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Case for Change
Modernisation of Acute Mental Health Care in South Staffordshire

1. Introduction

In implementing the Next Steps Review, the Trust will focus on Quality, Innovation, Productivity and Performance (QIPP). This will require a whole-system focus on designing and implementing more efficient and productive services that do not compromise the quality and safety of care and which enhances the service user experience.

"No Delays" was the name given to the system wide Service Improvement Project for Mental Health Services in the South Staffordshire Division of the South Staffordshire & Shropshire Healthcare NHS Foundation Trust (SSSFT).

Commencing in April 2008, "No Delays" was born of a commitment to work together with commissioners to bring about measurable improvements in key areas of our services, with the detail of these proposed changes being shaped through engagement with different stakeholders.

The time for change was prompted by several local and national issues. National drivers set the scene for changes in the NHS and Social Care landscape, including a move towards a "personalised" service driven by service user needs as opposed to a service-driven/resource driven model. In addition, feedback from General Practitioner colleagues, service users and carers served to highlight the need for a reshaped service that is able to fully deliver more responsive, timely and appropriate interventions for service users in an appropriate setting.

The following principles were agreed by our stakeholders:

- Needs rather than age led services with a recovery ethos so that there is no upper age limit preventing access to the full range of services for individuals presenting with complex mental health needs and no lower age limit for adults presenting with dementia.

- Shared understanding and deployment of the "stepped-care" model to ensure interventions are delivered in the right place and at the right time.

- Reducing the length of hospital stays by having enhanced services in the community such as Home Treatment and Acute Day Care Opportunities.

- Development of Home Treatment teams providing intensive care interventions that will offer adult and older adults alternatives to hospital admission.

- Improving the experience of carers through the facilitation of early assessment of need and ensuring timely access to appropriate information, assessment and support.

- Re-designed services that ensure that there is a timely and appropriate face-to-face assessment of all referrals made to the Community Mental Health and Crisis teams.

- Locality teams that better mirror local authority and practice based commissioning boundaries.

- A revised single point of access for local services that improves the timeliness of access by being more responsive and adaptable to local need.

- Enhancement of Early Intervention services for younger adults to include a multi-disciplinary approach to the detection and treatment of psychosis and other complex mental health problems in their early stages.

- A transformative and needs-led Dementia Service that will deliver the recommendations of the National Dementia Strategy in full.

- A multi-disciplinary "care package" approach to psychological therapies that will ensure timely access to a range of evidence-based interventions.

- Improving and minimising transitions for service users, thus ensuring an improvement in the service user experience through a smooth, high-quality journey through services and across services.

- Enhanced collaboration between Community teams and primary care providers including development of locality forums.

This appraisal document identifies the areas of significant change that have been identified throughout the discussion and engagement events for "No Delays". It is aimed at identifying a preferred option for in-patient beds provided by mental health services in South Staffordshire and follows the work undertaken on reviewing pathways for people with functional mental health conditions and with regards to; access to psychological therapies, crisis and in patient care, dementia services across South Staffordshire and third sector primary care and day care services.

2. What needs to change and why – the productivity challenge.

The aim of an effective acute care pathway for people with a functional mental illness is that as service users become more ill, intensive community support both enables them to recover without requiring acute inpatient admission and if this is unavoidable, facilitates early discharge. Admission remains an option, but only for a short period and a small minority of service users.

The aim of an effective acute care pathway for people with dementia is that there is a range of community support services able to respond to individuals needs. Admission should only be considered when the service user is so seriously ill as to require intensive medical supervision and treatment, and when the home circumstances mean this is impossible without admission.

Engagement with GPs and service users so far about their experience of acute and crisis mental health services has provided great insight. A very strong theme – evident through the bed reduction project in 2010/2011 (Appendix 1) – is that access to and the quality of interventions; provided by Crisis and Home Treatment Service has significantly improved following new investment. Evidence from the Audit Commission and other sources is that Crisis Resolution and Home Treatment Teams have a tremendous impact on the need for hospital beds where they are genuinely round the clock services and can gate keep effectively as part of an integrated pathway.

In order to have an effective acute care pathway, and not over use and over invest in inpatient services, we have clinically re-designed the community services provided. To support this redesign and gain increased confidence from key stakeholders the Trust embarked upon a bed reduction project, in collaboration with key partners, with the aim of identifying whether community resources within South Staffordshire could support this new model of service delivery.

Most available data on mental health services differentiates between adults of working age (18-65) and older adults (over 65) and the content of the paper reflect this. Mental Health Services in South Staffordshire have been redesigned to ensure services will be drawn around functional illnesses and organic illnesses / dementia, and they will be age inclusive.

The purpose of this paper is to present a revised ‘Case for Change’ in which to consider options for the proposed reconfiguration of in-patient beds.

3. Background

South Staffordshire and Shropshire Healthcare Foundation NHS Trust are proposing changes to inpatient services. The main driver for these proposals is that there has been a gradual shift over time in clinical delivery of mental health care, in that for at least 10 years there has been a move from delivering mental health care in inpatient wards to delivering care in the community. The clinical case for this is well researched and has led to a reduction in the number of admissions and the length of stay of people admitted.

The number of sites for inpatient mental health care in South Staffordshire is largely historical and the quality of the environments on these sites varies considerably. In addition, every inpatient site requires a significant infrastructure in order to operate, for example access to support services and on site medical presence. The greater number of inpatient sites the more is spent on administrative and other support services and the less efficient the Trust is overall.

Over the last 10 years the proportion of service users with complex conditions on inpatient wards has increased as other people are being cared for in the community. This has increased the need for support from adjacent wards and enhanced staffing to ensure safety when an incident occurs. National experience from having larger inpatient sites or sites where the estate can be added to has been that there have been many advantages, including enhanced support staff and greater flexibility in the deployment of clinical staff in times of high need.

Reducing the number of sites and the consolidation of inpatient beds of the same type together improves quality and safety and support for services and is also more efficient.

These proposals are in line with developing effective a robust acute care service, such as Crisis and Home Treatment Teams, Acute Day Care, Enhanced Community Mental Health Services and Assertive Outreach approaches. These alongside investments in primary care and third sector day provision have made significant improvements in the quality and availability of care for local people, have reduced our use of inpatient beds and increased choices for service users and carers who prefer, and recover better, with community based care.

The Functionalised model aims to support with achieving the three core values of the organisation. It is recognised that the service user is central to everything that we do and ultimately their experience of our services is one that we strive to improve. The model is aimed at empowering professionals to work in new ways to develop the acute care pathway and the services within, ensuring efficient and effective services are delivered. The Functionalisation model of acute care was initiated across adult acute and community mental healthcare services in December 2010. This ended the previous sectorised way of working for consultants in adult psychiatry in the Trust, whereby consultant psychiatrists provided care for service users across the inpatient / outpatient interface, with periods of support from the crisis resolution / home treatment team.

Key features of a functionalised model include:-

- Service users to have an allocated a ‘named nurse’ who will remain involved in their care throughout the length of their stay and have a key role in planning and reviewing care. The anticipated time saved by more efficient meetings is planned to release nursing time for interaction with service users.

- Service User contact with their consultant and other members of the medical staff to occur mostly on a 1:1 basis or together with the named nurse as service users reported during the pre evaluation that ward reviews were intimidating and not well liked.
- Daily review meetings ('morning meetings') have been initiated to ensure care is more dynamic, and progress in a service users care plan can be reviewed and updated on a daily basis.
- Formulation meetings to review the person's needs intensively.
- Active in-reach by the CRHT to enable service users to be discharged with the support of the CRHT as soon as is clinically appropriate and practicable.
- Development of the occupational therapy service to allow more access to therapeutic activities and a higher level of activities taking place on the ward which patients can become involved in if they wish.
- A psychologist with dedicated time for the inpatient service for formulation of patient needs through the 72 hour formulation meetings; for supervision and training of nursing staff in psychological interventions; and specialist direct input where required.

This model has also supported the bed reduction plans across the directorate thus it is imperative to develop services to strengthen alternatives to inpatient admission, and reduce average length of stay on the wards in line with national evidence based guidance.

A number of evaluation processes have taken place since the introduction of functionalisation and in summary the following benefits have been realised:

- Increased numbers of short stay admissions and reduced numbers of long (over 90 days) stay admissions
- Increased multidisciplinary input to wards
- Increased levels of activity for inpatients
- Increased access to doctors in South Staffordshire

3.1 Main Drivers for Proposed Change

Nationally there has been a reduction in the number of mental health beds and this is the proposal for South Staffordshire; following a number of years of investments in community treatment approaches. Changes have taken place in the last decade in the way mental health needs are assessed in the community, how individual care plans are produced and availability of treatments that service users find helpful and are evidence based.

Over the last 2 years there has been some development of primary care services for people of all ages across South Staffordshire, new investment to strengthen crisis response and home treatment services and equitable re-provision of third sector day opportunities across all localities.

Legislative changes, in particular the introduction of Community Treatment Orders in November 2008, have also supported the emphasis on community based approaches to mental health care.

Historically, mental health services have been divided into two categories - “working age” services and services for those individuals aged 65yrs and over. “Working age” services are traditionally delivered to those individuals who have left formal schooling and up to age 65. For those aged 65 and over, services are delivered by separate “services for older people”.

“No Delays” adopted a transformative agenda through the provision of mental health services that should be needs led rather than age led. Provision of services based solely on the age of the service user institutionalises arbitrary and discriminatory age-distinctions and disadvantages a significant proportion of our older service users.
This new approach is not without contention. There are careful considerations to be made about how best to maintain and incorporate the skills of clinicians to meet the needs of those service users whose distress is characterised by difficulties in adjusting to later life. Furthermore, competencies in differentiating organic disorders such as dementia from other functional illnesses will need to be addressed.

In regards to service users with a Functional mental health problem, the trust has developed integrated, ageless functional teams across the localities. These teams provide input to all adults with functional mental health issues. Experienced multi-disciplinary professionals with experience of working with older adults are integrated within these teams to ensure that the needs of older adults with functional problems can be specifically addressed. This change has meant that adults over the age of 65 will have access to services that have traditionally only provided input to those under 65 such as Assertive Outreach and Crisis response / Home Treatment services. Educational sessions with the professionals working within these teams have been provided to ensure that staff are aware and up to date with older people’s issues in mental health. There are identified link workers available to provide this support in the longer term with this also being addressed by the arrival of experienced older adult professionals to these teams.

Proposals have thus been developed on an “ageless” basis and services will be delivered to adults aged 18 (16 or above if a service user has left formal schooling) or above with no upper age limit. These proposals are currently being worked through locally with all professional groups becoming part of the locality Community Mental Health Teams. These teams are locally based and have three essential functions carried out by the CMHT’s: -

- Assessment of referrals via SPA / Duty.
- Therapeutic navigation of the service user via CPA.
- Preventing breakdown of care and delivering recovery-focused interventions.

There has been an emphasis within the CMHT’s of an inclusive approach to care with a proposed shift in emphasis from the strict medical model to a socially inclusive recovery-focussed model.

Within South Staffordshire the locality teams for older people have historically delivered all aspects of memory assessment, diagnosis and treatment for older people with dementia as a component of the block contract however until 2010 there have been no formal commissioning arrangements for this service. In 2010 South Staffordshire PCT identified £500,000 additional funding for people with Dementia to support the National Dementia Strategy. This resulted in the commissioning of a dedicated memory assessment, diagnosis and treatment service for people with dementia from MAC UK and this service became fully operational in July 2011.

MAC UK have been commissioned for three years, by South Staffordshire PCT, and are working alongside the Alzheimer's Society and Approach Carer Training providers on the delivery of the newly formed "South Staffordshire Memory Service".

The service specification for these three providers is for the assessment, diagnosis and treatment, where appropriate, of any type of dementia including monitoring and, at least, an annual review. The Dementia Adviser role provided by the Alzheimer's Society will offer carers and service users support at home and assistance with sign posting to the appropriate services where required. This is in line with the National Dementia Strategy and mirrors the national picture of community dementia services at present. 'Approach Carer Training' deliver this training in Stoke on Trent presently, providing a set of three sessions for carers to attend, offering education on dementia and ways of managing situations that carers may be presented with when caring for their loved ones. They will work alongside MAC UK on providing training in locations suitable for the South Staffordshire population.

In line with the newly commissioned service from MAC UK and as part of the decisions agreed by PCT and GP representatives from the PBC's in relation to quality, safety and efficiency, SSSFT will provide a multi-disciplinary service to people with dementia and their carers who are affected by complex and challenging needs . This service will be delivered through teams located in the east and west of South Staffordshire. These teams will have focus on delivering a person centred approach to their service delivery, in line with evidence based research on the management of challenging and complex behaviour in dementia. The service model is designed to address the needs of this group of service users and their carers, as MAC UK's specification does not include a service for challenging needs in dementia. A pathway between the two service providers has been developed to ensure that service users are signposted to the appropriate service following assessment and intervention, where it is assessed as appropriate to meet their needs.

This has extended the choice of alternatives to inpatient care, so that the irreversible loss of independence which frequently occurs on hospital admission can be avoided. This investment in community services gives service users and carers a better experience and will delay or prevent the need for expensive nursing home placements.

Although major improvements have been made in mental health care in the last decade, there is still room for improvement. The local organisations that fund health services (PCT's and CCG's) have asked the Trust to move further in the direction of shifting care from hospitals to community settings.

The proposals will reduce the number of sites from which inpatient services are provided (from 3 to 2) because information from a wide range of sources shows that fewer beds are needed and that many service users and carers prefer, and recover better, with community-based care. The more sites there are, the higher the running costs of our services.

It is proposed that running services from two sites will allow the best balance between geographic accessibility and safety, quality and efficiency. At present, it would not be viable to run from only one site – such as St Georges Hospital – because the site is not large enough.

The Trust has a duty to ensure quality is of the highest standard and that resources are used as efficiently as possible. The case for reducing the unnecessary use of inpatient

beds is argued in the recent Kings Fund paper 'Mental Health and the Productivity Challenge'. The proposals for change to inpatient services will lead to the delivery of a significant financial contribution to the Health Economy. The estimated savings that might occur if the proposals are implemented are approximately £1.4m.

The case for moving onto fewer inpatient sites is therefore consistent with national and Trust level strategic drivers in that:

- Currently care pathways are not optimally aligned. The business case will provide an opportunity for the Trust to reorganise care pathways.
- Services will be strengthened across acute care and community services.
- Recurrent efficiency savings will be generated in line with the Long Term Financial Model.
- In line with the NHS Operating Framework, the business case shows restraint in terms of the levels of investment and will deliver efficiency savings.
- Making savings in terms of inpatient services will ensure that the necessary levels of spending for community services are not impaired, allowing the continued development of a comprehensive range of community services, which will bring care closer to people's homes.
- Concentrating services on fewer sites will provide sufficient service volume to support greater individualised and specialised care.
- Fewer inpatient sites will provide a greater concentration of staffing expertise, supporting innovation and specialisation in line with the core focus on research and teaching.
- Fewer sites will provide a higher level of staff support for wards to draw on.
- Economies of scale will make it easier to develop high quality support and training and research facilities for the largest site, and
- It will be easier to standardise services on fewer sites providing a greater equality of care

3.2 Clinical drivers for change (including local factors and national guidelines)

There is a wide consensus amongst mental health clinicians, service providers and NHS Trusts that the numbers of inpatient beds should reduce, and this is evidenced in bed reductions both nationally and locally through the recent bed reduction project. The clinical case for change has been strongly supported by the NCAT independent clinical review of the proposals for change in this paper (Appendix 2).

Research studies provide evidence that backs up the views of GPs, service users and carers about the success of community services.

National studies show that the key to improving safety, satisfaction and outcomes in mental health care is to have as wide a choice as possible of community-based alternatives to inpatient admission and beds. Bed use statistics show that reduction in the number of beds in South Staffordshire in recent years has not led to a shortage of beds for admission when needed. We have always guaranteed admission if clinically necessary and will continue to do so.

The Government strategy for mental health, 'New Horizons, a shared vision for Mental Health', published in December 09, emphasised prevention of mental ill health, and specifically refers to reducing occupied bed days in secondary care. This is also the theme of the coalition's mental health strategy 'No Health without Mental Health'. It is for these reasons that mental health continues to be recognised as one of four national priority services in England.

The direction of recent national policy can be summarised as follows:

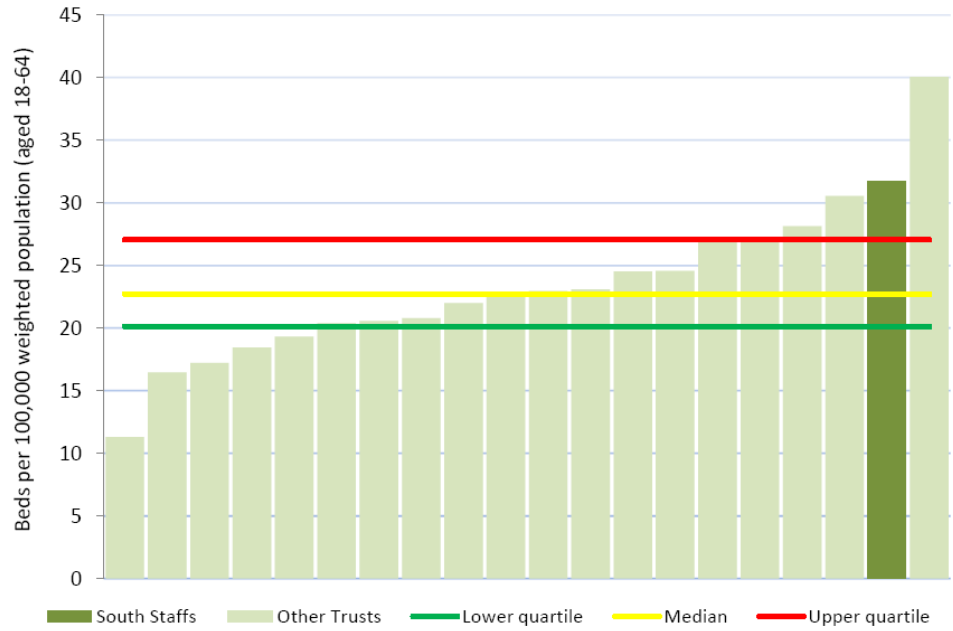
- a focus on community based provision bringing care closer to home;
- integrating care pathways to include primary and social care;
- delivering greater equality;
- demonstrating restraint in terms of capital spending; and
- delivering efficiency savings.

3.3 Benchmarking Data

The Trust has received its first quarterly report from Mental Health Strategies relating to quarter 1 in 2011/2012. The report covers mental health people's services, with a particular focus on the inpatient setting.

The benchmarking data identifies high numbers of adult beds as identified below in the graph:

Figure 9: Adult acute inpatient beds per 100,000 weighted population (aged 18-64) at 30 June 2011

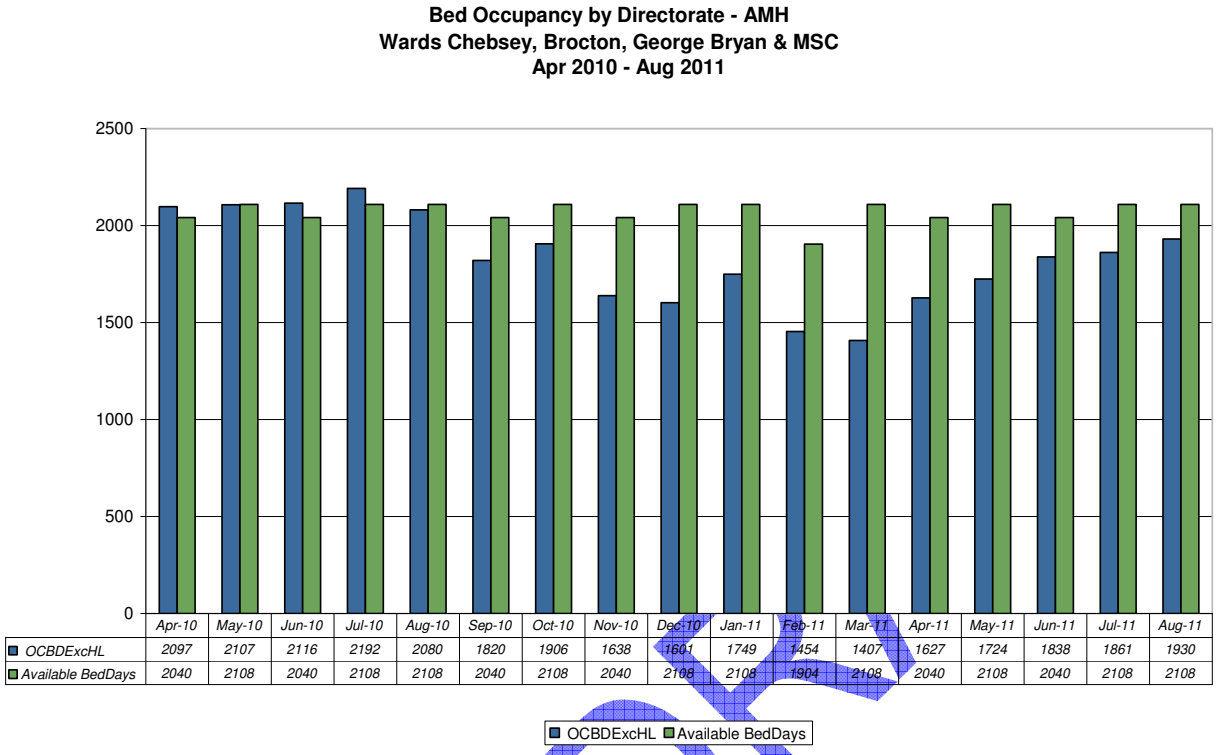


This source of data indicates South Staffordshire and Shropshire have significantly higher numbers of beds than comparator Trusts, even when data is adjusted for need.

3.3.1 Vacant bed days

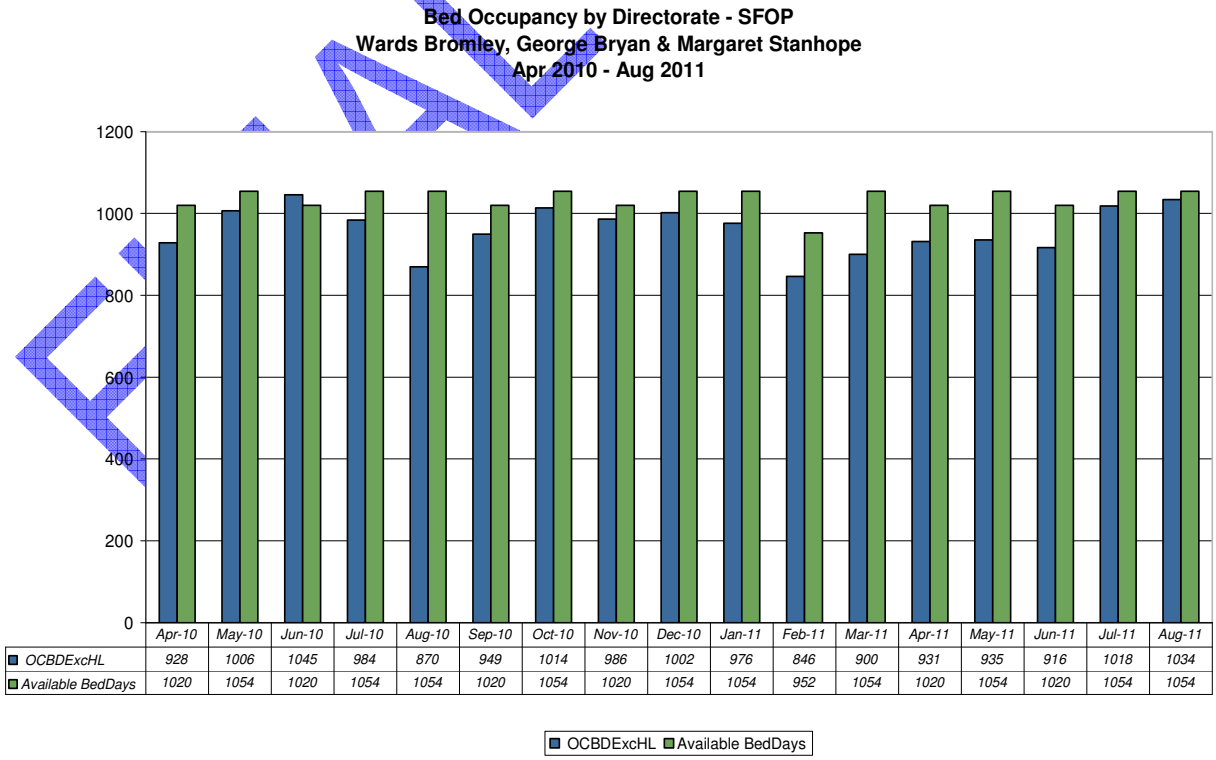
The number of vacant inpatient beds in South Staffordshire has also increased over the past 24 months, although the numbers have changed since the temporary bed closures linked to the bed reduction project. The increase in vacant beds is attributed to a range of factors including the success in improving patient flows following the introduction of functionalisation within acute care. There is also good evidence of the effectiveness of the Crisis Response and Home Treatment Services in both avoiding inpatient admissions and facilitating early discharge from hospital (Appendix 1, Bed Reduction Project). Data on available bed days is shown below in tables 2 and 3.

Table 2 – Available Bed Days - Adult Wards



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11
OCBDExcHL	2097	2107	2116	2192	2080	1820	1906	1638	1601	1749	1454	1407	1627	1724	1838	1861	1930
Available BedDays	2040	2108	2040	2108	2108	2040	2108	2040	2108	2108	1904	2108	2040	2108	2040	2108	2108

Table 3 – Available Bed Days - Older peoples Wards



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11
OCBDExcHL	928	1006	1045	984	870	949	1014	986	1002	976	846	900	931	935	916	1018	1034
Available BedDays	1020	1054	1020	1054	1054	1020	1054	1020	1054	1054	952	1054	1020	1054	1020	1054	1054

3.3.2 Inpatient Lengths of Stay Data

Inpatient lengths of stay have reduced considerably over the past 12 months, since the introduction of functionalisation. The average length of stay for inpatient care across the Trust is shown in the tables 6 - 10 below. These figures include both adult and older adult wards but exclude the dedicated ward for Dementia.

Table 4 – MSC Adult

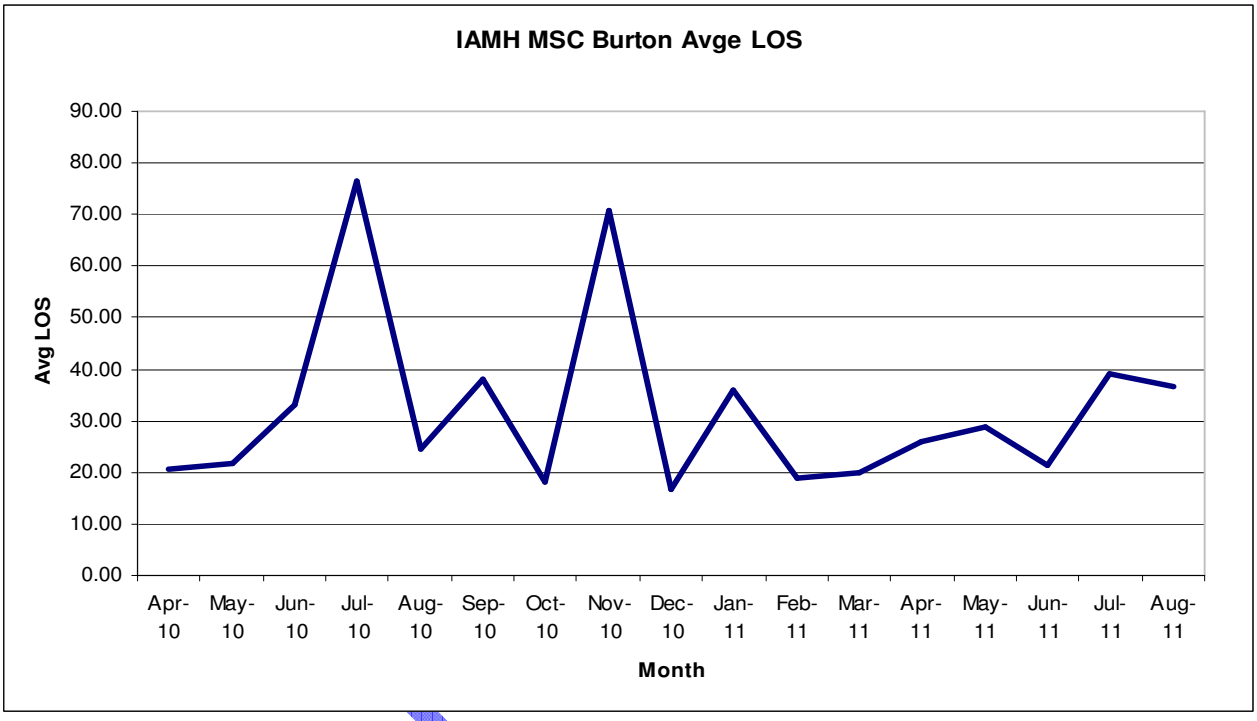


Table 5 – Brocton

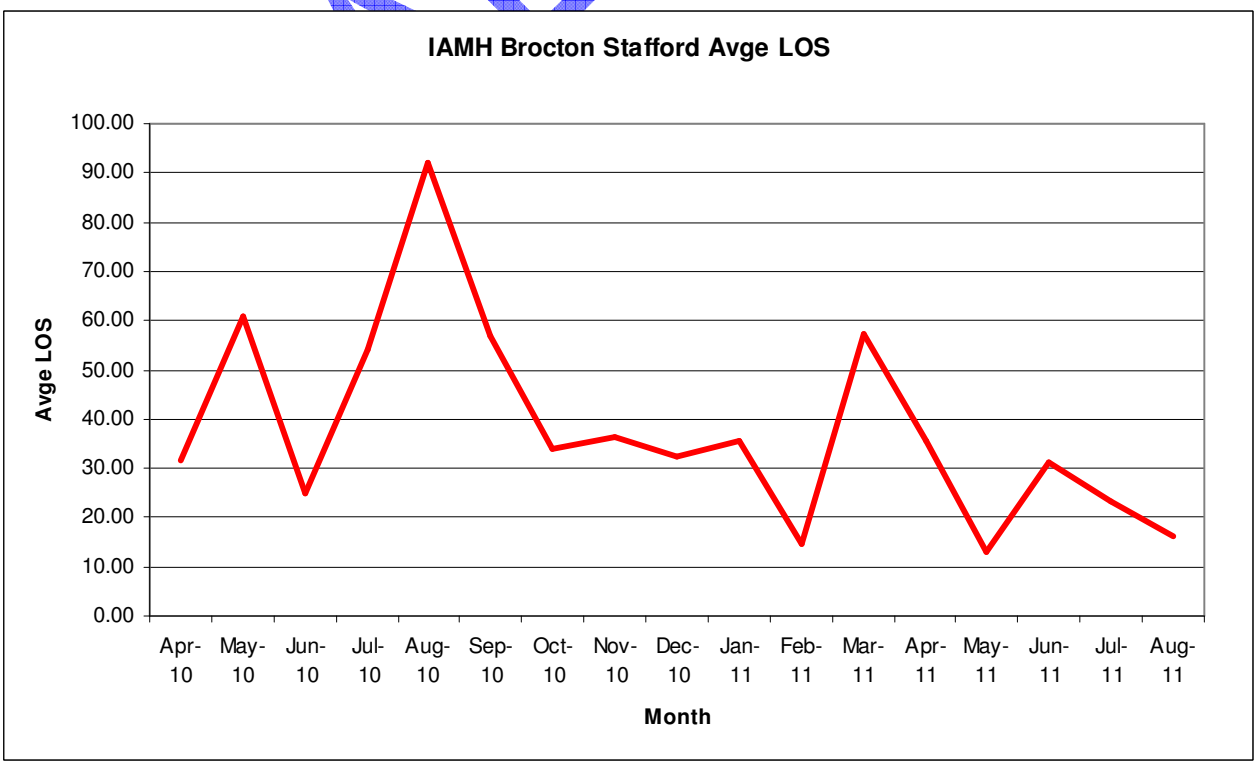


Table 6 – Chebsey

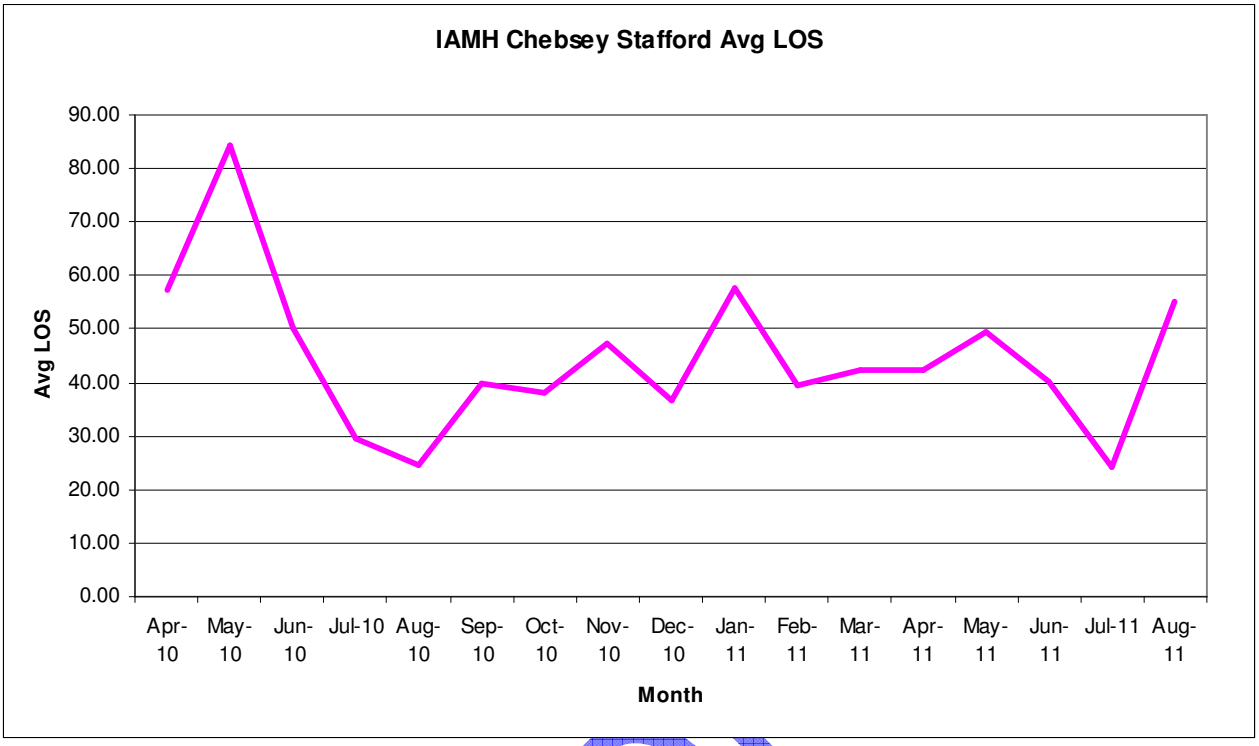


Table 7 – GBC West Wing

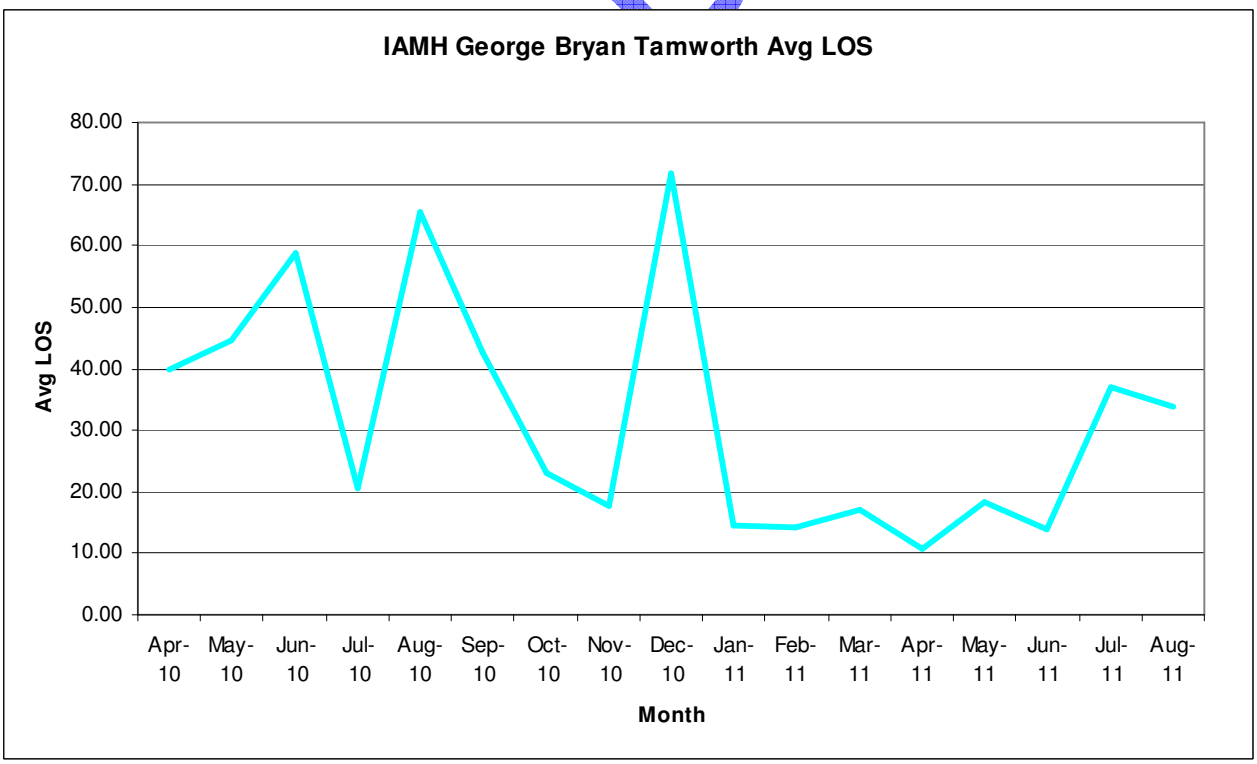


Table 8 – MSC Older Adult

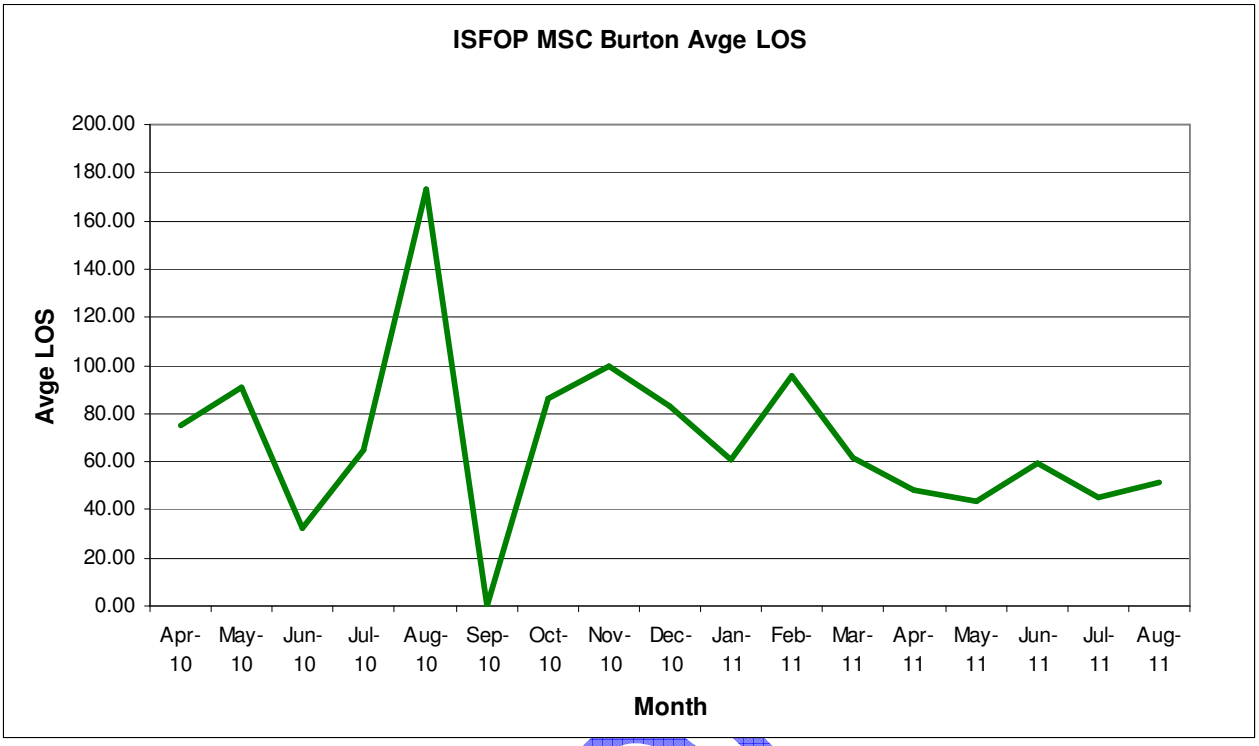


Table 9 – GBC East Wing

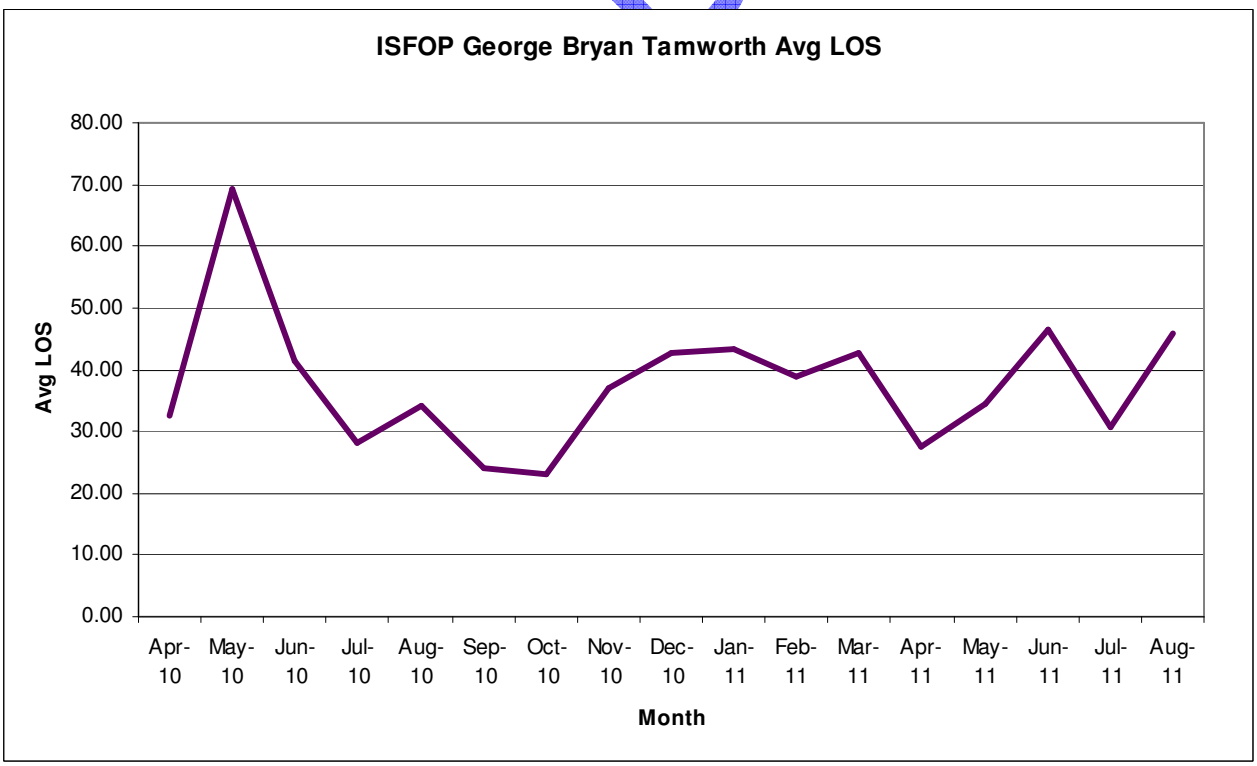
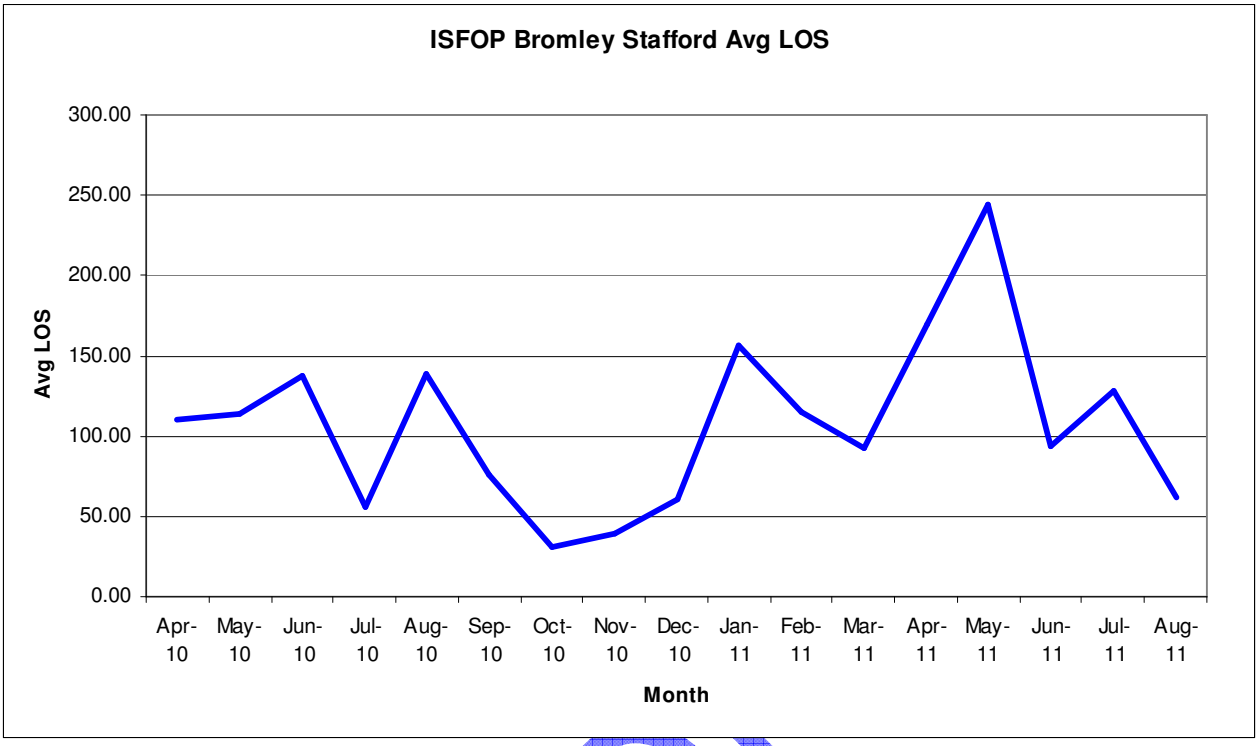


Table 10 – Bromley



3.3.3 Financial drivers for change

The NHS has a duty to ensure quality is of the highest standard and that resources are used as efficiently as possible.

The NHS and public services generally, are expected to find savings from efficiencies over the next three to five years. It is expected that the savings that can be made from site reductions is approximately £1.4m. This would make a significant contribution to the Health Economies overall savings target.

4. Options

Objectives of the proposed scheme:

To develop options for delivering care closer to home that would improve the quality and efficiency of services and increase equality and choice for service users.
To demonstrate that options for reconfiguration of inpatient services reflect evidence of clinical effectiveness.
To ensure that options for reconfiguration of inpatient services are developed and consulted on through effective engagement of service users, the public , GPs, commissioners and partner organisations.

4.1 Current Inpatient Bed Numbers.

Mental Health beds in South Staffordshire are currently distributed over three main sites, these are as follows:

Site	Ward	Number of Beds	Total on Site
St Georges Hospital, Stafford	Brocton House (Adult Acute) Chebsey House (Adult Acute) Bromley House (Older People) Baswich Ward (Dementia) Norbury House (PICU)	16 20 14 12 10	72
Margaret Stanhope Centre, Burton	Adult Acute Older People	18 8	26
George Bryan Centre, Tamworth	West Wing (Adult Acute) East Wing (Older People)	20 11	31

St Georges Hospital, Stafford: This is a large hospital site in the centre of Stafford with a range of other inpatient and community services alongside the wards identified above. The bulk of the accommodation was purpose built as a mental health inpatient site beginning in the mid 1990's and all beds are in single rooms with the majority having en-suite toilet and shower facilities. The site is owned by South Staffordshire and Shropshire Healthcare Foundation NHS Trust. The site has the benefit of canteen facilities for staff and visitors, and is co-located with support services such as the Community Mental Health Teams, Specialist inpatient services, Crisis Teams and others. Beds on this site are utilised by the whole of South Staffordshire population regardless of their home address and is the closest inpatient services for localities such as Seisdon, Cannock, Rugeley and Stone. It is universally considered to be the Trust's best site overall in terms of facilities, environment and functionality.

Margaret Stanhope Centre, Burton: This is a stand alone unit on the Queens Hospital complex in Burton; it is located on The Outwoods Site and was originally built as a maternity unit. The site holds 2 inpatient wards and is the only accommodation in South Staffordshire that has shared sleeping space. It is a stand alone unit housing no other mental health services. The site is rented by the Trust from Queens Hospital and has access to all the facilities available within the Acute Trust. This is the only site in the Trust where car parking is not free to staff, service users and their visitors. The site is in close proximity to Burton town centre where the majority of community mental health services are sited.

George Bryan Centre, Tamworth: This is a stand alone unit on the Sir Robert Peel Hospital site. The site houses two inpatient units that are purpose built and all beds are in single rooms with the majority having en-suite toilet and shower facilities. The site is owned by South Staffordshire and Shropshire Healthcare Foundation NHS Trust. The site has access to canteen facilities and local services housed within Sir Robert Peel. Car parking on the site is free and there is scope for the site to extend for future requirements.

4.2 Why reduce the number of sites

Spreading inpatient services across multiple sites is less efficient than consolidating them onto fewer locations. Each inpatient site operated incurs administration and support costs many of which are site specific, rather than relating to the number of beds, and reduce or are eliminated if the site is vacated. A reduction in sites would mean that savings would be made in relation to whichever site was vacated, although the costs vary. This is separate from the reduced cost in nursing, medical and other staff which would be achieved through a reduction in the overall number of beds and inpatient activity. The same level of saving would not be achieved by reducing a small number of beds form each inpatient ward across the Trust as the costs for running the ward in relation to buildings and staffing would not be realised.

4.3 Deciding the Options

The options were developed through the work undertaken for No Delays as part of the redesign of the following pathways and associated services within these pathways:

- Acute Care Pathway
- Dementia Pathway

The Project Team identified a total of five options for consideration and they are as follows: -

Option1:

This is the No Change Option. In-patient services would stay as they are currently.

Option 2:

Reduce acute in-patient by 18 and older adult beds by 7 across all wards in South Staffordshire.

Option 3:

Close the Margaret Stanhope Centre, Burton-on Trent, resulting in a reduction of 18 acute beds and 7 older adult beds and re-provide 1 older adult bed at George Bryan Centre.

Option 4:

Close the George Bryan Centre, Tamworth, resulting in a reduction of 20 acute beds and 11 older adult beds.

Option 5:

Close an acute ward and older adult ward at St Georges Hospital, Stafford, resulting in a loss of 20 acute beds and 14 older adult beds.

In developing these options there were many different permutations on how the impact of a better developed Home Treatment Service and Community Mental Health service could affect in patient beds. All of the options look at a system wide approach to a new service model recognising the reduction of demand for in patient beds with the development of Home Treatment teams and the implementation of functionalisation. All three in patient sites have been considered for the option of reprovision of a full site. However the number of beds at the Margaret Stanhope Centre plus the ability to redesign in the future on alternative sites has led to this site being most suitable for reprovision under option 3.

4.4 Benefit Appraisal

The benefit appraisal is a process of quantifying and comparing the potential benefits of the options in terms of non financial criteria. Benefit criteria are used to select and evaluate the possible options for satisfying the need for change and to determine the preferred option.

4.4.1 Benefit Criteria and Weights

The No Delays Project Team met and agreed to establish the benefit criteria in line with four key areas. This criteria was used to rate each option, weighted relative to their importance to the provision of safe, quality care. The criteria and their weightings are listed below

4.4.2 Weighting of Benefit Criteria

Each of the four criteria is described in the following table.

Table Description of Benefit Criteria

Benefit Criteria	Description of Criteria	Weighted Total Score out of 100
Quality and safety of services that meet individual service users needs	This criterion will examine each option in relation to how it will innovatively deliver the future model of mental health care and how it promotes clinical effectiveness of the whole mental health system and provides a consistent approach to service quality and a safe service provision. Consideration is also given to the effective management and use of in patient mental health beds, the quality, safety and efficiency of the environments linked to national standards and guidance. The criterion also explores how each option facilitates rapid, safe access to services, minimising delays.	35
Sound financial management and commercial achievements	This criterion considers each option in relation to productivity, affordability, and future developments. Consideration is given to the effective use of resources in the management of South Staffordshire Mental Health Division. This criterion also explores the options for sustainability and growth for the future of mental health services in South Staffordshire, including developments of further services in the future.	35
Knowledge, training, development and engagement of staff	This criterion examines the impact on staff development and enhanced skills and knowledge. It will also explore how staff skills can be utilised in the best way making sure there are the right staff, doing the right thing at the right time. Options which promote integrated team working and facilitate a cohesive staff culture which improves working facilities for staff will score higher.	20
Internal perspective and other strategic elements	This criterion explores the impacts each option has on other parts of the Trust, including other strategies, e.g. The Estate Strategy; Performance Strategy. Assessment of each option in terms of impact on other services in other Directorates and flexibility of each site for expansion for future services.	10

4.4.3 Methodology for Measuring and Comparative Analyses of In-patient and Domiciliary Mental Health Care Services

The methodology utilised was supported by the work undertaken by Nick Adams and is based on analyses from the past 7 years of the Acute Care Programme delivered by the Regional Development Centre's (formerly the National Institute for Mental health in England and Care Services Improvement Partnership), particularly in relation to addressing the staffing, performance and cost analysis needs of providers and commissioners of acute in-patient mental health services.

This methodology is dependent upon assumptions, such as length of stay in both hospital and domiciliary services, which should be derived from audits of local activity data taken over a sufficient time period that short term anomalies, such as peaks in admission rates or outlying extreme lengths of stay, can be taken into consideration. Variations in assumed data will produce variations in calculated results. To maintain transparency each of these assumptions should make reference local data in all instances, supported by practice guidance wherever possible, this giving a methodological and local evidence base to calculated results.

The Trusts work was further supported by the review that was undertaken as part of the Gateway Review to support the proposals in this case for change and the report undertaken by Nick Adams is attached as Appendix 4. This report supports the recommendation for 25 beds to be safely reduced in line with the data available within the Trust.

4.4.4 Scoring of Options

Each option was scored against the agreed criteria. Options were scored on each of the criteria on a scale of 0 to 10. Those options which scored higher demonstrate their ability to meet the requirements within the set of agreed criteria.

Table - Scoring of Options

Benefit Criteria	Wgt	Option 1		Option 2		Option 3		Option 4		Option 5	
		score	Weight score	score	weight score	score	weight score	score	weight score	score	weight score
Quality and safety of services that meet individual service users needs	35	6	210	7	245	9	315	5	175	5	175
Sound financial management and commercial achievements	35	5	175	6	210	9	315	6	210	5	175
Knowledge, training, development and engagement of staff	20	6	120	7	140	7	140	7	140	7	140
Internal perspective and other strategic elements	10	5	50	7	70	8	80	8	80	7	70
Total	100		555		665		850		605		560

4.4.5 Analysis of Options

Option 1 scored the lowest during the appraisal as the no change option does not reflect the strategic developments within mental health and the Trust. It does recognise however the internal views of some staff that maybe affected by proposed models of change. It is recognised in this criterion the feedback that service users and their carers have made about the service they receive at The Margaret Stanhope Centre. This is the reason behind the higher score. The current provision though does not address an innovative service model that meets the principles of No Delays. Comments around travel for in patient services are recognised in the scoring of this option.

Option 2 scored second highest overall with a score of 665 as this provides the Trust with the option to reduce a safe number of beds and provide in-patient services within the localities they are already operating from. However this option does not enable the Trust to deliver efficiency savings in relation to staffing, estates and support costs. In option 2 the reduction of beds by a percentage at each site will not release capital resource and only limited revenue resource as there will be on-going costs required to ensure safety

and quality of any beds. This option also does not provide the Trust with the ability to utilise its resources in the most efficient manner in line with its strategic intent and national best practice. It would also require capital funding to support refurbishment at Margaret Stanhope Centre to ensure the quality of the environment matched other sites. This score also recognises the issues raised around travel for in patient services for the people of Burton.

Option 3 scores highest in this appraisal with a score of 850 as it is the option that addresses all the principles raised through the engagement and involvement of our stake holders during the development of a new service model for No Delays. Option 3 scores highest in three of the four criterions. This option scores highest in criterion 1 as it is the site with the fewest beds with which the Trust believes it could manage safely without based on current models and investments for community services. It is also the site where the quality of the environment impacts upon the delivery of a modern mental health service and requires investment to bring the standard of the physical environment in line with other sites. This option received the top score in criterion 2; this was in relation to making best use of the resources available across South Staffordshire. This option scored highest in criterion 4 alongside option 3 because to some extent it reflected strategic intent within the Trust. The Estate Strategy and standards for the environment would require a refurbishment of the Margaret Stanhope Centre and will require capital development which would impact on other strategies, including any potential for further development on the site. This option can meet all the requirements to deliver a productive service within the financial allocation.

Option 4 scored 605 across the criterion this is largely as a result of the current bed numbers at the George Bryan Centre as these are significantly higher than what the Trust believes would be safe to reduce based on national guidance. This site is also owned by the Trust and fits with the strategic direction of the organisation in relation to potential developments on the site.

Option 5 was put forward for consideration however this option would not fit with the Trust strategic elements as this is a large mostly purpose site that has received significant investment in capital developments. Delivering services across a large hospital site also enables the Trust to utilise its resources in the most efficient way, particularly in relation to workforce and support structures. Moving forward on this option would not fit with the Trusts estates strategy.

Criterion Three:

This criterion scores each option the closest with option 2, 3, 4 and 5 all scoring a 7 for different reasons. As a forward thinking and dynamic organisation it is inconceivable that even if an option is not agreed, that staff skills and training would suffer. Option 3 does promote the most innovative approach but it is recognised in the scoring that staff would take advantage of changes to support developments in options 2, 4 and 5 and maximise their skills accordingly. Option 1 as a no change option recognises that staff do enhance their knowledge but also that the system at present does not create or enable this to happen to its full extent.

4.4.6 Affordability

Savings have been calculated for each option based on a detailed review of current costs. Details of the savings assumed relating to the existing Service Level Agreements and offsetting costs are incorporated into the financial assessment. No savings have been assumed for Option 1 because there is no change.

Additional costs have been included for both Options 4 and 5 for the relocation of some inpatient beds to support these options.

The following table summarises the savings and costs included for each option:

OPTION APPRAISAL RE CLOSURE OF 18 ACUTE AND 7 OLDER ADULT BED	Aug-11						
		Numbers of beds			Reprovide beds		
	Saving £	Adult	OA	Total	Number	Cost £	Net Saving £
Option 1 Do nothing	0	0	0	0		0	0
Option 2							
Reduce beds across wards in South Staffs	342,836	18	7	25		0	342,836
Option 3							
Close the Margaret Stanhope Unit, Burton-on-Trent	1,490,000	18	7	25		0	1,490,000
Option 4							
Close the George Bryan Unit, Tamworth	1,311,740	20	11	31	6	254,000	1,057,740
Option 5							
Close an acute and older peoples wards at St Georges	1,449,174	20	14	34	9	384,000	1,065,174

5. Conclusions

On the basis of the analysis of the listed options in relation to the Trust's key performance areas, option 3 is the preferred option. The ranking of the options is detailed in the table below

Table - Rank of options following the scoring exercise:

Rank	Option	Weighted Score
1	Option 3	850
2	Option 2	665
3	Option 4	605
4	Option 5	560
5	Option 1	555

The preferred option will deliver the following inpatient based quality improvements:

- Single bedrooms on all ward
- Safest number of beds the Trust can reasonably reduce with the current spend on community resources
- improved safety and privacy;
- better access to external space;
- better staff back up, support and shared expertise;
- less inequality in terms of service provision and service standards; and
- In addition the preferred option will deliver estimated disinvestment savings of £1.4m.

Appendix 1

PROJECT TO SHIFT ACUTE MENTAL HEALTH CARE PROVISION FROM HOSPITAL TO COMMUNITY IN SOUTH STAFFORDSHIRE APRIL 2011

Contents Page

1. EXECUTIVE SUMMARY

The purpose of this paper is to review the above project which commenced in October 2010 and ended in March 2011 with the final two of the proposed bed closures.

The project was agreed between South Staffordshire Healthcare NHS Foundation Trust (SSSFT) and South Staffordshire Primary Care Trust (SSPCT) in conjunction with the Joint Commissioning Unit (JCU), Practice Based Commissioners (PbC) and following engagement with service users.

There were two projects which ran in simultaneously to enable the reduction of available beds in South Staffordshire which would enable the mental health services to maintain more people at home when seriously ill and reduce dependence on inpatient beds. These projects are this one (PROJECT TO SHIFT ACUTE MENTAL HEALTH CARE PROVISION FROM HOSPITAL TO COMMUNITY IN SOUTH STAFFORDSHIRE) and a project to improve the specialised care required when someone really does need inpatient care (FUNCTIONALISATION).

It was agreed that 15 different data set items (some staged and complimentary) would be collected through the six month project period. These were quantitative and qualitative in nature. The delivery of incremental targets and service improvement would enable the Trust to reduce the number of inpatient beds available for “functional illness” to be reduced at the rate of two per month.

Altogether eleven of the proposed twelve beds were closed. Each remained available to be reopened should the clinical need of a service user require admission and no bed be available. This was not necessary during the duration of the project.

The one bed that did not close was an older adult bed and the reason for non closure was the delayed delivery of training in older peoples care to the Crisis Resolution and Home Treatment Team rather than a capacity or quality problem.

Bed occupancy has decreased during the period and there was an 89% occupancy rate of working age adult beds during February 2011. Data is currently being analysed to identify further detailed information.

Quality audits have generally improved month on month with a good level of satisfaction from service users, carers and referrers for month 5 and 6 of the project.

This is the first summary paper for the project and further, continuing analysis will take place to monitor the continued development of community services and utilisation of inpatient services.

2. INTRODUCTION

The purpose of this paper is to present a reflective analysis of the project to shift acute mental health care provision from hospital to community in South Staffordshire. The project was agreed between South Staffordshire and Shropshire Healthcare NHS Foundation Trust and key groups and individuals.

The project ran from October 2010 and as such concluded at the start of March 2011. In all eleven beds were removed (temporarily) for the duration of the project and remain closed.

The theory and background of the project was described in the project proposal and the key overview factors include:

- The well known and extensive progress of mental health services universally to move away from a hospital based service to a community based provision for people suffering from a mental health problem;

- Development of community based mental health specialist teams providing both assessment and treatment;

- Mental health service development built on the principles of the National Service Framework for Mental Health;

- More recent development of Primary Care Based early detection and treatment of the more common mental health difficulties;

- Pump priming investment by the Primary Care Trust in Crisis Resolution and Home Treatment Teams across South Staffordshire.

This, of course, is in line with a social movement away from a reliance on inpatient care driven by both service user and political opinion.

As this is the first summary report completed soon after the conclusion of the project there will be further information, data presentation and ‘next steps’ emerging from the project in the next few weeks. Service development continued monitoring/auditing and action planning will be a dynamic and evolving process.

3. PROJECT PROPOSAL

The plan involved four wards over a 6 month period, commencing October 2010. This demonstrated the success of bed closures based on sound community resource and through the monitoring of key quality indicators.

The plan proposed a total of 12 reversible bed closures:

- MSC Adult Admission Ward (Burton) – 5 beds
- Brocton Adult Admission Ward (Stafford) – 4 beds
- Bromley Older People Admission Ward (Stafford) – 1 bed
- MSC Older People Admission Ward (Burton) – 2 beds

Bed Reduction Progression - Table illustrates planned closure and actual bed close against plan.

Date	Ward	Bed Reduced	Comment
October 2010	Margaret Stanhope Centre Adult Bed	1	
	Brocton Ward Adult Bed	1	
November 2010	Margaret Stanhope Centre Adult Bed	1	
	Brocton Ward Adult Bed	1	
December 2010	Margaret Stanhope Centre Adult Bed	1	
	Brocton Ward Adult Bed	1	
January 2011	Margaret Stanhope Centre Adult Bed	1	
	Bromley Older Adult Bed	1	
February 2011	Brocton Ward Adult Bed	1	
	Margaret Stanhope Centre Older Adult	NIL	Bed not closed due to training plan for Older Adult not complete with team
March 2011	Margaret Stanhope Centre Adult Bed	1	
	Margaret Stanhope Centre Older Adult	1	

This phasing took into consideration the development of the service in relation to the enhancement of Home Treatment and also the need to safely build capacity for meaningful Home Treatment for older people presenting with functional disorders.

However, without key aspects of the planned service e.g. Acute Day Services and additional resource from proposed disinvestments for specialised older people input, the full plan for Home Treatment could not be delivered within the project plan.

3.1 KEY PROPOSED SERVICE CHANGES

A gradual, reversible reduction of inpatient beds across South Staffordshire at the rate of two per month and totalling 12 beds;

- A defined baseline of community based services to be in place before each bed reduction;

- A structured review of quality data as changes are implemented, including service user feedback, review of complaints and compliments, untoward incidents and an audit of Crisis Resolution and Home Treatment communications**.**

3.2 MONITORING PROCESS

The proposed plan was carefully monitored on a monthly basis prior to the each proposed bed closure, a report was produced identifying compliance with the planned community resource and qualifying parameters e.g. no out of area patients (those service users placed outside of the PCT catchment area). This report was shared with internal stakeholders and commissioners. If the compliance fell short of the expectation then the planned bed closure was reviewed. In one month a bed was not closed due to a delay in providing training to the Home Treatment Team rather than a challenge over capacity.

After each period of the plan, a quality and safety report was be produced and shared with stakeholders and any concerns over quality, safety or service user/carer experience was addressed before further bed closures are made. Each bed closure was agreed at Executive and Divisional Level.

4. SUMMARY OF MONITORING RESULTS

There were a number of qualitative and quantitative measures for each project period. The following is a brief description of each item and the results through the project period.

4.1 Crisis Resolution & Home Treatment Staff in Post against Plan (Percentage)

During the project period it was planned to increase the staffing level within the Crisis Resolution and Home Treatment Team from 70% to 95%. This was achieved through an actual incremental increase from 74% to 96%.

4.2 Working Age Admissions Assessed Face to Face by Core CR/HTT Staff

This was a challenging target to monitor and record by definition during team development. However, the percentage of compliance for the project rose from 49% at project commencement to 98% at project conclusion. This was against a target of 45% rising to 95%.

4.3 Number of Staffordshire patients in out of area acute beds - Monthly Total

During the project period there were no South Staffordshire patients who needed to be admitted to beds outside the Trust**.**

4.4 Evidence of Delivery of Home Treatment Episodes Equivalent to Number of Bed Days

This too was a difficult data item to measure in many ways. The definition used was the number of day's treatment received by patients recorded as being Home Treatment provided by the Crisis Resolution and Home Treatment Team. The contribution by other teams to preventing the need for admission was discounted. Therefore the project took a conservative view on the number of days which were likely to have otherwise required admission. In all the targets were generally comfortably achieved each period which rose from 60 Days in October 2010 to 300 Days in February 2011.

4.5 Significant Home Treatment for Older People with Functional Disorder

The measure for Home Treatment in this data item was the number of episodes of Home Treatment recorded as provided to people over the age of 65 years. This target commenced in the project from December 2010. The actual number achieved was:

- December 9 Episodes;
- January 10 Episodes;
- February 8 Episodes

4.6 Staff Training in Working with Older People

This requirement was the one which prevented the planned closure of an older adult bed on the 1st February 2011. The majority of staff in the Home Treatment Team are experienced in working with people of working age; a training plan was devised to ensure that staff knowledge was refreshed in working with older adults. The training plan was delayed for a number of reasons and although the team were working with the patient group and there was capacity to 'close' a bed it decided to keep the bed open to ensure that individual needs could safely be met which was the primary consideration of the project.

4.7 Carer Questionnaire Survey Results

In month one of the project, a questionnaire format was tested with ten carers. This was then used by the team to survey carers of service users to ascertain their opinion of the service. While the number of respondents was disappointing the overall satisfaction of carers through the survey period was very good. A summary report is attached in Appendix 1.

4.8 GP Phone Feedback Questionnaires

This measure was key to the success of the project as historically there has been wide ranging negative feedback from GP's about the Trusts out of hour's teams. The comments were essential in enabling the team to be responsive to the needs of primary care colleagues during this phase of tem development. Initial comments on the service were very concerning to the team and they have worked exceptionally hard to improve the feedback through the duration of the project. There has been significant improvement in the feedback received over the six month period with an overall satisfaction rating of 4 out of a possible 5 being achieved at the final sampling point from 17 respondents. Further details are shown in Appendix 2.

4.9 Complaints and Compliments in Acute Pathway

During the duration of the project there were no formal complaints made regarding the Acute Care Pathway related to bed availability or the delivery of Crisis Resolution and Home Treatment.

4.10 Serious Incident Review

There have been no serious incidents related to the bed reduction project in the duration of the project. The one incident which occurred prior to the project which may have been linked has been comprehensively investigated and no link to the actions of the team or bed availability identified**.**

4.11 Adverse Incident Review

There have been no adverse incidents reported through the duration of the project that gave any cause for concern regarding bed reduction.

4.12 Peer Notes Review

The teams across South Staffordshire and Shropshire have been auditing the quality of record keeping during the project. This has highlighted areas which do need to be improved in service user records of their mental health episode. Priorities for improvement have been identified and included within a team service improvement action plan.

4.13 Service User Feedback Survey Results

The Service user experience is being collated over the project period; however the month to month responses indicate a very positive experience being received. This is one of the data items that all involved in the project considered one of the most important aspect of all. Service users were positive in their comment about the service they received.

Service Users are given the opportunity to comment on the quality of services that they have received from the Trust. There were 46 people who took the opportunity to comment on the Crisis Resolution and Home Treatment team. Of these 45 rated the service as good or excellent. The one exception response to this rated the service as OK. There was one service user who responded no when asked 'Have you been given (or offered) a written or printed copy of your care plan?'

There were two questions which consistently received a significant proportion of responses suggesting no consistent delivery of the quality requirement. These were:

- *Were both the purpose and the side effects of medications explained to you?*
- *Do you know what to do if you are not pleased with the service you received?*

The teams are working to improve the positive response rate of these questions.

4.14 Service User Feedback from Service User Reference Forum (SURF)

- Questions were asked about the ultimate aim of closing Margaret Stanhope Centre and concerns over consultation with service users and carers raised.
- Service users were pleased that the beds could be re-opened if necessary.
- Carers raised issues over the support they currently receive from in patient services if these no longer available.
- Concerns were raised over the anxiety of staff over uncertainty that could impact on service users.
- Service User Network reported that service users are feeling stressed over the potential changes.

- General concerns raised by carers over information they receive on medication.

4.15 Audit of Crisis Resolution and Home Treatment Team Communications e.g. Quality of Assessment Letters

At the project commencement a quality audit of team communication with referring and registered GP was conducted on the service user record to evidence communication. The audit report is attached and illustrates a good improvement and compliance with the standards.

Of the 26 quality items checked within the audit, 4 scored less than 100% (85% compliance rate with standards). Of the 4 not fully met there was evidence of compliance of at least 50% giving a compliance rate across the audit of 93% (156 data items, evidence not available on 11 data items). Based on the same 156 data items in month 1 (Nov 2010) there has been an improvement from 36% to 93% compliance in evidence of communication. The results from the GP satisfaction questionnaire do not give any conflicting evidence to this audit. Details are shown in Appendix 3.

5. Functionalisation

The functionalisation model of inpatient care was introduced in South Staffordshire working age adult mental health services on the 1st December 2010. This project is currently undergoing evaluation to identify what has been delivered and what benefits remain to be delivered.

For both projects the other one will be a confounding variable impossible to eliminate from any evaluation programme. Each service development is complimentary to the other and while academically it would be useful to identify what change has generated which improvement; in practice it was beneficial to introduce the two in tandem.

As can be seen from the table below, there is a gradual but sustained reduction in the level of bed occupancy despite there having been a reduction in the number of beds available.

Further more detailed data analysis is being undertaken on bed occupancy rates as part of both projects.

5.1_Bed Occupancy

The table below illustrates the number of mental health beds available in South Staffordshire for older adults and working age adults and the percentage bed occupancy for each. This table includes both home leave and inpatients from out of area.

		Sept.10	Oct 10	Nov 10	Dec 10	Jan. 11	Feb 11	Mar11
Working Age	Beds Available	88.00	86.40	84.00	82.00	80.10	80.00	79.00
	Beds Occupied	85.60	85.80	78.14	73.60	75.30	71.10	
	Average Occupied	97.27	99.31	93.02	89.76	94.01	88.88	
		Sept.10	Oct 10	Nov 10	Dec 10	Jan. 11	Feb 11	Mar11
Older Adult	Beds Available	46.00	46.00	46.00	46.00	45.10	45.00	44.00
	Beds Occupied	46.90	46.90	48.24	46.95	45.10	43.40	
	Average Occupied	101.96	101.96	104.87	102.07	100.00	96.44	

6. Conclusions

This project has provided a good governance framework within which to reduce the number of inpatient beds within South Staffordshire whilst 'building up' both the resource and competence available in the community, particularly within the Crisis Resolution and Home Treatment Team.

There are two particularly encouraging aspects to the quality dimensions of the project. Firstly, the very positive feedback from service users and carers which has been consistently good through the duration of the project. The second dimension which is so welcome is the ability of the teams to react to negative feedback, the project has seen significant improvement in the feedback from GP's which has be corroborated by the improvement in the results of the communication audit.

It is disappointing that 100% of the targets were not achieved throughout the duration of the project with just one bed of the twelve planned not being closed.

Significant credit is due to the Crisis and Home Treatment Teams in particular and Inpatient Staff on the wards involved for the hard work, effort and energy they have invested in making these improvements within a relatively short time period by any standard.

The progress and outcomes of this project has been reviewed by the Trust with key partners and agreement has been made to undertake a public consultation on permanent bed closures.

It is the intention of both the Crisis Resolution and Home Treatment Teams and Division managers to continue to closely monitor the development of community based treatment and reduction in the need for admission to hospital. This will make use of quantitative and qualitative data that has been established as part of this project and will now focus on reducing the onerous nature of additional data collection the team have responded to so well.

The Creating Capable Teams programme has been part of the teams' developmental process and the action plan arising from this will contribute to future development plans.

The No Delays project in South Staffordshire included a workstream on the acute care pathway. This is being continuously refreshed through the community and inpatient developments that have taken place in both the bed reduction and functionalisation projects.

APPENDIX 1

Mental Health Directorate

Home Treatment Carer Satisfaction Survey

MH 368.10.11

November 2010 - February 2011

Report compiled by:

Clinical Audit Team

Background

Work being undertaken as part of the monitoring of the impact of the increased acute community based provision and related bed reduction.

Results of this survey are to be compiled monthly and along with additional information requirements, considered and shared with South Staffs PCT.

This report includes data from November, December 2010 and January, February 2011

Aim and Objectives

Monitor the quality impact of increased acute community based provision and reduced bed reduction.

Methodology

- Questionnaires were given to carers by members of the CRH Teams in Stafford and Burton.
- Freepost envelopes available to return.
- Analysed by Clinical Audit Team.
- Ongoing, monthly comparison.
- Monthly feedback to Clinical Director.

The data detailed within this report has been validated in line with the Clinical Audit Team's operating procedure

Results

	November 2010	December 2010	January 2011	February 2011
1. Which Home Treatment Team is this questionnaire regarding?				
(East - n=)	(2)	(2)	(3)	(1)
(West - n=)	(7)	(1)	(2)	(1)
Combined - n=	9	3	5	2
2. I felt that the staff were approachable and supportive	100%	100%	100%	100%
3. Were you given enough time to discuss your relative's/partner's/friend's treatment and condition?	100%	75%	60%	100%
4. I was able to talk to someone when needed regarding my relative's/partner's/friend's treatment and condition and my questions were answered.	100%	88%	100%	100%
5. I was given enough information about my relative's/partner's/friend's treatment and condition, knew why they were receiving care from Home Treatment and their treatment plan.	100%	100%	100%	100%
6. When your relative/partner/friend was receiving care from the Home Treatment Team, were you given information on how to contact/access the service out of hours?	100%	100%	100%	100%
7. I felt as though I was involved in decisions about their care and treatment, their treatment was discussed with me and I could say what was helpful for them.	100%	100%	100%	100%
8. Is there anything about the service that particularly pleased you?	100%	88%	100%	100%

9. Is there anything about the service that you feel needs to change?	11%	0%	0%	0%
10. Do you know what to do if you were not pleased with the service you received?	56%	100%	100%	100%

Q2 I felt that the staff were approachable and supportive. Comments (November 2010)

- Very Friendly.
- All Staff lovely and calming helpful.
- Definitely.
- Fantastic.
- I did not know that a crisis team existed but after experiencing their care I realize that they are absolutely essential to monitor seriously ill patients.
- Difficult to know how crisis deal with things, feel frustrated that things can't be dealt with immediately.

(January 2011)

- Very Much so.

Q3 Were you given enough time to discuss your relative's/partner's/friend's treatment and condition? Comments (November 2010)

- More than enough time.
- Good able to talk during visits.
- Very supportive team.

(January 2011)

- Not always. Some only stayed a few minutes.
- Plenty of time to discuss any issues he had.

Q4 I was able to talk to someone when needed regarding my relative's/partner's/friend's treatment and condition and my questions were answered. Comments
(November 2010)

- Prompt responses. Too many people involved - continuity of people involvement.

(December 2010)

- Some information was restricted due to confidentiality.
- They had to get my wife's consent first. What would have happened if she refused?

(January 2011)

- Satisfactory.

Q5 I was given enough information about my relative's/partner's/friend's treatment and condition, knew why they were receiving care from Home Treatment and their treatment plan. Comments
(November 2010)

- Didn't get any specific information. Was told to access website.

(December 2010)

- Crisis Team staff answered my questions about medication.

Q6 When your relative/partner/friend was receiving care from the Home Treatment Team, were you given information on how to contact/access the service out of hours? Comments
(November 2010)

- Good knowledge of circumstances of case.

(December 2010)

- On a care plan – clearly written.
- They gave me a number to call at any time.

Q7 I felt as though I was involved in decisions about their care and treatment, their treatment was discussed with me and I could say what was helpful for them. Comments
(November 2010)

- Encouraged by CRS to support X with his recovery which really helped.
- Felt very included.
- Couldn't have coped.
- The team were very knowledgeable about my partners treatment/s with other doctors.
- Happy for 'experts' to deal with things. Present upon discussions but happy to sit back.

(December 2010)

- Sometimes.

(January 2011)

- Everything was explained.
- Wasn't made too feel he couldn't raise concerns if he had any but chose to sit quiet during the assessment.

Q8. Is there anything about the service that particularly pleased you? Comments
(November 2010)

- Felt time keeping of staff was very good. Always phoned prior to visiting.
- Nice to know that we were there.
- All staff are very helpful.
- Same person – continuity was good.
- Felt very personal, comfortable to talk to you – felt like part of the family – very supportive.
- Overall it fantastic – all of it amazing.
- Everything pleased me.
- Everything seems to be working. Responsive to engagement.

(December 2010)

- Felt people cared about both of us.
- Crisis Team Staff always arranged times to visit.

(January 2011)

- Everyone was very helpful.
- Marvellous Service
- Everyone was friendly welcoming.
- Everyone was friendly and seemed to generally care.

(February 2011)

- Response and good support.
- 24 access to assistance.

Q9 Is there anything about the service that you feel needs to change? Comments
(November 2010)

- Felt Crisis Team did a good job.
- Continuity but did try best to accommodate needs.
- Not really except problems with continuity.

(December 2010)

- Not sure.

(January 2011)

- Not with present input.

Q10 Do you know what to do if you were not pleased with the service you received? Comments
(November 2010)

- In service pack.
- (No) Not necessary.
- Has made previous complaints to PALS for medical problems.

(December 2010)

- They gave me information on who to make complaints to.

(January 2011)

- Speak to one of the team.
- Would contact us.

(February 2011)

- Speak directly to a member of the team.

Is there anything else you would like to add about the Home Treatment Teams?
(November 2010)

- Found the service very helpful and supportive. Felt staff were very good. Also felt that his son had a very good rapport with X.

- Very thorough and very friendly. Do a good job.
- Well worth it and grateful to people coming to the house.
- They know what that are doing, all we have had dealings with, should receive a Blue Peter Badge, for their commitment to their job. Well done all of them. Thank you.

- Thought you were ???? brilliant you looked after the whole family's needs, and level of distress. You helped me focus and supported me and gave me confidence to look after xxx.
- I can't believe how good they are – we were so worried about xxxx and felt unable to cope. They came in several times a day and gradually withdrew as he got better. Thank you so much.
- Keep up the good work..

(December 2010)

- Thank you.
- No.

(January 2011)

- No.
- Very impressed. First class team.

(February 2011)

- We are very grateful for the support provided.
- Very supportive team.

Conclusion / Summary

November 2010 - Overall the response to the service as represented in the questionnaire was very positive with all respondents answering 100% positive to Questions 2 to 7.

Continuity was mentioned twice when asked if there were any changes that needed to be made to the service.

Four respondents stated they didn't know what to do if they weren't pleased with the service they received.

The vast majority of comments received were positive in nature.

December 2010 – Overall the response to the service remains positive with a slight reduction in satisfaction on questions 3, 4 and 8. An increase in satisfaction is to be noted in question 10.

January 2011 – Overall improvement apart from question 3 with just 3 out of 5 were given enough time to discuss their relative's/partner's/friend's treatment and condition?

February 2011 – 100% satisfaction reported this month.

APPENDIX 2

Mental Health

GP Survey on Satisfaction with CRHT

MH 382.10.11

February 2011
(January/February 2011 data)

Report compiled by:

Clinical Audit Team

Background

Work being undertaken as part of the monitoring of the impact of the increased acute community based provision and related bed reduction.

Results of this survey are to be compiled monthly and along with additional information requirements, considered and shared with South Staffs PCT.

Methodology

A survey tool was developed and GPs who made a referral to the Crisis Resolution Team during the months of January and February 2011 were asked to complete the tool either over the telephone or by email.

The completed tools were returned to the Clinical Audit department where the data was analysed and validated in line with the Clinical Audit Team's operating procedure.

Results n=17

The answers for questions 1 to 3 were based on a rating scale of 1 to 5 with 1 being very dissatisfied and 5 being very satisfied as below:

Very Dissatisfied 1 ----------2----------3----------4----------5 Very Satisfied

1. When you referred your patient to the Crisis Resolution and Home Treatment Team, how satisfied with the initial response were you?	4
2. How satisfied were you with the communication you had with the Crisis Resolution and Home Treatment Team?	4
3. How satisfied were you overall with the service provided by the Crisis Resolution and Home Treatment Team?	4

4. Are there any comments you would like to make about your experience of using the Crisis Resolution and Home Treatment Team?

- Patient had to go to A&E for acute confusion & to rule out medical cause for confusion. Overall very professional handling of the case. Thanks for all help provided by the Crisis Team Services.
- Generally v helpful appropriate and useful service
- I find the Crisis Team useful when involved with my patients is generally good. However I think sometimes the boundaries of who to refer to which service at what time can be unclear.
- Referral made to Dr X who did referral to Crisis Team. Dr Y believed the patient was psychotic the Crisis Team said not. Crisis Team went out to visit and patient was seen by Dr X the next morning.
  Dr Y has no idea what's happening to the patient now and agreed to put this through the GP helpline for a response within 5 working days.
  RESOLVED- Z contacted Dr Y regarding this morning. Initial assessment information was faxed to Dr Y on 14.1.11 and she confirms she has received it. Z has given her an update on our, and Dr X's, current involvement and she will be further updated by us when the patient is discharged.
- The Crisis Resolution Service was offered to me – I did not think we could access that service if he was not a current "service user", but I am pleased it was offered & it did, I think, *resolve the crisis*.
- Prompt response. Discussed management plan – short term whilst waiting for AMHT review.
- The Crisis Resolution Team have always responded on the day to any requests to see patients.
- Crisis Team involvement good, but no handover or follow up with local mental health team so after crisis intervention stopped, she deteriorated, self-harmed and needs referral to local MHT.
- Fantastic result. Patient very complimentary too. Keep up the good work.
- The service seems to be more prompt and helpful recently, being apparently more focussed on patient need.
- Crisis Team have been great. The problem has been the transfer to the CMHT.
- The lady was not referred by me but I have always been very impressed by the service Crisis Response provide.

APPENDIX 3

Mental Health Directorate

Crisis Resolution and Home Treatment Team Communication with GP Audit

MH 369.10.11

November 2010 - February 2011

Report compiled by:

Clinical Audit Team

Introduction

An audit of six case notes (preferable) was completed on a random sample of cases assessed monthly from November 2010, three from the East Team and three from the West Team.

This was the first audit using a tool devised by mental health service managers which included items considered important to communicate to patients GP's following assessment. Evidence on the quality items was looked for either in letter form or recorded as having been verbally communicated to the GP.

The data in this report covers the months of November, December 2010 and January, February 2011.

The audit tool used is shown at the end of this summary.

The data detailed within this report has been validated in line with the Clinical Audit Team's operating procedure

Results

	November 2010 n=6	December 2010 n=6	January 2011 n=5	February 2011 n=6
1. Timeliness				
1.1. Following initial assessment, is there evidence of feedback being provide to the GP? (verbal or written)	**100%**	**100%**	**100%**	**100%**
1.2. If Yes, was it within 24hrs of initial contact?	**50%**	**83%**	**100%**	**100%**
2. Nature and details of initial contact				
Does the communication identify:				
2.1. when the initial contact took place?	**17%**	**83%**	**100%**	**100%**
2.2. where the initial contact took place?	**17%**	**50%**	**60%**	**100%**
2.3. who was in attendance at the initial contact?	**17%**	**67%**	**80%**	**100%**
2.4. any specific assessment tools used?	**17%**	**0%**	**40%**	**67%**
3. Presenting needs				
Does the communication clearly identify				
3.1. Appearance and behaviour	**17%**	**83%**	**100%**	**100%**
3.2. Mental State and presenting symptoms	**50%**	**100%**	**100%**	**100%**
3.3. Speech, mood and nature of thoughts	**50%**	**67%**	**100%**	**100%**
3.4. Suicidal ideation/intent	**83%**	**100%**	**100%**	**100%**
3.5. Ideas of harming others	**0%**	**83%**	**100%**	**100%**
3.6. Level of service user insight	**50%**	**67%**	**100%**	**100%**
3.7. Other (please state)	**0%**	**60%**	**100%**	**100%**

	November 2010 n=6	December 2010 n=6	January 2011 n=5	February 2011 n=6
4. Predisposing and precipitating factors				
Does the communication include:				
4.1. Psychiatric history	**33%**	**83%**	**100%**	**100%**
4.2. Medical history	**0%**	**67%**	**100%**	**100%**
4.3. Social history	**50%**	**83%**	**100%**	**100%**
4.4. Past MH involvement	**50%**	**83%**	**100%**	**100%**
4.5. Contingency plans from previous contact	**0%**	**0%**	**20%**	**50%**
4.6. Identification of precipitating factors to the current crisis	**67%**	**100%**	**100%**	**100%**
5. Service user perspective				
Does the communication include evidence that the service user:				
5.1. understands the current crisis	**67%**	**100%**	**80%**	**100%**
5.2. has had their views/wishes taken into account	**50%**	**100%**	**100%**	**100%**
Does the communication include evidence that the carer:				
5.3. understands the current crisis	**0%**	**100%**	**40%**	**50%**
5.4. has had their views/wishes taken into account	**0%**	**100%**	**40%**	**50%**
6. Clinician's impression/Assessment summary				
6.1. The communication should include the clinician's impression/judgement/recommendations by way of formulation, care pathway, summary of the crisis situation?	**50%**	**100%**	**60%**	**100%**
6.2. Does it include a statement on ongoing risk/safety issues?	**50%**	**83%**	**40%**	**100%**
7. Outcome and next steps				
7.1 Does the communication clearly identify the outcome of the assessment, including next steps, future interventions/treatment, and any agreed actions with the service user?	**67%**	**100%**	**100%**	**100%**

Quality Standards

Quality standards for communication with GP for CRHT

The division is developing quality standards for communication and standard letters for hybrid through the Golden Thread. However as part of the quality assurance for the Bed Reduction Project there is a requirement to audit CRHT letters to GPs for the December report in support of the planned bed closures.

Standards

1. Timeliness

   Following initial assessment feedback to the GP either verbal and/or written should be provided within 24 hours of initial contact

2. Nature and details of initial contact

   Communication should identify details of the initial contact, when, where, who was in attendance and any specific assessment tools used

3. Presenting needs

   Communication should clearly identify presenting needs and risks e.g.
   - Appearance and behaviour
   - Mental State and presenting symptoms
   - Speech, mood and nature of thoughts
   - Suicidal ideation/intent
   - Ideas of harming others
   - Level of service user insight

4. Predisposing and precipitating factors

   Communication should include any pertinent past history, psychiatric, medical, and social (including current and past involvement of other MH professionals)and any contingency plans in place from any previous contact. Any precipitating factors to the current crisis should be identified.

5. Service user perspective

   Communication should include the service user and carer(if present) understanding and view of the current crisis and their wishes and choices for the resolution of the crisis
6. Clinician's impression/Assessment summary

The communication should include the clinician's impression/judgement/recommendations by way of formulation, care pathway, summary of the crisis situation. This must include a statement on ongoing risk/safety issues.

7. Outcome and next steps

   The communication should clearly identify the outcome of the assessment, including next steps, future interventions/treatment, and any agreed actions with the service user.

NB

In meeting the above standards and to reduce duplication it is reasonable to evidence the requirements through entries on the contemporaneous record for verbal feedback, and the inclusion of the care plan with the covering letter.

Appendix 2 – Audit Tool

CRHT – Communication with GP
Audit Tool

1. Timeliness

1.3. Following initial assessment, is there evidence of feedback being provide to the GP? (verbal or written) Yes ❒ No ❒
1.4. If Yes, was it within 24hrs of initial contact? Yes ❒ No ❒

2. Nature and details of initial contact

Does the communication identify:

2.1. when the initial contact took place? Yes ❒ No ❒
2.2. where the initial contact took place? Yes ❒ No ❒
2.3. who was in attendance at the initial contact? Yes ❒ No ❒
2.4. any specific assessment tools used? Yes ❒ No ❒ N/A ❒

3. Presenting needs

Does the communication clearly identify

3.1. Appearance and behaviour Yes ❒ No ❒
3.2. Mental State and presenting symptoms Yes ❒ No ❒
3.3. Speech, mood and nature of thoughts Yes ❒ No ❒
3.4. Suicidal ideation/intent Yes ❒ No ❒
3.5. Ideas of harming others Yes ❒ No ❒
3.6. Level of service user insight Yes ❒ No ❒
3.7. Other (please state) Yes ❒ No ❒

……..

4. Predisposing and precipitating factors
Does the communication include:

4.1. Psychiatric history Yes ❒ No ❒
4.2. Medical history Yes ❒ No ❒
4.3. Social history Yes ❒ No ❒
4.4. Past MH involvement Yes ❒ No ❒

4.5. Contingency plans from previous contact Yes ❒ No ❒ N/A ❒

4.6. Identification of precipitating factors to the current crisis
Yes ❒ No ❒ N/A ❒

5. Service user perspective

Does the communication include evidence that the service user:

5.1. understands the current crisis Yes ❒ No ❒ N/A ❒
5.2. has had their views/wishes taken into account Yes ❒ No ❒ N/A ❒

Does the communication include evidence that the carer:

5.3. understands the current crisis Yes ❒ No ❒ N/A ❒
5.4. has had their views/wishes taken into account Yes ❒ No ❒ N/A ❒

6. Clinician's impression/Assessment summary

6.2. The communication should include the clinician's impression/judgement/recommendations by way of formulation, care pathway, summary of the crisis situation?
Yes ❒ No ❒ N/A ❒

6.3. Does it include a statement on ongoing risk/safety issues?
Yes ❒ No ❒ N/A ❒

7. Outcome and next steps

7.1. Does the communication clearly identify the outcome of the assessment, including next steps, future interventions/treatment, and any agreed actions with the service user?
Yes ❒ No ❒ N/A ❒

Appendix 2 – NCAT REPORT - South Staffordshire Review of In-patient Mental Health Services
Test three – clarity on the clinical evidence base

NCAT REPORT

West Midlands SHA – Adult Mental Health – Inpatient Pathway redesign

National Clinical Advisory Team Visitor – Dr John Morgan
Date of Visit – 13 July 2011

Introduction

West Midlands NHS (NWNHS) approached the National Clinical Advisory Team (NCAT) on the 4th to 6th July 2011 to conduct a clinical review of the proposals to close the inpatient beds at the Margaret Stanhope Centre following the investment in the community services.
The visit took place on 13 July 2011 at Edwin House, Burton, Margaret Stanhope Centre, Burton and George Bryan Centre, Tamworth.
Meetings or telephone conversations were held with appropriate stakeholders including:

Public and service user engagement

Vanessa Day – PCT Patient lead
Suzanne Cole – Project coordinator, South Staffordshire network for mental health.
Cyril Burton - Links
Geoffrey Morrison – member of HOSC

Clinicians

Abid Khan – Lead consultant, Adult MH services, SSSHFT
Guy Taylor – Ward manager adults
Claire Hartland – Ward manager older adults
Paul Bowers – Ward manager, adults
XXXX – Ward manager, older adults Margaret Stanhope
Dr El Nadeef and crisis and home support team – consultant and other members of team
Iggy Agell – consultant psychiatrist

Trust management

Neil Brimblecombe – chief operating officer
Lisa Agell – Deputy service director
Dr Abid Khan

Commissioners and GPs

Andy Donald – SRO and Director of Commissioning (Staffordshire Cluster)
Liz McCourt – Delegated services commissioning manager
Nicky Bromage – Commissioning manager – mental health, Staffordshire Joint Commissioning Unit
Dr Phil Ballard – GP
Dr Sherlock – GP

Prior to the meeting, I was sent:

- Background to proposed bed reduction disinvestment proposal
- Disinvestment history – letter from South Staffordshire and Shropshire Healthcare NHS Foundation Trust 9 June 2010
- Briefing paper from South Staffordshire and Shropshire Healthcare NHS Foundation Trust on disinvestment options and risk assessment

<u>Practice Based Commissioning (PBC), PCT and South Staffordshire and Shropshire Healthcare NHS Foundation Trust disinvestment meetings.</u>

- Notes of PBC event held on 20 October 2010
- Notes of PBC event held on 25 November 2010
- Notes of PBC event held on 21 March 2011

<u>Bed pilot information</u>

- Bed pilot project summary outline. Project to shift acute mental health care provision from hospital to community in South Staffordshire.
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust update report on project to shift acute mental health care provision from hospital to community in South Staffordshire (March 2011).
- South Staffordshire and Shropshire Healthcare NHS Foundation Home Care carer satisfaction survey (November 2010 to March 2011).
- Sample of monthly project report circulated to PBC Chairs and leads (9 March 2011).
- CRHT East and West survey carried out 26 January to 21 February 2011.
- Functionalisation model background information (easy read version)
- Bed pilot project projection outline. Project to shift acute mental health care provision from hospital to community in South Staffordshire.

<u>Other information (Not SSPCT info)</u>

- Outline Business Case to support the relocation of Mental Health inpatient services in Manchester v006 18 August 2010
- Report to Central Manchester PBC Hub Board (including appendices) 8 September 2010
- Reports to Manchester Overview and Scrutiny Committee presented on the 3 September 2010 and 13 October 2010
- NHS North West terms of reference for NCAT 30 November 2010
- Engagement documents and feedback form (full and summary) on Changing and improving mental health Services in Manchester – information for you 26 November 2010
- Chapter 3 and section 5.44 of the IBP (version 5.0)
- Four tests applied to service change briefing submitted to SHA.
- SHA mental health leads assessment of supporting clinical evidence.

Context and Proposed changes

SSSHFT provide mental health services to the population of South Staffordshire approximately 615,000 people.
Two Crisis Resolution and Home Treatment Teams (CRHTTs) currently exist in South Staffordshire. Although the financial resource available for these teams was less than indicated by national guidance and they also carry the additional role of out of hours cover for Accident and Emergency Departments, they have made a measurable difference to patients' care, particularly in allowing for more speedy response to emergency referrals.

In 2009 the PCT invested a further £792,000 in the crisis and home treatment teams which supported the next step to provide a full and needs led intensive care and treatment to the patient in their own homes and offering an alternative to psychiatric hospital admission. In addition it supports timely discharge from hospital as well as providing a rapid, face-to face holistic assessment service.

In order to support a shift to intensive care and treatment at home rather than in hospital wherever this is clinically viable, the CRHTTs gate keep all potential admissions to psychiatric beds by assessing all patients - including those over the age of 65 years who present with a functional disorder – referred to the service via the CMHT's Single Point of Access (SPA) or directly to CRHTT out of hours – who are considered as potentially requiring admission to hospital.

All individuals who would benefit from intensive care and treatment at home as an alternative to psychiatric hospital treatment are assessed by a team of multi disciplinary professionals in order to initiate a programme of home treatment with frequent visits (typically multiple daily visits, but at least daily in the acute phase).

Home treatment continues until either the acute phase of the condition has passed, the risks reduced, the crisis resolved, the patient's needs are able to be met by less intensive input or hospital admission is recommended.

Intensive care and treatment at home typically does not exceed 6 weeks and, in some cases, the duration required will be a few days as opposed to weeks; however, each individual case is reviewed daily and clinical decisions based on ongoing assessment.

In addition to the expansion of the CRHTTs a structural change in the organisation and delivery of mental health has been instigated, known as 'Functionalisation'. This approach is characterised by:

- Consultant psychiatrists specialising in, either, inpatient, crisis or community roles. Thereby increasing specific expertise, reducing variation in approach by service area and strengthening team working through consistent membership
- Adopting an approach that meets service user needs and is more efficient, for example having daily reviews.

The Trust has had extensive contact with other organisations utilising this model, particularly in the Tees, Esk and Wear, and has learned from their successes and challenges in making this model effective.

Where a hospital admission is recommended by CRHTTs, they ensure a timely Admission and ensure it is focused on the service users needs through completing a 'Purpose of Admission Form' which sets out the treatment goals.

In 2009/10 the PCT and PBC informed SSSHFT of their intention to reduce their contract by £5m over the two financial years 2010/11 and 2011/12.The change in services and financial pressures led to a series of meetings between October 2010 and March2011 with the PBC, PCT and JCU to agree proposals and timescales to implement them.

Part of the agreement was for SSSHFT to run a 6 month bed pilot to temporarily close 12 beds. The aim of the pilot was to test out national research which demonstrated that having community teams who can provide service users with intensive treatment in their own homes can significantly reduce the need for hospital stays and improve service users' experiences. The plan, phased over the 6 month period, proposed a total of 12 reversible bed closures:

- MSC Adult Admission Ward (Burton) – 5 closed beds
- Brocton Adult Admission Ward (Stafford) – 4 closed beds
- Bromley Older People Admission Ward (Stafford) – 1 closed bed
- MSC Older People Admission Ward (Burton) – 2 closed beds

This phased approach took into consideration the development of the service in relation to the enhancement of Home Treatment and also the need to safely build capacity for meaningful Home Treatment for older people presenting with functional disorders.

However, without key aspects of the planned service e.g. Acute Day Services and additional resource from proposed disinvestments for specialised older people input, the full plan for Home Treatment cannot be delivered. The pilot demonstrated the feasibility of running the services with fewer beds, with good service user and GP feedback and no SUI or adverse incidents.

Pre consultation engagement

The draft consultation document has been shared with LINKS and South Staffordshire Network for Mental health for comments. Both have been supportive of the approach PBC/PCT are taking and clear on what is being consulted on.

In addition, LINKs has offered its support in facilitating and participating at the consultation events. Both organisations intend to circulate and promote the consultation.

In line with the notion of savings through bed closures, options were presented in November 2009 to the PCT and JCU. The options presented were:

Option 1 – do nothing

Following options includes redesign inpatient beds and enhance the provision of a Home Treatment service

Option 2 – remove a percentage of beds from each site.

Option 3 – remove beds at the Margaret Stanhope Centre.

Option 4 – remove beds at Margaret Stanhope Centre but to include transfer of four beds to George Bryan Centre, Tamworth.

All 3 sites were considered, however the preferred option agreed by the PCT/JCU was the closure of the 2 wards at the Margaret Stanhope Centre.

This decision was based upon:

- The number of beds at Margaret Stanhope Centre is the best fit in regards to the percentage reduction of beds based on national evidence.
- Closure of wards at St George's and George Bryan site would account for more than is appropriate or safe.
- SSSHFT own the other 2 sites and it is possible to change the buildings on these sites if future needs change. There is a lack of flexibility on the Margaret Stanhope Centre site.
- SSSHFT lease Margaret Stanhope Centre. Therefore additional leasing related savings are possible to be achieved by closing this as opposed to the other sites.

<u>Proposal</u>

The proposal to reduce the number of mental health beds by 25. This is in line with national evidence that delivering a robust home treatment service can free up 30% hospital capacity which would allow for bed reductions.

To achieve this level of savings SSSHFT proposed a number of disinvestments which included the closure of the Margaret Stanhope Centre adult and older mental health inpatient beds (with some reinvestment).

These proposals were submitted and approved by the PCT Board 30 June 2010. It was recognised that further work with stakeholders was required and public consultation.

This proposal will generate £1,491,000 financial savings. There are approximately currently 45.2 wte employed in the Margaret Stanhope Centre. SSSFHT are looking to redeploy staff where possible. Staff consultation cannot begin until the formal consultation has concluded.

Implementation

The plan was to go out to consultation in July 2011 with implementation in October 2011, this has now slipped to proposed consultation in October 2011 and implementation in April 2012.

Discussion and Conclusions

The discussions focused on the clinical need for the reduction in bed numbers with an emphasis on factors that might concern patients, their families, clinicians and commissioners.

Clarity on the Clinical Evidence base

The business case sets out the strategic context and rationale for the proposed reduction in inpatient beds following investment in home treatment and crisis teams.
A number of stakeholders including service users and carers made the point that the inpatient services are part of a care pathway and the community services need to be considered when reviewing the inpatient services. However the business case had little detail on the vision and strategic context for mental health services in South Staffordshire and how the current proposals fitted into this.

SSSHFT has run a 6 month bed pilot, based upon national research. This demonstrated that having community teams who can provide service users with intensive treatment in their own homes can significantly reduce the need for hospital stays and improve service users' experiences.

The SHA as part of its assurance process has undertaken a check on the assumptions behind the number of beds required following the community service investment, length of stay and demand trends. It concluded that the loss of the 25 beds at the Margaret Stanhope Centre would be compensated by the change in services that have occurred.

From my interviews it was clear that there was strong engagement and support from clinicians for the proposals. This was demonstrated in the Functionalisation programme which had required psychiatrists to adopt new roles.

Support from GP commissioners and the PCT

GPs and GP Consortia have been supported by the PCT and SSSHFT to consider the proposals and the collaboration of all organisations have selected the preferred way forward, which is now the subject of the consultation. SSSHFT held a series of disinvestment meetings with Practice Based Commissioning (PBC), PCT and Staffordshire Joint Commissioning Unit (JCU) to agree proposals and timescales to

implement. It was clear from my discussions that the GP community were supportive of the direction of travel and specific proposals. The GPs could be a powerful set of advocates with the secondary care clinicians when the public consultation commences.

Strengthened public and patient engagement

Communication and engagement occurred prior and during the pilot with a broad group of stakeholders.

Through pre-consultation work undertaken over the last 9 to 12 months including the bed reduction pilot the public and service users have been involved. Prior to 2010, work was also undertaken with service users and carers to gain their views of mental health services. This included, in July 2008, SSSHFT undertaking extensive discussions on the 'No delays' project. Both carers' and service users' satisfaction, of the bed reduction pilot, has been consistently positive, indicating acceptability of the service and good individual relationships between the Crisis Resolution Home Treatment Teams (CRHTTs) and both groups. In collating the consultation documents we held meetings with a range of key stakeholders groups to ensure that the approach to consultation is inclusive and that communications are appropriate. Discussions with the following organisations have been undertaken:

- Staffordshire Overview and Scrutiny Committee
- Staffordshire LINk
- South Staffordshire Network for Mental Health
- Carer Association South Staffordshire
- East Staffordshire Racial Equality Council
- Friends of Margaret Stanhope Centre
- SSSHFT plan to redeploy staff where possible and vacancies are being held to accommodate this, but redundancies at this stage cannot be ruled out.

Enhanced patient choice

The Trust has looked at the impact of the changes on patient accessibility. This risk assessment included distance and transport ease between the main urban centres and hospitals. Patients from Burton would likely need to travel to Tamworth some 20 miles but a choice of train and bus is available. Travel to Stafford from Burton is some 30 miles and requires a change on the bus or train

As part of the consultation further work will be undertaken to ensure that the patient choice has been considered and improvements in the patient experience are felt.
Service users clearly understand that there can be trade off between travelling a little further to access a better quality service.

Recommendations

1. The case for the reduction in bed numbers at the Margaret Stanhope Centre is sound and follows significant investment in community services notably the home treatment and crisis service. This pattern of change is consistent with national policy and with good clinical practice.
2. The business case requires a stronger articulation of the vision for mental health services in South Staffordshire and how these proposals fit into that.
3. The case for patient benefit (more support nearer home) can be more clearly articulated so that the benefits and downsides (slightly longer travel time for patients from Burton who are admitted into the inpatient service at Tamworth) can be better weighed up by the public.
4. The strong clinical engagement from both primary care and secondary care should be built on in selling these proposal to the public
5. A robust stakeholder and communication plan should be developed
6. The existing strong partnerships should be built on in taking the proposals forward

Summary

This NCAT visit provides a clinical review of proposed changes to the delivery of mental health services in South Staffordshire and in particular, the proposal to reduce the number of inpatient beds by closing the Margaret Stanhope Centre in Burton.
The proposal is sound and demonstrates some clear clinical, patient and organisational benefits.

On a broader note the case for change needs to be part of a wider vision for mental health services in South Staffordshire that incorporates the whole care pathway including community services.

There is good evidence of support from service users, carers and clinicians with GP commissioners and the PCT.

The proposals meet the four tests as set out in the Department of Health service reconfiguration guidance (Gateway reference 14543).

Appendix 3

Outline of a Methodology for Measuring and Comparative Analyses of In-patient and Domiciliary Mental Health Care Services

Nick Adams, Programme Specialist, Regional Development Centre, NHS West Midlands

1 Introduction

This paper has been written as a presentation of the methodology outlined to both the providers and commissioners of mental health services.

2 Aims of this Methodology

To clearly define the quantitative data and data relationships used to analyse the service capacities and service demands of in-patient and domiciliary mental health services.

To be broadly show how to apply these data and analyses to commissioning and service development intentions

3 Background and Experience Base

The methodology outlined here is based on analyses from the past 7 years of the Acute Care Programme delivered by the Regional Development Centre's (formerly the National Institute for Mental health in England and Care Services Improvement Partnership), particularly in relation to addressing the staffing, performance and cost analysis needs of providers and commissioners of acute in-patient mental health services. The explicit tools that are the components of this methodology are outlined in Appendix 1.

4 Limitations

This methodology does not support quality standards being compromised in the interests of resource issues.

This methodology is dependent upon assumptions, such as length of stay in both hospital and domiciliary services, which should be derived from audits of local activity data taken over a sufficient time period that short term anomalies, such as peaks in admission rates or outlying extreme lengths of stay, can be taken into consideration. Variations in assumed data will produce variations in calculated results. To maintain transparency each of these assumptions should make reference local data in all instances, supported by practice guidance wherever possible, this giving a methodological and local evidence base to calculated results. (The necessary assumptions are listed in Appendix 2).

This paper does not provide any recommended targets or performance indicators.

This paper does not constitute a framework for financial analysis.

Factors not included in this methodology, such as managing the assessed risks of hospital patients and environments and the resource requirements of staff shift patterns are not included in this methodology, (see Appendix 3).

5 Overview

The starting points for the methodology are to define:

1. What is being measured?
2. What unit of measurement should be used?

It is necessary to measure the capacity and the use of both inpatient services and community teams and to compare these in such a way that the effects of any changes in hospital services upon community services can be considered.

Common to both service areas is that all patients require an estimable amount of time to receive an appropriate service; therefore, a unit of measurement has to be applicable to both service areas. Whilst these times vary (and therefore require certain assumptions to be included in calculations, as well as calculations for patients requiring an excessively higher or lower service) we can use "time" as a common measurement across all service settings.

Whilst "an hour" is a universal and consistent unit of time that would require a level of precision that is beyond the scope of available inpatient data, however expressing the time required to deliver an appropriate service to patients in "days" is sufficiently practical and transferable to both service settings as demonstrated below:

5.1 Hospital settings:

At its most basic level, the capacity of an in-patient unit can be expressed as the maximum number of beds available, describing a quantitative aspect of a physical environment (not including workforce), which gives the maximum number of patients to whom a ward can provide a service to at any one time. Typical service descriptions usually extended this measurement to "bed days" to include the dimension of "time", however, this methodology combines three types of "bed days" as well as admission rate and length of stay data.

Potential Bed Days (PBD's)

The capacity of a hospital can be expressed as the number of potential bed days per year calculated as the number of beds multiplied by 365.25 (days per year including Leap years).

Commissioned Bed Days (CBD's)

The amount of service commissioned per year can be expressed as the number of "commissioned bed days" per year calculated as the number of commissioned beds multiplied by 365.25.

Occupied Bed Days (OBD's)

Finally, the number of beds that are actually used can be expressed as "occupied bed days", calculated by the sum total of all patients lengths of stay per year is measured in days.

Average Length of Stay (ALOS)

This approach also supports the calculation of "average length of stay" (measured in days) per admission, based upon annual admission rate. To illustrate:

"Example Ward" has 25 beds, therefore has 9131.25 potential bed days per year, of which "Example PCT" commissions 7305 bed days per year, which is 20 beds.

If the total number of patients of "Example PCT" uses a 6575 inpatient days (typically called "occupied bed days") per year that is only 90% of the level of service that is commissioned. If 6575 "occupied bed days" have been used for 188 admissions in one year then the average length of stay is 35 days (including leave days) per admission. (6575 / 188 = 34.9)

We can see that a "day" is a reasonable unit of measurement for inpatient based services that has PBD's. CBD's and OBD's as sub units. Also we can see that statistical reports that use these measures should include the admission rate and length of stay data.

These are measurements of a service expressed in terms of people and we will see that they apply with equal relevance to domiciliary services.
We can also see that any *changes* in capacity, or the levels of services commissioned or the levels of occupancy can be expressed the resultant length of stay or admission rates.

It is also important to note the following points:
That the admission rate is expressed as the number of actual patients who, depending upon whether the analysis is being applied retrospectively or prospectively, have actually been admitted to hospital, or the number of people for whom there is sufficient capacity to be admitted to hospital.
That the length of stay is the actual duration that a person has spent, or could spend spends as a hospital patient depending upon whether the analysis is being applied retrospectively or prospectively.
Occupancy can be calculated as a proportion of potential bed days, and or commissioned bed days, typically expressed as a percentage.
Even greater descriptive detail can be achieved if the number of "leave days" is accounted for within occupancy data.

5.2 **Domiciliary Services**:

The capacity of a domiciliary team is often expressed as the maximum acceptable caseload size per team - a domiciliary team has no "beds" to use as a discrete unit of measurement.
Such an approach is effectively using a patient as a proxy unit of measurement of capacity expressed as the maximum number of patients each team can provide a service to at any one time. If not adequately defined this proxy measure can be problematic, at best, it requires evidence of how much time is required to deliver an appropriate service to an "average" patient, which is therefore defining the "proxy patient" in units of time, that is, hours or days.

Such proxy measures may be useful in certain purposes but the methodology outlined here uses units of time as a direct measure which can then be used to define an evidence-based proxy measure.

The West Midlands Regional Development Centre has provided some guidance on this in relation to Crisis Resolution Home Treatment Teams where it showed that it is reasonable to assume that, given appropriate circumstances, one patient of a CRHT Team may

require approximately 57 hours of actual contact time, over an average length of stay of 28 days, This 57 hours allows for multiple staff per contacts though does not include travelling or administration in relation to the contact activity).

The WMRDC guidance also broadly shows how to estimate a team's capacity to provide domiciliary care, given that it has other essential time consuming functions, such as assessment, clinical management, communication and record keeping etc., (Appendix 1).

If a CRHT team's capacity to deliver domiciliary care is calculated, expressed as the maximum number of hours available for patient contact per 28 day period, then it is possible to estimate the maximum caseload size of that team expressed as a number of patients, as illustrated below:

> *"Example CRHT Team" has 14 whole time staff and can use up to 55% of their total contacted capacity to deliver domiciliary care. That is "Example CRHT" has a contacted capacity of 1769 hours per four week period on average accounting for annual leave and public holiday entitlements; (1642.5 x 14) / 13 = 1768.8 .*
>
> *If 45% of their capacity is taken by carrying out essential non domiciliary care activities then they have an average of 973 hours per four week period for delivering home treatment; calculated as 1769hours per four week period contracted capacity x 55% available for domiciliary care delivery = 972.9 hours per four week period.*
>
> *At a level of demand of 57 hours per patient per four week period this means that this team can provide that level of home treatment to 17 patients per four week period which is 222 patients per year; calculated as 973 hours per four weeks / 57 hours per patient per four weeks x 13 four week periods per year = 221.9 patients per year .*

5.3 Comparing Hospital Services and Domiciliary Services

The unit of measurement common to both service settings is a patient hour which is aggregated for hospital settings to a patient day. In order to compare the two service settings, for example to show how changes in one setting can lead to effects in another, then an assumption has to be made, based on defensible judgments and data. That assumption is *that a given period of in-patient stay (expressed as days) can be equivalent to a given level of domiciliary care (expressed as hours provided during a length of stay expressed as days),* or vice versa.

On the basis of such an assumption, changes in in-patients service capacities and performance (such as commissioned bed days, occupancy, lengths of stay and admissions rates), can be used to estimate the changes expected in domiciliary service demands and therefore the required performance and capacities of the domiciliary team(s), or vice versa.

Naturally changes in any of the data used, including the assumption that equates in-patient and domiciliary care, would result in changes in any calculated result.

Figure 1 Measuring and Comparing Hospital Services and Domiciliary Services

In-patient Services

Measurement of Service Capacity:
Bed Days
- ↳ Potential Bed Days (days per year)
- ↳ Commissioned Bed Days (days per year)

Measurement of Service Use per Patient:
Length of Stay (days per inpatient episode)
- ↳ Leave Days (accrued leave days per episode)

Measurement of Service Use per Hospital:
Occupied Bed Days (days per year)
- ↳ Leave Bed Days (days per year)

***Descriptive Statistics covering the same Period**:*
- *Average Length of Stay and Standard Deviation (days)*
- *Median Length of Stay (days)*
- *Admission Rate(patients admitted per year)*

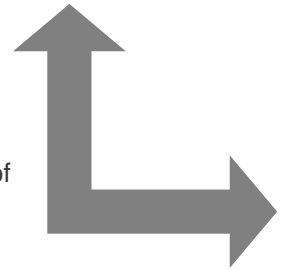
Domiciliary Services

Measurement of Service Capacity:
Commissioned Capacity (hours of workforce per year)
- ↳ Clinical or "service delivery" Capacity (hours of workforce per year)

Measurement of Service Use per Patient:
Length of Stay (days per domiciliary episode)
Staff hours of contact per episode (sum of staff x contact duration per contact)

Measurement of Service Use per Domiciliary Team:
Occupied Bed Days (days per year)
- ↳ Leave Bed Days (days per year)

***Descriptive Statistics covering the same Period**:*
- *Average Length of Stay and Standard Deviation (days)*
- *Median Length of Stay (days)*
- *Admission Rate (patients treated per year)*



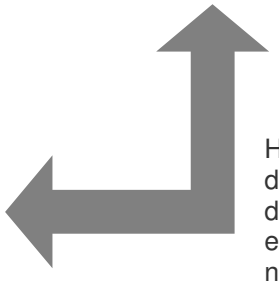
How many days of hospital care are equivalent to a given number of domiciliary care hours days?

Patients Receiving Services

Measurement of service use per patient
Patient Days
- ↳ Patient hours (Domiciliary Services)
- ↳ Bed days (Hospital Services)

Length of Stay (days per hospital or domiciliary episode)

***Descriptive Statistics of service use** include an aggregation of the above for each service plus a count of patients per service per year*



How many hours of domiciliary care delivery are equivalent to a given number of hospital days?

Tools Developed by NMIHE, CSIP and West Midlands Regional Development Centre

1.1 Acute Workload Calculator West Midlands Development Centre 2007

This calculator was development through working with a number of Trusts to estimate their CLINICAL staffing required to deliver care to their clients, based on a set of standardised care activities and other data that are set locally.

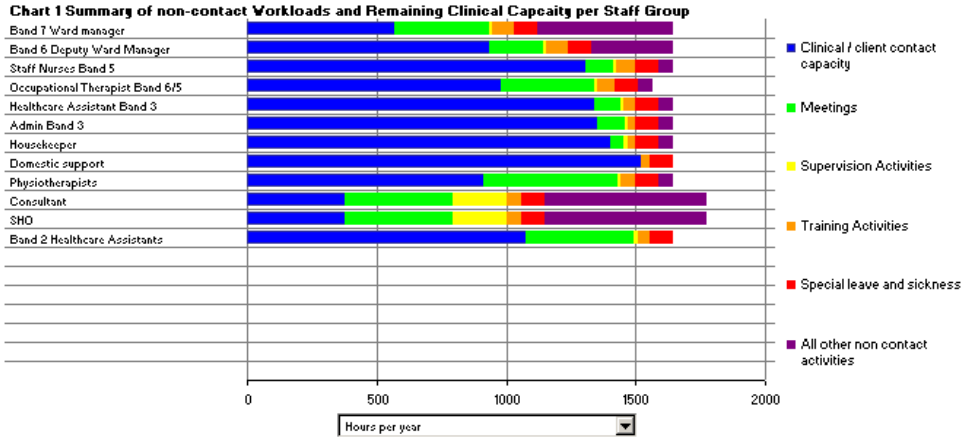
In comparison, traditional "benchmarking" methods we have reviewed included:

1. A Trust comparing its staffing establishment with that of other Trusts who cover a similar demography.
2. A Trust reviewing their own previous workforce budgets as a baseline from which to estimate additional staffing levels.

Admittedly these methods are relatively easier than making an estimate based upon detailed data, but in our view ,the risk of purely comparative "benchmarking" is that workforce plans may be validated against "norms" of workforce levels and may not include workload analyses based on local standards of care delivered to clients. The approach within the Workload Calculator is to base estimated staffing levels on LOCAL data including: Minimum guaranteed care standards, Patient's admissions and discharge rates and lengths of stay, Local HR policy or the Knowledge and Skills Framework that relates staff bands to care activities (matching staff skills to care delivery), The quantitative workforce effects of sickness, essential and mandatory study leaves, and essential non-clinical activities.

Figure 2 Screenshot of the Report Sheet of the Acute Workload Calculator

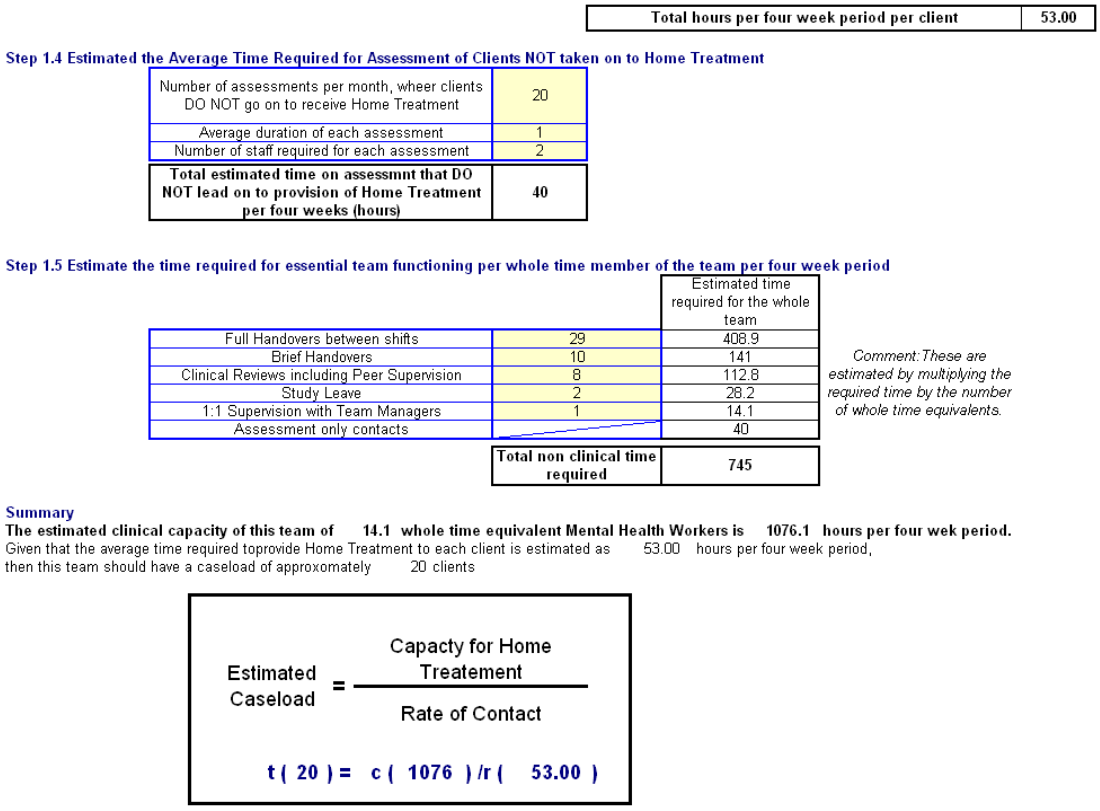
Band 7 Ward manager (0 WTE's).	0 hours per week.	Domestic support (0.2 WTE's).	5.95 hours per week.		0 hours per week.
Band 6 Deputy Ward Manager (1.1 WTE's).	19.83 hours per week.	Physiotherapists (0 WTE's).	0 hours per week.		0 hours per week.
Staff Nurses Band 5 (10.61 WTE's).	266.84 hours per	Consultant (0 WTE's).	0 hours per week.		0 hours per week.
Occupational Therapist Band 6/5 (0.04 WTE's).	0.67 hours per week.	SHO (2.12 WTE's).	15.4 hours per week.		0 hours per week.
Healthcare Assistant Band 3 (8.48 WTE's).	218.09 hours per week.	Band 2 Healthcare Assistants (2.86 WTE's).	53.33 hours per week.		0 hours per week.
Admin Band 3 (0 WTE's).	0 hours per week.		0 hours per week.	**All Staff 25.4 wte's.**	**586.54 hours per week.**
Housekeeper (0.01 WTE's).	0.37 hours per week.		0 hours per week.		



1.2 Acute Services Database West Midlands Development Centre 2009
A modified version of the tried and tested WMRDC "Activity and Outcomes Database"(2008) specifically for Acute Services Can be used by Inpatient, Day care and Home Treatment Acute Teams.

1.3 Framework for Relating Crisis Resolution / Home Treatment teams Capacity to Caseloads West Midlands NIMHE 2004
A framework that demonstrates the relationships between the capacity of a home treatment team and the number of clients that can be served by a team within the scope of the policy implementation guidance. The framework uses a formula "t=c / r", where "t" = trajectory or caseload, "c" = clinical capacity of the team and "r" = the required time for home treatment per client.

Figure 4 Screenshot of the Framework



Total hours per four week period per client	53.00

Step 1.4 Estimated the Average Time Required for Assessment of Clients NOT taken on to Home Treatment

Number of assessments per month, wheer clients DO NOT go on to receive Home Treatment	20
Average duration of each assessment	1
Number of staff required for each assessment	2
Total estimated time on assessmnt that DO NOT lead on to provision of Home Treatment per four weeks (hours)	**40**

Step 1.5 Estimate the time required for essential team functioning per whole time member of the team per four week period

		Estimated time required for the whole team
Full Handovers between shifts	29	406.9
Brief Handovers	10	141
Clinical Reviews including Peer Supervision	8	112.8
Study Leave	2	28.2
1:1 Supervision with Team Managers	1	14.1
Assessment only contacts		40
Total non clinical time required		**745**

Comment: These are estimated by multiplying the required time by the number of whole time equivalents.

Summary
The estimated clinical capacity of this team of 14.1 whole time equivalent Mental Health Workers is 1076.1 hours per four wek period.
Given that the average time required toprovide Home Treatment to each client is estimated as 53.00 hours per four week period,
then this team should have a caseload of approxomately 20 clients

$$\text{Estimated Caseload} = \frac{\text{Capacty for Home Treatement}}{\text{Rate of Contact}}$$

t (20) = c (1076) /r (53.00)

Assumptions

The assumptions which this methodology requires to be made, based upon analysis of local data include the following:

Hospital based services:

- Beds available
- The amount of service commissioned
- The amount of service used
- Admission Rate
- Lengths of Stay

If leave is being considered then accumulated lengths of leave should be included.

Domiciliary Services:

- Workforce data per team including contacted capacity per year accounting for leaves.
- Workloads associated with activities that are not proportionally related to providing patients Home treatment contacts, such as team meetings, supervision, assessments that do not lead to home treatment, etc.)
- Length of stay
- Service intensity provided to patients expressed including the duration of contact time and the number of staff providing actual contacts.
- The number of patients assessed per given period
- The number of patients provided home treatment per given period

Comparing the Service Areas

- How many hours of domiciliary care delivery (such as home treatment) are equivalent to a given number of hospital days, and vice versa.

Other Factors for Consideration in Estimating Staffing Levels for Acute In-patient Wards

In the experience of West Midlands Regional Development Centre, estimating the required staffing level for Acute Inpatient Units requires three analytic approaches, each reflecting the essential requirements of inpatient wards as outlined in national guidance and the Healthcare Commission Review of 2007:

1. Patient Safety – provide an adequate staffing presence on the wards to ensure a defensible level of safety.
2. Ensuring that there is adequate staff to provide the necessary clinical therapeutic activities.
3. Ensure that the combination of staffing on the ward provides the required skill mix to address these activities and to ensure governant management and leadership.

Staffing levels must be sufficient to deliver on all of the above, meaning that the recommended staffing levels will be based on whichever of the three analyses requires the greater staffing level as this will logically include sufficient staff to deliver the remaining two requirements.

1 Patient Safety:

Ensuring patient Safety is not the sole requirement of inpatients wards because therapeutic care *must* be provided, however, estimating the number of staff for this requirements is essential and requires defensible professional judgment rather than a predetermined quota.

Part of ensuring patient safety should include having sufficient staff present on each ward for the purposes of observation, the management of patient's ongoing safety and the management of any incidents or situations that may arise. Any such judgements must consider at least the following:

- The extent to which a physical environment facilitates ease of observation, management of groups of people, egress, communications between staff, responsiveness of staff in emergencies etc.
- The likelihood for incidents that present a hazard to patients, staff and the general public
- The number of staff required to manage any incident that present a hazard
- The skills and competence of staff to be able to ensure acceptable levels of patient safety.

2 Provide the Necessary Therapeutic Activities

The Acute Workload Calculator calculates the workload arising from a delivering a set of care activities to a given number of in-patients and presents the results as "hours of care work per week" for each staff group. It also calculates the available "clinical" or "care" capacity[1] that each staff group has for delivering care after their essential non contact activities such as training, meetings, administration activities, annual leave and sick leave rates have been accounted for. This enables the "hours of care work per week" to be translated into whole time equivalents for each staff group thus showing the number of care staff required to deliver the care activities. Note that this does not include the staffing requirements for ward management, clinical leadership, administration or other activities that are not directly related to delivering patients care

[1] 'Clinical capacity' or 'care' capacity is how much time staff have to actually spend on providing service user's care. Increasing 'clinical capacity' can be supported by "lean initiatives" addressing non-contact activities.

3 Ensuring that the Combination of Staffing on the Ward

This is often addressed through designing a staff rota or shift pattern that includes the range of staff roles and grades across the 24 hours period that appropriately meets the needs of the patients and the service itself.

Data on the required staff presence on a ward per week can be expanded to annual data that can be translated to workforce estimates and costs.

Performance issues that should be considered in this design include:

- Optimum handover periods between shift to ensure safe and governant communications and management.
- Compliance with employment legislation around working hours etc.
- As far as possible co-ordinate the scheduling of activities (workload) with availability of staff (workforce) and vice versa to maximise efficiency.

Appendix 4

Comments on the Use of Evidence for Service Change and Considerations of Changes in Choice in relation to the Closure of Margaret Stanhope Hospital

Nick Adams. Programme Specialist Mental Health, NHS West Midlands

15th June 2011

Introduction

This paper notes the points that were discussed at a meeting with the Mental Health Commissioner for South Staffordshire and I understand that there may be a need to handle some of them sensitively if distributing them, i.e. managing any possible interpretations about the Trust's previous performance of its inpatient beds. My comments are not intended as judgmental of the Trust's performance, rather, they refer to the data presented as evidence of a rational approach to service changes and commissioning.

Of the four areas that NHS West Midlands and local commissioners require evidence based assurance we looked specifically at two:

1. There has been full use of the evidence base for service change by clinical leaders across the continuum of care and
2. Commissioners have properly considered how the proposals affect choice of provider, setting and intervention, making a strong case for the quality of the proposed service and improvements in patient experience.

Summary

In my view there has been:

1. Use of an evidence base for service change by clinical leaders and commissioners, and that this evidence based methodology indicates the need for performance metrics
2. Commissioners and providers proper consideration how the proposals affect choice in relation to re-providing a hospital based service with a modern domiciliary based service.

NHS West Midlands are putting the case to the Operational Management Executive Committee on 20 June 2011 as part of its approval process that the four tests have been met.

General Comments

I acknowledge the significant amount of work that has been done to achieve the support of GP's and their confidence in mental health services, particularly in the eastern part of South Staffordshire, and that the work of the Trust through the Pilot Project was a key part of gaining this support whereby GPs concerns were addressed.

Whilst this GP support is valued we also reviewed the PCT's use of data as part of the evidence base for service change and consideration of the changes to choices and access to services for patients.

The meeting was also helpful to address the points I raised in my earlier email (dated 16 May 2011) about the consultation document.

The use of the evidence base for service change

In the meeting the MH Commissioner described the scope of service developments to include the rationalisation of the Community Mental Health teams for better geographic coverage and better use of their capacity, and the development of the Trust's psychological services. Additionally it was explained that all GP practices now have primary care based mental health services and that day services are being re-modelled to reduce duplication across NHS and Third Sector providers. Whilst these broader service changes should be taken into consideration as part of the general evidence base for service change and addressing choice and access for patients we looked in more detail at the changes in the capacity of the Crisis Resolution Home Treatment Services that provide patients with acute mental illness as an alternative to hospital admission, through 'Gatekeeping' admissions as well as facilitating an earlier discharge of some patients from hospital than may have been possiblr without the support of the CRHT Team.

My earlier point about 'investing £191,00 additional funding into the CRHTTs across South Staffordshire and increasing the number of clinical post' was corrected and I was assured that the MH commissioner had confidence that proper investment had been made, and that from April 2011 the CRHT workforce has increased by 11.6 wte's (from 44.7 wte's to 56.3 wte's).

We also referred to the data that came out of the PCT's supporting analysis on the consultation of proposed bed reductions, particularly the analysis of commissioned and occupied bed days carried separately out for adult inpatients services. The data shows that:

- In the year 2009/ 10 the PCT commissioned 28,277 bed days – which is equivalent to 77 beds, whilst only 26,442 of these days were occupied, equivalent to 72 beds, an under-occupancy equivalent to five beds.
- In the year 2010/11 the PCT commissioned 26,442 bed days (presumably based on the previous year's actual occupancy) which is equivalent to 72 beds, of which 22,373 days were occupied, equivalent to 61 beds, an under-occupancy equivalent to 11 beds.
- In this year 2011/12 the PCT have commissioned 23,507 bed days – equivalent to 64 beds (slightly more than the previous year's occupancy) and forecast that of these only 20,184 bed days will be occupied, equivalent to 55 beds, therefore a forecast under-occupancy equivalent to 11 beds.

The data presented (shown in Appendix 1) suggests that the forecast occupancy for 2011/ 12 is equivalent to 17 beds less than the number of beds actually occupied in 2009/10.

Based upon this data the PCT is applying a rationale that:

'The calculated under occupancy can be offset against the planned reduction of 25 beds, which is the net effect of closing Margaret Stanhope hospital. Applying such an offset means that it would not be necessary to re-provide an acute mental health service equivalent to 25 beds, rather the data suggest the need to re-provide approximately 8 beds.'

This is because the reported under-occupancy is equivalent to approximately 17 beds compared with 2009/10 and that 25-17=8. The service change that is being consulted up on here is an opportunity to address a trend of prior under-occupancy/ over commissioning.

In adopting this approach I would strongly recommend adding a margin of tolerance to reflect that fact that a hospital may not achieve an occupancy of 100% throughout a year and because annual occupancy data can mask real variations in the in-year demand for hospital beds, therefore I suggest that whilst the data shows under occupancy is equivalent to 17 beds this number is not used to rigidly determine the actual number of beds to be re-provided for within this service change.

Instead I suggest that it is accepted that the PCT's forecast occupancy for 2011/ 12 is taken to reflect an occupancy rate of 85% of the 65 beds that the PCT are commissioning for 2011/ 12. I believe it would be unrealistic to expect any ward to be achieving a constant occupancy of 100% for two reasons:

- It may increase the likelihood that 'out of area' placements will be made for those patients who need admission and cannot be provided a bed due to the hospital being 100% occupied, thus leading to a poorer experience for patients
- It may be contributory to the use of patients leave from hospital (which is a normal strategy for planned discharge from hospital) as a way of managing capacity to meet demand whenever a hospital is fully occupied, thus leading to a non-clinical use of leave.

Consequently I would suggest that in adopting this approach the PCT aim to re-provide acute mental health services that are equivalent to 12 beds on the basis that:

1. The Trust is expected to continue an annual occupancy rate between 85% and 96% (though you may define your own local expectation).
2. The difference between the number of beds the PCT commission in 2011/ 12 (65 beds) and the beds commissioned in 2009/ 10 (78 beds) is equivalent to 13 beds to be re-provided for.

To estimate the amount of CRHT that would be broadly required to meet this 12 bed re-provision we looked at the spreadsheet developed by the former West Midlands Regional Development Centre to compare workforce with caseload.

Applying the PCT's data to the WMRDC Tool we can calculate that 12 beds is 4383 bed days per year, which with an average length of stay of 31 days per admission, is equivalent to 142 admissions, or acute mental health episodes per year. For this to be re-provided by a CRHT where each episode requires an average of 53 hours contact time then we can assume that 12 hospital beds, or 4383 bed days could be re-provided by an increase in CRHT Team clinical capacity of 7526 hours per year. This increase in clinical capacity could be provided:

- 9.1 wte's CRHT caseworkers whose contact with clients is not less than 50% of their contracted capacity

Or

- 11.4 wte's CRHT caseworkers whose contact with clients is not less than 40% of their contracted capacity.

Given that the figures the PCT provide for the increase in CRHT show an increase of 11.6 wte's (from 44.7 wte's to 56.3 wte's) then it would appear that the planned increase of CRHT can be assumed sufficient to re-provide the closure of the 25 beds on condition that:

1. The occupancy rate of the remaining beds is in the range of 85% to 95%
2. The baseline period for the CRHT workforce of 11.6 wte's is 2009/10, that is, consistent with the baseline period for hospital occupancy.
3. That the contact with clients of the increased CRHT is not less than 40% of its contracted capacity.
4. That the average inpatients length of stay remains around 31 days per episode.

Limitations

I emphasis that these are assumptions and estimates and no precise predictions can be made, however this does show the use of the evidence base for service change and the activity/ performance data that the PCT should require of the Trust.

How the proposed service changes affect patient choice

We discussed this in some detail too and accepted that the change in choice is affected but that the positives outweigh the negative for patients.

The negative aspect is that for those patients who will require admission to mental health hospital then Margaret Stanhope Hospital will not be available. In our opinion this is outweighed by the wider positive that the increased capacity of CRHT will provide greater opportunity of patients to be looked after in their own homes whilst they are acutely mentally ill, rather than being admitted to hospital, and that of those patients who are admitted to hospital, many will be supported to have a reduced length of stay in hospital, again supported by the increased capacity in CRHT.

Appendix 1 Presented Data on Commissioned and Occupied Beds

Year		**Bed days**	**Beds** (rounded up to whole number)
2009/10	Commissioned Hospital Capacity	28277	78
	Occupied	26442	73
	Balance	-1835	-5
	Annual occupancy as % of commissioned capacity =93.51%.		
Year		**Bed days**	**Beds** (rounded up to whole number)
2010/11	Commissioned Hospital Capacity	26442	73
	Occupied	22373	62
	Balance	-4069	-11
	Annual occupancy as % of commissioned capacity = 84.61%		
Year		**Bed days**	**Beds** (rounded up to whole number)
2011/12	Commissioned Hospital Capacity	23507	65
	Occupied (forecast)	20184	56
	Balance (forecast)	-3323	-9
	Annual occupancy as % of commissioned capacity = 85.86%		

Appendix 5

The following table demonstrates distance and transport

Area	Distance to	Miles	Public Transport
Burton	Tamworth	20 miles	Bus change at Lichfield Train direct
Burton	Stafford	30 miles	Bus change at Lichfield Train 1 change
Uttoxeter	Burton	16 miles	Bus no change Train 1 change
Uttoxeter	Stafford	13 miles	Bus no change Train 1 change