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

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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%		