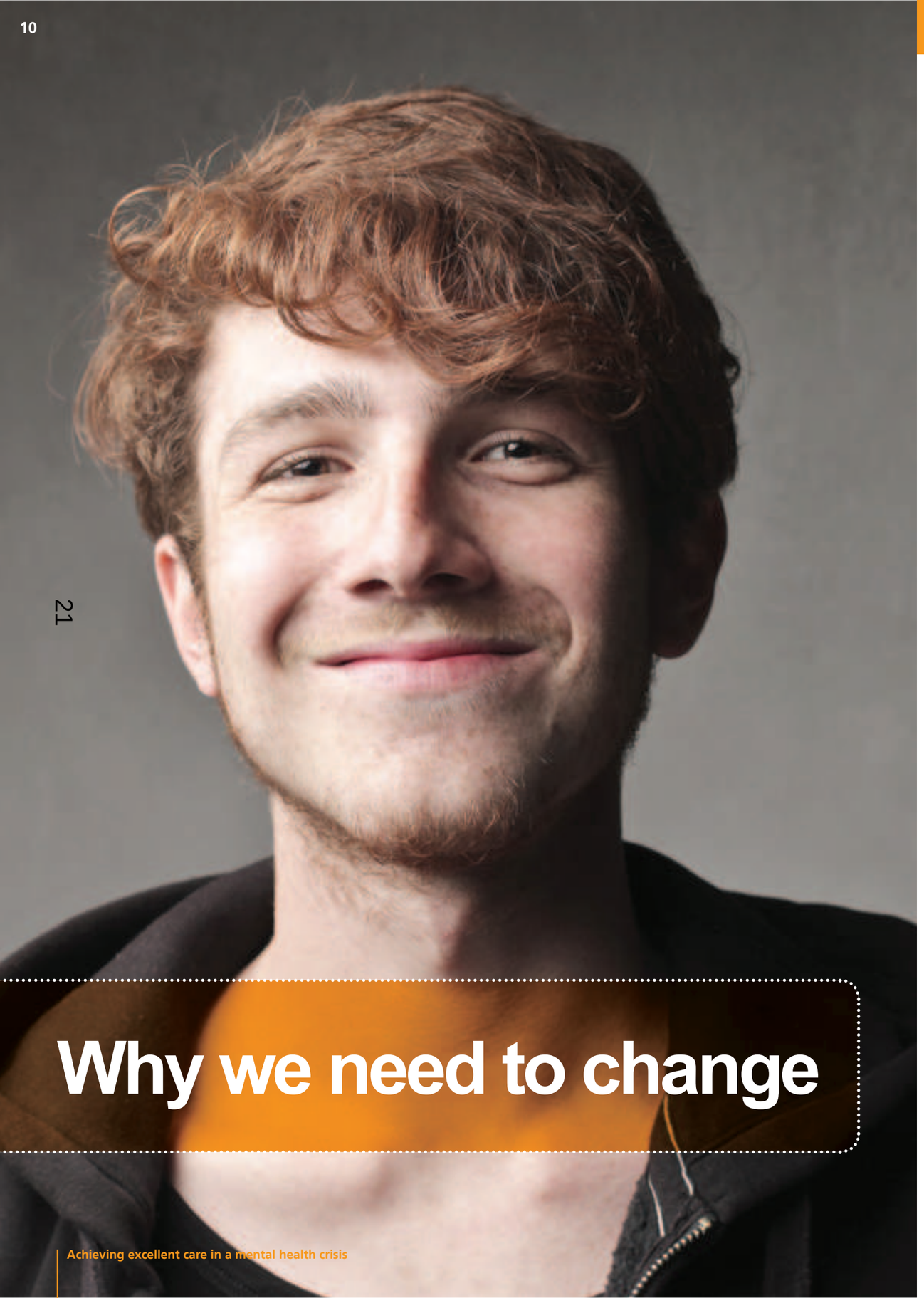
Dawn's daughter became ill with schizophrenia in 2006 when she was 18. Now, nearly six years on, she has been increasingly well for over 12 months and has been discharged from all mental health services.

"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

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 overspill 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

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."

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

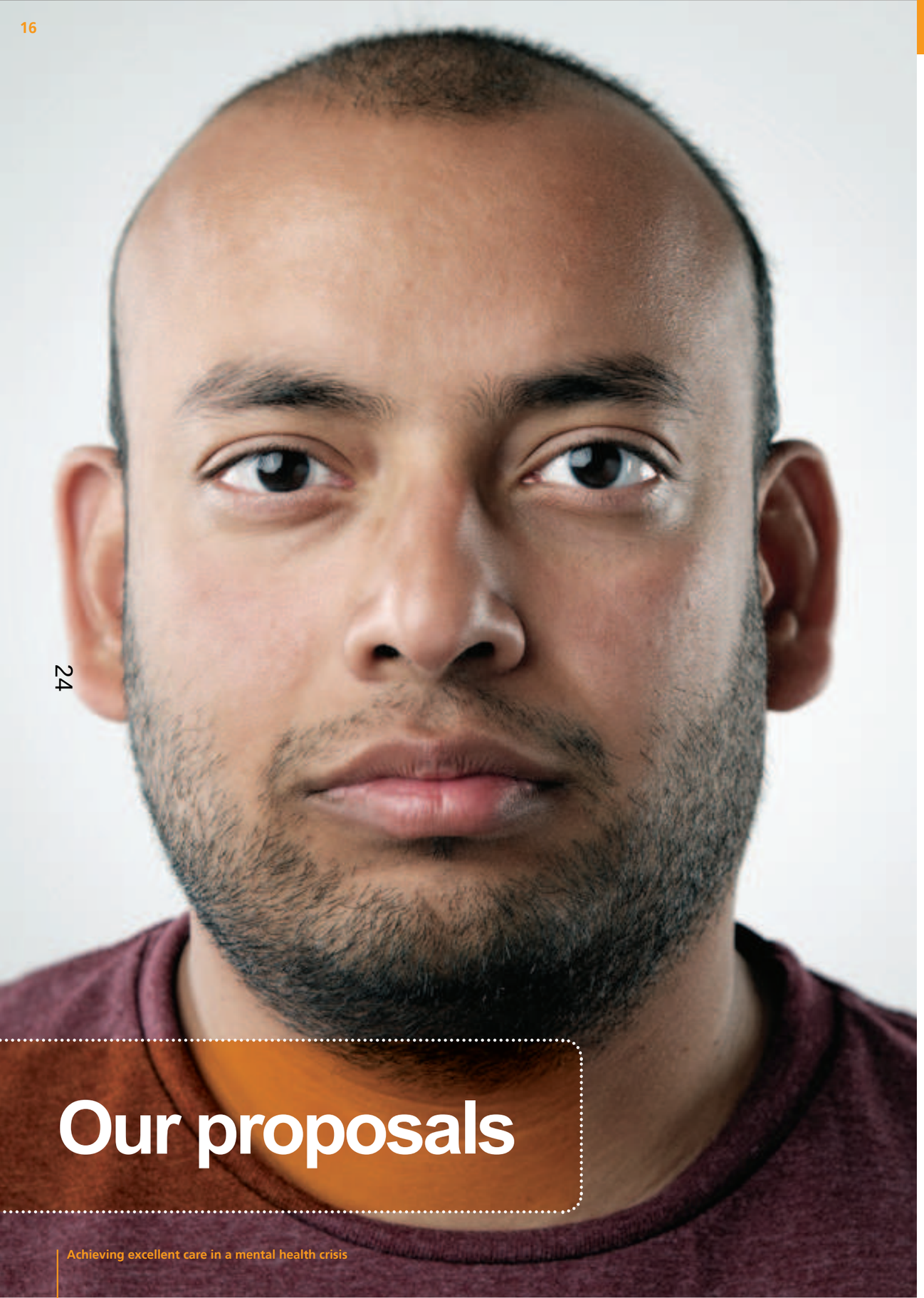
The purpose of psychiatric intensive care (PIC), rather like that of intensive care in a general hospital, is to give the patients more staff time and intensive nursing for a short period.

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.



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Our proposals

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 use*

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).

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

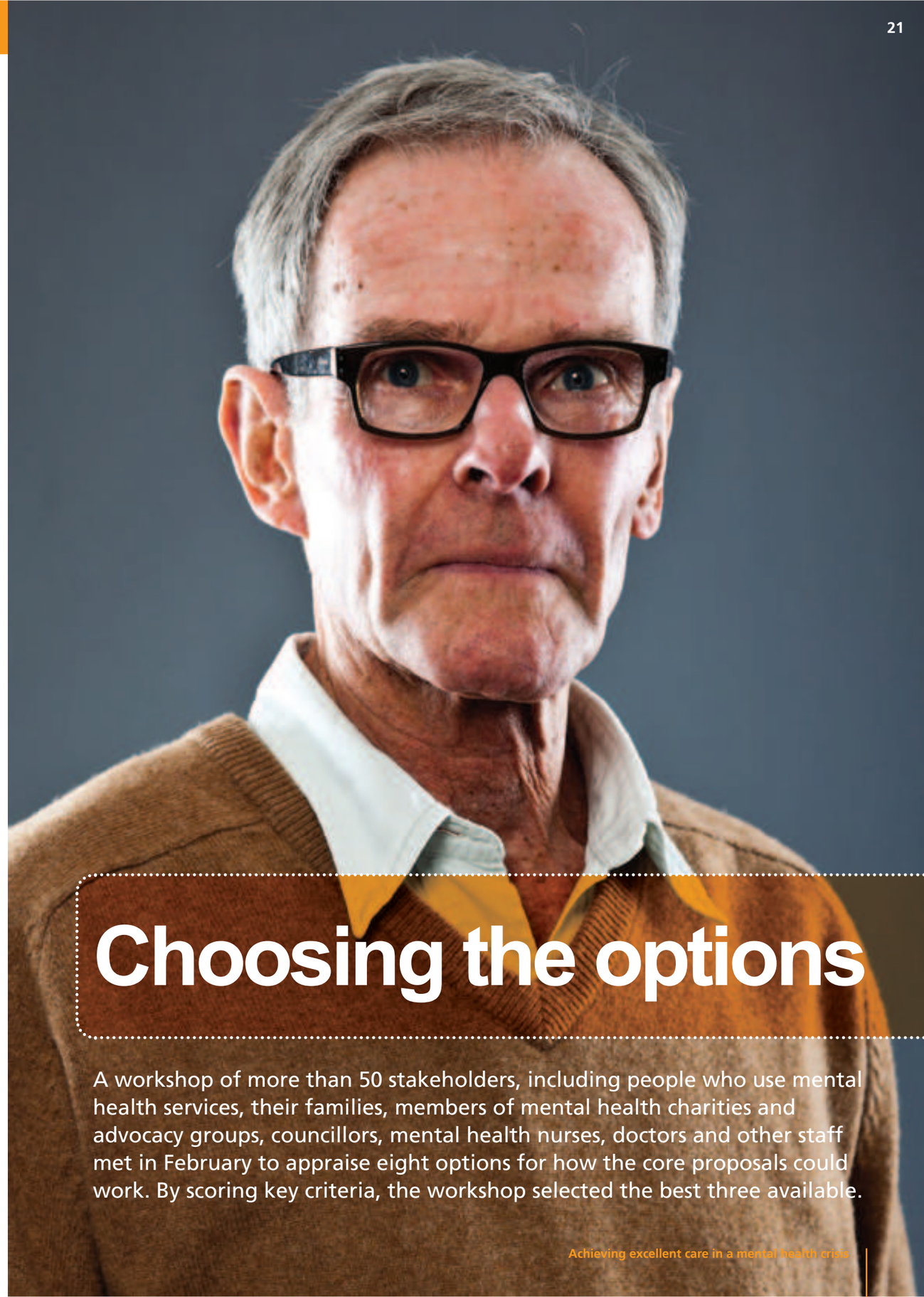
Patients' visitors will have

- 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.

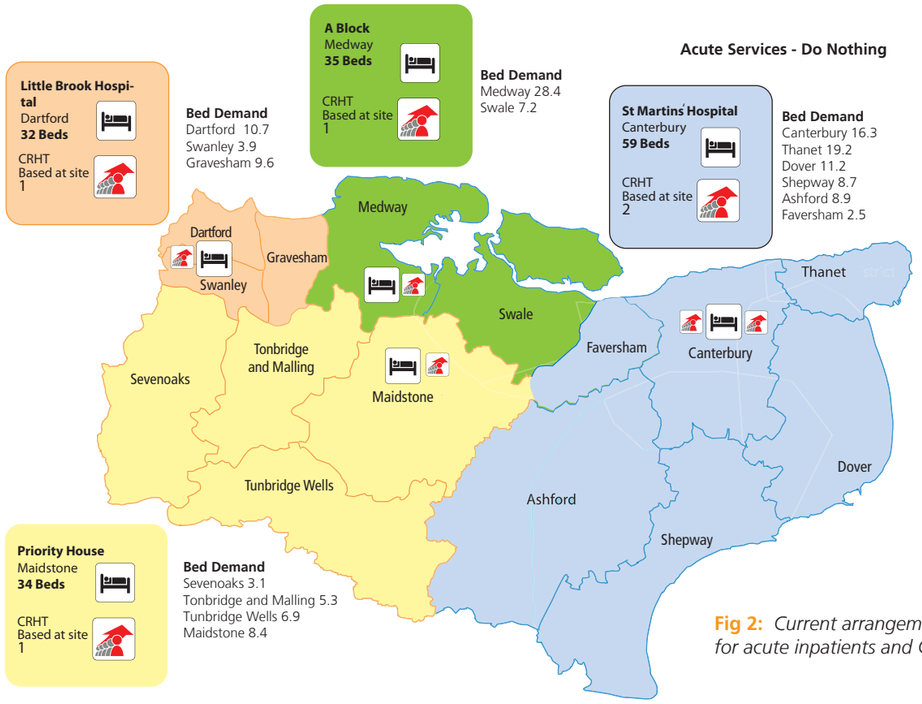


Fig 2: *Current arrangements for acute inpatients and CRHTs*

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.

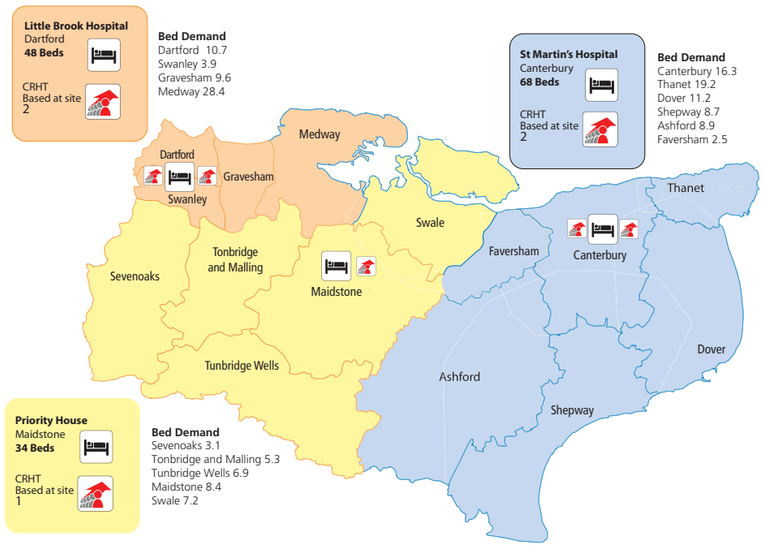


Fig 3: Option A – Catchment areas for acute inpatients and CRHTs

Advantages

- ✔ Patients will have much more chance of staying in the hospital for their area because east Kent overspills 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

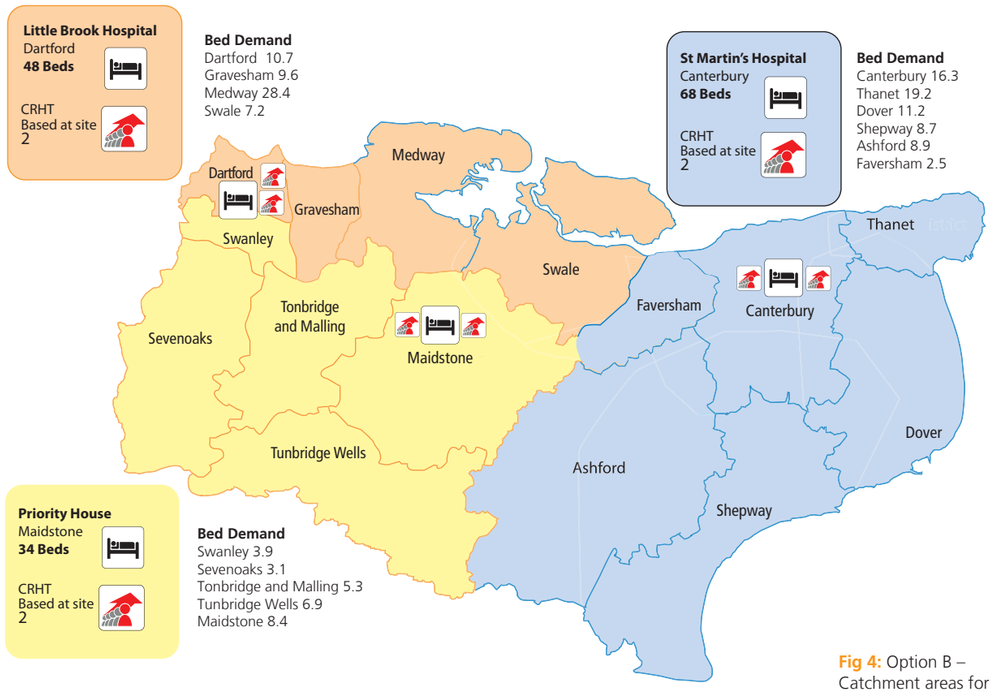


Fig 4: Option B – Catchment areas for acute inpatients

Advantages

- ✔ Patients will have much more chance of staying in the hospital for their area because east Kent overspills 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

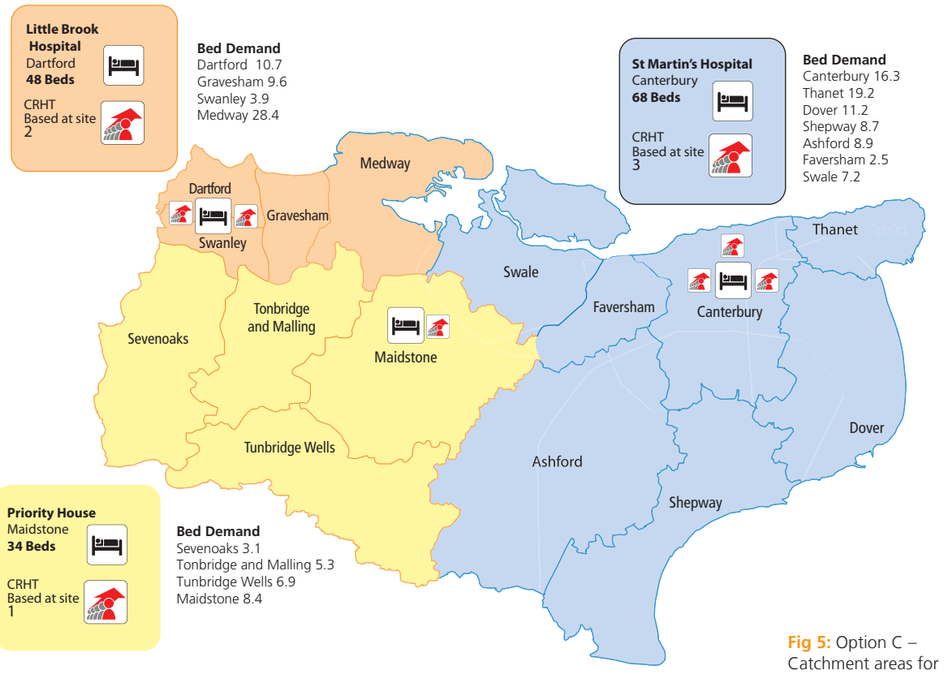


Fig 5: Option C – Catchment areas for acute inpatients and CRHTs

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

If you would like this document in other languages or formats, such as braille, easy read or audio, please call **0800 587 6757** or email **consultation@kmpt.nhs.uk**

Polish

Jeżeli chcieliby Państwo otrzymać tą broszurę w innym formacie np.: języku polskim, w wersji audio, alfabecie Braille's lub w wersji dla słabo widzących, prosimy o kontakt z Zespołem ds. Komunikacji (Commiunication Team) pod nr telefonu 0800 587 6757 lub za pomocą emaila: consultation@kmpt.nhs.uk

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Maidstone Borough Council

Maidstone and Tunbridge Wells Joint Health Overview and Scrutiny Sub Committee

Friday 14 September 2012

Future Work Programme and Scrutiny Officer Update

Report of: Overview & Scrutiny Officer

1. Introduction

1.1 To consider the Committee's future work programme.

2. Recommendation

2.1 That the Committee considers its future work programme (**Appendix A**)to ensure that it is appropriate and covers all issues Members currently wish to consider within the Committee's remit. Members are advised that their work programme and meetings are often in response to consultations and decisions made in the areas covered by the Maidstone and Tunbridge Wells NHS Trust.

3. Future Work Programme

3.1 Throughout the course of the municipal year the Committee is asked to put forward work programme suggestions. These suggestions are planned into its annual work programme. Members are asked to consider the work programme at each meeting to ensure that it remains appropriate and covers all issues Members currently wish to consider within the Committee's remit.

4. Parent Committees

4.1 This Committee has been appointed from Maidstone Borough Council's Parent Committee for the 2012/13 Municipal year, the Communities Overview and Scrutiny Committee and Tunbridge Wells Borough Council's respective Committee, the Overview and Scrutiny Committee along with Members from its Communities Cabinet Advisory Committee.

Appendix A

Maidstone and Tunbridge Wells Joint Overview and Scrutiny Sub Committee Work Programme 2012-13

Meeting Date	Agenda Items	Details and desired outcome
28 August 2012 CANCELLED	• Appointment of Chairman and Vice-Chairman • NHS Quality Accounts 2012/13 • Joint Health Protocols and Appointment of Substitute Members • Future Work Programme	• Appoint Chairman and Vice-Chairman for 2012-13 • To consider the Quality Accounts 2012/13 and prepare a response to be submitted to the NHS which will be included with the consultation responses on their website • To consider the report and the recommendation to amend the Joint Health Protocols to include Substitute Members • Select and develop review topics focusing on achievable outcomes
14 September 2012	• Appointment of Chairman and Vice-Chairman • NHS Consultation 'Improving care for people in a mental health crisis' • Joint Health Protocols and Appointment of Substitute Members • Future work Programme	• Appoint Chairman and Vice-Chairman for 2012-13 • To consider the Consultation options and formulate a response, to be approved by respective Cabinets • To consider the report and the recommendation to amend the Joint Health Protocols to include Substitute Members • Select and develop review topics focusing on achievable outcomes